ANESTHESIA

Anesthesia Preamble

The tariff is for all types of anesthetic service. This includes general and regional anesthesia, resuscitation and critical care, monitored anesthesia care, and any other procedure carried out with the assistance of an anesthesiologist at the request of the attending physician. The fees are payable to all anesthesiologists with the exception of consultations and continuing care by consultants which are payable only to certified specialists in anesthesia.

Intensity and Complexity Index

Intensity/Complexity Level	Fee Code	$ (per 15 minutes or part thereof)
2	01172	32.48
3	01173	34.20
4	01174	35.94
5	01175	37.67
6	01176	39.37
7	01177	41.10
8	01178	42.83
9	01179	44.58
10	01180	46.29
11	01181	48.04f

The Total Anesthetic Fee is determined by selecting the appropriate item, or items:

1. Pre-anesthestic evaluation fee.
2. Consultation and continuing care fees.
3. Anesthestic intensity/complexity levels.
4. Anesthestic procedural fee modifiers.
5. Resuscitation and critical care fees.
6. Diagnostic and therapeutic anesthetic fees.
7. Acute pain management fees.
8. Obstetrical analgesia fees.

1. Pre-Anesthetic Evaluation Fees

01151 and 13052 apply when a pre-anesthetic evaluation is performed for:

a) In-patients where a separate visit prior to anesthetic is required. The assessment when performed immediately prior to anesthestic will be paid using the anesthetic intensity/complexity level of the anesthetic procedure itself and 01151 or 13052 will not be paid in addition.

b) Out-patients where a separate visit for anesthetic assessment is required such as in a pre-anesthetic clinic.

2. Consultations

a) 01015 applies when a certified specialist anesthesiologist is requested to assess a patient because of the complexity, obscurity and/or seriousness of the case. It may or may not be associated with a subsequent anesthetic. If this consultation is followed by an anesthetic within 24 hours by the same consultant, a pre-anesthetic assessment will not be paid in addition. If the anesthetic is given by the same consultant after an interval of more than 24 hours, or a different anesthesiologist within 24 hours, then the appropriate pre-anesthetic evaluation will apply.

b) 01115 applies to two situations:

i) When a repeat consultation is done for the same condition within six months by the same consultant. If it is done by the same consultant for a different condition, or a different consultant for the same condition within six months, 01015 will be paid if the problem is appropriately complex, obscure and/or serious.

ii) 01115 also applies for a limited consultation when in the opinion of the consultant the problem does not warrant 01015. If a repeat or limited consultation is followed by an anesthetic within 24 hours by the same consultant, a pre-anesthetic assessment will not be paid in addition. If the anesthetic is given by the same consultant after an interval of more than 24 hours, or a different anesthesiologist within 24 hours then the appropriate pre-anesthetic evaluation (see preamble for fee item number 01151) will apply.

c) 01016 applies to consultations for complex diagnostic and/or therapeutic chronic pain management problems which require a comprehensive history and physical examination.

d) 01116 applies to two situations:

i) When in the opinion of the consultant the diagnostic and/or therapeutic chronic pain management problem is of a more limited nature.

ii) When the same consultant sees a patient in consultation within six months of billing 01016 for the same problem. When the same consultant sees the patient for a different problem within six months, or a different consultant sees the patient for the same problem within six months, then 01016 may be billed if the problem is appropriately complex.

e) 01107 specifically applies to patient visits in a private office setting where the physician has an increased overhead factor.

f) Continuing care items 01107 and 01108 cannot be billed with any other listings.

3. Anesthetic Procedural Fees

a) The **anesthetic procedural fee** is calculated by multiplying the anesthetic intensity/complexity level by the anesthetic time calculated in 15 minute increments.

b) The **anesthetic intensity/complexity level** is listed opposite the specific surgical, diagnostic and/or therapeutic procedure in the schedule. The anesthetic intensity/complexity level time units are indicated in the listing. These levels represent different degrees of complexity and/or intensity, and each procedure is allocated according to the complexity and/or intensity of the anesthetic service required.

c) The **anesthetic time** commences when the anesthesiologist is first present for the purpose of providing the anesthetic, and ends when the anesthesiologist is no longer in attendance, and the patient may be safely left in the care of the appropriate nursing staff. Time should be calculated in 15 minute periods or parts thereof, i.e. the final period of an anesthetic counts as a full 15 minute period, even if it lasts less than 15 minutes.

