GENERAL SERVICES

These listings cannot be correctly interpreted without reference to the Preamble.
No additional visit fee should be charged unless extra service is rendered.

B - Service included in visit fee. For an isolated service, see Clause D. 8. Preamble.

Y - Office or hospital visit on same day extra to procedure fee.

		$	Anes. Level

Injections

Code	Service	$	Anes. Level
B00010	Intramuscular medications	10.32	
B00011	Intravenous medications	12.18	

The following test is not payable to laboratories, vested interest laboratories and/or hospitals:

Code	Service	$	Anes. Level
00012	Venepuncture and dispatch of specimen to laboratory, when no other blood work performed	5.68	

Notes:

i) *This is the only fee applicable for taking blood specimens and is to apply in those situations where a single bloodwork service is provided by an unassociated facility or person.*

ii) *Where a blood specimen is taken by physician's office and dispatched to another unassociated physician's office or diagnostic facility, the original physician's office may charge 00012 only when it does not perform another laboratory procedure using blood collected at the same time. (See Preamble Clause C. 21.)*

iii) *When billed with another service such as an office visit, 00012 may be billed at 100%.*

Code	Service	$	Anes. Level
B00013	Intra-arterial medications	15.28	
Y00014	Intra-articular medications by injection – hip (initial injection)	24.35	
Y00015	- tendons, bursae, and all other joints (initial injection)	16.19	
	(subsequent injections, injection fee only, includes visit fee)		
00016	Intrathecal medications by injection	32.49	
00024	Vein dissection for intravenous therapy *(Not paid in the immediate pre and post-operative phase of surgery)*	35.38	
00019	Venesection for polycythaemia or phlebotomy - procedural fee	30.06	
00018	Autologous ascitic infusion	46.93	
00017	Insertion of central venous pressure catheter	23.32	

Blood Transfusions

Code	Service	$	Anes. Level
00020	Administered outside hospital	59.92	
00021	Administered in hospital	36.38	
00022	Serum transfusion	23.84	
00023	With vein dissection - extra	50.68	

Note: *The above rates include cross-matching, taking and giving of blood, and are applicable only when the Canadian Blood Service is not available and the attending physician accepts responsibility of the laboratory technique involved. When using blood or plasma provided free by the Canadian Blood Service, it is to be made clear that no charge is being made other than ordinary call rates which are applicable.*

		$	Anes. Level

Dialysis Fees

(A) Acute renal failure

a) Haemodialysis:

Code	Description	$	Anes. Level
33750	Blood dialysis - physician in charge	521.05	
33751	Repeat blood dialysis - physician in charge	195.80	

Notes:

i) Maximum number of repeat dialysis on one patient is four. Thereafter bill as chronic renal failure, under fee item 33758.

ii) When Items 33750 or 33751 are charged, there should be no charge under items 33710, 33708, or 00081.

Code	Description	$	Anes. Level
33752	Blood dialysis - fee for cut down by surgeon to be charged in addition to items 33750 or 33751	131.73	

b) Peritoneal dialysis:

Code	Description	$	Anes. Level
33708	Subsequent hospital visits	26.85	
33756	Reinsertion of peritoneal catheter after 10 days from initial insertion	51.21	

Note*: Item 00081 not to be charged in addition to item33723.*
Where an initial peritoneal dialysis is performed and for various reasons, haemodialysis initiated within next 48 hours, the subsequent service should be charged under item 33758 plus item 33756 for the insertion of catheter.

(B) Chronic renal failure:

a) Haemodialysis:

Code	Description	$	Anes. Level
33758	Performance of haemodialysis - fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis, for each dialysis	51.00	

Note: *Other medical situations which may arise such as septicaemia, etc., to be covered by item 00081 and always to be accompanied by an explanation when billing the Plan.*

b) Peritoneal Dialysis:

Code	Description	$	Anes. Level
77380	Insertion of permanent catheter, procedural fee only	187.01	3
33723	Performance of initial peritoneal dialysis chronic or acute renal failure, to include consultation and two weeks' care	389.82	
33759	Performance of each peritoneal dialysis thereafter, - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions, and any other problem that may arise during dialysis	51.21	

Notes:

i) Other situations requiring medical care such as bacteriaemias, etc., to be covered by item 00081 in the Payment Schedule and always to be accompanied by an explanation.

ii) If a period greater than three months elapses since last dialysis, then charge as initial dialysis 33723.

Home Dialysis

Code	Description	$	Anes. Level
33761	Supervision of home dialysis - per week	61.91	

Note*: This fee item covers all services per week necessary for home or limited care dialysis and includes consultations and visits of all types. Should a patient take ill with a condition totally unrelated to renal care or require hospitalization for any reason, then other appropriate fee items may be billed in lieu of fee item 33761.*

		$	Anes. Level

Immunization Skin Tests

Code	Description	$	Anes. Level
B00030	Diagnostic skin tests (Schick, Dick, TB., and Frei.)	8.52	
B00031	Vaccination against smallpox (with certificate)	8.28	
B00034	Subcutaneous injections, including desensitization treatments, immunization, oral polio vaccine, etc. (maximum charge per sitting - 3)	10.30	

Immunizations for Patients 18 Years of Age or Younger

Notes:

i) For immunizations of patients age 19 or older, use fee item B00010, B00034.
ii) Not payable for immunizations required for travel, employment and emigration.
iii) Payable per injection.
iv) Payable in full with an office visit to a maximum of 4 injections per patient per day.
v) Not payable on the same day with B00010, B00034.

