Newfoundland Labrador

mcp
Medical Care Plan

Medical Payment Schedule

Medical Care Plan
Department of Health & Community Services

October 1, 2019

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

GENERAL PREAMBLE

1. This Payment Schedule identifies the amounts prescribed as payable and rules and conditions of payment under the Physicians and Fee Regulations (Schedule A), governed by the Medical Care Insurance Act for insured services rendered by licensed physicians. The items and fees listed apply to services rendered on and after the “effective date” at the top of each page.

   The amounts published in Payment Schedule are subject to existing payment policies authorized by the Medical Care Plan (MCP).

   Additions, deletions and changes to be made to the Payment Schedule require recommendation by MCP and approval by the Minister of Health and Community Services, in consultation with the Newfoundland and Labrador Medical Association (NLMA).

   Any changes made during the effective life of the Payment Schedule are published in MCP Newsletters when necessary. It is the responsibility of claiming physicians to ensure these changes are reflected in their billings.

2. INTRODUCTION

The Payment Schedule is divided into a number of sections:

- General Preamble
- Appendices
- Visit Premiums
- Consultations and Visits
- Telemedicine
- Critical Care
- Diagnostic and Therapeutic Services
- In-Hospital Diagnostic and Therapeutic Services
- Radiology
- Nuclear Medicine
- Obstetrics
- Anaesthesia for Surgical-Dental Procedures
- Surgical Procedures
- Tables

2.1 General Preamble

This section sets out the general definitions and constituent elements common to all insured services, as well as the specific elements for these services.

2.2 Appendices

This section gives listings referred to within the Preamble. These are:

- Approved Category “A” Facilities – 24-Hour On-Site Emergency Department Coverage
- Approved Category “B” Facilities – Emergency Department Coverage
- **DHCS** Designated Long Term Care Facilities With Long Term Beds
- Immunization of Designated Target Population
- Non-Insured Services List
- Scar Revision
- Hyperbaric Oxygen Therapy

2.3 Visit Premiums

This section lists the rates and conditions for the billing of premium fees associated with special visits.

2.4.1 Consultations and Visits

(a) Visit codes are listed for each of the specialties, beginning with **Family Medicine** followed by a listing for each of the recognized specialty groups. One letter, usually the first letter in each visit code title, is underlined and printed in boldface type, and this letter corresponds to the first letter in the title of the definition/description of the service contained in Section 7 of the Preamble, which is an alphabetical listing.

(b) For specialty groups, rates are listed for referred patients. Specialists treating "walk-in" or "non-referred" patients should bill for services rendered to such patients using the rates for comparable services as listed in the **Family Medicine** Section.

(c) Each Consultation and Visit Section is divided into sub-sections based on the site where the insured service is rendered. Namely:

- Office (or visit to Physician's Residence)
- Home
- **DHCS** Designated Long Term Care Facilities with Long Term Beds
- Hospital In-Patient
- Hospital Out-Patient and Emergency
- Physician on Duty at Designated 24-Hour On-Site Emergency Department (see Appendix "A')
- Hospital Pain Clinic

These sites of insured service delivery are defined and described in the subsequent Definitions of Terms/Conditions Section in this Preamble.

2.4.2 Telemedicine

This section of the Schedule describes the terms and conditions for billing Telemedicine consultations and reassessments, and lists the fees and approved Telemedicine sites.

2.5 Critical Care

This section of the Schedule lists the fees for CPR and the per diem fee payable to the physician-in-charge for ICU/CCU/NICU Care, and for care in the Provincial Perinatal Care Unit.

2.6 Diagnostic and Therapeutic Services

Fees for miscellaneous diagnostic, therapeutic and surgical services are listed in this section.

2.7 In-Hospital Diagnostic and Therapeutic Services

Fees for specific diagnostic and therapeutic services performed in hospital are listed in this section.

2.8 Radiology

This section of the Schedule lists fees and describes conditions for billing of Diagnostic Imaging Services except Nuclear Medicine Services.

2.9 Nuclear Medicine

This section of the Schedule lists fees and describes conditions for the billing of Nuclear Medicine Services.

2.10 Obstetrics

This section of the Schedule is designed for the billing of services related to pregnancy and delivery. Other related services may be found in the Surgical Procedures Section.

2.11 Anaesthesia for Surgical-Dental Procedures

This section of the Schedule lists fees payable for anaesthesia services for surgical-dental procedures.

2.12 Surgical Procedures

The surgical procedures are listed by anatomical system. Under each system the procedures carried out within the system have been grouped under such sub-headings as Incision, Excision, Suture, Repair, etc. Each procedure listed may be located through determination of the anatomical system to which it applies, and the type of procedure performed. This method of listing has no relationship to the specialty which may be engaged in surgery upon this particular system.

Fees for Surgical Assistants, **Family Physicians**, Specialists and Anaesthesiologists may be listed for each procedure. Where no fee is listed for Assistants or Anaesthesiologists, the service must be billed Independent Consideration (IC).

2.13 Tables

Tables are given for convenience when billing:

- I - Anaesthesia Basic Fee Code Rates
- II - Anaesthetic Time Units – Surgical Procedures
- III - Epidural Anaesthesia for Pain Control
- IV - SHV – Subsequent Hospital Visits – Type 2
- V - SHV – Subsequent Hospital Visits – Types 3 and 4
- VI - Units Table for Surgical Assistants – Billing According to Standard Method
- VII - Units Table for **FP** Surgical Assistants – Billing According to Dedicated Time Method

3. INSURED/NON-INSURED SERVICES

3.1 Insured Services

An insured service is defined as one that is:

(a) listed in Section 3 of the Medical Care Insurance Insured Services Regulations;

(b) medically necessary. In a medical audit context, the clinical need of the provision and claim of an insured service may be evaluated by the Medical Consultants' Committee of MCP;

Queries as to the insurability of a specific service should be directed to the Office of the Assistant Director of Medical Services. Regulations with respect to insurability of scar revision are listed in Appendix F.

3.2 Non-Insured Services

The following situations/conditions qualify as non-insured services:

(a) specific services as listed in Section 4 of the Medical Care Insurance Insured Services Regulations or Appendix E of this Preamble,

Queries as to the insurability of a specific service should be directed to the Office of the Assistant Director of **Medical Services**,

(b) services not included in the Preamble Section that describes Common Elements of an Insured Service,

(c) any medical services provided at the request of a third party, or which are covered by other agencies,

(d) medical services provided to patients not insured by MCP or any other provincial Health Care Plan,

(e) services provided as a result of physician solicitation,

Services which are reviewed by the Medical Consultant's Committee (based on claim detail, patterns of practice, physician records and patient evidence) and found to have been rendered as a result of direct solicitation by a physician, and found to be medically inappropriate are not insured by MCP. However, it is recognized that a small percentage of patients who require periodic medical assessment may be incapacitated or otherwise unable to visit their doctor's office. In these instances, where medical necessity can be clearly demonstrated, it is not deemed to represent solicitation.

A physician, who notifies patients who are part of a target population designated by the **DHCS** for immunization that it is time to receive the injection, is not deemed to be "soliciting visits".

A recall program of women for **speculum exams** will not be viewed by MCP as constituting solicitation.

(f) services provided as a result of medical research and experimentation.

Medical and professional services which are research-related or experimental are not insured and are not the financial responsibility of MCP. Only those services related to routine, accepted care of a patient's problem and that are not in support of the research related or experimental services are considered to be insured services.

3.3 Common Elements of Insured Services

Elements that are common to all insured services, and therefore not billable as an additional item to either MCP or the patient, are:

(a) being available to provide follow-up insured services to the patient and making arrangements for coverage when not available,

(b) making any arrangements for appointment(s) for the insured service,

(c) making arrangements for any related assessments, procedures or therapy and/or interpreting results,

(d) obtaining and reviewing information (including history taking) from any appropriate source(s) so as to arrive at any decision(s) made in order to perform the elements of the service, unless stated otherwise,

(e) obtaining consents or delivering written consents,

(f) keeping and maintaining appropriate physician's records,

(g) preparing or submitting documents or records or providing information for use in programs administered by the **DHCS**,

(h) conferring with and/or providing advice, direction, or information to physicians and other health professionals associated with the health and development of the patient. However, **family physicians** who are eligible and registered with the Fee Code Initiative of the Family Practice Renewal Program may bill fee code 520 (Shared Care),

(i) providing premises, equipment, supplies and personnel for the common elements of the service, and

(j) direct physical encounter with the patient including any appropriate physical examination and ongoing monitoring of the patient's condition where indicated, unless specifically listed as a "monitoring only" fee.

4. CLAIM SUBMISSION AND DOCUMENTATION REQUIREMENTS

4.1.1 All service items billed to MCP are the sole responsibility of the physician rendering the service with respect to appropriate documentation and billing.

4.1.2 If a specific fee code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution.

4.1.3 Claims for services rendered in hospitals and long term care facilities must include the hospital/facility number of the institution where the service was rendered.

4.1.4 For all services in the In-Hospital Diagnostic, Radiology and Nuclear Medicine Sections, the date of service is the date the service is reported rather than the date the patient is subject to the procedure. For all other services, date of service is the date of patient contact.

4.1.5 Documentation of services which are to be billed to MCP must be completed before claims for these services are submitted to MCP.

4.1.6 All claims submitted must be verifiable from the physician's records with regard to the examination and/or procedure claimed. Where specific elements of record requirement are listed in this Preamble, but do not appear in the patient record of that service, that element of the service is deemed not to have been rendered and the fee component represented by that element is not payable.

4.1.7 A physician shall, upon request by MCP, make available to MCP copies of patient records as may be required to clarify or verify services for which fees have been claimed.

4.1.8 For MCP Audit purposes, it is required that physicians maintain records supporting services billed to MCP for a period of six years. MCP Audit is routinely two years.

4.2 Minimum Required Documentation for Claims

4.2.1 Consultations

See Section 6.2

4.2.2 Visits

To be claimed as an insured service, the minimum record of a visit must include:

(a) patient identification which includes the patient's name and MCP number,

(b) date of service for which payment is being claimed,

(c) reason for the visit e.g. presenting complaint or other reason for that visit, and

(d) findings through history, physical examination, working diagnoses, and/or plan of investigation or treatment.

4.2.3 Timed Based Services

(a) Where a premium fee is applicable based on the time the service is rendered, the starting time indicator for that service must appear in the patient's record. (For home visits, an approximate time will be sufficient).

(b) Where the fee payable is based on time units, the start and finish times for time unit fees for which payment is being claimed, must be part of the patient record of that service.

4.2.4 Procedures

When a procedural fee is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the fee(s) claimed. For all services listed in the In-Hospital Diagnostic, Radiology, and Nuclear Medicine Sections, the date of service is the date the service is reported rather than the date the patient is subject to the procedure. For all other services, date of service is the date of patient contact.

For additional documentation requirements, refer to the specific codes being claimed.

4.3 Independent Consideration (IC)

4.3.1 Specific services in this Schedule are designated as billable on an IC basis only. Physicians are required to identify claims for these services as IC and to provide additional applicable information, according to instructions in this Schedule or the Physician's Information Manual (PIM).

4.3.2 Services not specifically defined in this Schedule, or for which a set fee is not listed, must be billed IC. For these services an IC claim must include:

(a) the time involved in direct continual attendance with the patient or in performing the procedure claimed, whichever applies,

(b) a list of all examinations and procedures performed which are represented by the claim,

(c) the actual size of lesions removed or laceration repaired, or the area of any defect which was repaired, if applicable,

(d) comparison in scope and difficulty of the procedure with other procedures defined in the Payment Schedule, and

(e) a copy of the operative report along with the actual operating time for complex surgical procedures.

4.3.3 New technology services which are under review by **DHCS** may be billed IC with approval by **DHCS**.

4.4 Use of Provider Number

4.4.1 Claims must be submitted using the Provider Number of the physician who actually rendered or directly supervised the service.

4.4.2 Physicians are required to request prior approval from MCP for all arrangements where payment is to be directed to a designated payee. The claim must indicate a designated payee in the Payee Number Section.

4.5 Time Limitations on Claim Submission

4.5.1 All claims must be submitted within 90 days of the date of service. In exceptional circumstances this time period may be extended as per the MCP Late Claims Policy which is available on the MCP website. A letter giving a full explanation for lateness must be submitted to the Manager of Claims Processing for special consideration.

4.5.2 All queries from MCP must be answered within the times specified on the queries. If no time is specified, a reply must be received within 90 days of the date of query.

4.5.3 All requests for changes to claims and queries on them must be submitted within 90 days after the date of payment for the claims concerned.

5. DEFINITIONS OF TERMS/CONDITIONS

5.1 Site of Insured Visit Services

5.1.1 **Office Visit** – is a service rendered to a patient in a physician's office or home.

5.1.2 **Home Visit –** is a service rendered following travel to a patient's home or normal place of residence.

(a) Patients seen in a nursing home other than one listed in Appendix C, rest home, boarding home or similar setting should be claimed as home visits, with the appropriate home visit fee code being claimed for the first patient seen. Additional patients seen during the same visit should be claimed as extra patients seen.

(b) Visits by **Family Physicians** to residents of **DHCS** designated long term care facilities (see Appendix C) must be claimed using dedicated nursing home visit codes for **Family Medicine**. The home's facility number must be entered on claims for these services.

(c) Patients seen in the same apartment complex: The first person seen should be claimed using the appropriate home visit codes. Other patients seen within the same apartment should be claimed as extra patients seen. A visit to another apartment in the same complex should be claimed as a separate home visit with the same rules applying to additional patients seen.

(d) Visits to two apartments in a private dwelling are regarded as visits to two separate homes and should be claimed accordingly.

5.1.3 **Hospital In-Patient** – is a visit by the physician to a registered hospital in-patient. For claiming purposes, MCP recognizes facilities designated by the **DHCS** as hospitals. The following rules apply regardless of diagnosis and referring physician:

(a) When a patient is admitted to a hospital and the attending physician has not claimed for a major examination of the patient within the previous 30 days, the initial in-patient visit may be claimed as a major examination (i.e. Consultation, General or Specific Assessment) according to the service rendered.

(b) If the attending physician has claimed for a major examination on the patient within the previous 30 days, the initial in-patient visit may only be claimed as a reassessment or lesser visit code.

(c) In the case of in-patients, the attending physician may claim only one major examination (Consultation, General or Specific Assessment, General or Specific Reassessment) per admission except when the patient is transferred to a physician in a different specialty. In such cases, if the physician who attended the patient initially in the admission is requested by the (new) attending physician to see the same patient, they may claim the appropriate examination. A short explanation justifying this service is necessary.

(d) If a physician sees a non-critical patient in the OPD, at home or in the office and admits the patient to hospital on his/her own service, on the same day, only one assessment/ consultation or reassessment for that day's service to the patient is payable.

5.1.4 **Hospital Out-Patient or Emergency Department** - is a visit by the physician to the Out-Patient or Emergency Department of a hospital for the purpose of rendering a service to a beneficiary who is not a registered in-patient of that institution.

5.1.5 **Visits to Other Sites** - Occasionally, based on medical necessity, physicians may be requested to provide insured services to beneficiaries at sites other than the designated sites listed above. There are no visit codes specific to these sites, but the visit may be charged to MCP by claiming a fee commensurate with the service rendered.

5.2 Delegated Procedure

When a procedure(s) is carried out by a physician's employee(s) under the direct supervision of the physician in their office, claim(s) may be made for those procedure(s) which are generally and historically accepted as those which may be carried out by the nurse or other medical assistant in the employ of the physician. "Procedures" in this context do not include such services as assessments, consultations, psychotherapy, etc. Direct supervision requires that, during the procedure, the physician be physically present in the office or clinic at which the service is rendered. While this does not preclude the physician from being otherwise occupied, they must be in personal attendance to ensure that procedures are being performed competently and they must at all times be available immediately to approve, modify or otherwise intervene in a procedure as required in the best interest of the patient.

5.3 Age (unless otherwise specified):

(a) Newborn (neonate) - up to and including 28 days of age,

(b) Infant - 29 days up to but less than 2 years,

(c) Child - 2 years up to and including 15 years,

(d) Adolescent - 16 years up to and including 17 years, and

(e) Adult - 18 years and over.

5.4 Most Responsible Physician

5.4.1 The most responsible physician is the attending physician who is primarily responsible for the day to day care of the patient in hospital. In cases where the consultant assumes the role of the most responsible physician, the consultant may claim Subsequent Hospital Visits (SHVs) and the **family physician** may claim Supportive Care, if applicable.

5.4.2 Where the **family physician** remains the most responsible physician and request only a consultation, the **family physician** may claim SHVs and the consultant may claim a consultation only. Subsequent assessments by the consultant during the same admission may only be claimed as SHVs and must be requested by the attending physician.

5.5 Referral and Transferral

5.5.1 A **referral** takes place when one physician requests for their patient the services of another physician. The services of the latter may consist of:

(a) an opinion (i.e. a consultation),

(b) diagnostic tests or procedures (e.g. skin test, biopsy, etc.), and

(c) treatment (surgical or medical)

5.5.2 A referral also takes place when a primary care physician is not available and a Nurse Practitioner request for his or her patient the services of a specialist physician and it is appropriate to the patient needs and practice setting to do so as described in the Nurse Practitioner Primary Health Care Regulations.

5.5.3 A **transferral**, as distinguished from a referral, takes place where the responsibility for the care of the patient is completely transferred permanently or temporarily, from one physician to another (e.g. where the first physician is leaving temporarily on holidays and is unable to continue to care for the patient).

Transferral to a physician in the same specialty or discipline should be considered as continuing care and the physician to whom the patient is transferred is not entitled to claim for a consultation.

5.5.4 For hospital in-patients, transferral to a physician in the same specialty or discipline should be considered as continuing care and SHV rates are payable as for one period of hospitalization. The visit fee on the date of transfer is payable only to the second physician. In such cases, the physician to whom the patient is transferred is not entitled to claim for a major exam. When a patient is transferred to a physician in another specialty, the patient is deemed to have been referred and the rates payable are as for a new admission. Where the family physician transfers the day-to-day responsibility for the care of the patient to the consultant for a period of time, the consultant should claim on a per diem basis and the family physician should not claim for the period.

5.5.5 Physicians who are substituting for other physicians should consider that patients of the other physician have been temporarily transferred (not referred) to their care. The physician to whom the patient is transferred should be regarded as substituting for the other physician.

5.5.6 When a specialist assesses a non-referred patient, the service should be claimed using the specialist fee code billed at the corresponding **Family Medicine** rate. If there is no equivalent **Family Medicine** code, then the service should be billed at the rate for **Family Medicine** fee code 121. In either case, the claim must be identified as non-referred.

5.6 Team Care in Teaching Units

5.6.1 When a patient is seen in a Clinical Teaching Unit by a member of a medical team consisting of a staff physician (teacher - physician) and resident, intern or clinical clerk, the staff physician may bill for the services rendered subject to the following conditions:

(a) The responsible staff physician must assume full responsibility for the appropriateness and the quality of the services rendered. Claims rendered should be in the name of the responsible staff physician. The billing physician must document, by signing the patient record, that they actually supervised the service that was provided or saw the patient for whom the visit was billed.

(b) In order to claim for physician procedures being carried out by an intern or resident, the responsible staff physician must be in the clinical teaching unit and immediately available to intervene.

(c) In a **family medicine** setting, the staff physician should only claim for visits (except SHVs) on the days when actual supervision of that patient's care takes place through the presence of that staff physician in the clinical teaching unit on that day. This, of course, involves a physical visit to the patient and/or a chart review with detailed discussion with the other member(s) of the health team.

(d) In all other specialties the responsible staff physician must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient.

(e) In psychotherapy, where the presence of the staff physician would distort the psychotherapy milieu, it is appropriate for the staff physician to claim for psychotherapy when a record of the interview is carefully reviewed with the intern or resident and the procedure thus supervised. However, the time charged by the staff physician may not exceed the total time spent by them in both such interview and direct supervision and should not exceed the total time spent by a physician with the patient.

(f) In those situations where on a regular basis a staff member might supervise multiple procedures or services concurrently through the use of other members of the team, the total claims made by the staff physician shall not exceed the amount that the staff physician might make in the absence of the other members of the team.

5.6.2 The fees for services rendered in Clinical Teaching Units shall be those established for the profession as a whole.

6. DEFINITIONS/REQUIREMENTS OF SPECIFIC VISIT CODES-CONSULTATIONS

6.1 General Definition

"Consultation" refers to the situation where licensed physicians or Nurse Practitioners request the opinion of a physician competent to give advice in their field because of the complexity, obscurity or seriousness of the case. Except where otherwise specified, the consultant is required to obtain a complete history and perform a physical examination commensurate with the presenting complaint, review pertinent x-ray films, laboratory or other data, and submit their opinion and recommendations to the referring physician.

6.2 Documentation

The acceptable method of documenting consultations will vary according to the site where the service is rendered:

(a) Office or scheduled OPD clinic consultations must be documented with a written request from the referring physician, a record of the history and physical examination, and a letter back to the referring physician.

(b) For in-patient consultations, the written request, history and physical examination, and reply to the referring physician must be documented on the patient's hospital chart or the official hospital "Consultation Report" form.

(c) For emergency department consultations made at the request of the emergency physician, the written request, history and physical examination, and reply to the referring physician must be documented on the patient's emergency department record or the official hospital "Consultation Report" form.

(d) Emergency department consultations made at the request of a physician who saw the patient in the community or at another facility must be documented with a written request from the referring physician, a record of the history and physical examination, and a written reply to the referring physician.

6.3 General Rules

6.3.1 Subject to Preamble limitations, a consultation fee may be claimed in addition to the fee for surgical, diagnostic or therapeutic procedures performed.

6.3.2 Not more than one major examination (Consultation, General Assessment, or Specific Assessment) per patient per physician may be claimed within a 90-day period except in case of a true emergency on a subsequent occasion. Such claims must be submitted IC clarifying the nature of the emergency.

This rule applies regardless of diagnosis and referral source.

6.3.3 A consultant may claim one major examination for long stay (chronic care) patients, (if requested to see the patient again) every 90 days. All other visits must be claimed as SHVs.

This rule applies regardless of diagnosis and referral source.

6.3.4 If a physician sees a non-critical patient in the OPD, at home or in the office, and admits the patient to hospital on their service, on the same day, only one consult/visit fee for that day's service to the patient is payable.

6.3.5 For in-patient consultative services, when the attending physician maintains day-to-day responsibility for care, and requests only a consultation, the attending physician should claim on a per diem basis and the consultant should charge only a consultation fee. Follow-up visits by the consultant must be requested by the attending physician and claimed only as concurrent care using fee code 360.

6.3.6 A consultation is not to be claimed when:

(a) the patient presents to a consultant's office without the prior knowledge of the primary physician. The sending of a report to the primary physician under these circumstances does not justify a consultation.

(b) the primary physician is not asked for professional advice but is simply asked by the patient for the name of a specialist in a particular field and the patient seeks out the specialist themselves,

(c) consults are a result of hospital policy, or

(d) a patient is assessed by an Anaesthesiologist in an organized pre-anaesthetic clinic, regardless of referral,

(e) a physician is asked to provide surgical assistant's services.

6.3.7 A subsequent consultation requires all of the elements of a full consultation and implies interval care by the primary physician. The situation in which the consultant requests the patient to return for a later examination is not to be claimed as another consultation, regardless of the interval between the earlier examination and the follow up examination. Each consultation claimed must be the result of a new referral. Referral letters solicited by consultants for follow up examinations do not meet the definition or requirements for billing consultations.

6.4 **Major Consultations:** These visit codes are to be claimed when a normal consultation does not recognize the time, effort and complexity involved in the case. The categories and description of Major Consultations are as follows:

6.4.1 **Major Medical Consultation:** This service may only be claimed by specialists in Internal Medicine and Paediatrics and consists of a general assessment of the patient and findings of disorders in three major systems which result in three separate diagnoses requiring investigation and treatment by the consultant.

The minimum time period for major medical consultations (to be claimed as such) is 50 minutes. The start and finish times or duration of the service must be part of the patient record for that service.

A Major Medical Consultation may not be claimed:

(a) when associated with a diagnostic or therapeutic procedure performed by the same physician (e.g. GI endoscopy, cardiac angiography, etc.), except for office ECGs,

(b) when performed as a pre-operative consult rendered within 48 hours of the surgical procedure, and

(c) for pre-arranged patient admission to chronic care facilities.

6.4.2 **Trauma Consultation:** This service may be claimed by specialists in General Surgery, Neurosurgery and Orthopaedic Surgery and consists of evaluation and management of a patient with multiple major systems trauma which requires consultation to other surgical specialties and coordination of the patient's care by the attending surgical specialist.

6.4.3 **Major Surgical Consultation:** This code is to be claimed for services rendered by a surgeon to a patient who is severely ill and whose condition requires a minimum of 50 continuous minutes of attendance for assessment and stabilization.

The start and finish times or duration of the service must be part of the patient record for that service.

6.4.4 **Back Consultation:** This is payable only to Orthopaedic Surgeons for consultative services provided to a patient with a suspected spinal disorder.

6.4.5 **Special Ophthalmology Consultation:** This is payable only to Ophthalmology Specialists. It is applicable to claims for consultative services requested by a Neurologist, Paediatric Neurologist, Neurosurgeon or another Ophthalmologist, where decisions regarding medical or surgical treatment are complicated or require extra consideration, judgment and implementation of specialized knowledge and experience. It also applies to consultative services (and the use of low vision aids) provided to "low vision" patients registered with the CNIB and requiring low vision aids.

The minimum time period for special ophthalmology consultations (to be claimed as such) is 40 minutes. The start and finish times or duration of the service must be part of the patient record for that service.

6.4.6 **Major Neurological Consultation:** This service rendered by a Neurologist shall consist of a detailed assessment of a patient with a complex neurological problem.

The minimum time period for major neurological consultation (to be claimed as such) is 50 minutes. The start and finish times or duration of the service must be part of the patient record for that service.

6.5 **Prenatal Consultation:** This service is payable to a Paediatrician or Neonatologist for a requested consultation on a high-risk fetus between 16 and 32 weeks gestation upon referral from an Obstetrician or Perinatologist. Only one prenatal consult is payable per pregnancy per physician. This code is to be billed using the mother's MCP number. Detention is not payable with this service.

6.6 **Intraoperative Consultation:** This service may be claimed when a consultant is called to the operating room by the operating surgeon to give advice when a case is complicated and/or additional judgement, based on specialized knowledge and experience, is required.

The consultant should review the pertinent history, intraoperative findings, x-ray and laboratory data as necessary, and submit their opinion and recommendations in writing to the referring surgeon.

6.7 Consultations required of Psychiatrists under the Mental Health Act, or by court order, are payable by MCP. The patient record must show that the attending Psychiatrist performed an examination commensurate with needs of the patient.

6.8 **Nuclear Medicine Therapeutic Consultation:** Is only payable when no isotope treatment is carried out. It is intended to recognize evaluation of the patient for whom treatment is found and to be not indicated. To claim this fee the Nuclear Medicine Specialist is required to obtain from the patient a full history of the presenting problem, to perform a full physical examination (General Assessment) of the patient and review laboratory reports with respect to the requested treatment with non-sealed radioisotopes. When the decision is made to not proceed with the requested treatment or with any alternative treatment, a consultation report shall be sent to the physician who requested the isotope treatment, stating all the above findings and giving the basis for the decision to not proceed. This service may be claimed as often as it is medically necessary.

6.9.1 **Diagnostic Radiology Consultation:** A diagnostic radiology consultation applies when insured imaging studies made elsewhere are referred to a Radiologist for his/her written opinion. It is not payable for the reading of insured imaging studies sent for reporting. As well, a consultation does not apply when the insured imaging studies, referred to above, are used for comparison purposes with images made in the consultant's facilities. Claims for consultation must be submitted IC and accompanied by a copy of the referring letter and the Radiologist's report. This service may be claimed as often as it is medically necessary.

6.9.2 **Interventional Radiology Consultation: An Interventional Radiology (IR) Consultation applies when an Interventional Radiologist is requested by a physician or nurse practitioner to assess a patient referred for an interventional radiological procedure which requires extensive discussion with the patient. Examples of such procedures include, but are not limited to, the following: endovascular obliteration of cerebral aneurysms and vascular malformations including pelvic congestion syndrome, embolization of uterine fibroids, percutaneous image guided radiofrequency ablation of solid tumours, trans-arterial chemo embolization. The IR consultation is not payable for the following procedures: simple biopsies or aspirations; the routine task of obtaining consent; or for any procedures where direct interaction with the patient is not warranted. The Interventional Radiologist must give their opinion in writing to the referring physician or nurse practitioner. This opinion must include documentation of the pertinent patient history and physical examination, and a discussion of the risks and limitations of the procedure. The consultation is payable whether or not the Interventional Radiologist actually performs the procedure.**

Billing of an IR Consultation is restricted to those physicians certified by the Royal College of Physicians and Surgeons of Canada in Interventional Radiology. Other Interventional Radiologists may be considered upon request to the Assistant Medical Director.

6.10 **Dermatology Consultation in a DHCS Designated Long Term Care Facility:** This is payable only to Dermatology Specialists. It is applicable to claims for elective consultative services requested by a staff **Family Physician** or Nurse Practitioner on behalf of a patient with a complex dermatological problem. The service is rendered to a resident of a **DHCS** Designated Long Term Care Facility in that facility. **DHCS** Designated Long Term Care Facilities are listed in Appendix C of this Preamble. The facility number must be entered on the claim. The service should be documented on the resident's chart.

Special visit premiums do not apply to elective consultations. Emergency consultations and special visits must be billed using appropriate consultation, visit and premium fee codes.

6.11 **High Risk Perinatal Consultation by Maternal-Fetal Medicine Specialist:** A high risk perinatal consultation is a consultation by a maternal-fetal medicine specialist requiring a minimum of 40 minutes of contact with the patient for the management of a documented significant maternal and/or fetal risk factor(s) where the mother and/or fetus are at significant risk for serious complications during the pregnancy.

The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

A regular consult would still apply in cases where:

1. the condition does not pose a significant risk for pregnancy (for example, the patient is referred for hypothyroidism, but upon seeing the patient she is no longer hypothyroid or is well controlled on meds.)

   OR

2. the maternal-fetal medicine specialist spends less than 40 minutes in contact with the patient. This may occur where the significant risk does not require 40 minutes for the consult (for example, a woman referred for advanced maternal age and who has no other complications would not usually require a 40 minute consult.)

6.12 **According to MCP policy, eligibility for billing consultations is restricted to those Family Physicians belonging to one or more of the following categories:**

(a) those having additional expertise, obtained via formal training;

(b) those asked, in the absence of an appropriate specialist, to see a patient whose illness is so severe and/or complex that assessment by a second physician is deemed medically necessary;

(c) those practicing full time in a specialty where the consultation is in reference to a medical problem appropriate to that specialty;

(d) those who receive a referral from a specialist requesting **family medicine** expertise;

(e) Palliative Care Unit physicians asked to assess patients' suitability for admission to the PCU;

(f) Miller Centre Physicians asked to assess patients' suitability for admission to the Rehabilitation Unit.

(g) **those prescribing methadone or suboxone for opioid dependence.**

6.13 **Psychiatry Emergency Department Consultation:** This service may only be claimed by Psychiatrists and consists of unscheduled evaluation and management of a patient with an acute mental health crisis. This fee code can only be claimed when a patient is assessed in a hospital emergency department on an urgent basis.

7. DEFINITIONS/REQUIREMENTS OF VISIT CODES OTHER THAN CONSULTATIONS

This section contains definitions and/or descriptions of services which are listed in the Consultations and Visits Section of the Payment Schedule. In order to facilitate location, the services are arranged alphabetically according to the letter which is printed in boldface type and underlined in the Consultations and Visits Section.

Unless otherwise stated, the term visit used in this Schedule means each separate and distinct time a physician provides services to a patient in a given day. To be recorded as separate visits, multiple services provided to a patient may not be initiated by the physician, or may not be a continuation of a service which began earlier in the day. An example of continuation of services is the time spent with a patient to review x-ray or laboratory results ordered during an examination of the patient earlier in the day. If the patient initiates the second and subsequent visit(s) or the physician is requested to attend the patient by hospital or nursing home staff based on medical necessity, additional visits and/or premiums may be claimed.

7.1 Add-on Fee for Scheduled After Hours Family Medicine Clinics

(a) Fee code 139 can be billed by **Family Physicians** who see patients in regular scheduled clinics between the hours of 6:00 p.m. and midnight on weekdays, on weekends, or on MCP Statutory Holidays. It can be billed in addition to **Family Medicine** fee codes 101, 111, 112, 114, 118, 121, 122, 123, 124, 126, 131, 132 and 136. It is not payable with any other codes;

(b) Fee Code 139 is not payable when special visit codes either 50, 52 or 53 are claimed;

(c) To document this code for services rendered on weekdays between 6:00 p.m. and midnight, the start time for the patient encounter must be entered on the record of service for the associated visit code. For weekends and MCP Statutory Holidays, the date of service is sufficient.

7.2 Attendance at High Risk Delivery

This service may be claimed by a Paediatrician (or by a **FP** in the absence of a Paediatrician) who is requested by the attending physician to care for the newborn at a high risk operative delivery. In cases of multiple births, 100% is payable for each additional infant being managed by the same physician. Where Preamble requirements are met, claims for consultation and/or assisting at an operative delivery may be payable in addition.

7.3 Case Consultation

This service may be claimed by Psychiatrists who consult with a child welfare or correctional worker, teacher, community health nurse, or other allied professional, in person, on behalf of a child or adolescent.

7.4 Chronic and Convalescent Care

The physician shall be remunerated for this care on a per visit basis with a maximum of one visit every five days. If the patient is seen for the first time on admission, a general or specific assessment may apply in addition to the above fees. In acute illnesses requiring special visits, premiums also apply in addition to fees allowable under the above formula.

7.5 Complex Assessment

A Complex Assessment is payable to physicians when they are providing dedicated On-Site Emergency Department Coverage at designated hospital facilities listed in Appendix A. The following services qualify for claiming a Complex Assessment:

(a) Evaluation of a new or existing medical condition that necessitates a detailed medical history, review of previous medical records and necessary physical examination of three or more organ systems. It may include a review of diagnostic tests and the initiation of appropriate therapy/treatment. For the purposes of claiming this code the organ systems are defined as: cardiovascular, respiratory, digestive, genitourinary, musculoskeletal, hemolymphatic, integumentary, nervous, ears-nose-throat, ophthalmic and mental.

OR

(b) Prolonged observation and/or continuous therapy and multiple reassessments (not including discharge assessment) of patients whose illness requires it. Please note that payment for the discharge assessment is included in the complex assessment fee and is not billable in addition.

OR

(c) Management of patients presenting with life or limb threatening illness or injury that requires immediate evaluation and/or intervention and/or emergent treatment by the physician.

7.6 Chronic Disease Management

Chronic Disease Management can be claimed when a **family physician** sees a patient under the age of 75 years, in the office setting, for a minimum of 15 minutes where the principle reason for the visit is management of one or more documented chronic conditions that require complex care. Other conditions may be dealt with during the same encounter but no other visit fee can be claimed.

The patient record for Chronic Disease Management must include the actual start and end times for the encounter. The patient record must also meet the minimum documentation requirements for visits as described previously in this General Preamble.

The chronic conditions that qualify for billing Chronic Disease Management and the applicable diagnostic codes are:

Chronic Diseases	**Applicable Diagnosis Codes**
Chronic Obstructive Lung Disease	491, 492, 493, 494, 495, 496
Cancer	140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 170, 171, 172, 173, 174, 175, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208
Inflammatory Bowel Disease	555, 556
Chronic Kidney Disease	581, 582, 583, 585, 587, 589
Chronic Liver Disease	571
Congestive Heart Failure/Cardiomyopathy	425, 428
Diabetes	250

Mental Health	290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319
Chronic Neurological Disease	138, 330, 331, 332, 333, 334, 335, 336, 337, 340, 341, 342, 343, 344, 345, 741
Ischemic Heart Disease	412, 413, 414
Cerebral Vascular Accident/Trans Ischemic Attack (CVA/TIA)	435, 436, 437, 438
Complex Chronic Infection	010, 011, 012, 013, 014, 015, 016, 017, 018, 030, 031, 046, 070, 084, 087, 090, 091, 092, 093, 094, 095, 096, 097, 137
Chronic Immune Deficiency (includes HIV)	279
Chronic Pain	307
Complex Endocrine Disease	243, 252, 253, 254, 255, 258
Connective Tissue Disorder	710, 711, 713, 714, 720, 725
Peripheral Vascular Disease (PVD)	441, 442, 443

7.7 Concurrent Care

7.7.1 This refers to the clinical situation where care by more than one physician is required for a hospital in-patient. Concurrent Care must be verifiable as having been requested by the attending physician. The documentation requirements for Concurrent Care are the minimum documentation requirements for visits as described in this Preamble.

7.7.2 Concurrent Care of a registered hospital in-patient is an assessment by a consultant following the consultant's first major assessment. The attending physician continues to be responsible for ongoing care but requests Concurrent Care by the consultant. Concurrent Care in settings other than ICU, NICU or CCU must be billed using fee code 360.

7.7.3 Concurrent Care for a patient in an ICU, NICU or CCU must be billed using fee code 51790. Concurrent Care visits made on multiple days should be billed as multiple units of fee code 51790. The date the final visit was made should be used as the date of service for claiming purposes.

7.7.4 When a non-IOP surgical procedure is performed on an in-patient by a physician other than the attending physician, the fee payable includes post-operative care for 14 days in hospital. In this case, the patient is considered to have been transferred to the care of the operating physician and the attending physician may not continue to claim for daily care unless the need for such Concurrent Care can be verified. The claim must be billed as fee code 360.

7.8 Detention

7.8.1 Detention may be charged in addition to a visit when the physician is required to spend extra time in continuous active bedside treatment of a seriously ill patient to the exclusion of all other work, except as noted below.

7.8.2 Detention is not payable for:

(a) usual preoperative or postoperative care by the operating surgeon,

(b) the same physician in addition to fees for ICU, CCU and NICU care for the same day unless so specified elsewhere in this Payment Schedule,

(c) procedural fee codes or in lieu of procedural fees, and

(d) time spent waiting for x-rays, lab reports, the operating room, patient arrival or for patient transfer to another facility.

7.8.3 Claims for detention must be billed IC and include information as to the nature of the patient's condition requiring physician presence, actual time spent in continuous attendance and a brief description of the service(s) rendered.

7.8.4 Formula for the Claiming of Detention:

(a) A unit of detention time is a completed 15-minute period. The start and finish times for detention must be part of the patient record of the service.

(b) All claims for detention must be accompanied by a claim for the preceding visit with the exception of Critical Escorts.

(c) For specialists' claims, the following times are considered to have been taken up with the visit code claimed:

(i) Partial Assessment, Complex Assessment, Subsequent Hospital Visit - first 30 minutes of the service time,

(ii) General Reassessment, Specific Reassessment - first 40 minutes, and

(iii) Consultation (any type), General Assessment, Specific Assessment - first 60 minutes.

(d) For **Family Physicians'** claims, detention time units are calculated beginning at the time the patient encounter commences.

7.9 Escort of a Critically Ill Patient

7.9.1 Claims for this visit code must reflect the time in actual transit with the patient using the code listed for the service in the "Hospital Out-Patient and Emergency" Section for each specialty. Fee code 482 should be billed regardless of the point of origin or destination of the escort.

7.9.2 All Claims must be submitted IC and should include:

(a) the actual start and finish time for the in-transit period (finish time is defined by the time the patient is transferred to the care of a physician willing to accept responsibility of the patient), and

(b) the critical nature of the illness requiring physician presence.

7.9.3 A minimum of one unit should be claimed for any escort. Additional units may be claimed for each completed 15-minute period after the first 15 minutes.

7.10 Family Medicine Counselling

Family Medicine Counselling may be billed in addition to an office-based partial assessment when, due to the complexity of the patient problem or situation, a *prolonged* educational

dialogue is required. This prolonged educational dialogue occurs between a family physician and a beneficiary with complex health needs or the person(s) most responsible for the care of an infirm or dependent beneficiary with complex health needs. The intent of this service is to develop awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and information in respect of diagnosis, treatment, health maintenance, and prevention.

7.10.1 The minimum time period for Family Medicine Counselling (to be claimed as such) is 15 minutes. Claims for one or more units of Family Medicine Counselling should reflect the following requirements of actual documented time spent counselling the beneficiary or person(s) most responsible for the care of the beneficiary.

1 unit – 15 to 29 minutes
2 units – 30 to 44 minutes
3 units – 45 to 59 minutes
4 units – 60 to 74 minutes
5 units – 75 to 89 minutes, and so on

7.10.2 There is a limit of 125 total units of Family Medicine Counselling per family physician per year.

7.10.3 The patient record must meet the minimum documentation requirements for a partial assessment of the beneficiary as previously described in the preamble.

7.10.4 Start and end times for Family Medicine Counselling must be recorded in the patient record for that service.

7.10.5 The diagnostic code submitted on the claim for the partial assessment must match that of Family Medicine Counselling.

7.10.6 When Family Medicine Counselling is provided to the person(s) most responsible for the care of an infirm or dependent beneficiary, both the partial assessment and Family Medicine Counselling claims must be submitted under the MCP number of the infirm or dependent beneficiary presenting for the partial assessment.

7.11 General Assessments

7.11.1 A General Assessment shall consist of a full history, an enquiry into, and an examination of all systems.

Note:
The "clinical need" for a General Assessment rather than a Partial Assessment is also reviewed by the MCP Consultant's Committee and such relevant notation should also be included in the patient's record.

7.11.2 For billing purposes, an appropriate record of a General Assessment shall contain information which highlights, at least the positive and significant negative findings for the past history, the functional enquiry and the physical examination. The patient record must show the findings with respect to the cardiovascular, respiratory, and digestive systems and also the findings for at least two of the following systems: genitourinary, musculoskeletal, hemolymphatic, ear-nose-throat, integumentary and nervous systems (central and peripheral).

7.11.3 Provided preamble requirements are met, a General Assessment can be claimed:

(a) for the first ever visit for the purpose of initiating the use of the birth control pill.

(b) when a physician admits a patient to hospital and performs the admission history and physical examination of all systems.

(c) for evaluation of a patient whose acute condition(s) is/are such that based on signs and symptoms, examination of all systems is medically necessary.

7.11.4 A General Assessment is payable for annual and admission General Assessments rendered to residents of **DHCS** designated long-term care facilities listed in Appendix C (fee code 285) and to all other nursing home residents (fee code 210) who require level 2 or 3 care subject to the following conditions:

(a) only one is payable per nursing home resident per year,

(c) no other home visit or premium is payable in addition for the same visit to the same resident,

(c) where applicable, the first patient seen may be claimed as an elective home visit (visit code 246 or 286), rather than as a General Assessment, and

(d) extra residents seen in addition to the first patient and residents who required admission or annual General Assessments should be claimed using code 252 or code 292.

7.11.5 **A General Assessment cannot be claimed:**

(a) by physicians when they are providing dedicated on-site Emergency Department coverage at designated hospital facilities listed in Appendix A.

(b) solely because a patient presents for assessment 90 or more days after a general assessment was previously performed.

(c) for screening of patients with chronic disease(s) who do not have acute signs or symptoms involving all the body systems.

7.11.6 Not more than one major examination (Consultation, General Assessment, or Specific Assessment) per patient per physician may be claimed within a 90-day period regardless of diagnosis and referral source, except in case of true emergency. Such claims must be submitted IC clarifying the nature of the emergency.

7.12 General Reassessment

A General Reassessment shall consist of the same services, terms and conditions and record keeping as a General Assessment except that the service is rendered within 90 days of the previous General Assessment or Consultation.

Not more than one General Reassessment per patient per physician may be billed within a 60-day period, regardless of diagnosis and referral source.

A General Reassessment cannot be claimed by physicians when they are providing dedicated on-site Emergency Department coverage at designated hospital facilities listed in Appendix A.

7.13 Geriatric Surcharge for Internists

Specialists and sub-specialists in Internal Medicine may claim a fee in addition to applicable consultation, assessment, reassessment, detention, critical care, and escort codes for patients 65 years of age and older (codes 190, 290, 390, or 490). These codes cannot be billed in addition to codes for SHVs, diagnostic and therapeutic procedures, in-hospital diagnostic procedures, and surgical procedures.

7.14 High Risk Prenatal Assessment

A high risk prenatal assessment is an assessment by a maternal-fetal medicine specialist requiring a minimum of 20 minutes in direct contact with the patient for the management of a documented significant maternal and/or fetal risk factor(s) where the mother and/or fetus are at significant risk for serious complications during the pregnancy. The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

7.15 Home Visits by Family Physicians

7.15.1 An **Elective Home Visit** rendered by a **Family Physician** is a visit to a patient's home or normal place of residence which is initiated by the physician in the management of known illness. The fee for elective home visits is the same regardless of the time that the service is rendered, or the type of service provided.

7.15.2 A **Non-Elective Home Visit** rendered by a **Family Physician** is a visit that is requested by the patient or by the patient's attendant and which is made by the physician on the same day. The fee payable for a non-elective home visit is determined by the time or day that the service is rendered. The time of service must be documented on the record for the visit.

7.15.3 For **Extra Patient(s) Seen**, only fee code 252 or 292 as applicable may be claimed.

7.16 In-Patient Surcharges

7.16.1 Fee code 355 may be claimed by **Family Physicians** providing continuing care of hospital in-patients. It is payable during the first seven days of an admission on a per diem basis. It can be billed in addition to the applicable admission assessment code, or SHV code, and code 359.

7.16.2 Fee code 359 may be claimed by **Family Physicians** providing continuing care of hospital in-patients. It is payable once during a period of admission on the day the patient is discharged from hospital. It can be billed in addition to the applicable SHV code and code 355. The billing physician is responsible for preparing the discharge summary, the discharge prescriptions and follow up care as necessary.

7.16.3 Fee code 359 may be claimed by Internal Medicine Specialists and Sub-specialists providing continuing care of hospital in-patients. It is payable once during a period of admission on the day the patient is discharged from hospital. It can be billed in addition to the applicable SHV code. The billing physician is responsible for preparing the discharge summary, the discharge prescriptions and follow up care as necessary.

7.16.4 Fee codes 352 and 353 may be claimed by Psychiatrists providing continuing care of hospital in-patients as the attending physician. Fee code 352 is payable during days 1 to 14 of an admission on a per diem basis. It can be billed in addition to the admission assessment code, or codes 356 and 359. Fee code 353 is payable during days 15 to 28 on a per diem basis and can be billed in addition to codes 356 and 359.

7.16.5 Fee code 359 may only be claimed by Psychiatrists providing continuing care of hospital in-patients as the attending physician. It is payable once during a period of admission on the day the patient is discharged from hospital. It can be billed in addition to the applicable SHV code. It can be billed in addition to fee code 352 or 353 if applicable. The billing physician is responsible for:

- preparing the discharge summary at the time of discharge and forwarding a copy to the patient's **family physician.** The discharge summary must include:
    - psychiatric diagnosis;
    - medical diagnosis;
    - medication recommendations including:
        - list of medication trials including reasons for discontinuing (i.e. intolerances, allergies, etc.);
        - current medications including recommendation for dosage adjustment and duration of treatment;
        - monitoring that will be required while taking specific medications; and
        - any cautions regarding medications.
    - relevant risk management recommendations (i.e. suicide, psychosis, driving, urine drug screening, etc.); and
    - relevant information from other mental health services to include:
        - interventions utilized;
        - ongoing psycho-social needs; and
        - follow-up required with mental health services.
- providing information and advice to the patient or patient's representative on matters related to the patient's diagnosis/care; and
- arranging follow up care as necessary.

7.17 Interviews

In specific clinical settings, interviews are insured services and may be claimed using the appropriate visit code and the patient's MCP number. Eligibility of claiming for these services is limited to the following specialties:

- Developmental Neurology*
- Paediatrics
- Developmental Paediatrics*
- Physiatry*
- Psychiatry*

*Where the fee payable for interviews is based on time units, the start and finish times of the interview for which payment is being claimed must be part of the patient record of that service.

7.18 Newborn Baby Care

7.18.1 This is the routine in-hospital care of a well-baby for up to 10 days following delivery. This service should include a complete physical examination of the baby and necessary instructions to the mother.

7.18.2 For care of a sick newborn, the appropriate visit codes should be claimed.

7.19 Partial Assessment

7.19.1 This shall consist of the necessary history, an enquiry concerning and the necessary examination of the affected part, region or system. This includes visits for following the progress of treatment and initial visits wherein the patient's condition does not clinically warrant a General Assessment/ Reassessment, or a Specific Assessment/Reassessment.

7.19.2 Follow-up visits for monitoring the use of birth control pills qualify as Partial Assessments, with or without fee code 54614, depending on the nature of the examination performed.

7.19.3 A visit for a requested **speculum exam** and/or breast examination, without other significant medical complaints or illness, qualifies as a Partial Assessment, with or without fee code 54614, depending upon the nature of the examination performed.

7.20 Partial Assessment of a Patient who is 65 to 74 Years of Age

This is a Partial Assessment of a patient who is 65 to 74 years of age.

7.21 Partial Assessment of a Patient who is 75 Years of Age and Older

This is a Partial Assessment of a patient who is 75 years of age and older.

7.22 Partial Assessment of a Patient Who Received a WHSCC Service during the Same Office Visit

This applies when a physician performs a Partial Assessment of a patient for an MCP insured problem(s) immediately before or after examination/treatment of a problem covered by the WHSCC during the same office visit. This fee code (126) is only billable for non-WHSCC, MCP insured services and should only be billed to MCP.

If the service provided is more extensive than a Partial Assessment (e.g. a General Assessment or Reassessment, Psychotherapy), it should be billed IC giving the reason(s) why a more extensive examination was necessary.

7.23 Physiatric Management

This applies to Physiatrists regulating the day-to-day management of patients, when medical necessity requires prescription development, advice and supervision. It may be billed on the days when rehabilitation services are provided to patients seen previously be the Physiatrist for consultation or assessment. This fee is not meant as an administrative fee for supervising a department of rehabilitation nor is it to be charged on the same day as claims are made for any other services which are provided by the Physiatrist to the same patient. It applies only to those patients who require and receive frequent attention by the physician during the course of rehabilitation with regard to rehabilitative services of physician and occupational therapy, speech therapy or discharge planning.

7.24 Pre-Anaesthetic Clinic Assessment

7.24.1 Fee code 409 is applicable for patients assessed by Anaesthesiologists in organized pre-anaesthetic clinics prior to surgery, including day surgery.

7.24.2 Consultation fee codes may not be claimed by an Anaesthesiologist in respect of patients assessed in an organized pre-anaesthetic clinic, regardless of referral.

7.24.3 This visit code is not payable in addition to another consultation or assessment performed by the same Anaesthesiologist prior to surgery.

7.25 Pre-Dental General Assessment

This service shall consist of examination and documentation as is required for patients undergoing a general anaesthetic for surgical dental procedures only.

Family Physicians may also bill this code for examination and documentation as is required for:

i) children and adolescents undergoing diagnostic imaging studies under conscious sedation and:

ii) patients undergoing a general anaesthetic for ECT.

7.26 Psychiatric Care

7.26.1 This service is any form of assessment and treatment by a Psychiatrist for mental illness, behavioural maladaptation and/or other problems that are assumed to be of an emotional nature, in which there is consideration of, and alteration of the patient's biological and psychosocial functioning.

7.26.2 Charges for hospital visits, home or office fees do not apply on a day when ECT or Psychiatric Care is charged (same diagnosis, same physician).

7.26.3 Psychiatric Care is not payable on the same day as ECT.

7.26.4 Rules for the Claiming of Psychiatric Care

The minimum time period for Psychiatric Care (to be claimed as such) is 15 minutes. Claims for one or more units of Psychiatric Care should be made reflecting the following requirements of actual documented time spent with the patient.

Individual
1 unit – 15 to 44 minutes
2 units – 45 to 74 minutes
3 units – 75 to 104 minutes
4 units – 105 to 134 minutes
5 units – 135 to 164 minutes, and so on

7.27 Psychiatric Day Care

This service may be claimed by Psychiatrists for visits to patients who are seen in a Psychiatry Day Care setting. It is not a per diem rate and may only be billed for a patient with whom an actual exchange took place during that visit.

7.28 Psychotherapy

7.28.1 For purposes of being an MCP-insured service, psychotherapy is defined as the treatment of mental illness, behavioural maladaptions, and/or other problems that are of an emotional nature, in which a physician deliberately establishes a professional relationship with a patient for the purpose of removing, modifying, or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and/or promoting positive personality growth and development.

7.28.2 Psychotherapy may only be claimed when the physician purposefully undertakes to treat the patient's emotional problem and that undertaking must be reflected in both the patient's record and the diagnostic code used on the claim. The patient's record must also include a note of the actual time spent as "psychotherapy" during that visit.

7.28.3 Counselling of a patient with a complex non-psychiatric illness is included in the visit fee and should not be claimed as psychotherapy. Marital and family counselling may be claimed as psychotherapy.

7.28.4 Charges for hospital visits, home or office fees do not apply on a day when ECT or individual psychotherapy is charged (same diagnosis, same physician).

7.28.5 Psychotherapy is not payable on the same day as ECT.

7.28.6 The minimum time period for psychotherapy (to be claimed as such) is 15 minutes. Claims for one or more units of psychotherapy should be made reflecting the following requirements of actual documented time spent with the patient.

Individual	Group
1 unit – 15 to 44 minutes	1 unit – 30 to 89 minutes
2 units – 45 to 74 minutes	2 units – 90 to 149 minutes
3 units – 75 to 104 minutes	3 units – 150 to 209 minutes
4 units – 105 to 134 minutes	4 units – 210 to 269 minutes
5 units – 135 to 164 minutes, and so on	5 units – 270 to 329 minutes, and so on

7.29 Routine Post-Operative Care by Family Physicians

Fee codes 118 and 418 must be claimed by **Family Physicians** who provide routine post-operative care to patients during the 42-day post-operative period.

7.30 Sexual Assault Assessment

7.30.1 This comprehensive assessment is performed for the investigation of alleged sexual assault using a sexual assault examination kit.

7.30.2 A provider cannot bill any other consultation or visit code in association with a sexual assault examination.

7.31 Specific Assessment

7.31.1 This shall consist of a full history of the presenting complaint, enquiry concerning, and detailed examination of the affected part, region or system as needed to make a diagnosis, exclude disease and/or assess function and advice to the patient.

7.31.2 Not more than one major examination (Consultation, General Assessment, or Specific Assessment) per patient per physician may be claimed within a 90-day period regardless of diagnosis and referring source, except in cases of true emergency. Such claims must be submitted IC clarifying the nature of the emergency.

7.32 Specific Reassessment

7.32.1 This shall consist of a full relevant history and examination of one or more systems of a patient not requiring a comprehensive evaluation of the patient as a whole.

7.32.2 Specific Reassessments apply in the ongoing management and assessment of disease and for following the progress of treatment.

7.32.3 The second and subsequent Specific Assessments on a patient within each 90 days should be claimed as Specific Reassessments.

7.32.4 Follow-up visits for monitoring the use of birth control pills qualify as Specific Reassessments, with or without fee code 54614, depending on the nature of the examination performed.

7.32.5 A visit for a requested **speculum exam** and/or breast examination, without other significant medical complaints or illness, qualifies as a Specific Reassessment, with or without fee code 54614, depending upon the nature of the examination performed.

7.32.6 An Anaesthesiologist may claim a specific reassessment for patient visits for the management of post-operative obstructive sleep apnea where the billing physician is not also claiming per diem fees and/or non-IOP procedural fees. A maximum of one specific reassessment may be claimed for this purpose per patient per period of admission.

7.33 Specific Neurocognitive Assessment

7.33.1 This is an assessment of neurocognitive function rendered personally by a psychiatrist where all of the following requirements are met:

a) This assessment involves testing memory, attention, language, visuospatial function and executive function. While administration of the Mini-Mental State Examination ("Folstein") would not be eligible for billing a specific neurocognitive assessment, examples of eligible neurocognitive assessment batteries for billing this service include the short form of the Behavioral Neurology Assessment (BNA) or the Dementia Rating Scale (DRS).

b) This assessment must take a minimum of 20 consecutive or non-consecutive minutes. This time must be dedicated exclusively to assessing neurocognitive

function but may include test administration and scoring as long as all components are completed on the same day.

7.33.2 Start and stop times must be recorded in the record of service.

7.34 Subsequent Hospital Visits (SHVs)

SHVs may be claimed for continuing care of hospital in-patients by attending physicians. These visits are payable on a per diem basis and may only be claimed once for each patient day regardless of the number of actual visits to a patient on any one day. Information on the patient's hospital chart satisfies documentation requirements for SHVs. Premiums for any additional "Special Visits" as defined in this Preamble may be applicable.

7.35 Supportive Care

Supportive Care is the (non-surgical) care rendered in-hospital by the referring **family physician,** who is not actively treating the case (e.g. writing orders), to a patient under the care of another physician at the desire of the patient or family, for purposes of liaison or reassurance. Supportive Care may be claimed by **family physicians** only, using either Visit Code 371 or 372.

7.36 Visit for Procedure Only

When the sole reason for a visit is the performance of a procedure listed in the Diagnostic and Therapeutic Section of the Schedule, visit codes should not be claimed. This service should be claimed by billing the appropriate procedural code and fee code 54000, unless otherwise specified.

7.36.1 Transfer of Care Surcharge

Fee code 160 may only be claimed by Psychiatrists who provide office-based care. It is payable for patients who are discharged from the psychiatrist's practice to their **family physician** with a written treatment plan for the ongoing management of the patient's mental health. The written treatment plan fulfills the documentation requirement for this service. A minimum of six separate follow up visits must occur before code 160 may be billed.

The transfer of care code is intended to assist in the safe transition of appropriate patients, whose medical needs can be managed within primary care, from the psychiatrist to the primary care physician. The billing psychiatrist must meet the established visit requirements for this fee code and must provide a transition of care treatment plan to the **family physician** or designate that will provide guidance on bio-psycho-social recommendations for the patient. This plan must include the following elements:

- psychiatric diagnosis:
- medical diagnosis;
- medication recommendations including:
    - list of medication trials including reasons for discontinuing (i.e. intolerances, allergies, etc.);
    - current medication including recommendations for dosage adjustment and duration of treatment;
    - monitoring that will be required while taking specific medications; and
    - any cautions regarding medications.
- relevant risk management recommendations (i.e. suicide, psychosis, driving, urine drug screening, etc.); and
- relevant information from other mental health services to include:
    - interventions utilized;
    - ongoing psycho-social needs; and

- follow-up required with mental health services.

7.37 Transition-Related Surgical Readiness Assessment

The Transition-Related Surgical (TRS) Readiness Assessment is a comprehensive fee code that may include multiple visits in order to make a recommendation for insured TRS procedures. Recommended content of the surgical readiness is available at https://www.health.gov.nl.ca/health/mcp/pdf/TRS Recommended Content SRA.pdf. A TRS Readiness Assessment is payable to the family physician or psychiatrist who possess the minimum credentials for mental health professionals who work with adults presenting with gender dysphoria. These credentials are available at https://www.health.gov.nl.ca/health/mcp/pdf/TRS SRA Cert Rec.pdf.

7.37.1 The TRS Readiness Assessment is only payable for assessments for TRS procedures that are covered by Newfoundland and Labrador's provincial health insurance plans. A list of insured TRS procedures is available at https://www.health.gov.nl/health/mcp/pdf/TRS Policy.pdf. The TRS readiness assessment is payable whether or not the physician recommends the proposed insured surgery.

7.37.2 There is no payment available for completion of the TRS Request for Prior Approval.

7.37.3 The record of service must meet all the documentation requirements of a visit as described in Section 4.2.2 of the MCP Medical Payment Schedule. If surgery is recommended, the record of service must also include the written surgical readiness assessment as well as the TRS Readiness Assessor Certification and Recommendation form located at https://www.health.gov.nl.ca/health/mcp/pdf/TRS SRA Cert.pdf.

7.37.4 There are no other fee codes payable in addition to this fee code for this patient on the same day by the same physician that a TRS readiness assessment is provided.

7.37.5 There are no premiums payable in addition to this code.

7.38 Well-Baby Care Visit

This is to be claimed for the periodic visits of a well-baby during the first two years of life involving complete examination with necessary weight and measurement, haemoglobin and urinalysis when indicated, necessary immunization(s) (excluding cost of materials), and instructions to the parent(s) regarding health care. This visit code must be claimed unless the infant is not a "well baby."

8. CRITICAL CARE

8.1 Neonatal Intensive Care Unit (NICU)

8.1.1 These fees apply to the services of being in constant or periodic attendance during a one day period, to provide all aspects of care to the patients in Neonatal Intensive Care Units designated by the **DHCS**. There are three levels of care depending upon the procedures performed.

8.1.2 These are team fees which apply to Neonatologists/Pediatricians/Anaesthesiologists providing complete daily care and should be claimed by the physician in charge of the patient. The daily fee includes the initial consultation, subsequent assessments, and the ongoing monitoring of the patient's condition, including the following procedures as required:

(a) insertions of IVs, arterial and CVP lines,

(b) use of pressure infusion sets,

(c) endotracheal intubation and tracheobronchial toilet,

(d) insertion and maintenance of urinary catheters and nasogastric tubes,

(e) securing and interpreting the results of arterial blood gas samples, and

(f) the use or artificial ventilation.

8.1.3 These fees may be claimed in the post-operative period for patients receiving either Level A or B care. Level C care cannot be claimed for post-operative infants.

8.1.4 Physicians not part of the daily care team, whose additional expertise is required, may bill for each item of service performed, including Concurrent Care (fee code 51790).

8.1.5 When a patient's care is transferred to a higher or lower level, the second day rate for that level applies. However, in any one period of NICU care, the first day rate for the highest level is payable for the date the patient transferred to that level. Only one first day rate is payable per NICU period.

8.1.6 Consultations or other assessments are not payable on transfers out of a NICU to the physician who cared for the patient in the NICU. However, consultations or assessments consistent with Preamble definitions are payable to other physicians, including those in the same specialty as the NICU physician, who render subsequent care to the patient transferred out of the NICU.

8.1.7 When a patient is readmitted to the NICU within 48 hours of discharge, second day benefits apply. After 48 hours, first day benefits apply.

8.1.8 All claims for NICU must contain the facility number of the hospital in which the service was provided.

8.2 ICU and CCU Care

8.2.1 These fees apply to the services of being in constant or periodic attendance during a one day period, to provide all aspects of care to patients in Intensive or Coronary Care Units designated by the **DHCS**. There are four levels of care depending upon the procedures performed:

(a) Comprehensive Care – This is the service rendered by a physician who provides complete care (both Critical Care and Ventilatory Support) to Critical Care Area patients. Comprehensive Care fees are not payable for services rendered to stabilized patients in ICUs or patients admitted for ECG monitoring or observation alone.

(b) Critical Care – This is the service rendered by a physician who provides all aspects of care to a Critical Care Area patient except Ventilatory Support. Critical Care fees are not payable for services rendered to stabilized patients in ICUs or patients admitted for ECG monitoring or observation alone.

(c) Observatory Care – This is the service rendered to stable ICU or CCU patients without invasive monitoring and without assisted ventilation.

(d) Ventilatory Support – This is the service provided by a physician other than the one claiming Critical Care. It includes management of the intubated airway, tracheal toilet by suction catheter with or without instillation, and supervision of mechanical ventilation of the critically ill patient.

8.2.2 These are team fees which apply to physicians providing complete daily care and should be claimed by the physician in charge of the patient. The daily fee includes payment for the initial consultation, subsequent assessments, and the ongoing monitoring of the patient's condition, including the following procedures as required:

(a) insertion of IVs, intraosseous, arterial and CVP lines,

(b) use of pressure infusion sets,

(c) endotracheal intubation and tracheobronchial toilet,

(d) insertion and maintenance of urinary catheters and nasogastric tubes,

(e) securing and interpreting the results of laboratory tests, oximetry, arterial blood gas samples,

(f) infusion or injection of pharmaceutical agents, and

(g) intracranial pressure monitoring, interpretation and assessment.

8.2.3 The following services may be claimed in addition to the daily intensive care fee codes:

(a) insertion of Swan-Ganz catheter,

(b) cardiopulmonary resuscitation,

(c) insertion of transvenous pacemaker,

(d) all services listed for renal dialysis,

(e) electrical cardioversion,

(f) endotracheal intubation, where it is necessary to be rendered by a physician other than the physician in charge, and

(g) insertion of ICP measuring device.

8.2.4 These fees may be claimed in the pre- and post-operative period for patients receiving either Comprehensive, Critical, Ventilatory or Observatory Care.

8.2.5 If the patient is transferred to the ICU or CCU directly from the OR or the Recovery Room, second day rates apply. However, when the care required supersedes the normal post-operative care for the surgery performed, and the patient is transferred from the surgeon to the attending ICU/CCU physician, first day rates apply.

8.2.6 Physicians not part of the daily care team, whose additional expertise is required, may bill for each item of service performed, including Concurrent Care (fee code 51790).

8.2.7 When a patient's care is transferred to a higher or lower level, second day rates for that level applies. However, in any one period of ICU/CCU care, first day rates for the highest level is payable for the date the patient transferred to that level. Only one first day rate is payable per ICU/CCU period.

8.2.8 When a patient is readmitted to ICU/CCU with 48 hours of discharge, second day benefits apply. After 48 hours, first day benefits apply.