The **anesthetic procedural fee** covers all services rendered by an anesthesiologist during the procedure, except those listed in the "anesthetic procedural fee modifier" and “acute pain management” sections of the fee schedule.

d) P.A.R. (Post-Anesthetic Recovery)

There are three different ways to bill care in P.A.R. according to the situation:

i) **Routine P.A.R. care:** Time spent with the patient subsequent to the end of the anesthetic, in the P.A.R. for routine problems, is to be billed at the same rate as the anesthetic, and included in the anesthetic procedural fee. For example, in a patient with post-operative hypertension after a cholecystectomy, the P.A.R. time is added to the anesthetic time and billed at the cholecystectomy procedural hourly rate.

ii) **Critical care in P.A.R.** can be billed as fee item number 01088 where time spent with the patient begins when the anesthetic finishes. (e.g.: post-operative abdominal aortic aneurysm on a ventilator).

iii) **Resuscitation in life threatening emergencies in the P.A.R.** should be billed as fee item number 01088 (e.g.: respiratory arrest in the recovery room requiring intubation).

e) **Multiple procedures:** When more than one surgical, diagnostic and/or therapeutic procedure is performed during the same anesthetic service the procedural rate for the total anesthetic time will be the rate for whichever of those procedures having the highest procedural rate (e.g.: emergency craniotomy with compound fracture femur will be paid at the procedural rate for craniotomy).

4. Anesthetic Procedural Fee Modifiers

a) These fee items are to be paid in addition to the anesthetic procedural fee. They apply to all general, regional and monitored anesthetic care for all surgical, therapeutic and/or diagnostic procedures. These fees are payable to all anaesthesiologist(s). They do not apply to diagnostic and therapeutic anesthesiology fees.

b) 01059, 01065, 01070, 01071, 01072, 01077, 01082, 01084, 01192, 01093, 01096, 01164, 01166 and 01168 are fixed fees which are paid in addition to the anesthetic procedural fee. They are not included in the anesthetic procedural fee for the application of 01080.

c) 01080 is a multiplier and applies only to the anesthetic procedural fee. When 01080 is applicable, multiply the total anesthetic procedural fee [including routine P.A.R. care as is 3 d) i)] by 10%.

d) 01080 can only be used once per case, even if it qualifies more than once (e.g.: ASA 5E cardiac surgical case with an I.A.B.P. lasting 12 hours will be paid at 10%).

e) Emergency cardiac surgery is defined for this purpose as surgery which is so urgent that it has to be done outside normal elective operating time, or necessitates "bumping" cases previously booked on the elective slate.

5. Resuscitation Fees

These fees refer to resuscitation by anesthesiologist.

a) **Resuscitation:** 01088 refers to treatment of acute life threatening emergencies that require constant bedside attendance. It includes all services provided by the anesthesiologist, such as endotracheal intubation, crico-thyroidotomy, invasive monitoring, chest tube drainage, and/or temporary pacemaker insertion. Consultations will not be paid. Written explanation is normally not required.

Timing begins when the anesthesiologist is first in attendance with the patient and ends when constant bedside attendance is no longer necessary. If resuscitation precedes a surgical procedure (e.g.: a patient with a ruptured thoracic aneurysm) resuscitation timing will finish when surgery is commenced as noted on the O.R. record and the anesthetic time will then start.

b) **Neonatal Resuscitation:** 01090 refers to resuscitation of a severely depressed neonate when the Apgar score at one minute is 5 or less as noted on the delivery record. It includes all services performed by the anesthesiologist including endotracheal intubation and/or umbilical catheterization. Consultations will not be paid. Written explanation is normally not required.

c) 01088, 01090, 01091, 01094, 00017, 01095 are eligible for out of office hours service charges and/or continuing care surcharges.