Code	Description	$	Anes. Level
10010	DTaP-P (Diphtheria, Tetanus, Pertussis, Polio)	5.18	
10011	DTaP-P-Hib (Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b) ***Note**: Not payable with 10010 or 10018 on the same day, same patient.*	5.18	
10012	Td (Tetanus, Diphtheria)	5.18	
10013	TdP (Tetanus, Diphtheria, Polio) ***Note:** Not payable with 10012 or 10019 on the same day, same patient.*	5.18	
10014	TdaP (Tetanus, Diphtheria, Pertussis) ***Note:** Not payable with 10013 on the same day, same patient.*	5.18	
10015	Flu (Influenza)	5.18	
10016	HA (Hepatitis A)	5.18	
10017	HB (Hepatitis B)	5.18	
10018	HiB (Haemophilus influenza type b) ***Note**: Not payable with 10011 on the same day, same patient.*	5.18	
10019	IPV (Polio Vaccine - Inactivated) ***Note:** Not payable with 10010, 10011 or 10013 on the same day, same patient.*	5.18	
10020	MEN-C-C (Meningococcal-Conjugate-ACYW135)	5.18	
10021	MEN-C-ACYW135 (Meningococcal-Conjugate-ACYW135)	5.18	
10022	MMR (Measles, Mumps, Rubella)	5.18	
10023	PNEU-C-13 (Pneumococcal 13-valent Conjugate)	5.18	
10024	PNEU-P-23 (Pneumococcal-Polysaccharide-23)	5.18	
10025	RAB (Rabies)	5.18	
10026	VAR (Varicella)	5.18	
10027	Infanrix hexa vaccine (Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, and Haemophilus Influenza type b (Hib) ***Note:*** *i) Not billable with fee items 10010,10011,10012, 10013, 10014,10017, 10018.*	5.18	
10028	HPV vaccine (Human Papiloma Virus) ***Note:** Applicable for females born in or after 1994.*	5.18	
10029	Rotavirus vaccine, oral	5.12	

		$	Anes. Level

Miscellaneous

T00039 Methadone or buprenorphine/naloxone treatment only 22.73

Notes:

i) The physician does not necessarily have to have direct face-to-face contact with the patient for these fees to be paid.

ii) 00039 is the only fee payable for any visit or medically necessary service associated with methadone maintenance therapy. This includes but is not limited to the following:

- *a) At least one visit per week with the patient during the induction of methadone or buprenorphine/naloxone/methadone or buprenorphine/naloxene stabilization.*
- *b) At least two visits per month with the patient after induction/ stabilization on methadone or buprenorphine/naloxone is complete. Exceptions to this criterion are where the patient resides/works in an isolated locale which is a significant distance from the prescribing physician.*
- *c) Case management/treatment planning with care team.*
- *d) Supervised urine drug screening and interpretation of results.*
- *e) Counselling by a physician.*
- *f) Communication with non-physician counsellor.*
- *g) Communication with dispensing/supervising pharmacist.*
- *h) Communication with primary care physician.*
- *i) Communication with hospital-based physician when patient admitted to hospital.*
- *j) Completion and submission of documentation relating to registration, termination or transfer.*

iii) Claims for visit fees are not payable in addition.

iv) This fee is payable once per week per patient regardless of the number of visits per week.

v) This fee is not payable with out of office hours premiums.

vi) Eligibility to submit claims for this fee item is limited to physicians who:

- *a) have a current valid license to prescribe methadone or buprenorphine/naloxone for addiction.*
- *b) are actively supervising the patient's continuing use of methadone or buprenorphine/naloxone within the provincial methadone program.*

vii) This payment stops when the patient stops taking methadone or buprenorphine/naloxone.

P15039 GP Point of Care (POC) testing for methadone or buprenorphine/naloxone maintenance 12.22

Notes:

i) Restricted to physicians who have exemptions to prescribe methadone or buprenorphine/naloxone for their patients with opioid dependency in B.C.

ii) Restricted to patients registered in the B.C. Methadone Maintenance Treatment Program.

iii) Maximum billable: 26 per annum, per patient.

iv) Confirmatory testing (reanalyzing a specimen which is positive on the initial POC test using a different analytic method) is expensive and seldom necessary once a patient has enrolled in the Methadone Maintenance Program. Accordingly, confirmatory testing should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management.

v) This fee includes the adulteration test.

vi) Only POC urine testing kits that have met Health Canada Standards are to be used.

