VASCULAR SURGERY

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

Note: Asterisk items (*) operation only - refer to Orthopaedic Preamble 1.

		$	Anes. Level

Referred Cases

77010	**Consultation**: to include complete history and physical examination, review or x-ray and laboratory findings, if required, and a written report	127.62
77012	**Repeat or Limited Consultation:** to apply where a consultation is repeated for same condition within 6 months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full fee	57.43
	Continuing Care by Consultant:	
77007	Subsequent office visit	25.47
77008	Subsequent hospital visit	21.73
77009	Subsequent home visit	43.77
77005	Emergency visit when specially called (not payable in addition to out of office hour premiums nor within 10 post-operative days from a surgical procedure) ***Note:*** *Claim must state time sevice rendered.*	87.36
77006	Directive care in emergent surgical conditions, per visit ***Note:*** *Fee Item 77006 charged only where no other consultant is involved in directive care of this emergent condition. Use only where further resuscitation and assessment is medically required in preparation for surgery.*	23.78

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, intubation (as part of a cardiac arrest).

		$	Anes. Level

4. 00081 includes the time required for the use and monitoring by the physicians 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.

9. When a second or third physician becomes involved in the emergency care of an 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.

00081	Emergency care, per half 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	

		$	Anes. Level

Out-Of-Office Hours Premiums

These listings cannot be correctly interpreted without reference to the Explanatory Notes in the Out-of-Office Hours Premiums Section.

Call-Out Charges

Extra to consultation or other visit or to procedure if no consultation or other visits charged.

01200	Evening (call placed between 1800 hours and 2300 hours and service rendered between 1800 hours and 0800 hours)	59.04	
01201	Night (call placed and service rendered between 2300 hours and 0800 hours)	82.94	
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours)	59.04	

Note: *Claims must state time service rendered.*

Continuing Care Surcharges

a) NON-OPERATIVE

Applicable when an out-of-office hours call-out charge is applicable or when specially called for an emergency. Timing begins after the first 30 minutes for consultations, visits or anesthetic evaluation. Payment is based on one half hour of care or major portion thereof. Therefore, the first surcharge is billable after 45 minutes of continuous care.

Applicable also, without the 30 minute time lapse and with timing continuing, to immediately subsequent patients seen on the same call-out as an emergency.:

Surcharges do not apply to time spent standing by and are based on the amount of time providing care, regardless of the number of patients attended or services provided.

01205	Evening (service rendered between 1800 hours and 2300 hours) - per half hour or major part thereof	54.30	
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	74.24	
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	54.30	

Notes:

i) Claim must state start and end times

ii) Where timing is continuous, submit an account for each patient, indicating "CCFPP" (continuing care from previous patient).

iii) Not applicable to full or part-time emergency physicians or to onsite practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.

		$	Anes. Level

b) OPERATIVE

Applicable only to emergency surgery or to elective surgery which, because of intervening emergency surgery, commences within the designated times. Applicable only to surgical procedure(s) requiring general, spinal or epidural anesthesia and/or requiring at least 45 minutes of surgical time.

01210	Evening(1800 hours to 2300 hours) – 37.78% of surgical (or assistant) fee		
	- minimum charge	53.11	
	- maximum charge	366.45	
01211	Night (2300 hours to 0800 hours) –60.57% of surgical (or assistant) fee		
	- minimum charge	74.61	
	- maximum charge	514.59	
01212	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 37.78% of surgical (or assistant) fee		
	- minimum charge	53.11	
	- maximum charge	366.45	

Notes:

i) When surgery commences within evening time period (1800 -2300 hrs) and continues into night time period (2300-0800hrs), the appropriate item for billing is determined by the period in which the major portion of the surgical time is spent.

ii) When emergency surgery commences prior to 1800, even if the major portion of surgical time is after 1800, surgical surcharges are not applicable.

iii) If emergency surgery commences prior to 0800 and continues after 0800 hours, surcharges are applicable to the entire surgical time.

iv) Claim must state time surgery commenced.

Surgical Assistant Or Second Operator

Total operative fee(s) for procedures:

00195	less than $317.00 inclusive	131.64
00196	$317.01 to 529.00 inclusive	185.59
00197	Over $529.00	243.04
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	27.80

Notes:

i) In those rare situations where an assistant is required for minor surgery a detailed explanation of need must accompany the account to the Plan.

ii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anesthetic, s/ he may charge a separate assistant fee for each operation, except for bilateral procedures, procedures within the same body cavity or procedures on the same limb.

iii) Visit fees are not payable with surgical assistance listings on the same day, unless each service is performed at a distinct/separate time. In these instances, each claim must state time service was rendered.