6. Diagnostic and Therapeutic Anesthetic Fees

a) These fees apply to nerve blocks and intravenous procedures done for diagnostic and/or therapeutic chronic pain management problems.

b) Consultations will be paid where appropriate.

c) Anesthetic procedural fee modifiers will not be paid with these fee items.

d) Diagnostic and/or therapeutic anesthetic fees are not eligible for out of office service charges and continuing care surcharges.

e) DTAFs and/or FIs 00424 and/or 00811 paid to a maximum of three fees.

f) When multiple DTAFs, and/or FIs 00424 and/or 00811 are billed, the fee with the largest value may be claimed in full and the remaining two procedures at 50 percent of the listed fee(s).

g) Trigger point injections within 60 cms of a peripheral nerve block(s) are considered included in the peripheral nerve block fee.

h) FI 01125 is the only peripheral nerve block fee regardless of the anatomic location of each nerve (e.g.: sciatic and occipital nerve blocks are paid as FI 01125).

7. Acute Pain Management

a) Acute pain management listings are applicable to the management of “acute” pain in: post-operative surgical patients, surgical patients who may not undergo surgery but have

"acute" pain problems, and medical patients who have "acute" pain problems. These listings are not applicable to pain management during labour.

b) When catheters are inserted in the O.R. prior to or immediately following surgical, therapeutic and/or diagnostic procedures for the purpose of acute pain management in the post-operative period, the procedural fees for insertion of catheters are paid as anesthesiology procedural modifiers (01071, 01072, 01082, 01084). Catheters placed subsequently in the P.A.R. and/or ICU will be paid according to the acute pain management listings (01025, 01026, 01074, 01007). Catheter supervision visits (01076, 01021, 01073) in the P.A.R. should be billed as routine P.A.R. care as per 3 d) i).

c) All acute pain management fee items are eligible for out-of-office hours service charges and continuing care surcharges in accordance with the Schedule and Preamble for out-of-office hours premiums.

d) Repeat injections of previously inserted catheters will be paid to a maximum of four in 24 hours without written explanation. Written explanation will be required by the Medical Services Plan (MSP) for payment of repeat injections in excess of this.

e) Visits for continuous infusions and patient controlled analgesia will be paid to a maximum of two in 24 hours without written explanation to the MSP. Payment in excess of this will require written explanation to MSP.

f) Anesthetic procedural fee modifiers will not be paid with acute pain management fee items.

g) Consultations for assessment of the patient for acute pain management:

i) 01013 is not applicable to referrals from another certified specialist in anesthesiology.

ii) 01013 applies to consultations requested for post-operative acute pain management prior to surgery (but after admission) or within 24 hours following the end of surgery. When a certified specialist in anesthesiology is requested to consult on a patient for acute pain management not associated with surgery, or more than 24 hours following the end of surgery, then either 01016 or 01116 will be applicable.

iii) The peri-operative assessment of the routine patient PCA post operatively is included in the anesthetic fee. In exceptional circumstances, item 01013 may be applicable. Such claims will require an explanatory note in the claim note record. Fee item 01013 may also be applicable for cases requiring epidural, axillary plexus or intrapleural infusions and/or PCA for control of unanticipated, prolonged or severe or other exceptionally painful conditions unrelated to the surgery.

Note: *Consultation (01015) or pain consultation (01013) may not be billed for routine PCA post-operative pain management.*

h) Referred consultations for acute pain management assessment post-operatively will be paid as 01013. In more complex situations (e.g.: acute pain management of terminal cancer patients) 01016 will be appropriate and paid as such. Pre-anesthetic evaluations will not be paid.

i) Hospital visits for supervision of epidural, axillary plexus and/or intrapleural catheters and/or PCA are to be billed only when the physician is in attendance for the purpose of assessing the patient's response to, and/or adjustment of the infusion/PCA, and/or treating adverse reactions.

j) Acute pain management listings are not applicable in addition to claims for critical care fee items (01088, 01412, 01413, 01422, 01423, 01432, 01433, 01442 and 01443) when claimed by an anesthesiologist capable of acute pain management.