		$	Anes. Level
P15040	GP Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone	12.08	

Notes:

i) Not billable for patients enrolled in the B. C. Methadone Maintenance Treatment Program.
ii) Confirmatory testing (re-analysing a specimen which is positive on the initial POC test using a different analytic method) is expensive and should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management.
iii) This fee includes the adulteration test.
iv) Only POC urine testing kits that have met Health Canada Standards are to be used.

		$	Anes. Level
00040	Stomach lavage and gavage	25.72	
B00041	Ultrasound treatments	8.52	
00042	Mileage, per mile one way (in the country beginning 5 miles [8 kilometres] from town centre, in the city from the boundary the city)	2.63	

Note: *To be billed only in unusual emergencies; submit explanation with claim.*

		$	Anes. Level
00043	Anticoagulation therapy by telephone	6.66	

Hyperbaric Chamber

Note: *Use of hyperbaric chamber is insured under the Medical Services Plan only for a limited number of conditions. (Diagnosis required with submission of account).*

		$	Anes. Level
00025	Where no other fee is charged - physician in chamber - 1st ½ hour	78.36	7
00026	- each additional 15 mins.	40.24	
00027	- physician outside chamber - 1st ½ hour	53.37	5
00028	- each additional 15 mins.	28.33	
00046	Additional charge to pertinent medical, anesthetic or surgical fee, per hour	27.24	

Eye Bank Services

		$	Anes. Level
00050	Enucleation of eye(s) for use in corneal transplant	136.00	

Note: *Payment of this fee item is limited to:*
i) enucleations yielding tissue which is confirmed by the Eye Bank of British Columbia as falling within its guidelines for enucleations and
ii) enucleations where the donors were insured by the Medical Services Plan at the time of death.

		$	Anes. Level
00051	Corneal tissue processing	368.41	

Note: *Payment of this fee item is limited to:*
i) corneal tissue which is processed by the Eye Bank of British Columbia
ii) corneas which are used for transplant into recipients who are insured under the Medical Services Plan.

		$	Anes. Level

Certificates, etc.

Code	Description	$	Anes. Level
00062	Initial "in-care" or adoption examination of a well baby or child (with report) (fee for each doctor)	73.71	
00064	Subsequent "in-care" or adoption examination by same doctor within six months	33.14	
00065	Investigation, with completion of B.C. Mental Health Act Forms 3, 4 or 6 (fee per doctor)	66.23	
00066	Completion of B.C. Mental Health Act Forms 3, 4 or 6, on previously assessed or treated cases	29.77	
00067	Investigation with cancellation of B.C. Mental Health Act Forms 4 or 6, and subsequent voluntary treatment status	29.69	

Anes.
$ Level

Emergency Care

1. 00081 is to be used for the evaluation, diagnosis and treatment of a critically ill patient who requires constant bedside care by the physician.

2. A critically ill patient may be defined as a patient with an immediately life threatening illness/injury associated with any of the following conditions: (which are given as examples)
   a) Cardiac Arrest
   b) Multiple Trauma
   c) Acute Respiratory Failure
   d) Coma
   e) Shock
   f) Cardiac Arrhythmia with haemodynamic compromise
   g) Hypothermia
   h) Other immediate life threatening situations

3. 00081 includes the following procedure items where required: defibrillation, cardioversion, peripheral intravenous lines, arterial blood gases, nasogastric tubes with or without lavage and urinary catheters (as part of a cardiac arrest).

4. 00081 includes the time required for the use and monitoring by the physician of pharmacologic agents such as inotropic or thrombolytic drugs.

5. All other procedural fee items not specifically listed in #3 above are not included in 00081. Below are listed some of the procedures that are not included and which therefore, may be billed in addition when rendered: (note - the time required for these procedures should be noted with the claim and deducted from the 00081 time).
   a) Endotracheal Intubation - as a separate entity, i.e. not part of a cardiac arrest or followed by an anesthetic.
   b) Cricothyroidotomy
   c) Venous cutdown
   d) Arterial catheter
   e) Diagnostic peritoneal lavage
   f) Chest tube insertion
   g) Pacemaker insertion

6. 00081 is not intended for standby time such as waiting for laboratory results, or simple monitoring of the patient.

7. When a consultation fee is charged in addition to 00081, for billing purposes the consultation fee shall constitute the first half hour of the time spent with the patient.

8. When surgery is performed by the same doctor after prolonged emergency care, the surgical fee may be charged in addition to the appropriate emergency care fee.

		$	Anes. Level

9. When a second or third physician becomes involved in the emergency care of a acutely ill patient requiring continuous bedside care, item 00081 is applicable just as it is to the attending physician who is first on the scene.