T70019	Certified surgical assistant (where it is necessary for one certified surgeon to assist another certified surgeon, an explanation of the need is required except for procedures prefixed by the letter "C" - for up to one hour	251.70

Note: *Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.*

		$	Anes. Level
T70020	Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof	26.28	

Notes:

i) After 3 hours of continual surgical assistance for one patient, bill under fee item 00198 (time after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof).

ii) Please indicate start and end time of service on claim.

Second Operator:

77025	Second operator, synchronous combined bypass graft - extremities	294.41	
77030	- trunk	294.41	

Note: *Item 77025 and 77030 provide operative report by second operator when requested by MSP.*

Abscess And Infection

13605	Opening superficial abscess, including furuncle - operator only	42.38	2
07041*	Aspiration: abdomen or chest (operation only)	41.05	2
	Abscess:		
07059	- deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	56.37	2
07027	- under general anesthesia (operation only)	125.26	2
07061	- deep, post operative wound infection under general anesthesia (operation only)	79.88	2
07045	Anterior closed space abscess - operation only	38.60	2
06028	Web space abscess - operation only	70.15	2
06029	- under general anesthetic (operation only)	250.00	2
07685	Pilonidal cyst or sinus - excision or marsupialization (operation only)	272.08	2
	Osteomyelitis:		
*52380	Osteomyelitis, acute, decompression	183.13	2
*52385	Osteomyelitis, debridement with or without reconstruction	315.90	3

Note: *52380 and 52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.*

Wounds – Simple:

13610	Minor laceration or foreign body - not requiring anesthesia - operation only	33.95	

Notes:

i) Intended for primary treatment of injury.

ii) Not applicable to dressing changes or removal of sutures.

iii) Applicable for steri-strips or glue to repair a primary laceration.

13611	Minor laceration or foreign body - requiring anesthesia - operation only	63.21	2
06063	Removal of foreign body requiring general anesthesia - operation only	150.00	2
13612	Extensive lacerations greater than 5 cm. (maximum charge 35 cm) - operation only - per cm	12.67	2

		$	Anes. Level

Debridement of Soft Tissues for Necrotizing Infections or Severe Trauma

V70155	Debridement of skin and subcutaneous tissue restricted to genitalia and perineum for necrotizing infection (Fournier's Gangrene) (stand alone procedure)	403.86	3
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	231.19	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	115.59	3
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	256.88	
V70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	128.44	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	282.56	3
V70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	141.28	3
70168	Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area – operation only	77.06	3

Notes:

i) Payable when rendered at the bedside but only when performed by a medical practitioner.

ii) Requires wound assessment and dressing change and may include VAC application.

i) Applicable with or without anesthesia.

70169	Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area (operation only)	123.30	

Notes:

i) Payable only when performed by a medical practitioner in the operating room under general anesthesia or conscious sedation.

ii) Requires wound assessment and dressing change and may include VAC application.

iii) Debridement not payable in addition.

Wounds - Avulsed and Complicated:

06075	Lips and eyelids	332.87	3
06076	Nose and ear	418.15	3
06077	Complicated lacerations of the scalp, cheek and neck	326.71	3

Notes: *The following conditions are necessary for 06075, 06076 or 06077 to apply:*

i) A layered closure is required and at least one of:*

a) Injuries involving necrotic tissue requiring debridement such that simple suture closure is precluded; or

b) Injuries involving tissue loss such that simple suture is precluded; or

c) Wounds requiring tissue shifts for closure aside from minor undermining or advancement flaps; or

d) Skived, ragged or stellate wounds where excision of tissue margins is necessary to obtain 90 degree closure; or

e) Contaminated wounds that require excision of foreign material, or

		$	Anes. Level

ii) Lacerations requiring layered closure and key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or
iii) Lacerations into the subcutaneous tissue requiring alignment and repair of cartilage and layered closure.
iv) A note record indicating how the service meets the above criteria must accompany claims billed under these fee items.