8. Obstetric Analgesia Fees (Epidural Analgesia in Labour)

a) Consultation will be appropriate when referred because of complex, obscure and/or serious problems. For example, patients with pregnancy induced hypertension, thrombocytopenia, or any other medical or obstetrical complications would be appropriate for an anesthetic consultation.

9. An anesthesiologist's continuous attendance

An anesthesiologist's continuing attendance, by request of the attending physician at any procedure for monitored anesthetic care, is payable at the same anesthetic intensity/complexity level as for administration of anesthetic for the procedure.

10. Payment of two anesthesiologists

a) Where two anesthesiologists are medically required in the interest of the patient both may charge a full fee. When billing MSP support the need for charges with a written statement.

b) Where one anesthesiologist takes over from another part way through a procedure, the total fee billed by both anesthesiologists should not exceed the fee that one anesthesiologist would have billed, had the replacement not occurred.

11. Payment of anesthetic when performed by the surgeons

When a surgeon is required to administer an anesthetic in addition to performing a surgical procedure it is recommended that a charge NOT be made for the anesthesiology in addition to the procedure performed. In emergency situations it may be necessary for the surgeon to act as the anesthesiologist; a charge for such service should be accompanied by a written explanation of the circumstances by the surgeon concerned when billing the Plan.

12. Anesthetic fees not included in the schedule

a) Such fees shall be computed in equity with procedures of similar anesthetic responsibility, difficulty and skill. When submitting an account to MSP use fee item 01999 and state reason for the charge.

b) The foregoing also applies to anesthetic procedural units for surgical or diagnostic procedures charged under a miscellaneous 999 number (see clause C. 4., Preamble).

c) Anesthesiologists will not normally perform simultaneous services. In the rare event where a life-threatening emergency presents to an anesthesiologist already in attendance at one service, AND a second anesthesiologist is not immediately available, AND a delay to await the arrival of a second anesthesiologist would pose an unacceptable risk of adverse outcome to the second patient, SO THAT, in the judgment of the attending physicians and the attending anesthesiologist has no option other than performing two services simultaneously, THEN the attending anesthesiologist may perform two services

simultaneously and may bill the full fee for both services until the second anesthesiologist arrives. Written explanation to the payment agency is required. This does not apply to simultaneous services of a less than life-threatening nature or where one of the two services is conducted or supervised by a resident or intern or student.

For example, a patient with a respiratory arrest in a P.A.R. requires intubation. The patient undergoing a procedure in the O.R. has to be left with appropriate alternate care for a brief period while the P.A.R. patient is intubated and stabilized.

Another example would be setting up a second operating room for a “STAT” caesarian section for life threatening fetal distress and supervising two anesthestics with appropriate help until a second anesthesiologist can arrive to take over.

Similarly, when there is a life-threatening Neonatal Resuscitation required and the “baby doctor” is not available to perform the resuscitation, it is acceptable that the initial patient be supervised under appropriate alternate care until either the “baby doctor” arrives, or the baby is stabilized.

d) Where unusual detention with the patient before, and/or after anesthetic is necessary, this time will be compensated at the same intensity/complexity level as the anesthetic except when it is appropriate to bill for resuscitation, or when requested to attend at delivery to resuscitate the neonate if necessary.

   i) Examples where unusual detention may be required include (but are not limited to) patients with: prolonged neuromuscular paralysis, haemodynamic instability, post-extubation laryngeal stridor, bronchospasm and bleeding diathesis.

   ii) T01112 is applicable where the attendance of the anesthesiologist is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and where the anesthesiologist is in constant attendance. For example, this applies to the situation where an anesthesiologist is requested to be present at delivery for the purpose of neonatal resuscitation. If resuscitation is necessary, then T01112 stops at the time of delivery and 01090 commences.