		$	Anes. Level
00081	Emergency care, per ½ hour or major portion thereof	100.80	
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof	60.47	

Crisis Intervention

00083 Personal or family crisis intervention: Applies to situations where the attending physician is called upon to provide continuous medical assistance at the exclusion of all other services in periods of personal or family crisis caused by rape, sudden bereavement, suicidal behaviour or acute psychosis - per ½ hour or major portion thereof 100.81

Notes:

i) Timing for this listing begins after the first hour if a consultation or complete physical examination is rendered or after 30 minutes if a regional examination, counselling, etc. is rendered. Claims for more than 3 hours under fee item 00083 will be given independent consideration by the Medical Services Plan.

ii) The item does not include time spent collecting legal evidence of possible sexual assault. Such is billable to the local police station or RCMP.

00084 Accompanying patient(s) to a distant hospital, where medically required - per ½ hour or major portion thereof 211.86

Notes:

i) When accompanying a patient to a distant hospital, charge portal to portal for time while patient is under the exclusive care of the accompanying physician.

ii)) Time for standing by and return trip are included and may not be billed in addition.

iii) Payment is not applicable to layover or return travel time. Claims for travel, board and lodging are not payable by the Plan. Physicians who accompany a patient who is being transferred will, upon application to the Health Authority, be reimbursed for expenses reasonably incurred during, and necessitated by, the transfer. Please refer to Preamble C. 23.

Trauma - General Services:

These fees are intended for the Trauma Team Leader (TTL) within the facility (or facilities) that a trauma patient may arrive at, requiring treatment.
Trauma Team Leader Assessment and Support fees (P10087, P10088, and P10089) will be paid for services to patients demonstrating any one of the following criteria:

Trauma Team Activation Criteria:

i) Shock - confirmed Blood Pressure ≤ 90 at any time in adults.
ii) Airway Compromise including intubations.
iii) Transfer patients from other Emergency Departments receiving blood to maintain vital signs.
iv) Unresponsiveness – Glasgow Coma Score ≤ 8 with a mechanism suggestive of injury.
v) Gunshot or other penetrating wounds to head, neck, chest, abdomen or proximal extremity (at or above knee or elbow).

vi) Autolaunched Trauma Patient.
vii) Pediatric Trauma Patient under 16 years of age.
viii) Special consideration will be given for patients with significant co-morbidities, pregnant patients, and patients <5 years of age and >65 years of age.

Trauma Team Consults:

i) Spinal cord injury (confirmed or suspected).
ii) Vascular compromise of an extremity with a traumatic mechanism.
iii) Amputation proximal to the wrist or the ankle.
iv) Crush to the chest or pelvis.
v) Two or more proximal long bone fractures (ie: humerus, femur).

vi) Burns
- Partial thickness (2°) burn ≥ 10% and full thickness (3°) burn
- Electrical or lightning burn
- Chemical burn or Inhalation injury
- Burn injury in patients with significant co-morbidities
- Burn injury with concomitant trauma

vii) Obvious significant injury and - Falls > 20 feet.
viii) Obvious significant injury and - Pedestrian hit (thrown or run over).
ix) Obvious significant injury and - Motorcycle crash with separation of the rider and bike.
x) Obvious significant injury and -Motor vehicle crash with either
- Ejection
- Rollover
- Speed > 70 kph
- A death at the scene

xi) Patients with possible head injury and GCS less than 13.

All Trauma Assessment and Support fees include:

- Consultation and assessment
- subsequent examinations of the patient
- family counselling
- teleconference with higher level trauma facilities
- ongoing and active daily surgical management of trauma patients including but not limited to:
    - performing tertiary and quaternary survey physical exams
    - assessment and management of active and passive body core warming
    - care of traumatic wounds or burns (including suturing) not requiring a general anesthetic
    - obtaining appropriate surgical consultations and transfer to higher level facilities when needed
    - coordinating with the transplant organ retrieval team, family counselling (related to organ donation) and obtaining consent for organ procurement

- usual resuscitative procedures such as endotracheal intubation, tracheal toilet and artificial ventilation
- extraordinary resuscitative procedures such as resuscitative thoracotomy or emergency surgical airway
- all necessary measures for respiratory support
- insertion of intravenous lines, peripheral and central
- bronchoscopy
- chest tubes
- lumbar puncture
- cut-downs
- arterial and/or venous catheters and insertion of SWAN-GANZ catheter
- pressure infusion sets and pharmacological agents
- insertion of CVP lines

- defibrillation
- cardio-version and usual resuscitative measures
- insertion of urinary catheters and nasal gastric tubes
- securing and interpretation of laboratory tests
- oximetry
- transcutaneous blood gases
- intra-cranial pressure (ICP) monitoring, interpretation and assessment when indicated
- suturing of wounds not requiring a general anesthetic
- ensuring adequate DVT prophylaxis
- reduction of fractures and dislocations (including casting) not requiring a general anesthetic
- clearance of C-spines or appropriate referral

		$	Anes. Level
P10087	Trauma Team Leader - Initial Assessment, Secondary Survey and Support	296.07	

Notes:

i) Indicated for those patients experiencing any of the Trauma Team Activation Criteria.
ii) Minimum of 2 hours of bedside care required on Day 1 (excluding stand by time).
iii) Start and end times to be recorded on patient's chart.
iv) Payable in addition to the adult and pediatric critical care fees at 100%.
v) Not paid with any consult, visit or emergency care fees, by the same practitioner on the same date of service.
vi) Paid to only one physician for one patient, per facility, per day.