** A layered closure is required when the defect would require too much tension for an acceptable primary closure. It involves at least two layers of deep dissolving sutures to close off dead space and take tension off the wound. A deep cartilage closure is also considered a layered closure.*

V70150	Complicated lacerations of tongue, floor of mouth	265.30	3
	Tumours of skin - removal not requiring skin graft:		
	Removal of tumour (including intraoral)		
06017	- 5 cm. to 10 cm.	256.85	2
06018	- more than 10 cm.	443.84	2
	Note: *Fee items 06017 and 06018 are not intended to apply to the removal of localized malignant soft tissue tumours - use 06999 instead and submit a written report (See Preamble, Clause C. 4.).*		
	Excisional biopsy of lymph glands for suspected malignancy:		
70023	- neck (operation only)	131.24	3
V70024	- axilla	232.76	2
70025	- groin (operation only)	79.87	2
	Foreign Body:		
	Excision of skin and subcutaneous tissue of hidradenitis suppurative:		
07072	- axillary (operation only)	119.77	2
07075	- inguinal (operation only)	119.77	2
07076	- perianal (operation only)	119.77	2
07082	- perineal (operation only)	119.77	2
06166	Excision of axillary sweat glands for hyperhidrosis - unilateral	318.88	4
	Notes:		
	i) Direct closure included when open procedure used.		
	ii) Includes aggressive curettage and resection of apocrine sweat glands by aspiration or direct excision with scissors or scalpel.		
	Tenotomy:		
07073	- congenital torticollis (operation only)	131.91	3
V07074	- resection	253.02	3
	(Section of transverse carpal ligament - bill under 06258)		
13630	Paronychia (operation only)	33.86	2
13631	Removal of nail - simple (operation only)	33.86	2
13632	- with destruction of nail bed (operation only)	68.50	2
13633	Wedge excision of one nail (operation only)	60.44	2
V07053	Excision of nail bed, complete, with shortening of phalanx	135.32	2
	Biopsy of nerve or artery:		
07025	Temporal artery biopsy (operation only)	77.72	2
07028	Biopsy of sural nerve (operation only)	72.20	2

Free Skin Grafts And Myeloplasty

		$	Anes. Level
	Split-thickness grafts:		
	Note:		
	<u>Non-functional</u> areas include posterior or trunk, anterior trunk, arm (above elbow), forearm (below elbow), thigh, leg (below knee).		
	<u>Functional areas</u> include head, face, neck, shoulder, axilla, elbow, wrist, hand, groin, perineum, knee, ankle and foot. Also includes coverage of exposed vital structures (bone, tendon, major vessel, nerve).		
	Non-functional areas: (total area treated, whether at one operation or at staged intervals):		
06046	- less than 6.5 sq.cm.(operation only)	101.71	2
06047	- 65 sq.cm. (operation only)	190.40	2
06048	- 650 sq.cm.	380.79	2
06049	For each 6.5 sq.cm. over 650 sq.cm. (operation only)	7.27	3
	Note: *Refrigerated graft - 50% of appropriate fee.*		

Vascular Access

	<u>Broviac type catheter:</u>		
07139	- insertion of	159.42	2
V07140	- insertion of - less than 3 months of age or less than 3 kg.	263.85	4
07141	- removal of (operation only)	37.59	2
	Totally implantable venous access port with subcutaneous reservoir (port-a-cath type device):		
07142	- insertion of	251.05	2
77142	Removal of totally implantable access device (e.g.: portacath), operation only	125.49	2
	Notes:		
	i) Not paid with 07143.		
	ii) Tray fees are not applicable when the service is performed at a funded facility (e.g.: hospital, D&T Center, Psychiatric Institution etc.)		
V07143	- revision (removal and reinsertion)	288.10	2
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	54.90	
07145	Intra osseous - access (operation only)	39.90	2
V07134	Peritoneal venous shunt for ascites	382.85	6
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee	21.67	
00319	Insertion of central catheter for total parenteral nutrition (operation only)	55.46	2

Venous

	Chronic or Varicose Veins:		
77045	Varicose veins, injection, each visit	13.20	
	Note: *Treatment for cosmetic purposes is not a benefit under MSP.*		
	Compression sclerotherapy, initial:		
77050	- uncomplicated	79.26	2
77055	- complicated	118.71	2
77060	Compression sclerotherapy - repeat	37.14	2
	Note: *77050 and 77055 may be charged only once per 12 month period for each leg, and 77060 only twice in the same period.*		