13. Anesthetic for non-insured dental procedures

Preface:

This policy is restricted to non-cosmetic non-insured dental procedures where it is impossible for the dentist or oral and maxillofacial surgeon to properly manage the patient by any other means except with general anesthetic. The exceptions will apply to dental services regardless of the location in which they are performed.

Policy:

Dental related anesthetic services are only a benefit when the dental procedure is an insured service under MSP unless one of the following exceptions exists:

i) children requiring extensive dental rehabilitation and could not be otherwise managed/treated due to the length of time for the treatment and the dental treatment is scheduled to last more than one hour; or

ii) the patient has a severe mental or physical disability that precludes the performance of the dental procedure(s) under local anesthetic; or

iii) there is a demonstrated medical contra-indication (e.g.: allergy) to local anesthetic precluding the performance of the dental procedure(s) under local anesthetic; or

iv) there is difficulty with access to the airway precluding the performance of the dental procedure(s); or

v) the presence of dental disease adds a significant risk of complication(s) to a planned major surgical procedure, medical treatment, or post-operative care such as for cancer treatment and/or the patient's presenting medical condition is severe enough to preclude the performance of the dental procedure(s) under local anesthetic; or

vi) the emergent nature of the dental condition requires immediate attention under general anesthetic.

Notes:

1. *The term extensive dental rehabilitation will include surgery for trauma, fillings, and other traditional rehabilitation services.*

2. *Prior approval may be sought for those cases not fulfilling the exception criteria listed above when the dentist or oral and maxillofacial surgeon is of the opinion general anesthetic is essential for the safe and efficient performance of a medically required dental procedure. It is important to note that fear and/or anxiety does not warrant coverage of dental anesthetic by MSP. Requests for prior approval should be forwarded in writing (with appropriate documentation to make a decision) to the Director, Claims Branch, Medical Services Plan.*

3. *The Association of Dental Surgeons has agreed that in the case of an audit resulting in the recovery of inappropriately billed anesthetic claims, the dental or oral and maxillofacial surgeon requesting the anesthesiology will be responsible for reimbursement. Recoveries will be applied to the Available Amount for physician services.*

ANESTHESIA

These listings cannot be correctly interpreted without reference to the Preamble.

Total Fee $

Visit / Evaluation

01107 Office visit 53.80
01108 Hospital visit.....44.85
Note: *01107 and 01108 are not paid with other listings.*

01151 Pre-anesthetic evaluation (applies to standard pre-anesthetic evaluation) 44.85
Note: *Applicable to certified anesthesiologists only.*

Referred Cases

Consultations:

01015 **Consultation by a certified specialist in Anesthesia:** Because of the complexity, obscurity and/or seriousness of the case. Includes appropriate history and physical examinations, review of radiological and laboratory findings and a written report. 103.41

01115 **Repeat or limited consultation by a certified specialist in Anesthesia:** To apply where a consultation is repeated for the same condition/problem within six months by the same consultant, or where, in the judgment of the consultant, the consultative service does not warrant 01015. To include appropriate history and physical examination, review of radiological and laboratory findings and a written report. 68.93

01016 **Consultation by a certified specialist in Anesthesia:** For diagnostic opinion and/or therapeutic management of complicated chronic pain, and/or related problems. To include comprehensive history and physical examination, review of radiological and laboratory findings and a written report. If followed by a diagnostic or therapeutic nerve block the consultation may be charged in addition to the nerve block fees on the first occasion.....191.25

01116 **Repeat or limited consultation by a certified specialist in Anesthesia:** To apply for a diagnostic opinion and/or therapeutic pain management where a consultation is repeated for the same condition/problem within six months by the same consultant, or where in the judgment of the consultant, the consultative service does not warrant a 01016. .....95.61
Notes:
- *i) 01016, 01116 do not apply to evaluation of pain during confinement.*
- *ii) Fee item 01116 plus a nerve block would be payable for the initial re-referral at the same sitting.*
- *iii) In cases where the consultant sets down a treatment plan that requires the patient to return to follow-up nerve blocks for the same condition, only the nerve block is payable.*
- *iv) In some cases, a single nerve block will be performed at the initial consultation and no further nerve blocks are planned at that time. The course of treatment is to monitor the effectiveness of the first block. If, however, the patient is re-referred for further blocks within 6 months, then a follow-up consultation (01116) plus the nerve block is payable.*