8.2.9 Consultations or other assessments are not payable on transfers out of the ICU or CCU to the physician who cared for the patient in the ICU or CCU. However, consultations or assessments consistent with Preamble definitions are payable to other physicians, including those in the same specialty as the ICU/CCU physician, who rendered subsequent care to the patient transferred out of the ICU or CCU.

8.2.10 All claims for ICU and CCU must contain the facility number of the hospital in which the service was provided.

8.3 Provincial Perinatal High Risk Unit

8.3.1 The fees listed are only applicable to patients who are admitted to the unit and have been designated as high risk and are payable only to the physician in charge of the patient. The Concurrent Care fee for ICU, fee code 51790, may also be claimed by a second obstetrical specialist sharing in the on-going care of the patient.

9. DIAGNOSTIC AND THERAPEUTIC SERVICES

9.1 This section of the Schedule identifies the amounts payable for miscellaneous professional services. Designation of site for claiming the service is based on where the procedure is performed rather than where it is interpreted.

9.2 If a procedure is performed in a hospital and is listed both in this section and the In-Hospital Diagnostic Section, it must be claimed using the fee code listed in the In-Hospital Diagnostic Section.

9.3 When a procedure(s) is the sole reason for a visit, no consultation or visit fees should be charged. However, fee code 54000 may be claimed, unless stated otherwise.

9.4 Billing rules for immunization of beneficiaries who belong to target populations designated by the **DHCS** are as follows:

(a) visit for assessment plus single immunization – claim visit fee only,

(b) visit for assessment plus two immunizations – claim visit fee plus one unit of fee code 54656, and

(c) visit for immunization against pneumococcal disease only – claim one unit each of fee codes 54000 and 54658.

9.5 Satellite Haemodialysis

9.5.1 General

(a) Fee codes 54494 and 54496 are benefits for managing chronic haemodialysis where the patient undergoes dialysis at a **DHCS** approved satellite site remote from the site where the billing physician is located.

(b) For the purpose of claiming these codes “remote” means patient and physician are located in different municipalities and the physician does not attend the patient’s dialysis sessions at the satellite site in person.

(c) All claims for fee codes 54494 and 54496 must include the facility number of the satellite site where the patient is located. See the MCP Physician Information Manual for a list of numbers.

9.5.2 Supervision and administration – Fee Code 54494

(a) When fee code 54494 is billed, the claim date must be the last date of each completed week or supervision where a week begins 12:00 a.m. Monday and ends 11:59 p.m. Sunday.

(b) If the billing physician provides in person dialysis services to the patient at the satellite site, the amount that can be claimed for fee code 54494 that week must be reduced by 50%.

9.5.3 Teledialysis Assessment with Patient, Once Per Week, Per Patient – Fee Code 54496

(a) “Teledialysis Assessment” is a medical service provided to a chronic haemodialysis patient present at a **DHCS** approved satellite haemodialysis site in Newfoundland and Labrador, through a direct interactive video link with a receiving physician at an approved telemedicine site

in Newfoundland and Labrador. The patient must be present at the same time as the physician. The physician may initiate the service. This code is payable to a maximum of one physician per patient, per week.

(b) The record of a teledialysis assessment must include the findings through history, observations from visual inspection (if any), and plan of investigation or treatment. It is understood that the diagnosis is chronic renal failure and that the reason for the visit is review of the dialysis patient's status.

(c) When fee code 54496 is billed, the date of service must be the actual date the physician-patient teledialysis encounter took place. For the purpose of billing this code, a week begins 12:00 a.m. Monday and ends 11:59 p.m. Sunday.

9.6 Electrophysiologic Pacing, Mapping and Ablation

9.6.1 Fee code 54333 is billable under the following conditions:
The advance mapping system is used in hospital for mapping the following arrhythmias:

Atrial arrhythmia	Atrial fibrillation Atypical atrial flutter Post-surgical atrial flutter Atrial tachycardia Redo typical atrial flutter Redo reentrant tachycardia (accessory pathways, AV nodal reentry)
Ventricular arrhythmia	Ischemic ventricular tachycardia/premature ventricular ectopics Non-ischemic ventricular tachycardia/premature ventricular ectopics Idiopathic ventricular tachycardia/premature ventricular ectopics (e.g. fascicular, ARVD, bundle branch reentry, aortic cusp, outflow tract, etc.)
Other	Congenital heart disease arrhythmia

9.6.2 Examples of procedures lasting more than 4 hours and not utilizing the advance mapping system are mapping and ablation of multiple accessory pathways and/or thick band accessory pathway(s).

10. IN-HOSPITAL DIAGNOSTIC SERVICES

10.1 This section of the Schedule identifies the amounts payable for professional services related to specific procedures performed in a hospital.

If the same procedures are performed in a non-hospital environment, they must be billed using fee codes and fee in the Diagnostic and Therapeutic Procedures Section.

Diagnostic procedures not listed in the Diagnostic and Therapeutic Procedures Section or the In-Hospital Diagnostic Procedures Section are not MCP insured services.

10.2 Only the physician who produces the official hospital report may claim these fees. Interpretations done by attending physicians during care of the patient are considered to be included in the daily care or other fees payable for these patients.

11. RADIOLOGY

11.1 Diagnostic imaging services are insured services under MCP and are payable according to the rates listed in the Radiology Section of this Schedule. The fee codes and fees in this section may be claimed by Radiologists or those physicians designated by individual hospitals to provide imaging services. MCP should be notified in writing by the hospital's administration of the names of physicians so designated and the specific imaging services for which they have been given privileges.

11.2 The fees listed include:

(a) consultation between the Radiologist and referring physician,

(b) the procedure and/or interpretation as specified in the fee code item,

(c) producing the usual report, and

(d) supervision of diagnostic imaging services by the Radiologist.

11.3 If the examination requested by the referring physician yields abnormal findings, or if it would yield information which in the opinion of the Radiologist would be insufficient, or if a different examination is necessary to obtain the diagnostic information required, then, governed by the needs of the patient, the Radiologist may add additional views or change the examination and claim accordingly. Such additions or changes must be noted on the examination request form or in the report for that exam and signed by the Radiologist.

11.4 Certain procedures require Independent Consideration (IC) submission along with the regular claim. The IC should include all the information necessary for the determination of the appropriate fee. Essential information includes:

(a) time taken to do the procedure,

(b) any medical complication which impacts the procedure,

(c) the specific type of scan or examination required,

(d) specific circumstances requiring the Radiologist's presence,

(e) specific service performed by the Radiologist,

(f) reference to any fee code item considered equivalent to the service being performed, and

(g) fee requested.

Note: See the Physician's Information Manual for requirements specific to codes listed IC.

11.5 A stereo pair is to be counted as two views.

11.6 No additional fees are to be charged for:

(a) rapid sequence IVP,

(b) the use of image intensifying equipment,

(c) fluoroscopy, when it is regarded as an integral part of the examination, e.g., examination of the GI tract special procedures,

(d) routine abdominal and chest studies billed with gastrointestinal examinations, and

(e) routine abdominal and/or pelvic views in addition to lumbar spine examination requests.

11.7 Conventional films of the spine before myelography may only be obtained and billed if the Radiologist is unable to obtain films done at their or other institutions. IC is required.

11.8 An unsuccessful procedure should be claimed as successful. IC is required.

11.9 Procedural ultrasound fees must be billed IC and may only be claimed:

(a) where no technician is available to do the required procedure and the clinical urgency of the case will not permit waiting until a technician is available, or

(b) where the technician available is not trained to do the required procedure, or

(c) where the procedure is so complicated that it must be performed by, or under the direct guidance of a Radiologist, who must be continually in attendance.

11.10 No fee may be claimed for interpretation of views of the joint unless all of the views normally required for that joint have been examined.

11.11 IV injection fees are not included in any interpretation fee but are included in procedural fees which normally require intravenous injection.

11.12 The fee for a “special additional view” may only be claimed for interpretation of a view which is not considered to be included in the routine examination of that part or area and which has been specifically requested by the referring physician or deemed clinically necessary by the interpreting Radiologist.

11.13 When claiming fluoroscopy services, fees are only billable when the Radiologist is present during the procedure, with the Radiologist actively providing or guiding the fluoroscopy.

11.14 Complex head CT scans are multi-planar and must include one or more of the following areas: pituitary fossa, posterior fossa, internal auditory meati, orbits and related structures, the temporal bone and its contents, and the temporomandibular joints.

Fee codes 73800, 73801 and 73802 cannot be billed in addition to fees for complex head studies.

11.15 Special visit premiums are payable in addition to the procedural fees. The premiums apply when the Radiologist is asked to return to the hospital after normal working hours as follows:

(a) Daytime special visit – (Monday to Friday),

(b) Special visits during evenings – (6:00 p.m. to midnight, Saturdays, Sundays and Statutory Holidays), or

(c) Special visits during the night – (midnight to 8:00 a.m.)

11.16 Only one special visit premium per trip to the hospital is payable regardless of the number of x-rays examined. An additional premium is payable for additional trips made within the same shift or period as outlined.

12. NUCLEAR MEDICINE

12.1 Nuclear Medicine services are insured services under MCP and are payable according to the rates listed in the Nuclear Medicine Section of this Schedule. The fee codes and fees in this section may be claimed by Nuclear Medicine Specialists or those physicians designated by individual hospitals to provide such services. MCP should be notified in writing by the hospital's administration of the names of physicians so designated and the specific imaging services for which they have been given privileges.

12.2 The fees listed include:

(a) consultation between the Nuclear Medicine Specialist and referring physician,

(b) the procedure and/or interpretation as specified in the fee code item,

(c) producing the usual report, and

(d) supervision of diagnostic imaging services by the Nuclear Medicine Specialist.

12.3 If the examination requested by the referring physician yields abnormal findings, or if it would yield information which in the opinion of the Nuclear Medicine Specialist would be insufficient, or if a different examination is necessary to obtain the diagnostic information required, then, governed by the needs of the patient, the Nuclear Medicine Specialist may add additional views or change the examination and claim accordingly. Such additions or changes must be noted on the examination request form or in the report for that exam and signed by the Nuclear Medicine Specialist.

12.4 An unsuccessful procedure should be claimed as successful. IC is required.

12.5 IV injection fees are not included in any interpretation fee.

12.6 The fee for a "special additional view" may only be claimed for interpretation of a view which is not considered to be included in the routine examination of that part or area and which has been specifically requested by the referring physician or deemed clinically necessary by the interpreting Nuclear Medicine Specialist.

12.7 Special visit premiums are payable in addition to the procedural fees. The premiums apply when the Nuclear Medicine Specialist is asked to return to the hospital after normal working hours as follows:

(a) Daytime special visit – (Monday to Friday), or

(b) Special visits during evenings – (6:00 p.m. to midnight, Saturdays**,** Sundays, and Statutory Holidays), or

(c) Special visits during the night – (midnight to 8:00 a.m.)

12.8 Only one special visit premium per trip to the hospital is payable regardless of the number of scans examined. An additional premium is payable for additional trips made within the same shift or period as outlined.

13. OBSTETRICS

13.1 The SURGICAL PROCEDURES Section of this Preamble applies to all obstetrical procedures unless otherwise stated.

13.2 The delivery fee includes routine in-hospital pre-delivery assessment and daily care as well as the management of labour.

13.3 Illnesses or conditions resulting from, or associated with, pregnancy requiring added hospital care should be charged on a per diem basis up to the day prior to delivery. Remarks Code 07 should be indicated on claims for these SHVs.

13.4 "Attendance at Labour" is payable when a **Family Physician** refers a patient in labour to another physician for delivery because of complications. If the complication results in a Caesarean or other operative delivery and the **Family Physician** assists, that physician is entitled to the assistant's fee as well as the "Attendance at Labour" fee.

13.5 Care of the newborn is not included in the obstetrical fee.

13.6 The Anaesthesiologist's services include ordinary and immediate care of the newborn. When active resuscitation is necessary, add three units of anaesthetic time.

13.7 Fee code 80010 represents routine post-partum in-hospital care, regardless of the number of days the patient remains in hospital.

14. SURGICAL PROCEDURES

14.1 Surgical procedural codes and their associated fees are intended to remunerate the physician for all parts of the procedure that are the integral components of the procedure. It is not appropriate to unbundle (de-construct) the procedure into constituent parts and bill MCP for these codes in addition to the procedure codes. Unless otherwise stated, the fee listed for a surgical procedure is a composite fee that includes payment for the following:

(a) the procedure, including the surgical approach and closure,

(b) identification and protection of structures within or adjacent to the operative field such as arteries, nerves, ureters, etc.,

(c) administration of an anaesthetic and/or other medication prior to, during, or immediately after the procedure(s) (unless otherwise specified in this Payment Schedule),

(d) the use of imaging guidance by the physician(s) performing the procedure,

(e) all examinations other than consultations rendered within two days prior to the procedure,

(f) pre-operative care for two days prior to the procedure,

(g) post-operative SHVs for up to 14 days of care commencing on the day after surgery,

The starting point for the calculation of SHV benefits after the 14 days included in the procedural fee is the date of admission if admitted by the surgeon or the date of transferal, if transferred for another specialty.

When immediate post-operative chemotherapy for malignancy is commenced, SHVs are payable to the physician rendering the service. Claims must be submitted IC.

(h) routine post-operative office or out-patient visits, for up to 42 days commencing on the day after surgery, are included in the surgical fee and are not eligible to be claimed by another physician in the same specialty as the operating surgeon. However, post-operative visits may be claimed if the patient is seen by a physician in the same specialty as the operating surgeon, and the service is rendered at a site in excess of 16 kilometers from the community in which the surgical procedure was performed. This requires the use of Remarks Code 25 on the claim form.

14.2 The following items are not included in the surgical fee and may be claimed in addition, if applicable:

(a) consultation prior to surgery,

(b) subsequent surgical procedures, including Diagnostic and Therapeutic Section fee code, for the same condition,

(c) premium on non-elective, non-scheduled surgical procedures,

(d) premium applicable to a special in-patient visit requested by the hospital for which a visit fee is not payable,

(e) premium for specific, approved major surgical procedure(s) on morbidly obese patients,

(f) pre and post-operative visits not related to procedure:

Visits made within the 2-day pre-operative period or 42-day post-operative period for a condition unrelated to the one for which the procedure was done, are eligible to be claimed by any physician rendering the service.

Remarks Code 20 must be used by **Family Physicians** claiming these services.

(g) visits related to complications of surgery:

Office, home or out-patient visits made within the 42-day post-operative period because of complications are eligible to be claimed by any physician rendering the service. Remarks Code 24 must be used.

(h) routine post-operative care by **Family Physicians**:

Family Physicians are eligible to claim office or out-patient visits for routine post-operative care during the 42-day post-operative period. Fee code 118 or 418 must be claimed.

14.3 For claim assessment purposes, a surgeon who performs a non-IOP surgical procedure on a patient is deemed to be the attending physician for the first 14 post-operative in-patient days and for the first 42 total post-operative days.

14.4 When a procedure is specified as “Independent Operative Procedure” (IOP), the procedural fees may be charged in addition to visit fees, consultation, etc.

IOPs when not included in another procedure or visit fee, are payable at the full listed fee whether done alone or with another procedure. Fees for non-IOPs are not affected by IOPs done at the same sitting.

When an IOP is done in conjunction with other non-IOPS, there should be no charge for pre- and post-operative care related to the IOP, but the listed IOP fee should be charged in these circumstances.

When multiple IOPs are performed at the same time by the same physician, the listed procedural fees should be charged in full but the pre- and post-operative visit fees should be charged as if only one procedure had been performed.

14.5 When different operative procedures are done by two different surgeons under the same anaesthetic for different conditions, the fee will be 100% of the listed fee for the major procedure for each surgeon.

14.6 If the nature or complexity of a procedure requires more than one operating surgeon, each providing a separate service in a specialized field, each surgeon may claim the full listed fee for the procedure performed. This however, does not apply to those cases where an additional surgeon is involved simply because they may be more skilled in carrying out the procedure. Neither does it apply to those cases where one or more additional surgeons perform components of a main procedure for which there is listed a combined tariff. In those cases, the additional surgeon may claim assistant’s fee only for the procedures.

14.7 When more than one operative procedure is performed by the same surgeon at the same time under the same anaesthetic, the fee shall be the full fee for the major procedure and all other procedures shall be paid at the rate of 85% of the listed fee for each procedure (exception: IOPs). However, in the case where an appendix or ovarian cysts(s) is removed incidentally during an operation, no additional charge should be claimed.

14.8 When a patient is re-admitted to hospital because of a post-operative complication which does not require a surgical procedure, the physician attending this re-admitted patient should claim as for a new admission.

14.9 When an emergency surgical procedure is performed in the course of a home visit, the visit fee should be charged in addition to the procedure fee. A note of explanation is required to expedite processing.

14.10 Procedures that are non-elective, unscheduled, and which either require the services of an Anaesthesiologist, or which are performed using one of the regional nerve blocks specified in fee code 54150 for local anaesthetic purposes, qualify for premiums as listed in the Premiums Section of the Preamble.

14.11 When a physician administers an anaesthetic and/or other medication prior to, during, or immediately after a procedure(s) which the physician performs on the same patient, the procedure(s) only should be claimed. However, when a physician administers a retrobulbar, stellate ganglion, femoral, sciatic, ilioinguinal, iliohypogastric, ulnar, median, radial block for local anaesthetic purposes, or epidural for delivery block in addition to performing the procedure, fee code 54150 should be claimed in addition to the procedure fee.

14.12 Where hypothermia is used, a charge in addition to the procedure fee should be made by the surgeon, unless otherwise specified. See fee codes 94802. For Anaesthesiologist's charge, see fee codes 94800 and 98100.

14.13 The fee for total hip replacement includes denervation of the hip joint and adductor or abductor tenotomy.

14.14 When laryngoscopy and bronchoscopy are carried out as combined procedures, the physician may claim for only one of the procedures.

14.15 No claim should be made for bronchoscopy carried out immediately following thoracic surgery under the same anaesthetic by the same surgeon.

14.16 When debridement of ears under microscopy is carried out for the removal of cerumen for access purposes only, no charge should be made for the debridement.

14.17 The benefit for obtaining a bone graft is <u>not</u> to be claimed in cases of pseudoarthrosis repair, fusions or for listings in which bone grafting is included.

15. FRACTURES

15.1 Open Reduction shall mean the reduction of a fracture or dislocation by an operative procedure to include the exposure of the fracture or dislocation or intramedullary means of fixation or Roger Anderson type of apparatus.

15.2 Closed Reduction shall mean the reduction of a fracture or dislocation by non-operative methods, including skin traction, K-wire, or Steinman's pin for balanced traction.

15.3 No Reduction shall mean the treatment of a fracture or dislocation where no reduction is required and shall include 42 days of care for that injury.

15.4 The stated fee covers full treatment including necessary after care up to 42 days by physicians of the same specialty. This includes the removal of a wire or other device when used for traction or external fixation in the treatment of a fracture or other orthopaedic procedures. A charge may be made for removal of a device used for internal fixation in addition to the procedural fee.

15.5 The benefit for obtaining a bone graft is not to be claimed in cases of pseudoarthrosis repair, fusion, or for listings in which bone grafting is stated to be included in the fee.

15.6 In multiple fractures or dislocations treated at the same sitting, the fee for the major procedure shall be the full listed fee and the other fractures or dislocations shall be at 85% of the listed fee.

15.7 In cases where two or more reductions (closed or open) are performed for one fracture by one or more surgeons, the full fee should be charged for the final reduction and after care. Previous reduction(s) should be charged at 85%.

15.8 Compound fractures or dislocations requiring extensive debridement qualify for an additional fee which is listed after the fee for open reduction of the fracture.

15.9 If reconstructive procedures on soft tissues are required, such services should be claimed on their own merit. Claims must be billed IC and the OR report submitted.

15.10 Where a patient is transferred to another surgeon for after care of a fracture or dislocation treated by "no reduction" or "closed reduction", the surgeon rendering the initial care should claim 75% of the listed fee and the surgeon rendering the subsequent care 50% except where otherwise specified. In cases involving open reduction, the percentages are 80% and 40% respectively.

15.11 The fee for emergency splinting of a fracture in the Emergency Department should be on the basis of the emergency room visit plus application of cast if rendered. For claiming purposes, a cast is defined as "rigid dressing, moulded to the body while pliable and hardening as it dries, to give firm support."

15.12 Fees for fractures or dislocations include all applications of plaster whether done during the surgery or at a later date.

15.13 In the case of fractures, dislocations or minor evulsion fractures not requiring reduction, visit fees shall apply unless a specific fee is listed. For fractures listed as “visit fees” the following also apply:

(a) when two or more fractures, each listed as “visit fees” are treated, only one visit fee should be claimed for each visit, even though more than one fracture is assessed, treated, or reassessed.

(b) when fractures which are listed as “visit fees” are treated along with treatment of fractures which have definite fees listed, visit fees are not payable in addition to claims for the other fracture care, and

(c) when fractures which are listed as “visit fees” are treated along with other non-IOP surgery, visit fees are not payable in addition to claims for surgery.

16. SURGICAL ASSISTANT'S SERVICES

16.1 Standard Method of Billing

16.1.1 Assistant fees (except specialist assistants) should be claimed by billing the listed basic fee applicable to the procedure performed and the appropriate fee for the number of time units.

16.1.2 Time units are calculated per operation on the basis of time spent by the physician assisting at that particular surgery. For the purpose of this calculation, time includes scrub time and time spent in the operation room. Assistant time units are calculated by allowing one unit for each 15 minutes, except for the final unit of eligible time which is equal to 15 minutes or part thereof. Units tables for convenience of billing are located in the Tables Section of this Payment Schedule. For the current time unit rate, please refer to this table.

Time units should be billed on a separate line using the basic procedural fee code as the first 5 digits and adding 1, for a total of six digits in the time units fee code.

16.1.3 Claims for assistants' fees for surgical procedures with no listed assistant basic rate are required to be submitted IC, and must include the reason why, based on medical necessity, an assistant was required.

16.1.4 When multiple or bilateral surgical procedures are performed during the same anaesthetic, the assistant is entitled to claim the basic fee code for the major procedure only, plus any applicable add-ons, plus total time units. Total time units claimed should be billed under the time unit code for the major procedure only.

16.1.5 When more than one assistant is required for a surgical procedure, the fee for the second assistant is calculated in the same manner as the fee for the first assistant.

16.1.6 Where the attendance of a physician is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and when the physician is in constant attendance, the benefit shall be 3 time units plus time. (Fee code 90020).

16.1.7 When an anaesthetic has begun and the operation is cancelled prior to commencement of surgery, the assistant who has scrubbed but is not required to do more, should claim using fee code 90040 plus time.

Note 1: If the operation is cancelled after surgery has commenced, the performed procedural basic plus time units will apply.

Note 2: If the procedure is cancelled prior to the induction of anaesthesia and the assistant is scrubbed, an SHV only may be claimed.

16.2 Dedicated Time Method of Billing

16.2.1 Physicians have the option of billing for surgical assistant's services according to either the Standard method described above or the Dedicated Time method.

16.2.2 Dedicated time is defined as time spent in hospital for the provision of requested surgical assistant's services. Payment for dedicated time represents payment for all insured services rendered during the dedicated time. The period of time claimed as dedicated time must not be interrupted in order to bill for insured services under other methods of billing.

16.2.3 No other insured services may be billed to MCP during the time claimed as dedicated time.

16.2.4 Actual time spent assisting at non-MCP insured procedures, e.g. WHSCC or out-of-province patients must be subtracted from the time claimed as dedicated time.

16.2.5 Dedicated time units are equal to 15 minutes, except for the final unit of eligible time which is equal to 15 minutes or part thereof. Units tables for convenience of billing are located in the Table Section of this Payment Schedule. For the current time unit rate, please refer to this table.

Note: Instructions with respect to preparation and submission of claims for surgical assistant's services using the Dedicated Time method of billing are included in the MCP Physician's Information Manual.

16.2.6 When a physician has set aside time to provide assistant's services and is given less than 18 hours notice that the scheduled surgical list has been cancelled, the physician may claim payment of time units. The number of units payable is based on the scheduled start time for the surgical list and ends when the physician resumes working. A maximum of 12 units of dedicated surgical assist time units may be claimed. The physician must identify on the claim that the fee claimed is the result of a cancelled surgical list.

16.3 Specialist Assistant

When two surgeons are working together at a procedure for which neither a team fee nor other method of claiming is set out in the Schedule, one surgeon should be identified as the operating surgeon and claim accordingly; the surgeon which is assisting should be identified as such and claim the assistant's benefit. Certain procedures, because of their difficulty or complexity, require the services of a specialist assistant and a list of eligible procedures can be obtained from the MCP **Manager of Claims Operations**. If a claim is made for a procedure not on this list, it is subject to internal review and/or adjudication by the Medical Advisory Committee. The specialist assistant rate is not payable on the sole basis that the assistant is a specialist; the criteria of difficulty and/or complexity must also be met. The specialist assist rate is 75% of the primary surgeon's fee and these claims must be submitted IC.

16.4 Premiums

Premiums are payable for non-elective, non-scheduled surgical procedures which are performed outside of normal working hours. See Section 18.

17. ANAESTHESIOLOGY SERVICES

17.1 The tariffs listed are for all types of anaesthesia and cover the fees for professional services including pre-anaesthetic examination (excluding Pre-anaesthetic Clinics) and post-anaesthetic follow up and all immediate supportive measures, but do not include the cost of material used.

17.2 Anaesthetic fees should be claimed by billing the listed basic fee (for the major procedure performed) and the appropriate fee for the number of time units. When multiple or bilateral surgical procedures are done during the same anaesthetic, only one basic fee is payable.

17.3 Anaesthesia basic fees are listed as unit values. Anaesthesia basic fees must be claimed as dollar amounts and not as unit values. The amounts payable for each unit value are located in the Tables Section of this Payment Schedule.

17.4 Anaesthetic time begins when the Anaesthesiologist is first in attendance with the patient for the purpose of creating an anaesthetic state and ends when they are no longer in personal attendance.

17.4.1 Anaesthesia time units are calculated by allowing one unit for each 15 minutes, except for the final unit of eligible time which is equal to 15 minutes or part thereof.

(a) Time units greater than one hour but less than two hours are payable at double the listed time unit rate. A units table for convenience of billing is located in the Tables Section of this Payment Schedule.

(b) Time units greater than two hours are payable at triple the listed time unit rate for all cases, regardless of the basic fee amount.

17.4.2 Time units should be billed on a separate line using the basic procedural fee code as the first 5 digits and adding ‘1’ as the sixth digit in the time units fee code.

17.5 In most cases, additional fees are not payable. However, any codes listed as “extra” or “add”, and having a listing in the anaesthesiology columns are billable in addition to the “basic”. See also “Additional Fees Payable” below. In addition to these service in capacity 3, and any service rendered in capacity 0 that are not a routine component of the anaesthesiology service are also payable.

17.6 **Epidural Anaesthesia:**

(a) **Obstetrical Cases**

Epidural for Labour – Claim using basic fee code 80042. For the maintenance, claim using fee code 80044. A maximum of 12 units of 80044 is payable. Time for the (routine) delivery may be claimed using 800401. A second basic is not payable except in the case of Caesarean Sections and Operative Deliveries which are considered to be separate procedures.

Epidural for Post-delivery Pain – This is payable in addition to Epidural for Labour and the delivery “time”. To bill this, use fee code 54134 only (an additional basic is not payable). However, if the epidural was set up for post-delivery pain only, use both codes 54132 and 54134.

(b) **Epidural for Non-Obstetrical Cases** – Bill using fee code 54132. Bill for the maintenance using fee code 54134. A maximum of 12 units of the maintenance (code 54134) is payable per 24-hour period.

17.7 Cancelled Surgery:

(a) When an anaesthetic has begun and the operation is cancelled due to a complication prior to the commencement of surgery, the Anaesthesiologist should claim fee code 90040 plus time.

(b) If the operation is cancelled after the surgery has commenced, the performed procedural basic fee plus time units will apply.

17.8 Anaesthesiology Consults:

17.8.1 Generally, consultations are not payable in addition to anaesthetic fees.

17.8.2 However, an anaesthesiology consultation is payable before a procedure if the consultation is formally requested by a physician in respect of a complicated patient considered for anaesthetic. Claims for anaesthesiology consultations must be submitted IC supporting the need for the service claimed.

17.8.3 Routine pre-anaesthetic evaluation of the patient at the request of a physician does not qualify as a consultation. Consultation fee codes may not be claimed by an Anaesthesiologist in respect of patients assessed in an organized pre-anaesthetic clinic, regardless of referral.

17.9 Additional Fee Codes Billable in Capacity 3:

When an Anaesthesiologist administers an anaesthetic to a patient in the following situations, an additional fee may be claimed as indicated. These fees should be claimed in Capacity 3.

(a) Anaesthetic wake-up test – This is payable when the patient under general anaesthetic is awakened during a procedure to assess neurological function, following which the anaesthesia is recommended. Use fee code 90014.

(b) Fiberoptic intubation – This is payable only when the regular intubation is impossible and is not payable as a routine replacement. Use fee code 90016.

(c) One lung anaesthesia – This is payable when double-leumen endotracheal tube is placed which permits selective ventilation of either lung as required by the thoracic procedure. Use fee code 90018.

(d) Children under the age of 1. Use fee code 90024.

(e) Patients over the age of 70. Use fee code 90026.

(f) Patients who are in a constant life threatening condition. Use fee code 90028.

(g) Patients who receive anaesthetic in the prone or sitting positions. Use fee code 90030.

(h) Patients who weigh less than 5 kgs. Use fee code 90032.

(i) Controlled hypotension – This technique is used in conjunction with anaesthesia to reduce the patient's blood pressure to a level at least 25% below the normal for that patient. Bill using fee code 90034.

(j) Malignant hyperthermia set up and management – This applies when a patient is known to have malignant hyperthermia or there is a strong suspicion of susceptibility and the Anaesthesiologist requires full malignant hyperthermia set up and management. Bill using fee code 90036. This add-on does not apply with fee code 90144.

(k) Anaesthesiologist management for the emergency relief of acute upper airway (above the carina) obstruction, excluding choanal atresia. Use fee code 90038.

(l) Patient with body mass index (BMI) greater than 40 who receives general anaesthesia. Use fee code 90042.

17.10 In special cases where the services of more than one Anaesthesiologist are deemed necessary in the interest of the patient, the basic fee shall be increased by 50% of that listed for the procedure; each Anaesthesiologist to be entitled to one half of the total basic benefit. Each Anaesthesiologist will claim for the anaesthesia time they are present. Claims must be submitted IC. "Additional codes billable" are each payable at 100% of the listed rate to each Anaesthesiologist.

17.11 Where one Anaesthesiologist starts a procedure and is replaced by another part way through a surgical procedure or delivery, the first Anaesthesiologist should claim the appropriate basic fee plus time units for the time present. The second Anaesthesiologist may claim for their time units only. Each Anaesthesiologist should state on their claim which part of the anaesthetic is being claimed as well as the time begun and completed by them.

17.12 In procedures where no fee is listed, or where IC is indicated, the basic portion of the calculated fee will be the same as listed for a comparable procedure considering region and modifying conditions or techniques.

17.13 When a by-pass pump, with or without an oxygenator, and with or without hypothermia, is employed in conjunction with an anaesthetic, the anaesthetic "Basic Value" shall be the equivalent of 28 time units. To compensate for variations in anaesthesiology practice, special respiratory intensive care or detention for the purpose of intensive treatment of other types should be billed separately under the appropriate headings.

17.14 When a physician administers an anaesthetic and/or medication prior to, during, or immediately after the procedure(s) which the physician performs on the same patient, the procedure(s) only should be claimed. However, when a physician administers a retrobulbar, stellate ganglion, femoral, sciatic, ilioinguinal, iliohypogastric, ulnar, median, radial block for local anaesthetic purposes, or epidural for delivery block, in addition to performing the procedure, a claim may be made in addition to the procedure fee, using fee code 54150.

17.15 Where the attendance of the Anaesthesiologist is requested by the patient's other medical attendants for monitoring, special care, or for immediate availability and where the Anaesthesiologist is in constant attendance, bill using fee code 90020 plus time. The claim must be submitted IC. This does not apply to waiting time for scheduled procedures or to the normal preparation time for emergency procedures.

17.16 Where unusual detention with the patient before or after anaesthesia is essential for the safety and welfare of the patient, the necessary time will be valued on the same basis as indicated for the anaesthetic time. For detention not associated with anaesthesia, detention rates and criteria apply.

17.17 When hypothermia is used by the Anaesthesiologist in procedures not specifically identified as requiring hypothermia, the basic value is 25 units. This basic value replaces the basic value listed in the schedule for the procedure. The claim must be submitted IC.

17.18 Anaesthesia time units may not be claimed by the same Anaesthesiologist for rendering anaesthesia or other time-reimbursed services to more than one patient at the same time, with the exception of fee codes 54068, 54134, 54162 and 80044.

17.19 Premiums are payable for non-elective, non-scheduled surgical procedures which are performed outside of normal working hours.

18. PREMIUMS

18.1 General Premium Rates

(a) Where a premium fee is applicable based on the time the service is rendered, a starting time indicator for that service must appear in the patient's record.

(b) Premiums are not payable for:

i. patients seen for convenience by the physician during a special visit,

ii. visits on regular rounds to registered bed patients,

iii. admission assessments of patients who have been admitted to hospital on an elective basis, regardless of the time performed, and

iv. maintenance or monitoring procedural fee codes.

(c) Statutory Holidays are as listed in the appropriate MCP Newsletter for that year and do not include additional Civic Holidays (e.g. Regatta Day). Premiums may be claimed for services provided on the ACTUAL Statutory Holiday but not on a day held in lieu of the holiday.

18.2 Special Visit Premiums

(Special visit premiums applicable to Radiologists and Nuclear Medicine Specialists are described in Section 11 and 12 of this Preamble):

(a) A special visit is one initiated by a patient or the patient's representative where the physician is required to travel from one location to another to see the patient. The type of premium to be claimed is dependent on where the service is provided, the time of day, and what day the service is rendered.

(b) A special visit may also involve an emergency call with sacrifice of office hours. The benefits for this type of special visit applies in a situation where the demands of the patient or the physician's interpretation of the patient's condition are such that the physician responds immediately.

(c) A special visit premium will also be payable for special in-patient visits requested by the hospital for which no fee is otherwise payable.

(d) Only one special visit premium may be claimed for the same patient, same visit.

(e) Special visit premiums are to be claimed as separate line items or on the same line with the visit claim. Separate line items apply when no visit is payable or when SHV applies.

18.2.1 Home Visit Premiums

This term applies to all physicians and home visits except home visit made by **Family Physicians**. Home visits and "extra patient seen" during a home visit by **Family Physicians** are not eligible for the additional claim of a premium as the visit fee listed represents the total fee payable.

For home visits made by specialists, an extra patient seen warrants a premium only if the patient seen was ill enough to warrant a special visit themselves.

18.2.2 Office (or Physician's Residence) Visit Premiums

A special visit premium is payable for the first patient seen when the physician makes a special trip to the office or to the physician's own home from another site (see definition of "Site of Insured Service" in Section 5.1 of this Preamble) to see a patient outside of normal office hours. Subsequent patients seen during the same visit do not qualify for an additional premium claim.

If a regular clinic is held on a Saturday, Sunday, or Statutory Holiday, special visit rates do not apply.

18.2.3 Hospital OPD/Emergency and In-Patient Visit Premiums

A premium is payable for the first patient seen when the physician makes a special trip to the hospital to see the patient, provided that the visit has been specifically requested by the hospital staff or another physician because of the patient's condition. Subsequent patients seen during the same visit warrant an "extra patient seen" premium only if the physician is requested by the hospital staff or another physician to see those additional patients after arriving for the visit. A special visit premium is payable for special in-patient visits requested by the hospital staff for which no fee is otherwise payable.

Premiums payable to physicians who are providing dedicated on-site Emergency Department coverage, and billing for services rendered on a fee-for-service basis, are listed as premium codes 80 to 89.

18.3 Procedural Premiums (For deliveries see 18.4 below)

(a) All Surgeons, Anaesthesiologists, Surgical Assistants who participate in procedures that are non-elective, unscheduled and which either require the services of an Anaesthesiologist, or are performed using one of the regional nerve blocks specified in fee code 54150 for local anaesthetic purposes, are eligible for payment of a premium when the procedures commence between 6:00 p.m. and 7:00 a.m., or on Saturdays, Sundays, and Statutory Holidays.

(b) The procedural premium code and amount must be billed on the same line as the procedural fee code and, where applicable, the time units fee code.

18.3.1 Surgeons' Procedural Premiums:

(a) For procedures that qualify and commence between 6:00 p.m. and midnight, or on Saturdays, Sundays, or Statutory Holidays:
Claim 30% of each procedure billed, using premium code 01.

(b) For procedures that qualify and commence between 12:00 a.m. and 7:00 a.m.:
Claim 50% of each procedure billed, using premium code 03.

18.3.2 Anaesthesiologists' Procedural Premiums:

(a) For procedure that qualify and commence between 6:00 p.m. and midnight, or on Saturdays, Sundays, or Statutory Holidays:
Claim 46% of the basic and time unit fees billed, using premium code 02.

(b) For procedures that qualify and commence between 12:00 a.m. and 7:00 a.m.:
Claim 50% of the basic and time unit fees billed, using premium code 03.

18.3.3 **Surgical Assistants' Procedural Premiums:**

(a) For procedures that qualify and commence between 6:00 p.m. and midnight, or on Saturdays, Sundays, or Statutory Holidays:
Claim 30% of each assistant's fee payable, using premium code 01.

(b) For procedures that qualify and commence between 12:00 a.m. and 7:00 a.m.:
Claim 50% of each assistant's fee payable, using premium code 03.

18.4 Delivery Premiums

18.4.1 Vaginal deliveries, Caesarean sections, and other operative deliveries performed after hours qualify for after-hours surgical procedure premiums.

18.4.2 For the delivering physician and surgical assistant, procedure premium code 01 applies from 6:00 p.m. to midnight, or on Saturdays, Sundays, and Statutory Holidays. For the delivering physician and surgical assistant, procedure premium code 03 applies any night between 12:00 a.m. and 7:00 a.m.

18.4.3 For the Anaesthesiologist, procedure premium code 02 applies from 6:00 p.m. to midnight, or on Saturdays, Sundays, and Statutory Holidays. For the Anaesthesiologist, procedure premium code 03 applies any night between 12:00 a.m. and 7:00 a.m.

18.4.4 Vaginal deliveries, Caesarean sections and other operative deliveries performed at times other than those specified above do not qualify for a premium.

19. SESSIONAL ARRANGEMENTS

19.1 General Policy on Sessional Arrangements

19.1.1 Sessional payment is for clinical time spent rendering insured services in lieu of fee-for-service claims for the services rendered during that time. Administrative meetings/annual program reviews are not eligible to be claimed as a sessional arrangement.

Physician's travel time does not constitute "time spent" in a sessional arrangement.

19.1.2 Only physicians eligible to bill fee-for-service are allowed to bill for sessional payment.

19.1.3 No fee-for-service claims may be submitted for insured services rendered while on Sessional duty. Any exceptions to this rule are listed under the descriptions of the individual sessional arrangements.

19.1.4 Claims for the sessional arrangements must be submitted as described in the Physician's Information Manual.

19.1.5 Sessional Approval Process

(a) Sessional arrangements require individual pre-approval from the Department of Health and Community Services and must be requested in writing to the Administrator of the institution requiring the sessional service. The written request should include information about the nature of the insured service to be provided, anticipated patient volume, and clinic frequency.

(b) To qualify for approval as a sessional arrangement, insured physician services must be provided in a publicly funded facility; either:

i. A multidisciplinary clinic which is dedicated to offering **family medicine** or specialist service to patients with chronic/complex problems.

OR

ii. A correctional institution.

19.2 Organized Sessional Clinics

19.2.1 A claim for sessional payment should represent the time "set aside" or dedicated by a physician for sessional services.

19.2.2 One session should represent a "committed morning, afternoon, or evening."

19.2.3 On average, a claim for a half-day session should equate to three hours of service.

19.2.4 Physicians have the option to bill either fee-for-service or sessional for the duration of a clinic.

19.2.5 No fee-for-service billings should occur during the time dedicated to the session, at or outside of the sessional arrangement. However, emergency services that result from a physician's on-call commitment, which occur during "committed sessional time", may be submitted IC for consideration for payment. Physicians may bill patients for non-insured services, or services provided to WHSCC, or out-of-province patients during the time period that a sessional is claimed.

19.2.6 The rates listed are for a half day and represent a committed morning, afternoon, or evening in an approved organized sessional clinic.

Family Medicine	$500.00 per half day
Specialist	$600.00 per half day

19.3 On-Site Emergency Department Coverage

19.3.1 Fee-for-service physicians who provide dedicated on-site emergency department coverage at designated facilities are eligible for remuneration at an hourly sessional rate. Currently designated facilities are listed in Appendix A.

19.3.2 If billing as sessional, no fee-for service billings should occur during the time dedicated to a sessional, at or outside the sessional arrangement, with the exception of out-of-province, out-of-country, and WHSCC claims. Sessional is intended to cover time spent in the facility.

19.3.3 Physicians have the option to bill either fee-for-service or sessional for the duration of a shift.

19.4 Dedicated On-Site 24-Hour ICU Sessional Coverage

19.4.1 This sessional is for the claiming of dedicated, on-site, ICU services at facilities designated by the **DHCS**.

19.4.2 The facilities designated for the claiming of this sessional arrangement are:

(a) General Hospital, St. John's

(b) St. Clare's Mercy Hospital, St. John's

19.4.3 Payment of the 24-hour sessional for each facility is based on the number of designated beds multiplied by the applicable daily bed rate.

19.4.4 MCP must officially be notified if and when the number of beds in a unit changes.

19.4.5 For claiming purposes, the 24-hour sessional starts at 8:00 a.m.

19.4.6 If, at any time, during a 24-hour sessional period, a bed is occupied by a non-Canadian, out-of-province, or third party patient, the claim for payment should be reduced by the value of the daily bed rate multiplied by the number of such patients.

20. CATEGORY 'B' EMERGENCY DEPARTMENT COVERAGE BY FEE-FOR-SERVICE FAMILY PHYSICIANS

20.1 Fee-for-service **Family Physicians** who are scheduled to immediately respond to the emergency needs for a Category 'B' designated facility, that provides 24-hour emergency services, are eligible to bill an hourly fee.

20.2 Eligible facilities are listed in Appendix B and include **DHCS** facilities designated as either an Acute Care Facility or Health Care Centre that require 24-hour primary care emergency services, excluding those facilities listed in Appendix A.

20.3 Daytime coverage on weekdays

An hourly fee of $**50.00** must be billed for daytime coverage, 8:00 a.m. to 6:00 p.m. Monday to Friday. During that time fee-for-service **Family Physicians** may also bill for individual insured services using the appropriate fee code as listed in this payment schedule.

After hours, weekend and statutory holiday coverage

Fee-for-service **Family Physicians** may bill an all-inclusive hourly rate of $73.00 for after-hours coverage from 6:00 p.m. to 8:00 a.m. Monday to Friday, all day Saturday, all day Sunday, and all day on RHA designated statutory holidays. If the hourly rate of $73.00 is billed, no fee-for-service claims are payable. Alternatively, they may bill the hourly rate of $**50.00** plus fee-for-service billings. The method of billing is at the physician's discretion but must apply for the entire shift or period of ED coverage provided.

Shift definition

A shift is a period of continuous ED coverage by a physician. For example, when a physician provides weekend coverage from 6:00 p.m. on Friday to 8:00 a.m. on Monday that period is considered a single shift for billing purposes. A shift must be of at least eight hours duration; it cannot be divided into shorter periods for billing purposes.

20.4 Instructions with respect to preparation and submission of claims for this service are included in the MCP Physician's Information Manual.

21. LONG TERM CARE FACILITY COVERAGE BY FAMILY PHYSICIAN

21.1 Fee-for service **Family Physicians** who provide clinical services and coverage to **DHCS** designated long term care facilities that have long term care beds are eligible for payments of a per diem fee.

21.2 To qualify for claiming the per diem fee, physicians must provide comprehensive 24-hour coverage for all medically necessary services to the facility.

21.3 The fee for each facility is unique, based on the number of registered beds in the facility. Currently, designated facilities, the applicable facility numbers, and rates are listed in Appendix C.

21.4 Instructions with respect to preparation and submission of claims for this service are included in the MCP Physician's Information Manual.

21.5 Direct patient care visit(s) to these facilities can be claimed on a fee-for-service basis and paid in addition to the per diem fee. These services must be claimed using the dedicated nursing home visit codes for **Family Medicine**. The home's facility number must be entered on claims for these services.

22. RURAL FAMILY PHYSICIAN HOSPITAL PREMIUM

22.1 During claims processing, MCP automatically applies a 20% premium to claims submitted by **Family Physicians** for specific hospital fee codes in Capacities 0 and 3. It is not necessary to claim this premium.

22.2 The premium is applied to specific services rendered in the following approved facilities**:**

Facility Number	Facility Name
0051	Baie Verte Peninsula Health Centre, Baie Verte
0141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony
0159	Captain William Jackman Memorial Hospital, Labrador City
0167	Labrador Health Centre, Happy Valley-Goose Bay
0183	Sir Thomas Roddick Hospital, Stephenville
0191	Dr. C.L. LeGrow Health Centre, Port aux Basques
0221	Notre Dame Bay Memorial Health Centre, Twillingate
0230	Carbonear General Hospital, Carbonear
0248	Dr. G.B. Cross Memorial Hospital, Clarenville
0299	Brookfield/Bonnews Health Care Centre, Brookfield
0302	Burin Peninsula Health Care Centre, Burin
0311	Connaigre Peninsula Health Care Centre, Harbour Breton
0329	Fogo Island Hospital, Fogo
0337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
0345	Bonavista Community Health Centre, Bonavista
0353	Dr. Walter Templeman Community Health Centre, Bell Island
0388	Calder Health Care Centre, Burgeo
0396	Rufus Guinchard Health Care Centre, Port Saunders
0418	Placentia Health Centre, Placentia
0426	Green Bay Community Health Centre, Springdale
0434	A.M. Guy Memorial Health Centre, Buchans
0442	Bonne Bay Health Centre, Bonne Bay

22.3 The premium is applied to the following approved fee codes during claims processing:

Hospital Visit Premiums	70-99
Hospital Visits	301-481
Diagnostic & Therapeutic Services	540000-551561
Obstetrical Procedures	800020-810381
Surgical Dental Procedures	840400-849301
Surgical Procedures	900080-994921
Procedure Premiums	01-03

23. PHYSICIAN REGISTRATION

23.1 All physicians receiving funding from MCP for clinical services provided must be registered with MCP through completion of a Provider Registration Form.

23.2 Additions to, or changes in location of practice, either full or part-time require notification to MCP prior to the changes being effective.

24. LOCUM COVERAGE

Written documentation of locum practice/services is required for all physicians. Contact MCP for current policy and forms.

APPROVED CATEGORY 'A' FACILITIES

24-HOUR ON-SITE EMERGENCY DEPARTMENT COVERAGE

Hospital Number	Hospital Name
0141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony
0159	Capt. Wm. Jackman Memorial Hospital, Labrador City
0167	Labrador Health Centre, Happy Valley-Goose Bay
0175	Western Memorial Regional Hospital, Corner Brook
0183	Sir Thomas Roddick Hospital, Stephenville
0205	James Paton Memorial Hospital, Gander
0213	Central Newfoundland Regional Health Centre, Grand Falls-Windsor
0230	Carbonear General Hospital, Carbonear
0248	Dr. G.B. Cross Memorial Hospital, Clarenville
0256	General Hospital, Health Sciences Centre, St. John's
0264	St. Clare's Mercy Hospital, St. John's
0281	Janeway Children's Health & Rehabilitation Centre, St. John's
0302	Burin Peninsula Health Care Centre, Burin

APPROVED CATEGORY 'B' FACILITIES

24-HOUR EMERGENCY DEPARTMENT COVERAGE

Facility Number	Facility Number
0016	Grand Bank Community Health Centre, Grand Bank
0022	U.S. Memorial Health Centre, St. Lawrence
0051	Baie Verte Peninsula Health Centre, Baie Verte
0191	Dr. C.L. Legrow Health Centre, Port aux Basques
0200	North Haven Emergency Centre, Lewisporte
0221	Notre Dame Memorial Health Centre, Twillingate
0299	Brookfield/Bonnews Health Care Centre, Brookfield
0311	Connaigre Peninsula Health Care Centre, Harbour Breton
0329	Fogo Island Hospital, Fogo
0337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
0345	Bonavista Community Health Centre, Bonavista
0353	Dr. Walter Templeman Community Health Centre, Bell Island
0388	Calder Health Care Centre, Burgeo
0396	Rufus Guinchard Health Care Centre, Port Saunders
0400	Dr. William Newhook Community Health Centre, Whitbourne
0418	Placentia Health Centre, Placentia
0426	Green Bay Community Health Centre, Springdale
0434	A.M. Guy Memorial Health Centre, Buchans
0442	Bonne Bay Health Centre, Bonne Bay
0451	Dr. Hugh Twomey Health Care Centre, Botwood

DHCS DESIGNATED LONG TERM CARE FACILITIES WITH LONG TERM BEDS

Facility Number	Facility Name	Rate
0800	Glenbrook Lodge, St. John's	$196.70
0802	St. Patrick's Mercy Home, St. John's	$292.33
0804	St. Luke's Nursing Home, St. John's	$173.48
0806	Agnes Pratt Nursing Home, St. John's	$185.79
0808	Masonic Park Senior Citizens Home, St. John's	$56.01
0810	Pleasant View Towers, St. John's	$630.20
0815	Carbonear Long Term Care	$274.00
0818	Blue Crest Interfaith Home, Grand Bank	$102.45
0819	Dr. Albert O'Mahony Memorial Manor, Clarenville	$60.10
0820	Lakeside Homes, Gander	$147.54
0822	Carmelite House, Grand Falls-Windsor	$81.96
0825	Corner Brook Long Term Care Home, Corner Brook	$322.39
0827	**Western Long Term Care Home, Corner Brook (Eff. 2020-06-22)**	**$41.10**
0828	Bay St. George Senior Citizens Home, Stephenville Crossing	$172.13
0832	John M. Gray Centre, St. Anthony	$66.93
0834	Labrador South Health Centre, Forteau	$10.93
0836	Long Term Care Home, Happy Valley-Goose Bay	$66.93

IMMUNIZATION OF DESIGNATED TARGET POPULATIONS

Immunization of target populations designated by DHCS are MCP insured services. Rules for billing these services are included in Section 9.4 of the Preamble.

The contacting of target population patients to remind them of the availability of the immunization will not be viewed by MCP as solicitation.

IMMUNIZATION AGAINST PNEUMOCOCCAL DISEASE WITH PNEUMOCOCCAL POLYSACCHARIDE 23 (PNEU-P-23)

The target population designated by the DHCS for immunization against pneumococcal disease with Pneu-P-23 is limited to the following categories of beneficiaries:

- **All residents of long term care or residential facilities,**
- **People aged 65 and over,**
- **Aboriginal population,**
- **All persons receiving or with cochlear implants*,**
- **All persons with chronic conditions requiring medical treatment and follow-up. For example:**
    - **Chronic cardiac disease;**
    - **Chronic respiratory disease;**
    - **Diabetes mellitus;**
    - **Chronic renal disease;**
    - **Nephrotic syndrome;**
    - **Cirrhosis;**
    - **Asplenia or splenic dysfunction*;**
    - **Sickle-cell disease*;**
    - **Immunosuppression (e.g. induced through HIV infection and other conditions)*;**
    - **Alcoholism**
- **Other chronic conditions which increase an individual's risk for pneumococcal invasive disease.**

An asterisk indicates those conditions that are also indications for immunization with Pneumococcal Conjugate C-13 (Pneu-C-13) in addition to Pneu-P-23. Please be advised that these Pneu-C-13 and Pneu-P-23 are not administered at the same time. Please refer to the appropriate medical authority and/or policy for guidance.

IMMUNIZATION OF DESIGNATED TARGET POPULATIONS

IMMUNIZATION AGAINST INFLUENZA

Immunization against influenza is now available universally.

NON-INSURED SERVICES LIST

Services which are not insured services under the Medical Care Insurance Act are defined in the Medical Care Insurance Insured Services Regulations. The following list represents current MCP policy with respect to non-insured services based on the Medical Care Insurance Insured Services Regulations. Inquiries relating to the insurability of a specific service not listed in the Insured Services Regulations or the Medical Payment Schedule should be directed to the office of the **Assistant Director of Medical Services.**

- health examinations, including pre-employment, pre-school, periodic and insurance physicals,
- vaccination of persons who are not part of target populations designated by the **DHCS**. (See Appendix D),
- visits for renewal of prescription only,
- x-ray, laboratory or other diagnostic and therapeutic services provided outside a hospital, unless approved by **DHCS**,
- experimental treatments and procedures,
- services associated with clinical trials,
- laser surgery for vascular lesions not listed in existing **DHCS** policy,
- services associated with hair transplantation,
- injection of asymptomatic superficial veins,
- epilation,
- excision of redundant skin for elimination of wrinkles,
- excision or destruction of tattoos, and
- surgery, including laser surgery, for correction of refractive errors.

SCAR REVISION

1. Trauma Scars

   (a) Neck or Face:

      i. Includes ears and non-hair bearing areas of the scalp.

      ii. Repair of all such scars is an insured benefit, except for scars resulting from previous surgery to alter appearance that was not originally a benefit.

      iii. Repair procedures will depend upon the lesion but may include excision, revision, dermabrasion, etc. Rhytidectomy procedures for cosmetic reasons, however, are not insured benefits.

   (b) Scars in other Anatomical Areas:

      i. Repair of scars which interfere with function or which are significantly symptomatic (pain, ulceration, etc.) is an insured benefit.

      ii. Scars with no significant symptoms or functional interference:

         - Repair is an insured benefit if such a repair is part of a pre-planned post-traumatic (including post-surgical) staged process.

         - Other post-traumatic scar revision is not an insured benefit.

         - Scar revision should not be claimed when excision of a scar is the method of gaining access to the surgical site of the major procedure.

   Scar revision codes (90336 to 90348) should be used when the method employed involves cutting of tissue and closure with sutures. Dermabrasion fee codes (90576 to 90584) should be used in cases involving dermabrasion or laser surgery.

2. Keloids

   (a) Head or Neck:

      i. The repair of all such keloids is an insured benefit.

      ii. Repair procedures may include excision, injection, dermabrasion or planing.

   (b) Excision of keloids in other areas:

      i. Not an insured benefit unless significantly symptomatic (pain, ulceration, etc.) or there is a functional impairment.

   Scar revision codes (90336 to 90348) should be used when the method employed involves cutting of tissues and closure with sutures. Dermabrasion fee codes (90576 to 90584) should be used in cases involving dermabrasion or laser surgery.

HYPERBARIC OXYGEN THERAPY

The following indications are approved uses of hyperbaric oxygen therapy as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society. They are insured by and billable to MCP:

- Air or Gas Embolism
- Carbon Monoxide Poisoning
  Carbon Monoxide Poisoning Complicated by Cyanide Poisoning
- Clostridial Myositis and Myonecrosis (Gas Gangrene)
- Crush Injury, Compartment Syndrome, and other Acute Traumatic Ischemias
- Decompression Sickness
- Enhancement of Healing in Selected Problems Wounds
- Exceptional Blood Loss (Anemia)
- Intracranial Abscess
- Necrotizing Soft Tissue Infections
- Osteomyelitis (Refractory)
- Delayed Radiation Injury (Soft Tissue and Bony Necrosis)
- Skin Grafts and Flaps (Compromised)
- Thermal Burns

CONSULTATIONS AND VISITS

SPECIAL VISIT PREMIUMS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP	Spec.
	Office (or visit to Physician's Residence)- see applicable Preamble section		
	Special visit to the office premiums - (1st patient seen) – to be billed in addition to applicable office visit fee code		
50	Monday to **Friday** between 8:00 a.m. and 6:00 p.m. outside regular scheduled office hours	20.18	14.25
52	**Saturdays**, Sundays or Statutory Holidays or 6:00 p.m. to midnight ……	25.18	28.50
53	Patient initiated non-elective (special) service rendered between midnight and 8:00 a.m. …	30.18	42.80
	Notes:		
	1. Special visit premiums are not payable in addition to the following services: - visit for well-baby care - detention		
	2. No premiums are payable for extra patients seen outside regular hours in the physician's office or residence.		
	Home Not applicable to Family Medicine – see applicable Preamble section		
	Special visit to the home premiums – (1st patient seen) – to be billed in addition to applicable home visit fee code.		
	Monday to **Friday** between 8:00 a.m. and 6:00 p.m.		
60	- without sacrifice of office hours……	**NC**	14.25
61	- with sacrifice of office hours ……	**NC**	28.50
62	**Saturdays**, Sundays or Statutory Holidays or 6:00 p.m. to midnight……..	**NC**	28.50
63	Patient initiated non-elective (special) service rendered between midnight and 8:00 a.m. …	**NC**	42.80
	Extra patient seen premiums		
	Monday to **Friday** between 8:00 a.m. and 6:00 p.m.		
66	- without sacrifice of office hours……..	**NC**	8.15
67	- with sacrifice of office hours …….....	**NC**	12.20
68	**Saturdays,** Sundays or Statutory Holidays or 6:00 p.m. to midnight……..…	**NC**	12.20
69	Midnight to 8:00 a.m. …….....	**NC**	18.70
	Notes: 1. Special visit premiums are not payable in addition to detention. 2. **NC = No charge**		
	Hospital In-Patient (see applicable Preamble Section)		
	Premiums on in-patient services – (1st patient seen) – to be billed in addition to applicable in-patient fee code or alone if visit is not payable		
	Monday to **Friday** between 8:00 a.m. and 6:00 p.m.		
	Physician in-hospital……	**NC**	**NC**
70	- special visit, without sacrifice of office hours……..	16.07	16.07
71	- special visit with sacrifice of office hours ……	32.04	32.04
72	**Saturdays**, Sundays or Statutory Holidays or 6:00 p.m. to midnight ……	45.05	45.05
73	Non-elective (special) service rendered between midnight and 8:00 a.m. ……	67.59	67.59
	Extra patient seen premiums – (in-patient) (when the physician has been specifically requested to see the patient)		
	Monday to **Friday** between 8:00 a.m. and 6:00 p.m.		
76	- without sacrifice of office hours ……	9.14	9.14
77	- with sacrifice of office hours ……..……	13.73	13.73
78	**Saturdays**, Sundays, or Statutory Holidays or 6:00 p.m. to midnight ……...	21.96	21.96
79	Midnight to 8:00 a.m. ……..	33.03	33.03
	Notes: 1. Special visit premiums are not payable in addition to detention. 2. **NC = No Charge**		

CONSULTATIONS AND VISITS

SPECIAL VISIT PREMIUMS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP	Spec.
	Hospital Out-Patient and Emergency – (see applicable Preamble section)		
	Premiums for physicians doing dedicated on-site emergency department coverage at approved Category 'A' facilities – to be billed in addition to visit fee code		
	Note: First patient seen during on-site coverage may be claimed as a special visit.		
	First patient seen on shift		
80	- Monday to **Friday**, 8:00 a.m. to 6:00 p.m.	23.00	14.25
82	- **Saturdays**, Sundays or Statutory Holidays, or 6:00 p.m. to midnight	28.00	28.50
83	- midnight to 8:00 a.m.	33.00	42.80
	Each additional patient seen on shift		
	- Monday to **Friday**, 8:00 am to midnight	**NC**	**NC**
88	- **Saturdays**, Sundays or Statutory Holidays, 8:00 a.m. to midnight	3.60	3.60
89	- midnight to 8:00 a.m.	5.90	5.90
	Premiums on Emergency or OPD services – for physicians not doing dedicated on-site emergency department coverage at approved Category 'A' facilities – (1st patient seen) – to be billed in addition to applicable visit fee code.		
	Monday to **Friday** between 8:00 a.m. and 6:00 p.m.		
	- physician already in-hospital	**NC**	**NC**
90	- special visit, without sacrifice of office hours	24.82	16.07
91	- special visit, with sacrifice of office hours	31.54	32.04
92	**Saturdays**, Sundays or Statutory Holidays or 6:00 p.m. to midnight	45.55	45.05
93	Non-elective (special) service rendered between midnight and 8:00 a.m.	57.79	67.59
	Extra patient seen premiums – (Emergency or OPD)		
	Monday to **Friday** between 8:00 a.m. and 6:00 p.m.		
96	- without sacrifice of office hours	9.14	9.14
97	- with sacrifice of office hours	13.73	13.73
98	**Saturdays**, Sundays or Statutory Holidays or 6:00 p.m. to midnight	22.96	21.96
99	Midnight to 8:00 a.m.	33.03	33.03

Notes:

1. Special visit premiums are not applicable for scheduled OPD clinics.
2. Special visit premiums are not payable in addition to detention.
3. **NC = No Charge**

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**82.46**
108	**Sexual assault assessment**	**308.70**
111	Pre-dental general assessment	**65.97**
112	General assessment	**82.46**
114	General reassessment	**41.24**
118	Routine post-operative care	**32.98**
121	Partial assessment	**32.98**
122	Visit for well-baby care	**65.97**
123	Partial assessment of a patient who is 65 to 74 years of age	**41.24**
124	Partial assessment of a patient who is 75 years of age or older	**49.48**
126	Partial assessment of a patient who received a WHSCC service during the same office visit	**32.98**
127	Chronic Disease Management of a patient under **75** years of age	**49.48**
129	**Family Medicine Counselling, bill using fee code 121, 123, or 124, per ¼ hour**	**add 10.00**
	Psychotherapy:	
131	Individual, per ½ hour or major part thereof	**65.97**
132	Group (4 to 8 people) per member, per hour or major part thereof	**24.74**
136	Family therapy (2 or more family members), per ½ hour, per family	**74.22**
139	Add on fee for patients seen in scheduled after hours clinics, billed using fee code 101 through 136	add 10.00
150	**Transition-Related Surgical Readiness Assessment**	**250.00**
181	Detention per ¼ hour	**35.71**
	Home	
210	Nursing home general assessment (except **DHCS** designated facilities)	**82.46**
246	(a) "elective" and rendered any hour on any day (first patient seen), or (b) "non-elective" and rendered between 8:00 a.m. and 6:00 p.m. Monday through **Friday** (first patient seen)	**89.05**
248	"Non-elective" rendered between 8:00 a.m. and midnight on a **Saturday**, Sunday or Statutory Holiday (first patient seen)	**115.44**
249	"Non-elective" rendered between 6:00 p.m. and midnight (first patient seen)	**115.44**
250	"Non-elective" rendered between midnight and 8:00 a.m. (first patient seen)	**148.43**
251	Emergency visit with sacrifice of office hours – rendered as an immediate response to a call from the patient or the patient's attendant	**115.44**
252	Extra patient seen during any home visit	**47.82**
281	Detention per ¼ hour	**35.71**

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	DHCS Designated Long-Term Care Facilities With Long Term Beds	
285	Nursing home **g**eneral assessment	**82.46**
286	(a) nursing home visit "elective" and rendered any hour on any day (first patient seen), or (b) nursing home visit "non-elective" and rendered between 8:00 a.m. and 6:00 p.m. Monday through Friday (first patient seen)	**89.05**
288	"Non-elective" nursing home visit rendered between 8:00 a.m. and midnight on a Saturday, Sunday or Statutory Holiday (first patient seen)	**115.44**
289	"Non-elective" nursing home visit rendered between 6:00 p.m. and midnight (first patient seen)	**115.44**
290	"Non-elective" nursing home visit rendered between midnight and 8:00 a.m. (first patient seen)	**148.43**
291	Emergency nursing home visit with sacrifice of office hours – (first patient seen) (this service must be in response to a medical emergency and must be rendered as an immediate response to a call from the patient or the patient's attendant)	**115.44**
292	Extra patient seen during any nursing home visit	**47.82**
	Hospital In-Patient	
301	Consultation	**82.46**
311	**P**re-dental general assessment	**65.97**
312	**G**eneral assessment	**82.46**
314	**G**eneral reassessment	**41.24**
	Psychotherapy	
331	Individual, (per ½ hour or major part thereof)	**65.97**
355	**I**n-patient surcharge for first 7 days – per diem	**13.19**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**41.23**
357	6th to 13th week inclusive – per diem (visit type 3)	**25.93**
358	After 13th week – per diem (visit type 4)	**11.77**
359	**I**n-patient surcharge, day of discharge	**49.48**
360	**C**oncurrent care, per visit	**32.98**
361	**N**ewborn baby care	**65.97**
	Supportive Care	
371	In 1st 7 days – not exceeding 1 visit every 2 days – per visit	**24.74**
372	After 1st 7 days – not exceeding 1 visit every 4 days – per visit	**24.74**
	Chronic and convalescent care:	
373	Maximum of 1 visit every 5 days	**32.98**
374	Attendance at high risk deliveries (per infant)	**156.68**
376	Medical Assistance in Dying (MAiD) related hospital in-patient during Contemplative Phase	80.51
381	Detention per ¼ hour	**35.71**

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital Out-Patient and Emergency	
401	Consultation	**82.46**
408	**Sexual assault assessment**	**308.70**
411	**P**re-dental general assessment	**65.97**
412	**G**eneral assessment	**82.46**
414	**G**eneral reassessment	**41.24**
418	**R**outine post-operative care	**32.98**
421	**P**artial assessment	**32.98**
423	**P**artial assessment of a patient who is 65 to 74 years of age	**41.24**
424	**P**artial assessment of a patient who is 75 years of age or older	**49.48**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	**32.98**
	Psychotherapy:	
431	Individual, per ½ hour or major part thereof	**65.97**
432	Group (4 to 8 people) per member, per hour or major part thereof	**24.74**
436	Family therapy (2 or more family members) per ½ hour, per family	**74.22**
450	**Transition-Related Surgical Readiness Assessment**	**250.00**
481	**D**etention per ¼ hour	**35.71**
482	**E**scort of a critically ill patient per ¼ hour	**71.43**
	Physician on Duty at Designated 24 Hour On-Site Emergency Department (see Appendix A)	
401	Consultation	**82.46**
411	**P**re-dental general assessment	**65.97**
416	**C**omplex assessment	**57.65**
418	**R**outine post-operative care	**32.98**
421	**P**artial assessment	**32.98**
423	**P**artial assessment of a patient who is 65 to 74 years of age	**41.24**
424	**P**artial assessment of a patient who is 75 years of age or older	**49.48**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	**32.98**
	Psychotherapy:	
431	Individual, per ½ hour or major part thereof	**65.97**
432	Group (4 to 8 people) per member, per hour or major part thereof	**24.74**
436	Family therapy (2 or more family members) per ½ hour, per family	**74.22**
481	**D**etention per ¼ hour	**35.71**

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate

FAMILY PRACTICE RENEWAL PROGRAM

The following codes apply only to eligible **family physicians** registered with the Fee Code Initiative of the Family Practice Renewal Program.