		$	Anes. Level
77065	High ligation, long saphenous	218.74	2
V07108	Stripping long saphenous	251.26	2
V07109	Stripping short saphenous	144.85	2
	Multiple ligations and stripping tributaries:		
07110	- 3 to 5 incisions (operation only)	108.28	2
V07111	- 6 or more incisions	188.11	2
V07112	Ligation of 2 or more perforators	196.20	2
77070	Complete fasciotomy with or without multiple ligations ***Note:*** *For decompression fasciotomy, see 77360.*	313.10	2
77075	Re-exploration of groin and/or popliteal fossa	294.41	2
V07116	Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy)	513.33	3
77077	Excision of ulcer and grafting - add full fee to venous procedures (operation only)	117.96	3
77079	Venous crossover graft for iliac obstruction	598.13	7
	Acute Venous:		
77082	Ligation of femoral vein	145.97	2
77084	Ligation or fenestration of inferior vena cava (requires laparotomy)	485.72	5
77086	Thrombectomy for acute ilio-femoral thrombophlebitis	608.65	5
V07146	Insertion of inferior vena cava filter; percutaneous placement or cutdown (e.g.: Kimray Greenfield filter)	360.76	2
	Portosystemic Shunting:		
C77090	Spleno-renal shunt	926.84	8
C77092	Porto-caval shunt	926.84	8
	Mesocaval graft:		
C77094	- synthetic	926.84	8
C77096	- autogenous	986.83	8

Arterial System

Notes: Repeat Vascular Surgery

i) Same procedure within 24 hours - 75% of listed fee.

ii) Same procedure after 24 hours - see repeat surgery items 77043, 77112 and applicable notes.

	Removal of synthetic graft:	
77100	- without replacement (payable at 100% of the current fee listed for the initial insertion).	
77102	- with replacement at the same site (payable at 50% of the current fee listed for the initial insertion), extra to the replacement graft.	
77104	- with replacement at a different site (payable at 75% of the current fee listed for the initial insertion), extra to the replacement graft.	

Notes:

i) 77100, 77102, & 77104 are payable only where more than 21 days have elapsed since insertion and where more than 50 percent of the graft is removed.

ii) 77043 is not payable in addition to 77100, 77102, 77104, nor to the replacement graft where removal also is claimed.

		$	Anes. Level

iii) Initial graft procedure fee code should be submitted with claim as a note record.
iv) Anesthetic procedural fee should be claimed in equity with that listed for the initial insertion (for 77100), and in equity with that listed for the replacement graft (for 77102, 77104).

Repeat Surgery

Groin Dissection:

C77110	Re-exploration of groin for bleeding or hematoma (operation only)	123.06	4
77112	Re-dissection of groin (after 21 days) - extra	129.92	4

Note: *Not payable with fee items 77100, 77102, 77104, or 77043.*

Re-operation:

77043 Re-dissection of artery/vein at site of previous anastomosis, arteriotomy or venotomy - (after 21 days) - extra. Payable at 25% of listed fee for surgery performed.

Notes:
i) Payable once per side only.
ii) Not payable with fee items 77100, 77102, 77104, or 77112.

Arterial Procedures

Therapeutic procedures utilizing radiological equipment:

T10900 Abdominal aortic aneurysm repair using endovascular stent graft – second operator 706.90

Notes:
i) Intraoperative renal artery angioplasty payable in addition at 50% of fee item 00982 when done.
ii) Intravascular stent placement – extra (10919) paid in addition under 10919 at 100%.
iii) This fee will not be paid to the primary operator.

Angioplasty

PS77113 Intraoperative open or percutaneous tibial artery angioplasty 576.54 2

Notes:
i) Restricted to Vascular Surgeons.
ii) When PS77113 is combined with another vascular surgery, multiple angioplasties will be paid as follows: 50% for the first, 25% for the second and 12.5% for the third angioplasty.
iii) When angioplasty is performed as an isolated procedure, multiple angioplasties done during the same procedure are paid as follows: the first is paid at 100%, second at 50%, third at 25%.
iv) Payable to a maximum of 3 angioplasties.
v) Any and all diagnostic imaging required to complete the procedure is considered included.

PS77114 Intraoperative open or percutaneous angioplasty 388.15 3

Notes:
i) Restricted to Vascular Surgeons.
ii) When PS77114 is combined with another vascular surgery, multiple angioplasties will be paid as follows: 50% for the first angioplasty, 25% for the second angioplasty and 12.5% for the third angioplasty.