Total Fee $

Anesthetic Procedural Fee Modifiers

01059	Prone position	28.97
01065	Patients under 1 year of age ***Note:*** *Not to be billed in addition to 01168.*	38.60
01070	Controlled hypotension in neurosurgical anesthetic to lower mean blood pressure to 60 mm Hg or less, or the appropriate safe lower limit	57.94
01071	Thoracic epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up	51.46
01072	Lumbar epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up.	39.58
01077	Pulmonary artery catheterization	52.72
01082	Axillary catheter insertion during anesthetic, to include initial injection and/or infusion set-up	22.99
01084	Intrapleural catheter insertion during anesthetic, to include initial injection and/or infusion set-up	26.47
01093	Spinal cord monitoring (interpretation of SSEP during anesthetic)	38.64
T01096	Retrobulbar/peribulbar block administered by an anesthesiologist in conjunction with an anesthetic	32.28
01164	Patients 70 – 79 years of age	19.32
T01165	Patients 80 years of age and over	39.41
01166	Sitting position where there is a danger of venous air embolism	57.94
01168	Neonates (less than 42 gestational weeks and/or 4000 grams or less)	77.21
T01192	Awake intubation by any means in the patient with a suspected or proven difficult airway ***Note:*** *Applicable only when airway score is 3 or 4.*	57.94

01080 In the following cases an additional 10% of the procedural fee will be paid:

a) All patients (except cardiac surgery patients) who have an incapacitating, systemic disease which is a constant threat to life, or who are not expected to survive for 24 hours, i.e. ASA 4 or 5.
b) Cardiac surgery patients who have emergency surgery, i.e. ASA 4E or 5E.
c) Cardiac or transplant surgery patients who require an IABP or mechanical assist device.
d) All cases where the surgical time as noted on the OR record is 8 hours or more. This includes cardiac surgery.

Controlled hypothermia and/or pump oxygenation in non-cardiac anesthesia should be billed as 01999, with a written report.

		Total Fee $

Diagnostic and Therapeutic Anesthetic Fee Items

The anesthetic fee is for professional services. Consultations (fee items 01016, 01116, and 01013) when requested, will be charged in addition. Anesthetic evaluation (fee item 01151), or Continuing Care items (fee items 01107, 01108) will not be charged in addition. These fees are for diagnostic and therapeutic procedures not associated with surgery.

01022	Nerve plexus	128.44
T01124	Peripheral nerve block - single	60.83
T01125	Peripheral nerve block - multiple	91.94
01035	Gasserian ganglion	241.19
	Epidural Blocks:	
01135	Lumbar	142.54
01036	Thoracic	216.17
01037	Cervical	249.44
01138	Caudal blocks	142.54
	Nerve Root or Facet Blocks:	
	Cervical:	
01140	- single	173.61
01141	- multiple	231.47
	Thoracic:	
01142	- single	158.99
01143	- multiple	211.98
	Lumbar:	
01144	- single	144.39
01145	- multiple	192.54
	Subarachnoid (Spinal) Blocks:	
01032	Subdural (spinal)	151.70
01034	Differential spinal	202.26
	Sympathetic Nerves:	
01040	Stellate ganglion	111.78
01042	Paravertebral (lumbar sympathetic)	183.78
01044	Coeliac plexus	255.80
	Permanent Cryosection and/or Neurolysis:	
01146	Major plexus or nerve root	334.50
01147	Single peripheral nerve	158.20
01148	Multiple peripheral nerves	211.98
01149	Epidural or subarachnoid neurolysis	376.39
01150	Gasserian ganglion neurolysis	376.39
	Injection Tendon Sheath, Ligaments, Trigger Points:	
01156	Single injection	57.60
01157	Multiple injections	72.24
T01159	IV injection for diagnosis and/or therapeutic management of pain syndromes - local anesthetic only	57.60
T01160	IV injections for diagnosis and/or therapeutic management of pain syndromes – guanethidine or bretylium only	115.21

Total Fee $

Resuscitation by an Anesthesiologist

Consultations and anesthetic assessments are not payable in addition to critical care fees, however, when they are done prior to the surgery for the purpose of the anesthetic they are payable.