520 Shared Care (maximum 2 units per day) …….. 30.00

Payable to fee-for-service **Family Physicians** for two-way collaborative conferencing, either by telephone or in person, between the **family physician** and at least one primary health care provider (excluding other **family physicians** and specialists). Conferencing cannot be delegated.

1. The conference may include, but does not require, the participation of the patient, and possibly family members, due to the severity of the patient's condition.
2. If the patient is present, the conference is payable at $30.00 per 15 minutes (i.e. one unit), in addition to the normal visit fee. If the patient is not present, the conference is payable at $30.00 per 15 minutes or greater part thereof (e.g. after 8 minutes of visit time). The conference is payable in addition to an office visit (same day) if required.
3. Conferences are payable to a maximum of 2 units per patient per day and to a maximum of 100 units per physician annually.
4. A care plan must be recorded in the patient chart and must include the following information:
   · Patient's name· Date(s) and time(s) of service · Diagnosis · Reason for need of Clinical Action Plan · Health care providers with whom the physician conferred & their role in provision of care · Clinical plan determined, including tests ordered and/or administered
5. This fee is not payable for situations where the purpose of the conference is to:
   a. book an appointment; or
   b. arrange for an expedited consultation or procedure; or
   c. arrange for laboratory or diagnostic investigations; or
   d. arrange a hospital or long term care bed for a patient; or
   e. provide notification of services performed.
6. The conference must:
   a. be pertinent to the treatment of the patient's current condition; and
   b. involve two-way collaboration to determine an appropriate care plan for the patient.
7. If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
8. The payment is made to the **family physician** regardless of who initiates the consultation.
9. This fee is not payable to physicians who are working under salary, service contract or sessional arrangements.

CONSULTATIONS AND VISITS

FAMILY MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate

Family Practice Renewal (Cont'd)

521 Patient Care Telephone (maximum **4** units per day) …….. 10.00

Payable to fee-for-service **Family Physicians** for two-way telephone communication between the physician (or other primary health care provider employed within the physician's office) and the patient (or the patient's medical representative).

1. This code is not tied to a specific condition but requires a diagnostic code.
2. This code can be used at the discretion of the **family physician** for any patient for whom he/she is the designated primary care physician.
3. The telephone call is payable at $10.00 per 5 minutes. (i.e. one unit)
4. Calls are payable for **4** units per patient per day and to a maximum of 225 units per physician annually.
5. Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.
6. This fee is payable on the same calendar day as a visit or service fee by the same physician for the same patient.
7. This fee is not payable for simple prescription renewals, notifications of normal test results, or notification of office, referral or other appointments.
8. The payment is made to the **family physician** regardless of who initiates the call.
9. The fee is not payable to physicians who are working under salary, service contract or sessional arrangements.

CONSULTATIONS AND VISITS

ANAESTHESIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate

Fees for Anaesthesiology Consultations and Visit must be coded as capacity "0" on claims.

Hospital In-Patient

301	Consultation	114.49
302	Major medical consultation	114.49
308	Intra-operative consultation	114.49
311	**P**re-dental general assessment	55.16
312	**G**eneral assessment	54.24
313	**S**pecific assessment	47.50
315	**S**pecific reassessment	31.45
381	**D**etention per ¼ hour	34.87

Hospital Out-Patient and Emergency

401	Consultation	114.49
409	**P**re-anaesthetic clinic assessment	92.20
411	**P**re-dental general assessment	55.16
412	**G**eneral assessment	54.24
413	**S**pecific assessment	47.50
415	**S**pecific reassessment	31.45
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

Hospital Pain Clinic

These fee codes may only be billed by Anaesthesiologists working in an organized hospital pain clinic approved by the Regional Integrated Health Authority.

400	Pain clinic consultation	140.60
419	Pain clinic reassessment	42.90

Pain Clinic Consultation – This service may only be claimed by Anaesthesiologists working in organized hospital pain clinics who are requested by other physicians to examine patients suffering from chronic pain and provide their opinion and recommendations in writing to the referring physician. The general definition and rules respecting consultations as described in General Preamble Section 6.1 apply to Pain Clinic Consultations.

Pain Clinic Reassessment – Follow up visits to Anaesthesiologists working in organized hospital pain clinics are claimed using this code. This service consists of the necessary reassessment of the patient's response to treatment and an appropriate record.

CONSULTATIONS AND VISITS

DERMATOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**95.20**
113	**S**pecific assessment	**49.81**
115	**S**pecific reassessment	39.16
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	**95.20**
203	Consultation in **DHCS** Designated Long Term Care Facility (see Appendix C)	147.30
213	**S**pecific assessment	**49.81**
215	**S**pecific reassessment	39.16
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	**95.20**
313	**S**pecific assessment	**49.81**
315	**S**pecific reassessment	39.16
	Subsequent Visits:	
356	Up to 5 weeks – per diem (visit type 2)	**34.56**
357	6th to 13th week inclusive - per diem (visit type 3)	**23.52**
358	After 13th week – per diem (visit type 4)	**22.65**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	**95.20**
413	**S**pecific assessment	**49.81**
415	**S**pecific reassessment	39.16
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

EMERGENCY MEDICINE SPECIALIST

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital Out-Patient and Emergency	
401	Consultation	86.33
416	**C**omplex assessment	57.55
421	**P**artial assessment	23.87
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

GENERAL, CARDIAC, VASCULAR OR THORACIC SURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**95.94**
103	Trauma consultation	160.00
113	**S**pecific assessment	56.12
115	**S**pecific reassessment	**43.79**
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	**95.94**
203	Trauma consultation	160.00
204	Major surgical consultation	160.00
213	**S**pecific assessment	56.12
215	**S**pecific reassessment	**43.79**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	**95.94**
303	Trauma consultation	160.00
304	Major surgical consultation	160.00
308	Intra-operative consultation	**95.94**
313	**S**pecific assessment	56.12
315	**S**pecific reassessment	**43.79**
	Subsequent Visits:	
356	Up to 5 weeks – per diem (visit type 2)	**35.86**
357	6th to 13th week inclusive – per diem (visit type 3)	**24.41**
358	After 13th week – per diem (visit type 4)	**23.51**
360	**C**oncurrent care, per visit	**35.86**
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	**95.94**
403	Trauma consultation	160.00
404	Major surgical consultation	160.00
413	**S**pecific assessment	56.12
415	**S**pecific reassessment	**43.79**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

INTERNAL MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**153.51**
102	Major medical consultation	177.92
112	**G**eneral assessment	79.85
113	**S**pecific assessment	79.85
114	**G**eneral reassessment	60.44
115	**S**pecific reassessment	60.44
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
190	**G**eriatric surcharge for patients 65 years of age and older	6.90
	Home	
201	Consultation	**153.51**
202	Major medical consultation	177.92
212	**G**eneral assessment	79.85
213	**S**pecific assessment	79.85
214	**G**eneral reassessment	60.44
215	**S**pecific reassessment	60.44
281	**D**etention per ¼ hour	34.87
290	**G**eriatric surcharge for patients 65 years of age and older	6.90
	Hospital In-Patient	
301	Consultation	**153.51**
302	Major medical consultation	177.92
308	Intra-operative consultation	**153.51**
311	**P**re-dental general assessment	79.85
312	**G**eneral assessment	79.85
313	**S**pecific assessment	79.85
314	**G**eneral reassessment	60.44
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**41.23**
357	6th to 13th week inclusive – per diem (visit type 3)	**28.06**
358	After 13th week – per diem (visit type 4)	**27.03**
359	**I**n-patient surcharge, day of discharge	**80.00**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
390	**G**eriatric surcharge for patient 65 years of age and older	6.90
	Hospital Out-Patient and Emergency	
401	Consultation	**153.51**
402	Major medical consultation	177.92
411	**P**re-dental general assessment	79.85
412	**G**eneral assessment	79.85
413	**S**pecific assessment	79.85
414	**G**eneral reassessment	60.44
415	**S**pecific reassessment	60.44
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74
490	**G**eriatric surcharge for patients 65 years of age and older	6.90

CONSULTATIONS AND VISITS

NUCLEAR MEDICINE SPECIALIST

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital In-Patient	
301	Consultation*	111.14
	Hospital Out-Patient and Emergency	
401	Consultation*	111.14

***A Nuclear Medicine Consultation is payable:**

1. When no isotope treatment is carried out. It is intended to recognize evaluation of the patient for whom treatment is found to be not indicated. To claim this fee the Nuclear Medicine Specialist is required to obtain from the patient a full history of the presenting problem, to perform a full physical examination (General Assessment) of the patient and review laboratory reports with respect to the requested treatment with non-sealed radioisotopes. When the decision is made to not proceed with the requested treatment or with any alternative treatment, a consultation report shall be sent to the physician who requested the isotope treatment, stating all of the above findings and giving the basis for the decision to not proceed.

OR

2. When scans done elsewhere are referred to a Nuclear Medicine Specialist for his/her written opinion. It is not payable for the reading of scans sent for reporting. As well, a consultation does not apply when the scans referred to above are used for comparison purposes with scans made in the consultant's facilities. Claims for consultation must be submitted IC and accompanied by a copy of the referring letter and the Nuclear Medicine Specialist's report.

CONSULTATIONS AND VISITS

DEVELOPMENTAL NEUROLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	145.00
102	Major neurological consultation	165.04
112	**G**eneral assessment	**82.19**
113	**S**pecific assessment	63.10
114	**G**eneral reassessment	**64.46**
115	**S**pecific reassessment	**47.77**
144	Scheduled interview with parent or teacher for investigation/management of a child's learning disability-per ½ hour or major part thereof	63.80
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	145.00
202	Major neurological consultation	165.04
212	**G**eneral assessment	**82.19**
213	**S**pecific assessment	63.10
214	**G**eneral reassessment	**64.46**
215	**S**pecific reassessment	**47.77**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	145.00
302	Major neurological consultation	165.04
312	**G**eneral assessment	**82.19**
313	**S**pecific assessment	63.10
314	**G**eneral reassessment	**64.46**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**41.23**
357	6th to 13th week inclusive – per diem (visit type 3)	**27.43**
358	After 13th week – per diem (visit type 4)	**25.81**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	145.00
402	Major neurological consultation	165.04
412	**G**eneral assessment	**82.19**
413	**S**pecific assessment	63.10
414	**G**eneral reassessment	**64.46**
415	**S**pecific reassessment	**47.77**
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

NEUROLOGY (Except Developmental Neurology)

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	145.00
102	Major neurological consultation	165.04
112	**G**eneral assessment	**82.19**
113	**S**pecific assessment	63.10
114	**G**eneral reassessment	**64.46**
115	**S**pecific reassessment	**47.77**
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	145.00
202	Major neurological consultation	165.04
212	**G**eneral assessment	**82.19**
213	**S**pecific assessment	63.10
214	**G**eneral reassessment	**64.46**
215	**S**pecific reassessment	**47.77**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	145.00
302	Major neurological consultation	165.04
308	Intraoperative consultation	145.00
312	**G**eneral assessment	**82.19**
313	**S**pecific assessment	63.10
314	**G**eneral reassessment	**64.46**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**41.23**
357	6th to 13th week inclusive – per diem (visit type 3)	**27.43**
358	After 13th week – per diem (visit type 4)	**25.81**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	145.00
402	Major neurological consultation	165.04
412	**G**eneral assessment	**82.19**
413	**S**pecific assessment	63.10
414	**G**eneral reassessment	**64.46**
415	**S**pecific reassessment	**47.77**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

NEUROSURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**122.97**
103	Trauma consultation	145.14
104	Major surgical consultation	145.14
112	**G**eneral assessment	**63.85**
113	**S**pecific assessment	**63.85**
114	**G**eneral reassessment	**51.76**
115	**S**pecific reassessment	**51.76**
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	**31.08**
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	**122.97**
203	Trauma consultation	145.14
204	Major surgical consultation	145.14
212	**G**eneral assessment	**63.85**
213	**S**pecific assessment	**63.85**
214	**G**eneral reassessment	**51.76**
215	**S**pecific reassessment	**51.76**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	**122.97**
303	Trauma consultation	145.14
304	Major surgical consultation	145.14
308	Intraoperative consultation	**122.97**
312	**G**eneral assessment	**63.85**
313	**S**pecific assessment	**63.85**
314	**G**eneral reassessment	**51.76**
315	**S**pecific reassessment	**51.76**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**38.19**
357	6th to 13th week inclusive – per diem (visit type 3)	**25.99**
358	After 13th week – per diem (visit type 4)	**25.03**
359	**In-patient surcharge, day of discharge**	**48.31**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	**122.97**
403	Trauma consultation	145.14
404	Major surgical consultation	145.14
412	**G**eneral assessment	**63.85**
413	**S**pecific assessment	**63.85**
414	**G**eneral reassessment	**51.76**
415	**S**pecific reassessment	**51.76**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	**31.08**
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

OBSTETRICS AND GYNECOLOGY AND GYNECOLOGICAL ONCOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**92.17**
104	Major surgical consultation	**148.10**
113	**S**pecific assessment	**54.13**
115	**S**pecific reassessment	**39.88**
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	**92.17**
204	Major surgical consultation	**148.10**
213	**S**pecific assessment	**54.13**
215	**S**pecific reassessment	**39.88**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	**92.17**
304	Major surgical consultation	**148.10**
307	**H**igh risk prenatal consultation by MFM specialist, 40 minutes or more	**148.10**
308	Intra-operative consultation	**92.17**
313	**S**pecific assessment	**54.13**
315	**S**pecific reassessment	**39.88**
317	**H**igh risk prenatal assessment by MFM specialist, 20 minutes or more	**78.69**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**38.14**
357	6th to 13th week inclusive – per diem (visit type 3)	**25.01**
358	After 13th week – per diem (visit type 4)	**24.09**
360	**C**oncurrent care, per visit	31.00
361	**N**ewborn baby care in hospital (up to 10 days)	63.50
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	**92.17**
404	Major surgical consultation	**148.10**
407	**H**igh risk prenatal consultation by MFM specialist, 40 minutes or more	**148.10**
413	**S**pecific assessment	**54.13**
415	**S**pecific reassessment	**39.88**
417	**H**igh risk prenatal assessment by MFM specialist, 20 minutes or more	**78.69**
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

OPHTHALMOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation*	**91.58**
106	Special ophthalmology consultation	**151.16**
113	**S**pecific assessment	57.32
115	**S**pecific reassessment	37.50
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation*	**91.58**
213	**S**pecific assessment	57.32
215	**S**pecific reassessment	37.50
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation*	**91.58**
306	Special ophthalmology consultation	**151.16**
308	Intraoperative consultation	**91.58**
313	**S**pecific assessment	57.32
315	**S**pecific reassessment	37.50
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	31.00
357	6th to 13th week inclusive – per diem (visit type 3)	21.10
358	After 13th week – per diem (visit type 4)	20.32
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87

CONSULTATIONS AND VISITS

OPHTHALMOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital Out-Patient and Emergency	
401	Consultation*	**91.58**
406	Special ophthalmology consultation	**151.16**
413	**S**pecific assessment	57.32
415	**S**pecific reassessment	37.50
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

In addition to a physician, referrals will be accepted from an optometrist with the proviso that a copy of the consultation report be sent to the patient's **Family Physician.*

CONSULTATIONS AND VISITS

ORTHOPAEDIC SURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**95.00**
103	Trauma consultation	143.09
104	Major surgical consultation	143.09
105	Back consultation for suspected spinal disorder	119.52
113	**S**pecific assessment	**51.74**
115	**S**pecific reassessment	**36.41**
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	**95.00**
203	Trauma consultation	143.09
204	Major surgical consultation	143.09
205	Back consultation for suspected spinal disorder	119.52
213	**S**pecific assessment	**51.74**
215	**S**pecific reassessment	**36.41**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	**95.00**
303	Trauma consultation	143.09
304	Major surgical consultation	143.09
305	Back consultation for suspected spinal disorder	119.52
308	Intraoperative consultation	**95.00**
313	**S**pecific assessment	**51.74**
315	**S**pecific reassessment	**36.41**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**33.91**
357	6th to 13th week inclusive – per diem (visit type 3)	**23.08**
358	After 13th week – per diem (visit type 4)	**22.23**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	**95.00**
403	Trauma consultation	143.09
404	Major surgical consultation	143.09
405	Back consultation for suspected spinal disorder	119.52
413	**S**pecific assessment	**51.74**
415	**S**pecific reassessment	**36.41**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

OTOLARYNGOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**83.38**
113	**S**pecific assessment	**48.49**
115	**S**pecific reassessment	33.49
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	**83.38**
213	**S**pecific assessment	**48.49**
215	**S**pecific reassessment	33.49
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	**83.38**
308	Intraoperative consultation	**83.38**
313	**S**pecific assessment	**48.49**
315	**S**pecific reassessment	33.49
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**32.47**
357	6th to 13th week inclusive – per diem (visit type 3)	**22.10**
358	After 13th week – per diem (visit type 4)	**21.28**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	**83.38**
413	**S**pecific assessment	**48.49**
415	**S**pecific reassessment	33.49
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

PAEDIATRICS (Except Developmental Paediatrics)

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**195.84**
102	Major medical consultation	179.18
107	Prenatal consultation	**195.84**
112	**G**eneral assessment	98.72
113	**S**pecific assessment	**98.72**
114	**G**eneral reassessment	**93.05**
115	**S**pecific reassessment	**93.05**
122	Visit for **w**ell-baby care	**32.49**
141	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
181	**D**etention per ¼ hour	**35.98**
	Home	
201	Consultation	**195.84**
202	Major medical consultation	179.18
207	Prenatal consultation	**195.84**
212	**G**eneral assessment	98.72
213	**S**pecific assessment	**98.72**
214	**G**eneral reassessment	**93.05**
241	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
252	Extra patient seen	15.41
281	**D**etention per ¼ hour	**35.98**
	Hospital In-Patient	
301	Consultation	**195.84**
302	Major medical consultation	179.18
307	Prenatal consultation	**195.84**
308	Intra-operative consultation	**195.84**
311	**P**re-dental general assessment	98.72
312	**G**eneral assessment	98.72
313	**S**pecific assessment	**98.72**
314	**G**eneral reassessment	**93.05**
341	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**35.34**
357	6th to 13th week inclusive – per diem (visit type 3)	**22.38**
358	After 13th week – per diem (visit type 4)	**21.55**
360	**C**oncurrent care, per visit	31.00
361	**N**ewborn baby care in hospital	**64.98**
374	**A**ttendance at high risk delivery (per infant)	149.58
381	**D**etention per ¼ hour	**35.98**

CONSULTATIONS AND VISITS

PAEDIATRICS (Except Developmental Paediatrics)

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital Out-Patient and Emergency	
401	Consultation	**195.84**
402	Major medical consultation	179.18
407	Prenatal consultation	**195.84**
411	**P**re-dental general assessment	98.72
412	**G**eneral assessment	98.72
413	**S**pecific assessment	**98.72**
414	**G**eneral reassessment	**93.05**
415	**S**pecific reassessment	**93.05**
421	**P**artial assessment	**33.52**
441	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
481	**D**etention per ¼ hour	**35.98**
482	**E**scort of a critically ill patient per ¼ hour	**71.96**
	Physician on Duty at Designated 24 Hour On-Site Emergency Department (see Appendix A)	
401	Consultation	**195.84**
402	Major medical consultation	179.18
407	Prenatal consultation	**195.84**
411	**P**re-dental general assessment	98.72
413	**S**pecific assessment	**98.72**
415	**S**pecific reassessment	**93.05**
416	**C**omplex assessment	56.29
421	**P**artial assessment	**33.52**
441	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
481	**D**etention per ¼ hour	**35.98**
482	**E**scort of a critically ill patient per ¼ hour	**71.96**

CONSULTATIONS AND VISITS

DEVELOPMENTAL PAEDIATRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**195.84**
102	Major medical consultation	179.18
107	Prenatal consultation	**195.84**
112	**G**eneral assessment	98.72
113	**S**pecific assessment	**98.72**
114	**G**eneral reassessment	**93.05**
115	**S**pecific reassessment	**93.05**
122	Visit for **w**ell-baby care	**32.49**
141	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
144	Scheduled **i**nterview with parent, guardian or other professional for investigation/management of a patient's physical, cognitive or emotional disability – per ½ hour or major part thereof	100.46
181	**D**etention per ¼ hour	**35.98**
	Home	
201	Consultation	**195.84**
202	Major medical consultation	179.18
207	Prenatal consultation	**195.84**
212	**G**eneral assessment	98.72
213	**S**pecific assessment	**98.72**
214	**G**eneral reassessment	**93.05**
241	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
252	Extra patient seen	15.41
281	**D**etention per ¼ hour	**35.98**
	Hospital In-Patient	
301	Consultation	**195.84**
302	Major medical consultation	179.18
307	Prenatal consultation	**195.84**
311	**P**re-dental general assessment	98.72
312	**G**eneral assessment	98.72
313	**S**pecific assessment	**98.72**
314	**G**eneral reassessment	**93.05**
341	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**35.34**
357	6th to 13th week inclusive – per diem (visit type 3)	**22.38**
358	After 13th week – per diem (visit type 4)	**21.55**
360	**C**oncurrent care, per visit	31.00
361	**N**ewborn baby care in hospital	**64.98**
374	**A**ttendance at high risk delivery (per infant)	149.58
381	**D**etention per ¼ hour	**35.98**

CONSULTATIONS AND VISITS

DEVELOPMENTAL PAEDIATRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital Out-Patient and Emergency	
401	Consultation	**195.84**
402	Major medical consultation	179.18
407	Prenatal consultation	**195.84**
411	**P**re-dental general assessment	98.72
412	**G**eneral assessment	98.72
413	**S**pecific assessment	**98.72**
414	**G**eneral reassessment	**93.05**
415	**S**pecific reassessment	**93.05**
421	**P**artial assessment	**33.52**
441	**I**nterview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	**64.31**
481	**D**etention per ¼ hour	**35.98**
482	**E**scort of a critically ill patient per ¼ hour	**71.96**

CONSULTATIONS AND VISITS

PHYSICAL MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	94.42
113	**S**pecific assessment	47.39
115	**S**pecific reassessment	36.93
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	94.42
213	**S**pecific assessment	47.39
215	**S**pecific reassessment	36.93
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	94.42
313	**S**pecific assessment	47.39
315	**S**pecific reassessment	36.93
342	**I**nterviewing and counselling of patients and/or relatives, per ½ hour or major part thereof	39.53
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	31.00
357	6th to 13th week inclusive – per diem (visit type 3)	20.35
358	After 13th week – per diem (visit type 4)	19.60
360	**C**oncurrent care, per visit	31.00
375	**P**hysiatric management	2.71
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	94.42
413	**S**pecific assessment	47.39
415	**S**pecific reassessment	36.93
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
442	**I**nterviewing and counselling or patients and/or relatives, per ½ hour or major part thereof	39.53
475	**P**hysiatric management	2.71
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

PLASTIC SURGERY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	**84.93**
104	Major surgical consultation	**169.85**
113	**S**pecific assessment	**43.35**
115	**S**pecific reassessment	**34.89**
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	**84.93**
204	Major surgical consultation	**169.85**
213	**S**pecific assessment	**43.35**
215	**S**pecific reassessment	**34.89**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation	**84.93**
304	Major surgical consultation	**169.85**
308	Intraoperative consultation	**84.93**
313	**S**pecific assessment	**43.35**
315	**S**pecific reassessment	**34.89**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**35.39**
357	6th to 13th week inclusive – per diem (visit type 3)	**24.09**
358	After 13th week – per diem (visit type 4)	**23.20**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation	**84.93**
404	Major surgical consultation	**169.85**
413	**S**pecific assessment	**43.35**
415	**S**pecific reassessment	**34.89**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

CONSULTATIONS AND VISITS

PSYCHIATRY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation	250.00
113	**S**pecific assessment	79.85
115	**S**pecific reassessment	61.25
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
128	**Specific neurocognitive assessment**	**62.75**
130	**P**sychiatric care, per ½ hour or major part thereof	**90.35**
	Psychotherapy	
131	Individual, per ½ hour or major part thereof	**90.35**
133	Group of 4 people, per member, per hour or major part thereof	34.37
134	Group of 5 people, per member, per hour or major part thereof	27.50
135	Group of 6-12 people, per member, per hour or major part thereof	22.91
136	Family therapy, 2 or more family members, per ½ hour, per family	91.10
137	**I**nitial interview with parent or guardian (when seen separately) on behalf of emotionally disturbed child	62.75
138	**C**ase consultation with a child welfare or correctional worker, teacher, community health nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour or major part thereof	**91.00**
139	**I**nterview with child or adolescent – per ½ hour or major part thereof	53.36
140	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
150	**Transition-Related Surgical Readiness Assessment**	**250.00**
160	Transfer of care surcharge – after a minimum of 6 follow up visits	**99.78**
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation	250.00
213	**S**pecific assessment	79.85
215	**S**pecific reassessment	61.25
216	**S**pecific assessment at the lock-up at the custodian's request	116.26
228	**Specific neurocognitive assessment**	**62.75**
230	**P**sychiatric care, per ½ hour or major part thereof	**90.35**
	Psychotherapy	
231	Individual, per ½ hour or major part thereof	**90.35**
233	Group of 4 people, per member, per hour or major part thereof	34.37
234	Group of 5 people, per member, per hour or major part thereof	27.50
235	Group of 6-12 people, per member, per hour or major part thereof	22.91
238	**C**ase consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour or major part thereof	**91.00**
239	**I**nterview with child or adolescent – per ½ hour or major part thereof	53.36
240	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
252	Extra patient seen	12.44
281	**D**etention per ¼ hour	34.87

CONSULTATIONS AND VISITS

PSYCHIATRY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital In-Patient	
301	Consultation	250.00
313	**S**pecific assessment	79.85
315	**S**pecific reassessment	61.25
328	**Specific neurocognitive assessment**	**62.75**
330	**P**sychiatric care, per ½ hour or major part thereof	**90.35**
	Psychotherapy:	
331	Individual, per ½ hour or major part thereof	**90.35**
333	Group of 4 people, per member, per hour or major part thereof	34.37
334	Group of 5 people, per member, per hour or major part thereof	27.50
335	Group of 6-12 people, per member, per hour or major part thereof	22.91
336	Family, where at least one member is an in-patient, 2 or more family members, per ½ hour, per family	91.10
338	**C**ase consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour major part thereof	**91.00**
339	**I**nterview with child or adolescent – per ½ hour or major part thereof	53.36
340	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
	In-patient surcharge	
352	- day 1 to 14, per day	**29.35**
353	- days 15 to 28, per day	**17.61**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**36.39**
357	6th to 13th week inclusive – per diem (visit type 3)	**25.90**
358	After 13th week – per diem (visit type 4)	**24.93**
359	In-patient surcharge, day of discharge	100.00
360	**C**oncurrent care, per visit	**36.39**
381	**D**etention per ¼ hour	34.87

CONSULTATIONS AND VISITS

PSYCHIATRY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital Out-Patient and Emergency	
401	Out Patient Clinic Consultation	250.00
402	Emergency Department Consultation	325.00
413	**S**pecific assessment	79.85
415	**S**pecific reassessment	61.25
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
428	**Specific neurocognitive assessment .....**	**62.75**
430	**P**sychiatric care, per ½ hour or major part thereof	**90.35**
	Psychotherapy:	
431	Individual, per ½ hour or major part thereof	**90.35**
433	Group of 4 people, per member, per hour or major part thereof	34.37
434	Group of 5 people, per member, per hour or major part thereof	27.50
435	Group of 6-12 people, per member, per hour or major part thereof	22.91
436	Family therapy, 2 or more family members, per ½ hour, per family	91.10
438	**C**ase consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour major part thereof	**91.00**
439	**I**nterview with child or adolescent – per ½ hour or major part thereof	53.36
440	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75
450	**Transition-Related Surgical Readiness Assessment .....**	**250.00**
476	**P**sychiatry day care – per visit, per patient	22.71
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient, per ¼ hour	69.74

* In addition to a physician, referrals for patients aged 2 to 17 years will be accepted from a child welfare or correctional worker, guidance counselor or teacher with the proviso that a copy of the consultation report be sent to the patient's **family physician.**

CONSULTATIONS AND VISITS

UROLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Office	
101	Consultation*	84.86
104	Major surgical consultation	138.40
113	**S**pecific assessment	**54.51**
115	**S**pecific reassessment	**38.67**
126	**P**artial assessment of a patient who received a WHSCC service during the same office visit	31.00
181	**D**etention per ¼ hour	34.87
	Home	
201	Consultation*	84.86
204	Major surgical consultation	138.40
213	**S**pecific assessment	**54.51**
215	**S**pecific reassessment	**38.67**
281	**D**etention per ¼ hour	34.87
	Hospital In-Patient	
301	Consultation*	84.86
304	Major surgical consultation	138.40
308	Intraoperative consultation	84.86
313	**S**pecific assessment	**54.51**
315	**S**pecific reassessment	**38.67**
	Subsequent visits:	
356	Up to 5 weeks – per diem (visit type 2)	**34.91**
357	6th to 13th weeks inclusive – per diem (visit type 3)	**23.76**
358	After 13th week – per diem (visit type 4)	**22.88**
360	**C**oncurrent care, per visit	31.00
381	**D**etention per ¼ hour	34.87
	Hospital Out-Patient and Emergency	
401	Consultation*	84.86
404	Major surgical consultation	138.40
413	**S**pecific assessment	**54.51**
415	**S**pecific reassessment	**38.67**
426	**P**artial assessment of a patient who received a WHSCC service during the same visit	31.00
481	**D**etention per ¼ hour	34.87
482	**E**scort of a critically ill patient per ¼ hour	69.74

* Includes, when necessary, urethral calibration, catheterization and prostatic fluid examinations but not to include endoscopic examination.

CONSULTATIONS AND VISITS

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Hospital In-Patient	
301	Diagnostic Radiology Consultation ……	127.17
302	Interventional Radiology Consultation ……....	127.17
	Hospital Out-Patient and Emergency	
401	Diagnostic Radiology Consultation ……	127.17
402	Interventional Radiology Consultation ……....	127.17

1. A Diagnostic Radiology Consultation applies when insured imaging studies made elsewhere are referred to a Radiologist for his/her written opinion. It is not payable for the reading of insured imaging studies sent for reporting. As well, a consultation does not apply when the insured imaging studies referred to above are used for comparison purposes with images made in the consultant's facilities. Claims for consultation must be submitted IC and accompanied by a copy of the referring letter and the Radiologist's report.

2. **An Interventional Radiology (IR) Consultation applies when an Interventional Radiologist is requested by a physician or nurse practitioner to assess a patient referred for an interventional radiological procedure which requires extensive discussion with the patient. Examples of such procedures include, but are not limited to, the following: endovascular obliteration of cerebral aneurysms and vascular malformations including pelvic congestion syndrome, embolization of uterine fibroids, percutaneous image guided radiofrequency ablation of solid tumours, trans-arterial chemo embolization. The IR consultation is not payable for the following procedures: simple biopsies or aspirations; the routine task of obtaining consent; or for any procedures where direct interaction with the patient is not warranted. The Interventional Radiologist must give their opinion in writing to the referring physician or nurse practitioner. This opinion must include documentation of the pertinent patient history and physical examination, and a discussion of the risks and limitations of the procedure. The consultation is payable whether or not the Interventional Radiologist actually performs the procedure.**

Billing of an IR Consultation is restricted to those physicians certified by the Royal College of Physicians and Surgeons of Canada in Interventional Radiology. Other Interventional Radiologists may be considered upon request to the Assistant Medical Director.

VIRTUAL HEALTH
TELEMEDICINE PREAMBLE

1. GENERAL POLICY

1.1 "Telemedicine service" is a medical service provided to an MCP beneficiary presenting at an approved telemedicine site in Newfoundland and Labrador, through a direct interactive video link with a receiving physician at an approved telemedicine site in Newfoundland and Labrador (see Appendix H for the list of approved sites). The patient must be present at the same time as the physician.

1.2 Only physicians eligible to bill fee-for-service are allowed to bill MCP for telemedicine payments.

1.3 The codes listed in this Telemedicine Schedule must be used for telemedicine services without substitution. Claims must be coded with the hospital number for the site where the physician is located.

1.4 Teleradiology services should be billed using codes listed in the Radiology section of the MCP Medical Payment Schedule. They cannot be billed using the codes listed in the Telemedicine schedule.

2. TERMS AND CONDITIONS FOR TELEMEDICINE CODES

2.1 Telemedicine services must meet all the requirements, including documentation requirements, for comparable consultation and assessment codes listed in the MCP Medical Payment Schedule except that the requirement for physical examination does not apply:

(a) Telemedicine consultations must be documented with a written request from the referring physician, a record of the history, and a letter back to the referring physician.

(b) Telemedicine services for a non-referred patient should be claimed using a reassessment code.

(c) The record of a telemedicine reassessment must include: the reason for the encounter; findings through history; working diagnosis and/or plan of investigation or treatment.

2.2 Where a receiving physician, after having provided a telemedicine service to a patient, decides he/she must examine the patient in person, the physician may claim a MCP major examination fee for the in-person examination, notwithstanding that the in-person examination has been provided within ninety (90) days of the telemedicine service.

2.3 Where telemedicine services are interrupted for because of a loss of transmission capacity beyond the control of the physician, and are not able to be resumed within the time allocated, and are therefore not able to be completed:

(a) the physician shall be entitled to claim for the telemedicine services which he/she began to provide prior to the interruption, to the same effect as if the provision of the services had been completed. Remarks code 50 – Telemedicine service interrupted by loss of transmission capacity should be entered on claims for such services;

(b) where a telemedicine consultation service is provided to the patient for the same condition by the same physician subsequent to a service that was interrupted by a loss of transmission capacity, the physician shall be entitled to claim for the second telemedicine consultation service, notwithstanding that the second service has been provided within ninety (90) days of the initial interrupted telemedicine consultation service. The claim for the initial service must be coded with remarks code 50.

2.4 Where there is no loss of transmission capacity and telemedicine services did not take place because the time allocated expired or the physician temporarily discontinued telemedicine work for another reason, no claims can be submitted to MCP for the services that did not take place.

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	FAMILY MEDICINE	
502	Telemedicine partial assessment ……..	32.20
503	Telemedicine partial assessment of a patient who is 65 to 74 years of age ……..	40.26
504	Telemedicine partial assessment of a patient who is 75 years of age or older ……..	48.31
	Psychotherapy:	
511	Individual, per ½ hour or major part thereof ……..	64.41
512	Group (4 to 8 people) per member, per hour or major part thereof ……..	24.15
513	Family therapy (2 or more family members), per ½ hour, per family ……	72.46
	Supportive Care:	
531	In 1st 7 days – not exceeding 1 encounter every 2 days – per encounter ……	24.15
532	After 1st 7 days – not exceeding 1 encounter every 4 days – per encounter ……..	24.15
539	Add on fee for patient encounter between 6:00 p.m. and midnight on weekdays, on weekends, or on MCP Statutory Holidays ……..	10.00

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	DERMATOLOGY	
501	Consultation	91.52
502	Reassessment	41.70

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	GENERAL SURGERY	
501	Consultation	91.78
502	Reassessment	46.13

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	INTERNAL MEDICINE	
501	Consultation	150.82
502	Reassessment	66.91

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	NUCLEAR MEDICINE	
501	Consultation	111.14

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	DEVELOPMENTAL NEUROLOGY	
501	Consultation …….....	145.00
502	Reassessment ……	46.16
515	Scheduled interview with parent or teacher for investigation/management of a child's learning disability – per ½ hour or major part thereof …….....	63.80

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	NEUROLOGY	
501	Consultation	145.00
502	Reassessment	46.16

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	NEUROSURGERY	
501	Consultation	121.10
502	Reassessment	50.90

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	OBSTETRICS AND GYNECOLOGY	
501	Consultation	87.50
502	Reassessment	41.00

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	OPHTHALMOLOGY	
501	Consultation ……..	85.97
502	Reassessment ……..	44.10

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	ORTHOPAEDICS	
501	Consultation	90.74
502	Reassessment	40.11

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	OTOLARYNGOLOGY	
501	Consultation	79.34
502	Reassessment	36.83

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	PAEDIATRICS	
501	Consultation	174.04
502	Reassessment	89.80
513	Interview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months)	62.33

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	DEVELOPMENTAL PAEDIATRICS	
501	Consultation ……..	174.04
502	Reassessment …….	89.80
513	Interview with parent or guardian on behalf of seriously ill patient (maximum 1 visit every 3 months) ……	62.33
514	Scheduled interview with parent, guardian or other professional for investigation/management of a patients physical, cognitive or emotional disability - per ½ hour or major part thereof ……...	100.46

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	PHYSICAL MEDICINE	
501	Consultation	94.42
502	Reassessment	42.16

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	PLASTIC SURGERY	
501	Consultation	79.22
502	Reassessment	36.14

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	PSYCHIATRY	
501	Consultation	250.00
502	Reassessment	67.45
504	Psychiatric care, per ½ hour or major part thereof	86.57
	Psychotherapy:	
505	Individual, per ½ hour or major part thereof	86.57
506	Group of 4 people, per member, per hour or major part thereof	34.37
507	Group of 5 people, per member, per hour or major part thereof	27.50
508	Group of 6-12 people, per member, per hour or major part thereof	22.91
509	Family therapy, 2 or more family members, per ½ hour, per family	91.10
510	Case consultation with a child welfare or correctional worker, teacher, community health or nurse, or other allied professional, in person, on behalf of a child or adolescent – per ½ hour or major part thereof	62.75
511	Interview with child or adolescent – per ½ hour or major part thereof	53.36
512	Diagnostic or therapeutic interview with a parent, guardian, foster parent, or group home parent of a child or adolescent – per ½ hour or major part thereof	62.75

VIRTUAL HEALTH

TELEMEDICINE CONSULTATIONS AND REASSESSMENTS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	UROLOGY	
501	Consultation	84.86
502	Reassessment	40.00

Appendix H

VIRTUAL HEALTH

APPROVED TELEMEDICINE SITES

Facility Number	Telemedicine Site Name
Eastern Regional Health Authority	
022	U.S. Memorial Health Centre, St. Lawrence
112	Major's Path Community Health Clinic, St. John's
124	Dr. H. Bliss Murphy Cancer Centre, St. John's
230	Carbonear General Hospital, Carbonear
248	Dr. G. B. Cross Memorial Hospital, Clarenville
256	Health Sciences Centre, (General Hospital) St. John's
264	St. Clare's Mercy Hospital, St. John's
281	Janeway Children's Health and Rehabilitation Centre, St. John's
302	Burin Peninsula Health Care Centre, Burin
337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
345	Bonavista Peninsula Health Centre, Bonavista
353	Dr. Walter Templeman Health Care Centre, Bell Island
361	Waterford Hospital, St. John's
370	Dr. Leonard A. Miller Centre, St. John's
371	Dr. Leonard A. Miller Centre, Family Practice Clinic, St. John's
375	Eastern Health Opioid Treatment Centre
380	Eastern Health Recovery Centre
400	Newhook Community Health Centre, Whitbourne
418	Placentia Health Centre, Placentia
671	Clarenville Correctional Centre for Women, Clarenville
736	Newfoundland & Labrador Youth Centre, Whitbourne
800	Salvation Army Glenbrook Lodge, St. John's
802	St. Patrick's Mercy Home, St. John's
804	Saint Luke's Nursing Home, St. John's
806	Agnes Pratt Nursing Home, St. John's
810	Pleasant View Towers, St. John's
818	Bluecrest Nursing Home, Grand Bank
819	Dr. Albert A. O'Mahoney Memorial Manor, Clarenville
870	Grand Bank Health Centre, Grand Bank

Appendix H

VIRTUAL HEALTH

APPROVED TELEMEDICINE SITES

Facility Number	Telemedicine Site Name
Central Regional Health Authority	
051	Baie Verte Peninsula Health Centre, Baie Verte
205	James Paton Memorial Regional Health Centre, Gander
213	Central Newfoundland Regional Health Centre, Grand Falls-Windsor
221	Notre Dame Bay Memorial Health Centre, Twillingate
299	Brookfield Bonnews Health Care Centre, Brookfield
311	Connaigre Peninsula Health Centre, Harbour Breton
329	Fogo Island Health Centre, Fogo
426	Green Bay Community Health Centre, Springdale
434	A.M. Guy Memorial Health Centre, Buchans
451	Dr. Hugh Twomey Health Centre, Botwood
698	Bishop's Falls Correctional Centre, Bishop's Falls
824	North Haven Manor, Lewisporte
854	Glovertown Clinic, Glovertown
906	Bay d'Espoir Community Health Centre, St. Alban's
907	Conne River Health Clinic, Conne River
Western Regional Health Authority	
175	Western Memorial Regional Hospital, Corner Brook
183	Sir Thomas Roddick Hospital, Stephenville
191	Dr. Charles L. Legrow Health Centre, Port aux Basques
388	Calder Health Centre, Burgeo
396	Rufus Guinchard Health Centre, Port Saunders
442	Bonne Bay Health Centre, Norris Point
680	Stephenville Correctional Centre For Men, Stephenville
825	Corner Brook Long Term Care, Corner Brook
826	J.I. O'Connell, Corner Brook
828	Bay St. George Long Term Care Facility, Stephenville Crossing
877	Deer Lake Clinic, Deer Lake
884	Ramea Medical Clinic, Ramea
920	Francois Clinic, Francois

Appendix H

VIRTUAL HEALTH

APPROVED TELEMEDICINE SITES

Facility Number	Telemedicine Site Name
Labrador-Grenfell Integrated Health Authority	
141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony
159	Capt. William Jackman Memorial Hospital, Labrador City
167	Labrador Health Centre, Happy Valley-Goose Bay
834	Community Health Centre, Forteau
863	Labrador South Health Centre, Forteau
864	Straits of Belle Isle Health Centre, Flower's Cove
865	White Bay Central Health Centre, Roddickton
867	Churchill Falls Clinic, Churchill Falls
868	Nain Nursing Station, Nain
894	Mary's Harbour Nursing Station, Mary's Harbour
896	Natuashish Nursing Station, Natuashish
898	Hopedale Nursing Station, Hopedale
908	St. Lewis Community Clinic, St. Lewis
909	Groswater Bay Clinic, Rigolet
910	Postville Community Clinic, Postville
911	Port Hope Simpson Community Clinic, Port Hope Simpson
912	Makkovik Community Clinic, Makkovik
913	Charlottetown Nursing Station, Charlottetown
914	Black Tickle Nursing Station, Black Tickle
915	Cartwright Nursing Station, Cartwright

CRITICAL CARE

NEONATAL INTENSIVE CARE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Level A: Infant in Neonatal Intensive Care Unit maintained by artificial ventilation (all modalities) and with full invasive monitoring and parenteral alimentation.	
51730	- first day	**435.56**
51732	- 2nd to 10th day (inclusive), per diem	**217.70**
51734	- 11th day onwards, per diem	**108.86**
	Level B: Infant in Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive with O_2 administration and IV therapy but without Ventilatory Support	
51738	- first day	**281.62**
51740	- 2nd day onwards, per diem	**79.64**
	Level C: Infant in Neonatal Intensive Care Unit requiring O_2 administration and non-invasive monitoring and gavage feeding	
51744	- first day	**188.85**
51746	- 2nd day onwards, per diem	**39.39**
	Concurrent Care (NICU)	
51790	Physician rendering care concurrently with the physician in-charge, per diem	**28.60**

CRITICAL CARE

NEONATAL INTENSIVE CARE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code	Rate

CRITICAL CARE

ICU AND CCU

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Comprehensive Care: is the service rendered by an Intensive Care physician who provides complete care (both Critical Care and Ventilatory Support to Critical Care Area patients)	
51750	- first day ……	**342.75**
51752	- 2nd day to 10th day, per diem ……	**171.37**
51754	- 11th day onwards, per diem ……	**85.69**
	Critical Care: is the service rendered by a physician for providing, in a Critical Care Area, all aspects of care of a critically ill patient excluding Ventilatory Support	
51756	- first day ……	**232.74**
51758	- 2nd to 10th day, per diem ……	**116.38**
51760	- 11th day onwards, per diem ……	**58.20**
	Observatory Care: ICU or CCU patient without invasive monitoring and without assisted ventilation	
51766	- first day ……	**132.00**
51768	- 2nd day to 10th day, per diem ……	**66.00**
51770	- 11th day onwards, per diem ……	**32.99**
	Ventilatory Support: is the provision of Ventilatory Care by a physician other than the one claiming Critical care. It includes assessment of the patient and use of artificial ventilator and all necessary measures for its supervision	
51774	- first day ……	**110.00**
51776	- 2nd day to 10th day, per diem ……	**54.99**
51778	- 11th day onwards, per diem ……	**27.50**
	Concurrent Care (ICU, CCU)	
51790	Physician rendering care concurrently with the physician in-charge, per diem ……	**28.60**

CRITICAL CARE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	CARDIO-PULMONARY RESUSCITATION	
	Cardiac Arrest	
51820	First unit (0 to 15 minutes or any portion thereof) ……	61.70
51822	Subsequent units (each subsequent 15 minutes or part thereof) ……	28.44
	(1) Units are timed from the onset of the arrest and the presence of the physician.	
	(2) A maximum of three physicians will be paid for each time unit.	
	(3) The unit fees include all necessary resuscitative measures, e.g., defibrillation, cardioversion, cut-down, etc.	
	PROVINCIAL PERINATAL HIGH RISK UNIT	
	Physician in Charge	
51920	- first day ……	101.44
51922	- subsequent days ……..……	46.93
	Concurrent Care (ICU, CCU, Provincial Perinatal High Risk Unit)	
51790	Physician rendering care concurrently with the physician-in-charge, per diem ……..	**28.60**

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
54000	Visit for diagnostic and therapeutic service(s) only ……	4.60	

ALLERGY

54004	Acute desensitization; e.g., ATS penicillin ……..	4.91	
54006	Direct nasal tests, (maximum of 3 tests) …….....	.98	
54008	Hyposensitization, (1 or more injections) visit fee and/or fee code 54000 not payable in addition ……	13.08	
54016	Ophthalmic tests, (maximum 5 tests) …….....	.98	
54018	- quantitative ……	7.85	
54020	Passive transfer tests …….....	28.34	
54022	Patch test, (maximum **65** tests) ……	2.00	

Note:
Patch testing may only be claimed when performed according to generally accepted criteria.

54026	Provocative testing ……..	**213.25**	
54027	**- after the first hour, per quarter hour or major part thereof, add …….. **	**29.05**	

Notes:

1. **No visit or consultation fees can be charged in addition to 54026 or 54027.**
2. **Billing of 54026 and 54027 is restricted to only those physicians certified by the Royal College of Physicians and Surgeons of Canada in Clinical Immunology and Allergy. Other physicians providing this service in a hospital may be considered upon request to the Assistant Medical Director.**
3. **54027 is billed to a maximum of three hours or twelve units. Start and end times for fee code 54027 must be documented in the record of service.**

54030	Repository therapy, per injection ……..	75.00	
54032	**Scratch/intradermal skin tests, per series (maximum of two series) .....**	**43.92**	
54033	**- for third series, add .....**	**25.41**	

Notes:

1. **There is a maximum of three series total per visit.**
2. **Skin tests must fall into one of six series: indoor aeroallergens, outdoor aeroallergens, food allergens, latex, medication, and venom.**

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.

ANAESTHESIOLOGY/THERAPEUTIC

54054	Hypothermia (therapeutic) induction and management ……..	62.07	

Nerve Blocks

1. Fees listed in the **FP** or Spec. columns must be coded as capacity "0" on claims.
2. These codes may not be used when claiming for a procedural anaesthetic except for fee code 54150.
3. Anaesthetic time units to not apply unless specified.
4. When alcohol or other sclerosing solutions are used, add 50% to the appropriate nerve block fee as listed with the exception of 54130, 54132, 54134 and 54150.
5. Therapeutic Anaesthesiology services provided in approved organized hospital pain clinics must be billed using the applicable fee code listed in the In-Hospital Diagnostic and therapeutic services Section of this Payment Schedule.

54060	Arnold's ……..	55.10	
54062	Brachial Plexus ……..	54.65	
54064	Coeliac Ganglion ……...	106.80	
54066	Epidural/Spinal Block ……	75.10	
54067	Introduction of intraspinal narcotic (not to be billed in addition to spinal anaesthesia) …..	49.70	
54068	24-hour monitoring of spinal narcotic given for analgesia ……..	59.64	
54072	Gasserian Ganglion ……..	55.10	
54073	Intrapleural Block - single injection …….....	44.25	
54074	- with the introduction of a catheter for the purpose of continuous analgesia …….....	77.25	
54076	Ilioinguinal and iliohypogastric nerves ……	54.65	
54078	Infraorbital ……...	34.20	
54080	Intercostal nerve root ……	34.20	
54082	- for each additional one ……..	16.95	
54084	Intrathecal Spinal ……..	75.10	
54086	Lumbar, sacral and coccygeal nerves …….....	34.20	
54088	Mandibular ……..	75.10	
54090	Mental branch of mandibular nerve ……	34.20	
54092	Occipital ……..	34.20	
54094	Other cranial nerve blocks ……...	84.00	
54096	Paravertebral nerve block of thoracic and lumbar roots – each (maximum of 4 units) …..	54.65	
54098	Pudendal …….	54.65	
54102	Sciatic nerve ……...	54.65	
54106	Single somatic nerve …….	69.30	
54108	Spheno-palatine ganglion ……	55.10	
54110	Splanchnic ……..	55.10	
54112	Stellate ganglion ……	55.10	
54114	Supraorbital ……	34.20	
54116	Sympathetic block (lumbar or thoracic) …….....	64.08	
54118	- bilateral …….....	85.44	
54120	Transverse scapular nerve ……..	55.10	
54122	Intravenous injection and infusion with lidocaine for the treatment of chronic pain ……	55.10	
54124	Auditory ganglion ……..	55.10	

Code		FP/ Spec.	Anaes.
	ANAESTHESIOLOGY/THERAPEUTIC (Cont'd)		
	Nerve Blocks (Cont'd)		
54126	Femoral nerve - unilateral	54.65	
54128	- bilateral	81.95	
54130	Intrathecal or epidural injection of phenol in iodized oil	165.50	
54132	Introduction of epidural catheter for relief of pain, institution		5
54134	Maintenance: claim 1 unit for each subsequent injection or ¼ hour of maintenance; maximum 12 units per day, per unit		1
54138	Lateral femoral cutaneous nerve	55.10	
54140	Lumbar sympathetic chain	85.44	
54142	Maxillary nerve at its foramen	64.08	
54144	Maxillary or mandibular division of trigeminal nerve	75.10	
54146	Obturator nerve - unilateral	54.65	
54148	- bilateral	82.45	
54150	Retrobulbar, femoral, sciatic, ilioinguinal, iliohypogastric, ulnar, median radial, stellate ganglion block for local anaesthetic purposes or epidural for delivery block	**57.06**	
54152	Retrobulbar injection of alcohol for acute glaucoma	34.20	
54154	Trigeminal ganglion	84.75	
54156	Superior laryngeal nerve	34.20	
54158	Epidural blood patch	75.10	
54160	Insertion of catheter to provide sustained regional nerve block for relief of pain (Rate payable for insertion is 50% of the fee for the appropriate nerve block – claim also the fee code and fee for that nerve block). (Applicable nerve block fee code must be indicated in the comments section and it must be billed as IC giving this information)		
54162	Maintenance of sustained regional nerve block – per half hour to maximum of 3 hours per day	13.78	
54164	Intubation – not associated with anaesthesia	55.10	

Patient controlled analgesia is an acute pain management modality utilized in lieu of traditional intramuscular narcotic injection for pain management. It allows the patient to exercise control of their acute pain. Initiation of PCA involves patient assessment, education, and the actual activation of the PCA apparatus by an Anaesthesiologist. Maintenance of PCA involves 24-hour coverage of patients on PCA. This includes visits and telephone consultation by same or different Anaesthesiologist.

Initiation or maintenance of PCA is only payable once per day, same or different Anaesthesiologist. Also, it is not payable in addition to a consultation, visit, ICU or hospital care by the same Anaesthesiologist. PCA services are payable to the same Anaesthesiologist on the same service date as general anaesthesia if at a separate session.

	Patient Controlled Analgesia (PCA) – for parenteral control of acute pain		
54166	- initiation	60.00	
54167	- maintenance	30.00	

Code		FP/ Spec.	Anaes.
	HYPERBARIC OXYGEN THERAPY (HBOT) – Being in constant attendance with the patient (either inside or outside the chamber) for the time billed to provide hyperbaric therapy, including ongoing monitoring of the patient's condition and intervening as appropriate.		
	Physician in chamber with patient, per dive per patient		
54180	first ¼ hour ……..	83.80	
54182	after first ¼ hour (per ¼ hour or major part thereof) ……	41.90	
54184	after 2 hours in chamber (per ¼ hour or major part thereof) ……..	83.80	
	Physician not in chamber with the patient, per dive per patient		
54188	first ¼ hour ……..	71.85	
54190	after first ¼ hour (per ¼ hour or major part thereof) ……	35.90	
54192	after 2 hours (per ¼ hour or major part thereof) …….....	71.85	
	After Hours Hyperbaric Premiums		
54194	Physician attendance commences between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidays …add 46% to total fee claimed per patient		
54196	Physician attendance commences any night between midnight and 7:00 a.m. …add 50% to total fee claimed per patient		
	Medical Assessments		
54198	Initial medical assessment of a patient referred for HBOT ……	121.00	
54199	Medical reassessment of a patient undergoing HBOT ……	36.92	

Notes:

HBOT is <u>not</u> an insured benefit for treatment of some conditions. For a list of currently insured conditions, please see Appendix G.

Fee codes 54184 and 54192 are billable in cases of true emergency only: decompression sickness, arterial air embolism and carbon monoxide poisoning.

When a patient is referred for consideration of HBOT by a physician to another physician qualified to administer HBOT, the second physician may bill fee code 54198 if: i) he or she performs an examination commensurate with the presenting complaint and; ii) he or she advises the referring physician of his or her opinion in writing.

Special visit premium(s), and other separately billable procedures may be claimed on a per patient basis when these services are rendered. Fees listed for HBOT <u>must</u> be coded as capacity "0" on claims.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
	CARDIOVASCULAR		
	Vascular Cannulation		
54202	Arterial Puncture	8.20	
54204	Cannulation of artery or central vein	41.27	
54206	Arterial cut down	57.77	
54208	Umbilical artery catheterization (including obtaining of blood sample)	27.25	
54210	Umbilical vein catheterization	9.81	
54212	Insertion of Swan-Ganz catheter (not included in anaesthesiology respiratory or critical care benefits)	159.30	4
54214	- measurement of cardiac output either thermal or dye dilution done at same setting (maximum 2 units payable) add	28.66	
54218	Therapeutic venesection (phlebotomy)	5.89	
54220	Insertion of permanent feeding line under general anaesthesia (e.g. Hickman or Broviac catheter)	150.84	4
54221	Insertion of subcutaneous port (e.g. Port-a-Cath) by surgical creation of a pocket	237.69	4
54222	Surgical removal of permanent feeding line or catheter	36.34	4
54223	Removal of subcutaneous port (i.e. Port-a-Cath)	111.65	4
54226	Anticoagulant Supervision – long term – per month	15.00	
	Blood Transfusions		
	Exchange transfusions		
54250	- initial (includes consultation and continuing care)	132.44	
54252	- subsequent	105.95	
54254	- multiple	IC	
54256	Assistant at exchange transfusion	IC	
54258	Indirect transfusion	14.36	
54260	Intra-uterine foetal transfusion	98.10	
54264	Plasmapheresis (includes cannulation) donor cell pheresis (platelets or leukocytes)	9.16	
	Therapeutic plasma exchange		
54266	- initial and repeat (maximum of 5 per year), each	60.78	
54268	- more than 5 per year, each	22.89	
54270	Manual plasmapheresis	IC	
	Cardioversion		
54274	Cardioversion or defibrillation (maximum 3 per patient, per day)	83.16	5
	Cardiac Catheterization		
	Notes:		
	1. Cardiac catheterization procedures (54280 to 54366) include insertion of catheter (including cutdown and repair of vessels if rendered), catheter placement, contrast injection, imaging and interpretation.		
	2. When more than one procedure is carried out by the same physician at one sitting, the additional procedures (codes 54280 to 54366) are to be charged at 50% of the listed fees.		
	Hemodynamic/Flow/Metabolic Studies		
	Right heart		
54280	- pressures only	116.92	5
	Left heart		
54284	- retrograde aortic	199.39	5
54286	- transseptal	297.15	5
54288	Dye dilution densitometry and/or thermal dilution studies – coronary flow index benefit covers all studies on the same day (in conjunction with Swan-Ganz insertion use fee code 54214)	54.50	
54290	Oxymetry and/or Fick determination	57.23	

Code		FP/ Spec.	Anaes.
	CARDIOVASCULAR (Cont'd)		
	Hemodynamic/Flow/Metabolic Studies (Cont'd)		
54294	Metabolic studies; e.g., coronary sinus lactate and pyruvate determinations	54.50	
54296	Exercise studies during catheterization ..... **add**	54.50	
	Angiography		
54310	Angiograms (any number of injections)	**86.62**	
54312	By-pass graft angiogram (including internal mammary artery implant) - per graft injection	66.50	
54314	Selective coronary catheterization	186.59	5
54316	- with drug interventional studies ..... add	80.70	
54318	His bundle ECG	83.93	
54320	Specialists assisting at cardiac catheterization	65.40	
54322	Translumenal coronary angioplasty including angiography with or without pressure measurements, per vessel	438.43	5
54324	Coronary angioplasty stent, per stent ..... add	67.00	
	Electrophysiologic Pacing, Mapping and Ablation Includes percutaneous access, insertion of catheters and electrodes, electrocardiograms, intracardiac echocardiograms and image guidance when rendered.		
54330	- atrial pacing and mapping	317.08	
54332	- ventricular pacing and mapping	395.38	
54333	- with the use of an advanced nonfluroscopic computerized mapping and navigation system ("advanced mapping system") and/or procedure duration >4 hours	690.25	10
	Note: 54333 is only eligible for payment when rendered with 54330 or 54332. See Preamble for additional terms and conditions.		
	For complex cardiac ablations requiring two Interventional Cardiologists trained in electrophysiology and involving 3D mapping:		
	- The assisting Cardiologist may bill the **FP** surgical assist Dedicated Time Method as set out in the General Preamble ($27.50 per quarter hour)		
	- The specialist assist provision as set out in the General Preamble does not apply		
	- Documentation of time spent assisting will be provided upon request		
54334	- catheter ablation therapy	333.99	
54336	- repeated	105.47	
54338	External cardiac pacing (temporary transthoracic) once per 24-hour period (**Note:** note to be claimed with CPR)	43.92	
54340	Electrophysiologic measurements (includes 1 or all of sinus node recovery times, conduction times and refractory periods). Includes insertion of electrodes	219.75	

Code		FP/ Spec.	Anaes.
	CARDIOVASCULAR (Cont'd)		
	Electrophysiology/Pacing (Cont'd)		
	Arrhythmias: Induction of arrhythmias to include programmed electrical stimulation, drug provocation and termination of arrhythmia if necessary, once per patient per 24 hours.		
	(**Note:** CPR not payable with these services)		
54342	- induction of atrial arrhythmias ……..	314.04	
54344	- induction of ventricular arrhythmias ……..	363.63	
54346	Testing of arrhythmia inductability by acute administration of anti-arrhythmia drugs – to a maximum of 2 per 24 hours ..……..	140.83	
54350	Insertion of permanent or temporary endocardial electrodes ……	154.10	5
54352	Repositioning of permanent endocardial electrode (as separate procedure	323.75	5
54353	Repositioning of temporary endocardial electrode (as separate procedure) ……...	64.25	5
54354	Implantation of pack ……..	119.19	5
54356	Insertion of endocardial electrode and implantation of pack (includes insertion of temporary transvenous lead at same surgical procedure by same surgeon) ….....	323.75	5
54358	Replacement of pack (single or multiple leads) ……	146.45	5
54360	Intracardiac electrocardiography and/or atrial pacing ……..	54.50	
54362	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes …….....	454.55	5
	Trans-catheter Aortic Valve Implantation (TAVI)		
54364	TAVI ……	1,862.76	28
54365	TAVI - Monitoring Transesophageal Echocardiography …….....	505.00	28

Notes:

1) Fee code 54364 is only payable to an Interventional Cardiologist.
2) Fee code 54364 is a composite fee that pays the billing physician for all aspects of the TAVI procedure including, but not limited to: patient assessment prior to the procedure; electrocardiograms; insertion of catheters and electrodes; cut-down and repair of vessels; pressure measurements; use of imaging guidance; administration of drugs and angiography. A maximum of one unit is payable per procedure. No other fee code is payable in addition.
3) A Cardiologist that assists at the procedure may bill the **FP** surgical assist Dedicated Time Method as set out in the General Preamble ($27.50 per quarter hour).
4) The specialist assistant provision as set out in the General Preamble does not apply to fee code 54364.
5) When transoesophageal monitoring of TAVI is performed during the procedure a Level lll Echo Trained Specialist (other than the physician billing fee code 54364) may bill Fee Code 54365.
6) Visit and procedural premiums are not payable in association with TAVI as it is a scheduled procedure.
7) An Anesthesiologist may bill fee code 54364 (28 basic units), plus time and other fees as normally billed.

	Endomyocardial Biopsy		
54366	Transvenous endomyocardial biopsy ……..	99.19	

Note: Includes insertion of catheter.

Code		FP/ Spec.	Anaes.
	CARDIOVASCULAR (Cont'd)		
	Vasomotor Syncope Testing		
54368	Tilt Table Testing of Vasomotor Syncope to include arterial cannulation, provocative and blocking drugs (physician must be continually present)	103.00	
	Cardiography: (includes technical component)		
54370	Apex	19.62	
54374	Echo	24.53	
54375	Saline study (including venipuncture)	10.83	
54376	Insertion of oesophageal transducer	45.00	
54377	Transoesophageal echocardiography by Anaesthesiologist or other qualified specialist for intraoperative monitoring of cardiac surgery and/or assessment of unexplained hypotension or hemodynamic instability ..... Note: Fee code 54377 includes payment for echocardiography and cardiac Doppler studies	120.00	
	Umbilical arterial catheterization		
54378	- (including obtaining of blood sample)	26.16	
	Electrocardiogram		
54380	Office - technical component	9.13	
54382	- professional component	9.27	
54384	Home - technical component	11.84	
54386	- professional component	12.36	
54388	Ballisto cardiogram	21.80	
	Before and after exercise		
54390	- technical component	10.90	
54392	- professional component	10.90	
	Maximal stress ECG or submaximal stress ECG		
54394	- technical component	19.08	
54396	- professional component	30.52	
54397	- dobutamine stress test – when rendered outside of hospital ..... add	37.26	
54400	Dipyridamole Thalium Stress Test	64.75	
54402	12 to 23 hour arrhythmia tapings (interpretation)	30.52	
	Interpretation of telephone transmitted ECG rhythm strip		
54406	- professional component	3.20	
54408	- technical component	1.60	
	Single chamber reprogramming including electrocardiography		
54410	- professional component	8.50	
54412	- technical component	8.50	
	Dual chamber reprogramming including electrocardiography		
54414	- professional component	16.95	
54416	- technical component	11.30	
	Pacemaker pulse wave analysis including electrocardiography		
54418	- professional component	8.50	
54420	- technical component	8.50	
	Interrogation, Reprogramming of Automatic Implantable Defibrillator		
54421	Interrogation of automatic implantable defibrillator	27.80	
54422	Interrogation and reprogramming of automatic implantable defibrillator	45.21	

Code		FP/ Spec.	Anaes.