		$	Anes. Level
P10088	Trauma Team Leader – Tertiary Assessment (after 24 hrs. and before 72 hrs.)	102.00	

Notes:

i) Not paid on same date of service as P10087 or P10089.
ii) Not paid unless P10087 has been previously claimed (on same PHN).
iii) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
iv) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.
v) Payable to only one physician for one patient, per facility, per day.

		$	Anes. Level
P10089	Trauma Team Leader Subsequent Hospital Visit (Days 3 – 15 inclusive)	77.20	

Notes:

i) Not paid on same date of service as P10087 or P10088.
ii) Not paid unless P10087 has been previously claimed (on same PHN).
iii) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
iv) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.
v) Payable to only one physician for one patient, per facility, per day.

		$	Anes. Level
	Tray Service Fee		
00044	Mini Tray Fee	4.98	
	Notes: *i) 00044 is applicable to fee items 00190, 00217, 00744 and 14560 only.* *ii) Applicable to 14560 only when disposable speculum is used.*		
00080	Minor Tray - is defined as the use of sterile tray suitable for cautery, cryotherapy, dilation or similar procedure	10.00	
00090	Major Tray - is defined as the use of sterile instrument tray requiring local anesthetic and/or suture material or similar supplies, or plaster cast material, and endoscopy requiring sterile instrumentation	30.01	
	Note: *Applicable to 04111 only when rendered in private (non-funded) facilities. Not applicable when rendered in hospital or other publicly-funded facilities*		

Notes – General for Tray Fees

i) Tray fees are only applicable where the costs are actually incurred by the physician.

ii) Tray fees are only applicable in conjunction with the procedures included in the attached lists. Other procedures will be given independent consideration with the British Columbia Medical Association Tariff Committee.

iii) Tray fees are not applicable when the service is performed at a funded facility (eg., hospital, D&T Centre, Psychiatric Institution, etc.).

PROCEDURES ELIGIBLE FOR MAJOR TRAY FEES

S00571	Pediatric Oesophagogastroduodenoscopy in a patient 16 years of age and under
S00701	Direct laryngoscopy
S00704	Cystoscopy dilation and Panendoscopy
SY00715	Sigmoidoscopy with biopsy
SY00716	Sigmoidoscopy Flexible
SY00718	Sigmoidoscopy Flexible with Biopsy
S00723	Sialogram (per duct) or galactograms (per blast) - procedure fee for Injection
S00727	Salpingogram - procedural fee
S00732	Voiding cysto-urethrogram – procedural fee
S00745	Peripheral or Subcutaneous Lymph Node Biopsy
S00747	Prostate biopsy - procedural fee
ST00748	Bone biopsy under local/regional anesthetic
S00759	Chest Aspiration Paracentesis
S00760	Paracentesis Abdominal
S00785	Endometrial biopsy
S00807	Diagnostic Hysteroscopy
S00808	Diagnostic Hysteroscopy with Biopsy(s)
S00874	Urethral Profilometry
S00878	Cystometry (includes pelvic floor EMG)
SY00907	Endoscopic Examination of the Nose and Nasopharynx
SY00908	Endoscopic Examination of the Nose and Nasopharynx with biopsy
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy
01036	Epidural Block: Thoracic
01037	Epidrual Block: Cervical
01135	Epidural Block: Lumbar
01138	Epidural Block: Caudal blocks
01140	Nerve root or facet blocks – cervical - single
01141	Nerve root or facet blocks – cervical - multiple
01142	Nerve root or facet blocks – thoracic - single
01143	Nerve root or facet blocks – thoracic - multiple
01144	Nerve root or facet blocks – lumbar - single
01145	Nerve root or facet blocks – lumbar - multiple
S02107	Repair of eyelid margin defect, requiring layered closure
S02150	Chalazion Excision
S02152	Tarsorrhaphy
S02153	Ectropion - Ziegler or Simple Procedure
S02156	Eyelid Margin Tumour - Benign Excision (operation only)
S02157	Eyelid Tumour - Benign Excision (operation only)
S02171	Pterygium or Limbus Tumour (operation only)
02251	Myringoplasty
02254	Myringotomy unilateral - with insertion of aerating tube (operation only)
02255	Exploratory tympanotomy
02266	Myringoplasty - Paper patch, ear drum (operation only)
02274	Myringotomy bilateral - with insertion of aerating tube (operation only)
02307	Naso-antral window – single (operation only)
02308	Naso-antral window - double
02317	Electrocoagulation of turbinates – one side (operation only)
02318	Electrocoagulation of turbinates – both sides (operation only)
S02322	Removal of nasal polypi – unilateral (operation only)
S02323	Removal of nasal polypi - bilateral
02324	Antral lavage – unilateral (operation only)
02325	Antral lavage – bilateral (operation only)
02341	Posterior nasal packing – to include balloon control of epistaxis (operation only)