01088 Resuscitation by an anesthesiologist, requiring continuous bedside care - per 15 minutes or part thereof 75.66

Notes:

i) Includes endotracheal intubation, cricothyroidotomy, chest tube drainage, monitoring, and pacemaker insertion.

ii) Consultation not paid in addition.

01090 Neonatal resuscitation by an anesthesiologist - per 15 minutes (or part thereof) 75.66

Notes:

i) Applicable where the Apgar score is 5 or less, as noted on the delivery record.

ii) Includes endotracheal intubation and/or umbilical vessel catheterization.

iii) Consultation not paid in addition.

01091 Intubation requested by attending physician, with no responsibility for subsequent care. 161.42

Notes:

i) Applicable to removal and reinsertion of ET tube.

ii) Consultation not paid in addition.

01094 Pulmonary artery catheter placement (not associated with an anesthetic). 158.39

01095 Intra-arterial catheter placement - isolated procedure 32.66

00017 Insertion of central venous pressure catheter 23.32

Acute Pain Management

See Anesthesia Preamble for application and limitations.

01013 Consultation by a certified specialist in anesthesia for assessment of the patient for post operative acute pain management, when the consultation is requested after admission and either prior to surgery or within 24 hours following the end of surgery, to include review of the relevant history and physical examination, x-ray and laboratory findings, and a written report. 68.93

T01026 Thoracic epidural catheter insertion, to include initial injection and/or infusion set up 216.17

T01025 Lumbar or caudal epidural catheter insertion, to include initial injection and/or infusion set up 142.54

T01050 Repeat injection via indwelling epidural catheter to a maximum of 4 per day - per injection 44.85

Note: *Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.*

T01073 Hospital visit for supervision of epidural infusion to a maximum of 2 per day - per visit 31.60

Note*: Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.*

		Total Fee $
T01074	Axillary catheter insertion, to include initial injection and/or infusion set up	68.77
T01075	Repeat injections via indwelling axillary catheter to a maximum of 4 per day – per injection ***Note**: Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.*	44.85
T01076	Hospital visit for supervision of axillary catheter infusion to a maximum of 2 per day - per visit ***Note:** Where more than two visits per day are necessary, an explanatory note in the claim note record is required.*	31.60
T01007	Intrapleural catheter insertion, to include initial injection and/or infusion set up	79.20
T01019	Repeat injections via indwelling intrapleural catheters to a maximum of 4 per day - per injection ***Note:** Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.*	44.85
T01021	Hospital visit for supervision of intrapleural infusion to a maximum of 2 per day - per visit ***Note:** Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.*	31.60
T01011	Patient controlled analgesia (PCA) - first day only (to include set up)	20.66
T01012	Hospital visit for supervision of patient controlled analgesia during second and subsequent days, to a maximum of 2 visits per day - per visit ***Notes:*** *i) Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.* *ii) T01012 is not payable on the same day as T01011.*	31.60
T01186	Major peripheral nerve block - single	43.46
T01187	Major peripheral nerve block - multiple	65.67

Obstetric Analgesia Fees

01102	Insertion of epidural catheter. To include initial injection and/or set-up of infusion for analgesia during labour.	120.80

Supervision of Labour Epidural Analgesia

PG01047	Medical Supervision of Labour Epidural Analgesia: Daytime (Monday to Friday, 0800-1800 hrs), per 5 minutes (or major portion thereof)	9.08
PG01048	Medical Supervision of Labour Epidural Analgesia: Evening (Monday to Friday, 1800-2300 hours), and Weekends (Saturday & Sunday, 0800-2300 hours) and Statutory Holidays (0800-2300 hours), per 5 minutes (or major portion thereof)	13.62