CARDIOVASCULAR (Cont'd)

Interrogation, Reprogramming of Automatic Implantable Defibrillator (Cont'd)

Notes:

1. The fees for codes 54421 and 54422 include payment for electrocardiography.
2. Fee code 54421 can be billed when a Cardiologist or Internist with appropriate training situated in a hospital performs remote interrogation of an automatic implantable defibrillator. It can also be billed when a patient presents to a hospital and a Cardiologist or Internist with appropriate training interrogates an automatic implantable defibrillator but does not reprogram the device.
3. Fee codes 54421 and 54422 are not payable for the same patient on the same date.

Hospital Vascular Laboratory Fees

54425	Ankle pressure determination – not chargeable during surgery or during the patient's post-operative stay in hospital	9.64
54426	Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings	27.14
54427	Ankle pressure measurements with exercise and/or quantitative measurements added to above	11.75
	Venous Evaluation – Duplex Scan i.e. Simultaneous Real Time B-Mode Imaging for Suspected DVT, or for Evaluation for Dialysis Grafting, or for Suspected Thrombosed Dialysis Graft	
54428	- interpretation	16.75
54429	- procedure	28.48

Code		FP/ Spec.	Anaes.

DERMATOLOGY

Laser Treatment of Insured Vascular Lesions

54430	First ½ hour portion thereof …….	135.58	
54432	Each additional 15 minutes after the initial ½ hour …….. add	67.79	

Laser treatment of specific congenital vascular malformations is billable according to the rules listed below. Laser treatment of pigmented congenital lesions such as naevi, café-au-lait spots, etc., is not an insured service.

GENERAL RULES

(a) A visit fee is not payable in addition to the listed fees.
(b) All congenital vascular lesions with the exception of spider naevi, in children less than 18 years of age, are insured.

INSURED VASCULAR SKIN LESIONS

The following outlines, either by diagnosis and/or criteria, eligibility for MCP payment for the laser treatment of vascular skin lesions:

By diagnosis:

Blue Rubber Bleb Syndrome – Bill using remarks code 28.

By diagnosis, age and site:

Port Wine Stains – Bill using remarks code 26.
Angiofibromas of Tuberous Sclerosis – Bill using remarks code 29.

- Insured if age 18 and under;
- Insured after age 18 only if on the face and/or neck.

By diagnosis, age and medical necessity:

Strawberry haemangiomas – Bill using remarks code 27.
Cherry haemangiomas – Bill using remarks code 30.
Haemangio-lymphangiomas – Bill using remarks code 31.
Arterio-venous malformations – Bill using remarks code 33.

- Insured if age 18 and under;
- Insured after age 18 only if medical necessity, as defined by MCP, is met.

Laser treatment of all other vascular lesion not listed above:

To be eligible for MCP payment, the laser treatment of all other vascular lesions must meet the definition of medical necessity, as defined by MCP.

MEDICAL NECESSITY – DEFINITION

Medical necessity is defined as significant impairment of function (eye, nose or mouth), chronic skin ulcerations(s), soft tissue hypertrophy and/or recurrent bleeding, which is refractory to standard medical treatments.

- This excludes either a single episode of bleeding or episodes of bleeding that are widely spaced in time and respond to standard medical treatment, such as bandaging or medications (topical or oral).

For each lesion treated with laser, the condition of medical necessity must be met.

PRE-AUTHORIZATION

To be eligible for payment from MCP, all requests related to the laser treatment of vascular lesions must be preauthorized by either the Director or Assistant Medical Director of **Medical Services**.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
	DIALYSIS: team fees to include listed items. (This does not include preliminary investigation of the case)		
	Haemodialysis		
54450	Initial acute (to include surgical components)	584.88	
54452	Repeat acute	198.82	
54454	Insertion of Cannula or Screibner Shunt (included in the initial fee)	158.05	6
54456	Medical component (included in the initial fee)	426.83	
54458	Chronic	65.00	
	Management of cannula, shunt, or by pass-graft		
	Revision of Cannula or Screibner Shunt		
54460	- single	61.04	4
54462	- both	87.20	4
54464	De-clotting of Cannula or Screibner Shunt	53.46	
54465	Removal of cannula or AV shunt	72.00	4
54466	By-pass graft for haemodialysis – complete surgical care	290.54	7
	Peritoneal dialysis		
54480	Acute (up to 48 hours) – includes stylette cannula insertion (temporary)	198.82	
54482	Repeat acute	198.82	
54484	Chronic – maximum of 2 per week	56.14	
	Management of peritoneal cannula or catheter		
54486	Insertion of peritoneal cannula by laparotomy **or laparoscopy** – complete surgical care	256.10	6
54487	Removal of peritoneal cannula by laparotomy or laparoscopy – complete surgical care	256.10	**6**
54488	Insertion of Tenchkov type peritoneal catheter – chronic – by trocar	154.40	4
54490	Removal of Tenchkov type peritoneal catheter	63.10	4
	Home Dialysis		
54492	Monthly retainer for administration and supervision ..... Claim date must be last date of each completed month of supervision.	**181.82**	
	Satellite Haemodialysis		
54494	Weekly fee for administration and supervision of Satellite Haemodialysis patients, per patient	75.00	
	Notes: 1. Fee code 54494 is the benefit for managing chronic haemodialysis where the patient undergoes dialysis at a **DHCS** approved satellite site remote from the site where the billing physician is located. 2. For the purpose of claiming this code “remote” means patient and physician are located in different municipalities and the physician does not attend the patient’s dialysis sessions at the satellite site in person. 3. All claims for fee code 54494 must include the facility number of the satellite site where the patient is located. See the MCP Physician Information Manual for a list of numbers. 4. For MCP billing purposes, the claim date must be the last date of each completed week of supervision where a week begins 12:00 a.m. Monday and ends 11:59 on Sunday. 5. If the billing physician provides in person dialysis services to the patient at the satellite site, the amount that can be claimed for code 54494 that week must be reduced by 50%		
54496	Teledialysis assessment with patient, once per week, per patient	65.00	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.

ENDOCRINOLOGY AND METABOLISM

54500	Antidiuretic hormone response test	14.72
54502	Basal metabolic rate	9.81
54504	Benzodioxine test	9.81
54514	Histamine test	11.99
54518	Implantation of hormone pellets	11.99
54520	Insulin sensitivity test	26.16
54526	Pentagastrin Stimulation for calcitonin	37.80
54532	Rogetine test	11.99
54538	Water tolerance test	11.99

GASTROENTEROLOGY

54550	Oesophageal tamponade (insertion of Blakemore bag)	44.36
54552	Oesophageal motility test	65.40
	Oesophageal pH study for reflux	
54560	- adult	24.53
54562	- paediatric	45.00
54563	- with 24-hour pH monitoring ..... add	5.50
54564	Oesophageal potential difference test	24.53
54566	Oesophageal perfusion test	21.80
54568	Duodenum aspiration – by intubation for secretion test (after 1 hour, charge detention extra)	11.99
	Gastric lavage:	
54570	- diagnostic	6.54
54572	- therapeutic	20.71
	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin)	
54576	- procedure, supervision and interpretation	18.53
54578	Combined pH and motility test	73.58
54580	Combined pH motility and potential difference test	88.29
54582	Fluorescent string test for gastro intestinal bleeding	24.53
54584	Ano-rectal manometry	45.30
54586	Capsule endoscopy	342.10

Notes:

1. Payable for review of imaging done in hospital and report to the referring physician.
2. A visit cannot be claimed at the same sitting as the initiation of capsule endoscopy.
3. Fee code 54586 is only insured for patients who have previously undergone some or all of the following: esophagogastroduodenoscopy, colonoscopy, small bowel enteroscopy and/or small bowel series radiography & fluoroscopy.

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.

FAMILY MEDICINE

Opioid Agonist Maintenance Therapy – Monthly stipend for overseeing patients on opioid agonist treatment (OAT).

54596	Per patient, once per month ……	70.00	

Notes:

1. OAT means the administration of methadone or buprenorphine/ naloxone (Suboxone) for opioid dependency.
2. For physicians working in a primary care setting who are managing patients in the induction, stabilization, and/or maintenance phases of OAT.
3. Entitlement to this monthly stipend is limited to physicians who:
   (a) prescribe methadone or buprenorphine/naloxone for addiction; and
   (b) *are* actively supervising the patient's continuing use of methadone or buprenorphine/naloxone.
4. Only one physician will be paid the monthly stipend.
5. Visits for each patient contact would be paid as at present.
6. Not eligible for premiums or surcharges.
7. This payment stops when the patient stops taking methadone or buprenorphine/naloxone.

54598	Ear syringing – uni or bilateral …….	5.00	**4**
	Note: May be billed for services rendered in office, home or hospital settings.		

GYNECOLOGY

54600	Artificial insemination ……	17.20	
54606	Huhner's test ……..	8.18	
54607	Medical Abortion ……	187.49	

Note: Fee code 54607 is a comprehensive fee which is billed one-time only when a physician prescribes a medication for medical abortion. This fee then includes all services associated with providing the medical abortion including: the consultation and/or visit during which the medication is prescribed; counselling; ordering and/or performing and/or interpreting of laboratory tests and diagnostic imaging; any follow-up communications or visits.

This fee may be billed for services rendered in office, home, hospital, or other health care facilities.

54614	**Speculum exam (**no charge if done as part of **the following:** consultation, repeat consultation, general or specific assessment, routine post-natal visit**, or surgical procedure requiring the use of a speculum) …….**	**19.25**	
54618	Pessary check ……	10.00	
	Note: May be billed for services rendered in office, home or hospital settings.		

Code		FP/ Spec.	Anaes.
	INJECTIONS OR INFUSIONS		
	Lateral discography		
54626	- lumbosacral disc as first disc.....	76.68	4
54628	- any other disc as first disc.....	40.06	4
54630	- second and subsequent discs, each	20.60	
	Injection of chemonucleolysis		
54632	- initial injection	11.45	
54634	- any subsequent injection at other levels, each	5.72	
54636	Injection of extensive keloids	20.50	
54638	- under general anaesthesia	37.50	4
54640	BCG inoculation, including tuberculin tests	5.45	
54644	Injection of bursa, joint or tendon sheath (not to be billed in addition to same site surgical benefits when performed at time of surgery), including preliminary aspiration	**24.77**	
54646	- each additional site or area (maximum 8 injections per visit) ..... add	19.90	
	Botulinum Toxin Injection for the following conditions: Oromandibular dystonia, limb dystonia, cervical dystonia or spasticity, hemifacial spasm, blepharospasm		
54652	First injection	45.00	
54654	- each additional injection to a maximum of 11, to 54652 ..... add	10.00	
	Intradermal, intramuscular or subcutaneous – with visit – first injection ..... **(NC=No Charge)**	**NC**	
54656	- each additional injection ..... add	1.31	
	Intradermal, intramuscular or subcutaneous sole reason		
54658	- first injection	2.62	
54656	- each additional injection ..... add	1.31	
54660	Intralesional infiltration (1 or more lesions)	14.92	
	Intravenous		
	No fee is payable for injections into an established IV apparatus.		
54664	Newborn or infant	**11.01**	
54666	- scalp vein	15.36	
54668	- cut down	20.26	
54670	Child, adolescent or adult	**4.02**	
54674	- cut down	19.01	

Code		FP/ Spec.	Anaes.

INJECTIONS OR INFUSIONS (Cont'd)

Chemotherapy with each injection supervised by a physician for intravenous infusion for treatment of malignant or autoimmune disease. Physicians must be physically present in the clinic in which the injection is administered, at the time of injection and for the duration of the infusion and must during all of that period be available to intervene immediately, if required.

Chemotherapy and patient assessment provided by physician in hospital based clinics or to in-patients. The following benefits include patient assessment for a 24-hour period, drug administration, venipuncture, and establishment of any vascular access line.

Note:

1. Fee codes 54688, 54690, 54692 and 54696 are only eligible for payment with respect to the following classes of biologic agents:
   a. monoclonal antibodies; and
   b. cytokines
2. Examples that are not considered biologic agents for payment purposes are blood products, insulin and immunizing agents.

54688	Standard chemotherapy – agents with minor toxicity that require physician monitoring	59.68	
54690	- each additional standard chemotherapy agent, other than initial agent ……. add	8.47	

Note:
Examples of standard chemotherapy agents include cyclophosphamide, methotrexate, fluorouracil, leucovorin and zoledronic acid.

54692	Complex single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) that can cause vesicant damage, infusion reactions, cardiac, neurologic, marrow or renal toxicities that may require immediate intervention by the physician ……...	82.50	

Note:
Examples of complex single agents include rituxamib, bevacizumab, trastuzumab, anthracyclines, bortezomib, taxanes, cisplatin and etoposide fludarabine.

54696	Special single agent or multi-agent chemotherapy and/or biologic agent(s) with major toxicity that require frequent monitoring and prolonged administration periods and may require immediate intervention by the physician ……	115.67	

Note:
Examples of special agent therapy include high-dose methotrexate with folinic acid rescue, methotrexate given in a dose of greater than 1 g/m2, high dose cisplatin greater than 75 mg/m2 given concurrently with hydration and osmotic diuresis, high dose cystosine, arabinoside (greater than 2 g/m2) high dose cyclophosphamide (greater than 1 g/m2), ifosfamide with MENSA protection, combination of biologic agents with complex chemotherapy**.**

Code		FP/ Spec.	Anaes.

INJECTIONS OR INFUSIONS (Cont'd)

Management of Special Oral Chemotherapy

This is the service for the supervision of oral chemotherapy treatment for malignant disease where the agent(s) has a significant risk of toxicity in the period immediately following initiation. The physician must be available to intervene in a timely fashion for a 24-hour period following the initiation of the treatment.

In addition to the Common Elements in this Schedule, this service includes the provision of the following services to the same patient:

(a) evaluation of any relevant laboratory, diagnostic and/or imaging investigations; and

(b) all discussion or advice, whether by telephone or otherwise, involving the patient, staff, patient's relative(s) or patient's representative related to the oral chemotherapy for a period of one month following initiation of the agent(s).

54698	Management of special oral chemotherapy for malignant disease ……...	22.55	

Notes:

1. 54698 is not eligible for payment for the same patient in the same month where 54700 is payable.
2. 54698 is only eligible for payment once every month.
3. Examples of special oral chemotherapy include fludarabine, imatinib, dasatanib, nilotinib, erlotinib, capecitabine, sunitinib, sorafenib, thalidomide, temazolamide and lenalidomide.

54700	Supervision of oral or intramuscular chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) – monthly ……...	14.63	
54702	Pneumothorax - initial …….....	15.82	
54704	- subsequent ……	15.82	
54706	Pneumoperitoneum - initial ……..	15.82	
54708	- subsequent …….....	9.81	
	Varicose veins (per visit)		
54710	- single injection ……..……...	5.45	
54712	- two or more injection (unilateral or bilateral) ...……..	7.63	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
	NEUROLOGY		
54800	Electrocorticogram – supervision and interpretation …….	153.75	
	Electroencephalography		
54802	- complete procedure ……..	28.89	
54804	- interpretation ……..	11.45	
54806	- with activating drugs; e.g., megamide ……... add	11.45	
54808	- inserting subtemporal needle electrodes ……..... add	11.45	
54810	- attendance and supervision of ECG during major surgery …….....	114.45	
54816	- tensilon testing …….....	18.00	
54820	Amytal test – bilateral – supervision and coordination of tests ……..	62.95	
	OPHTHALMOLOGY		
54846	Intravitreal injection of anti-VEGF substance (unilateral) 1 unit per eye, 2nd eye to be billed at 85% …….....	125.00	
54848	Ocular Coherence Tomography in association with intravitreal injection of anti VEGF substance in office (uni-or bilateral) ……... add	30.00	

Notes:

1. The above fee codes are insured for treatment and examination of neovascularization associated with: macular degeneration, diabetic macular edema, and retinal venous occlusion.
2. A maximum of one unit of IVI is payable per eye regardless of the number of injections.
3. If both eyes are injected, the second eye should be billed at 85% of the listed rate.
4. A maximum of one unit of office OCT is payable per patient treatment session regardless of the number of injections.
5. The office OCT fee code is only payable as an add-on to IVI; it is not payable as an add-on to any other fee code and is not payable when billed alone.
6. Intravitreal injection of anti-VEGF is not payable when delegated to another health care professional, physician employee, or assistant when provided in a clinic outside of the hospital setting.
7. Payment for the use of topical or local anaesthesia will be included in the fee for IVI.

Code		FP/ Spec.	Anaes.

OPHTHALMOLOGY (Cont'd)

Contact lens fitting is not an insured service except for the following conditions:
(a) Aphakia, monocular and binocular
(b) high myopia, greater than nine (9) dioptres
(c) irregular astigmatism (post-corneal grafting or corneal scarring resulting from disease states), and
(d) keratoconus

Note:
Fee codes 54850, 54852 and 54854 must be billed IC indicating the condition for which the procedure was done.

54850	Contact lens fitting (with follow-up for 3 months) …….....	156.90
54852	One eye only, when the other eye has been previously fitted by the same physician (with follow-up for 3 months) …….....	80.80
54854	Hydrophilic "Bandage" lens fitting ……	**90.30**

Note:
Fee code 54000 will not apply for fee code 54860 to 54896

54860	Intravenous fluorescein angiography – professional and technical component ……...	**58.88**
54864	Glaucoma provocative tests, including water drinking tests ……	17.44
54868	Ophthalmodynamometry ……...	5.45
54870	Orthoptics (assessment or treatment) ……	**6.28**
	Radioactive phosphorous examination	
54872	- anterior approach ……..	28.89
54874	- posterior approach ……	57.77
54876	Sonography ……	42.67
54877	**Fundus photo, technical fee and retinophoto interpretation .....**	**20.00**
54878	Static perimetry (uni or bilateral) …….....	**40.21**
54880	Tonography (to include tonometry) ……..	12.26
54882	- with water ……...	17.44
54884	Tonometry (uni or bilateral) ……... (not to be charged if done in conjunction with an ophthalmological consultation, specific assessment or reassessment)	10.27
54888	Subconjunctival or sub-Tenons capsule injection ……	14.30
54896	Botulinum toxin injection of extra ocular muscle with electro-myographic control, per muscle ……..	75.00

Code		FP/ Spec.	Anaes.

OPHTHALMOLOGY (Cont'd)

Ocular Photodynamic Therapy (PDT) – is, subject to the limitations set out below, an insured service when rendered by an Ophthalmologist. PDT includes retinal photography, establishment of intravenous access, supervision of drug infusion and personal application of non-thermal diode laser for activation of verteporfin.

PDT is insured only if the patient's clinical condition meets all of the following criteria:

(i) the patient has predominantly classic subfoveal choroidal neovascularization (CNV) secondary to either age-related macular degeneration (AMD) or occult or 'minimally classic' AMD less than 4 disc diameters. 'Predominantly' means that the area of classic subfoveal CNV is equal to or greater than 50% of the total CNV lesion, as determined by fluorescein angiography and documented by retinal photographs;

(ii) treatment is commenced within 12 months after initial diagnosis of predominantly classic subfoveal CNV secondary to either AMD or occult or 'minimally classic' AMD less than 4 disc diameters;

(iii) the patient's visual acuity is equal to or worse than 20/40; and

(iv) for each repeat therapy, recurrent or persistent CNV leakage is detected by fluorescein angiography and documented by retinal photographs.

Retinal photographs must be made prior to the procedure and permanently retained. Maximum one PDT (unilateral or bilateral) per patient, per day.

54897	- unilateral PDT per patient, per day ……	300.00	
54898	- bilateral PDT per patient, per day …….....	375.00	

Notes:

1. Intravenous injection fee codes are not payable for the same patient on the same date as fee codes 54897 and 54898.
2. Fee codes 54897 and 54898 cannot both be claimed for the same patient on the same date.
3. Assessments and angiography are payable in addition to PDT. Retinal photography is insured as a specific element of the assessment and is not payable separately.

54899	Remote Retinophoto interpretation ……..	9.44	

Notes:

1. For remote use only
2. No visit code is billable in addition to 54899
3. Maximum one unit per patient (unilateral or bilateral) per month
4. Maximum of 25/week per Ophthalmologist

Code		FP/ Spec.	Anaes.
	OTOLARYNGOLOGY		
54900	Particle repositioning manoeuvre for benign paroxysmal positional vertigo ……	19.49	
	Audiometric tests		
	Fee code 54000 will not apply for fee codes 54906 and 54910		
	Pure tone air and bone conduction		
54906	- professional component …….....	4.50	
54910	- professional component with speech tests ……..	13.93	
	Impedance audiometry		
54916	- professional component …….....	8.17	
	Advanced testing (may include recruitment sisi, tone decay, malingering, Bekesy test) (per test to a maximum of 2 tests)		
54924	- professional component …….....	5.00	
	Hearing aid evaluation, including pure tone air and bone conduction and speech tests		
54932	- professional component …….....	2.45	
	Cortical audiometry		
54940	- professional component …….....	15.40	
	Vestibular function tests		
	Caloric testing with electronystagmography		
54952	- professional component …….....	16.80	
	Minimal caloric		
54954	- professional component …….....	4.58	
	Fitzgerald-Hallpike method		
54956	- professional component …….....	14.44	
	Electronystagmography		
54960	- professional component …….....	14.10	
	Electrogustometry		
54962	- professional component …….....	9.27	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
	PHYSICAL MEDICINE		
54970	Nerve stimulation ……...	22.89	
	Therapeutic Procedures		
54976	Manipulation - major joint …….....	7.96	
54978	- minor joint ……	3.92	
54980	Miscellaneous therapeutic procedures not exceeding one hour as listed below ……	5.00	
	- Intermittent positive pressure breathing treatments (office) - Heat-diathermy, heat cabinets, heat cradles or bakers, radiant heat, whirlpool baths, paraffin baths, microtherm, etc. - Pulsed-diathermy Light-Ultraviolet – general, local, orifical, etc. - Electrotherapy – Galvanic, Faradic and sinusoidal currents, iontophoresis, etc. - Ultrasound - Hydrotherapy – contrast baths – hotpacks; Local (arm and leg, whirlpool baths): general (Hubbard) for body immersion or Body Tanks; therapeutic pool, under water exercises, cryotherapy - Mechano Therapy – massage, mechanical device traction, pulleys and weights, treadles stationary bicycles, shoulder wheels - Therapeutic Exercise - Occupational Therapy – Programme adapted to individual's needs - Activities of daily living (ADL) functional and supportive programme, woodwork, metal, leather, basketry, looms, etc. - Inhalation Therapy		
	Thermography of hand, foot or large joint – 1 or more areas		
54982	- technical component ……...	13.00	
54984	- professional component …….....	6.50	

DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		FP/ Spec.	Anaes.
	PSYCHIATRY		
54990	ECT ……..	80.30	4
	Charges for hospital visits, home or office fees do not apply on a day when ECT or individual psychotherapy is charged. (same diagnosis, same physician)		
	UROLOGY		
55024	Cystometrogram and/or voiding pressure studies (micturition studies) ……	56.72	
55034	Prostatic massage ……...	5.78	
55036	Penile pressure recordings – 2 or more pressures ……..	9.64	
	VENIPUNCTURE		
55040	Newborn or infant ……..	5.45	
55042	- scalp vein …….....	10.57	
55044	Child, adolescent or adult ……...	**6.90**	
55046	Therapeutic venisection ……	6.54	
	Finger prick blood sampling is not considered to be a “venipuncture”.		
	Venipuncture fees are not payable for the office collection of blood if the sample is collected less than 16 kilometers from the nearest hospital or satellite laboratory unless a patient’s illness or disability does not permit him/her to travel to the normal collection site.		

CLINICAL PROCEDURE ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

This section is for the use of physicians other than Radiologists and those physicians designated by individual hospitals to provide imaging services.

These procedural fees are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except oral or rectal administration for study of the alimentary tract).

When the following listings involve bilateral procedures, add 50% to the listed fee(s).

Fee code 54000 is not payable in addition to the following procedures:

Code		FP/ Spec.	Anaes.
55050	Arthrogram	17.44	4
55056	Bronchogram	11.45	6
55060	Cerebral angiogram	45.78	5
55064	Dacryocystogram	11.45	4
55066	Discogram	40.33	4
55074	Hypotonic duodenogram	22.89	4
55076	Hysterosalpingogram	50.11	4
55080	Laryngogram	11.45	
55082	Lymphogram	26.16	
55088	Myelogram	26.16	4
55094	Nephrotomogram		4
55106	Percutaneous transphepatic cholangiogram	28.51	4
55108	Peripheral angiogram	17.44	4
55110	Peritoneal pneumogram	17.44	4
55118	Tomogram		5
55120	Urethocystogram	5.78	
55122	Vasogram	28.89	5
	Thoracic or abdominal angiogram		
	Introduction by		
55140	- translumbar aorto or venogram	45.78	5
55142	- percutaneous arterial or venous needle (or cut-down on superficial peripheral vein)	45.70	5
	- percutaneous arterial or venous catheter (or cut-down on superficial vein)		
55150	- non selective	57.77	5
55152	- selective	87.20	5
	Exposure of major artery		
55154	- non selective	87.20	5
55156	- selective	114.45	5

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	ELECTROCARDIOGRAMS	
56000	Electrocardiogram interpretation ……	9.71
56010	Stress electrocardiogram (physician present during testing procedure) Before and after exercise (Masters criteria, Levy Ischemia or Frasher Exercise test) includes complete resting tracing and multiple leads taken immediately and 3 and 6 minutes post exercise …….....	20.70
56020	Maximal stress testing – with treadmill or ergometer and oscilloscopic continuous monitoring, including ECGs taken during the procedure and resting ECGs before and after the procedure	62.95
	Continuous Ambulatory ECG Monitoring	
56050	Interpretation of continuous ambulatory ECG scan ……	30.91
56060	Partial review of scan and interpretation …….....	37.40
56070	Complete review of scan and interpretation …….....	63.25
	Cardiac Loop Monitoring	
56080	Implantation or replacement of loop recorder …….....	119.19
	Note: Fee code 56080 includes payment for removal of loop recorder.	
56082	Removal of loop recorder without replacement ……...	54.38
56084	Loop recorder event interpretation and/or reprogramming …….....	12.65
	ELECTROMYOGRAPHY AND NERVE CONDUCTION	
56500	Complete procedure, e.g. conduction studies on 2 or more nerves and EMG of multiple muscles; detailed study of neuromuscular transmission ……...	**173.39**
56525	Limited procedure, e.g. conduction studies on a single nerve plus limited needle electrode examination in 1 area; or conduction studies on 2 nerves without EMG ……	109.72
56550	Short procedure, e.g. stimulation of a single nerve; or repeat EMG of 1 or 2 muscles without nerve conduction ……	44.17
56575	Single fibre EMG ……..	128.01
	ELECTROENCEPHALOGRAPHY	
57000	Electroencephalogram interpretation ……	41.16
57010	- with use of sleep inducing drugs and/or sleep deprivation …… add	**35.78**
57020	- inserting subtemporal needle electrodes …… add	28.38
57025	- videotape recording of clinical signs in association with EEG ……... add	33.33
	Polygraphic recording of parameters in addition to EEG, e.g., respiration, eye movement, ECG muscle movement	
57030	- 1 item ……... add	16.21
57035	- 2 items …… add	32.43
57040	- 3 or more items …….. add	47.21
	SLEEP APNEA STUDIES	
57050	Sleep apnea (overnight study) with continuous monitoring of oxygen saturation and ventilation **-** to include physician attendance at set up, monitoring and interpretation (extra or special visits not chargeable) ……...	223.23
57060	**-** interpretation only ……	83.04

IN-HOSPITAL DIAGNOSTIC AND THERAPEUTIC SERVICES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate

EVOKED POTENTIAL STUDIES

57500	Simple average evoked potential studies with 1 sensory modality of stimulation (interpretation by physician)	42.69
57510	Complex evoked potential studies involving several sensory modalities, multiple threshold determinations of more than 4 simultaneous channels of recording (partial supervision by physician and interpretation)	53.82
57520	Complex evoked potential studies performed completely under the direct supervision of a physician and interpretation	107.93

DERMATOLOGY

57600	Hospital Phototherapy Unit Supervision (per patient, per week)	10.00

Notes:

1. Fee code 57600 is only payable to specialists in Dermatology who have been granted privileges by their Regional Health Authority (RHA) to assess patients and supervise phototherapy treatment provided in a unit operated by the RHA. They must attend the unit regularly to assess phototherapy patients and must respond to inquiries from RHA staff who administer phototherapy treatment when requested.

2. Such Dermatologists will be deemed 'approved Dermatologists' by MCP for payment purposes upon receipt of written notification from the RHA that the applicable privileges have been granted.

3. To be eligible to bill fee code 57600 an 'approved Dermatologist' must review a patient's response to phototherapy treatment in person, or through a direct interactive video link at approved telemedicine sites, with the unit nurse, or other health care provider approved by the RHA, and prescribe changes, or order continuation or termination of the current treatment. Fee code 57600 is not billable before the patient commences phototherapy treatment and is not billable after the patient has completed a course of treatment.

4. Fee code 57600 is payable once weekly per patient if the above conditions are met.

5. When an approved Dermatologist examines a phototherapy patient in the phototherapy unit the Dermatologist may bill the applicable consultation or visit fee code, provided Preamble requirements are met. However, fee code 57600 may not be billed in addition during the same week.

6. Phototherapy unit records will satisfy the documentation requirements for fee code 57600.

7. The institution number for the phototherapy unit must be entered in the 'Hospital No.' field on all claims for fee code 57600.

Code		Rate
	OBSTETRICS AND GYNECOLOGY	
57700	Non-stress test – interpretation only ……...	9.65
	If the non-stress test is done in conjunction with a consultation, the interpretation is considered to be included in the consultation fee	
	Maternal Fetal Medicine (MFM)	
	The fee codes listed in this section can only be billed by MFM Specialists who have been designated by their hospital to provide imaging services.	
	Echography – Scan B-mode, per fetus (bill each additional fetus I.C. at 85% of the listed rate)	
	First trimester scan for viability and dating, transvaginal or transabdominal	
57710	- interpretation ……..	46.22
57711	- procedure ……	33.36
	Nuchal translucency determination by MFM Specialist (once per pregnancy)	
57712	- interpretation ……..	25.30
57713	- procedure ……	40.00
	Note: Routine screening of Nuchal translucency without biochemical markers in singleton pregnancies is not an insured service.	
	Placenta localization	
57714	- interpretation ……..	**34.20**
57715	- procedure ……	**25.00**
	Transvaginal assessment of cervical length in pregnancy at increased risk for preterm birth by MFM Specialist	
57716	- interpretation ……..	**34.20**
57717	- procedure ……	25.00
	Note: Routine screening of cervical length of pregnancy is not an insured service.	

Code		Rate

OBSTETRICS AND GYNECOLOGY (Cont'd)

Fetal anatomy scan by MFM specialist

57718	- interpretation ……..	**53.20**
57719	- procedure ……	75.00

Fetal Doppler evaluation of middle cerebral artery, and/or IVC and/or ductus venosus

57720	- interpretation ……..	31.60
57721	- procedure ……	32.90

Note:
These codes are only eligible for payment when rendered by a MFM Specialist for assessment of fetal anemia, intrauterine growth retardation measuring below the 10th percentile or twin-twin transfusion syndrome.

Fetal assessment in–utero for physical condition of the fetus

57730	- interpretation and procedure ……...	45.60

OPHTHALMOLOGY

57780	Ocular Coherence Tomography – interpretation, uni or bilateral ……...	30.00

Note:
This fee code can only be claimed by Ophthalmologists when OCT is performed in the hospital for the following indications: intravitreal injection of anti-VEGF or for evaluation in hospital of macular diseases of the retina or patients with previously documented features of glaucoma such as ocular hypertension, established visual field defects and optic nerve morphology consistent with a diagnosis of glaucoma. Screening of patients with ocular coherence tomography is not an insured service.

57782	Corneal Pachymetry, uni or bilateral ……..	**3.60**

Note:
This fee code can only be claimed in hospital once per calendar year per patient, by a maximum of one Ophthalmologist for measurement of corneal thickness in glaucoma patients. Claims by a second Ophthalmologist are not payable unless billed IC with an explanation of the medical necessity for the second measurement. Screening of patients with corneal pachymetry is not an insured service.

Electro-retinography

57792	Full field electro-retinography – interpretation …….....	30.00

Notes:
1. Fee code 57792 is limited to 2 services per patient per 12 month period.

Code		Rate

ORGANIZED PAIN CLINIC

Notes:

1. These fee codes may only be billed by Anaesthesiologists working in an organized hospital pain clinic approved by the Regional Health Board.
2. Fees listed for Organized Pain Clinics must be coded as capacity "0" on claims.
3. These codes may not be used when claiming for a procedural anaesthetic.
4. Anaesthetic time units do not apply.
5. When alcohol or other sclerosing solutions are used, add 50% to the appropriate nerve block fee as listed.
6. Therapeutic Anaesthesiology services provided in settings other than approved organized hospital pain clinics must be billed using the applicable fee code listed in the Diagnostic and Therapeutic Procedures Section of this Payment Schedule.

57800	Epidural steroid injection ……..	105.15
57802	Intercostal nerve block(s) (maximum 2 units)……	95.41
57804	Paravertebral nerve block of thoracic and lumbar roots – each (maximum 4 units) ……..	84.12
57806	Peripheral nerve block for chronic pain (maximum 2 units) ……	84.12
57808	Cranial nerve/branch block for chronic pain (maximum 2 units) ……	105.15
57810	Stellate ganglion block ……..	105.15
57812	Intravenous sympathetic block by injection and infusion of Bretylium, Guanethidine and Reserpine ……	126.18
57814	Intravenous injection and infusion with lidocaine for the treatment of chronic pain ……	157.71
57816	Infiltration of tissues for the treatment of chronic pain (one or more sites, uni- or bilateral)	69.30

OTOLARYNGOLOGY

57840	Laryngeal Videostroboscopy (procedure and interpretation) ……	108.50

Code		Rate

PULMONARY FUNCTION STUDIES

The benefits for simple spirometry and standard lung mechanics represent the best of three recorded test results with or without bronchodilator.

The benefit for standard lung mechanics includes simple spirometry.

Vital capacity and flow volume loop cannot be claimed at the same time.

58000	Simple spirometry, e.g., vital capacity, without permanent record by transducer equipment FVC, FEV, MVV (MBC), etc. ……..	7.85
	Standard lung mechanics (with permanent record)	
58010	- Vital capacity, FEV, FEV/FVC ……	4.28
58015	- Repeat of 58010 after bronchodilator ……	1.73
58020	- 58010 plus MMEFR calculation ……..	7.10
58025	- Repeat of 58020 after bronchodilator …….	2.76
58030	- MVV done together with 58010 or 58020 …….	.84
58040	- Flow volume loop (FVC, FEV, FEV/FVC, V_{30}, V_{25}) ……..	10.75
58050	- Repeat of 58040 after bronchodilator ……	6.45
	Complex Lung Mechanics'	
58100	- Functional residual capacity by gas dilution method ……..	17.55
58110	- Functional residual capacity by body plethysmography ……	17.85
58120	- Airways resistance by plethysmography or estimated using esophageal catheter ……	16.05
58130	Lung Compliance (pressure volume curve of the lung from TLC to FRC) ……..	48.15
58140	Carbon monoxide diffusing capacity by steady state of rest ……..	11.25
58150	Carbon monoxide diffusing capacity by single breath method ……..	18.00
	Pulmonary Function Response to O_2 and CO_2	
58160	CO_2 ventilatory response ……	14.60
58170	O_2 ventilatory response (physician must be present) ……	21.80
	Exercise Assessment – physician must be in attendance at all times	
58180	- Exercise diffusing capacity ……..	16.03
58200	- Stage I: Graded exercise to maximum tolerance exercise (must include heart rate, Ventilation and ECG at rest and at each workload: ECG monitored at least 5 minutes post exercise ……..	50.75
58210	- Same as 58200 plus 58010, 58020 or 58040 before and after exercise …….	60.10
58220	- Stage II: Repeated steady state graded exercise (must include heart rate, ventilation, VO_2, VCO_2, BP, ECG end tidal and mixed venous CO_2 at rest, 3 levels of exercise and recovery) ……	65.40
58230	- Stage III: Same as 58220 plus arterial blood gases, PH and bicarbonate or lactate …….	88.26
58240	Exercise induced asthma assessment (workload sufficient to achieve a heart rate of 85% of max.; measurement of 58010, 58020 or 58040 before exercise and 5-10 minutes post exercise …….....	24.50

Code		Rate
	PULMONARY FUNCTION STUDIES (Cont'd)	
	Gas Analysis	
58270	- Arterial puncture for blood gas analysis	10.20
58300	- A-a oxygen gradient (measurement of RQ by sampling mixed expired gas and using alveolar air equation)	16.79
58310	- Estimate of venous admixture (Qs/Qt) breathing pure oxygen	20.30
58320	- Mixed venous PCO_2 by the rebreathing method	4.70
58330	- O_2 saturation by oximeter (at rest and exercise)	10.80
58340	- Standard O_2 consumption and CO_2 production	6.45
58350	- Histamine or methylcholine threshold test	34.70

RADIOLOGY

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	GENERAL RADIOLOGY	
	Head and Neck	
70100	Skull – routine (includes Towne's views)	14.88
70101	Sella turcica	7.45
70110	Facial bones	11.92
70111	Nose	7.45
70112	Mandible	10.35
70113	Temperomandibular joints	11.92
70120	Sinuses	10.35
70121	Mastoids - acute	14.25
70122	- chronic	14.25
70130	Teeth - up to ¼ set	3.00
70131	- up to ½ set	6.70
70132	- full set	13.40
70133	- bitewing	4.46
70140	Eye, for foreign body	13.40
70141	- for localization (stereo-optics) additional	26.52
70142	Optic foramina	10.45
70150	Salivary gland region	8.94
70160	Neck for soft tissues	8.94
70170	Internal auditory canal	11.92
70190	Special additional view of any head and neck item	3.18
	Spine and Pelvis	
70200	Cervical spine	14.88
70210	Thoracic spine	14.88
70220	Lumbar or lumbosacral spine	14.88
70225	Sacrum and/or coccyx	7.45
70230	Pelvis - single view	8.94
70235	Pelvis and hips	11.92
70240	Sacroiliac joints	10.35
70245	Spine - scoliosis series	23.80
70250	Ribs - unilateral	8.94
70251	- for bilateral extra	7.85
70260	Sternum	8.94
70270	Special additional view of any spine and pelvis item	3.18
	Extremities	
70300	Clavicle	8.94
70301	Sternoclavicular joint	8.94
70303	Acromioclavicular joints – bilateral (with or without weighed distraction)	10.35
70310	Shoulder	8.94
70320	Scapula	8.94
70330	Humerus	8.94
70331	Elbow	8.94
70332	Ulna and radius	8.94
70333	Wrist	8.94
70334	Wrist and Hand	8.94
70335	Hand	13.05
70336	Finger	5.95
70337	Thumb, including metacarpals	7.45
70338	Scaphoid	8.94
70350	Hip	8.94
70351	Hip pinning, interpretation only	8.94

Code		Rate
	GENERAL RADIOLOGY (Cont'd)	
	Extremities (Cont'd)	
70352	Femur	8.94
70353	Orthoroentgenogram	11.92
70360	Knee (including patella)	11.72
70364	Tibia and fibula	8.94
70366	Ankle	8.94
70368	Calcaneous	8.94
70370	Foot	8.94
70380	Toe	5.95
70390	Special additional view of any item in the section headed "extremities"	3.18
70395	Post reduction check	8.94
	Skeletal Surveys	
	Skeletal survey for bone age	
70430	- single film	7.45
70431	- 2 or more films or views	11.92
	Other surveys	
70440	- basic for rheumatoid survey	3.30
70450	- basic for metabolic survey	3.30
70460	- basic for metastatic survey	3.30
70465	- plus per film or view for either of the above	3.30
	Chest	
70501	Single film	6.40
70502	2 views	10.75
70503	3 or more views	12.45
70520	Mammography - unilateral	19.36
70522	- bilateral	30.79
70525	Screening mammography program	30.79
	Note: Fee code 70525 should be claimed for screening mammograms performed as part of the screening program established by the Department of Health and Community Services. All other mammograms should continue to be billed as either fee code 70520 or 70522.	
	Abdomen	
70600	Survey film (not to be billed in addition to 70601)	8.94
70601	Additional film studies (acute abdomen)	10.45
70610	Oesophagus	21.40
70620	Stomach and duodenum	38.15
70621	Stomach and duodenum with small intestinal series	58.40
70625	Small bowel only	25.53
70626	Upper GI - double contrast	46.40
70630	Colon - barium enema	29.40
70631	- with air study	49.80
70634	Defecography	28.00

Code		Rate
	GENERAL RADIOLOGY (Cont'd)	
	Abdomen (Cont'd)	
70640	Cholecystogram	11.60
70645	T-Tube cholangiogram	23.80
70650	Operative cholangiogram, interpretation only	11.10
70651	Intravenous cholangio – tomography	17.89
70652	Intravenous cholangiogram	17.89
	GU Tract	
70700	Survey film	8.94
70705	Retrograde pyelogram	11.92
70710	Intravenous pyelogram	25.42
70714	- with nephrotomogram	76.22
70721	Diuretic washout or infusion IVP	76.22
70724	- with nephrotomogram	35.72
70730	Urethrocystogram	8.94
70735	Stress urethrocystogram	22.67
70738	Voiding urethrocystogram	22.67
70741	Vasography	8.94
70745	Nephrostogram	29.55
	Obstetrics and Gynaecology	
70800	Survey film	7.36
70810	Pelviometry	23.80
70814	Placentogram	9.80
70824	Hysterosalpingogram	14.88
70830	Intra-uterine foetal transfusion – radiological control	30.97

Code		Rate

SPECIAL PROCEDURES

Arteriography – General

	Flush aortograph – includes aortic root, thoracic, lumbar and retrograde femoral	
71100	- procedure	125.17
71101	- interpretation	42.36
	Translumbar aortography	
71105	- procedure	119.98
71106	- interpretation	46.60
	Single selective arteriogram (renal, celiac, mesenteric, carotid, vertebral, splenic, subclavian, femoral and hepatic, etc.)	
71111	- procedure	217.44
71112	- interpretation	56.29
	Bilateral and multiple selective arteriograms	
71116	- procedure	391.37
71117	- interpretation	112.62
	Percutaneous femoral	
71120	- procedure	43.49
71121	- interpretation	56.29
	Percutaneous brachial	
71125	- procedure	43.50
71126	- interpretation	56.29
	Percutaneous angioplasty	
71130	- procedure	434.60
71131	- interpretation	56.29
71140	Embolization, e.g., for treatment of haemangioma or renal carcinoma (add to angiographic procedural fees)	108.26
71150	Percutaneous removal of intravascular foreign bodies	303.73
71160	Intra-arterial infusion of drugs, e.g., for control of gastrointestinal haemorrhage, charge appropriate angiographic procedural and radiological fees plus a per diem supervision fee of	29.55
71190	Percutaneous transhepatic catheter portal venography	311.05

Venous Studies

	Vena cavagram	
71200	- procedure	144.94
71201	- interpretation	56.29
71202	Percutaneous insertion of vena cava filter	459.12
	Selective venography (spinal, hepatic, axillary, lumbar, renal and thymic, etc.)	
71204	- procedure	217.44
71205	- interpretation	56.29
	Selective bilateral and multiple (e.g., renal vein studies)	
71210	- procedure	391.37
71211	- interpretation	46.60
	Single peripheral venogram (lower limb, orbital, etc.)	
71216	- procedure	36.00
71217	- interpretation	46.60
	Bilateral peripheral and pelvic	
71220	- procedure	59.98
71221	- interpretation	77.63
	Splenoportogram	
71225	- procedure	59.98
71226	- interpretation	31.05

Code		Rate
	SPECIAL PROCEDURES (Cont'd)	
	Venous Studies (Cont'd)	
	Lymphangiogram – single	
71230	- procedure	59.98
71231	- interpretation	31.05
	Lymphangiogram – bilateral	
71232	- procedure	119.98
71233	- interpretation	62.14
	Cardiac Angiography	
	All cardiac angiography except bilateral coronary studies	
71301	- interpretation	53.78
	Bilateral coronary angiography	
71306	- interpretation	110.34
	Note: These codes only apply when cardiac and/or bilateral coronary angiograms are referred to a Radiologist by a Cardiologist or Cardiac Surgeon for his/her written opinion.	
	Neuro Angiography	
71390	Percutaneous embolization of spinal or cerebral AV malformations	437.30
71394	Carotid or vertebral artery occlusion by detachable balloon – percutaneous	297.30
	Percutaneous carotid angiogram – single (brachial)	
71400	- procedure	168.56
71401	- interpretation	56.29
	Percutaneous carotid angiogram – bilateral	
71402	- procedure	303.40
71403	- interpretation	93.78
	For repeat angiograms (oblique vies, stereo magnification, basil, etc.)	
71404	- procedure – single	202.26
71405	- interpretation – single	56.29
71406	- procedure – bilateral	364.09
71407	- interpretation – bilateral	93.78
	Myelogram (complete) prone	
71410	- procedure	89.90
71411	- interpretation	37.51
	Myelogram – supine (second puncture)	
71415	- procedure	37.19
	Posterior fossa myelogram	
71421	- procedure	37.19
	Discography	
71425	- procedure	55.79
71426	- interpretation	31.05
	Discography (each additional level)	
71427	- procedure	27.91
	Risagram	
71451	- interpretation	93.23

Code		Rate
	SPECIAL PROCEDURES (Cont'd)	
	Gastro-Intestinal	
	Sialogram	
71500	- procedure	23.99
71501	- interpretation	15.52
	Insertion of nasogastric tube	
71504	- procedure	8.37
	Ba. Swallow H-type fistula	
71508	- procedure	37.19
71509	- interpretation	IC
71510	Percutaneous gastrostomy	230.24
	Hypotonic duodenography	
71514	- procedure	23.99
71515	- interpretation	IC
71518	Biliary duct calculus removal via T-Tube tract	116.20
71519	Percutaneous transhepatic biliary drainage including biliary stenting	386.24
	Transhepatic cholangiogram	
71520	- procedure	72.46
71521	- interpretation	37.51
71522	Change of biliary drainage tube	144.94
71523	Injection of biliary drainage tube for reassessment	37.51
71524	ERCP - total procedure performed by a Radiologist	238.01
71525	- interpretation	10.62
	Small bowel enema	
71528	- procedure	70.20
71529	- interpretation	15.52
	Reduction of intussusception	
71534	- procedure and interpretation	44.25
71536	Oral or percutaneous placement of jejunostomy tube	70.20
	Gastrografin enema	
71538	- procedure	37.18
71539	- interpretation	IC
	Pneumoperitoneal and retroperitoneal air insufflation	
71541	- procedure	84.01
71542	- interpretation	46.60
	Sinogram	
71549	- procedure	23.99
71550	- interpretation	15.52
	Dacrocystogram	
71560	- procedure	23.99
71561	- interpretation	15.52
71570	Abscess management (intra-abdominal or deep organ) i.e. localization, placement of tube, drainage under fluoroscopy, ultrasound and/or CT	136.65
	Respiratory System	
	Laryngogram	
71600	- procedure	23.99
71601	- interpretation	31.23
	Single bronchogram	
71612	- procedure	23.99
71613	- interpretation	31.23

Code		Rate
	SPECIAL PROCEDURES (Cont'd)	
	Respiratory System (Cont'd)	
	Bilateral bronchogram	
71614	- procedure	36.00
71615	- interpretation	46.60
	Percutaneous lung biopsy	
71618	- procedure and interpretation	137.85
	Injection of air into the anterior mediastinum	
71624	- procedure	59.98
71625	- interpretation	15.52
	Injection of contrast into pleural cavity	
71626	- procedure	36.00
71627	- interpretation	15.52
	Genito-Urinary	
	Hysterosalpingogram	
71700	- procedure (fluoroscopy) and interpretation	56.70
	Kidney film	
71710	- procedure (fluoroscopy)	15.52
71711	- interpretation	15.52
71714	Percutaneous antegrade insertion of ureteric stent	102.02
71715	Change of nephrostomy tube	144.94
	Cyst puncture (renal)	
71718	- procedure	121.95
	Injection of dye into cystic cavity	
71724	- procedure	36.00
71725	- interpretation	15.52
	Loopogram	
71728	- procedure	12.02
71729	- interpretation	12.02
	Catheterization	
71730	- procedure and interpretation	8.55
	Percutaneous nephrostomy	
71740	- performed by a Radiologist	175.70
	Arthrogram, Tenogram, or Bursogram	
71800	- procedure	36.00
71801	- interpretation	34.09

Code		Rate
	OTHER ITEMS	
	Other	
71840	Mammary ductography …….....	29.35
71850	Intra-mammary needling for localization under mammographic control (procedure and interpretation)	
	- unilateral …….....	70.35
	Special Visit Premium	
71927	Daytime special visit (Monday to Friday) ……	33.12
71928	Evening (6:00 p.m. to midnight), Saturday, Sunday and Statutory Holidays ……	110.37
71929	Night (midnight to 8:00 a.m.) …….....	165.56
	Note: The above special visit premiums are payable in addition to the x-ray examination fees; however, only one premium per trip is payable regardless of the number of x-rays examined.	
	IV Injections	
71941	Adult ……...	15.00
71942	Cut-down ……...	10.36
71948	Paediatric IV injection ……	10.36
71949	Scalp vein or cut-down ……	20.68
71950	Catheterization ……	10.36
71951	Injection – bursae, joints or tendon sheath …….....	20.25
	Tomography	
71960	1 plane ……...	12.01
71961	2 planes ……	23.95
	Fluoroscopy	
71980	Fluoroscopy alone, of any part ……..	20.63
71985	Fluoroscopy control of a procedure done by another physician, per ¼ hour or part thereof (IC required indicating the name of the procedure, the physician who did the procedure and the amount of time involved.) ……...	27.40

Code		Rate

DIAGNOSTIC ULTRASOUND

Procedure codes indicated as IC must be billed IC indicating why the procedure had to be done by the Radiologist. See item 11.4 of the Preamble.

Notes:

1. A-mode – Implies a one-dimensional ultrasonic measurement procedure.
2. M-mode – Implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
3. Scan B-mode – Implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

Doppler Studies:

The Doppler fee codes listed in this section may be billed in combination with diagnostic ultrasound fee codes when a Doppler study is medically necessary and aids in the clinical decision making process. The written report must include a description of the findings when a Doppler fee code is billed. The use of Doppler for screening without a specific indication is not billable.

General

72050	Ultrasound control of a procedure, done by another physician, per ¼ hour or part thereof (IC required indicating the name of the procedure, the physician who did the procedure and the amount of time involved) ……	27.50

Head and Neck

	Echoencephalography – midline, A-mode	
72100	- interpretation ……	12.09
72101	- procedure (IC) ……	23.22
	Complete (midline and ventricular size)	
72104	- interpretation ……	18.18
72105	- procedure (IC) ……	23.22
	Echography – ophthalmic	
	Quantitative, A-mode	
72110	- interpretation ……	49.78
72111	- procedure (IC) ……	23.22
	B-scan immersion	
72112	- interpretation ……	66.36
72113	- procedure (IC) ……	23.22
	B-scan contact	
72114	- interpretation ……	33.20
72115	- procedure (IC) ……	23.22
	Biometry (axial length – A-mode)	
72116	- interpretation ……	44.25
72117	- procedure (IC) ……	23.22
	Foreign body localization	
72118	- interpretation ……	IC
72119	- procedure (IC) ……	23.22
	Echography – neck (e.g., thyroid, neck mass or other pathology including A and/or B scans)	
72130	- interpretation ……	24.17
72131	- procedure (IC) ……	23.22
72132	- Doppler evaluation of neck pathology, one or more, uni- or bilateral…….. add to 72130	16.33

Code		Rate

DIAGNOSTIC ULTRASOUND (Cont'd)

	Neonatal/paediatric cranial scan – complete	
72140	- interpretation	40.29
72141	- procedure (IC)	23.22
	Neonatal/paediatric spinal scan – complete	
72150	- interpretation	40.29
72151	- procedure (IC)	23.22
	Heart/Major Blood Vessel	
	Echography, pericardial effusion, M-mode	
72200	- interpretation	26.84
72201	- procedure (IC)	23.22
	Ultrasound pericardiocentesis	
72210	- procedure and interpretation	50.51
	Echocardiography	
	Complete study - 1 dimension	
72220	- interpretation	45.06
72221	- procedure (IC)	17.92
	Complete study - 2 dimensions	
72222	- interpretation	83.64
72223	- procedure (IC)	21.08
	1 and 2 dimension study on same patient visit	
72224	- interpretation	92.13
72225	- procedure (IC)	26.00
	Limited study 1 or 2 dimensions for follow-up studies	
72226	- interpretation	20.71
72227	- procedure (IC)	15.46
	Doppler echocardiography	
72228	- interpretation	51.05
72229	- procedure (IC)	20.21
	Aorta only	
72230	- interpretation	57.61
72231	- procedure (IC)	23.22
	Vena cava only	
72232	- interpretation	57.61
72233	- procedure (IC)	23.22
	Peripheral Vascular System	
	Extra-cranial vessel assessment above the aortic arch (bilateral, carotid and/or subclavian and/or vertebral arteries only)	
72240	- Doppler scan or B scan	25.32
72241	- frequency/ spectral analysis	25.32
72242	- frequency/ spectral analysis with Doppler scan	34.54
72243	- duplex scan, i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis	62.22

Note:
Only one of fee codes 72240, 72241, 72242 and 72243 can be billed per patient per day.

Code		Rate

DIAGNOSTIC ULTRASOUND (Cont'd)

	Duplex Doppler assessment of hepatic and portal venous systems	
72244	- interpretation ……	16.33
72245	- procedure ……	19.72

Note: Fee code 72244 should only be billed in cases where hepatic and portal vessels are analyzed and should include a colour study of both systems and duplex study of at least one of the two systems.

	Post-operative organ transplant arterial and/or venous Doppler assessment (assessment of the vascularity to the organ transplant rather than the ultrasound examination of the organ itself)	
72246	- interpretation ……	16.33
72247	- procedure ……	19.72
	Transcranial Doppler assessment	
72248	- interpretation ……	21.50
72249	- procedure ……	26.06
	Peripheral artery evaluation distal to inguinal ligament or axilla (<u>not</u> to be billed routinely with 72241, 72242 or 72243)	
72250	- Doppler scan or B-scan ……....	20.95
72252	- frequency/spectral analysis with Doppler scan ……..	28.79
72253	- duplex scan, i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis ….	33.60

Notes: The following fee code combinations are not billable: 72250 with 72252 and 72253 with either of 72250 or 72252.

	Venous evaluation – duplex scan i.e. simultaneous real time, B-mode imaging	
72254	- interpretation ……	20.40
72255	- procedure ……	31.43
	Duplex Doppler assessment of post-operative shunts	
72256	- interpretation ……	16.33
72257	- procedure ……	19.72
	Doppler assessment of one or more intra-abdominal and pelvic vessels, uni- or bilateral	
72258	- interpretation ……	25.76
72259	- procedure ……	22.36

Notes:

1. Doppler evaluation of intra-abdominal and pelvic vessels should not be performed routinely; it should be limited to investigation of problems where the result will influence management. Examples of acceptable uses for MCP billing purposes include:
   a) placement of colour Doppler upon kidneys to assess for twinkle artifact if the presence of small stones is suspected;
   b) assessment for ureteric jets if reduced or obstructed flow is suspected;
   c) **evaluation of a solid lesion**;
   d) **evaluation of a cyst with one or more walls or septations**;
   e) evaluation of vessels where stenosis or occlusion is suspected;
2. The use of Doppler to distinguish the common bile duct from a vessel is not billable.
3. Fee code 72258 and 72259 are not to be billed for screening purposes; they should be billed for problem solving purposes.
4. A maximum of one unit of fee code 72258 is payable per patient session.
5. A maximum of one unit of fee code 72259 is payable per patient session.

Code		Rate
	DIAGNOSTIC ULTRASOUND (Cont'd)	
	Thorax	
	Chest masses, pleural effusion – A and B-mode	
72340	- interpretation	40.29
72341	- procedure (IC)	23.22
	Ultrasonic thoracentesis	
72350	- procedure and interpretation	32.45
	Breast masses – scan B-mode (per breast)	
72360	- interpretation	36.04
72361	- procedure (IC)	33.96
72362	- Doppler evaluation of breast masses, one or more, uni- or bilateral ... add to 72360	16.33
	Abdomen and Retroperitoneum	
	Abdominal scan, major (includes multiple organs and/or spaces)	
72400	- interpretation	57.11
72401	- procedure (IC)	60.83
	Abdominal scan, limited (e.g. single organ or follow-up study)	
72403	- interpretation	41.16
72404	- procedure (IC)	23.22
	Scrotum/ Penis (includes Doppler examination)	
	Testicular (1 or both) or scrotal scanning	
72450	- interpretation	47.57
72451	- procedure (IC)	23.22
72452	Doppler evaluation of testicular flow when indicated, uni- or bilateral and/or evaluation of testicular/scrotal masses, one or more, uni- or bilateral ... add to 72450	16.33
	Obstetrics, Gynaecology and Pelvis	
	Echography – Scan B-mode	
	Early pregnancy diagnosis	
72500	- interpretation	46.22
72501	- procedure (IC)	33.36
	Foetal age determination	
72510	- interpretation	28.43
72511	- procedure (IC)	21.44
	Placenta localization	
72520	- interpretation	28.43
72521	- procedure (IC)	22.36
	IUCD localization	
72530	- interpretation	28.43
72531	- procedure (IC)	22.36
	Pregnancy, complete	
72540	- interpretation	**53.20**
72541	- procedure (IC)	75.00
	Foetal assessment in – utero for physical condition of the fetus (requested by the specialist)	
72545	- interpretation and procedure	41.31
	Pelvic mass	
72570	- interpretation	46.21
72571	- procedure (IC)	22.36
	Endocavitary Scan	
72575	- interpretation	81.61
72576	- procedure	22.36
72578	Transvaginal sonohysterography, includes procedure, interpretation and introduction of saline or other intracavitary contrast media	123.65
	Ultrasonic amniocentesis	
72580	- interpretation and procedure	36.85

Code		Rate
	DIAGNOSTIC ULTRASOUND (Cont'd)	
	Doppler assessment of one or more fetal vessels including umbilical artery and vein	
72590	- interpretation	25.76
72591	- procedure	22.36
	Extremities, including Doppler examination of soft tissue mass	
	Extremities, per limb (excluding vascular study)	
72610	- interpretation	17.37
72611	- procedure (IC)	23.22
	Scan of popliteal space	
72620	- interpretation	24.17
72621	- procedure (IC)	23.22
	Soft tissue mass, other than neck or limb (with or without Doppler examination)	
72630	- interpretation - single mass	17.37
72631	- interpretation - each additional mass (maximum of 2 units payable); ..... add	12.08
72632	- procedure - per patient session, any number of masses (IC)	23.22
	THERAPEUTIC ULTRASOUND	
72650	Occlusion of femoral or brachial pseudo-aneurysm under colour Doppler ultrasound guidance.....	136.55

Code		Rate

COMPUTED TOMOGRAPHY

Head

73800	- without IV contrast	**84.30**
73801	- with IV contrast	**89.50**
73802	- with and without IV contrast	**113.65**

Complex Head

73805	- without IV contrast	**84.25**
73806	- with IV contrast	97.21
73807	- with and without IV contrast	111.02

Neck

73810	- without IV contrast	86.60
73811	- with IV contrast	97.50
73812	- with and without IV contrast	108.30

Thorax

73815	- without IV contrast	**99.42**
73816	- with IV contrast	**99.68**
73817	- with and without IV contrast	**119.80**

Cardio-thoracic

Cardio-thoracic CT is an imaging service of the cardio-thoracic structures including cardiac gating and 3D imaging post-processing, cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) and requires imaging without contrast material followed by contrast material(s).

73818	Cardio-thoracic	147.50

Notes:

1. The service described by 73818 includes the supervision of oral beta blockers and/or IV injection where clinically indicated.

2. Fee code 73818 is only eligible for payment when the service is performed using a minimum of a 64-detector CT scanner.

3. Fee code 73818 is only eligible for payment when a) one or more of the following indications are present: arterial and venous aneurysms; traumatic injuries of arteries and veins; arterial dissection and intramural haematoma; arterial thromboembolism; vascular congenital anomalies and variants; percutaneous and surgical, vascular interventions; vascular infection, vasculitis and collagen vascular disease; sequelae of ischemic coronary disease (i.e. myocardial scarring, ventricular aneurysms, thrombi); cardiac tumors and thrombi; pericardial diseases; cardiac function evaluation, especially in patients in whom cardiac function may not be assessed by magnetic resonance imaging or echocardiography OR b) a clinically stable symptomatic patient with low to intermediate probability of obstructive coronary disease; a clinically stable symptomatic patient who has planned surgery for valvular or structural heart disease; a patient has low to intermediate probability of stent stenosis where the stent has a diameter > 3mm; a patient with suspected clinically relevant congenital coronary artery anomalies.

4. Fee codes 73815, 73816 and 73817 are not eligible for payment with 73818.

Code		Rate

5. Fee code 73818 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post-processing, two or three dimensional reconstruction(s), and administration of contrast.

6. Fee code 73818 includes payment for a diagnosis of the entire detailed field of view including the lymph nodes, pleura, lungs, mediastinum, airways, bony thorax, spine and heart, veins, arteries and other related anatomical structure.

7. Fee code 73818 includes payment for a documented quantitative evaluation of coronary calcium for risk stratification when clinically appropriate.

8. CT coronary angiography is not insured:
   a. for a patient with a high pre-test probability of obstructive coronary artery disease or ECG or cardiac enzyme evidence of an acute coronary syndrome
   b. for purposes of screening, risk stratification or calcium scoring in asymptomatic patients.

	Abdomen	
73820	- without IV contrast ……	111.02
73821	- with IV contrast ……	124.83
73823	- with and without IV contrast ……	138.80
	Extremities (1 or more)	
73825	- without IV contrast ……	**94.73**
73826	- with IV contrast ……	**97.37**
73827	- with and without IV contrast ……	97.21
	Spine(s)	
73830	- without IV contrast ……	111.02
73831	- with IV contrast ……	124.83
73832	- with and without IV contrast ……	138.80
	Pelvis	
73835	- without IV contrast ……	111.02
73836	- with IV contrast ……	124.83
73837	- with and without IV contrast ……	138.80
73838	CT Colonography ……....	235.30

Notes:

1. Fee code 73838 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post processing, two or three dimensional reconstruction(s), administration of contrast and faecal tagging, if rendered.

2. Fee codes 70631, 73820, 73821, 73823, 73835, 73836, 73837 are not eligible for payment with 73838.

3. CT colonography is an insured service only in the following circumstances:
   a. individuals who are at moderate risk for colorectal cancer based on family history and the patient refuses colonoscopy or where the patient has been advised of the relative risks and benefits of CT colonography and colonoscopy and the patient refuses colonoscopy;

b. for surveillance examination in patients with a history of previous colonic neoplasm, where clinically appropriate;
c. when rendered for a patient for whom colonoscopy is technically infeasible, has been difficult in the past, or contraindicated;
d. for patients who are at increased risk for complications during endoscopy such as advanced age, sedation or anti-coagulation therapy, prior incomplete or difficult colonoscopy;
e. when double contrast barium enema services are unavailable or regarded as inadequate for clinical or diagnostic reasons.

4. Fee code 73838 includes payment for a diagnosis of the entire detailed field of view including colonic and extra-colonic structures.

5. CT colonography also refers to and includes “virtual colonoscopy”.

Code		Rate
	MAGNETIC RESONANCE IMAGING	
	Head	
73850	- multislice SE (1 or 2 echos)	99.67
73851	- multislice IR	64.91
73852	- repeat (another plane, different pulse sequence – max. 2)	49.73
73853	- when gating is performed, (fee = 30% of applicable imaging fee)	IC
	Neck	
73855	- multislice SE (1 or 2 echos)	99.67
73856	- multislice IR	64.91
73857	- repeat (another plane, different pulse sequence – max. 2)	49.73
	Thorax	
73860	- multislice SE (1 or 2 echos)	116.15
73861	- multislice IR	99.67
73862	- repeat (another plane, different pulse sequence – max. 2)	58.02
73863	- when gating is performed, (fee = 30% of applicable imaging fee)	IC
	Abdomen	
73865	- multislice SE (1 or 2 echos)	116.15
73866	- multislice IR	99.67
73867	- repeat (another plane, different pulse sequence – max. 2)	58.02
73868	- when gating is performed, (fee = 30% of applicable imaging fee)	IC
	Pelvis	
73870	- multislice SE (1 or 2 echos)	116.15
73871	- multislice IR	99.67
73872	- repeat (another plane, different pulse sequence - max. 2)	58.02
	Extremity	
73875	- multislice SE (1 or 2 echos)	99.67
73876	- multislice IR	64.91
73877	- repeat (another plane, different pulse sequence – max. 2)	49.73
	Spine	
	Spinal segments recognized are cervical, thoracic, and lumbo-sacral	
	Limited spine – 1 segment	
73880	- multislice SE (1 or 2 echoes)	116.15
73881	- multislice IR	99.67
73882	- repeat (another plane, different pulse sequence – max 2)	58.02
	Intermediate spine – 2 adjoining segments	
73886	- multislice SE	135.37
73887	- multislice IR	153.05
73888	- repeat (another plane, different pulse sequence – max. 2)	67.62
	Complex spine – 2 or more non-adjoining or complete segments	
73891	- multislice SE	201.24
73892	- multislice IR	153.05
73893	- repeat (another plane, different pulse sequence – max. 2)	100.18
73895	When gating of spine is performed, (fee = 30% of applicable imaging fee)	IC

Code		Rate	

INTERVENTIONAL RADIOLOGY

74000	PET/CT One Region ……...	507.88	
74001	PET/CT Two or More Regions ……..	596.32	
74100	Endovascular obliteration of cerebral aneurysms by any technique ……..	**1,901.39**	I.C.