		$	Anes. Level

iii) When angioplasty is performed as an isolated procedure, multiple angioplasties done during the same procedure are paid as follows: first is paid at 100%, second at 50%, third at 25%.
iv) Payable to a maximum of three angioplasties.
v) Any and all diagnostic imaging required to complete the procedure is considered included.
vi) When done with 77177, payable once, to either the primary or second operator

Surgical Procedures

Thrombectomy, Embolectomy:

C77115	Thrombectomy - with or without angioplasty	546.01	5
C77120	Embolectomy - trunk or extremities (subclassified by location and incision)	608.65	5
C77125	- one side	437.51	5

Neck or Thoracic:

C77130	Bypass graft (synthetic) and/or thrombo-endarterectomy - carotid arteries	892.97	8
77135	- innominate	764.12	5
C77140	- subclavian	830.19	5
C77145	Ligation of carotid artery	250.46	5

Aortoiliac:

C77150	Bypass graft (synthetic) and/or thromboendarterectomy- aorta and/or iliac (unilateral)	875.05	9
C77155	- aorta and/or iliac (bilateral)	1,077.39	9
C77160	- aorto-femoral or ilio-femoral (unilateral)	849.70	9
C77165	- aorto-femoral or ilio-femoral (bilateral)	1,077.39	9

Aneurysm:

Note: *Peripheral aneurysm - charge associated bypass graft procedure.*

77170	Arteriovenous aneurysm	485.72	9
C77175	Abdominal aneurysm, with grafting	1,155.13	9
T77177	Abdominal aortic aneurysm repair using endovascular stent graft – vascular surgery component	1,155.13	9

Notes:
i) In order to bill T77177, vascular surgeon must be present throughout entire procedure.
ii) Includes iliac endarterectomy/iliac artery repair.
iii) Fem-fem crossover payable in addition at 50% of 77230 or 77235 when done.
iv) When done with 77177, if second operator present, primary operator cannot bill 00982, 77114 or 10919.

C77180	Resection of abdominal aneurysm with associated femoral dissection - one or both sides (extra fee to be added to procedure) (operation only)	121.72	9

Note: *Peripheral aneurysm - charge associated bypass graft procedure.*

C77185	Ruptured aneurysm, with grafting	1,328.60	10

Mesenteric:

C77190	Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy	875.04	7
C77195	Superior mesenteric bypass graft (autogenous vein)	875.04	7

		$	Anes. Level
	Renal:		
C77200	Renal bypass graft (synthetic) and/or thromboendarterectomy	875.04	7
C77205	Renal bypass graft (autogenous vein)	875.04	7
	Axillo - Femoral:		
C77210	Axillo-femoral bypass graft (synthetic) and/or thromboendarterectomy - unilateral	727.98	7
C77215	-bilateral	849.70	7
C77220	Axillo-femoral bypass graft (autogenous vein) - unilateral	811.12	7
	Femoral Crossover:		
C77230	Femoro-femoral crossover bypass graft (synthetic) and/ or thromboendarterectomy	765.66	5
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	765.66	5
	Infrainguinal:		
C77240	Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	485.72	5
C77245	- popliteal (endarterectomy)	666.50	5
C77250	- popliteal (synthetic)	608.58	5
C77255	- anterior, posterior tibial or peroneal	727.98	5
	Bypass graft (autogenous vein):		
C77260	- femoral	702.67	5
C77265	- popliteal	930.08	5
C77270	- anterior, posterior tibial or peroneal	976.70	5
77275	- in situ vein graft, (extra)	252.07	7
77280	- non-ipsilateral long saphenous graft; (extra)	249.75	7
77285	- short saphenous graft; (extra)	249.75	7
77290	- superficial femoral vein graft; (extra)	249.75	7
77295	- arm vein graft; (extra)	249.75	7
77300	- A-V fistula with bypass graft in limb salvage; (extra)	181.99	7
	Profundoplasty:		
C77310	Profundoplasty bypass graft (synthetic) and/or thromboendarterectomy	542.36	5
C77315	- extended	736.42	5
	Trauma:		
	Repair of injury of major vessel in extremity:		
C77330	- suture	572.50	6
C77335	- graft	736.42	6
	Repair of injury of major vessel in trunk:		
C77340	- suture	859.34	9
C77345	- graft	1,146.20	9
77350	Supra-renal aortic cross-clamp - extra to abdominal vascular or major trauma cases (operation only) ***Note:*** *Operative report required.*	112.02	
V07447	Repair of mesenteric injury ***Note:*** *Trauma fee item 07447 is to be charged in cases of blunt and/or penetrating abdominal injury. It does not apply to incidental intraoperative injury to abdominal structures.*	561.69	6