02345 Drainage of abscess or haematoma of septum (operation only)
02346 Posterior nasal packing with trans-oral gauze pack, under local, topical or general anesthesiology (operation only)
02412 Biopsy of larynx and/or cauterization (including laryngoscopy) (operation only)
02413 Operative control of post-tonsillectomy or post-adenoidectomy haemorrhage requiring local or general anesthetic
02419 Direct or indirect laryngoscopy with foreign body removal
02447 Incision of peritonsillar abscess – under local anesthetic (operation only)
02535 Maxillary Sinus Endoscopy
02538 Laryngostroboscopy
03211 Muscle Biopsy
04032 Biopsy of vulva, excisional lesion > /= 2 cm
04111 Therapeutic abortion (vaginal), by whatever means – less than 14 weeks gestation (operation only)
04300 Hymen Incision (operation only)
04301 Bartholin's cyst excision (operation only)
04312 Resection of labia minora (operation only)
04317 Biopsy Vulva, lesion <2 cm
04404 Cyst Vaginal Inclusion Removal (operation only)
04405* Removal of other vaginal cyst (operation only)
04406 Operation for removal of vaginal septum (operation only)
S04500 Cervix dilatation and curettage (operation only)
04510 Biopsy of cervix, with dilation and curettage (operation only)
04536 Cone Biopsy Cervix (includes D&C)
06016* Removal of tumour or scar under GA or regional block (operation only)
06017 Removal of Tumour
06019 Skin grafts - single or multiple flaps under 2 cm (operation only)
06020 Skin grafts - single
06021 Skin grafts - single with free skin graft to secondary defect
06022 Skin grafts - multiple
06023 Skin grafts - multiple with free skin graft to secondary defect
06024 Skin Graft - eyebrow, eyelid, lip, ear, nose
06027 Repair of torn (split) earlobe (simple)
06040 Free Skin Graft - finger, phalanx
06041 Free Skin Graft, ear eyelid, lip, nose
06043 Free Skin Graft - finger tip (operation only)
06044 Free Skin Grafts - sole or palm
06046 Free Skin Grafts - less than 6.5 sq. cm (operation only)
06051 Free Skin Grafts - finger tip (operation only)
06052 Free Skin Grafts - head and neck - 6.5 sq. cm or less
06060 Free Skin Grafts - mouth
06069 Tumour or scar excision – face (operation only)
06075 Eyelid and lip wounds avulsed and complicated
06076 Nose and ear wounds avulsed and complicated
06077 Lacerations of the scalp, cheek and neck complicated
06079 Minor burns debridement, surgical (operation only)
06125 Blepharoplasty - Simple
06126 Blepharoplasty - Complicated
06130 Accessory Auricle (operation only)
06156 Periperhal nerve: transplant of neuroma
T06182 Ganglia of tendon sheath or joint
06184 Extensor - primary or secondary repair
06186 Tenoplasty
06187 Tenoplasty - 2 or more tendons
06188 Tenolysis
06193 Palmar Fasciectomy - more than one digit
06197 Tenosynovitis, finger (operation only)
06210 Neurolysis external

06218	Amputation, Transmetacarpal
06219	Amputation, Finger (operation only)
S06258	Neurolysis and exploration of Peripheral Nerve
07025	Biopsy, Temporal Artery (operation only)
07041	Aspiration: abdomen or chest (operation only)
07045	Abscess Anterior Closed Space (operation only)
V07053	Excision of nail bed, complete, with shortening of phalanx
07110	Multiple ligations and stripping tributaries: - 3 to 5 incisions (operation only)
V07111	Multiple ligations and stripping tributaries: - 6 or more incisions
V07112	Ligation of 2 or more perforators
07464	Sigmoidoscopy, flexible; diagnostic – with removal of polyp(s) (operation only)
V07470	Microdochectomy, Nipple exploration
07516	Excision of salivary cyst (operation only)
07685	Pilonidal Sinus
S08262	Meatotomy and plastic repair (operation only)
S08264	Urethra dilation (operation only)
S08301	Dorsal slit (operation only)
S08340	Epididymis abscess incision (operation only)
S08345	Vasectomy – bilateral (operation only)
08513	Dacrocystogram
08595	Cystogram or Retrogradeurethrogram (not including catheterization)
SY10714	Proctosigmoidoscopy, rigid, diagnostic
SY10750	Transnasal esophagogastroduodenoscopy (TGD), procedural fee
SP10761	Esophagogastroduodenoscopy (EGD) , including collection of specimens by brushing or washing, per oral - procedural fee
SP10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee

Excision - Diagnostic, Percutaneous:

S11230	Shoulder Girdle, Clavicle and Humerous Needle biopsy under GA
S11330	Elbow, Proximal Radius and Ulna Needle biopsy under GA
S11430	Hand and Wrist Needle biopsy, under GA
S11530	Pelvis, Hip and Femur Needle biopsy, under GA
S11630	Femur, Knee Joint, Tibia and Fibula Needle biopsy, under GA