Notes:

1. Includes all neurological exams done in association with the procedure, any diagnostic angiography performed at time of the procedure, fluoroscopy and any other necessary imaging performed at the time of the procedure;
2. Separate micro catheterization and stenting included if required;
3. Multiple aneurysms paid as follows: 2nd at 50%, 3rd at 25% (to a maximum of three aneurysms);
4. Radiological specialist assists are billable in Capacity “1” at 75% of the listed rate for code 74100 as per General Preamble;

74300	Percutaneous image guided radiofrequency ablation of solid tumor ……..	575.00	

Notes:

1. Payable only for non-resectable liver, kidney, lung tumors, colorectal metastases and osteoid osteoma;
2. Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 50% for second and third lesion;
3. Includes all imaging guidance by any method necessary to complete the procedure.

DIAGNOSTIC BIOPSY

74520	Image-guided biopsy, any organ, by any radiographic technique ……	103.69	See biopsy codes

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate

Fee code items which read "with computer data manipulation" may be claimed in addition to preceding fee code item(s) if quantification or data manipulation is carried out in addition to visual inspection of imaging studies. Such activity must add significant diagnostic information not available by inspection alone and does not include simple image enhancement techniques such as smoothing, background subtraction, etc. Recording of images on video tape for replay and production of images on the video display of a computer do not in themselves justify claims for "computer data manipulation."

Cardiovascular System

75000	Venography – peripheral and superior vena cava	41.28
75001	- with computer data manipulation ... add	12.22
75002	First transit without blood pool images	16.31
75003	First transit with blood pool images	32.60
75004	- when done in conjunction with an organ scan	**19.08**
75005	- with computer data manipulation ... add	9.78
75006	Cardioangiography – first pass for shunt detection, cardiac output and transit studies	58.62
	Myocardial perfusion scintigraphy	
75007	- immediate post stress	**68.18**
75008	- delayed	30.78
75009	- with computer data manipulation ... add	23.09
75010	Myocardial scintigraphy – acute infarction injury	41.28
75011	Myocardial wall motion studies	57.30
75012	- repeat same day (max. of 3 repeats)	28.69
75013	Myocardial wall motion studies with ejection fraction	96.35
75014	- repeat same day (max. of 3 repeats)	43.98
75015	- with computer data manipulation ... add	27.92
75016	Detection of venous thrombosis with radioiodinated fibrogen – up to 10 days	43.98
75018	Intravenous Dipyridamole Stress test - includes monitoring time spent with the patient by the Nuclear Medicine Physician (EKG interpretation payable in addition)	**29.63**

Endocrine System

75020	Adrenal scintigraphy with iodocholesterol	66.15
75021	- with iodocholesterol and dexamenthasone suppression	66.15
75022	- with MIBG	62.90
	Thyroid uptake	
75023	- initial	**26.90**
75024	- repeat	10.63
	Thyroid scintigraphy	
75025	- with TC99m or I-131	42.98
75026	- with I-123	43.60
	Parathyroid scintigraphy	
75027	- dual isotope technique with T1201 and TC99m iodine	78.63
75028	- with computer data manipulation ... add	**25.73**
75029	Metastatic survey with I-131	**72.08**

Gastrointestinal System

75034	C15 breath test for *Helicobacter pylori*	**24.95**
	Schilling test	
75035	- single isotope	17.96
75036	- dual isotope	16.01
	Malabsorption test	
75037	- with C14 substrate	17.96
75038	- with whole body counting	22.54

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Gastrointestinal System (Cont'd)	
75039	Gastrointestinal protein loss	26.88
75040	Gastrointestinal blood loss Cr51	12.04
75041	Calcium absorption – Ca45	12.04
75042	Calcium47 absorption/excretion	43.98
75043	Esophageal motility studies – 1 or more	123.30
75044	Gastrointestinal transit	**59.79**
75045	Gastroesophageal reflux	49.60
75046	Gastroesophageal aspiration	**59.59**
	Abdominal scintigraphy for gastrointestinal bleed	
75047	- TC99m sulphur colloid or TC04	**59.59**
75048	- labelled RBCs	**65.08**
75049	- LeVeen shunt potency	43.98
75050	Biliary scintigraphy	74.82
75051	Liver/spleen scintigraphy	**59.59**
75053	Salivary gland scintigraphy	54.67
75054	With computer data manipulation add	**17.15**
	Genitourinary System	
75060	Dynamic renal imaging	78.63
75061	Computer renal function (includes first transit)	78.63
75062	- repeat after pharmacological intervention	**26.31**
75063	Static renal scintigraphy	**59.70**
75064	ERPF by blood sample method	10.63
75065	GFR by **four** blood sample method	**94.18**
	Note: GFR by fewer than four blood samples is not payable. GFR by more than four samples is payable at the listed rate.	
75066	Cystography for vesicoureteric reflux	32.60
75067	Testicular and scrotal scintigraphy (includes first transit)	55.93
75068	With computer data manipulation add	**25.73**
	Hematopoietic System	
75069	Plasma volume	8.99
75070	Red cell volume	8.99
75071	Ferrokinetics – clearance, turnover and utilization	42.08
75072	Red cell, white cell or platelet survival	26.02
75073	Red cell survival with serial surface counts	35.95
75074	Bone marrow scintigraphy	**75.65**
75075	Single site	47.88
75076	In-111 leukocyte scintigraphy - whole body	**80.95**
75077	- single site	58.06
75078	Indium-CL scintigraphy	47.88
75079	With computer data manipulation add	13.43

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Musculoskeletal System	
75080	Bone scintigraphy - general survey	**71.32**
75081	- single site	47.00
75082	Gallium scintigraphy - general survey	**79.13**
75083	- single site	56.39
75084	Bone mineral density, by single photon method	10.63
75085	Total bone calcium – neutron activation	75.18
75086	Bone mineral content by dual photon absorptiometry - single site	43.45
75087	- 2 or more sites	59.01
75088	With computer data manipulation ... add	16.21
	Nervous System	
	CSF circulation	
75090	- with TC99 m or I-131 HSA	54.42
75091	- with Indium-111	**67.66**
75092	- via shunt puncture	**72.08**
75093	Brain scintigraphy	54.67
75094	- cerebral blood flow study ... add	**57.58**
75095	- with computer data manipulation ... add	14.66
75096	HMPAO regional brain perfusion with SPECT	**79.45**
	Respiratory System	
75100	Perfusion lung scintigraphy	50.07
75101	Ventilation lung scintigraphy	46.66
75102	Perfusion and ventilation scintigraphy – same day	**108.69**
75103	With computer data manipulation ... add	11.79
	Miscellaneous	
75200	Radionuclide lymphangiogram	74.32
75201	Ocular tumour localization	77.25
75202	Tear duct scintigraphy	55.95
75203	Total body counting	62.67
75205	Other scan (approved but not currently listed)	60.03
75206	With computer data manipulation ... add	10.99
	SPECT	
75210	SPECT – Single Photon Emission Computerized Tomography	36.85
75212	SPECT – with transmission attenuation correction	**53.01**

Notes:

1. SPECT <u>includes</u> quantification and data manipulation.
2. The specific organ or system imaged can be claimed using the applicable fee code in addition to 75210 or 75212.
3. Only one of 75210 and 75212 can be claimed for SPECT imaging.

	Special Visit Premiums	
75227	Daytime special visit (Monday to Friday)	**34.41**
75228	Evening (6 p.m. to midnight), Saturdays, Sundays, and Statutory Holidays	**123.08**
75229	Night (midnight to 8 a.m.)	169.37

Note: The above special visit premiums are payable in addition to nuclear medicine fees, however, only one premium per trip is payable regardless of the number of services provided.

NUCLEAR MEDICINE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	Therapy using Radioisotopes	
	The rate listed includes treatment planning, dosage calculation and preparation of materials. Appropriate visit and procedural benefits (e.g., paracentesis) may be claimed in addition. Thyroid benefits (75250, 75251 and 75252) include administration(s) within any 3 month period.	
75250	Thyroid malignancy	**102.70**
75251	Hyperthyroidism	**93.35**
75252	Induction of hypothyroidism	79.81
75255	Prostate malignancy	79.81
75256	Polycythaemia	45.57
75257	Metastatic disease of bone	**84.95**
75260	Ascites and/or pleural effusion(s) due to malignancy	56.86
75261	Arthritis – single or multiple site	37.51
75262	Metastatic disease with radioactive lymphogram	56.86

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	OBSTETRICAL CARE			
80002	Multiple births – each child extra		**154.84**	
80004	Delivery		**519.65**	
80006	Vaginal birth following a Caesarean Section	add	**53.14**	
80010	Post-natal care in hospital		**57.47**	
80012	Post-natal care in office		**36.16**	
80014	Attendance at labour by **Family Physician**		423.10	
80016	Attendance at delivery by Obstetrician		**220.07**	
	High risk pregnancies			
80018	Fetal Doppler arterial flow frequency analysis (IOP)		**23.97**	
80020	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis) (IOP)		165.40	
80024	Double set up examination to rule out placenta previa – patient subsequently allowed to labour (same physician)		58.0	
80026	Double set up – trial of forceps – failed leading to Caesarean Section (same physician)		**60.44**	
80028	Chorionic villus sampling (IOP)		153.00	
80030	Application of scalp electrode in high risk pregnancy		**23.86**	
80032	Insertion of intrauterine catheter		22.90	
80034	Foetal scalp blood sampling		40.80	

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	ANAESTHESIOLOGY			
80040	Anaesthesia for delivery ……			5
80042	Continuous conduction anaesthesia for labour, introduction of catheter …...			5
80044	Maintenance of continuous conduction anaesthesia (1 unit for each subsequent injection or ¼ hour of maintenance, maximum of 12 units) per unit ……			1
	If the patient has an operative delivery, a maximum of 12 one-quarter hour units for epidural prior to delivery, plus the units of time for the delivery, plus, if necessary, another maximum of 12 one-quarter hour epidural units post-delivery, are payable for management of pain. (Claim IC when total epidural/anaesthetic time units in the above combination exceed 12).			
80046	Anaesthesiologist called to attend obstetrical delivery without participation (IC) ……...			4 units + time

Anaesthesiology Notes re delivery following epidural:

1. The subsequent operative delivery or delivery by Caesarean Section is considered to constitute a separate anaesthetic procedure.
2. Time units for the subsequent delivery will be considered as additional to the total number of quarter-hour units of epidural anaesthetic and payable at double the time unit rate when in excess of 2 hours anaesthetic time.

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	OPERATIVE DELIVERY, excluding low or outlet forceps delivery			
81002	- Caesarean Section with or without sterilization, procedure and post-operative care only ……..	49.02	**618.30**	6
81004	- Caesarean Section, plus hysterectomy …….....	49.02	**872.41**	8
81006	- Operative delivery – other than Caesarean Section …….....	49.02	**558.10**	5

OBSTETRICS

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SURGICAL OBSTETRICS			
	Induction			
	Notes: 1. Only the first induction may be claimed per patient per pregnancy, regardless of the number of attempts at induction or the number of physicians involved. 2. Induction is only payable when the physicians who bill for induction and delivery (other than Caesarean Section) are in different specialties. 3. Induction cannot be claimed by the physician who bills for delivery (other than Caesarean Section).			
81010	Surgical induction of labour …….		28.07	3
81012	Medical induction of labour (oxytocin infusion) …….		**63.09**	
	Abortion			
	- complete – under 20 weeks ……..		VF	
81014	- D&C for incomplete abortion (IOP) ……..		**135.26**	4
81016	- surgical …….....		**195.36**	4
81018	Amniocentesis (IOP) ……		**106.28**	
81020	Hysterotomy – abdominal or vaginal with or without sterilization ……..	49.02	194.10	6
81022	Missed abortion, with or without intra-uterine hypertonic solution ……		**166.63**	4
81023	Insertion of laminaria device ……..... add		**6.04**	
	Note: Fee code 81023 can be billed in addition to fee codes 81016 or 81022 when a laminaria device is used to dilate the cervix prior to these procedures. It cannot be billed in addition to any other fee code or for medical induction of labour**.**			
81024	Repair of third degree laceration ……		**72.53**	4
81026	Repair of vaginal laceration and/or large haematoma ……		**49.13**	4
81028	Retained placenta removal ……..		**49.13**	4
	Fee codes 81024, 81026 and 81028 are not payable to the same physician in addition to the delivery fee.			
81030	Ectopic pregnancy ……	49.02	**353.53**	6
81032	Suture of incompetent cervix during pregnancy …….....		**151.19**	4
81034	Emergency removal of sutures (except at delivery) ……			4
81036	Sterilization – postpartum (same physician), in addition to delivery and postpartum fee ……..	49.02	114.50	6
81038	Uterine inversion, manual replacements …….....		**131.03**	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	For rules applicable to billing for Anaesthesiologists' services including premiums, please refer to the Anaesthesiology Services Section of the Preamble	
	EXTRACTIONS	
84040	Removal of erupted tooth, uncomplicated procedure ……	4
84044	Surgical removal of erupted tooth, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of tooth ……....	4
84046	Removal of residual roots - covered by soft tissue …….	4
84050	- covered by bone ……..	4
	EXTRACTION OF IMPACTED TEETH	
84060	Impaction, requires incision of overlying soft tissue and removal of tooth …….	4
84062	Impaction, requires incision of overlying soft tissue, elevation of flap, and either removal of bone or sectioning and removal of tooth ……....	4
84064	Impaction, requires incision of overlying soft tissue, elevation of flap and removal of completely bone covered tooth ……	4
84066	Impaction, requires incision of overlying soft tissue, elevation of flap, removal of bone and/or sectioning of tooth for removal and/or presents unusual circumstances or difficulties ….....…	4
	SURGICAL EXPOSURE OF TEETH	
	Surgical exposure	
84070	**-** uncomplicated, soft tissue coverage ……	4
84072	**-** complex, hard tissue coverage ……..	4
84074	**-** unerupted tooth with orthodontic attachment ……..	4
	SURGICAL MOVEMENT OF TEETH	
84080	Repositioning, surgical ……	4
84082	Transplantation - erupted tooth …….	4
84084	- unerupted tooth ……	4
	REMODELLING AND RECONTOURING ORAL TISSUES	
84100	Alveoloplasty - in conjunction with extractions ……...	4
84102	- not in conjunction with extractions ……	4
	Remodelling of Bone	
84104	Mylohyoid ridge, remodelling ……	4
84106	Genial tubercles, remodelling …….	4
	Excision of Bone	
84108	Nasal bone ……	4
84110	Torus palatinus ……	4
84112	Torus mandibularis ……..	4
84114	Removal of Bone, Exostosis, Multiple ……..	4
84116	Reduction of Bone, Tuberosity ……..	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	REMODELLING AND RECONTOURING ORAL TISSUES (Cont'd)	
	Gingivoplasty and/or Stomatoplasty	
84120	Gingivoplasty	4
84122	Gingivectomy	4
84124	Excision of vestibular hyperplastic tissue	4
84126	Surgical shaving of papillary hyperplasia of the palate	4
84128	Excision of pericoronal gingiva (for retained tooth/implant)	4
	Remodelling Floor of Mouth	
84130	Full arch lowering of the floor of the mouth	10
	Vestibuloplasty	
84132	Submucosal, uncomplicated	4
84134	Secondary epithelialization, uncomplicated	4
84136	Vestibuloplasty - with labial inverted flap (secondary epithelialization, complicated)	5
84138	- with skin graft	5
84140	- with mucosal graft	5
	Alveolar Ridge Reconstruction	
84142	Alveolar ridge reconstruction, with autogenous bone/arch	10
84144	Ceramic grafting	4
	TESTS, HISTOLOGICAL	
84150	Biopsy - soft oral tissue, by incision	4
84152	- hard oral tissue, by incision	4
	SURGICAL EXCISIONS	
	Surgical Excision, Tumours, Benign	
84160	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue - less than 2 cm.	4
84162	- over 2 cm.	4
84164	Tumours, benign, bone tissue - less than 2 cm.	4
84166	- over 2 cm.	5
84168	Extra-large lesions over 3 cm. or complicated	5
	Surgical Excisions, Tumours, Malignant	
84170	Tumours, malignant, soft tissue - less than 2 cm.	4
84172	- over 2 cm.	4
84174	Tumours, malignant, bone tissue - less than 3 cm.	5
84176	- 3 to 6 cm.	5
84178	Large Lesions over 6 cm. or complicated	10
	Cheiloplasty (lip shave)	
84180	Cheiloplasty - partial	4
84182	- total	4
84190	Grafts, bone, to the jaw	10

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	SURGICAL EXCISIONS (Cont'd)	
	Augmentations, Prosthetic, of the Jaw	
84200	Implantation of intraosseous prosthesis (continuity defect)	10
84202	Removal of intraosseous prosthesis	4
84204	Augmentation of the chin	4
	Surgical Excision of Cysts/Granulomas	
84210	Less than 2 cm.	4
84212	Over 2 cm.	4
84214	Cyst, complicated (over 6 cm.)	5
84216	Marsupialization	4
	SURGICAL INCISIONS	
	Surgical Incision and Drainage and/or Exploration, Intraoral	
84220	Intraoral surgical exploration, soft tissue	4
84222	Intraoral abscess - soft tissue	4
84224	- in major anatomical area with drain	5
	Surgical Incision and Drainage and/or Exploration, Extraoral	
84230	Extraoral abscess - superficial, soft tissue	4
84232	- deep, soft tissue, with drain	5
	Surgical Incision for Removal of Foreign Bodies	
84240	From skin or subcutaneous alveolar tissue	4
84242	Of reaction-producing foreign bodies	4
84244	Of needle from musculoskeletal system	4
	Sequestrectomy (for Osteomyelitis)	
84250	Sequestrectomy - for osteomyelitis	7
84252	- and saucerization	7
84254	Extraoral sequestrectomy (complicated)	7
	Mandibulectomy	
84260	- partial (3-6 cm.)	4
84262	- hemi (6-12 cm.)	5
84264	- total (more than 12 cm.)	7
	Maxillectomy	
84270	- partial (3-6 cm.)	4
84272	- hemi (6-12 cm.)	5
84274	- total (more than 12 cm.)	7
	Apicoectomy	
84280	Apicoectomy and/or apical curettage - 1 root	4
84282	- 2 roots	4
84284	- 3 roots or more	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	TREATMENT OF FRACTURES	
84300	Intermaxillary fixation	5
84302	Intramaxillary suspension (wiring)	5
84304	Circumzygomatic wiring	5
84306	Removal of wire, plate and screw	5
84308	Removal if intermaxillary fixation	5
84310	Occlusal equilibration	5
	Fractures, Reduction, Mandible	
84330	- closed (simple)	5
84332	- open (simple)	5
84334	- open (multiple)	5
	Fractures, Reduction, Maxilla	
	Horizontal, LeFort I	
84340	- closed (simple)	5
84342	- open (simple)	6
84344	- open (multiple)	6
84346	Compound fracture of maxilla (requiring reduction and soft tissue repair)	8
	Pyramidal, LeFort II	
84350	- closed (simple)	5
84352	- open (unilateral)	8
84354	- open (bilateral)	8
	Fractures, Reduction, Naso-orbital	
84360	- closed (simple)	5
84362	**-** open (single)	5
84364	- open (multiple)	6
	Fractures, Reduction, Malar Bone	
84370	- closed (simple)	5
84372	- open (simple)	5
84374	**-** open, complicated, orbit involved	6
	Fractures, Reduction, Zygomatic Arch	
84380	- closed	5
84382	- open	5
	Fractures, Reduction, Craniofacial Dysfunction, LeFort III Transverse	
84390	- closed	5
84392	- open	10
	Fractures, Reduction, Alveolar	
84400	Fracture, alveolar, debride, teeth removed - no fixation	4
84402	Reduction, alveolar - closed, with teeth	4
84404	- open, with teeth	4
84406	Replantation, avulsed tooth	4
84410	Repositioning of traumatically displaced teeth	4
84412	Repairs, lacerations - uncomplicated, 5 cm. or less	4
84414	- complicated, up to 5 cm.	4
84416	- complicated, over 5 cm.	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate

TREATMENT OF MAXILLOFACIAL DEFORMITIES

Osteotomy, Ostectomy, Ramus of Mandible

84426	Osteotomy - unilateral	8
84428	- subcondylar, closed	10
84430	- subcondylar, open	10
84432	- ramus, oblique, extraoral	10
84434	- ramus, oblique, intraoral	10
84436	Osteotomy/ostectomy body of mandible	10
84438	Osteotomy - coronoidectomy	5
84440	- condylar neck	10
84442	- saggital split	10

Osteotomy, Miscellaneous

84444	- oblique with bone graft	10
84446	- inverted “L”	10
84448	- “C”	10

Osteotomy, Maxilla

84450	Osteotomy - maxilla, LeFort I	20
84452	- maxilla, LeFort II	20
84454	- maxilla, LeFort III	20
84464	Closure or cleft fistula - alveolar	4
84466	- palatal	6
84468	Pharyngoplasty	8
84470	Submucous resection	4

Osteotomy, Maxilla/Mandible, Segmental

	Maxilla	
84480	Osteotomy, segmental - anterior	10
84482	- posterior	10
84484	Osteotomy, midpalate split - anterior	10
84486	- complete	10
	Mandible	
84488	Osteotomy, segmental - anterior with transfer of mental eminence	10
84490	- anterior without transfer of mental eminence	10
84492	- posterior	10
84494	Osteotomy, lower border, mandible	10
84496	Osteotomy, total dento-alveolar	10

Osteotomy, with “Interpositional Graft”

84500	- using bone	10
84502	- using alloplast	10
84504	- using cartilage	10

Genioplasty

84510	Genioplasty - sliding	10
84512	- reduction	10
84514	- augmentation with graft	10
84516	Myotomy, suprahyoid	10

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate

TREATMENT OF MAXILLOFACIAL DEFORMITIES (Cont'd)

Miscellaneous Treatment of Maxillofacial Deformities

84520	Corticotomy, per 9 cuts	10
84522	Interdental septotomy	4
84524	Surgical expansion of the palate	8

Palatorraphy

84530	Palatorraphy - anterior (closure of palatine fissure)	8
84532	- posterior	8
84534	- total	8
84536	- with bone graft separate	8
84538	- with bone graft to anterior alveolar ridge separate	8

Frenectomy

84540	Frenectomy	4
84542	Frenoplasty	4

Glossectomy

84550	Glossectomy - partial, anterior wedge	8
84452	- full postero-anterior wedge	8

Cleft Surgery

84560	Primary unilateral cleft lip repair	8
84562	Secondary unilateral cleft lip repair	8
84564	Primary bilateral cleft lip repair	8
84566	Secondary bilateral cleft lip repair	8
84568	Reconstruction of cleft lip with lip switch flap	8
84570	Complex reconstruction or revision of cleft lip	8
84572	Closure of alveolar cleft	8

Oronasal Fistula

84580	Primary closure at time of initial surgery	4
84582	Secondary closure - with palatal flap	4
84584	- with pharyngeal flap	4
84586	- with tongue flap	4
84588	- with buccal flap	4

TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

TMJ, Dislocation, Management

84600	TMJ, dislocation - open reduction (exposure of joint)	5
84602	- closed reduction, uncomplicated	4
84604	- closed reduction under general anaesthetic	4
84608	TMJ, luxation reduction, under general anaesthetic	4
84610	TMJ, manipulation under general anaesthesia	4
84612	TMJ, fixation (arch bars)	5

TMJ, Capsule, Management of

84616	Menisectomy	5
84618	Capsulorraphy	5
84620	Myotomy, lateral pterygoid muscle	5
84622	Plication, posterior attachment of the disk of the TMJ, in cases of internal derangement	5

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (Cont'd)	
	TMJ, Condylar, Surgical	
84626	Condylectomy	5
84628	Condylotomy	5
84630	Osteotomy, oblique, with silastic interposition for ankylosis (graft)	10
	TMJ, Articular Eminence, management of	
84634	Reconstruction of the glenoid fossa, zygomatic arch and temporal bone (Obwegeser technique)	5
84636	Articular eminence, arthroplasty	5
	TMJ, Arthrocentesis	
84640	Puncture and aspiration	4
	TMJ, Management by Injection	
84644	Anti-inflammatory drugs	4
84646	With sclerosing agent	4
	TMJ Appliance Splints (for use ONLY in post-surgical cases)	
84650	Maxillary	5
84652	Mandibular	5
84654	Occlusal adjustment	5
	TREATMENT OF SALIVARY GLANDS	
84670	Salivary duct - dilation	4
84672	- insertion of polyethylene tube	4
84674	- sialodochoplasty	4
84676	- reconstruction	4
84678	- sialolithotomy anterior 1/3 of canal	4
84680	- sialolithotomy posterior 2/3 of canal	4
84682	- external approach	4
84684	Excision - submandibular gland	4
84686	Excision - sublingual gland	4
84688	Excision - mucocele	4
84690	Excision - ranula	4
84692	Marsupialization of ranula	4
84694	Salivary gland removal, parotid	4
	NEUROLOGICAL DISTURBANCES	
	Trigeminal Nerve	
84700	Injection for destruction	4
84702	Avulsion at periphery	4
84704	Alcoholization of a branch	4
84706	Infiltration of a branch for diagnosis	4
	Inferior Dental Nerve	
84716	Complete avulsion	4

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	NEUROLOGICAL DISTURBANCES (Cont'd)	
	Surgery	
84720	Injured nerve repair - primary	IC
84722	- secondary	IC
84724	Neural transposition and decompression	IC
84726	Implantation of electrode for peripheral nerve stimulation	IC
84728	Excision of tumour or neuroma	4
84732	Nerve repair with graft	IC
	ANTRAL SURGERY	
	Recovering Foreign Bodies	
84740	Immediate recovery of dental root or foreign body from the antrum	4
84742	Immediate closure of antrum by another dental surgeon	4
84744	Delayed recovery of a dental root with oral antrostomy	4
84746	Antral surgery with nasal antrostomy	4
	Oro-antral Fistula Closure (same session)	
84758	Closure - with buccal flap	4
84760	- with gold plate	4
84762	- with palatal flap	4
	Oro-antral Fistula Closure (subsequent session)	
84766	Closure - with buccal flap	4
84768	- with gold plate	4
84770	- with palatal flap	4
	HAEMORRHAGE CONTROL	
84780	Secondary haemorrhage control	4
84782	Haemorrhage control - using compression and haemostatic agent	4
84784	- using haemostatic substances and sutures (includes removal of bony tissues if necessary)	4
	GRAFTS, SURGICAL	
	Harvesting of Intraoral Tissue for Grafting to Operative Site	
84800	Bone	4
84802	Cartilage	4
	Harvesting of Extraoral Tissue for Grafting to Operative Site (to include illium, rib, etc.)	
84820	Bone	4
84822	Cartilage	4
	EMERGENCY PROCEDURES	
84850	Tracheotomy	5
84852	Crico- thyroidotomy	5

ANAESTHESIA FOR SURGICAL DENTAL PROCEDURES

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Rate
	SPECIAL PROCEDURES	
84920	Anaesthetic standby at the request of the attending physician	3
84922	Monitoring under IV sedation	4
84926	Anaesthetic additional fee for adults 70 or older ..... add	1
84930	For patients undergoing anaesthesia in the prone or sitting position	1
84934	Controlled hypotension ..... add	10

SURGICAL PREMIUMS

Special Visit Premiums

Please see Visit Premiums, 18.2 of the Preamble**.** Anaesthesiologists, please note that visit premium fees do not apply to maintenance procedural fee codes.

After Hours Surgical Procedure Premiums

Surgical procedures that are non-elective, unscheduled and which either require the services of an Anaesthesiologist, or are performed using one of the regional nerve blocks specified in fee code 54150 for local anaesthetic purposes, qualify for premiums when commenced between 6:00 p.m. and 7:00 a.m. or on Saturdays, Sundays or Statutory Holidays.

Vaginal deliveries, Caesarean sections and other operative deliveries qualify for premiums when commenced between 6:00 p.m. and 7:00 a.m. or on Saturdays, Sundays or Statutory Holidays.

Prem Code		Assist	FP/ Spec.	Anaes.
01	Procedures that qualify and commence between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidays ……..... add	30%	30%	
02	Procedures that qualify and commence between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidays (Anaesthesiologists only) …… add			46%
03	Procedures that qualify and commence any night between midnight and 7:00 a.m. …… add	50%	50%	50%

Morbidly Obese Patients

Premium code 04 is eligible for payment once per patient per physician in addition to the amount eligible for payment for specific, approved major surgical procedure(s) listed below where a morbidly obese patient undergoes major surgery to the neck, hip, peritoneal cavity, pelvis or retroperitoneum and:

a. the patient has a Body Mass Index (BMI) greater than 40 for major surgery on the peritoneal cavity, pelvis, retroperitoneum and hip or a BMI greater than or equal to 45 for major surgery on the neck;

b. the surgery is rendered in hospital under general anaesthesia using either an open technique for the neck and hip, or an open or laparoscopic technique for the peritoneal cavity, pelvis, retroperitoneum; and

c. the principal surgical technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, mediastinoscopy, thoracoscopy, cautery, ablation nor catheterization.

Prem Code		Assist	FP/ Spec.	Anaes.
04	Approved procedures on morbidly obese patients ..... add	10%	10%	

Note:
Premium code 04 is only payable with the following fee codes:

Obstetrics

81002	81004	81030

Operations on the Musculoskeletal System

92740	92764	92774	92888	92988	93024
92742	92766	92776	92910	92996	93026
92754	92768	92778	92920	92998	93030
92760	92770	92882	92932	93000	93032
92762	92772	92884	92944	93022	93046

Operations on the Respiratory System

94460	94466	94482	94532	94542
94462	94468	94484	94536	94550
94464	94480	94530	94540	

Operations on the Cardiovascular System

95136	95152	95164	95176	95188	95296
95138	95154	95166	95178	95190	95306
95142	95156	95168	95180	95192	95320
95144	95158	95170	95182	95222	95326
95146	95160	95172	95184	95258	
95150	95162	95174	95186	95260	

Operations on the Haemic and Lymphatic System

95370	95413	95415	95438

Operations on the Digestive System

95870	96060	96164	96442	96570	96660
95872	96062	96170	96444	96572	96662
95874	96064	96174	96448	96574	96672
95876	96066	96176	96450	96576	96676
95878	96068	96178	96452	96578	96678
95900	96074	96200	96454	96582	96702
95906	96076	96204	96460	96584	96720
95916	96078	96206	96470	96586	96732
95918	96080	96208	96508	96590	96734
95920	96092	96220	96514	96594	96748
95922	96096	96230	96516	96596	96750
95932	96098	96260	96518	96598	96752
95934	96100	96262	96520	96620	96754
95936	96102	96268	96524	96622	96760
95950	96106	96270	96530	96626	96762
95952	96108	96272	96532	96634	96770
95956	96112	96278	96534	96636	96772
95962	93130	96304	96536	96642	96780
95964	96132	96314	96542	96644	
95966	96134	96316	96550	96646	
95980	96136	96434	96560	96648	
95982	96154	96436	96562	96650	
95984	96162	96438	96564	96652	

Operations on the Urogenital System

96820	96865	96972	97018	97142	97234
96822	96868	96974	97020	97144	97236
96824	96872	96976	97024	97150	97238
96826	96874	96978	97026	97152	97240
96828	96876	96980	97028	97154	97260
96832	96880	96982	97030	97156	97262
96836	96884	96990	97040	97160	97264
96838	96886	96992	97042	97162	97266
96840	96888	97000	97044	97164	97330
96842	96910	97002	97046	97166	97332
96844	96912	97004	97130	97168	97334
96850	96940	97006	97132	97174	97370
96852	96944	97008	97136	97228	
96854	96948	97010	97138	97230	
96860	96970	97012	97140	97232	

Operations on the Male Genital System

97600	97610	97612	97630	97634	
97606	97611	97624	97632	97636	

Operations on the Female Genital System

97784	97832	97854	97866	97942	97984
97794	97834	97856	97930	97948	
97798	97838	97858	97932	97950	
97820	97844	97860	97934	97952	
97822	97850	97862	97938	97954	
97830	97852	97864	97940	97982	

Operations on the Endocrine System

98020	98024	98027	98040	98044	98048
98022	98026	98028	98042	98046	98050

Code		Assist	FP/ Spec.	Anaes.
	SPECIAL PROCEDURES			
90008	Examination under general anaesthesia (when not elsewhere specified and when sole procedure) (IOP)		28.34	4
90010	Insertion of radium			4
90012	General anaesthetic for CAT Scan/MRI			5
90014	Anaesthetic wake-up test ..... add			6
90016	Fibreoptic intubation ..... add			10
90018	One-lung anaesthesia ..... add			6
90020	Anaesthesiologist or assistant standby at the request of the attending physician (IC)	24.51		3
90022	Monitoring under IV sedation			4
90024	Anaesthesiology additional fee for children under 1 year of age ..... add			3
90026	Anaesthesiology additional fee for adults 70 or older ..... add			1
90028	For patients of any age with an incapacitating systemic disease that is a constant threat to life (ASA IV) or to a moribund patient who is not expected to survive for 24 hours, with or without the operation (ASA V) ..... add			4
90030	For patients undergoing anaesthesia in the prone or sitting position ..... add			4
90032	For patients undergoing anaesthesia who weigh less than 5 kg ..... add			3
90034	Controlled hypotension ..... add			10
90036	Malignant hyperthermia set up and management ..... add			5
90038	Anaesthesiology management for the emergency relief of acute upper airway obstruction ..... **add**			10
90040	Anaesthetic begun and operation cancelled prior to commencement of surgery	24.51		4
90042	Patient with body mass index (BMI) greater than 40 who receives general anaesthesia ..... add			2

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	Incision (IOP)			
	Abscess or Haematoma			
	Incision under local anaesthetic			
90100	- subcutaneous - 1		**28.19**	
90102	- 2		30.82	
90104	- 3 or more		41.35	
90106	- perianal		20.39	
90108	- ischiorectal or pilonidal		44.98	
90110	- palmar or plantar spaces		44.98	
	Incision under general anaesthetic			
90112	- subcutaneous - 1		44.98	4
90114	- 2 or more		73.73	4
90116	- perianal		66.00	4
90118	- ischiorectal or pilonidal		108.00	4
90120	- palmar or plantar spaces		79.77	4
	Comedones, Acne Pustules, Millia			
90122	- ten or less		3.97	
90124	- eleven or more		13.82	
	Foreign body removal – not to be claimed for the routine removal of sutures within 42 days of surgery			
90126	- removal under local anaesthetic		25.25	
90128	- removal under general anaesthetic	24.51	90.07	4
90130	- complicated removal	32.68	IC	4
90132	Intramuscular abscess or haematoma		103.10	4
90134	Aspiration of superficial lump for cytology		28.66	
	Biopsy(s)			
90140	- when sutures are used *		29.60	
90141	- when sutures are not used (maximum of 1 unit)		29.60	
90142	- extensive, complicated or requiring general anaesthetic, when sole procedure	IC	IC	4
90144	- for malignant hyperthermia, 3 or more (fee code 90036 not payable in addition)		155.11	10

* Fee code 90140 may be allowed more than once on an IC basis if medically necessary (in order to make a diagnosis or plan treatment), to biopsy more than one lesion or to obtain a second biopsy from an extensive lesion. If claimed, may be allowed with chemical treatment of lesion (code 90560).

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	Excision			
	When excision of benign or malignant lesions are corrected by advancement, rotation, transposition, "Z" plasty, flap or graft, claim appropriate benefit listed under Repair Section instead of excision benefits.			
	Excision of Benign Lesions			
	The fee codes for excision, electrocoagulation, curetting, cryosurgery and laser surgery of benign lesions are specific to the lesions identified in the definition. Payment for treatment of unlisted benign lesions requires prior approval from MCP.			
	Single or multiple sites, uni or bilateral (with or without biopsy)			
	Group 1 – verruca, papilloma, benign keratosis, pyogenic granuloma, spider naevus, Campbell de Morgan spots (IOP)			
	Removal by excision and suture			
90150	- single lesion ……		20.00	4
90152	- 2 lesions ……....		26.50	4
90154	- 3 or more lesions ……...		44.25	4
	Paring of warts and corns without complete removal		VF	
	Removal by electrocoagulation and/or curetting and/or cryosurgery and/or laser surgery			
90156	- single lesion ……		10.55	4
90158	- 2 lesions ……....		15.85	4
90160	- 3 or more lesions ……...		26.20	4
	Group 2 – naevus (IOP)			
	Removal by excision and suture			
90162	- single lesion ……		18.59	4
90164	- 2 lesions ……....		25.29	4
90166	- 3 or more lesions ……...		38.49	4
90168	- congenital (extensive) – state measurement and site ……..	IC	IC	IC
	Group 3 – palmar or plantar verruca (IOP)			
	Paring of warts and corns without complete removal		VF	
	Removal by excision and suture			
90170	- single lesion ……		26.05	4
90172	- 2 lesions ……....		38.90	4
90174	- 3 or more lesions ……...		64.60	4
	Removal by electrocoagulation, and/or curetting and/or cryosurgery and/or laser surgery			
90176	- single lesion ……		**28.89**	4
90178	- 2 lesions ……....		30.30	4
90180	- 3 or more lesions ……...		59.95	4

Code		Assist	FP/ Spec.	Anaes.
	Excision of Benign Lesions (Cont'd)			
	Group 4 – cycst, haemangioma, lipoma (IOP)			
	Face or neck			
	Local anaesthetic			
90182	- single lesion		38.50	
90184	- 2 lesions		67.80	
90186	- 3 or more lesions		78.00	
	General anaesthetic			
90188	- single lesion	24.51	65.35	4
90190	- 2 lesions	24.51	98.55	4
90192	- 3 or more lesions	24.51	117.40	4
90194	- extensive or massive	24.51	IC	5
	Other Areas			
	Local anaesthetic			
90196	- single lesion		32.00	
90198	- 2 lesions		45.00	
90200	- 3 or more lesions		60.00	
	General anaesthetic			
90202	- single lesion	24.51	50.76	4
90204	- 2 lesions	24.51	66.57	4
90206	- 3 or more lesions	24.51	109.06	4
90208	- extensive or massive	24.51	IC	5
	Lipoma			
90210	- 5 to 10 cm.	24.51	80.00	4
90212	- over 10 cm.	24.51	160.00	5
	Congenital dermoid cyst			
90214	- adult	24.51	126.22	4
90216	- infant or child	24.51	203.94	4
90218	- midline, e.g. nasal	24.51	276.79	4
90220	Giant cell tumour	24.51	200.00	4
	Excision of Pressure sore or decubitus ulcer (IOP)			
90224	- minor, less than 1 cm. average diameter		33.93	4
90226	- intermediate, 1-5 cm. average diameter		72.75	4
90228	- major or complex		IC	5
	Pilonidal cyst			
90234	**-** simple excision or marsupialization	24.51	**200.95**	4
90236	- excision and skin shift	24.51	280.00	4
	Inguinal, perineal or axillary skin and sweat glands for hyperhydrosis and/or hidradenitis			
90240	**-** unilateral	24.51	248.80	5
90242	**-** with skin graft(s) or rotation flap(s)	24.51	338.60	6

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	Excision of Malignant and Premalignant Lesions **Single or multiple sites, uni or bilateral** **(Includes biopsy of each lesion)**			
	Simple excision			
	Face or Neck			
90246	- single lesion ……	24.51	92.15	4
90248	- 2 lesions ……	24.51	139.20	4
90250	- 3 or more lesions ……	24.51	242.80	4
	Other areas			
90252	- single lesion ……	24.51	59.03	4
90253	- 2 lesions ……	24.51	97.10	4
90254	- 3 or more lesions ……	24.51	194.20	4
90256	- in hospital excision tumour for tumour free margins with frozen section (payable in addition to excision or repair fees) ……		56.65	
	Curettage, electrodesiccation or cryosurgery of malignant and premalignant lesions			
	Face or Neck			
90258	- single lesion ……	24.51	62.61	4
90260	- 2 lesions ……	24.51	101.20	4
90262	- 3 or more lesions ……	24.51	202.30	4
	Other areas			
90264	- single lesion ……	24.51	49.30	4
90266	- 2 lesions ……	24.51	81.20	4
90268	- 3 or more lesions ……	24.51	186.83	4
90270	Chemosurgery (Mohs technique) ……		IC	IC
	Repair			
90300	Severe contracture release by excision of scar, e.g., joint ……		100.00	4
	Debridement and Dressing (IOP) (not chargeable in addition to any surgical procedure unless complications require such care in excess of the usual post-operative care)			
	- minor ……		VF	
90304	- major ……		14.05	
90306	- requiring general anaesthetic ……	32.68	50.40	4
90308	- extensive ……	32.68	IC	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	Repair (Cont'd)			
	Suture of Laceration (IOP)			
90310	- up to 5 cm. ……..		**20.03**	4
90312	- up to 5 cm. if on face and/or requires tying of bleeders and/or closure in layers …….....		**41.27**	4
90314	- 5.1 to 10 cm. …….....		36.14	4
90316	- 5.1 to 10 cm. if on face and/or requires tying of bleeders and/or closure in layers …….....		72.40	4
90318	- 10.1 to 15 cm. ……..		51.21	4
90320	- 10.1 to 15 cm. if on face and/or requires tying of bleeders and/or closure in layers …….....		102.88	4
90322	- more than 15 cm. …….....		IC	4
90324	- if inhalation general anaesthesia (other than 50% N_2O/O_2 mixture) is used …….. add		55.83	
90326	- when rendered in private office or home …….... add		10.51	
	Note: The above benefits include the use of sutures, local anaesthetic and tetanus toxoid.			
	Muscle Repair			
90330	- simple muscle repair to include repair of involved skin …….....	24.51	88.60	4
90332	**-** complex …….....	32.68	IC	6
	Scar Revision –any method of closure			
	Up to 2.5 cm.			
90336	- face or neck ……	24.51	115.60	4
90338	- other areas ……..	24.51	77.35	4
	2.6 to 5 cm.			
90340	- face or neck ……	24.51	194.85	4
90342	- other areas ……..	24.51	130.10	4
	5.1 to 10 cm.			
90344	- face or neck ……	24.51	277.90	5
90346	- other areas ……..	24.51	185.60	5
90348	Greater than 10 cm. ……..	32.68	IC	6
	Tissue Expanders			
90352	Insertion by separate incision ……..	24.51	304.10	5
90354	Removal of tissue expander injection port under general anaesthetic (IOP) …..	49.02	75.45	6
90356	Removal of tissue expander injection port under local anaesthetic (IOP) ……..		37.70	**8**
90358	Percutaneous inflation of tissue expander, per visit (IOP) ……..		23.05	
90360	Inflation of each additional expander to a maximum of 3 …….. add		11.55	
90362	Replacement of tissue expander by permanent prosthesis (IOP) …….....		195.85	4

Code		Assist	FP/ Spec.	Anaes.
	<u>Repair</u> (Cont'd)			
	Skin Flaps			
	Advancement flap fees are intended to include payment for excision of a lesion if this is the technique of closure			
	Defect 2.1 to 5 cm.			
90370	- face or neck ……	24.51	89.95	4
90372	- other areas ……	24.51	67.40	4
	Defect 5.1 to 10 cm.			
90374	- face or neck ……	24.51	247.15	5
90376	- other areas ……	24.51	161.75	5
90378	Defect larger than 10 cm. ……	32.68	IC	6
	Note: The medical necessity for a single or multiple flap occurs when a defect cannot be closed by elevating or undermining the edges and suturing subcutaneous tissue and skin.			
	An advancement flap does not qualify for the listings above unless the repair involves at least one level of deep sutures and each edge of the defect is undermined a distance equal to or greater than: (a) …….. 1 cm – nose, ear, eyelid, lip (b) …….. 1.5 cm – other face and neck (c) …….. 2.5 cm – rest of body The listings are only to be used where the dissection meets the criteria above, whether the advancement involves one or both sides of the wound. If the wound can be closed in a straight line, 5 cm or less in length, a tissue advancement flap should not ordinarily be required.			
	Rotations, Transpositions, "Z" plasties (includes undermining)			
	Defect less than 2cm.			
90382	- face or neck ……	24.51	203.70	4
90384	- other areas ……	24.51	133.40	4
	Defect 2.1 to 5 cm.			
90386	- face or neck ……	24.51	335.15	4
90388	- other areas ……	24.51	205.30	4
	Defect 5.1 to 10 cm.			
90390	- face or neck ……	32.68	477.45	4
90392	- other areas ……	32.68	318.45	4
90394	Defect larger than 10 cm. ……	32.68	IC	5
	Pedicle Flaps			
90398	Small, e.g., cross finger ……	32.68	146.05	4
90400	- each subsequent stage ……	32.68	108.29	4
90402	Intermediate, e.g. cervical finger ……	32.68	293.75	5
90404	- each subsequent stage ……	32.68	221.58	5
90406	Large, e.g., cross leg, deltopectoral, forehead ……	32.68	416.30	6
90408	- each subsequent stage ……	32.68	311.45	6
90410	Preparation of a contracted recipient site, add to 90402 or 90406 ……	24.51	134.75	4
90412	Delay of tube or pedicle ……	24.51	62.65	4
90414	Delay, intermediate flap ……	24.51	131.35	4
90416	Delay, major flap ……	32.68	289.58	5

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	Repair (Cont'd)			
	Myocutaneous flaps (to include closure by any means)			
90420	Sternomastoid, tensor fascia lata, gluteus maximus, gracilis, satorius, rectus femoris, gastrocnemius, trapezius	24.51	613.30	5
90422	Pectoralis major, latissimus dorsi, unilateral rectus abdominus	32.68	734.95	6
90424	Lower transverse rectus abdominus flap	49.02	984.55	8
90426	- repair of abdominal defect - same surgeon		321.00	
90428	- different surgeon		377.65	
90430	Myocutaneous – osseous flaps	49.02	720.00	8
90432	Other	IC	IC	8
	Skin Grafts (includes taking the skin for grafting)			
	Split Thickness Grafts			
90440	Very minor, very small areas		92.30	4
90442	Minor, medium sized areas, e.g. small or average varicose ulcer, breast, etc.	24.51	140.25	4
90444	Intermediate or large areas on the trunk, arms, legs, etc.	32.68	259.10	4
90446	Major or complex areas on the face, neck, hands, etc.	32.68	527.27	5
90448	Extensive major, very large areas	32.68	567.95	6
	Full Thickness Grafts			
90450	Minor – less than 1 cm. average diameter		93.41	4
90452	Intermediate – 1 to 5 cm. average diameter	24.51	178.90	4
90454	Major – over 5 cm.	40.85	280.15	6
90456	Complex – eyelid, nose, lip, face	32.68	263.95	6
90460	Appendage or tissue revascularization involving microanastomosis with or without micro neuro-anastomosis	IC	IC	IC
90462	- revision of above	IC	IC	IC
	Stasis Ulcer			
90464	- with skin graft – per leg	24.51	195.85	5
90466	- multiple ligation and skin graft – per leg	40.85	341.55	5
	Neurovascular Island Transfer			
90470	- minor, e.g., fingertip	24.51	140.25	4
90472	- intermediate finger to thumb	32.68	259.20	5
90474	- major foot to heel	32.68	430.85	6
	Free Island Flaps			
	Skin and subcutaneous tissue			
90490	- elevation and closure of donor site	81.70	874.60	10
90492	- preparation of microvascular site		925.85	
90494	- transplant with microvascular anastomosis		925.85	
	Innervated skin and subcutaneous tissue flap			
90496	- elevation	81.70	900.10	10
90498	- preparation of site		900.10	
90500	- transplantation		841.50	

Code		Assist	FP/ Spec.	Anaes.
	Repair (Cont'd)			
	Skin Grafts (includes taking the skin for grafting) (Cont'd)			
	Free Island Flaps (Cont'd)			
	Skin and muscle flap			
90502	- elevation	81.70	874.60	10
90504	- preparation of site		925.85	
90506	- transplantation		874.60	
	Muscle with tendon and nerve			
90508	- elevation	81.70	1,035.55	10
90510	- preparation of site		1,035.55	
90512	- transplantation		1,035.55	
	Bone flap			
90514	- elevation	81.70	765.50	10
90516	- preparation of site		810.00	
90518	- transplantation		900.10	
	Skin and bone flap			
90520	- elevation	81.70	1,048.60	10
90522	- preparation of site		1,048.60	
90524	- transplantation		1,048.60	
	Free toe or finger			
90526	- elevation	81.70	918.30	10
90528	- preparation of site		918.30	
90530	- transplantation		1,080.10	
90532	Revision of free island flaps	81.70	IC	10
90534	Flaps other than above	IC	IC	IC
90540	Digital reimplantation	65.36	1,439.40	10
	Destruction			
	Finger or toenail (IOP)			
	Simple, partial or complete			
90550	- 1		33.10	4
90552	- multiple		35.70	4
	Radical, including destruction of nail bed			
90554	- 1		62.75	4
90556	- multiple		74.10	4
	Chemical and/or cryotherapy treatment of minor skin lesions (IOP)			
90560	- 1 or more lesions, per treatment		11.65	
	Plastic planing, dermabrasion – face for acne. Maximum per session equivalent to rate for whole face			
90576	- forehead or nose or chin or single cheek		93.20	4
90578	- both cheeks		189.00	4
90580	- whole face		288.00	4
90582	- single area, e.g., trauma scar		51.65	4
90584	Rhinophyma, removal by shaving		231.40	4

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	Repair (Cont'd)			
	Webbed Fingers			
90590	- 1 web space	32.68	400.00	5
	Webbed Toes			
90596	- 1 web space	32.68	250.00	4
	Burns			
	Resuscitation – major burn			
90600	- initial 24 hours (IOP)		106.25	
90602	- continuing care (up to 3 days) per day, (IOP)		53.10	
	For burn care requiring Anaesthesiologist's and/or assistant's services, the following fees apply:			
90610	Minor burns – up to 15%	32.68		5
90612	Moderate burns – 16% to 30%	49.02		10
90614	Major burns – more than 30%	65.36		15
90620	Debridement and excision, per % of total body treated (other than hand, head or neck)		29.65	
	Debridement and excision			
90622	- hand, each digit		28.90	
90624	- dorsum palm – each		47.95	
90626	- nose, cheek, lip, ear, forehead, scalp, neck, eyelid –each		28.90	
90640	Grafting of burn, per % of total body treated (other than hand, head or neck)		59.50	
	Graft of burn			
90644	- hand, each digit		71.38	
90646	- palm, dorsum – each		142.88	
90648	- nose, lip(s) – each		238.19	
90650	- cheek(s) – forehead – each		238.19	
90652	- ear		238.19	
90654	- eyelid		238.19	
90656	- scalp, less than 10%		119.13	
90658	- up to 50%		297.75	
90660	- over 50%		IC	
90662	- neck, less than 10%		119.13	
90664	- up to 50%		261.86	
90666	- over 50%		IC	
	Subdermal Birth Control Devices (IOP)			
90668	- implantation		40.00	
90669	- explantation		60.00	

SURGICAL PROCEDURES

OPERATIONS ON THE INTEGUMENTARY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.

Plastic Surgery Procedures

The setting of fees covering the various procedures of plastic surgery is very difficult, if not an impossible problem. The charging of the repair of lacerations by the inch, or of free grafts by the square inch has no legal basis since the importance of location and function is not considered. Since many procedures are divided into stages which have to be considered in assessing a fee, it is felt that all such plastic surgical procedures should be classed by the responsible specialist as very minor, minor, intermediate, major, or extensive major. Fees should be charged according to procedures set forth in the tariff, except in cases which are difficult to define.

All claims for plastic surgery procedures must be accompanied by an IC form stating the medical indication for the procedure and giving a description of the procedure as performed. A copy of the operative report may be forwarded in place of the description.

The fee for each class of plastic surgical procedures is as follows:

90670	Very minor plastic surgery procedures		97.68	4
90672	Minor	24.51	148.40	4
90674	Intermediate	32.68	274.25	4
90676	Major	32.68	410.57	5
90678	Extensive major	32.68	602.04	6

SURGICAL PROCEDURES

OPERATIONS ON THE BREAST

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	Incision			
90680	Needle biopsy – 1 or more (IOP) ……..		24.31	
90682	Aspiration of cyst – 1 or more (IOP) …….....		22.30	
	Drainage of intramammary abscess single or multiloculated (IOP)			
90684	- drainage under local anaesthetic ……...		22.30	
90686	- drainage under general anaesthetic ……..		61.20	4
	Excision			
90700	Tumor or tissue for biopsy (single or multiple – same breast) …….....	24.51	169.95	4
90701	- with wire/needle localization …….... add		76.38	
90702	Partial mastectomy or wedge resection …….	24.51	269.40	4
90704	- with radical axillary node dissection …….. add		383.12	2
	Mastectomy –male (benign)			
90706	- unilateral – simple …….....	24.51	241.20	4
90708	- subcutaneous with nipple preservation ……	32.68	273.95	5
	Mastectomy –female (with or without biopsy)			
90710	- simple ……..	24.51	**301.37**	5
90712	- subcutaneous with nipple preservation ……	24.51	**428.59**	5
90714	Mastectomy, radical or modified radical (with or without biopsy) …….....	24.51	562.80	6
	Repair			
	Post-mastectomy breast reconstruction			
90720	- breast mound creation by prosthesis and/or soft tissue …….....	32.68	350.00	5
90724	- breast skin reconstruction by local flaps or grafts ……...	32.68	438.58	5
90726	- with breast mound creation by prosthesis and/or soft tissue……. add		101.78	
90728	- revision of breast mound …….....	24.51	253.40	4
	Nipple-areolar			
90730	- preservation and tissue banking …….....	24.51	116.57	4
90732	- re-implantation of banked nipple-areola …….....	24.51	135.99	4
90734	- nipple reconstruction by grafts …….....	24.51	300.00	4
90740	Reduction mammoplasty (female, to include nipple transplantation or grafting) – unilateral …….....	40.85	490.10	7
90744	Augmentation mammoplasty – unilateral …….....	32.68	198.92	4
90748	Removal of breast prosthesis and/or fibrous capsule (IOP) …….....	24.51	150.00	4
	Breast capsulotomy, closed (IOP)			
90750	- breast capsulotomy without anaesthetic ……..		12.25	
90752	- breast capsulotomy under general anaesthetic ……..	24.51	78.68	4
90754	Open capsulectomy with or without replacement of breast prosthesis (IOP) ...	24.51	195.95	4
90756	Myocutaneous flaps, pectoralis major, latissimus dorsi, unilateral rectus …….	32.68	729.07	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	GENERAL FEES			
	Bone/Fascial/Dermis Grafts			
	Note: The benefit for obtaining a bone graft is not to be claimed in cases of pseudoarthrosis repair, fusions or for listings in which the bone grafting is included.			
90800	Autogenous - separate incision		86.30	
90802	- same incision		58.45	
90804	- different surgeon (IOP)		193.00	
90806	Homogenous – bank ..... add		25.15	
90808	Allograft - donor - 85% of excision fee		IC	
90810	- cadaver – each long bone		140.90	
	Fixation			
90830	Methyl methacrylate (not arthroplasty)		57.76	
90832	Rigid external fixation (excluding casts) for closed reduction ..... add		55.93	
90834	Cast – bracing with closed reduction ..... add		55.93	
90836	Percutaneous pinning ..... add		41.95	
90838	Rigid external fixation – pseudoarthrosis		76.10	
	Removal of internal fixation device			
90840	- removal under general anaesthetic	24.51	158.65	4
90842	- removal under local anaesthetic		104.27	
90844	Removal of extensive external fixation device under general anaesthetic		48.25	4
90846	Insertion traction pin – excludes fractures and dislocations (IOP)		33.35	
	Wound Care			
90860	Secondary closure		97.35	
90862	Closed irrigation during a surgical procedure		61.41	
90866	Excision of foreign body		107.70	4
	Electrical Stimulation			
90870	External or internal (IOP)		187.84	4
	Casts (IOP)			
	Note: Corrective splints must be “corrective” to qualify for benefits. The corrective splint listings are not applicable to simple immobilization such as with a Jones bandage or a metal finger splint following soft tissue injury.			
90900	Finger		11.96	
90902	Hand		17.95	4
90904	Arm, forearm or wrist		28.72	4
90906	Foot		17.95	4
90908	Below knee, knee splints (Stove pipe, etc.)		**30.65**	4
90910	Whole leg (mid-thigh to toes)		34.83	4

Code		Assist	FP/ Spec.	Anaes.
	GENERAL FEES (Cont'd)			
	Casts (IOP) (Cont'd)			
90912	Toes		11.96	
90914	Head and torso	24.51	116.85	4
90916	Shoulder spica	24.51	116.85	4
90918	Body cast		69.27	4
90920	Hip spica - unilateral		116.85	4
90922	- bilateral		146.23	4
90924	Wedging of casts in other than fracture treatment		11.96	
90926	Application of Unna's paste		17.95	
90928	Application of cast brace (must include hinge)		81.23	
90930	Removal of plaster (not associated with fractures or dislocations within 4 weeks of initial treatment)		11.96	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	HAND AND WRIST			
	Amputation			
90950	Phalanx		161.45	4
90952	- each additional ..... **add**		94.60	
90954	Metacarpal or metaphalangeal joint		190.20	4
90956	- each additional ..... add		94.60	
90958	Transmetacarpal 2nd or 5th ray		279.35	4
90960	Hand – all metacarpals	24.51	289.50	4
90962	Wrist	32.68	281.79	5
	Arthrodesis			
90970	Finger, thumb	24.51	256.15	4
90972	Wrist	24.51	379.35	4
	Arthroplasty			
90980	Wrist - interposition	24.51	374.00	5
90982	- total	49.02	415.05	6
90984	Removal only	24.51	187.84	6
90986	Hand - interposition - single	24.51	247.16	5
90988	- multiple	24.51	447.11	6
90990	Single joint – total	24.51	282.71	5
90992	Multiple joints – total max	24.51	774.90	6
90994	Removal only	24.51	140.90	4
90996	Carpal replacement	24.51	322.05	5
90998	Revision of arthroplasty ..... add		139.82	
	Arthroscopy			
91010	Diagnostic arthroscopy (sole procedure)	24.51	178.86	4
91011	Wrist arthroscopy setup, includes when rendered debridement, synovectomy, synovial biopsy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or wrist ganglion debridement	49.02	400.00	7

Notes:

1. A wrist procedure listed in the Hand and Wrist section of the Schedule performed arthroscopically is eligible for payment in addition to 91011 if that procedure is not described as a component of 91011 or described by an add-on code to 91011.
2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 91011 when the service described by the code is a generally accepted component of a procedure described in Note #1.

91025	Arthroscopy of midcarpal and/or distal radio-ulnar joint, through separate portals, to 91011 ..... add		192.00	
91026	Pinning of osteochondral fragment, to 91011 ..... add		251.55	

Note:
Fracture procedures are not eligible for payment with 91026 for the same fracture.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	HAND AND WRIST (Cont'd)			
	Arthroscopy (Cont'd)			
91029	Triangular fibrocartilage complex repair, to 91011 ..... add		350.65	
91030	Soft tissue capsular release, for contractures, without bone procedure, to 91011 ..... add		251.55	
91032	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to 91011 ..... add		326.55	
	Notes: 1. Synovectomy less than 90 minutes in duration is included in 91011. 2. Only one of 91030 or 91032 is eligible for payment same patient same day.			
	Arthrotomy			
91040	Finger		168.00	4
91042	Wrist	24.51	207.26	4
	Biopsy			
91050	Bones - punch, x-ray control (IOP)		70.45	4
91052	- open biopsy or taking of bone graft by other than operating surgeon (IOP)	32.68	144.80	4
91054	Joint - via arthroscope		10.65	
91056	- needle (IOP)		47.43	
91058	- open finger		163.05	4
91060	- open wrist	24.51	207.26	4
91062	Muscle (IOP)		103.05	4
	Decompression – Denervation			
91070	Decompression median nerve at wrist	24.51	191.62	4
91072	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding median nerve at wrist)	32.68	256.15	4
	Incision and Drainage (e.g. Osteomyelitis)			
	Incision and drainage			
91080	- phalanx/metacarpal/carpus	24.51	182.90	4
	Sequestrectomy			
91082	- phalanx/metacarpal/carpus	24.51	144.80	4
	Saucerization and bone graft			
91084	- phalanx/metacarpal/carpus	24.51	235.76	4
91086	Incision and drainage - joint (finger)		168.00	4
91088	- joint (wrist)	24.51	212.50	4
91090	Tendon sheath	24.51	225.00	4
	Examination/Manipulation			
91100	Manipulation – hand/wrist – under general anaesthetic (IOP)		24.10	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	HAND AND WRIST (Cont'd)			
	Excision – Bone			
91110	Proximal row carpectomy ……..	24.51	329.66	5
91112	Carpal – bone (1) …….....	24.51	214.45	4
91114	Dorsal exostosis (triquetrum) …….....	24.51	204.64	4
91116	Radial styloid …….....	24.51	228.12	4
91118	Phalanx/metacarpal …….....	24.51	207.58	4
91120	Bone tumour …….....	IC	IC	IC
	Excision – Joint			
	Synovectomy/capsulectomy/debridement			
91130	- finger joint …….....	24.51	226.40	4
91132	- 2 or more joints …….....	24.51	339.65	4
91134	Synovectomy – extensor or flexor tendons …….....		224.45	4
91136	Synovectomy/debridement – wrist …….....	24.51	342.55	4
91138	Radio-ulnar menisectomy ……	24.51	225.60	4
	Excision – Muscle and Tendon			
91150	Muscle - simple …….....	24.51	187.84	4
91152	- complex …….....	32.68	471.52	6
	Tendon sheath			
91154	- single …….....	24.51	235.76	4
91156	- each additional (max of 1) …… add		92.60	
	Excision – Soft Tissue			
91158	Excision of fascia for Dupuytren's (palmar fibromatosis), single ray, with or without flaps …….....	49.02	322.15	7
91160	- excision of fascia for Dupuytren's, one or more additional rays, to 91158 ……..... add		273.85	
91162	- use of skin grafts, or revision surgery (with or without skin grafts), to 91158 ……..... add 30%			

Notes:

1. 91158 is not payable for treatment of Dupuytren's by aponeurotomy.
2. A maximum of one 91158 is eligible for payment per limb, per day.
3. Services listed under "Skin Flaps and Skin Grafts" are not eligible for payment with 91158.
4. 91158, 91160 and 91162 include the palmar and digital components of the Dupuytren's procedure, when rendered.