Total Fee $

PG01049 Medical Supervision of Labour Epidural Analgesia: Night (Monday to Sunday, 2300-0800 hours), per 5 minutes (or major portion thereof) 18.16

Notes:

i) Fees are payable to the same physician concurrently with services provided to other patients, including concurrent payment of fee items PG01047, PG01048, PG01049 for more than one patient.

ii) The fee items PG01047, PG01048, PG01049 are payable to a maximum of 48 units per patient, per maternity.

iii) Payment begins immediately after the labour epidural catheter is inserted.

iv) Payment continues until the earliest of the following:
- *4 hours duration of medical supervision (48 time units)*
- *Time of birth*
- *Time when payment begins for anesthetic care on the same patient related to c-section, complicated delivery, or surgical delivery.*

v) Fees include payment for labour epidural analgesia top-up and supervision visit services.

vi) Reinsertion of a labour epidural catheter is payable under fee item 01102, and does not form part of the medical supervision period.

vii) Out-of-Office Hours Premiums (Call-Out Charges and Continuing Care Surcharges {Non-operative and Anesthesiology}) are not applicable.

viii) The time period (e.g.: daytime, evening, night) during which the medical supervision begins determines which fee item is paid for the entire duration, even when the supervision time continues into a new time period.

ix) Start and end times required in the time field.

Miscellaneous Anesthetic Procedural Fees

T01005 Anesthesia for Magnetic Resonance Imaging (MRI) or CT scanning - per 15 minutes or part thereof 35.94

Note: *Intended to apply only to very heavy sedation, general anesthesiology and/or ventilatory assistance associated with MRI or CT scanning.*

T01105 Anesthesia for cataract surgery – per one minute increment.....2.02

Note: *This item applies to fee codes S02188, S02190, S02192, S02196, and S22191.*

01106 Anesthesia for electroconvulsive therapy - per 15 minutes or part thereof.....32.48

01110 Anesthesia for dental procedures (all procedures unless otherwise listed) - per 15 minutes or part thereof 34.22

01111 Anesthesia for emergency relief of acute upper airway obstruction (above the carina) - per 15 minutes or part thereof.....48.04

Notes:

i) Applicable to conditions such a acute epiglottitis, but not applicable to condition such as choanal atresia.

ii) If the patient proceeds to immediate tracheostomy, timing continues under this listing.

Note: *Anesthetic evaluations and/or consultations as appropriate apply to 01106, 01110, and 01111.*

T01112 Anesthetic attendance - per 15 minutes or part thereof 30.74

Note: *Timing begins when the anesthesiologist is specifically in attendance for the purpose of providing anesthetic or neonatal resuscitation. Timing ends either when standby is no longer required or when the anaesthesiologist initiates neonatal resuscitation or provides another anesthetic service.*

01158 Epidural blood patch.....172.36

	Anes. Level
Anesthetic Levels for Transplant Surgery:	
Pulmonary transplant - single or double	11
Repeat intrathoracic surgery in the pulmonary transplant recipient during initial hospitalization	10
Cardiac Harvest with Preservation-Donor	7
Cardiac transplant	9
Cardio-pulmonary transplant	10
Repeat intrathoracic surgery in the cardiac or cardio-pulmonary transplant recipient during initial hospitalization	10
Heart-Lung Harvest with Preservation-Donor	7
Hepatic transplant	11
Lung Harvest with Preservation-Donor	7
Repeat hepatic transplant	11
Renal transplant	6
Repeat intra-abdominal surgery in the hepatic transplant recipient during initial hospitalization	10
Pancreatic transplant	6
Pancreatic - renal transplant	7
Repeat intra-abdominal surgery in the pancreatic or pancreatic-renal transplant recipient during the initial hospitalization	8
Anesthetic level for retrieval of organ(s) for transplant	7