Excision - Diagnostic:

S11730	Tibial Metaphysis (Distal), Ankle and Foot Needle biopsy, under GA

Excision - Diagnostic, Percutaneous:

Vertebra, Facette and Spine

S11830	Needle biopsy - soft tissue/bone - thoracic spine, under GA
S11831	Needle biopsy - soft tissue/bone - lumbar spine, under GA
13600	Biopsy of skin or mucosa (operation only)
13601	Biopsy of facial area (operation only)
13611	Laceration or foreign body, Minor (operation only)
13612	Laceration, Extensive (operation only)
13620	Scar or tumour Excision (operation only)
13622	Localized carcinoma of skin, proven histopathologically (operation only)
13632	Removal of nail - with destruction of nail bed (operation only)

13633	Wedge excision of one nail (operation only)
13650	Hemorrhoid Thrombotic, Enucleation (operation only)
14540	Insertion of IUD
	Local tissue shifts: Advancements, rotations, transpositions, "Z" plasty, etc:
P20221	Single or multiple flaps under 2 cm in diameter used in repair of a defect (except for special areas as in P20225) (operation only)
P20222	Single
P20223	Multiple
P20224	- with free skin graft to secondary defect
P20225	Eyebrow, eyelid, lip, ear, no se - single
	Full-thickness grafts:
P20226	Eyelid, nose, lips, ear
P20227	Finger, more than one phalanx
P20228	Sole or palm
SP33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only
S33373	Colonscopy with flexible colonoscope - biopsy
33374	Colonscopy with flexible colonscope – removal polyp
51016	Cast - Short Arm (elbow to hand)
51017	Cast - Long Arm (axilla to hand)
51019	Cast - Below Knee
51020	Long leg cylinder
51021	Cast - Long Leg
57270	Fasciectomy - plantar
61025	Blepharoplasty, simple, non-cosmetic (bilateral)
61026	Blepharoplasty, complicated, non-cosmetic (bilateral)
	Cell-assisted Lipotransfer – Aspiration
PS61250	- Volume less than 20 ml
PS61251	- Volume between 21-60 ml
PS61252	- Volume greater than 60 ml
	Trunk, Arms and Legs
SP61310	Resulting in repair less than 5 cm (operation only)
SP61311	Resulting in a repair 5 - 10 cm (operaton only)
	Face, scalp, neck, genitalia, hands, feet, axilla
SP61313	Resulting in repair less than 5 cm (operation only)
SP61314	Resulting in repair 5 -10 cm (operation only)
	Eyelids, ears, lips, nose, mucous membrane, eyebrow
SP61316	Resulting in repair less than 2 cm (operation only)
SP61317	Resulting in repair 2 - 4 cm (operation only)
SP61318	Resulting in repair greater than 4 cm (operation only)
	Advancement flap fees - Nose, Lids, Lips or Scalp:
P61325	- 2.1 to 5 cm (operation only)
P61327	- 5.1 to 10 cm (operation only)
	Advancement flap fees - Other areas:
P61326	- 2.1 to 5 cm (operation only)
P61328	- 5.1 to 10 cm (operation only)
P61329	- defects more than 10 cm (such as a thoracic abdominal flap)

Rotations, transpositions, Z-plasty, Limberg or V-Y type flaps
Trunk

P61330 Defect up to 40 cm^2
P61331 Defect 40 cm^2 to 100 cm^2
P61332 Defect greater than 100 cm^2

Arms, legs and scalp

SP61333 Defect up to 6 cm^2
P61334 Defect 6 cm^2 to 19 cm^2
P61335 Defect greater than 19 cm^2

Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck

SP61336 Defect up to 6 cm^2
SP61337 Defect 6 cm^2 to 19 cm^2
P61338 Defect greater than 19 cm^2

Ears, eyelids, lips and nose

SP61339 Defect up to 6 cm^2
SP61340 Defect 6 cm^2 to19 cm^2
SP61341 Defect greater than 19 cm^2

Revision of Graft

P61342 Revision, less than 2 cm
P61343 Revision, between 2 and 5 cm
P61344 Revision, greater than 5 cm

Full-thickness grafts:

P61350 Trunk (2 to 19 cm^2) (operation only)
P61351 Arms, legs, scalp (2 to 19 cm^2)
P61352 Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm^2)
P61353 Ears, eyelids, lips and nose (2 to 19 cm^2)
SP61354 Graft (pinch, split or full thickness) to cover small ulcer, toe pulp graft, finger- tip or other minimal open area (up to 2 cm diameter) (operation only)

Wounds – Simple, or involving minor debridement of traumatic wounds

SP61300 - up to 5 cm – other than face, simple closure (operation only)
SP61301 - up to 5 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)
SP61302 - 5.1 to 10 cm - other than face, simple closure (operation only)
SP61303 - 5.1 to 10 cm - on face and/or requiring tying of bleeders and/or closure in layers (operaton only)
P61360 Eyebrow ptosis repair- simple skin excision- non-cosmetic – unilateral
P61361 Eyebrow ptosis repair – simple skin excision – non-cosmetic – bilateral