	Excision – Ganglion			
91170	Simple or complex ……..	24.51	177.80	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	HAND AND WRIST (Cont'd)			
	Reconstruction – Bone			
	Osteotomy			
91180	- phalanx – terminal		173.03	4
91182	- phalanx – middle, proximal or metacarpal	24.51	193.20	4
91184	- each additional ... add		158.65	
91186	Pseudoarthrosis - phalanx, metacarpal	24.51	260.75	4
91188	- scaphoid	24.51	500.00	4
	Reconstruction – Ligaments			
91200	Simple/single repair – wrist	24.51	301.60	4
91202	Extensive/multiple repair – wrist	24.51	511.45	4
91204	Metacarpal phalangeal repair	24.51	316.75	4
	Reconstruction – Tendon			
91210	Tenoplasty - 1	24.51	223.65	4
91212	- each additional ... add		77.05	
91214	Tendon graft – 1	24.51	324.86	4
91216	- each additional ... add		259.85	
91218	Reconstruction of flexor tendon pulley, per finger		97.35	4
91220	Silicone rod insertion - 1	24.51	294.20	4
91222	- each additional ... add		245.90	
91224	Transplant/transfer - single	24.51	284.95	4
91226	- each additional ... add		236.10	
91228	Tendon repair - extensor - single		164.10	4
91230	- each additional (same incision) ... add		70.95	
91231	- each additional (separate incision) ... add		118.57	
91232	Tendon repair - flexor - single	24.51	307.60	4
91234	- each additional (same incision) ... add		128.95	
91235	- each additional (separate incision) ... add		222.24	
	Mallet finger - closed		VF	
91238	- K-wire		130.68	4
91240	- open	24.51	147.20	4
	Boutonniere - closed		VF	
91242	- open	24.51	156.51	4
91244	- late	24.51	246.65	4
	Reconstruction – Extremities			
91250	Pollicization	49.02	577.14	6
91252	Digital reimplantation involving microvascular and neuro anastomosis	65.36	1,548.15	8
91254	Revision of 91250 or 91252	65.36	IC	8
91258	Reconstruction and plastic repair of traumatically amputated extremities	65.36	IC	8

Code		Assist	FP/ Spec.	Anaes.
	HAND AND WRIST (Cont'd)			
	Release - Tendon			
91270	Tenolysis - flexor and/or extensor tendon of 1 digit	24.51	194.05	4
91272	- each additional digit ..... add		165.20	
91274	Flexor tenolysis with pulley preservation	24.51	309.00	4
	Tenotomy or fasciotomy (closed) (IOP)			
91276	- finger - 1		49.20	4
91278	- 2		72.35	4
91280	- 3 or more		99.15	4
91282	- palmar or plantar		73.70	4
	Tendon release (open)			
91284	- finger, palm		156.50	4
91286	- wrist	24.51	190.08	4
91288	- more than 1 ..... add		140.90	
	Reduction – Fractures			
91300	Phalanx - no reduction, rigid immobilization		49.20	
91302	- closed		99.25	4
91304	- each additional ..... add		22.25	
91306	- open	32.68	298.45	4
91307	- extensive debridement of compound fracture ..... add		149.23	
91308	Metacarpal - no reduction, 1 or more, rigid immobilization		49.20	
91310	- closed, 1 or more		99.25	4
91312	- open	32.68	262.60	4
91314	- each additional (open) ..... add		142.90	
91315	- extensive debridement of compound fracture ..... add		131.30	
91316	Intra-articular - closed		119.75	
91318	- open	32.68	335.80	4
91319	- extensive debridement of compound fracture ..... add		82.12	
91320	Bennett's - no reduction, rigid immobilization		48.51	
91322	- closed	24.51	119.80	4
91324	- open	32.68	237.87	4
91325	- extensive debridement of compound fracture ..... add		118.94	
91326	Carpus - no reduction, rigid immobilization		49.20	
91328	- closed, 1 or more		115.10	4
91330	- open, 1 or more	32.68	346.15	4
91331	- extensive debridement of compound fracture ..... add		173.08	
91332	Scaphoid - no reduction, rigid immobilization		49.20	
91334	- open	32.68	480.00	4
91336	- excision	32.68	187.90	4

Code		Assist	FP/ Spec.	Anaes.
	HAND AND WRIST (Cont'd)			
	Reduction - Dislocations			
91350	Finger - closed - 1		57.50	4
91352	- each additional ..... add		10.25	
91354	- open	24.51	196.50	4
91355	- extensive debridement of compound fracture ..... add		98.25	
91356	Metacarpal/phalangeal - closed - 1		57.50	4
91358	- each additional ..... add		10.25	
91360	- open	24.51	181.85	4
91361	- extensive debridement of compound fracture ..... add		90.93	
91362	Carpal - closed		128.05	4
91364	- open	24.51	241.30	4
91365	- extensive debridement of compound fracture ..... add		120.65	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	ELBOW AND FOREARM			
	Amputation			
91370	Through radius and ulna ……..	32.68	306.30	5
91372	Elbow disarticulation ……	32.68	289.50	5
	Arthrodesis			
91380	Elbow ……...	24.51	400.00	4
	Arthroplasty			
91390	Ulna replacement (lower end) ……	24.51	296.90	4
91392	Implant radial head ……...	24.51	**301.55**	4
91394	Removal of total replacement ……..	24.51	402.75	7
91396	Complete arthroplasty replacement ……...	49.02	619.90	8
91398	Interposition arthroplasty ……..	49.02	435.20	7
91400	Revision of elbow arthroplasty ……... add		**312.92**	
	Arthroscopy			
91410	Diagnostic arthroscopy (sole procedure) ……...	24.51	178.86	4
91411	Elbow arthroscopy setup, includes when rendered debridement, synovectomy, synovial biopsy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or arthroscopic epicondylar release	49.02	400.00	7
	Notes: 1. An elbow procedure listed in the Elbow section of the Schedule performed arthroscopically is eligible for payment in addition to 91411 if that procedure is not described as a component of 91411 or described by an add-on code to 91411. 2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 91411 when the service described by the code is a generally accepted component of a procedure described in Note #1.			
91426	Pinning of osteochondral fragment, to 91411 …….. add **Note:** Fracture procedures are not eligible for payment with 91426 for the same fracture.		251.55	
91430	Osteochondroplasty (extensive bone and arthrofibrotic tissue removal requiring a minimum of 2 hours to resect), to 91411 ……... add		500.00	
91432	Soft tissue capsular release for contractures without bone procedure, to 91411 ……..... add		251.55	
91434	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to 91411 …… add		326.55	
	Notes: 1. Only one of 91430, 91432 or 91434 is eligible for payment same patient same day. 2. Synovectomy less than 90 minutes in duration is included in 91411. 3. Osteochondroplasty less than 2 hours in duration is included in 91411.			

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	ELBOW AND FOREARM (Cont'd)			
	Arthrotomy			
91440	Elbow, loose body, etc.	24.51	199.55	4
	Biopsy			
91450	Bone - needle (IOP)		72.35	
91452	- open (IOP)	32.68	144.80	4
91454	Joint - via arthroscope		10.65	
91456	- open	24.51	171.45	4
91458	Muscle/soft tissue (IOP)		103.05	4
	Decompression/Denervation			
91470	Fasciotomy for compartments syndrome (not including secondary closure wound)	24.51	320.20	4
91472	Secondary closure		103.05	4
91474	Catheter - insertion (IOP)		49.20	
	- monitoring		VF	
91478	Exploration and/or decompression and/or transposition and/or neurolysis of ulnar nerve (elbow)	32.68	215.35	4
91480	Denervation - elbow	24.51	258.00	4
	Incision and Drainage (osteomyelitis)			
91490	Acute, incision and drainage	24.51	302.55	4
91492	Sequestrectomy	24.51	355.35	4
91494	Saucerization and bone grafting	24.51	452.90	4
91496	Soft tissue or bursa, incision and drainage		97.35	4
91498	Elbow, incision and drainage	24.51	199.55	4
	Examination/Manipulation			
91510	Manipulation - elbow and forearm - under general anaesthetic (IOP)		23.02	4
	Excision – Bone			
91520	Radial head	24.51	217.95	4
91522	Radial styloid	24.51	234.75	4
91524	Ulna lower end	24.51	193.00	4
91526	Olecranon	24.51	207.90	4
91528	Olecranon with fascial repair	24.51	309.00	4
	Excision – Bursae			
91540	Olecranon	24.51	101.25	4
	Excision - Joint Contents			
91550	Synovectomy/capsulectomy/debridement, etc.	24.51	311.85	4
	Excision – Muscles			
91560	Myositis ossificans	32.68	289.50	5
91562	Foreign body removal		107.70	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	ELBOW AND FOREARM (Cont'd)			
	Excision - Soft Tissues Tumours			
91570	- superficial		196.05	4
91572	- deep	40.85	484.35	6
	Excision - Bone Tumours			
91580	Exostosis	32.68	165.20	4
91582	Simple excision	32.68	289.50	4
91584	Extensive with replacement	32.68	677.50	6
	Reconstruction - Bone – Pseudoarthrosis			
91590	Radius or ulna	24.51	304.40	4
91592	Radius and ulna	24.51	411.20	4
	Reconstruction - Bone – Osteotomy			
91600	Radius or ulna	24.51	297.85	4
91602	Radius and/or ulna and reconstruction congenital abnormality, synostosis, etc.	24.51	398.10	4
	Reconstruction - Fascial Defects			
91610	- small	24.51	144.80	4
91612	- large with or without synthetic graft or rotation flap	32.68	290.55	5
	Reconstruction – Ligaments			
91620	Simple/single repair	24.51	301.60	4
91622	Extensive/multiple repair	24.51	511.45	4
	Reconstruction – Tendons			
91630	Suture extensor tendon - single	24.51	164.10	4
91632	- each additional	add	70.95	
91634	Suture flexor tendon - single	24.51	307.60	4
91636	- each additional	add	128.95	
91638	Tenoplasty - single	24.51	217.91	4
91640	- each additional	add	74.64	
91642	Tenolysis - single	24.51	196.93	4
91644	- each additional (max. of 2)	add	84.86	
	Transposition/transplantation/transfer			
91646	- single	24.51	278.08	4
91648	- each additional (max. of 1)	add	89.70	
91650	Steindler flexoplasty	24.51	336.49	5
	Release			
91660	Muscles and tendons - simple	32.68	132.78	4
91662	- radical, e.g., muscle slide	40.85	306.21	5

ELBOW AND FOREARM (Cont'd)

Code		Assist	FP/ Spec.	Anaes.
	Reduction - Dislocations			
91670	Elbow joint - closed reduction		82.39	4
91672	- open reduction, acute	24.51	245.44	4
91674	- repair chronic, recurrent	24.51	369.45	4
91676	Radial head - closed reduction		38.50	4
91678	- open reduction - acute	24.51	187.84	4
91680	- recurrent	24.51	221.24	6
91682	- late	32.68	347.72	6
	Reduction – Fractures			
	Epicondyle			
91690	- no reduction		67.75	
91692	- closed reduction	24.51	126.25	4
91694	- open reduction	32.68	214.45	4
91695	- extensive debridement of compound fracture add		107.23	
	Transcondylar/condylar			
91696	- no reduction		67.75	
91698	- closed reduction	24.51	200.91	4
91700	- closed reduction with traction	24.51	312.70	4
91702	- open reduction	32.68	**497.85**	4
91703	- extensive debridement of compound fracture add		187.90	
	Olecranon			
91704	- no reduction, rigid immobilization		126.25	4
91706	- closed reduction	24.51	129.00	4
91708	- open reduction	32.68	**262.28**	4
91709	- extensive debridement of compound fracture add		112.28	
	Radius and ulnar shaft			
91710	- no reduction, rigid immobilization		67.75	
91712	- closed reduction	24.51	148.50	4
91714	- open reduction	32.68	**494.15**	4
91715	- extensive debridement of compound fracture add		184.20	
	Radius and ulna-Monteggia			
91716	- no reduction, rigid immobilization		67.75	
91718	- closed reduction		144.80	4
91720	- open reduction of ulna plus closed reduction radial head	24.51	**342.25**	4
91721	- extensive debridement of compound fracture add		121.13	
	Radius or ulna			
91722	- no reduction, rigid immobilization		81.30	
91724	- closed reduction	24.51	117.85	**4**
91726	- open reduction	32.68	**446.95**	**4**
91727	- extensive debridement of compound fracture add		137.00	
	Radius-distal, Colles', Smith's, Barton's etc.			
91728	- no reduction, rigid immobilization		67.75	
91730	- closed reduction	24.51	**154.00**	4
91732	- open reduction	32.68	**477.28**	4
91733	- extensive debridement of compound fracture add		227.00	
91734	Osteochondral – open reduction	32.68	244.58	**5**

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SHOULDER/ARM/CHEST			
	Amputation			
91750	Forequarter	81.70	490.95	15
91752	Shoulder disarticulation	73.53	373.10	9
91754	High humerus	32.68	369.35	5
	Arthrodesis			
91760	Shoulder	32.68	468.65	6
	Arthroplasty			
91770	Humeral prosthesis	32.68	449.20	6
91772	Total prosthesis	49.02	695.10	10
91774	Revision total arthroplasty shoulder	49.02	942.95	10
91776	Removal prosthesis/no replacement	24.51	397.20	8
91778	Revision of prosthesis ..... add		194.67	
	Arthroscopy			
91790	Diagnostic arthroscopy (sole procedure)	24.51	178.86	4
91791	Shoulder arthroscopy setup, includes when rendered debridement, synovectomy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or synovial biopsy	49.02	400.00	10
	Notes: 1. A shoulder procedure listed in the Shoulder section of the Schedule performed arthroscopically is eligible for payment in addition to 91791 if that procedure is not described as a component of 91791 or described by an add-on code to 91791. 2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 91791 when the service described by the add-on code is a generally accepted component of a procedure described in Note #1.			
91806	Pinning of osteochondral fragment, to 91791 ..... add		251.55	
	Note: Fracture procedures are not eligible for payment with 91806 for the same fracture.			
91810	Superior labral anterior posterior (SLAP) repair, to 91791 ..... add		336.65	
91812	Arthroscopic capsular release for frozen shoulder, to 91791 ..... add		240.50	
	Note: Fee code 91810 cannot be billed with fee code 92026.			
	Arthrotomy			
91820	Shoulder	24.51	217.42	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SHOULDER/ARM/CHEST (Cont'd)			
	Biopsy			
91830	Bones - needle/punch, x-ray control (IOP)		89.70	4
91832	- open (IOP)	32.68	144.80	4
91834	Joint - via arthroscope		10.65	
91836	- open	32.68	223.65	4
91838	Soft tissue - open (IOP)		103.05	4
	Incision and Drainage			
91850	Humerus/clavicle/scapula - incision and drainage	32.68	262.60	4
91852	Sequestrectomy	32.68	290.55	4
91854	Saucerization with bone graft	32.68	387.90	4
91856	Bursae/soft tissue		97.35	4
91858	Joint	32.68	223.65	4
	Examination and Manipulation			
91870	Manipulation - shoulder/arm/chest under general anaesthetic (IOP)		47.43	4
	Excision - Clavicle or Acromion			
91880	Simple (includes ligament)	32.68	211.60	4
91882	Major tumour	40.85	290.55	6
91884	Malignant tumour with reconstruction	40.85	484.35	6
	Excision – Humerus			
91890	Head	32.68	299.75	5
91892	Exostosis	32.68	165.20	4
91894	Benign tumour	32.68	289.50	4
91896	Malignant tumour with reconstruction	32.68	681.10	6
	Excision – Joint			
91900	Synovectomy and debridement	32.68	425.10	5
91902	Excision of subacromial bursae	24.51	211.60	4
	Note: Not to be billed with 91908, 91952 or 91954			
91904	Muscle/fascia - simple	24.51	204.75	4
91906	- complex	32.68	484.35	6
91908	Rotator cuff exploration (includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa but excludes simple excision of clavicle)	32.68	206.90	4
	Note: When 91908 is rendered in association with 91926, 91908 is payable at 85% and 91926 is payable at 100%.			
91910	Acromio/sterno-clavicular menisectomy	24.51	204.14	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SHOULDER/ARM/CHEST (Cont'd)			
	Reconstruction - Pseudoarthrosis and Osteotomy			
91920	Pseudoarthrosis - clavicle	32.68	269.10	4
91922	- humerus	32.68	346.15	4
91924	Osteotomy - humerus	32.68	292.35	4
91926	- clavicle	32.68	211.60	4
91928	- glenoid	32.68	279.35	4
	Reconstruction - Muscles/Soft Tissues			
91940	Muscle transplant - pectoralis major	49.02	434.25	6
91942	Muscle/tendon release	40.85	314.60	5
91944	Release - sternomastoid	40.85	296.05	5
91946	Scapulopexy - congenital evaluation	49.02	385.15	6
91948	Trapezius/sternomastoid/transplant	32.68	338.65	4
91950	Tendon repair - biceps	24.51	227.40	4
91952	Rotator cuff repair - simple, end to end or side to side (includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa)	32.68	345.35	5
91954	Rotator cuff repair - complex (includes implantation into bone, and as required, acromioplasty, excision of coraco-acromial ligament, subacromial bursa and excision of distal clavicle)	32.68	498.30	5
	Reduction – Fractures			
91960	Tuberosity - no reduction		67.80	
91962	- closed reduction	24.51	117.85	4
91964	- open reduction (without cuff tear)	32.68	**340.55**	4
91965	- extensive debridement of compound fracture ... add		145.28	
	Neck without dislocation of head			
91966	- no reduction		67.80	
91968	- closed reduction		133.60	4
91970	- open reduction	40.85	**377.55**	6
91971	- extensive debridement of compound fracture ... add		163.78	
	Neck with dislocation of head			
91972	- no reduction		67.80	
91974	- closed reduction	24.51	183.80	4
91976	- open reduction	40.85	**435.15**	6
91977	- extensive debridement of compound fracture ... add		192.58	
91978	Shaft - no reduction		67.80	
91980	- closed reduction	24.51	147.60	4
91982	- open reduction	32.68	**423.05**	4
91983	- extensive debridement of compound fracture ... add		161.53	
	Clavicle - no reduction		VF	
91984	- closed reduction with anaesthetic	24.51	62.20	4
91986	- open reduction	32.68	**450.00**	4
91987	- extensive debridement of compound fracture ... add		150.00	
91988	Scapula - no reduction		67.80	
91990	- closed reduction with anaesthetic	24.51	112.88	4
91992	- open reduction	32.68	242.25	5
91993	- extensive debridement of compound fracture ... add		121.13	

Code		Assist	FP/ Spec.	Anaes.
	SHOULDER/ARM/CHEST (Cont'd)			
	Reduction - Fractures (Cont'd)			
91994	Sternum - no reduction		65.72	
91996	- closed reduction		115.95	
91998	- open reduction - pleura open	73.53	IC	13
92000	- pleura closed	32.68	IC	4
92001	- extensive debridement of compound fracture ..... add		115.55	
	Ribs - no reduction		VF	
92004	- complicated - pleura open	73.53	IC	13
92006	- pleura closed	32.68	IC	4
	Reduction – Dislocations			
	Acromio-clavicular/sterno-clavicular			
92010	- no reduction		67.80	
92012	- closed with anaesthetic	32.68	134.55	4
92014	- open reduction	32.68	231.10	4
92016	- open reduction - late	32.68	286.70	4
	Glenohumeral joint			
92018	- closed reduction - without anaesthetic		49.20	
92020	- with anaesthetic		111.40	4
92022	- open reduction - early	32.68	323.85	6
92024	- late	32.68	580.90	7
92026	- recurrent	40.85	379.50	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SKULL AND MANDIBLE			
	Arthroplasty			
92040	Temporo-mandibular joint - unilateral	40.85	336.49	5
	Biopsy (IOP)			
92050	Bones - punch, simple		41.81	4
92052	- punch, x-ray control		103.05	4
92054	- open	32.68	204.75	4
	Incision and Drainage			
92060	Mandibular sequestrectomy (IOP)	57.19	281.25	7
	Excision			
92070	Bone - tumour	IC	IC	IC
92072	Maxilla, with exenteration of orbit and skin graft	32.68	513.04	7
92074	Maxilla advancement	32.68	424.09	8
92076	Mandible	32.68	353.10	7
92078	Mandibular condyle	32.68	266.63	5
92080	Temporo-mandibular menisectomy	24.51	240.82	5
	Reconstruction			
92090	Facial paralysis - static slings	32.68	295.94	5
92092	- dynamic slings	32.68	384.40	6
92094	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles	32.68	491.74	7
92096	- with meloplasty ... add		83.89	
	Orthognathic Surgery			
	Anterior dento-alveolar osteotomy, maxilla or mandible			
92100	- 1 segment	49.02	775.15	10
92102	- 2 segments	49.02	898.84	10
	Posterior dento-alveolar osteotomy, maxilla			
92104	- 1 side	49.02	775.15	10
92106	- both sides, single segment	49.02	898.84	10
92108	- both sides, separate segments	49.02	1,143.95	10
	Posterior dento-alveolar osteotomy, mandible			
92110	- 1 side	49.02	775.15	10
92112	- both sides	49.02	1,143.95	10
	Total U dento-alveolar osteotomy			
92114	- mandible	49.02	1,183.10	10
92116	- maxilla	49.02	1,267.43	10
92118	Mandibular or maxillary visor osteotomy for alveolar hypoplasia	49.02	1,104.05	10
	Genioplasty			
92120	- 1 segment	49.02	246.62	10
92122	- 2 segments, or for laterognathia	49.02	369.67	10
92124	- 3 segments	49.02	492.76	10
	Mandibular osteotomies for prognathism			
92126	- subcondylar	24.51	404.73	6
92128	- vertical ramus	49.02	897.98	10
92130	- sagittal split	49.02	897.98	10

Code		Assist	FP/ Spec.	Anaes.
	SKULL AND MANDIBLE (Cont'd)			
	Orthognathic Surgery (Cont'd)			
	Mandible osteotomies for retrognathia, any technique			
92140	- advancement - up to 10 mm	49.02	897.98	10
92142	- 10 to 20 mm	49.02	1,020.48	10
92144	- greater than 20 mm	49.02	1,307.44	10
92146	- for apertognathia or laterognathia ... add		246.62	
	LeFort I advancement			
92148	- in 1 segment	81.70	774.40	20
92150	- in 2 segments ... add		285.77	
92152	- in 3 segments ... add		572.51	
	LeFort I intrusion			
92154	- in 1 segment	81.70	1,020.48	20
92156	- in 2 segments ... add		285.77	
92158	- in 3 segments ... add		572.51	
	LeFort I extrusion			
92160	- in 1 segment	81.70	1,267.43	20
92162	- in 2 segments ... add		285.77	
92164	- in 3 segments ... add		572.51	
	LeFort I cleft palate			
92166	- in 1 segment	81.70	1,469.09	20
92168	- in 2 segments ... add		246.62	
92170	- in 3 segments ... add		493.25	
92172	- with SMR ... add		197.52	
92174	- with pharyngoplasty ... add		295.94	
92176	- with closure alveolar fistula with or without bone graft ... add		369.67	
92178	- with closure hard palate fistula with or without bone graft ... add		493.25	
92180	Naso-maxillary osteotomy without LeFort I	49.02	774.40	10
92182	LeFort II maxillary osteotomy and advancement	81.70	1,390.90	20
92184	Construction glenoid fossa and zygomatic arch	81.70	1,350.89	20
92186	Construction absent condyle and ascending ramus	49.02	774.40	10
92188	Combined LeFort I and LeFort III osteotomy in hemifacial microsomia	81.70	1,469.09	20
92200	Mandibular condylotomy	32.68	197.31	5
92202	Coronoidotomy	32.68	197.31	5
92204	Coronoidectomy	32.68	295.94	5
	Reconstruction mandible with bone grafts and/or plate or prosthesis			
92210	- unilateral - partial	32.68	409.55	10
92212	- complete	32.68	819.15	10
92214	- bilateral - partial	32.68	819.15	10
92216	- complete	32.68	1,023.95	10
	Oral vestibuloplasty			
92218	- with secondary epithelization	32.68	197.31	5
92220	- with skin graft	32.68	295.94	5
	Temporomandibular ankylosis			
92222	- excision bone or fibrous block	24.51	444.31	6
92224	- with insertion of prosthetic device or muscle flap	32.68	493.25	8
92226	- with construction of condyle and ascending ramus	32.68	641.67	10

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SKULL AND MANDIBLE (Cont'd)			
	Orthognathic Surgery (Cont'd)			
	Onlay bone grafts to face when not part of standard osteotomy for reconstruction			
92230	- mandible - unilateral		394.80	
92232	- bilateral		507.45	
92234	- maxilla - unilateral		394.80	
92236	- bilateral		507.45	
92238	- zygoma - unilateral		295.94	
92240	- bilateral		394.62	
92242	- temporal - unilateral		394.62	
92244	- bilateral		493.25	
92246	- frontal - unilateral		394.62	
92248	- bilateral		493.25	
	Application of dental arch bars, or splint, for facial osteotomy (IOP)			
92260	- 1 arch bar	32.68	128.10	4
92262	- 2 arch bars	32.68	197.31	4
92264	Interdental wiring for temporomandibular joint disorder	24.51	148.00	5
92266	Removal intermaxillary fixation devices under general anaesthesia- as sole procedure		102.35	4
	Orbito-cranial Surgery			
	Bilateral periorbital correction Treacher-Collins Syndrome			
92280	- with or without bone grafts (extra-cranial)	81.70	1,604.07	20
92282	- with skull and muscle transpositions (includes skull reconstruction) (intracranial)	81.70	2,044.08	25
92284	Pericranial flap to orbit or face - unilateral		307.15	4
92286	- bilateral		394.62	4
	- when in conjunction with coronal approach for main operation			
92288	- unilateral		172.41	
92290	- bilateral		285.77	
92292	LeFort III total maxillary advancement	98.04	1,962.02	25
92294	LeFort III and subcranial hypertelorism correction	98.04	2,494.95	25
92296	LeFort III and LeFort I maxillary advancement	98.04	2,248.87	25
92298	LeFort II, subcranial hypertelorism correction, LeFort I maxillary advancement	98.04	2,820.84	25
	Upper LeFort III advancement without occlusal change			
92300	- unilateral	49.02	897.98	10
92302	- bilateral	98.04	1,390.90	25
	Forehead advancement (bone grafts not included)			
92304	- unilateral	98.04	1,143.95	25
92306	- bilateral	98.04	1,390.90	25
92308	Cranial vault reshaping - anterior or posterior half	81.70	1,469.09	20
92310	Total cranial vault reshaping	98.04	2,001.97	25
92320	Medial transnasal canthopexy - unilateral	24.51	398.71	6
92322	- when done in conjunction with another procedure		148.00	
92324	Lateral canthoplasty - unilateral	24.51	197.31	6
92326	- when done in conjunction with another procedure		97.66	

Code		Assist	FP/ Spec.	Anaes.
	SKULL AND MANDIBLE (Cont'd)			
	Orbito-cranial Surgery (Cont'd)			
	Hypertelorism correction			
92328	- intracranial approach	98.04	2,248.87	25
92330	- subcranial U osteotomies	98.04	1,878.55	25
92332	- medial orbital wall osteotomies	81.70	1,183.10	20
92334	- medial and lateral orbital wall osteotomies	81.70	1,553.42	20
92336	Orbital dystopia - intracranial approach	98.04	1,878.55	25
92338	- extracranial approach	81.70	1,430.91	20
	Late correction traumatic enophthalmos – total periorbital stripping and bone grafts			
92340	- intracranial	98.04	1,923.83	25
92342	- extracranial	81.70	1,390.90	20
	Harvesting of bone graft when not included			
92350	- iliac bone graft		96.15	
92352	- rib graft - 1 rib		148.00	
92354	- each subsequent rib		74.00	
92356	- costochondral or chondral graft - 1 rib		221.99	
92358	- subsequent rib		148.00	
92360	- split cranial graft		197.31	
	Surgery for Correction of Down's Syndrome Facial Stigmata			
	Augmentation of zygoma (bilateral)			
92370	- with prosthetic implant		173.86	
92372	- with autogenous bone or cartilage		217.48	
	Augmentation of chin			
92380	- with prosthetic implant		144.98	
92382	- with autogenous bone or cartilage		178.86	
92384	Horizontal resection, red lower lip		173.86	
	Reduction – Fractures			
	Orbit			
	Open reduction rim/wall fracture			
92400	- zygomatic fracture dislocation	32.68	594.70	6
92402	- with miniplate(s) per major fracture line add		99.85	
92406	- blowout fracture or floor	32.68	667.00	6
92408	- secondary repair by combined or orbital approach	40.85	459.10	6
	Nasal bones (including septum)			
92410	- closed reduction		102.35	4
92412	- open reduction		316.35	5
92414	- with miniplate(s) per major fracture line add		63.95	
92415	- extensive debridement of compound fracture add		158.18	
92426	Middle 1/3 facial	40.85	451.12	8
92428	Cranial-facial separation	40.85	522.72	10

Code		Assist	FP/ Spec.	Anaes.
	SKULL AND MANDIBLE (Cont'd)			
	Reduction - Fractures (Cont'd)			
	Mandible			
92430	- closed reduction (includes wiring of teeth) ……		350.00	5
	- open reduction (may include wiring of teeth)			
92432	- 1 side ……	32.68	575.00	5
92434	- with miniplate(s) per major fracture line …….. add		104.00	
92436	- complicated ……..	IC	IC	IC
92438	- removal of interdental wire ……..			5
92439	- extensive debridement of compound fracture …….. add		287.50	
	Maxilla			
92440	- closed reduction and dental wiring …….		246.62	
92442	- open reduction - simple ……	32.68	256.40	5
92444	- with wiring and local fixation ……	40.85	685.20	6
92446	- with miniplate(s) per major fracture line ……... add		107.20	
92447	- extensive debridement of compound fracture …….. add		342.60	
	Temporo-mandibular joint			
92450	- closed reduction ……		51.65	4
92452	- open reduction ……..	40.85	256.40	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SPINE			
	Arthrodesis			
92470	Anterior or posterior fusion of 1 level	57.19	459.00	10
92472	Fusion of C1-2	65.36	621.16	10
92474	Each additional level (max. of 2) ..... add		95.55	
	Fusion with other procedure(s) – by same surgeon			
92476	- 1 level ..... add		272.11	
92478	- multiple levels ..... add		346.46	
92480	- anterior cervical interbody fusion, per level ..... add		90.92	
	Fusion by different surgeon			
92482	- 1 level		347.99	
92484	- multiple levels		409.29	
92486	- anterior cervical interbody fusion, per level ..... add		134.51	
92488	Repeat fusion ..... add		225.74	
92490	With instrumentation ..... add		154.49	
	Biopsy			
92500	Bone - needle (IOP)	32.68	162.03	4
92502	- open - posterior approach	32.68	271.12	7
92504	- anterior approach	49.02	346.76	8
92506	Soft tissue - open (IOP)		108.73	4
	Decompression - Anterior, Anterolateral or Posterolateral			
92510	Simple anterior cervical discectomy	65.36	826.20	10
92512	Simple anterior lumbar discectomy	49.02	1,101.60	10
92514	Anterior cervical spinal cord or nerve root decompression, including removal of disc or vertebral body, single disc level	65.36	676.21	10
92516	Anterior decompression with instrumentation	73.53	1,618.96	13
92518	Anterolateral or posterolateral decompression, lumbar or thoracic spine, single disc level	73.53	1,210.41	13
92520	- each additional disc level decompressed – to 92510, 92512, 92514, 92518 ..... add		291.90	
	Decompression – Posterior			
92540	Cervical hemilaminectomy for disc disease, with or without foraminotomy	49.02	904.23	10
92542	Lumbar hemilaminectomy for disc disease including removal of soft disc or osteophyte	49.02	800.70	8
92544	- multiple levels, to 92540, 92542 ..... add		229.50	
92546	- bilateral, to 92540, 92542 ..... add		230.50	
92548	Posterior laminectomy 1 or 2 levels, cervical, thoracic, lumbar	49.02	776.00	9

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SPINE (Cont'd)			
	Decompression – Posterior (Cont'd)			
92550	Repeat posterior exploration or reopening of posterior exploration, more than six months after original procedure, includes foraminotomy, discectomy or neurolysis	65.36	729.27	10
92552	- laminectomy extending over 3 or more laminae, to 92548, 92550 ..... add		175.02	
92554	- foraminotomy, to 92542, 92548 and 92550 per foramen decompressed ..... add		100.00	
92556	- opening of dura (associated with any decompressive procedure) ..... add		200.00	
92558	- spinal duroplasty (applies to any spinal procedure) ..... add		300.00	
	Incision and Drainage (Osteomyelitis)			
92570	Bone - incision and drainage only	32.68	337.55	4
	Sequestrectomy			
92572	- anterior	57.19	704.28	10
92574	- posterior	32.68	401.99	4
	Saucerization with bone grafting			
92576	- anterior	49.02	867.43	10
92578	- posterior	32.68	490.30	5
92580	Soft tissue		118.50	
	Examination/Manipulation			
92590	Manipulation - spine - under sedation/anaesthesia (IOP)		43.36	4
	Excision – Bone			
92600	Spinous process	32.68	271.37	4
92602	Lamina or transverse process	49.02	433.16	8
92604	Part of body or pedicle	49.02	649.99	8
92606	Total body (includes replacement)	73.53	1,082.65	13
	Excision - Muscle/Soft Tissue			
92610	Tumours - simple	49.02	239.57	8
92612	- radical resection	73.53	591.06	13
	Reconstruction - Osteotomy (includes fixation/fusion)			
92620	Anterior - via chest	73.53	811.28	13
92622	- via abdomen	73.53	867.43	9
92624	- via chest and abdomen	73.53	976.52	13
92626	Posterior	73.53	767.61	9
92628	- with rib or transverse release		137.92	
92630	Circumferential	73.53	1,300.22	9
92632	Cervical	81.70	1,138.92	12

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SPINE (Cont'd)			
	Instrumentation - Deformities			
	Anterior - includes fusion/disectomy			
92640	- via chest or abdomen	73.53	1,422.79	17
92642	- via chest and abdomen	73.53	1,569.54	17
92644	Posterior (Harrington) – with or without fusion (92648, 92650, 92652 may be billed as appropriate)	65.36	863.22	12
92646	Readjustment of instrumentation		162.03	4
92648	- Harrington instrumentation to sacrum or pelvis (payable in addition to 92644 or 92646 only) ..... add		86.71	
92650	- Harrington instrumentation, for each level over 6 (payable in addition to 92644 or 92646 only) ..... add		21.03	
92652	- with posterior osteotomy (payable with 92650 only) ..... add		164.63	
92654	Segmental procedure - with fusion	65.36	1,356.64	12
92656	- segmental instrumentation to pelvis, add to 92654		172.42	
92658	- segmental instrumentation, for each level over 6 ..... add		91.80	
92660	Removal of - anterior instrumentation	65.36	324.06	8
92662	- posterior instrumentation	65.36	292.89	8
	Revision of entire instrumentation			
92664	- with fusion	65.36	1,354.39	12
92666	- without fusion	65.36	1,082.65	12
92682	Removal of electrodes	65.36	285.11	8
92684	Muscle stripping spine prior to surgery	49.02	216.02	8
92686	Halo traction prior to surgery (complete care)	24.51	325.68	4
	Note: 92684 and 92686 allow full benefit if followed by surgery for correction of scoliosis in same hospitalization.			
	Anterior release including Halo traction			
92690	- via chest or abdomen	73.53	610.77	13
92692	- via chest and abdomen	73.53	758.34	13
92694	Localizer cast		148.55	4
	Reduction – Fractures or Fracture Dislocations			
	Fracture of spine without procedure		VF	
92702	Skull calipers (IOP)		56.04	
92704	Halo traction (IOP)		89.80	
92706	Reapplication of Halo traction (IOP)		56.04	
92708	- counter traction pins or vest ..... add		119.98	
92710	Closed reduction	40.85	226.48	5

Code		Assist	FP/ Spec.	Anaes.
	SPINE (Cont'd)			
	Reduction – Fractures or Fracture Dislocations (Cont'd)			
	Open reduction			
92712	- posterior approach ……	40.85	918.00	10
92714	- anterior approach ……..	57.19	918.00	10
92716	- with spinal cord injury (when total care by operating surgeon) ……. add		255.00	
92718	- with irrigation, including opening of dura, to fractures when combined with decompressive procedures …… add		347.99	
	- fusion by same surgeon			
92720	- 1 level …… add		272.11	
92722	- 2 or more levels ……... add		346.46	
	- fusion by different surgeon			
92724	- 1 level …… add		347.99	
92726	- 2 or more levels ……... add		409.29	
92728	-with instrumentation ……... add		154.49	
92729	-extensive debridement of compound fracture ……... add		204.65	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	PELVIS AND HIP			
	Amputation			
92740	Hemipelvectomy - hindquarter	81.70	796.20	15
92742	Hip disarticulation	81.70	476.85	10
	Arthrodesis			
92750	Sacro-iliac joint	40.85	395.25	5
92752	Symphysis pubis	40.85	387.00	6
92754	Hip	40.85	703.45	8
	Arthroplasty			
92760	Unipolar	49.02	577.48	8
92762	Bipolar	65.36	679.21	8
92764	Total hip replacement with take down of fusion	65.36	972.90	10
92766	Revision total arthroplasty hip	65.36	1,422.88	10
92768	Total hip arthroplasty	65.36	825.59	8
92770	- bone graft to acetabulum add		101.25	
92772	- acetabular reconstruction (extensive, including bone grafts) add		194.00	
92774	Reattachment of greater trochanter (late)		290.55	8
92776	Removal only - non-cemented	24.51	447.30	8
92778	- cemented	24.51	557.75	8
	Arthroscopy			
92790	Hip joint, sole procedure (IOP)		178.86	4
92792	- preceding surgery, same surgeon add		134.26	
	Arthrotomy			
92800	Sacro-iliac joint	40.85	282.22	6
92802	Hip - with removal of loose body	40.85	293.52	6
92810	Hip - infant or child, under general anaesthesia	24.51	61.84	4
	Biopsy			
92820	Bone - punch needle (IOP)		89.70	
92822	- under general anaesthetic (IOP)		72.35	5
92824	- open (IOP)	32.68	144.80	4
92826	Joint - via arthroscope		10.65	
92828	- open	40.85	301.60	6
92830	Soft tissue - open		97.35	4
	Denervation/Decompression			
92840	Decompression of lateral femoral cutaneous nerve	32.68	146.33	4
92842	Exploration and/or decompression of sciatic nerve	49.02	410.11	6
92844	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve	32.68	243.93	4
92846	Denervation of hip	32.68	387.00	5

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	PELVIS AND HIP (Cont'd)			
	Incision and Drainage			
92850	Bone, incision and drainage	24.51	290.55	4
92852	Sequestrectomy.....	32.68	379.50	4
92854	Saucerization and bone graft	32.68	627.30	5
92856	Bursae/soft tissue (IOP)		97.35	4
92858	Joint	40.85	301.60	6
	Examination/Manipulation			
92870	Manipulation - pelvis and hip - under general anaesthetic (IOP)		37.70	4
	Excision – Bone			
92880	Simple cyst, etc.	32.68	338.75	4
92882	Major resection tumour	32.68	629.65	6
92884	Radical resection tumour	65.36	1,007.35	8
92886	Coccyx	32.68	208.80	4
92888	Head and neck, femur	32.68	452.90	6
	Excision – Muscle			
92900	Simple	24.51	193.00	4
92902	Complex	32.68	484.35	6
92904	Myositis	32.68	289.50	5
	Excision – Joint			
92910	Synovectomy/debridement	40.85	470.50	5
	Excision – Bursae			
92920	GT trochanteric/ischial	24.51	201.40	4
	Reconstruction – Pseudoarthrosis			
92930	Pelvis.....	65.36	580.90	10
92932	Hip	49.02	477.90	6
	Reconstruction – Osteotomy			
92940	Pelvis - infant		399.00	8
92942	- other	65.36	580.90	8
92944	Hip	40.85	539.15	7
	Reconstruction - Muscle/Tendon			
92950	Muscle release	40.85	314.60	5
92952	Closed adductors - tenotomy (IOP)		49.20	4
92954	Open adductors - tenotomy (IOP)		97.35	4
92956	Iliopsoas - tenotomy	40.85	266.35	5
	Reconstruction - Tendon Transfer			
92970	Iliopsoas	40.85	520.60	6
92972	Abductor	40.85	339.65	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	PELVIS AND HIP (Cont'd)			
	Reduction – Fractures			
	Coccyx - no reduction		VF	
92982	- excision	32.68	208.80	4
	Pelvic ring - no reduction		VF	
92986	- closed reduction	24.51	442.45	4
92988	- open reduction	49.02	680.30	8
92989	- extensive debridement of compound fracture ... add		340.15	
	Sacrum - no reduction		VF	
	Femoral neck trochanteric, subtrochanteric			
	- no reduction		VF	
92994	- closed reduction/traction	24.51	426.90	4
92996	- open reduction - pin only	49.02	432.34	8
92998	- pin and plate	49.02	**589.08**	8
93000	- primary prosthesis	49.02	**586.86**	8
93002	- delayed/staged graft	49.02	289.50	8
93003	- extensive debridement of compound fracture ... add		249.48	
	Slipped epiphysis			
93004	- closed reduction/traction	49.02	387.00	8
93006	- closed reduction/internal fixation	49.02	387.00	8
93008	- open reduction/fixation	49.02	580.90	8
93009	- extensive debridement of compound fracture ... add		290.45	
	Reduction – Dislocations			
	Acetabulum - no reduction		VF	
93022	- open reduction - lips	57.19	612.45	8
93024	- 1 pillar	32.68	967.90	10
93026	- 2 pillars	65.36	1,451.45	12
93028	Hip - closed reduction		268.25	4
93030	- open reduction	57.19	406.45	7
93032	- late	57.19	774.90	10
93033	- extensive debridement of compound fracture ... add		203.23	
	Sacro-iliac			
93034	- closed, traction, spica, etc.		428.50	5
93036	- open reduction	40.85	593.00	5
93037	- extensive debridement of compound fracture ... add		296.50	
	Sacro-coccygeal			
	- closed reduction		VF	
93040	- open, removal of coccyx	40.85	193.00	5
93041	- extensive debridement of compound fracture ... add		96.50	
	Congenital hip			
93042	- closed reduction (includes tenotomy and cast)		190.20	4
93044	- repeat (includes cast)		131.80	4
93046	- open reduction (includes tenotomy and arthrotomy)	57.19	472.35	7
93048	Application Pavlik Harness or CDH splint		24.10	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	FEMUR			
	Amputation			
93060	Gritti-Stokes or Callander	40.85	379.64	5
93062	Through femur	40.85	348.30	5
	Biopsy (IOP)			
93070	Bone - core, punch		48.50	4
93072	- x-ray control/general anaesthetic		120.70	4
93074	- open	32.68	193.00	4
93076	Soft tissue - open		97.35	4
93078	Injection into bone cysts		117.00	
	Incision and Drainage (Osteomyelitis)			
93090	Incision and drainage, bone	24.51	325.75	4
93092	Sequestrectomy	24.51	395.25	4
93094	Saucerization and graft	40.85	619.90	6
93096	Soft tissue		103.05	4
	Excision – Bone			
93100	Simple cyst/exostosis	32.68	225.50	4
93102	Bone tumour - simple	32.68	629.65	6
93104	- with reconstruction/graft	65.36	1,007.35	8
	Excision – Muscle			
93110	Simple	24.51	193.00	4
93112	Complex	32.68	484.35	6
	Reconstruction – Pseudoarthrosis			
93114	Reconstruction - pseudoarthrosis	49.02	477.90	6
93116	- Intramedullary nail with distal and proximal locking screws - femur, to 93114 or 93208 ..... add		108.75	
	Reconstruction – Fascial			
93120	Simple	24.51	193.00	4
93122	Complex with or without synthetic graft or rotation flap	49.02	402.75	5
	Reconstruction – Osteotomy			
93130	Femoral shaft	32.68	532.65	5
93132	Supracondylar	49.02	387.00	6
	Reconstruction - Leg Length Operations			
93140	Femoral shortening - all types	32.68	480.70	4
93142	Femoral lengthening - all types	32.68	541.95	4
93144	Femoral epiphysiodesis	32.68	301.60	5
93146	Tibial and femoral epiphsiodesis	32.68	426.90	5
93148	Femoral stapling	32.68	313.65	4
93150	Tibial and femoral stapling	32.68	387.00	5

Code		Assist	FP/ Spec.	Anaes.
	FEMUR (Cont'd)			
	Reconstruction - Muscle/Tendons			
93160	Quadriceps repair - simple ……..	24.51	**413.70**	4
93162	- reconstructive ……	24.51	387.00	4
93164	Quadricepsplasty - all types ……...	32.68	381.40	5
93166	Ilio-tibial band ……...	24.51	191.10	4
93168	Closed release of ilio-tibial band (IOP) ……..		49.20	4
93170	Tenotomy of hamstrings - single ……...	24.51	168.85	4
93172	- multiple ……...	24.51	193.00	4
	Lengthening of hamstrings			
93174	- single ……...	24.51	223.65	4
93176	- each additional ……... add		77.05	
	Tendon or muscle transfer			
93178	- single ……...	24.51	307.15	5
93180	- each additional (max. of 1) ……... add		87.20	
93182	Excision of myositis ……..	32.68	289.50	5
	Reduction – Fractures			
	Femoral shaft/supracondylar			
	- no reduction, cast ……...		VF	
	- closed reduction - traction			
93202	- infant or child ……	24.51	258.00	4
93204	- adult or adolescent ……...	24.51	407.35	4
93206	- closed reduction, cast ……...	24.51	258.90	4
93208	- open reduction ……...	49.02	**543.80**	8
93209	- extensive debridement of compound fracture, infant or child ……. add		246.90	
93210	- extensive debridement of compound fracture, adult or adolescent ……... add		246.90	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	KNEE			
	Amputation			
93220	Through knee - disarticulation	40.85	305.25	5
	Arthrodesis			
93230	Knee	24.51	402.75	5
	Arthroplasty			
93240	Patellar arthroplasty	24.51	241.60	5
93242	Hemi-arthroplasty - single component	49.02	351.70	6
93244	- double component	49.02	619.90	6
93246	Total replacement/both compartments	65.36	619.90	8
93248	Total knee replacement with take down of fusion	65.36	838.00	8
93250	Revision total arthroplasty knee	65.36	1,223.54	8
93252	With associated patellar replacement or patelloplasty ..... add		94.60	
93254	Removal of hemi-arthroplasty - without replacement	32.68	242.25	5
93256	Removal of total arthroplasty - without replacement	32.68	368.40	5
93258	Revision of arthroplasty ..... add		169.94	
	Arthroscopy			
93270	Diagnostic arthroscopy (sole procedure)		192.37	4
93272	Synovial biopsy		42.81	
93274	Trimming of plica, tissue, meniscus		62.27	
93276	Removal of loose body, screw		187.84	
93278	Resection of plica		86.42	
93280	Lateral release		161.45	
93282	Synovectomy - anterior - 1 compartment		127.99	
93284	- anterior - more than 1 compartment		256.41	
93286	- total, anterior and posterior		469.58	
93288	Drilling of defect, includes removal of loose body		251.55	
93290	Pinning of osteochondral fragment		251.55	
93292	Debridement - 1 compartment		284.29	
93294	- more than 1 compartment		**380.45**	
93296	Microfracture and/or abrasion arthroplasty, for osteoarthritic cartilage deficiency (includes removal of loose body(ies))		281.79	
93298	Menisectomy		337.70	
93300	Repair medial or lateral meniscus		320.17	
93302	Arthroscopy in association with surgery including 93272 to 93300 – same surgeon ..... add		144.40	
	Arthrotomy			
93320	Knee - with or without removal of loose body	24.51	202.31	4
93322	Osteochondritis dissecans with drilling and/or internal fixation	24.51	267.25	4
	Biopsy			
93330	Bone/joint - needle (IOP)		120.70	4
93332	- open (IOP)	32.68	193.00	4
93334	- via arthroscope		10.65	
93336	Soft tissue – open (IOP)		97.35	4

Code		Assist	FP/ Spec.	Anaes.
	KNEE (Cont'd)			
	Denervation/Decompression			
93340	Denervation - of knee	24.51	258.00	4
93342	- of gastrocnemius	32.68	256.15	4
	Incision and Drainage			
93350	Soft tissue (IOP)		97.35	4
93352	Joint	24.51	193.00	4
	Examination/Manipulation			
93360	Manipulation - knee - under general anaesthetic (IOP)		23.02	4
	Excision			
93370	Baker's cyst - simple	24.51	148.50	4
93372	- extensive	32.68	264.50	6
93374	Cysts of meniscus	24.51	126.25	4
93376	Menisectomy	24.51	241.30	4
93378	Debridement of joint without synovectomy	24.51	290.55	4
93380	Synovectomy	24.51	430.65	5
93382	Pre-patellar bursae	24.51	149.45	4
93384	Patella - to include fascial repair	24.51	276.55	4
93386	Exostosis/cyst patella	24.51	126.25	4
	Reconstruction – Meniscus			
93390	Suturing of medial or lateral meniscus	24.51	242.25	5
	Reconstruction - Muscles/Tendons			
93400	Tenoplasty - 1	24.51	144.80	4
93402	- each additional add		77.05	
	Suture of patellar or quadriceps tendon			
93404	- early	24.51	227.40	4
93406	- late	24.51	387.00	4
	Transplant of tendon			
93408	- single	24.51	307.15	5
93410	- each additional (max. of 1) add		87.20	
93416	Tenotomy - open - 1	24.51	232.00	4
93418	- multiple	24.51	253.30	4
93420	Release patellar retinaculum	40.85	161.45	5
	Reconstruction - Ligaments			
93430	Simple - 1	24.51	361.95	4
93432	Extensive/multiple (including synthetics) includes when rendered preparation of intracondlyar notch	32.68	517.85	6
93434	Synthetic anterior/posterior cruciate	49.02	480.02	6
93436	Removal of synthetics	32.68	213.45	4

Code		Assist	FP/ Spec.	Anaes.
	KNEE (Cont'd)			
	Reduction - Fractures			
93450	Patella - no reduction ……		67.75	
93452	- open reduction/excision with/without repair ……	32.68	275.65	4
93453	- extensive debridement of compound fracture …… add		137.83	
93454	Osteochondral fracture - open reduction ……	32.68	392.40	5
	Reduction – Dislocations			
93460	Knee - closed reduction ……		207.90	4
93462	- open reduction ……	40.85	309.00	5
	Patella			
	- closed reduction			
93464	- without anaesthetic ……		62.20	
93466	- with anaesthetic ……		97.35	4
93468	- open reduction - early ……		290.55	5
93470	- late ……	32.68	484.35	6
93472	- repair recurrent dislocation, includes inspection of joint	32.68	393.40	5
93474	Congenital dislocation - knee (open) ……	32.68	484.35	6

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	FIBULA AND TIBIA			
	Amputation			
93490	Tibia/fibula	40.85	348.30	5
	Biopsy			
93500	Bone - simple - punch		120.70	4
93502	- open	32.68	193.00	4
93504	Soft tissue - open		97.35	4
93506	Injection into bone cysts		117.00	
	Decompression/Denervation			
93510	Decompression of fascial compartments	24.51	320.20	4
93512	Secondary closure		97.35	
93514	Catheter insertion (IOP)		49.20	
	Monitoring of pressure monitoring device		VF	
93518	Decompression of posterior tibial or common perineal nerve	32.68	165.20	4
	Incision and Drainage (Osteomyelitis)			
93530	Incision and drainage, bone	24.51	308.10	4
93532	Sequestrectomy	24.51	329.40	4
93534	Saucerization and bone grafting	24.51	411.20	4
93536	Soft tissue		97.35	4
	Excision			
93540	Exostosis/cyst	24.51	201.40	4
93542	Fibular head	24.51	193.00	4
93544	Tumour - simple	32.68	289.50	4
93546	- extensive with repair	40.85	659.20	6
93548	Excision bone ridge to include interpositional materials	40.85	385.15	6
93550	Muscle/soft tissue - simple	24.51	193.00	4
93552	- complex	32.68	513.96	6
	Reconstruction – Pseudoarthrosis			
93560	Tibia/fibula	32.68	348.00	5
93562	By-pass fibular graft	32.68	341.45	6
93564	Congenital pseudoarthrosis	32.68	484.35	6
93566	- Intramedullary nail with distal and proximal locking screws – tibia, to 93560 or 93564 or 93614 or 93616 or 93618 ..... add		81.55	
	Reconstruction – Osteotomy			
93570	Tibia and fibula	24.51	376.80	4
93572	Repair recurrent dislocation, includes inspection of the joint	32.68	393.40	6
	Reconstruction - Leg Length Operations			
93580	Tibial lengthening	32.68	470.50	4
93582	Tibial shortening	32.68	387.00	4
93584	Tibial and femoral epiphysiodesis	32.68	426.90	5
93586	Tibial epiphysiodesis	32.68	322.05	5
93588	Tibial stapling - 1 side	32.68	193.00	4
93590	- both sides	32.68	242.25	4
93592	Tibial and femoral stapling	32.68	387.00	5

Code		Assist	FP/ Spec.	Anaes.
	FIBULA AND TIBIA (Cont'd)			
	Reduction - Fractures			
	Tibia with or without fibula			
93610	- no reduction, rigid immobilization ……		115.95	
93612	- closed reduction ……..	24.51	180.05	4
93614	- open reduction - shaft …….	32.68	**457.25**	5
93616	- medial or lateral tibial plateau …….	32.68	**444.22**	5
93618	- both tibial plateaus, same knee ……..	32.68	**641.34**	5
93619	- extensive debridement of compound fracture …….. add		203.63	
93620	Fibula - no reduction, rigid immobilization …….		67.75	
93622	- closed reduction ……..		101.25	4
93624	- open reduction …….	32.68	230.20	4
93625	- extensive debridement of compound fracture …….. add		115.10	

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	FOOT AND ANKLE			
	Amputation			
93640	Metatarsal/phalanx disarticulation	32.68	155.90	4
93642	- each additional add		47.30	
93644	Ray (single)	32.68	234.38	4
93646	Symes	40.85	302.70	5
93648	Transmetatarsal/transtarsal	32.68	270.22	4
93650	Terminal Symes	40.85	200.68	5
	Arthrodesis			
93660	Ankle	24.51	**500.00**	4
93662	Interphalangeal	24.51	154.02	4
93664	- each additional add		41.55	
93666	Metatarsophalangeal	24.51	262.00	4
93668	Midtarsal/subtarsal	24.51	450.00	4
93670	Triple	24.51	**488.33**	5
93672	Pan-talar - 1 stage	24.51	626.45	6
	Arthroplasty			
93680	Ankle - total replacement	49.02	1,177.50	6
93682	Revision total arthroplasty ankle	49.02	1,589.63	6
93684	Removal of prosthesis without replacement	24.51	193.00	6
	Metatarsophalangeal interposition			
93686	- single	24.51	144.80	5
93688	- each additional add		38.00	
93690	Metatarsophalangeal	24.51	289.50	5
93700	- multiple	24.51	387.00	6
93702	Removal - prosthesis without replacement	24.51	144.80	4
93704	Revision of arthroplasty add		124.76	
	Arthroscopy			
93710	Diagnostic arthroscopy (sole procedure)	24.51	178.86	4
93711	Ankle arthroscopy setup, includes when rendered debridement, synovectomy, removal of loose body(ies) and/or screw, drilling of defect or microfracture and/or synovial biopsy	49.02	400.00	7

Notes:

1. An ankle procedure listed in the Foot and Ankle section of the Schedule performed arthroscopically is eligible for payment in addition to 93711 if that procedure is not described as a component of 93711 or described by an add-on code to 93711.
2. Arthroscopic add-on codes listed below are not eligible for payment in addition to 93711 when the service described by the add-on code is a generally accepted component of a procedure described in Note #1.

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	FOOT AND ANKLE (Cont'd)			
	Arthroscopy (Cont'd)			
93725	Arthroscopy of subtalar and/or intratarsal joint(s), through separate portals, to 93711 ..... add		192.00	
93726	Pinning of osteochondral fragment, to 93711 ..... add		251.55	
	Note: Fracture procedures are not eligible for payment with 93726 for the same fracture.			
93730	Osteochondroplasty (extensive bone and arthrofibrotic tissue removal requiring a minimum of 2 hours to resect), to 93711 ..... add		500.00	
93732	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to 93711 ..... add		326.55	
93734	Excision of Os Trigonum (sole procedure)	49.02	230.00	7
	Notes: 1. Only one of 93730 or 93732 is eligible for payment same patient same day. 2. Fee code 93711 is not eligible for payment in addition to 93734.			
	Arthrotomy			
93740	Ankle - removal of loose body, etc.	24.51	162.09	4
93742	- with osteotomy of malleolus ..... add		117.85	
93744	Mid tarsals	24.51	144.80	4
93746	Metatarsal/phalangeal	24.51	144.80	4
	Biopsy			
93760	Bone - needle - punch (IOP)		48.50	4
93762	- punch - under general anaesthetic		120.70	4
93764	- open	32.68	193.00	4
93766	Joint - via arthroscope		10.65	
93768	- open		168.00	4
93770	Soft tissue - open (IOP)		97.35	4
	Incision and Drainage			
93780	Incision and drainage - bone	24.51	227.40	4
93782	Sequestrectomy	32.68	193.00	4
93784	Saucerization and bone graft	32.68	387.00	4
93786	Bursae (IOP)		97.35	4
93788	Joints	24.51	176.67	4
93790	Soft tissue (IOP)		97.35	4
	Examination/Manipulation (IOP)			
93800	Manipulation - foot and ankle - under general anaesthetic		23.02	4
	Club foot, etc. - manipulation and cast/strapping			
93810	- without anaesthetic		19.45	
93812	- with anaesthetic		39.00	4

SURGICAL PROCEDURES

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	FOOT AND ANKLE (Cont'd)			
	Excision – Bone			
93820	Phalanx	24.51	127.15	4
93822	Metatarsal head	24.51	175.45	4
93824	- each additional add		41.70	
93826	Accessory navicular (scaphoid)	24.51	155.90	4
93828	Bunion/bunionette	24.51	150.30	4
93830	Calcaneal spur	24.51	135.52	4
93832	Exostosis (dorsal, subungual)	24.51	100.15	4
93834	Os calcis, talus	24.51	283.95	4
93836	Sesamoid, 1 or both	24.51	142.00	4
93838	Tarsal bar	24.51	230.20	4
93840	Tumour (foot)	24.51	241.30	4
	Excision – Joint			
93850	Ankle synovectomy	24.51	273.75	4
	Metatarsophalangeal synovectomy			
93852	- 1	24.51	226.40	4
93854	- 2 or more	24.51	339.65	4
	Excision - Soft Tissue			
93860	Ganglion - simple or complex	24.51	177.80	4
93862	Bursa	24.51	149.45	4
93864	Fascia (Dupuytrens) - partial or complete	24.51	322.66	4
93866	Muscle - simple	24.51	193.00	4
93868	- complex	32.68	484.35	6
	Reconstruction – Pseudoarthrosis			
93880	Malleoli	24.51	296.05	4
93882	Tarsals/metatarsals/phalanx	24.51	260.75	4
	Reconstruction – Osteotomy			
93890	Os calcis	24.51	297.85	4
93892	Metatarsals and phalanx	24.51	144.80	4
93894	- each additional add		41.70	
93896	Midtarsal/tarsal	24.51	242.25	4
93898	Shortening metatarsal - 1	32.68	225.50	4
93900	- 2 or more	32.68	272.80	4
	Reconstruction – Forefoot			
93910	Claw and hammer toe	24.51	151.25	4
93912	- each additional hammer toe add		41.70	
93914	Hallux Valgus - e.g., Mayo, Keller	24.51	217.15	4
93916	- e.g., Joplin, McBride	24.51	297.37	4
93918	Major forefoot reconstruction, must include the first MP joint and a minimum of 2 other MP joints	24.51	459.45	5
93920	Overlapping 5th toe	24.51	136.35	4

Code		Assist	FP/ Spec.	Anaes.
	FOOT AND ANKLE (Cont'd)			
	Reconstruction - Club Foot			
93930	Posterior or medial release	32.68	312.70	4
93932	Posteromedial release, lateral shortening, tendon transfers and fusion	32.68	371.20	4
93936	Plantar fascia release	24.51	165.20	4
	Reconstruction – Ligaments			
93950	Ankle - 1	24.51	301.60	4
93952	- extensive/multiple	24.51	511.45	4
	Reconstruction – Tendons			
93960	Exploration - tendon sheath	24.51	126.25	4
93962	Tenolysis - extensive release - 1	24.51	202.25	4
93964	- each additional digit (max. of 2) add		87.20	
93966	Tendon transfer foot and ankle - single	24.51	253.30	4
93968	- each additional (max. of 1) add		94.60	
93970	Tenodesis	24.51	258.90	4
93972	Graft	32.68	253.30	4
93974	- each additional add		94.60	
93976	Lengthening or shortening - 1	24.51	223.65	4
93978	- each additional add		77.05	
93980	Suture extensor tendon - 1	24.51	164.10	4
93982	- each additional add		70.95	
93984	Suture flexor tendon - 1	24.51	307.60	4
93986	- each additional add		128.95	
93988	Achilles tendon repair - early	24.51	227.40	4
93990	- late	24.51	387.00	4
93992	Tenotomy - open - 1 toe		87.20	4
93994	- more than 1 toe		193.00	4
93996	- closed - 1 toe (IOP)		49.20	4
93998	- more than 1 toe (IOP)		97.35	4
94000	Achilles or tibialis anterior/posterior tenotomy - open	24.51	171.70	4
94002	- closed		132.70	4
	Reduction – Fractures			
94020	Ankle - no reduction, rigid immobilization		67.75	
94022	- closed reduction	24.51	144.80	4
94024	- open - 1 malleolus	32.68	237.50	4
94026	- open - multiple malleoli or ligaments	32.68	**467.29**	5
94027	- extensive debridement of compound fracture add		217.00	
	Ankle fracture with tibial Plafond burst			
94028	- closed reduction	24.51	242.25	4
94030	- open reduction	32.68	**531.48**	6
94031	- extensive debridement of compound fracture add		181.48	

FOOT AND ANKLE (Cont'd)

Code		Assist	FP/ Spec.	Anaes.
	Reduction - Fractures (Cont'd)			
94032	Metatarsus - no reduction - 1 or more		49.20	
94034	- with rigid immobilization		67.75	
94036	- closed reduction - 1 or more	24.51	98.35	4
94038	- open reduction - 1	32.68	178.20	4
94040	- 2 or more	32.68	249.65	4
94041	- extensive debridement of compound fracture add		124.83	
94042	Os calcis - no reduction, rigid immobilization		97.35	
94044	- closed reduction		161.45	4
94046	- open reduction with repair of both the subtalar and calcaneocuboid joints	32.68	500.00	4
94047	- extensive debridement of compound fracture add		250.00	
	Phalanx			
	- no reduction, rigid immobilization			
94048	- 1		49.20	
94050	- each additional		12.05	
94052	- closed reduction - 1		72.35	4
94054	- each additional add		14.90	
94056	- open reduction	32.68	172.30	4
94057	- extensive debridement of compound fracture add		86.15	
	Tarsus excluding os calcis			
94058	- no reduction - rigid immobilization		98.10	
94060	- closed reduction	24.51	165.20	4
94062	- open reduction	32.68	**318.75**	4
94063	- extensive debridement of compound fracture add		118.75	
	Intraarticular fracture - IP joint			
94064	- closed reduction		77.95	
94066	- open reduction	24.51	144.80	4
94067	- extensive debridement of compound fracture add		72.40	
	Reduction – Dislocations			
	Ankle			
94080	- closed reduction	32.68	111.35	4
94082	- open reduction	32.68	252.45	4
94084	- recurrent dislocation and/or subuxation	32.68	367.45	5
	Interphalangeal			
94086	- closed reduction		57.50	4
94088	- each additional add		10.25	
94090	- open reduction	32.68	151.25	4
	Metatarsophalangeal			
94092	- closed reduction		57.50	4
94094	- each additional add		10.25	
94096	- open reduction	32.68	163.35	4
	Tarsus			
94098	- closed reduction		147.60	4
94100	- open reduction	32.68	252.45	4

SURGICAL PROCEDURES

OPERATIONS ON THE RESPIRATORY SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	NOSE			
94200	EUGA of nasopharynx for malignant disease including biopsies (IOP)		41.25	4
94202	EUGA of nasopharynx, if only procedure performed (IOP)		27.54	4
94208	Insertion of prosthesis for nasal septal perforation (IOP)		18.30	
94210	Fiber-optic endoscopy of nasal cavity and/or nasopharynx (IOP)		29.87	
94212	- with fiber-optic examination of larynx ..... add		15.00	
94214	- with biopsy of larynx ..... add		10.00	
	Incision (IOP)			
94220	Drainage of abscess or haematoma of septum - general anaesthetic		52.90	4
94222	Submucous turbinectomy		52.90	4
94224	Biopsy		48.45	4
	Excision			
	Nasal polyp (IOP)			
	Excision under local anaesthetic			
94230	- single		20.00	
94232	- multiple (unilateral)		52.90	
	Excision under general anaesthetic			
94234	- single		52.90	4
94236	- multiple (unilateral)		56.71	4
94238	- single choanal polyp		52.90	4
	Septum			
94260	- submucous resection including septoplasty		293.65	4
94262	Partial septorhinoplasty (excluding osteotomies)		526.00	7
94264	Complete septorhinoplasty		541.65	7
94266	- with autogenous bone graft		768.45	7
94268	- bone graft autogenous	32.68	360.45	4
94270	- non-autogenous - prosthetic implant	32.68	232.00	4
94276	Septodermoplasty		306.85	4
94278	Closure of septal perforation		358.70	4
94280	Localization of cerebrospinal rhinorrhea (fluorescein injection)		86.10	4
94284	Narrowing operations or implant for atrophic rhinitis - unilateral		241.85	4
94286	Excision of intranasal lesions by lateral rhinotomy approach	32.68	470.00	7
	Excision of choanal atresia			
94290	- anterior nasal approach	32.68	343.05	4
94292	- puncture and insertion of tube only		58.86	4
94296	Biopsy under local anaesthetic (IOP)		17.94	
94298	Biopsy under general anaesthetic (IOP)		48.45	4
	Repair			
94310	Choanal atresia - dilation		70.25	4
	Rhinoplasty for Reconstruction of Cleft Lip – Nasal Deformity			
94314	Rhinoplasty for reconstruction of cleft lip nasal deformity in adolescence or adulthood	32.68	391.02	7

Code		Assist	FP/ Spec.	Anaes.
	NOSE (Cont'd)			
	Removal of Foreign Body (IOP)			
	- simple		VF	
94330	- complicated, or involving general anaesthesia		48.45	4
	Destruction (IOP)			
94340	Cauterization of turbinates - uni or bilateral		52.90	4
94342	Cryosurgery of turbinates - uni or bilateral		52.90	4
	Treatment of Epistaxis (IOP)			
94350	Cauterization of nasal septum chemical or electrocautery		10.95	4
94352	Anterior packing		VF	4
94356	Anterior and posterior packing only		33.75	4
94360	Ligation of external carotid artery	49.02	282.85	6
94366	Endoscopic transnasal ligation of the sphenopalatine artery for posterior epistaxis – unilateral		123.70	
	ACCESSORY NASAL SINUSES			
	Antrum or sinus lavage (IOP)			
94370	- Proetz displacement		5.45	
94372	- Antrum or sinus lavage under local anaesthetic – unilateral		41.10	
94374	- Antrum or sinus lavage under general anaesthetic – uni or bilateral		41.10	4
	Sinusotomy, sinusostomy, sinusectomy as indicated			
	Maxillary			
94380	- intranasal - unilateral	32.68	119.09	4
94382	- radical, Caldwell-Luc - unilateral	32.68	235.40	4
94384	- maxillectomy	81.70	939.10	10
	Frontal			
94388	- trephine and sinusectomy		134.24	4
94390	- radical		438.00	5
94392	- external fronto - ethmoidal with sphenoid if necessary	32.68	438.00	6
94394	Coronal and/or osteoplastic procedure for frontal sinusectomy, reconstruction or obliteration – unilateral or bilateral	57.19	681.60	10
	Ethmoidal			
94398	- intranasal - unilateral		150.60	4
94400	- external - unilateral	32.68	343.05	4
94406	Sphenoidal - intranasal		308.46	4
	Introduction			
94420	Radium application to nasopharynx (IOP)		11.99	4
	Suture			
	Closure of antro-oral fistula			
94430	- very simple		28.34	4
94432	- with Caldwell-Luc		203.83	5
94434	- with palatal flap		232.17	5