		$	Anes. Level
	Operative repair – arteriorraphy – for iatrogenic injury during percutaneous endovascular aortic valve implantation :		
T77352	Repair of major vessel in extremity - suture	552.72	6
T77353	Repair of major vessel in extremity - graft	710.96	6
T77354	Repair of major vessel in trunk - suture	829.65	9
T77355	Repair of major vessel in trunk - graft	1,106.58	9
	Fasciotomy:		
77360	Decompression fasciotomy - subcutaneous ***Note:*** *77360 includes secondary closure.*	328.13	3
	Tibial Metaphysis (Distal) Ankle and Foot:		
	Incision - Therapeutic, Release:		
57250	Decompression, neurolysis, nerve (isolated procedure)	293.02	2
57260*	Fasciotomy, compartment syndrome	210.59	2
57269*	Fasciotomy, secondary wound closure	183.13	2
	Miscellaneous:		
77370	Release of popliteal entrapment syndrome ***Note:*** *Not to be billed if full femoral popliteal bypass is performed.*	328.13	3
S00722	Arteriography, operative - procedural fee	74.06	

Renal Access

77380	Insertion permanent peritoneal catheter; (procedure fee only)	187.01	3
77385	Removal by dissection of chronic peritoneal catheter; (operation only) ***Note:*** *For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.*	129.72	3
77395	Creation of internal arterio-venous fistula	364.00	4
P77396	Revision of AV fistula ***Notes:*** *i) Restricted to Vascular and General Surgeons.* *ii) Not paid with renal access fees (77380, 77385, 77395, 77402, 77405).* *iii) Not paid with the following vein graft fees (77275, 77280, 77285, 77290, 77295, 77300).* *iv) 77043 not paid with this fee.*	451.93	
77402	Creation of brachiobasilic arteriovenous fistula with vein transposition ***Note:*** *Not paid with 77260 to 77300 and 77395 .*	613.73	5
77403	Arm revascularization with distal revascularization and interval ligation (DRIL) ***Note:*** *Not paid with 77260 to 77300 and 77395.*	609.62	5
77405	Thrombectomy of arterio-venous fistula	342.29	3
	Sympathectomy:		
77420	Lumbar sympathectomy - unilateral	364.00	4
77422	Cervical sympathectomy - unilateral	492.21	5
77424	Preganglionic sympathectomy; upper dorsal region - unilateral	449.56	7
77426	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	449.56	7

		$	Anes. Level
	Lumbar sympathectomy with abdominal procedure:		
77428	- unilateral (extra)	121.73	
77430	- bilateral (extra)	243.47	
	Lymphatic System:		
V07361	TB glands - radical removal	263.85	4
V07363	Radical femoral, inguinal and/or iliac dissection	526.42	5
V07360	Splenectomy	632.22	6
VC07366	Laparotomy and staging of lymphoma to include splenectomy	765.44	6
VC07365	Isolated limb perfusion to include groin dissection and laparotomy	920.89	5
	Lymphoedema: Leg		
	Lymphoedema of limbs - excision and grafting:		
06127	- entire leg	686.56	3
06128	- entire lower extremity	1,026.42	3

Abdominal Surgery

	Miscellaneous:		
V07603	Resuture abdominal wound evisceration	263.85	5
V07451	Thoracic extension of abdominal incision (extra)	280.18	8
V07600	Exploratory laparotomy to include biopsy	339.60	5

Transplantation

	Implantation of kidney graft:		
77440	Vascular surgeon	820.35	7

Amputation

	Hand and wrist:		
06218	Transmetacarpal	250.00	2
06219	Finger, any joint or phalanx (operation only)	250.00	2
	Pelvis, Hip & Femur:		
55983	Above knee	640.96	4
55980	Hemicorpectomy	2,398.97	6
55981	Hemipelvectomy	1,336.84	6
55982	Hip disarticulation	1,016.37	6
55984	Knee disarticulation	640.96	4
55998*	Open injury, primary wound care	100.30	4
55999*	Open injury, secondary wound management	183.13	4
	Femur, Knee Joint, Tibia & Fibula:		
56980	Below knee	508.19	3
56998*	Open injury, primary wound care (operation only)	100.30	3
56999*	Open injury, secondary wound management	183.13	3

		$	Anes. Level
	Tibial Metaphysis (Distal), Ankle & Foot:		
57981	Midtarsal	480.71	2
57982	Transmetatarsal	398.30	2
57983	Single metatarsal/Ray resection	347.95	2
57980	SYME	521.90	2
57984	Toe	183.13	2
57998*	Open injury, primary wound care (operation only)	50.14	2
57999*	Open injury, secondary wound management (operation only)	91.57	2

Chest Wall Surgery

79125	Cervical rib resection	345.68	5
79130	Trans-axillary resection of first rib	832.53	5