Extensor - primary or secondary repair

P61368 - first tendon

70041 Fine Needle aspiration of solid or cystic lesion (operation only)
70470 Breast biopsy incisional (operation only)
70471 Breast biopsy excisional (operation only)
70472 Stereotactic or ultrasound-guided core needle biopsy: - 1 to 5 core samples (operation only)
70473 Stereotactic or ultrasound-guided core needle biopsy: - 6 to 10 core samples (operation only)

Removal of indwelling Enteral tubes with or without exploration of tube insertion site:

S71281 - requiring local or regional anesthesia (operation only)

SV71682	Botox injection for anal fissure
71684	Papillectomy or excision of anal tag or polyp – single (operation only)
71686	Papillectomy or excision of anal tag or polyp – multiple (operation only)
T71690	Hemorrhoid(s); office procedure –infrared photocoagulation to include proctoscopy (operation only)
72669	Excision rectal tumour - 0 to 2.5 cm (operation only)
72670	Excision rectal tumour - 2.6 to 5 cm
72672	Electrodessication or fulguration of malignant tumour of rectum (operation only)
77045	Varicose veins, injection, each visit
77050	Compression sclerotherapy initial - uncomplicated
77055	Compression sclerotherapy - complicated
77060	Compression sclerotherapy - repeat
77065	High ligation, long saphenous
77142	Removal of totally implantable access device (e.g.: portacath), operation only

PROCEDURES ELIGIBLE FOR MINOR TRAY FEES

00019	Venesection for polycythaemia or phlebotomy
00218	Curettage and electrosurgery of Skin carcinoma (operation only)
00219	Curettage skin carcinoma, additional lesion
00424	Botulinum toxin injection
S00743	Breast lesion, non-palpable localizing
S00762	Scratch test, per antigen
	Note: *Minor tray fees may be paid in addition if a minimum of 16 antigens are used.*
S00763	Scratch test – children under 5 years of age, per antigen
	Note: *Minor tray fees may be paid in addition if a minimum of 14 antigens are used.*
S00765	Annual maximum (to include scratch or intracutaneous tests) for each physician – per patient
S00784	Cervix punch biopsy
S00803	Loopogram
S00811	Joint injection, aspiration or arthrogram, under radiological guidance
01042	Nerve block paravertebral sympathetic
T01124	Periperhal nerve block - single
T01125	Peripheral nerve block - multiple
S02076	Botulinum toxin injection for strabismus
S02118	Snip procedure, two or three (operation only)
S02119	Dacryocyst-ostomy (operation only)
S02120	Punctum dilation
S02122	Lacrimal duct probing local anesthetic (operation only)
S02147	Trichiasis, electric (operation only)
S02148	Cryotherapy of eyelids (operation only)
S02167	Cauterization or cryotherapy of corneal ulcer (operation only)
02210	Paracentesis of the ear drum (operation only)
02221	Aural polyp removal or debridement, foreign body removal (operation only)
02303	Cauterization of septum, electric (operation only)
02364	Nasal fracture - simple reduction (operation only)
S02365	Nasal fracture - reduction and splinting (operation only)
02452	Sialolithotomy - simple, in duct (operation only)
04305	Venereal warts (operation only)
04503	Cervix, cryosurgery, cautery or excision (operation only)
04509	Cervical polypectomy (operation only)
04533*	Electric cauterization, cervix (operation only)
06028	Abscess, web space (operation only)
06271	Alveolar fracture (operation only)
07678	Abscess - Perianal, I & D, superficial (operation only)
08601	Radiographic study of sinus, fistula, etc., with contrast media, including injection and fluoroscopy, if necessary
13605	Abscess, superficial opening, including furuncle (operation only)
13610	Laceration or foreign body, minor (not requiring anesthesia) (operation only)
13630	Paronychia (operation only)
13631	Nail removal (operation only)
P20231	Biopsy, not sutured
P20232	Biopsy, not sutured, multiples same sitting, maximum of four (extra)
P61291	Biopsy, not sutured
70469	Breast biopsy needle core (operation only)
70674	Destruction of anal lesion, anus fulguration and condylomata (operation only)
	Removal of indwelling Enteral tubes with or without exploration of tube insertion site:
S71280	- not requiring anesthesia (operation only)
T71689	Hemorrhoid(s); office procedure (e.g.: band ligation) to include proctoscopy (operation only)

PROCEDURES ELIGIBLE FOR
MINI TRAY FEES

00190	Forms of treatment other than excision, X-ray or Grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc., per visit (operation only)
00217	Treatment of skin disorders and lesions other than: ultraviolet, x-ray, grenz ray, such as cryosurgery, electrosurgery, etc. – extra (operation only)
S00744	Thyroid biopsy
14560	Routine pelvic examination including Papanicolaou smear ***Note***: *Applicable to 14560 only when disposable speculum is used.*