Code		Assist	FP/ Spec.	Anaes.
	ACCESSORY NASAL SINUSES (Cont'd)			
	Repair			
94436	Trans-nasal endoscopic repair of CSF rhinorrhea (includes harvesting of graft material) with or without 3D CT/MRI image guided system		822.45	15
	LARYNX			
	Endoscopies (IOP)			
	Laryngoscopy			
	Direct (under general anaesthesia)			
94440	- with or without biopsy		63.52	6
94442	- with removal of foreign body		106.45	6
94444	- with removal of **lesion(s)**		218.60	6
94446	- with dilation of larynx and bronchoscopy		202.35	6
	Indirect			
94448	- with biopsy		22.89	6
94450	- with simple removal of bone		41.99	6
94452	Using operating microscope – add to charges for laryngoscopy		28.34	
94454	When using laser with microlaryngoscopy for benign disease, to 94444 ..... add		121.65	
	Introduction			
94456	Teflon augmentation larynx		163.20	6
94458	Botulinum toxin injection(s) for spasmodic dysphonia		120.00	
	Excision			
	Laryngectomy			
94460	- total	49.02	838.90	13
94462	- partial (laryngo-fissure)	49.02	444.85	8
94464	- with block dissection	49.02	514.48	8
94466	- hemilaryngectomy	49.02	845.85	9
94468	Arytenoidectomy	49.02	395.05	8
94470	Excision of benign growth(s)	49.02	226.35	8
	Repair (including laryngoscopy)			
94480	Laryngoplasty – e.g., repair of stenosis and fractures, transections (not to be billed with 94464 or 94466)		629.85	6
94482	Arytenoidopexy		375.95	8
94484	Creation of tracheo oesophageal fistula	24.51	234.60	4
94486	Insertion of voice prosthesis (IOP)		24.60	

Code		Assist	FP/ Spec.	Anaes.
	TRACHEA AND BRONCHI			
	Endoscopy (IOP)			
	Bronchoscopy			
94500	- with or without biopsy, suction or injection of contrast material		130.65	6
94502	- with removal of foreign body ..... add		40.53	6
94504	- with dilatation of stricture ..... add		38.80	
94506	- with selective endobronchial blocker or catheter insertion ..... add		46.25	
94508	- with palliative endobronchial tumour resection including laser or cryotherapy ..... add		61.45	
94510	- with selective brushings of all 18 segmental bronchi for occult carcinoma in situ; specimens labelled as to site ..... add		70.70	
94512	- with broncho alveolar lavage for obtaining specimens suitable for differential cellular analysis ..... add		120.50	6
94513	- with transbronchial lung biopsy under image intensification only ..... add		76.15	
94514	- transbronchial needle aspiration (TBNA) of mediastinal and/or hilar lymph nodes ..... add		104.00	
94515	- TBNA of lung mass ..... add		104.00	
94516	Endobronchial ultrasound (EBUS), for guided biopsy of hilar and/or mediastinal lymph nodes		203.05	
94517	- additional biopsy(s) performed by EBUS, to a maximum of 3, to 94516 ..... add		50.75	
94520	Tracheo-bronchial toilet		28.34	
94522	Transtracheal aspiration		11.99	
94524	Triendoscopy (where 3 separate instruments are used to examine the larynx, esophagus and bronchi)		291.58	
94526	Closure of persistent tracheostoma		127.45	
94528	Change of tracheostomy tube		10.75	
	Incision			
	Tracheostomy (IOP)			
94530	- emergency	40.85	273.15	5
94532	- elective	40.85	273.15	5
94536	Insertion of Montgomery “T” tube or similar laryngeal or tracheal stent	32.68	205.65	8
	Excision			
94540	Segmental resection cervical trachea	73.53	722.95	10
94542	- with resection of cricoid ..... add		229.00	
94546	Resection of mediastinal trachea with either sternotomy or thoracotomy	73.53	684.52	13
	Repair			
94550	Tracheal rupture, transcervical	73.53	565.00	10

Code		Assist	FP/ Spec.	Anaes.
	CHEST WALL AND MEDIASTINUM			
	Incision			
94560	Excisional biopsy of rib for tumour (IOP)	24.51	137.67	4
	Excision			
94570	Chest wall tumour involving ribs or cartilage and reconstruction of chest wall	73.53	500.86	13
94578	Excision of first rib and/or cervical rib to include scalenotomy when required	49.02	395.02	6
94580	Mediastinal tumour	106.21	640.06	13
94582	Anterior mediastinotomy – sole procedure	24.51	191.84	6
	Endoscopies (IOP)			
94590	Mediastinoscopy	49.02	181.38	6
94592	- with bronchoscopy	49.02	240.35	6
94593	- with transbronchial biopsy under image intensification (including bronchoscopy)	49.02	271.15	6
94594	- with mediastinotomy	49.02	344.46	6
94596	- with bronchoscopy and mediastinotomy	49.02	338.55	6
	Repair			
	Chest Wall			
94600	- pleura – closed		IC	5
94602	- pleura – open		IC	13
94610	Pectus excavatum or carinatum repair (by reconstruction, not implant)	49.02	668.31	11
	Surgical Collapse			
	Thoracoplasty			
94620	- 1 stage	81.70	213.64	10
94622	- multi-stage – each	73.53	141.70	9
	Pneumolysis			
94626	- intra pleural	40.85	141.70	5
94628	- extra pleural	40.85	213.64	5
	Apicolysis			
94630	- extra fascial	40.85	213.64	5
94632	- extra pleura	40.85	213.64	5
94634	Phrenicotomy (IOP)	40.85	59.95	5

Code		Assist	FP/ Spec.	Anaes.
	LUNGS AND PLEURA			
	Introduction – Thoracentesis (IOP)			
	Thoracic			
94660	- aspiration for diagnostic sample		20.26	
94662	- therapeutic drainage including sample		34.62	4
	Administration of chemotherapy, including therapeutic drainage and sample			
94664	- initial		55.14	4
94666	- repeat		24.53	4
94668	Lung lavage with or without bronchoscopy for pulmonary alveolar proteinosis		184.94	13
	Endoscopy (IOP)			
94680	Thoracoscopy or pleuroscopy with or without pleural biopsy, suction, etc.		201.00	5
94682	Transbronchial lung biopsy(s) including bronchoscopy		160.00	6
	Incision			
94690	Biopsy of lung, needle (IOP)		68.14	4
94694	Biopsy of pleura, needle (IOP)		35.17	4
	Thoracotomy			
94700	- insertion of chest tube (IOP)	24.51	80.40	4
94702	- rib resection for drainage or biopsy (IOP)	49.02	289.44	6
94704	- exploratory or removal of foreign body	106.21	378.12	13
94706	- thoracotomy with or without biopsy	106.21	378.12	13
94708	- thoracotomy for post-operative haemorrhage or empyema	106.21	378.12	13
94710	- thoracotomy with repair of ruptured diaphragm	106.21	512.85	13
94712	Insertion of permanent pleural drainage catheter		200.00	6
94714	Removal of permanent pleural drainage catheter		67.39	6
	Notes: i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter. ii) The fees for codes 94712 & 94714 include payment for local anaesthesia, thoracocentesis, aspiration, drainage and ultrasonic guidance by the physician who performs the procedure.			
94716	Decortication of lung with muscle graft and closure of pleural fistula	122.55	574.54	15
94718	Intercostal drainage with sclerosing agent (IOP)	49.02	132.97	6
	Excision			
	Biopsy of pleura or lung			
94730	- peripheral or parietal – including thoracotomy (IOP)	106.21	196.53	13
94732	- hilar – including thoracotomy	106.21	286.49	13
94734	Pneumonectomy – complete	106.21	926.17	14

Code		Assist	FP/ Spec.	Anaes.
	LUNGS AND PLEURA (Cont'd)			
	Excision (Cont'd)			
	Lobectomy			
94746	- complete	106.21	926.17	13
94748	- segmental resection	106.21	926.17	13
94750	- wedge resection	106.21	482.40	13
94754	- plus decortication	122.55	IC	15
94770	Excision of broncho-pleural fistula	81.70	IC	13
94772	Pleurectomy-pleural decortication	81.70	562.80	15
94774	Sleeve resection with lobectomy	114.38	993.90	13
94780	Lung transplantation	IC	IC	IC

SURGICAL PROCEDURES

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	GENERAL FEES			
94800	With hypothermia and without bypass, basic fee for cardiovascular procedures			25
94802	With hypothermia - extra		202.96	
94804	Pump bypass (extra for surgeon/basic for anaesthesiologists) – (bypass includes cannulating and de-cannulating heart or major vein, major artery, supervision of pump and pump run)		461.30	28
94805	Coronary artery repair commenced on a beating heart (extra for surgeon/basic for Anaesthesiologist)		461.30	28
94806	Circulatory assist device e.g., intra-aortic balloon (includes cannulation, post-operative care and supervision) (IOP)		245.94	5
94810	Decannulation of circulatory assist device (IOP)		97.12	5
94814	Repositioning of intra-aortic balloon pump (no claim to be made for repositioning within 24 hours of original insertion)		98.82	5
94818	Re-operation for failed vascular grafts – for repair or replacement of existing prosthesis (more than one month after original operation) in addition to appropriate benefit		140.25	
94820	Removal of failed vascular graft without arterial reconstruction - when sole procedure (IOP)		142.69	6
94822	Re-operation involving open heart procedures with pump (more than one month after initial operation) in addition to appropriate benefit)		140.25	
	HEART AND PERICARDIUM			
94830	Cardiotomy with exploration	147.06	563.20	20
94832	- with removal of foreign body	147.06	694.62	20
94834	- with removal of tumor	147.06	553.55	20
	Closure atrial septal defect			
94836	- secundum	147.06	719.63	20
94838	- endocardial cushion and valve defect	147.06	1,180.92	20
94840	- with anomalous pulmonary venous drainage	147.06	941.04	28
94842	Closure of ventricular septal defect	147.06	963.19	28
94844	Total repair trilogy	147.06	761.77	28
94846	Total repair Tetralogy of Fallot+	147.06	1,100.34	28
94848	- with previous arterial shunt	147.06	1,303.48	28
94850	Repair total anomalous pulmonary venous drainage	147.06	1,100.34	28
94852	Total correction transposition of great vessels	147.06	1,100.34	28
94854	Pulmonary valvotomy	147.06	660.20	28
94856	Pulmonary valvotomy and infundibular resection	147.06	761.77	28
94858	Tricuspid valvotomy	147.06	722.84	20
94860	Tricuspid annuloplasty	147.06	643.27	20
94862	Tricuspid valve replacement	147.06	843.25	28
94864	Mitral valvotomy	147.06	722.84	20
94866	Mitral valvotomy - re-stenosis	147.06	812.56	20
94868	Mitral annuloplasty	147.06	812.56	20
94870	Mitral replacement	147.06	1,088.66	28
94872	Aortic valvotomy	147.06	795.62	20
94874	Aortic infundibular resection (ventriculomyotomy)	147.06	914.13	28

HEART AND PERICARDIUM (Cont'd)

Code		Assist	FP/ Spec.	Anaes.
94876	Aortic valve replacement	147.06	1,324.85	28
94878	Aortic and mitral valvotomy - closed	147.06	931.05	20
94880	Aortic, mitral and tricuspid valvotomy - closed	147.06	1,100.34	20
94900	Coronary - endarterectomy	147.06	880.27	20
94902	- done in conjunction with coronary artery repair ... add		184.52	
	Coronary artery repair (aortic-coronary bypass graft) (includes internal mammary)			
94904	- 1	147.06	1,014.86	20
94906	- 2	147.06	1,568.41	20
94908	- 3 or more	147.06	1,780.62	20
	Implantation of internal mammary - sole procedure			
94910	- single	147.06	675.44	20
94912	- double	147.06	829.49	20
94914	Aspiration of pericardium (IOP)		151.47	
94916	Open biopsy of pericardium and drainage (transthoracic or epigastric)	147.06	295.23	13
94918	Ventricular tumour	147.06	609.41	28
94920	Ventricular aneurysm	147.06	998.78	28
94922	Aneurysm of sinus of Valsalva	147.06	880.27	28
	Pericardectomy			
94924	- 1 side open	106.21	608.90	20
94926	- both sides open or sternal split	106.21	1,199.37	20
94940	Implantation of epicardial electrode(s) - plus implantation of pack	49.02	511.63	20
	Pack replacement - see fee code 54358			
94942	Replacement or repair of epicardial pacemaker lead (IOP)	24.51	79.04	5
94943	Implantation of cardioverter-defibrillator by transvenous approach	40.85	712.54	12
94944	Removal and/or replacement of implantable cardiovertor-defibrillator (IOP)	24.51	411.77	5
94946	Implantation of coronary sinus lead for biventricular pacing	49.02	299.25	8
	Ligation or division of patent ductus			
94950	- child	106.21	507.44	20
94952	- adolescent or adult	106.21	844.80	20
	Resection coarctation			
94954	- child	106.21	660.20	20
94956	- infant under 1 year	106.21	761.77	20
94958	- adolescent or adult	106.21	931.05	20
	Congenital heart shunt procedures			
94960	- Potts	106.21	732.15	20
94962	- Blalock	106.21	655.04	20
94964	- Glenn	106.21	666.47	20
94968	Creation of ASD - by balloon septostomy	73.53	321.64	9
94970	Orthotopic cardiac transplantation	IC	IC	IC
94972	Donor cardiectomy	IC	IC	IC
94974	Cardiopulmonary transplantation	IC	IC	IC
94976	Donor heart-lung removal	IC	IC	IC
94980	Cardiac massage - open	106.21	217.73	13
94984	Thoracotomy - with or without biopsy	106.21	365.34	13
94986	- for post-operative hemorrhage	106.21	365.34	13

Code		Assist	FP/ Spec.	Anaes.
	HEART AND PERICARDIUM (Cont'd)			
94988	Pulmonary artery banding	106.21	502.77	20
94990	- with pressure studies by Anaesthesiologist, extra			5
94992	Correction of cor triatriatum	147.06	702.52	20
94994	Vascular ring	147.06	719.63	20
	Repair			
95000	Complete A-V canal	147.06	1,184.98	28
95002	Single ventricle	147.06	1,332.26	28
95004	Double outlet - right/left ventricle	147.06	1,184.98	28
95006	- ventricle with transposition	147.06	1,332.26	28
95008	Truncus arteriosus	147.06	1,332.26	28
95010	Interrupted aortic arch	147.06	1,184.98	28
95012	Aorto-pulmonary window	147.06	743.16	28
95014	R-V outflow tract with valve and tubular graft	147.06	829.49	28
95016	Debanding arterioplasty of pulmonary artery	147.06	744.85	28
	ARTERIES			
	Cannulation for infusion chemotherapy			
95050	- superficial temporal artery	24.51	73.65	4
95052	- hepatic artery	49.02	178.17	6
95054	- carotid	40.85	114.28	5
95056	Regional isolation perfusion, e.g. iliac	81.70	321.19	10
95058	Exploration of major artery	49.02	271.60	IC
	Incision			
95070	Arteriotomy (IOP)		90.19	4
	Note: 95070 is not allowed in addition to other major cardiovascular surgery when performed at same time.			
	Repair – traumatic			
95080	Suture of lacerated major artery or microscopic repair of digital artery	32.68	316.85	10
95082	Repair of lacerated major artery (including patch angioplasty)	81.70	598.40	10
95084	- by by-pass or interposition graft	81.70	467.08	10
	Ligation			
95090	Ligation of artery (as sole procedure)	24.51	120.02	8
95092	- internal maxillary artery (Caldwell-Luc approach)	57.79	388.40	10
95094	- anterior ethmoid artery	49.02	285.35	6
95096	- internal iliac artery (uni or bilateral)	57.19	269.70	10

ARTERIES (Cont'd)

Excision and/or Repair

Preamble

1. Repair of arteries implies either endarterectomy and/or by-pass graft.
2. Fee for gas endarterectomy of coronary artery should be the same fee as for coronary endarterectomy.
3. The fee listed for by-pass grafts include endarterectomy and/or thrombectomy of the artery being repaired.
   (a) Common femoral artery repair (e.g. 95158, 95160) includes repair to the profunda femoris artery as far as the first major branch.
   (b) If the repair extends beyond the first major branch of the profunda femoris artery, 95110 may be claimed in addition.
   (c) If the repair extends beyond the second major branch of the profunda femoris artery, 95188 instead of 95110 may be claimed in addition.

For procedures involving the application of a complete aortic cross clamp, the anaesthetic basic fee will depend on:
(a) the level of application of the cross clamp,
(b) the surgical exposure and extent of the aortic repair.

Code	Surgical Exposure	Aortic Cross Clamp	Assist	FP/ Spec.	Anaes.
95100	- Abdominal	- Supracoeliac			20
95102		- Infracoeliac			17
95106	- Thoracic				25
95108	- Thoraco-abdominal				30
95110	Anterioplasty with or without patch graft including microvascular anastomosis, arterial and/or venous, (other than listed below)		81.70	405.96	10
95112	Carotid - endarterectomy		81.70	666.65	10
95114	- carotid body tumour		81.70	715.76	10
95116	- aneurysm - reconstruction or excision with graft		81.70	763.04	10
	Aortic arch reconstruction				
95118	Innominate		81.70	799.46	10
95120	Subclavian		81.70	785.77	10
95122	Vertebral		81.70	720.89	10
95124	- with thoracotomy	add	24.51	140.54	7
95126	- ruptured	add		221.62	3
	Thoracic aorta aneurysm - repair or excision with graft				
95128	- ascending		81.70	1,318.53	20
95130	- arch		81.70	1,637.14	20
95132	- descending with or without temporary shunt		81.70	1,047.18	20
95134	- ruptured	add		221.62	3
95136	Thoraco - abdominal aneurysm		147.06	2,213.78	30

Code		Assist	FP/ Spec.	Anaes.
	ARTERIES (Cont'd)			
	Excision and/or Repair (Cont'd)			
95138	Abdominal aorta - aneurysm	81.70	1,084.28	17
95140	- plus unilateral common femoral repair	81.70	1,181.43	17
95142	- plus bilateral common femoral repair	81.70	1,275.09	17
95144	- plus implantation of inferior mesenteric artery ... add		160.68	
95146	- ruptured ... add		287.77	3
95148	Endovascular aneurysm repair using stent grafting	81.70	1,396.90	17
	Mesenteric or celiac artery repair			
95150	- aneurysm	81.70	341.33	10
95152	- excision of celiac ganglion or removal of band only	81.70	341.33	10
95154	- endarterectomy or graft	81.70	785.77	10
	Aorto-iliac repair			
95156	- including common iliac repair (uni or bilateral)	81.70	916.56	17
95158	- plus unilateral common femoral repair	81.70	1,075.81	17
95160	- plus bilateral common femoral repair	81.70	1,190.83	17
95162	- plus implantation of inferior mesenteric artery ... add		160.68	
95164	- embolectomy or thrombectomy of bifurcation (aorta or graft)	81.70	417.94	10
95166	Total removal of infected aortic graft (stem and limbs) (arterial reconstruction extra)	81.70	763.95	17
95168	Closure of duodenum ... add		105.61	
95170	Partial removal of infected aortic graft (one limb only) (arterial reconstruction extra)	81.70	311.71	10
95172	Renal artery - aneurysm - reconstruction or excision with graft	81.70	720.89	10
95174	Renal artery repair	81.70	720.89	10
95176	Splenic artery aneurysm - reconstruction or excision with graft	81.70	341.33	10
95178	Iliac repair to include internal iliac aneurysm	81.70	729.66	10
95180	Ilio-femoral by-pass graft	81.70	729.66	10
	Per-obturator ilio-femoral graft			
95182	- with saphenous vein	81.70	814.65	10
95184	- with prosthetic graft	81.70	729.51	10
95186	Common femoral/profunda femoris repair (profundoplasty) when sole procedure performed	81.70	506.56	10
95188	Extended profundoplasty	81.70	706.66	10
95190	Axillo-femoral, femoro-femoral or axillo-axillary graft	81.70	656.55	10
95192	Aorto-femoral unilateral graft (for bilateral see 95160)	81.70	785.77	17
95194	Femoral aneurysm - reconstruction or excision with graft	81.70	543.70	10
95196	Repair of false aneurysm at groin anastomosis	81.70	809.39	10
95198	Femoral-popliteal endarterectomy	81.70	687.99	10
	Femoro-popliteal (with or without endarterectomy)	81.70		
95200	- with saphenous vein	81.70	776.59	10
95204	- with prosthetic graft	81.70	607.67	10
	Femoro-anterior/posterior tibial/peroneal by-pass graft (with or without endarterectomy)			
95206	- with saphenous vein	81.70	801.14	10
95210	- with prosthetic graft	81.70	809.02	10
95212	Popliteal aneurysm	57.19	729.66	10
95214	Peripheral arteries other than listed - aneurysm	57.19	371.84	10
95216	Embolectomy - artery or graft (as sole procedure)	57.19	490.00	10
95218	Thrombectomy - artery or graft (as sole procedure)	57.19	490.00	10

Code		Assist	FP/ Spec.	Anaes.
	ARTERIES (Cont'd)			
	Excision and/or Repair (Cont'd)			
95220	Embolectomy and/or thrombectomy when done in conjunction with other vascular procedures ..... add		112.45	
95222	Gastric devascularisation - when sole procedure	81.70	422.52	10
	In-situ saphenous vein arterial by-pass			
95224	- popliteal	81.70	1,164.42	17
95226	- tibial	81.70	1,350.09	17
	VEINS			
	Excision			
	Resection of AV aneurysm or fistula with or without major graft			
95240	- major aneurysm	81.70	974.39	17
95242	- minor aneurysm	81.70	497.25	10
	Ligation			
95250	Saphenous (IOP)		48.18	4
95252	Femoral (IOP)	24.51	68.42	4
95254	Popliteal (IOP)	24.51	68.42	4
95256	Internal jugular (IOP)	40.85	134.61	5
95258	Internal iliac	49.02	357.72	10
95260	IVC - transabdominal	49.02	411.70	10
95262	- transvenous (umbrella)	49.02	330.89	10
95264	High ligation and stripping of long saphenous vein with groin dissection	32.68	208.61	4
95266	Stripping of short saphenous vein with popliteal dissection	32.68	97.37	4
95268	Multiple ligation and avulsion	32.68	200.00	4
95270	Recurrent varicose veins - multiple ligation and/or stripping	40.85	320.38	5
95272	Extra fascial and sub-fascial incompetent perforators by full fascial technique	40.85	348.65	6
95274	- plus stripping ..... add		115.94	
	Repair			
95290	Lacerated major vein, e.g., femoral, popliteal, vena cava, axillary, subclavian, brachial or microscopic repair of digital vein	32.68	273.14	4
95292	- including patch	81.70	450.45	10
95294	- by vein graft	81.70	793.55	10
95296	SVC by-pass graft	57.19	630.91	17
95298	Pulmonary embolectomy	147.06	720.18	20
95300	Ilio-femoral thrombectomy with or without femoral vein ligation	81.70	404.44	10
95304	Thrombectomy, other than above	57.19	302.80	10
95306	Distal spleno-renal shunt	81.70	1,047.37	10

Code		Assist	FP/ Spec.	Anaes.
	VEINS (Cont'd)			
	Anastomosis			
95320	Porto-caval ……	81.70	763.66	10
95326	Meso-caval ……		816.92	10
95328	Creation of AV fistula …….....	32.68	440.00	6
95330	Obliteration of AV fistula ……		82.55	4
95332	Ligation or removal of by-pass graft ……..		82.55	4

SURGICAL PROCEDURES

OPERATIONS ON THE HAEMIC AND LYMPHATIC SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SPLEEN AND MARROW			
	Incision (IOP)			
95350	Splenic puncture and aspiration		43.60	4
	Bone marrow			
95352	- aspiration		40.01	4
95354	- interpretation of marrow smear, including assessment of peripheral smear and iron stain		25.66	
95356	- aspiration and interpretation		65.67	
95358	Core biopsy (with biopsy needle)		63.35	4
	Bone marrow transplantation - team fee			
95360	- aspiration from donor	IC	IC	IC
95362	- infusion into recipient	IC	IC	IC
	Excision			
95370	Splenectomy	57.19	502.50	7
95372	Bone button (IOP)		35.97	4
	LYMPH CHANNELS			
	Excision			
95380	Cystic hygroma	49.02	231.68	6
	LYMPH NODES			
	Incision			
95400	Drainage of sub-fascial abscess (IOP)		77.23	4
	Excision			
95413	Neck - limited dissection, must include 2 levels (unilateral) or central compartment	65.36	568.70	8
95415	Neck - comprehensive dissection, must include 3 or more levels, unilateral	65.36	1,120.80	8
95418	Ilioinguinal, radical resection	49.02	308.91	8
95420	Axillary or inguinal nodes, radical resection	32.68	371.84	4
	Biopsy (IOP)			
95426	- cervical, axillary, inguinal	32.68	64.31	4
95428	- scalene	32.68	124.62	4
95430	- sentinel node biopsy (per draining basin)	49.02	330.45	6
95438	Staging pelvic lymphadenectomy	57.19	172.22	7

SURGICAL PROCEDURES

OPERATIONS ON THE DIGESTIVE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	MOUTH			
	Incision			
95450	Drainage of Ludwig's Angina, complete care		70.85	5
95452	Biopsy (IOP)		33.75	4
	Excision			
95460	Simple excision of lesion (IOP)	32.68	67.55	4
95462	Excision of ranula	32.68	157.80	4
95464	Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible	81.70	1,030.70	12
95466	Extended composite resection of lesion of oral cavity and oropharynx with partial resection of mandible and resection of maxilla	81.70	1,059.45	12
95468	Excision of intra-oral tumour (greater than 2.0 cm. average diameter)	32.68	325.80	6
	Oro-pharyngeal carcinoma			
95470	- excision floor of mouth, mandible and glands of neck	65.36	490.50	12
	Cryosurgery or treatment of premalignant or malignant lesion(s) of oral cavity or sinuses			
95474	- minor		52.32	4
95478	- intermediate		132.98	4
95482	- major - initial		185.30	6
95484	- repeat within 30 days		92.65	6
	LIPS			
	Incision			
95490	Biopsy (IOP)		35.40	4
	Excision			
95500	Wedge resection of lip vermillion	24.51	98.45	4
95502	Resection of lip with plastic repair	32.68	275.00	4
95504	Excision of lesion (IOP)	32.68	90.47	4
95506	Lip shave (Leukoplakia)	32.68	225.00	4
	Reconstruction			
95510	Cleft lip - unilateral	65.36	363.30	8
95511	- with nasal cartilage realignment, to 95510	add	304.30	
95512	Reconstruction with lip switch flap	65.36	444.40	8
95514	Complex reconstruction or revision of previous repair and excision	IC	IC	IC

Note:
Cleft lip reconstruction (95510, 95511, 95512, 95514) is not eligible for payment with 94314).

Code		Assist	FP/ Spec.	Anaes.
	TONGUE			
	Incision (IOP)			
95520	Biopsy		33.75	4
	Tongue tie			
95524	**-** release under local anaesthetic		48.45	
95526	- release under general anaesthetic		48.45	4
	Excision			
	Glossectomy			
95530	- partial	65.36	187.95	8
95532	- complete	65.36	268.30	8
95534	Wedge resection of lesion (IOP)		58.35	4
	Repair			
95540	Glossoplasty	32.68	187.95	4
	Suture			
95550	Extensive laceration	32.68	IC	4
	TEETH AND GUMS			
	Incision			
95560	Drainage of alveolar abscess, general anaesthetic (IOP)		48.45	4
	Excision			
	Extraction of tooth (complete care)			
95564	- single		30.00	4
95566	- each additional tooth ..... add		15.00	
	PALATE AND UVULA			
	Incision			
95570	Palate abscess (IOP)		21.80	4
95572	Fenestration of palate for radiotherapy			4
95574	Biopsy of palate (IOP)		33.75	4
	Excision			
95580	Uvulectomy or biopsy of local lesion (IOP)		33.75	4
	Repair			
95590	Cleft palate	65.36	369.25	8
95592	Removal of sutures		35.40	4
95594	Bone graft to palate	49.02	335.65	8
	Closure of fistula			
95600	- anterior alveolar	32.68	197.45	4
95602	- palate	49.02	281.95	6

Code		Assist	FP/ Spec.	Anaes.
	SALIVARY GLANDS AND DUCTS			
	Incision			
	Sialolithotomy			
95610	- simple	32.68	37.06	4
95612	- complicated	32.68	98.60	4
95614	Biopsy (IOP)	32.68	42.70	4
	Excision			
95620	Submaxillary gland	32.68	391.05	4
	Parotid gland			
95622	- total - with preservation of facial nerve	32.68	885.75	8
95624	- without preservation of facial nerve	32.68	593.00	8
95626	- subtotal - with preservation of facial nerve	32.68	752.10	7
95630	- without preservation of facial nerve	32.68	395.45	6
95634	Excision small tumor	32.68	51.23	4
	Introduction			
95638	Botulinum toxin injection(s) for sialorrhea (unilateral or bilateral)		50.00	
	Repair			
95640	Plastic repair of duct	32.68	202.25	4
95642	Dilation of duct (IOP)		43.15	4
	Probing			
95650	Duct (IOP)		7.09	
	PHARYNX, ADENOIDS AND TONSILS			
	Incision			
95660	Drainage of retropharyngeal, intra-oral or peritonsillar abscess (IOP)		48.45	4
95662	Drainage of lateral pharyngeal abscess	32.68	145.95	4
95668	Biopsy of pharynx (IOP)		33.75	4
	Excision			
	Branchial			
95670	- cyst	32.68	292.00	4
95672	- sinus	32.68	292.00	4
95674	- fistula	32.68	292.00	4
95676	Thyroglossal duct, cyst, sinus or fistula	32.68	292.00	4
95678	- recurrent procedure	32.68	390.55	4
	Tonsillectomy, includes adenoidectomy			
95680	- child under 16		178.35	4
95682	- adolescent or adult		178.35	4
95684	Adenoidectomy only - child or adult		101.25	4
95686	Secondary suture following T and A		121.05	4

Code		Assist	FP/ Spec.	Anaes.
	PHARYNX, ADENOIDS AND TONSILS (Cont'd)			
	Excision (Cont'd)			
95688	Excision of parapharyngeal space lesions with mobilization of parotid gland	32.68	583.05	8
95690	Pharyngectomy - trans-hyoid or lateral	65.36	752.75	11
95692	Pharyngo-laryngectomy	65.36	1,155.45	14
	Repair			
95696	Pharyngoplasty	65.36	360.45	8
	OESOPHAGUS			
	For procedures on the oesophagus the following basic fees for Anaesthesiologists and Assistants will apply except for endoscopies.			
95700	- cervical approach	49.02		7
95702	- thoracic approach	106.21		13
95704	- abdominal approach	57.19		8
	Endoscopies with or without biopsies (IOP)			
95710	Oesophagoscopy		72.04	4
95712	- with removal of foreign body add		43.87	
95713	- with brushing of oesophagus, stomach and/or duodenum add		46.30	
95714	- with injection of varices, initial add		38.60	
95716	- with injection of varices, subsequent add		38.60	
95718	- with dilation add		69.70	
95720	- with bronchoscopy add		59.59	2
95722	- with gastroscopy and gastric photography, same intubation add		41.58	
95724	- with gastroscopy and gastric photography, separate intubation add		52.32	
95726	- with gastroscopy with or without duodenoscopy add		50.93	2
95728	- with gastroduodenoscopy with cannulation of pancreatic and/or common bile duct add		242.76	2
95730	- management of uncomplicated upper gastrointestinal bleeding, by any technique add		61.30	**2**
95732	- management of complicated upper gastrointestinal bleeding by any technique in haemodynamically unstable patients with active bleeding during endoscopy add		84.70	**2**
95734	- with snare polypectomy first polyp (>1 cm) add		59.76	
95736	- each additional polyp, by snare polypectomy (>1 cm) (to a maximum of 2) add		29.88	
	Incision			
	Oesophagostomy			
95750	- cervical - other than neonatal		154.45	
95752	- neonatal		213.64	
95754	- thoracic		213.64	

Code		Assist	FP/ Spec.	Anaes.
	OESOPHAGUS (Cont'd)			
	Excision			
95770	Intrathoracic diverticulum ……		507.00	
95772	Crico pharyngeal diverticulum ……....		390.05	
95776	Partial oesophageal resection and reconstruction (including intestinal transposition) ……..		1,081.55	17
95778	Resection of oesophagus …….....		607.14	
95780	Total resection of oesophagus …….....		1,465.35	17
95781	- with reconstruction …….. add		678.85	
95782	Oesophago-gastrectomy ……..		**1,185.92**	
	Repair			
95794	Oesophagoplasty ……..		330.89	
95796	Heller procedure …….....		617.25	
95797	- with oesophageal hiatus hernia repair to 95796 ……..... add		217.35	
	Oesophageal hiatus hernia			
95798	abdominal or transthoracic approach with fundoplication ……..		750.00	
95802	- recurrent …….....		967.10	
95804	- with oesophagopasty …….. add		110.38	
95806	Ruptured oesophagus ……..		526.46	
95808	Oesophago-gastrostomy ……..		608.30	
95810	Oesophageal bypass, cervical …….....		912.60	
95812	Oesophageal stricture (Thal) – may include oesophageal hiatus hernia repair with or without gastroplasty, cervical …….		676.05	
	Suture			
95820	Closure of oesophago-tracheal fistula …….....		923.05	
	Dilation of oesophagus without oesophagoscopy (IOP)			
95830	- (active) with or without guiding string ……..		35.97	
95832	- (passive) using mercury filled tubes …….....		26.16	
95836	- pneumatic dilatator ……		110.85	
95842	- retrograde dilatation …….....		14.17	
	STOMACH			
	Incision			
	Gastrotomy			
95870	- with removal of tumour or foreign body ……..	57.19	406.85	7
95872	- with suture of bleeding peptic ulcer ……..	57.19	653.87	9
95874	Pyloromyotomy (Ramstedt's) ……..	81.70	452.14	10
95876	Gastrostomy ……..	57.19	345.85	7
95878	Full thickness revision gastrostomy ……..	49.02	228.84	6

Code		Assist	FP/ Spec.	Anaes.
	STOMACH (Cont'd)			
	Excision			
	Biopsy (IOP)			
95890	- by gastroscopy		84.62	4
95892	- by gastrotomy if sole procedure claim also 96636		47.09	
95894	- by intubation		22.01	
	Gastrectomy			
95900	- wedge resection for ulcer	57.19	520.00	7
95906	- partial or subtotal, with or without vagotomy	57.19	840.00	8
95916	- plus repair of hiatus hernia	57.19	946.55	8
95918	- after previous gastroenterostomy	57.19	946.55	8
95920	- after previous partial gastrectomy	57.19	657.55	8
95922	- total gastrectomy	57.19	1,235.00	9
95932	Excision of gastroduodenal lesion, recurrent ulcer	57.19	651.33	8
95934	Excision of gastrojejunal lesion, recurrent ulcer	57.19	651.33	8
95936	Vagotomy	57.19	387.55	7
	Bariatric Surgery			
95938	Gastric bypass for morbid obesity	57.19	1,000.00	10
95940	Sleeve Gastrectomy	57.19	1,000.00	10
95942	Adjustable gastric banding	57.19	1,000.00	10
95944	- with oesophageal hiatus hernia repair to 95938 or 95940 or 95942 add		217.35	
	Repair			
95950	Pyloroplasty	57.19	406.85	7
95952	Pyloroplasty and vagotomy	57.19	528.85	7
95956	Gastroduodenostomy or gastrojejunostomy	57.19	406.85	7
95962	Either of above plus vagotomy	57.19	554.15	7
95964	Pyloroplasty and vagotomy plus repair of oesophageal hiatus hernia	57.19	483.64	7
95966	Pyloroplasty or gastroenterostomy with vagotomy and cholecystectomy	57.19	492.07	8
	Suture			
95980	Closure of gastrostomy or other external fistula of stomach	40.85	345.85	6
95982	Gastrorrhapy (for perforated ulcer or wound)	57.19	503.15	7
95984	Closure of gastrocolic fistula	57.19	574.40	7

Code		Assist	FP/ Spec.	Anaes.
	INTESTINES (EXCEPT RECTUM)			
	Endoscopy, includes dilation for access (IOP)			
96000	Duodenoscopy, with or without biopsy		109.00	4
96006	Small bowel push enteroscopy		185.14	**4**
	Endoscopic retrograde cholangiopancreatography (ERCP)			
96010	- with cannulation of pancreatic and/or common bile duct		213.15	4
96020	- with intraductal cytology brushing or intraductal biopsy..... add		49.75	
	Colonoscopy using flexible scope			
96030	- of sigmoid to descending colon		60.61	4
96032	- to splenic flexure ..... add		60.13	
96034	- to hepatic flexure ..... add		43.12	
96036	- to caecum ..... add		34.50	
96038	- into terminal ileum ..... add		31.65	
96040	- if biopsy(s) and/or coagulation of angio-dysplastic lesion(s) ..... add		27.05	
96041	- management of uncomplicated lower gastrointestinal bleeding, by any technique ..... add		46.30	
96042	- multiple screening biopsies (> 34 sites) for malignant changes in ulcerative colitis, to 96030 only ..... add		54.25	
96044	- hydrostatic - pneumatic dilatation of colon stricture(s) through colonoscope ..... add		107.50	
96046	Fulguration or snaring of polyp through colonscope		49.80	
96048	- each additional polyp, (max. of 4) ..... add		24.25	
96050	Excision of polyp through colonscope		150.15	4
96052	- each additional polyp, (max of 2) ..... add		77.50	
96054	Total excision of very large sessile polyp (>3cm) through colonoscope, and may include fulguration, each ..... add		227.65	
	Incision			
	Enterotomy			
96060	Ileostomy	49.02	406.85	7
	Small intestine			
96062	- including excision of polyps or biopsy	49.02	406.85	7
96064	Insertion of feeding enterostomy (as sole procedure)	49.02	376.77	7
96066	- when done with another intraabdominal procedure ..... add		82.35	
	Large intestine			
96068	- including excision of polyps	49.02	406.85	7
96074	Colostomy	49.02	478.45	6
96076	Caecostomy	49.02	387.40	6

Code		Assist	FP/ Spec.	Anaes.
	INTESTINES (EXCEPT RECTUM) (Cont'd)			
	Incision (Cont'd)			
96078	Revision of stenosis or obstruction more than 4 weeks after original operation	49.02	82.73	6
96080	Entero-enterostomy	49.02	406.85	7
	Excision			
96090	Biopsy by intubation (IOP)		84.68	4
96092	Local excision of lesion of intestine	49.02	528.85	7
96094	Resection of exteriorized intestine	49.02	165.44	6
	Enterectomy with anastomosis			
	Small intestine			
96096	- duodenum	49.02	746.10	7
96098	- other	49.02	687.55	7
	Small and large intestine			
96100	- terminal ileum, caecum and ascending colon	49.02	799.55	7
96102	Large intestine - any portion	49.02	799.55	7
96106	Ileostomy, subtotal colectomy	49.02	1,057.70	7
96108	Total colectomy with ileorectal anastomosis	65.36	1,242.90	9
96112	Ileostomy plus total colectomy plus abdomino-perineal resection	65.36	1,566.58	10
96114	- 2 stage procedure - (1st stage)	65.36	878.86	10
96116	- (2nd stage)			**6**
96122	- repair of entero-cutaneous fistula in conjunction with bowel resection ..... add		347.63	
	Intestinal Obstruction (Mechanical)			
96130	Without resection - adult	49.02	538.26	6
96132	- child	49.02	476.15	6
96134	With entero-enterostomy	49.02	538.26	7
96136	With resection	49.02	645.91	7
96140	Intestinal atresia (newborn)	49.02	682.90	7
96142	Meconium ileus	49.02	682.90	7
	Repair			
	Revision of ileostomy or colostomy			
96152	- skin level	40.85	131.75	5
96154	- full thickness	49.02	350.65	6
96162	Caecopexy or sigmoidopexy (as sole procedure)	49.02	314.80	6
96164	Formation of an ileal pouch and primary anastomosis following total colectomy		1,549.49	7
	Suture			
96170	Suture of intestine	49.02	**376.57**	6
	Closure of colostomy or enterostomy			
96174	- with resection	49.02	406.85	7
96176	- without resection	40.85	406.85	7
96178	Plication of small intestine for adhesions	49.02	**433.55**	7

Code		Assist	FP/ Spec.	Anaes.
	INTESTINES (EXCEPT RECTUM) (Cont'd)			
	Manipulation (IOP)			
96190	Reduction of prolapse		25.25	4
96192	Dilation of enterostomy, colostomy, etc.		25.25	4
96196	Intubation of small intestine (with or without fluoroscopy)		79.80	4
	MECKEL'S DIVERTICULUM AND THE MESENTERY			
	Excision			
96200	Meckel's diverticulum	40.85	376.78	6
96204	Local excision of lesion	40.85	305.05	6
96206	Resection of mesentery	40.85	325.40	6
96208	Biopsy through laparotomy	40.85	165.44	6
	APPENDIX			
	Incision			
96220	Drainage of abscess, complete care	40.85	239.20	6
	Excision			
96230	Appendectomy	40.85	**367.12**	6
96232	- with gross perforation and peritonitis	40.85	451.50	6
	RECTUM			
	Endoscopy, includes dilation for access (IOP)			
96240	Sigmoidoscopy - rigid scope		36.80	4
96242	- with biops**(ies)**		44.55	4
96244	- with anoscopy (separate instrumentation)		29.70	4
	Incision			
	Proctotomy			
96250	- with exploration	32.68	77.06	4
96252	- with decompression (imperforate anus)	32.68	77.06	4
96254	- with drainage (perirectal abscess)	32.68	71.94	4
	Excision			
	Proctectomy			
96260	- Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	49.02	1,100.00	8
96262	Abdomino-perineal resection or pull through	65.36	1,300.00	10
96268	Hartmann procedure	49.02	890.00	9
96270	Reversal of Hartmann procedure	65.36	1,030.00	9
96272	Proctosigmoidectomy for prolapse	49.02	605.61	9
96274	Biopsy of rectosigmoid for Hirschsprung's disease (IOP)	24.51	82.35	4

Code		Assist	FP/ Spec.	Anaes.
	RECTUM (Cont'd)			
	Excision (Cont'd)			
96278	Presacral or transsacral proctotomy and excision of lesion	32.68	350.65	6
	Polyps or tumours of rectum or sigmoid (max. 2 polyps any size or technique) (IOP)			
96280	- electrocoagulation - base under 2 cm.		24.25	4
96282	- excision - base under 2 cm.	24.51	82.35	4
96284	- electrocoagulation or excision - base over 2 cm.	24.51	149.03	4
96286	Transanal Endoscopic Microsurgery	49.02	793.00	7
	Notes: 1. Restricted to fellowship trained colorectal surgeons 2. Paid only if a sealed and insufflating operating proctoscope is employed with visualization via an endoscopic camera. 3. Sigmoidoscopy/colonoscopy not billable with this procedure 4. Limited for use in the following conditions (one or more): a. Lesions not amenable to colonscopic resection b. Select low grade malignancies c. Complex anorectal fistulas			
	Repair			
96290	Anastomosis of rectum	32.68	488.20	6
96292	Proctostomy	32.68	211.26	4
	Rectal prolapse			
96300	Excision of mucous membranes	24.51	239.20	4
96302	Perineal repair, major	32.68	387.55	4
96304	Abdominal approach	49.02	554.10	8
96306	Insertion of Thiersh wire	24.51	190.85	4
	Suture			
	Suture of rectum, trauma			
96310	- external approach	32.68	239.20	4
96312	- intraperitoneal approach	49.02	384.00	6
	Closure of fistula			
96314	- recto vaginal (any repair)	32.68	430.61	6
96316	- recto vesical	32.68	446.90	6
	Manipulation (IOP)			
96320	Dilation and/or disimpaction under general anaesthesia (sole procedure)		58.15	4
96322	Fecal disimpaction - no anaesthetic		36.80	
96324	Removal of foreign body	IC	IC	IC

Code		Assist	FP/ Spec.	Anaes.
	OPERATIONS ON THE ANUS			
	Endoscopy, includes dilation for access			
96330	Proctoscopy (IOP)		7.09	
	Incision			
96340	Biopsy (IOP)		34.90	4
96342	Thrombosed haemorrhoid (IOP)		25.25	4
96344	Sphincterotomy	24.51	170.84	4
96346	- with repair of fissure	24.51	309.63	4
	Excision			
96350	Local excision of lesion, e.g., fissure	24.51	78.41	4
96352	Haemorrhoidectomy, with or without sigmoidoscopy or repair of fissure	24.51	309.63	4
96354	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation (IOP)		99.60	
96356	Barron non-operative haemorrhoidectomy (IOP)		34.60	
96360	Local excision for malignancy	24.51	153.05	4
96364	Anal polyp, haemorrhoidal tags	24.51	47.15	4
96366	Fistula-in-ano	24.51	309.63	4
96368	Perineal pull through for imperforate anus	24.51	124.72	4
	Introduction			
96380	Haemorrhoid injections, max. of 4 in any one year		27.05	
96382	Injections (including botulinum toxin) for pruritus ani or fissure		35.90	6
	Repair			
96396	Excision of scar for stenosis	24.51	142.40	4
96398	Anoplasty, for stenosis	32.68	275.05	4
96400	Repair of anal sphincter	32.68	275.05	4
96402	Repair of anal sphincter and ano-rectal ring	32.68	356.50	
	Destruction (IOP)			
96410	Curettage of fissure or fistula		33.09	4
96412	Cauterization of fissure		34.90	4
96416	Fulguration of condylomata		42.64	4
	Manipulation			
96420	Dilation of anal sphincter (IOP)		12.05	4

Code		Assist	FP/ Spec.	Anaes.
	LIVER			
	Incision			
96430	Biopsy - incisional (IOP)		102.10	
96432	**-** needle (IOP)		72.80	4
96434	Hepatotomy	57.19	249.44	7
	Excision			
	Hepatectomy			
96436	- local excision of lesion	57.19	429.54	7
96438	- lobectomy (includes cholecystectomy)	98.04	1,022.69	8
	Formal Anatomical Resection			
96442	- one or two liver segments		1,184.60	12
96444	- three or four liver segments		1,652.15	12
96448	- five or more liver segments		1,784.60	12
	Note: Cholecystectomy is not eligible for payment in conjunction with liver lobectomy involving liver segments #4 and/or #5, or formal anatomic resection involving liver segments #4 and/or #5.			
96450	Laparotomy, cholangiogram and biopsy (neonatal jaundice)	49.02	228.52	6
	Liver transplant			
96452	- donor	IC	IC	16
96454	- recipient	IC	IC	IC
	Repair			
96460	Marsupialization of cyst or abscess	57.19	249.44	7
	Suture			
96470	Rupture or wound	65.36	249.44	8

Code		Assist	FP/ Spec.	Anaes.
	BILIARY TRACT			
	Endoscopy, to include examination of stomach and duodenum (IOP)			
96480	Manipulation and/or removal of common bile duct stones with or without sphincterotomy …….		482.40	5
96482	Subsequent procedure (within 3 months of previous endoscopic procedure)		76.30	5
	Incision			
96504	Biliary duct calculus manipulation and/or removal via T-tube tract – when sole procedure performed (IOP) ……		116.20	7
96508	Cholecystostomy ……...	57.19	408.05	7
96510	Choledochotomy ……...	57.19	333.43	7
96514	Transduodenal sphincterotomy and choledochotomy (previous cholecystectomy) ……...	57.19	844.65	9
96516	Choledochoduodenostomy ……..	57.19	721.70	9
96518	Cholecystogastrostomy …….....	57.19	447.45	7
96520	Cholecystoenterostomy …….....	57.19	447.45	7
96524	Hepatic choledochoenterostomy …….....	57.19	915.30	9
	Excision			
96530	Cholecystectomy with or without cholangiogram ……	57.19	482.17	7
96532	Cholecystectomy and choledochotomy ……	57.19	592.08	8
96534	Cholecystectomy, choledochotomy and transduodenal sphincterotomy …….	57.19	711.94	9
96536	Cholecystectomy and hiatus herniorraphy …….....	57.19	657.46	7
96542	Choledochectomy ……...	57.19	414.88	8
	Repair			
96550	Common duct stricture ……	57.19	498.89	10

Code		Assist	FP/ Spec.	Anaes.
	PANCREAS			
	Incision			
96560	Biopsy - needle (IOP)		102.10	
96562	- incisional (IOP)		122.05	7
96564	Pancreatotomy	57.19	406.85	7
	Excision			
	Pancreatectomy			
96570	- complete	57.19	1,270.20	11
96572	- partial resection of head	57.19	1,005.00	11
96574	- "Whipple Type" operation	57.19	1,785.45	15
96576	- local excision of lesion	57.19	508.55	8
96578	- islet cell tumor	57.19	411.00	8
96582	Resection of entire body and tail of pancreas, spleen	73.53	986.05	11
96584	Excision pancreatic cyst	57.19	337.95	7
96586	Biopsy of other retroperitoneal lesion (IOP)		76.36	7
	Repair			
96590	Pancreatic - cystogastrostomy	57.19	589.95	8
96594	- cystojejunostomy	57.19	589.95	8
96596	Marsupialization of cyst	57.19	249.44	8
96598	Anastomosis of body and tail of pancreas to intestine (Puestow operation)	73.53	813.60	10
	LINEAR OR RADIAL ECHO-ENDOSCOPE (ENDOSCOPIC ULTRASOUND)			
	Upper gastrointestinal tract linear or radial echo-endoscopy			
96601	- excluding biliary or pancreatic examination (scope also used for therapeutic purposes)		197.73	4
96602	- including biliary and/or pancreatic examination (scope also used for therapeutic purposes)		246.50	4
96603	Lower gastrointestinal tract linear or radial echo-endoscopy (scope also used for therapeutic purposes)		130.00	4
	Add-ons for both upper and lower gastrointestinal tract linear or radial echo-endoscopy			
96604	- biopsy or fine needle aspiration, to a maximum of 3, per lesion ..... add		50.75	
96605	- dilation of stricture..... add		30.65	
96606	- injection of one or more of any of the following: metastases, nodes, masses or celiac plexus..... add		145.05	
96607	- drainage of pseudocyst (including stent insertion if performed) ..... add		203.05	

Code		Assist	FP/ Spec.	Anaes.
	ABDOMEN, PERITONEUM AND OMENTUM			
	General			
96610	Surgeon called to assist at an intra-procedural emergency, e.g., acute bleed during an abdominal procedure already in progress (claim IC)		178.22	
	Paracentesis (IOP)			
96620	Aspiration for diagnostic sample		31.30	
96622	Aspiration with therapeutic drainage with or without diagnostic sample		57.65	4
96626	Paracentesis with lavage for diagnosis		50.71	4
	Incision			
96630	Biopsy of omentum (single or multiple) (IOP)		48.00	
96632	Needle biopsy of peritoneum (IOP)		22.18	
96634	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity (IOP)		48.36	4
96636	Laparotomy (biopsy extra)	49.02	**319.94**	6
96642	Laparotomy for acute trauma	49.02	397.15	6
96644	- with repair of intestine, single add		142.40	3
96646	- multiple or with resection add		284.75	3
96648	- with splenectomy add	16.34	284.75	3
96650	- with repair of lacerated liver add	16.34	187.90	3
96652	- with repair of diaphragm add	16.34	122.05	2
	Peritoneal abscess			
96660	- subphrenic	57.19	370.95	7
96662	- abdominal	49.02	264.45	6
96664	Pelvic abscess, incision drainage - rectal or vaginal approach (IOP)		122.05	4
96670	Removal of infected sutures from abdominal wall - general anaesthetic (IOP)		94.85	4
96672	Umbilical vein intraabdominal dissection and catheterization	49.02	232.50	6
	Insertion of peritoneo - jugular shunt for ascites			
96676	- primary	57.19	281.85	7
96678	- revision within 30 days	57.19	208.15	7
	Excision			
96690	Desmoid tumour, depending on extent	32.68	IC	6
96694	Umbilectomy - plastic	32.68	78.41	4
96700	Panniculectomy	32.68	500.00	6
96701	- with repair of umbilical hernia add		122.05	
96702	Mesenteric cyst	49.02	335.15	6
	Endoscopy			
	Peritoneoscopy or laparoscopy (IOP)			
96710	- without biopsy		**146.12**	6
96712	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants		161.16	6
96714	Laser treatment of extensive pelvic disease (includes laparoscopy)		211.55	6

Code		Assist	FP/ Spec.	Anaes.
	ABDOMEN, PERITONEUM AND OMENTUM (Cont'd)			
	Repair			
96720	Omentopexy, as sole operative procedure	49.02	305.05	6
	Herniotomy			
96722	- Inguinal or femoral - single	32.68	331.80	4
96728	- with hydrocele	32.68	417.29	4
96730	- Unilateral with exploration of other side - infants and children	32.68	329.30	4
	- Strangulated or incarcerated			
96732	- without resection of bowel	49.02	**467.09**	4
96734	- with resection of bowel	49.02	660.50	7
96736	- Inguinal and femoral - same side	32.68	414.76	4
	- Umbilical			
96738	- adolescent or adult	32.68	**313.30**	4
96740	- child (operative)	32.68	165.44	4
96742	- umbilical hernia repair when done in conjunction with other abdominal surgery, to other surgery ..... add		96.85	
	Omphalocoele and gastrochisis			
96748	- 1 stage repair	57.19	375.80	7
	- multiple staged repair			
96750	- gross method of silon mesh	57.19	375.80	7
96752	- second stage repair (completion of abdominal wall closure)	57.19	382.35	7
	Diaphragmatic, other than oesophageal hernia - 1 stage procedure			
96754	- trans-abdominal	73.53	576.90	9
96756	- trans-thoracic	106.21	576.90	13
96760	Ventral	49.02	**403.03**	6
96762	Massive incisional hernia	49.02	500.00	6
96770	Epigastric	32.68	284.97	4
96772	- recurrent - all types ..... add		130.00	
	Note: Fee code 96772 can only be billed as an add-on to fee codes 96722 – 40, and 96754 – 96770.			
	Suture			
96780	Secondary closure for evisceration (sole operative procedure in abdomen)	49.02	350.00	6

SURGICAL PROCEDURES

OPERATIONS ON THE UROGENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	KIDNEYS AND PERINEPHRUM			
	1. No additional claim should be made for nephroscopy when done at the time of pyelolithotomy or nephrolithotomy.			
	2. In a routine surgical approach to the kidney and related procedures, no additional claim should be made for rib resection carried out for access purposes.			
	3. When an adrenalectomy is performed in conjunction with a nephrectomy and is incidental to the removal of the kidney, there should be no additional claim for the adrenalectomy.			
	Percutaneous Procedures (IOP)			
96802	Percutaneous nephrostomy		153.35	
96804	Insertion of stent		**131.22**	
96806	Dilation of tract		129.26	
96808	Selective catheterization of calyces		70.99	
96810	Nephroscopy		129.26	
96812	Removal of renal calculi	40.85	226.16	6
96814	- if disintegrated by any method, to 96812 ..... add		129.26	
96816	- percutaneous removal of staghorn calculus filling renal pelvis and extending into calyces, to 96812 ..... add		175.50	
	Incision			
96820	Renal biopsy, needle (IOP)		143.55	4
96822	Drainage of kidney abscess	57.19	475.00	7
96824	Drainage of perinephric abscess	57.19	475.00	7
96826	Exploration of renal and perirenal tissues with or without biopsy or unroofing of cyst	57.19	207.10	7
	Nephrotomy			
96828	- with drainage - nephrostomy	57.19	366.62	7
96832	- with removal of calculus	57.19	482.40	7
96836	Transection of aberrant renal vessels	57.19	226.72	7
96838	Pyelotomy - with drainage	57.19	300.00	7
96840	- with removal of calculus	57.19	437.20	7
96842	- with diversion of urine	57.19	442.78	7
96844	Removal of staghorn calculus filling renal pelvis and calyces- open, with or without x-ray control and/or anatrophic nephrolithotomy	57.19	657.75	9
	Excision			
96850	Calycectomy with diversion of urine	57.19	512.00	7
96852	Hemi-nephrectomy	57.19	875.00	7
96854	Partial or hemi-nephrectomy with total ureterectomy	57.19	757.85	7
	Nephrectomy			
96860	- simple	57.19	650.00	7
96865	- thoraco-abdominal or radical nephrectomy with or without gland dissection	106.21	929.70	13
	- with repair of vena cava for thrombus			
96866	**- above hepatic vein ..... add**		**236.70**	
96867	**- below hepatic vein ..... add**		**138.15**	
96868	- partial nephrectomy for malignancy	106.21	900.00	13
96872	Nephro-ureterectomy, total	57.19	834.44	10
96874	Nephro-ureterectomy, total, with resection of ureterovesical junction	57.19	900.00	10
96876	Excision of stenosed renal artery with reimplantation or homograft	57.19	414.20	15

Code		Assist	FP/ Spec.	Anaes.
	KIDNEYS AND PERINEPHRUM (Cont'd)			
	Repair			
96880	Pyeloplasty	57.19	**679.25**	7
96884	Nephropexy	57.19	226.72	7
96886	Renal sympathectomy	57.19	257.24	7
96888	Symphysiotomy, for horseshoe kidney with or without nephropexy and associated procedures	57.19	437.20	7
96890	When 96860 or 96865 or 96868 or 96872 or 96880 is performed laparoscopically ..... add 25%			
	Note: Fee code 96890 cannot be billed with any code not listed in the definition.			
	Suture			
96894	Ruptured or lacerated kidney - repair or removal	57.19	650.00	7
	Extra Renal Procedures			
96910	Excision of retroperitoneal tumour	57.19	381.60	7
96912	Exploration of retroperitoneal tumour	57.19	260.85	7
96914	Sacro-coccygeal teratoma	49.02	437.20	6
96916	Renal hypothermia - extra		32.70	
	Extracorporeal Shock Wave Lithotripsy (IOP)			
96918	- unilateral, any mode, per session, per patient		366.33	6
96920	- bilateral, any mode, per session, per patient		652.68	6
	Kidney Transplants			
96940	Kidney transplant (team fees, these fees do not include immunosuppressive therapy, which is on a fee-for service basis		1,553.15	13
96944	Donor nephrectomy (extra) team fee, uni or bilateral	57.19	1,050.00	16
96948	Renal autotransplantation		1,161.60	10

Code		Assist	FP/ Spec.	Anaes.
	URETER			
	Incision			
96970	Peri-ureteral abscess	49.02	130.80	6
	Ureterotomy, abdominal or vaginal exploratory or for drainage			
96972	- upper 2/3	49.02	282.60	6
96974	- lower 1/3	49.02	391.87	6
	with removal of calculus			
96976	- upper 2/3	49.02	376.80	6
96978	- lower 1/3	49.02	482.40	6
	where ureter has been previously opened			
96980	- upper 2/3	49.02	437.20	6
96982	- lower 1/3	49.02	522.50	6
	Excision			
	Ureterectomy			
96990	- including ureterovesical junction	57.19	437.20	7
96992	- other	57.19	331.70	7
	Repair			
97000	Trimming of ureter	49.02	257.24	6
97002	Uretero-vesical anastomosis or reimplantation - unilateral	49.02	**575.43**	8
97004	Re-implantation of bifid ureter	49.02	482.40	8
97006	Uretero-ileal conduit	49.02	788.15	9
97008	Uretero-ileal conduit with total cystectomy	49.02	788.15	15
97010	Uretero-ileal conduit with ureterectomy and ileal replacement	49.02	893.50	7
97012	Uretero-intestinal anastomosis or transplant - unilateral	49.02	331.70	6
97018	Uretero-ureterostomy	49.02	552.30	8
97020	Ureterostomy, cutaneous, unilateral	49.02	260.85	6
97024	Uretero-vaginal fistula	49.02	557.85	6
97026	Ureterolysis for periureteral fibrosis - unilateral	49.02	437.20	6
	Note: Fee code 97026 is not payable for identifying and protecting the ureter during abdominal, pelvic or retroperitoneal surgery.			
97028	Ureteroplasty (Hutch), unilateral	49.02	331.70	6
97030	Bladder flap (Boari), includes re-implantation of ureter	49.02	502.45	6
	Suture			
	Spontaneous/traumatic rupture or transection			
97040	- immediate - upper 2/3	49.02	381.60	6
97042	- lower 1/3	49.02	437.20	6
97044	- late repair - upper 2/3	49.02	437.20	6
97046	- lower 1/3	49.02	482.40	7
	Endoscopic Procedures			
97050	Calibration and/or dilation - 1 or both sides **(IOP)**		207.26	4
97052	Manipulation and/or removal of calculus including ureteral meatotomy if required		**296.90**	4
	Cystoscopy and diagnostic ureteroscopy above			
97054	Intramural ureter (IOP)		169.32	4
97056	- with removal of calculus ... add		226.16	
97058	- if disintegrated by ultrasound ... add		129.26	

Code		Assist	FP/ Spec.	Anaes.
	BLADDER			
	Endoscopy-Cystoscopy			
	Diagnostic Procedures, includes dilation for access (IOP)			
	Note: *Includes catheterization of ureters with or without collection or ureteral specimens, intravenous function test and retrograde injection of opaque media and/or manometry and/or meatotomy.*			
97070	Cystoscopy with or without urethroscopy ……		95.66	4
97072	Repeat within 30 days ……		47.83	4
97078	With transurethral biopsy, brush biopsy of renal pelvis and/or ureter …… add		33.54	
97079	With insertion of ureteral stent ……... add		134.35	4
97080	With retrograde pyelogram …… add		28.00	
97088	With needle biopsy of prostate …….. add		43.91	
	Therapeutic Procedures (payable with, add-on to code 97070)			
97090	With electrocoagulation of tumour …… add		67.21	
97092	With electrocoagulation of ulcer …… add		67.21	
	With excision of tumour or tumours including base and adjacent muscles and electrocoagulation if necessary			
97096	- single tumour **up to** 2 cm. diameter ……..... add		216.00	
97098	- single tumour over 2 cm. diameter …… add		300.00	
97100	- multiple tumours …… add		300.00	
97102	With resection bladder neck - female ……..... add		134.35	
97104	- male …….. add		350.88	1
97105	With laser photovaporization of bladder neck - male ……..... add		350.88	
97106	With electro-surgical ureteral meatotomy …… add		134.35	
97108	With removal of foreign body or calculus ……..... add		134.35	
97110	With intra-detrusor botulinum toxin injection(s) - one or more ..... add		75.00	
	Introduction (IOP)			
	Catheterization			
97120	- office ……		8.55	
97122	- home ……		16.25	
	- hospital ……...		VF	
97126	Intravesicular chemotherapy includes catheterization …….....		25.65	
	Incision			
97130	Aspiration (IOP) …….....		13.08	
97132	Cystotomy with trochar or cannula and insertion of tube ……..		85.30	5
97136	Incisional cystotomy or cystostomy ……..	40.85	215.80	5
97138	Incisional cystotomy or cystostomy and electrocoagulation of tumour ……...	40.85	194.02	5
97140	Cystolithotomy ……..	40.85	275.00	5
97142	Cutaneous vesicostomy ……	40.85	231.08	5
97144	Reduction cystoplasty (bladder plication) ……	40.85	215.80	5

Code		Assist	FP/ Spec.	Anaes.
	BLADDER (Cont'd)			
	Excision			
	Cystectomy			
97150	Partial for tumour or diverticulum (single or multiple)	49.02	381.60	6
97152	- with reimplantation of ureter	49.02	552.30	7
97154	- with reimplantation of ureters	49.02	733.50	7
97156	Complete cystectomy, without transplant	49.02	657.75	10
97160	Cystectomy with uretero-ileal conduit	65.36	1,600.00	15
97162	Cystectomy with continent diversion	73.53	2,000.00	15
97164	Excision of urachal cyst or sinus with or without umbilical hernia repair	49.02	296.30	6
97166	Excision of urachus, repair of bladder and diversion of urine	49.02	161.32	6
	Extrophy			
97168	- excision of bladder and repair of abdominal wall, inclusive of graft	49.02	215.80	6
97174	- plastic repair of extrophy using bladder and including skin flaps	49.02	657.75	6
	Repair			
97228	Urinary diversion procedure using intestine, without cystectomy	73.53	1,013.45	15
97230	Repair of ruptured bladder	40.85	330.90	6
97232	Cystoplasty, using intestine	40.85	657.75	9
97234	Suprapubic sphincterectomy for Marion's disease	40.85	194.02	5
	Plastic repair of bladder neck			
97236	- child	40.85	331.70	5
97238	- adult or adolescent	40.85	437.20	5
97240	- with diverticulectomy	40.85	493.88	7
	Destruction			
97250	Litholapaxy, visual or tactile and removal of fragments	40.85	215.80	4
	Suture			
	Closure of fistula			
97260	External, suprapubic	32.68	260.85	4
97262	Vesico-vaginal - vaginal approach	32.68	772.40	6
97264	- trans-vesical approach	40.85	467.00	6
97266	Vesico-rectal or vesicosigmoid	40.85	446.90	6

Code		Assist	FP/ Spec.	Anaes.
	URETHRA			
	Incision			
97280	Biopsy of urethra without endoscopy (IOP)		23.55	4
97282	Urethrotomy, external	24.51	215.80	4
97288	Urethrostomy	24.51	215.80	4
97290	Meatotomy and plastic repair		31.60	4
97296	Peri-urethral abscess- complete care		32.70	4
	Excision			
97300	Caruncle	24.51	85.30	4
97302	Urethral papilloma, single or multiple		85.30	4
	Stricture, including diversion			
97304	- 1 stage	24.51	226.72	4
97306	- 2 stage - first stage	24.51	128.62	4
97308	- second stage	24.51	194.02	4
97310	Diverticulectomy		300.00	4
97312	Posterior urethral valve	32.68	331.70	4
97314	Prolapse urethra, excision		85.30	4
97316	Urethrectomy - radical	32.68	215.80	4
	Endoscopy			
97320	Urethroscopy - diagnostic (IOP)		35.50	4
97322	- with biopsy (IOP)		77.70	4
97324	Internal urethrotomy		166.05	4
97326	Removal of foreign body or calculus		170.65	4
	Repair			
97330	Urethral sling	24.51	300.00	4
97331	**Male sling**	**24.51**	**381.60**	**4**
97332	Marshall Marchetti	40.85	293.82	5
97334	Insertion of artificial urinary sphincter	32.68	**854.37**	6
	Urethroplasty - 1st stage			
97336	- posterior	32.68	**419.76**	6
97338	- anterior	32.68	293.35	4
97340	- 2nd stage	32.68	235.35	4
97342	One stage repair (to include skin graft if necessary)	32.68	381.60	6
97344	Kauffman type procedures for urinary incontinence	24.51	200.56	5
97346	- where perineum has been previously operated on for incontinence	24.51	231.08	5
97348	- removal of perineal incontinence prosthesis	24.51	239.75	5
	Suture			
97360	Rupture, anterior urethra (diversion of urine, extra)	32.68	170.65	4
97362	Posterior urethra - immediate repair	32.68	437.20	4
97364	- late repair	32.68	552.30	5
	Fistula			
97366	- penile urethra (diversion of urine, extra)		92.10	4
97368	- perineal urethra	32.68	325.95	4
97370	- recto-urethral with diversion, colostomy and closure of colostomy	49.02	552.30	7

Code		Assist	FP/ Spec.	Anaes.
	URETHRA (Cont'd)			
	Destruction			
97380	Urethro-vesicolysis ……..	24.51	215.80	4
97382	Transurethral incision or resection of external sphincter (when sole operative procedure) ……...		325.95	4
	Manipulation (IOP)			
	Dilation of stricture, male			
97390	- dilation under local anaesthetic ……..		14.17	
97392	- dilation under general anaesthetic …….		52.70	4
97394	Dilation of urethra, female ……..		6.54	
97396	- dilation under general anaesthetic …….		41.65	4

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	PENIS			
	Incision			
	Slit of prepuce			
97410	- newborn		14.35	
97412	- child or infant		21.50	4
97414	- adult		30.25	4
	Excision			
	Circumcision - for physical symptomatology only			
97422	- infant		90.05	4
97424	- adult or child		179.40	4
	Notes: 1. Circumcision is an insured service only when medically necessary. As such, circumcision performed for ritual, cultural, religious or cosmetic reasons at any age is not an insured service. 2. Circumcision for neonatal phimosis is not an insured service.			
97426	Biopsy (IOP)		45.00	4
	Amputation			
97428	- partial	32.68	300.00	4
97432	- radical	49.02	450.00	7
	Condylomata (IOP)			
97434	- excision under local anaesthetic		32.60	
97436	- excision under general anaesthetic		78.60	4
97438	Excision plaque for Peyronies disease or Nesbitt or modified Nesbitt (graft extra)	32.68	300.00	4
	Repair			
	Hypospadias or Epispadias			
	One Stage Repair			
97441	- with meatus to, but not into glans	49.02	287.75	6
97443	- with advancement of meatus into glans	49.02	383.50	6
97444	- into glans using island flap pedicle (penoscrotal)	49.02	662.45	6
97446	- chordee repair	32.68	215.80	4
97448	Plastic reconstruction, urethra	32.68	331.70	4
97450	Closure urethro-cutaneous fistula		92.10	4
97452	Insertion of penile prosthesis	32.68	**440.00**	4
97454	- with inflatable prosthesis		100.00	
97456	Surgical removal of prosthesis	32.68	110.15	4
97460	Intracorporeal injection for impotence (IOP)		27.80	

Code		Assist	FP/ Spec.	Anaes.
	TESTIS			
	Incision			
97470	Abscess (IOP)		55.15	4
97472	Biopsy (IOP) - single		55.15	4
97474	- bilateral		83.35	4
97476	- with vasography		120.80	4
97478	Orchidectomy - unilateral	24.51	170.65	4
97480	Radical removal lymph nodes for testicular tumour	49.02	775.00	8
97481	Retroperitoneal lymph node dissection post-chemotherapy	65.36	1,085.00	11
97482	Radical orchidectomy for malignancy - unilateral	24.51	235.35	4
	Repair			
97490	Orchidopexy, any type, any stage	32.68	**364.80**	4
97494	Exploration for undescended testicle, without orchidopexy	32.68	260.85	4
97496	Reduction of torsion of testis or appendix testis and repair	24.51	235.35	4
97498	Ruptured testicle	24.51	170.65	4
97500	Insertion of testicular prosthesis	49.02	170.65	6
	Note: Insertion of testicular prosthesis at the time of orchidectomy is not eligible for payment.			
	EPIDIDYMIS			
	Incision			
97510	Abscess (IOP)		55.15	4
	Excision			
97520	Spermatocoele or spermatic granuloma excision	24.51	205.35	4
97522	Epididymectomy - unilateral	24.51	170.65	4
97524	Anastomosis epididymovasostomy	24.51	205.35	4
	TUNICA VAGINALIS			
	Incision			
97530	Hydocoele aspiration (IOP)		16.25	
	Excision			
97536	Hydrocoele - unilateral	32.68	205.35	4
	Note: Hydrocele excision with hernia repair is claimed as 96728.			

SURGICAL PROCEDURES

OPERATIONS ON THE MALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	SCROTUM			
	Incision			
97540	Abscess or haematocoele (IOP) ……..		60.00	4
97544	- and exploration - unilateral ……..	24.51	85.30	4
	Excision			
97550	Minor lesions, e.g., sebaceous cysts, fibromata, etc. ……...		47.95	4
97552	Resection of scrotum ……	24.51	136.34	4
	Suture			
	Note: For suture of lacerations, refer to the listings under Operations on the Integumentary System – Suture of Laceration.			
	VAS DEFERENS			
	Incision			
97560	Vasography (IOP) ……...		55.15	4
	Repair			
97564	Anastomosis, unilateral ……..	24.51	215.80	4
97566	- including biopsy and vasography ……...	24.51	260.85	4
	Note: Reconstruction following previous sterilization procedures is <u>not</u> an insured service.			
	Suture			
97580	Ligation - bilateral (IOP) …….	24.51	**126.05**	4
	SPERMATIC CORD			
	Excision			
97590	Hydrocoele - single …….	24.51	205.35	4
97592	Varicocoele - single ……	24.51	205.35	4
	SEMINAL VESICLES			
	Incision			
97600	Abscess (IOP) …….		120.80	4
	Excision			
97606	Vesiculectomy …….	24.51	552.30	4

Code		Assist	FP/ Spec.	Anaes.
	PROSTATE			
	Incision			
97610	Biopsy - needle (IOP)		**71.68**	4
97611	- with ultrasound guidance ..... add		**118.80**	
97612	- with drainage abscess (IOP)	32.68	73.94	4
97618	Biopsy, perineal, open	32.68	215.80	4
	Excision			
97620	Perineal	49.02	650.00	6
97622	Perineal with vesiculectomy	49.02	1,100.00	11
97624	Suprapubic - 1 or 2 stages	40.85	600.75	5
97630	Retropubic - simple	40.85	600.75	5
97632	- radical	40.85	1,100.00	5
97634	Transpubic total prostatovesiculectomy with pelvic lymph node dissection	65.36	496.82	11
	Notes: 1. Prostatectomy fees (97620-97634) do not include payment for investigative cystoscopy but do include payment for vasectomy when rendered. 2. The radical prostatectomy fee (97632) includes payment for plastic repair of bladder neck and/or vesiculectomy when rendered.			
97636	Staging pelvic lymphadenectomy for prostatic cancer	57.19	431.20	7
	Notes: 1. Must include at a minimum bilateral obturator nodes. 2. A sampling of nodes does not constitute a complete staging lymphadenectomy. When only a sampling of nodes is performed as the sole procedures either 95438 or 96712 may be eligible for payment depending on the procedure performed.			
	Endoscopy (Cystoscopy included)			
97640	Transurethral electrosection		**489.02**	5
97641	Laser photovaporization of prostate		486.78	5
97642	Transurethral drainage of abscess, complete care		85.30	5

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	In composite operations such as repair of cystocoele and rectocoele and D & C, or cystocoele and rectocoele and cauterization of cervix and biopsy, the fee shall, unless otherwise mentioned below, be that of the major procedure.			
	VULVA			
	Incision			
97660	Hymenotomy		32.56	4
	Abscess of vulva, Bartholin or Skene's gland (IOP)			
97662	- local anaesthetic		17.30	
97664	- general anaesthetic		50.90	4
97668	Perineotomy (IOP)		22.45	
	Excision			
97674	Hymenectomy (with or without perineotomy)		92.30	4
	Vulvectomy			
97676	- simple - partial or total	32.68	257.05	4
97678	- radical			
	- without gland dissection - partial or complete resection	49.02	431.45	6
97680	- with complete dissection of glands - uni or bilateral	49.02	546.75	7
97682	Cyst of Bartholin's gland	24.51	112.00	4
97684	Marsupialization of cyst (IOP)		164.00	4
	Condylomata - single or multiple (IOP)			
97686	Chemical -1		5.61	
97688	- 2		8.43	
97690	- 3 or more		11.23	
	Surgical excision or electrodesiccation (ED)			
97692	- excision or ED under local anaesthetic		26.85	
97694	- excision or ED under general anaesthetic		115.10	4
97696	Cryosurgery - initial or subsequent treatment		15.00	
	Laser destruction of vulval lesions			
97698	- laser destruction under local anaesthetic		22.40	
97700	- laser destruction under general anaesthetic		94.50	4
	Repair			
97710	Non-obstetrical injury to vulva and/or vagina, and/or perineum	IC	IC	IC
97712	Ligation of varicose vein of labia - uni or bilateral		44.91	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	VAGINA			
	Incision			
97720	Colpotomy, posterior, drainage or needle puncture		41.54	4
97722	Culdotomy, incision and exploration	24.51	81.96	4
97724	Culdoscopy including biopsy (IOP)		61.75	4
97726	Incision and drainage of cyst, abscess or haematoma		92.30	4
	Excision			
	Biopsy(s) - when sole procedure (IOP)			
97730	- biopsy under local anaesthetic		26.85	
97732	- biopsy under general anaesthetic		92.30	4
97734	Local excision of cyst	24.51	123.70	4
97736	Excision of congenital vaginal septum	24.51	281.85	4
97738	Colpectomy, partial or complete, for non-malignant lesions (not to be used to claim for biopsy)	32.68	255.98	6
97740	Colpectomy, radical for malignancy	65.36	480.00	8
97742	Laser treatment of vagina under general anaesthesia		150.00	4
	Repair			
97750	Cystocoele or rectocoele	24.51	222.37	5
97752	Cystocoele and rectocoele	24.51	361.77	5
97754	Cystocoele, rectocoele and enterocoele	24.51	361.77	5
97756	Rectocoele and enterocoele	24.51	341.54	5
97758	Cystocoele, rectocoele and prolapse (Fothergill)	24.51	222.29	5
97760	Cystocoele, rectocoele and excision cervical stump	24.51	349.00	6
97762	Vaginal vault prolapse (post hysterectomy) or enterocoele	24.51	407.37	6
97768	Rectocoele and repair of anal sphincter	24.51	272.40	5
97770	Perineorrhaphy	24.51	122.75	4
97772	Colpocleisis	40.85	257.05	5
97774	Operation for artificial vagina	32.68	235.77	6
	Closure of fistula			
	- vesico-vaginal			
97776	- 1 surgeon	32.68	322.20	6
97778	- 2 surgeons - vaginal surgeon	32.68	196.47	6
97780	- abdominal surgeon		196.47	
97782	- recto-vaginal (any repair)	32.68	**366.07**	6
97784	- uretero-vaginal	49.02	280.68	6
97786	- urethro-vaginal	32.68	129.11	4
97788	Urethral caruncle or prolapse of mucosa		59.50	4
97790	Retropubic urethropexy for stress incontinence	32.68	301.35	5
	Combined abdominal - vaginal procedure for stress incontinence			
97794	- 1 surgeon	49.02	**725.32**	7
97796	- 2 surgeons - vaginal surgeon	49.02	123.50	7
97798	- abdominal surgeon		215.56	
	Manipulation			
97808	Examination and/or dilation - vagina - general anaesthetic (IOP)		28.07	4

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	FALLOPIAN TUBE			
	Excision (unilateral or bilateral)			
97820	Salpingectomy and salpingo - oophorectomy ……	49.02	365.22	6
97822	Partial salpingectomy for sterilization ……..	49.02	189.66	6
	Repair			
	Tubal plastic operation			
97830	- fimbriolysis - unilateral …….	49.02	213.29	6
97832	- salpingostomy - unilateral ……	49.02	278.93	6
97834	- resection with reanastomosis ……..	49.02	288.83	6
97838	Repair of extensive tubal and peritubal disease using operating microscope (not to be charged for reconstruction following previous sterilization procedures) uni or bilateral) …….	65.36	567.97	8
	Suture			
97844	Ligation of tubes, all methods, all approaches ……...	49.02	235.95	6
	OVARY			
	Excision (uni or bilateral)			
97850	Biopsy of ovaries by laparotomy ……..	40.85	315.42	6
97852	Wedge resection of ovaries (e.g. Stein-Leventhal) ……...	40.85	257.05	6
97854	Oophorectomy …….	49.02	364.27	6
97856	Oophorectomy with omentectomy for malignant disease ……	49.02	468.77	6
97858	Oophorocystectomy ……	49.02	364.27	6
97860	Para ovarian cyst ……	49.02	364.27	6
97862	Oophorectomy with or without omentectomy for malignant disease and with pelvic and/or perioaortic Lymphadenectomy ……..	49.02	943.22	6
97864	Second look exploratory laparotomy including biopsies, when done as part of chemotherapy protocol for ovarian carcinoma with or without total omentectomy ……	49.02	431.45	6
97866	Culdectomy (extensive removal of pelvic peritoneum required for evacuation of malignancy extension of secondaries) ……	49.02	200.00	6
	UTERUS AND CERVIX UTERI			
	Endoscopy (IOP)			
97870	Colpomicroscopy (includes vagina) …….		49.12	4
97872	- with biopsy and/or endocervical curettage ……...		65.50	4
97874	Hysteroscopy ……...		138.04	
97876	- with biopsy …….		155.29	
97878	- with cannulization of tubes ……..		163.57	

SURGICAL PROCEDURES

OPERATIONS ON THE FEMALE GENITAL SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	UTERUS AND CERVIX UTERI (Cont'd)			
	Incision			
97890	Endometrial biopsy (IOP)		34.05	
97892	Biopsy, cervix (IOP)		20.00	4
97910	Hysterotomy	49.02	185.25	6
97914	Cryoconization, electroconization with or without endocervical curettage (IOP)		**59.51**	4
97916	CO_2 laser therapy with or without curettage for CIN (Cervical Intra-epithelial Neoplasia) (IOP)		79.22	4
	Excision			
	NOTE: *D & Cs are <u>not</u> billable in addition to code 97926 or 97928.*			
	Diagnostic curettage			
97920	- (with or without cauterization biopsy of cervix, removal of polypi or Rubin's test) (IOP)		92.30	4
97922	- and hystero-salpingography (IOP)		92.30	4
97924	- with knife conization of cervix (includes <u>additional</u> biopsies)	24.51	200.73	4
	Therapeutic hysteroscopy/endometrial ablation			
97926	- initial		234.58	6
97928	- repeat procedure within 1 year		145.00	6
	Hysterectomy (with or without adnexa or enterocoele)			
97930	Total, abdominal or vaginal	49.02	521.37	6
97932	- with cystocoele and rectocoele	49.02	581.92	6
97934	- with cystocoele or rectocoele	49.02	551.65	6
97938	Partial or subtotal	49.02	**361.70**	6
97940	- with cystocoele and rectocoele	49.02	407.72	6
97942	- with cystocoele or rectocoele	49.02	377.45	6
97948	Radical (total hysterectomy plus lymphadenectomy)	65.36	797.04	8
97950	Myomectomy	49.02	442.27	6
97952	Amputation of cervix	32.68	173.55	4
97954	Cervical stump - abdominal	49.02	321.90	6
97956	- vaginal	32.68	321.90	4
	Introduction (IOP)			
97960	Insufflation - Rubin's test		26.94	4
97962	Insufflation and endometrial biopsy		43.19	4
97964	Insertion of IUCD		35.00	
	Repair			
97970	Hysteropexy (uterine suspension)	49.02	204.32	6
97972	- with anterior and posterior repair	49.02	294.14	6
97974	- with anterior or posterior repair	49.02	267.19	6
97976	Cervix, incompetent	24.51	80.83	4
97978	Trachelorrhaphy (plastic repair of cervix) – not immediately following delivery	24.51	61.75	4
97982	Hysteroplasty - excision of septum (Strassman)	49.02	196.47	6
97984	Unification of double uteri	32.68	255.98	4
97986	Uterine inversion - manual		95.43	4
97988	- operative	32.68	196.47	6
97990	Presacral neurectomy	49.02	196.47	6

Code		Assist	FP/ Spec.	Anaes.
	UTERUS AND CERVIX UTERI (Cont'd)			
	Cautery of Cervix (IOP)			
	Office			
	- chemical cautery ……		VF	
97994	- electro-cautery or cryocautery ……		4.49	
97996	Hospital, general anaesthetic, dilation and cauterization or conization, single procedure ……..		26.94	4

SURGICAL PROCEDURES

OPERATIONS ON THE ENDOCRINE SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	THYROID GLAND			
	Incision			
98010	Aspiration, thyroid cyst (IOP)		38.00	
98012	Biopsy, needle (IOP)		71.30	6
98014	Abscess, complete care		70.85	4
	Excision			
	Biopsy			
98020	- surgical	49.02	213.15	6
	Thyroidectomy			
98022	- total	49.02	777.30	8
98024	- subtotal	49.02	618.25	7
98026	- hemi	49.02	525.15	7
98027	- parathyroid(s) re-implantation ..... add		184.60	
	Note: Fee code 98027 can be billed in addition to fee codes 98022, 98024 or 98026.			
98028	Excision of solitary nodule	49.02	289.10	6
	PARATHYROID, THYMUS AND ADRENAL GLANDS			
	Excision			
98040	Exploration and/or removal, parathyroids or parathyroid tumour	49.02	605.45	8
98042	- if requiring splitting of sternum	106.21	632.46	13
98044	Thymectomy	106.21	689.38	13
98046	Adrenalectomy or exploration, unilateral	81.70	646.30	10
98048	- bilateral, with or without oophorectomy	81.70	1,032.70	11
98050	Pheochromocytoma	98.04	871.80	13
98052	Thymus transplant (IOP)		44.69	4

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
98100	Hypothermia - when employed, basic fee for <u>any</u> procedure on nervous system			25
	BRAIN			
	Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour			
	Craniotomy plus excision			
98130	- supratentorial	89.87	1,562.90	15
98132	- infratentorial	89.87	1,726.80	15
98134	Craniotomy plus lobectomy	89.87	1,575.80	15
98136	Microsurgical removal ..... add		237.36	
	Meningioma and other tumourous lesions			
	Craniotomy plus excision			
98138	- supratentorial	89.87	**2,072.16**	15
98140	- infratentorial plus basal	89.87	2,305.62	15
98142	- microsurgical removal ..... add		237.36	
98144	- lesion greater than 4 cm. diameter ..... add		454.15	
98146	- team fee for acoustic neuroma ..... add		627.65	
	Intracranial aneurysm repair			
98150	**-** carotid circulation	89.87	**2,568.18**	15
98152	- vertebrobasilar circulation (including aneurysm of vein of Galen)	89.87	2,140.15	15
98154	- microsurgical approach ..... add		237.36	
	Cerebral arteriovenous malformation			
	Craniotomy for obliteration and/or excision			
98156	- supratentorial	89.87	1,953.14	15
98158	- infratentorial	89.87	1,532.10	15
98160	- microsurgical approach ..... add		237.36	
98164	Extracranial approach to include balloon catheter or embolization techniques	89.87	873.53	15
	Extracranial-intracranial microvascular anastomosis			
98168	- superficial temporal artery	89.87	1,203.09	15
98170	**-** occipital artery	89.87	1,255.30	15
98174	**-** use of graft (autogenous vessel or synthetic) ..... add		246.00	
	Carotid-cavernous fistula			
98178	**-** intracranial obliteration (to include combined cervical and intracranial procedure)	89.87	1,254.85	15
98180	**-** extracranial approach	89.87	763.30	15
	Spontaneous Intracerebral Haemorrhage			
	Craniotomy plus removal			
98182	**-** supratentorial	89.87	**1,262.13**	15
98184	**-** infratentorial	89.87	1,385.05	15
98186	Burr hole plus drainage	89.87	531.37	15

Code		Assist	FP/ Spec.	Anaes.
	BRAIN (Cont'd)			
	Intracranial Cyst			
	Craniotomy plus evacuation, to include interventriculostomy			
98188	- supratentorial	89.87	899.87	15
98190	- infratentorial	89.87	1,065.05	15
98192	Burr hole plus aspiration	89.87	426.95	15
	Brain Abscess			
98194	**-** crainiotomy and excision	89.87	1,416.50	15
98196	**-** burr hole and aspiration	57.19	587.87	7
98198	**-** subsequent aspiration through existing burr hole within 30 days	57.19	237.36	7
	Miscellaneous Procedures			
98200	Craniotomy for brain biopsy (other than for tumour)	89.87	774.90	11
98202	Hemispherectomy	89.87	1,878.35	15
98204	Temporal lobectomy and/or excision of cortical scar for epilepsy	89.87	2,184.20	15
98210	Craniotomy plus midline commissurotomy	89.87	1,035.40	15
98212	Repair of encephalocoele	89.87	798.80	15
98216	Posterior fossa decompression for Arnold Chiari malformation	89.87	1,500.00	15
98222	Stereotaxis - intracranial, to include ventriculography	89.87	1,377.58	11
98224	**Replacement of deep brain stimulation (DBS) system – Neurostimulator module .....**		**510.00**	**5**
98232	Burr hole plus needling of brain for biopsy (IOP)	57.19	453.60	7
98234	Ventriculogram, includes burr holes, air or positive contrast (IOP)		192.06	7
98236	Ventricular puncture through previous burr hole or fontanelle, or puncture and/or aspiration of cisterna magna (IOP)		90.49	7
98238	Ventriculoscopy, to include burr hole (IOP)		408.95	7
98242	- with interventriculostomy ..... add		301.70	
98244	External ventricular drainage (IOP)	40.85	237.36	5
98250	Insertion of intracranial catheter or transducer for purposes of monitoring (IOP)	40.85	350.45	5
98252	Subsequent revisions or replacements within 30 days (IOP) - each	40.85	279.55	5
98254	Re-opening of craniotomy for post-operative haematoma or infection, or for removal of bone flap	89.87	496.89	11
98256	Intracranial duraplasty (greater than 2 cm. diameter) to any intracranial procedure ..... add		265.67	
98260	Intra-operative electrophysiological monitoring and/or stimulation ..... add		222.64	
98262	Repeat craniotomy (excluding 98254), add to benefit for above surgery involving craniotomy		252.20	
98264	Stereotactic radiosurgery - per patient, per course of treatment		1,522.60	**11**

Note:

The fee for code 98264 represents payment to a neurosurgeon for the following services provided in hospital to a patient for whom stereotactic radiosurgery has been prescribed:

i. participation in multidisciplinary clinics;
ii. mapping and merging the patient care plan with the health professionals involved in the procedure;
iii. attendance during the administration of the radiosurgery;
iv. application of halo frame if required.

Code		Assist	FP/ Spec.	Anaes.
	BRAIN (Cont'd)			
	Cranio-Cerebral Injuries			
	Reduction of skull fracture			
98272	- simple, depressed	57.19	634.90	7
98274	- compound	89.87	773.15	11
98276	- with repair of dural laceration add		233.30	4
	Extracerebral haematoma			
98278	- drainage of burr hole(s) - unilateral	57.19	595.70	7
98280	- drainage and/or removal by craniotomy	89.87	**933.78**	11
	Cerebral Injury			
98290	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	89.87	1,040.65	15
98292	Removal of foreign body from brain	89.87	971.86	15
98294	CSF leak - intracranial repair	89.87	1,069.90	15
98296	Decompressive craniectomy (frontal, sub-temporal)	89.87	638.05	11
98298	Subdural tap(s) - unilateral (IOP)		58.60	
98300	Diagnostic burr hole(s), uni or bilateral (IOP)		272.10	7
	SKULL			
	Repair of skull defect:			
98310	- acrylic or metal cranioplasty	89.87	**677.12**	11
98314	- replacement of bone flap	89.87	484.25	11
98316	Skull tumour, excision	89.87	412.18	11
	Craniosynostosis			
	Linear Craniectomy			
98318	- 1 suture	89.87	474.97	11
98320	- multiple sutures	89.87	621.36	15
	Morcellation procedure			
98322	- 1 suture	89.87	476.40	11
98324	- multiple sutures	89.87	750.64	15
	Lateral canthal advancement			
	- unilateral			
98326	- 1 surgeon	89.87	767.86	15
98328	- 2 surgeons - major portion of surgery	89.87	439.79	15
98330	- lesser portion of surgery		355.43	
	- bilateral			
98332	- 1 surgeon	89.87	972.48	15
98334	- 2 surgeons - major portion of surgery	89.87	627.65	15
98336	- lesser portion of surgery		470.79	
98338	Craniotomy for craniofacial repair	89.87	1,087.27	15
98340	- with repair of frontonasal encephalocoele add		219.79	

SURGICAL PROCEDURES

OPERATIONS ON THE NERVOUS SYSTEM

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	ORBIT			
	Craniotomy			
98350	- plus removal of orbital tumour	89.87	1,139.94	15
98352	- plus orbital decompression (roof of orbit with or without lateral wall) ...	89.87	1,066.53	15
98354	- for decompression of optic nerve(s)	89.87	1,139.94	15
	PITUITARY			
98360	Hypophysectomy or excision of tumour, any technique except transphenoidal	89.87	2,000.00	15
98362	Hypophysectomy, transphenoidal, team fee	89.87	2,000.00	15
	CAROTID AND VERTEBRAL ARTERIES			
98372	Temporal artery - biopsy, ligation or crysurgery (IOP)		200.00	4
98374	Carotid endarterectomy - with or without bypass	81.70	465.50	10
98378	- with patch or graft	81.70	471.21	10
98380	Progressive carotid occlusion by Selverstone clamp (IOP)	81.70	284.65	10
	CSF SHUNTING PROCEDURES			
98409	CSF shunting procedures - all types	89.87	737.00	11
	Revision of CSF Shunt			
98411	- operative - all types	89.87	420.70	7
98413	- non-operative		51.50	
	Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial)			
98415	- includes removal of existing shunt	89.87	420.30	7
98416	Removal of shunt - any type	89.87	289.70	7
98420	Insertion CSF reservoir (Ommaya including burr holes)	89.87	370.50	11
98422	Third ventriculostomy	89.87	777.80	11
	CRANIAL NERVES			
98430	Percutaneous coagulation of gasserian (trigeminal) ganglion or root - unilateral	89.87	504.95	11
98432	Decompression gasserian ganglion	89.87	481.90	11
	Rhizotomy or differential section trigeminal nerve			
98434	- temporal approach	89.87	473.70	11
98436	- posterior fossa approach	89.87	1,021.89	11
98438	- avulsion supraorbital nerve	32.68	168.20	4
98440	- avulsion infraorbital nerve	32.68	168.20	4
98442	- avulsion mandibular nerve	32.68	195.34	4

Code		Assist	FP/ Spec.	Anaes.
	CRANIAL NERVES (Cont'd)			
98446	Anastomosis hypoglossal to facial nerve	49.02	727.80	6
98450	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	89.87	**1,478.82**	11
98452	Division vestibular nerve	89.87	946.19	11
98454	Division of glossopharyngeal nerve	49.02	946.19	6
98456	Division of nerves to sternomastoid in neck	49.02	305.60	6
	PERIPHERAL NERVES			
98470	Biopsy and/or avulsion of peripheral nerve (IOP)	24.51	109.95	4
	Brachial plexus exploration			
98472	- in posterior triangle	49.02	377.95	6
98474	- in axilla	49.02	384.54	6
98476	- in posterior triangle and axilla	49.02	520.12	6
98478	Decompression by scalenotomy	49.02	235.60	6
98480	- excision of cervical rib	81.70	428.01	6
98482	Exploration of major nerve (median, ulna, radial, sciatic, etc.) with or without neurolysis	32.68	191.62	6
98484	Removal tumour major peripheral nerve	32.68	317.85	4
	Suture of major peripheral nerve			
98486	- epineural repair	32.68	500.00	4
98488	- fascicular technique, first fascicle	32.68	325.56	4
98490	- each additional fascicle repaired add		54.98	
	Graft of major peripheral nerve			
98492	- epineural grafting	32.68	445.50	4
98494	- fascicular grafting, first fascicle	32.68	927.55	4
98496	- each additional fascicle grafted add		109.95	
	Suture or decompression of small peripheral nerve (e.g., digital)			
98498	- epineural technique	24.51	250.00	4
98500	- fascicular repair, first fascicle. Use fee code 98490 to claim for additional fascicles repaired		71.40	
	Graft of small peripheral nerve			
98502	- epineural technique	24.51	99.95	4
98504	- fascicular technique, including first fascicle. Use fee code 98496 to claim additional fascicles grafted		109.95	
98506	Delayed repair or graft (more than 4 weeks from date of injury) add		105.66	
98508	Microsurgical technique used add		254.00	
98510	Decompression median nerve at wrist	24.51	191.62	4
98512	Decompression ulnar nerve at elbow	24.51	215.35	4
98514	Transposition of ulnar nerve at elbow	24.51	235.60	4
98516	Decompression lateral femoral cutaneous nerve	32.68	139.93	4
98518	Division obturator nerve	49.02	235.60	6
98520	Morton's neuroma - excision	32.68	157.07	4
98522	Excision of glomus tumour (IOP)		109.95	4
98524	Neuroma - single, subcutaneous (IOP)		109.95	4
	Implantation or Replacement of Peripheral Neurostimulator			
98528	Implantation of electrode for peripheral nerve stimulation (IOP)	24.51	104.24	4
98530	Vagal nerve stimulator implantation	49.02	460.00	7
98531	Vagal nerve stimulator battery change	49.02	230.00	7

Code		Assist	FP/ Spec.	Anaes.
	AUTONOMIC NERVOUS SYSTEM			
	Sympathectomy			
98540	Cervical	49.02	314.14	6
98542	Cervicodorsal - unilateral	81.70	314.14	10
98546	- thoracic approach	106.21	314.14	13
98548	Lumbar - unilateral	49.02	279.87	6
98550	- bilateral	49.02	414.09	6
	SPINAL CORD AND NERVE ROOTS			
	For operations on the spinal cord and nerve roots, the basic Assistants' and Anaesthesiologists' fees will depend on the surgical approach			
98570	- cervical	65.36		10
98572	- dorsal or lumbar	57.19		8
	Tumours - partial or total			
98580	- extradural		980.43	
98582	- intradural (extramedullary)		1,530.00	
98584	- 3 segments or more ... add		175.74	
	Intramedullary			
98590	- biopsy and/or decompression		451.48	9
98592	- removal		1,765.75	12
98594	- 3 segments or more ... add		192.88	
98596	- with operating microscope (applies to intradural or intramedullary tumours) ... add		262.81	
	AV malformation of cord			
98604	Excision or operative obliteration with or without evacuation of haematoma		1,563.52	
98606	- 3 segments or more ... add		192.88	
98608	- with operating microscope ... add		262.81	
98612	Insertion/revision of implantable infusion pump		510.00	
98616	Implantation of permanent subcutaneous reservoir including laminectomy		510.00	
	Note: 98616 is not eligible for payment when rendered with any decompressive codes.			
98626	Laminectomy for intradural neurolysis or unusual lesions, e.g., diastematomyelia, tethered conus, intramedullary haematoma etc. – uni or bilateral		976.41	
98628	- laminectomy extending over 3 segments or more (applies to tethered conus, diastematomyelia extradural, intradural or tointramedullary tumour, AVM, or other decompressive laminectomy) ... add		192.88	
98630	- with operating microscope ... add		262.81	

Code		Assist	FP/ Spec.	Anaes.
	SPINAL CORD AND NERVE ROOTS (Cont'd)			
	Laminectomy and decompression of spinal cord			
98632	- no opening of dura		432.55	
98634	- with opening of dura (with or without dentate ligament section) no tumour		594.75	
	With fusion by same surgeon			
98638	- 1 level (payable in addition to fee codes above)		264.93	
98640	- 2 levels or more (payable in addition to fee codes above)		333.41	
	Fusion by separate surgeon			
98644	- 1 level		353.24	
98646	- 2 or more levels		410.91	
98648	Refusion of any of above		219.87	
98650	Re-opening of laminectomy for post-op haematoma, infection or CSF leak		201.85	
98656	Medullary spinal trigeminal tractotomy		1,146.55	
98658	- with operating microscope ..... add		243.35	
98664	Percutaneous cordotomy or tractotomy		594.75	
98668	Open myelotomy for lesion (e.g., tractotomy, midline commissurotomy, Bischoff's longitudinal myelotomy, etc.) – uni or bilateral		1,175.17	
98676	Spinal intradural anterior and/or posterior rhizotomy – uni or bilateral, any number of roots		787.62	
98678	- 3 segments or more ..... add		192.88	
98679	- with operating microscope ..... add		262.81	
98680	Repair of meningocoele		583.93	
	Repair of meningomyelocoele			
98682	- 1 surgeon		700.70	
	- 2 surgeons			
98684	- neurosurgeon		460.19	
98686	- reconstructive surgeon		309.84	
98688	Lumbar puncture (IOP)		75.00	
98690	- with instillation of medication (IOP)		88.03	
	Percutaneous lumbar rhizotomy or neurectomy (IOP)			
98700	- first level		100.92	4
98702	- additional levels - (to a max. of 4 additional levels) - each		32.44	
98704	Interpretation of CSF smear in malignancy (IOP)		25.18	

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
98800	Examination and unlisted minor procedures under general anaesthetic, when sole procedure (IOP)		**101.12**	4
	EYEBALL			
	Excision			
98810	Enucleation, donor eye, post-mortem (1 or both)		131.25	
	Repair			
98820	Removal of intraocular foreign body	32.68	572.54	6
98822	- non-magnetic-posterior segment	32.68	584.65	6
	Penetrating wound			
98824	- with prolapse of intraocular tissue	32.68	640.00	6
98826	- without prolapse of intraocular tissue	32.68	496.00	6
	CORNEA			
	Incision			
98830	Paracentesis (IOP)		**70.00**	4
	Removal embedded foreign body (IOP)			
	Note: Not to be claimed for the routine removal of sutures within 42 days of procedure.			
98832	- removal under local anaesthetic - 1 foreign body		**42.93**	
98834	- 2 or more foreign bodies		50.00	
98836	- removal under general anaesthetic		74.20	4
	Chelation of band keratopathy with EDTA (IOP)			
98838	- chelation under local anaesthetic		**37.08**	
98840	- chelation under general anaesthetic		72.82	4
	Excision			
98850	Pterygium - simple (unilateral)		175.00	4
98852	- with partial keratectomy	32.68	372.50	4
98854	- with lamellar graft	32.68	453.00	8
98856	- with autogenous conjunctival transplant ..... add		100.00	
98858	- with mucous membrane graft ..... add		113.20	
98860	Keratectomy	32.68	303.68	4
98861	Phototherapeutic Keratectomy		306.93	
	Note: **Prior approval from MCP is required.**			
	Excision of dermoid			
98862	- with partial keratectomy		303.68	4
98864	- with lamellar graft	32.68	542.00	8
	Cauterization of ulcer (IOP)			
98866	- local anaesthetic		25.75	
98868	- general anaesthetic		72.82	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	CORNEA (Cont'd)			
	Replacement			
	Corneal transplant			
98880	- penetrating	32.68	740.00	8
98882	- with artificial prosthesis add		52.40	
98884	- lamellar	32.68	590.00	8
98886	Division of iris to cornea		161.75	4
	SCLERA			
	Incision			
98890	Sclerotomy, posterior		166.45	4
98892	Anterior chamber - open evacuation of clot	32.68	363.40	6
	IRIS AND CILIARY BODY			
98900	Laser iridotomy	32.68	252.97	4
98902	Laser angle surgery		390.88	4
98904	Iridectomy - surgical - when sole procedure	32.68	308.30	4
98906	Glaucoma filtering procedures	32.68	1,133.89	6
98908	- with intraocular implant of seton add		156.16	
98910	Extraocular glaucoma procedures	32.68	182.75	4
98912	Ciliary body reattachment	32.68	505.45	8
	CRYSTALLINE LENS			
	Incision			
98920	Needling (discission) - primary or subsequent		161.75	5
98922	Capsulotomy (any method)	32.68	285.58	4
	Excision			
	Cataract			
98930	- all types of, by any procedure	32.68	473.09	8
98932	- dislocated lens extraction	32.68	597.98	6
98934	- insertion of intraocular lens add		101.38	
98936	Fixation of intraocular lens (McCannell suture procedure)	32.68	263.76	6
98938	Excision of secondary membrane with corneal section following cataract extraction	32.68	259.05	6
98940	Removal of intraocular lens	32.68	309.31	6
98942	Repositioning, surgical of dislocated intraocular lens		158.93	4
98946	Insertion of secondary intraocular lens	32.68	303.68	8

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	VITREOUS			
98950	Vitrectomy by infusion suction cutter technique	32.68	1,264.79	8
98952	- with transscleral retinal suturing ... add		213.20	
98954	Vitreous aspiration, posterior with needle for culture and/or injection of medication, with or without cryopexy	32.68	232.90	5
98956	Anterior vitrectomy (planned) when done in conjunction with another intraocular procedure ... add		105.00	
98958	Preretinal membrane peeling or segmentation to include posterior vitrectomy and coagulation	32.68	1,724.39	8
98960	Vitreous exchange (air, gas or artificial vitreous substance) - add to vitrectomy		120.31	
	RETINA			
98970	Reattachment of retina and choroid by diathermy, photocoagulation or cryopexy as initial procedure	49.02	459.55	6
98972	Scleral resection or buckling procedure with or without diathermy, photocoagulation or cryopexy, primary or subsequent procedure	49.02	1,554.70	6
98974	Secondary operation following unsuccessful operation or fresh detachment in the same eye by a different surgeon with or without diathermy, photocoagulation or cryopexy	49.02	1,123.80	6
98976	Removal of scleral implant		255.07	4
98978	Photocoagulation - 1 eye		297.20	6
98980	Cryopexy - extraocular or subconjunctival - 1 eye		216.03	6
98982	Pneumatic retinopexy		472.50	6
98984	Laser retinopexy for Retinopathy of Prematurity - one eye		750.00	6
98986	Laser retinopexy for Retinopathy of Prematurity - both eyes		1,245.00	6
	Note: Fee codes 98984 and 98986 cannot be billed for procedures performed on the same day as the Premature Infants Ophthalmology Clinic.			
	EXTRAOCULAR MUSCLES			
	Repair			
	Strabismus procedures			
98990	- 1 muscle, 1 or both eyes	24.51	369.00	5
98992	- 2 muscles, 1 or both eyes	24.51	460.00	5
98994	- 3 or more muscles, 1 or both eyes	24.51	542.00	5
98996	- for adjustable suture ... add		100.00	
98998	Repeat strabismus procedure (more than 2 previous repairs by different surgeon) ... add		175.00	

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	ORBIT			
	Incision			
99010	Drainage of abscess		350.00	6
	Excision			
99020	Enucleation, with or without primary implant	32.68	**677.50**	4
99022	Evisceration, with or without primary implant	32.68	542.00	4
99024	Exenteration	32.68	1,005.00	6
99026	- with major plastic repair ..... add		296.90	
99028	Secondary orbital implant	32.68	640.00	4
99030	Tumour or foreign body - anterior route	32.68	450.00	6
99032	- posterior exposure	32.68	640.00	6
99034	Biopsy - anterior		200.00	4
99036	- posterior exposure		308.30	4
99038	Lateral orbitotomy (Kronlein)	24.51	590.00	6
99040	Decompression - 2 walls	32.68	542.00	6
99042	- 3 walls	32.68	575.85	6
	Reconstruction			
99050	Dermis fat graft - immediately following enucleation		190.30	
99052	- delayed	32.68	514.80	6
99054	Fornix reconstruction		325.00	4
99056	- with mucous membrane graft		321.60	4
99058	- with autogenous conjunctival transplant ..... add		100.00	
	Free mucous membrane graft			
99060	- full thickness		222.65	4
99062	- split thickness		296.90	4
99064	Alloplastic volume replacement		411.20	4
	EYELIDS			
	Incision			
	Drainage of abscess (IOP)			
99070	- drainage under local anaesthetic		60.00	
99072	- drainage under general anaesthetic		225.00	4
	Excision			
	Verrucae, papilloma, keratosis, etc. (IOP) - see Skin and Subcutaneous Tissue-Integumentary System also Lid Tumours or Unlisted Plastic Procedures			
	Chalazion - single or multiple (IOP)			
99080	- excision under local anaesthetic		70.00	
99082	- excision under general anaesthetic		150.00	4
	Epilation			
99084	- by hyfrecator, electrolysis (IOP)		**26.60**	4
99086	- by cryopexy		64.91	4

Code		Assist	FP/ Spec.	Anaes.
	EYELIDS (Cont'd)			
	Suture			
99090	Tarsorrhaphy		150.00	4
99092	Double adhesion		161.75	4
	Repair			
99100	Ptosis	32.68	313.15	4
99102	- repeat or second repair	32.68	393.00	6
99104	Distichiasis - unilateral	32.68	289.00	4
99106	Trichiasis, repair by tarsal transplantation	32.68	241.70	4
99108	Entropion, other than Zeigler puncture	32.68	301.21	4
99110	- repeat by second surgeon add		52.40	
99112	- with mucous membrane graft add		113.20	
99114	Ectropion, other than Zeigler puncture	32.68	310.00	4
99116	- repeat by second surgeon add		52.40	
	- with skin graft, see Plastic Surgery Procedures -Integumentary System			
99120	Zeigler punctures (for entropion/ectropion) (IOP)		26.60	4
99122	Laceration - full thickness		225.00	4
99124	- including lid margin		300.00	4
99126	Laceration of eyelid including levator palpebrae superioris with ptosis	32.68	329.30	4
	Blepharoplasty			
99128	- excision of skin, with/without partial excision of the orbicularis oculi muscle - 1 lid		82.80	4
99130	- plus removal of orbital fat and/or lid fold reconstruction - 1 lid	32.68	**298.43**	4
99132	Lid lengthening procedure	32.68	288.35	4
99134	- with scleral graft add		80.90	
99136	Primary closure of full thickness lid defect	32.68	290.00	4
99138	- with cantholysis add		53.20	
99140	- with releasing rotation flap including cantholysis add		87.63	
99142	Transconjunctival flap and skin graft (Hughes)	32.68	484.35	6
99144	- second stage		108.45	4
99146	Lower or upper eyelid bridge flap	32.68	484.35	6
99148	- second stage		108.45	4
99150	Temporal rotation flap	32.68	514.80	6
99152	- with free posterior lamellar graft add		175.15	
99154	Free tarsal, scleral or cartilage graft with local skin mobilization	49.02	535.80	8
99156	Free composite eyelid graft	49.02	535.80	8
99158	Medial canthoplasty (skin and muscle)	32.68	253.49	4
	Medial canthal tendon			
99160	- tendon repair only	32.68	267.35	4
99162	- fixating to bone	32.68	405.60	6
99164	- when done in conjunction with another procedure		153.25	
	Lateral canthal surgery			
99166	Canthotomy - <u>not</u> to be claimed with 98930, 98932		51.45	4
99168	Cantholysis - when primary procedure		105.70	4
99170	Lateral canthopexy		200.14	4
99172	- when done in conjunction with another procedure add		102.35	
	Introduction			
99188	Insertion of gold weight(s) for facial nerve paralysis		81.58	4

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EYE

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	CONJUNCTIVA			
	Removal of foreign body ……		VF	
	Excision			
99190	Peritomy (Gunderson conjunctival flap) ……..		**157.81**	4
99192	Biopsy (IOP) ……		26.60	4
	Repair			
99200	Excision of conjunctival lesion ……..		100.00	4
99202	- with mucous membrane graft …….. add		113.20	
99204	- with autogenous conjunctival transplant …… add		100.00	
	LACRIMAL TRACT			
	Incision			
99210	Dacryocystotomy - general anaesthetic (IOP) ……...		51.55	4
99212	Three “Snip” punctum procedure (IOP) ……...		**65.70**	4
	Excision			
99220	Dacryocystectomy ……...	32.68	250.89	4
	Repair			
99230	Lacerated canaliculus - immediate repair ……	32.68	350.00	4
99232	- delayed repair ……	32.68	**411.20**	5
99234	Dacryocystorhinostomy ……..	40.85	542.88	5
99236	- repeat procedure by second surgeon …… add		85.90	
99238	- with lacrimal by-pass procedure (e.g., Lester Jones) or canalicular reconstruction …… add		79.52	
99240	Lacrimal by-pass procedure (e.g., Lester Jones) - when sole procedure ……		178.73	4
	Manipulation (IOP)			
99250	Irrigation of nasolacrimal system - uni or bilateral ……		**27.00**	
	Probing and dilation of duct - initial or repeat			
99252	- probing and dilation under local anaesthetic - unilateral ……		27.00	
99254	- probing and dilation under general anaesthetic - uni or bilateral ……..		79.52	4
99256	- with insertion of inlying tube or filament ……		158.06	4
99258	Reinsertion of Lester Jones tube ……..		51.55	**4**

SURGICAL PROCEDURES

OPERATIONS ON ORGANS OF SPECIAL SENSES
OPERATIONS ON THE EAR

These Listings Cannot be Correctly Interpreted Without Reference to the Preamble

Code		Assist	FP/ Spec.	Anaes.
	EXTERNAL EAR			
	Endoscopy			
	Removal of foreign body			
	- simple ……..		VF	
99302	- complicated - general anaesthetic, when sole procedure (IOP) ……		50.90	4
99304	- post auricular approach ……		125.35	4
99306	- from middle ear space ……..		125.35	4
99308	Removal of drainage tubes under general anaesthesia (IOP) ……		66.50	4
99310	Debridement of ear(s) under microscopy (IOP) ……		25.55	
99312	- under general anaesthesia (IOP) ……		48.45	4
	Note: "Debridement of ears" may only be claimed for removal of impacted cerumen by means other than syringing, or suction, or for the therapeutic removal of debris resulting from infection.			
	Incision			
99320	Biopsy, ear canal (IOP) ……..		24.60	4
99326	Limited incision for perichondritis, removal of cartilage and drainage ……		155.30	4
99328	Radical surgery for perichondritis ……		167.86	5
	Excision			
99330	Local excision polyp - office (IOP) ……		24.60	
99332	- hospital (IOP) ……...		48.45	4
99338	Amputation - partial ……		83.93	4
99340	- complete ……...		106.82	4
99342	Exostosis, simple endomeatal surgery and removal and drilling out of exostosis ……...		243.35	4
99344	- with multiple removal, with necessary grafting ……		235.40	4
99346	- posterior auricular approach ……		171.13	5
99348	Pre-auricular sinus (IOP) ……		59.60	
99350	- requiring general anaesthetic ……..		208.05	5
	Repair			
	Microtia			
99360	- minor repair ……	40.85	269.11	5
99362	- major repair or first stage of a major repair ……...	40.85	345.15	5
99364	- subsequent stages of a major repair (maximum of 2 subsequent stages) ……	40.85	269.11	5
99366	Congenital atresia of canal, includes necessary mastoid surgery ……..	40.85	348.80	5
99368	Otoplasty for correction of outstanding ears - unilateral ……...	40.85	247.35	5
	Note: Otoplasty for correction of outstanding ears is insured for patients 0-17 years of age. It is not an insured service for patients 18 years of age and older.			
99372	Meatoplasty or canalplasty for congenital malformation ……...	40.85	290.16	5
99374	- with grafting of canal …… add		197.54	1
99376	- with tympanoplasty and/or ossiculoplasty and/or mastoidectomy ……... add		390.31	2

Code		Assist	FP/ Spec.	Anaes.
	MIDDLE EAR			
	Introduction (IOP)			
	Eustachian Catheterization			
99380	- catheterization under local anaesthetic - unilateral		5.45	
99382	- catheterization under general anaesthetic - uni or bilateral		21.80	4
	Insufflation of eustachian tube		VF	
99383	Intratympanic injections		150.00	
	Incision (IOP)			
	Myringotomy, to include aspiration when indicated			
99390	- myringotomy under local anaesthetic		42.15	
99392	- with insertion of ventilation tube using operating microscope		78.60	
99394	- myringotomy under general anaesthetic – with/without operating microscope, unilateral		42.15	4
99396	- with insertion of drainage tube using operating microscope, unilateral		78.60	4
99398	Aspiration of serous otitis		11.45	4
	Excision			
	Mastoidectomy			
	- simple			
99410	- child	32.68	328.50	6
99412	- adult or adolescent	32.68	328.50	6
99414	- radical or modified radical	32.68	627.10	7
99416	- revision mastoidectomy with revision of middle ear and regrafting	32.68	526.45	7
99420	- with meatoplasty and/or canalplasty add		103.86	
99422	- with ossiculoplasty add		83.28	
	Repair			
99430	Myringoplasty	32.68	198.90	5
99432	Tympanoplasty including necessary mastoid or middle ear surgery	49.02	651.23	7
99440	Ossiculoplasty	32.60	415.49	7
99442	Facial nerve decompression	49.02	611.35	9
99444	Facial nerve graft	49.02	939.90	9
99446	Closure of mastoid fistula	32.68	239.95	4
99448	Exploratory tympanotomy		288.50	4
99450	Section tympanic plexus		352.20	6
99452	Tympanotomy with round or oval window fistula repair (IOP)		375.95	6

Code		Assist	FP/ Spec.	Anaes.
	INNER EAR			
	Incision			
	Labyrinthotomy or labyrinthectomy			
99470	Surgical including Tack or Fick procedures or ultrasound	49.02	521.95	7
	Repair			
99482	Fenestration of semicircular canals		348.80	6
99484	Stapes mobilization - unilateral		233.26	6
99486	Stapedectomy with prosthesis		644.54	6
99488	Posterior/Superior semicircular canal occlusion	49.02	612.70	8
99490	Endolymphatic shunt or sac decompression	32.68	629.60	9
99492	Temporal bone resection	32.68	1,379.10	9
	Permanent Cochlear Prosthesis Insertion			
99500	Extra-cochlear (round window, middle ear)	57.19	509.00	9
99502	Intra-cochlear	57.19	719.71	9
	Bone conduction hearing aid insertion			
99504	- implantable, including necessary mastoidectomy	32.68	345.15	6
	ACOUSTIC NERVE			
99520	Translabyrinthine resection of acoustic neuroma (includes surgical approach and closure, any method)	89.87	2,673.21	15

ANAESTHESIA BASIC FEE CODE RATES

Anaesthesia basic fees must be claimed as dollar amounts and not as unit values

Listed Unit Value	Rate
1	**$16.95**
2	**$33.90**
3	**$50.85**
4	**$67.80**
5	**$84.75**
6	**$101.70**
7	**$118.65**
8	**$135.60**
9	**$152.55**
10	**$169.50**
11	**$186.45**
12	**$203.40**
13	**$220.35**
14	**$237.30**
15	**$254.25**
16	**$271.20**
17	**$288.15**
18	**$305.10**
19	**$322.05**
20	**$339.00**
21	**$355.95**
22	**$372.90**
23	**$389.85**
24	**$406.80**
25	**$423.75**
26	**$440.70**
27	**$457.65**
28	**$474.60**
29	**$491.55**
30	**$508.50**

ANAESTHETIC TIME UNITS - SURGICAL PROCEDURES

TIME		Units	Rate
From	To		
1 minute	15 minutes	1	$14.53
16 minutes	30 minutes	2	$29.06
31 minutes	45 minutes	3	$43.59
46 minutes	60 minutes	4	$58.12
1 hour 1 minute	1 hour 15 minutes	5	$87.18
1 hour 16 minutes	1 hour 30 minutes	6	$116.24
1 hour 31 minutes	1 hour 45 minutes	7	$145.30
1 hour 46 minutes	2 hours	8	$174.36
2 hours 1 minute	2 hours 15 minutes	9	$217.95
2 hours 16 minutes	2 hours 30 minutes	10	$261.54
2 hours 31 minutes	2 hours 45 minutes	11	$305.13
2 hours 46 minutes	3 hours	12	$348.72
3 hours 1 minute	3 hours 15 minutes	13	$392.31
3 hours 16 minutes	3 hours 30 minutes	14	$435.90
3 hours 31 minutes	3 hours 45 minutes	15	$479.49
3 hours 46 minutes	4 hours	16	$523.08
4 hours 1 minute	4 hours 15 minutes	17	$566.67
4 hours 16 minutes	4 hours 30 minutes	18	$610.26
4 hours 31 minutes	4 hours 45 minutes	19	$653.85
4 hours 46 minutes	5 hours	20	$697.44
5 hours 1 minute	5 hours 15 minutes	21	$741.03
5 hours 16 minutes	5 hours 30 minutes	22	$784.62
5 hours 31 minutes	5 hours 45 minutes	23	$828.21
5 hours 46 minutes	6 hours	24	$871.80
6 hours 1 minute	6 hours 15 minutes	25	$915.39
6 hours 16 minutes	6 hours 30 minutes	26	$958.98
6 hours 31 minutes	6 hours 45 minutes	27	$1,002.57
6 hours 46 minutes	7 hours	28	$1,046.16
7 hours 1 minute	7 hours 15 minutes	29	$1,089.75
7 hours 16 minutes	7 hours 30 minutes	30	$1,133.34

EPIDURAL ANAESTHESIA FOR PAIN CONTROL
(Fee Codes 54134 and 80044)

TIME		Units	Rate
From	To		
1 minute	15 minutes	1	**$16.95**
16 minutes	30 minutes	2	**$33.90**
31 minutes	45 minutes	3	**$50.85**
46 minutes	60 minutes	4	**$67.80**
61 minutes	1 hour 15 minutes	5	**$84.75**
1 hour 16 minutes	1 hour 30 minutes	6	**$101.70**
1 hour 31 minutes	1 hour 45 minutes	7	**$118.65**
1 hour 46 minutes	2 hours	8	**$135.60**
2 hours 1 minute	2 hours 15 minutes	9	**$152.55**
2 hours 16 minutes	2 hours 30 minutes	10	**$169.50**
2 hours 31 minutes	2 hours 45 minutes	11	**$186.45**
2 hours 46 minutes	3 hours	12	**$203.40**
Maximum of 12 units payable per day			

Table IV **October 1, 2019**

NOTES:

A. For the day of admission to hospital, or of transfer from another specialty, claim for the admission exam – consult, assessment, reassessment as appropriate. Claim for day 2 as the first SHV date. Continue SHV billing as per the attached chart.

B. From the day of transfer within the same specialty, claim for SHV's only, claiming the type as a continuation from the first physician.

C. Separate claim items are required for each type SHV. That is, two types may not be combined and billed as one item. SHV's should be billed at least at the conclusion of type 2's and at the conclusion of type 3's, and, monthly thereafter.

SHV - SUBSEQUENT HOSPITAL VISIT - Type 2

Type SHV	Units	Rate
2	1	$31.00
2	2	$62.00
2	3	$93.00
2	4	$124.00
2	5	$155.00
2	6	$186.00
2	7	$217.00
2	8	$248.00
2	9	$279.00
2	10	$310.00
2	11	$341.00
2	12	$372.00
2	13	$403.00
2	14	$434.00
2	15	$465.00
2	16	$496.00
2	17	$527.00
2	18	$558.00

Type SHV	Units	Rate
2	19	$589.00
2	20	$620.00
2	21	$651.00
2	22	$682.00
2	23	$713.00
2	24	$744.00
2	25	$775.00
2	26	$806.00
2	27	$837.00
2	28	$868.00
2	29	$899.00
2	30	$930.00
2	31	$961.00
2	32	$992.00
2	33	$1,023.00
2	34	$1,054.00
2	35	$1,085.00

Table V **October 1, 2019**

NOTES:

A. From the day of transfer within the same specialty, claim for SHV's only, claiming the type as a continuation from the first physician.

B. Type 4 SHV's do not have a limitation. The rate listed is the rate per day after type 3 SHV's have concluded.

C. Separate claim items are required for each type SHV. That is, two types may not be combined and billed as one item. SHV's should be billed at least at the conclusion of type 2's and at the conclusion of type 3's, and, monthly thereafter.

SHV- SUBSEQUENT HOSPITAL VISIT - Type 3 and 4

Type SHV	Units	Family Medicine	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
3	1	$19.49	$21.61	$20.33	$19.63	$20.35	$22.06	$21.10
3	2	$38.98	$43.22	$40.66	$39.26	$40.70	$44.12	$42.20
3	3	$58.47	$64.83	$60.99	$58.89	$61.05	$66.18	$63.30
3	4	$77.96	$86.44	$81.32	$78.52	$81.40	$88.24	$84.40
3	5	$97.45	$108.05	$101.65	$98.15	$101.75	$110.30	$105.50
3	6	$116.94	$129.66	$121.98	$117.78	$122.10	$132.36	$126.60
3	7	$136.43	$151.27	$142.31	$137.41	$142.45	$154.42	$147.70
3	8	$155.92	$172.88	$162.64	$157.04	$162.80	$176.48	$168.80
3	9	$175.41	$194.49	$182.97	$176.67	$183.15	$198.54	$189.90
3	10	$194.90	$216.10	$203.30	$196.30	$203.50	$220.60	$211.00
3	11	$214.39	$237.71	$223.63	$215.93	$223.85	$242.66	$232.10
3	12	$233.88	$259.32	$243.96	$235.56	$244.20	$264.72	$253.20
3	13	$253.37	$280.93	$264.29	$255.19	$264.55	$286.78	$274.30
3	14	$272.86	$302.54	$284.62	$274.82	$284.90	$308.84	$295.40
3	15	$292.35	$324.15	$304.95	$294.45	$305.25	$330.90	$316.50
3	16	$311.84	$345.76	$325.28	$314.08	$325.60	$352.96	$337.60
3	17	$331.33	$367.37	$345.61	$333.71	$345.95	$375.02	$358.70
3	18	$350.82	$388.98	$365.94	$353.34	$366.30	$397.08	$379.80
3	19	$370.31	$410.59	$386.27	$372.97	$386.65	$419.14	$400.90
3	20	$389.80	$432.20	$406.60	$392.60	$407.00	$441.20	$422.00
3	21	$409.29	$453.81	$426.93	$412.23	$427.35	$463.26	$443.10
3	22	$428.78	$475.42	$447.26	$431.86	$447.70	$485.32	$464.20
3	23	$448.27	$497.03	$467.59	$451.49	$468.05	$507.38	$485.30
3	24	$467.76	$518.64	$487.92	$471.12	$488.40	$529.44	$506.40
3	25	$487.25	$540.25	$508.25	$490.75	$508.75	$551.50	$527.50

SHV - SUBSEQUENT HOSPITAL VISIT

Type SHV	Units	Family Medicine	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
3	26	$506.74	$561.86	$528.58	$510.38	$529.10	$573.56	$548.60
3	27	$526.23	$583.47	$548.91	$530.01	$549.45	$595.62	$569.70
3	28	$545.72	$605.08	$569.24	$549.64	$569.80	$617.68	$590.80
3	29	$565.21	$626.69	$589.57	$569.27	$590.15	$639.74	$611.90
3	30	$584.70	$648.30	$609.90	$588.90	$610.50	$661.80	$633.00
3	31	$604.19	$669.91	$630.23	$608.53	$630.85	$683.86	$654.10
3	32	$623.68	$691.52	$650.56	$628.16	$651.20	$705.92	$675.20
3	33	$643.17	$713.13	$670.89	$647.79	$671.55	$727.98	$696.30
3	34	$662.66	$734.74	$691.22	$667.42	$691.90	$750.04	$717.40
3	35	$682.15	$756.35	$711.55	$687.05	$712.25	$772.10	$738.50
3	36	$701.64	$777.96	$731.88	$706.68	$732.60	$794.16	$759.60
3	37	$721.13	$799.57	$752.21	$726.31	$752.95	$816.22	$780.70
3	38	$740.62	$821.18	$772.54	$745.94	$773.30	$838.28	$801.80
3	39	$760.11	$842.79	$792.87	$765.57	$793.65	$860.34	$822.90
3	40	$779.60	$864.40	$813.20	$785.20	$814.00	$882.40	$844.00
3	41	$799.09	$886.01	$833.53	$804.83	$834.35	$904.46	$865.10
3	42	$818.58	$907.62	$853.86	$824.46	$854.70	$926.52	$886.20
3	43	$838.07	$929.23	$874.19	$844.09	$875.05	$948.58	$907.30
3	44	$857.56	$950.84	$894.52	$863.72	$895.40	$970.64	$928.40
3	45	$877.05	$972.45	$914.85	$883.35	$915.75	$992.70	$949.50
3	46	$896.54	$994.06	$935.18	$902.98	$936.10	$1,014.76	$970.60
3	47	$916.03	$1,015.67	$955.51	$922.61	$956.45	$1,036.82	$991.70
3	48	$935.52	$1,037.28	$975.84	$942.24	$976.80	$1,058.88	$1,012.80
3	49	$955.01	$1,058.89	$996.17	$961.87	$997.15	$1,080.94	$1,033.90
3	50	$974.50	$1,080.50	$1,016.50	$981.50	$1,017.50	$1,103.00	$1,055.00
3	51	$993.99	$1,102.11	$1,036.83	$1,001.13	$1,037.85	$1,125.06	$1,076.10
3	52	$1,013.48	$1,123.72	$1,057.16	$1,020.76	$1,058.20	$1,147.12	$1,097.20
3	53	$1,032.97	$1,145.33	$1,077.49	$1,040.39	$1,078.55	$1,169.18	$1,118.30
3	54	$1,052.46	$1,166.94	$1,097.82	$1,060.02	$1,098.90	$1,191.24	$1,139.40
3	55	$1,071.95	$1,188.55	$1,118.15	$1,079.65	$1,119.25	$1,213.30	$1,160.50
3	56	$1,091.44	$1,210.16	$1,138.48	$1,099.28	$1,139.60	$1,235.36	$1,181.60

SHV - SUBSEQUENT HOSPITAL VISIT

Type SHV	Units	Family Medicine	Neurology	Obstetrics/ Gynecology	Pediatrics	Physical Medicine	Psychiatry	All Others
4	1	$6.80	$20.81	$19.58	$18.90	$19.60	$21.24	$20.32
4	2	$13.60	$41.62	$39.16	$37.80	$39.20	$42.48	$40.64
4	3	$20.40	$62.43	$58.74	$56.70	$58.80	$63.72	$60.96
4	4	$27.20	$83.24	$78.32	$75.60	$78.40	$84.96	$81.28
4	5	$34.00	$104.05	$97.90	$94.50	$98.00	$106.20	$101.60

UNITS TABLE FOR SURGICAL ASSISTANTS BILLING ACCORDING TO STANDARD TIME METHOD

Units	Rate
1	$30.00
2	$60.00
3	$90.00
4	$120.00
5	$150.00
6	$180.00
7	$210.00
8	$240.00
9	$270.00
10	$300.00
11	$330.00
12	$360.00
13	$390.00

Units	Rate
14	$420.00
15	$450.00
16	$480.00
17	$510.00
18	$540.00
19	$570.00
20	$600.00
21	$630.00
22	$660.00
23	$690.00
24	$720.00
25	$750.00

UNITS TABLE FOR SURGICAL ASSISTANTS BILLING ACCORDING TO DEDICATED TIME METHOD

Units	Rate
1	$27.50
2	$55.00
3	$82.50
4	$110.00
5	$137.50
6	$165.00
7	$192.50
8	$220.00
9	$247.50
10	$275.00
11	$302.50
12	$330.00
13	$357.50

Units	Rate
14	$385.00
15	$412.50
16	$440.00
17	$467.50
18	$495.00
19	$522.50
20	$550.00
21	$577.50
22	$605.00
23	$632.50
24	$660.00
25	$687.50