DIAGNOSTIC RADIOLOGY

These listings cannot be correctly interpreted without reference to the Preamble (Applicable in full for Certified Radiologists).

*Service is payable to Certified Radiologists only.

DIAGNOSTIC RADIOLOGY TELEMETRY

Definition: *The electronic transmission of radiological images from one site to another for interpretation.*

For diagnostic radiology telemetry services to be considered as benefits under the Medical Services Plan:

- the transmitting and receiving sites must be located within Medical Services Commission approved and Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients
- the services are billed in accordance with the Telemetry Billing Guidelines as follows.

Telemetry Billing Guidelines:

a) Services must be billed by the facility where the image was taken using the practitioner number of the physician who did the interpretation

b) Facility number field – the facility number of the diagnostic facility where the image was taken

c) Sub-Facility field - the facility number of the diagnostic facility where the image was interpreted
- zeros if interpreted at the same site where the image was taken

d) Service charges (fee items 01200 – 01202) are only billable when a physician is required to travel from home to hospital in order to perform a telemetry service for an outpatient and when the *MSC Payment Schedule* criteria are met.

e) The original site should ensure that only one interpretation is billed to MSP.

f) In those rare cases when a second radiological opinion is requested by the referring physician, a radiologist may bill for the service using fee item 08628, provided written radiological report is sent to the referring physician

		Total Fee $
Head and Neck		
08500	Skull - routine	51.25
08501	Skull - special studies - additional	33.88
08503	Paranasal sinuses	33.88
08504	Facial bones - orbit	33.88
08505	Nasal bones	33.88
08506	Mastoids	51.25
08507	Mandible	33.88
08508	Temporo-mandibular joints	33.88
08509	Salivary gland region.	33.88
08510	Sialogram	52.86
08511	Eye - for foreign body	33.88
08512	- for localization of foreign body - additional	50.73
08513	Dacryocystogram	33.52
08514	Nasopharynx and/or neck, soft tissue - single lateral view	22.00
08515	Laryngogram (excluding procedural fee) ***Note:*** *When less than a full series is performed, individual films may be charged up to the fee for a full series (08517).*	50.74
08518	Pre-MRI view(s) of orbits to rule out metallic foreign body	23.29
Upper Extremity		
08520	Shoulder girdle	33.88
08521	Humerus	33.88
08522	Elbow	33.88
08523	Forearm	33.88
08524	Wrist	33.88
08525	Hand (any part)	33.88
08526	Special requested views in upper extremity	17.08
Lower Extremity		
08530	Hip	33.88
08531	Femur	33.88
08532	Knee	33.88
08533	Tibia and fibula	33.88
08534	Ankle	33.88
08535	Foot (any part)	33.88
08536	Leg length films - whatever method	39.91
08537	Special requested additional views for lower extremity	17.08
Spine and Pelvis		
08540	Cervical spine	40.57
08541	Thoracic spine	33.88
08542	Lumbar spine	51.25

		Total Fee $
08543	Sacrum and coccyx	33.88
08549	Spine - requested additional views (flexion, bending views,etc.) ***Note:*** *This item shall not be used to cover normal oblique projections.*	31.92
08544	Pelvis	33.88
08545	Sacro-iliac joints	33.88
08546	Scoliosis film - single AP or lateral - 14 x 36 film taken at 6 feet (1.85 metres)	44.34
08547	Pelvis and additional requested views (i.e. sacro-iliac joints, hip, etc.)	40.57
08548	Myelogram and/or posterior fossa positive contrast (excluding procedural fee)	100.36

Chest

08550	Thoracic viscera	33.63
08551	Thoracic inlet	33.63
08552	- additional requested views	17.08
08553	Fluoroscopy, when requested	17.21
08554	Ribs - one side	33.88
08555	Ribs - both sides	51.25
08556	Sternum or sterno-clavicular joints	33.88
08557	Sternum and sterno-clavicular joints	51.25

Abdomen

08570	Abdomen	33.88
08571	Abdomen, multiple views	51.25

Gastrointestinal Tracts

08572	Oesophagus only	57.79
08573	Oesophagus, stomach, and duodenum	82.54
08574	Small bowel	82.54
08576	Colon or double contrast air studies	93.02
08577	Hypotonic duodenography	82.54
08578	Pancreatography (excluding procedural fee)	50.48
08579	Glucagon assisted contrast study - in addition to routine fee	36.32

Gall Bladder

08581	Intravenous cholangiogram	73.28
08582	Operative cholangiogram (transhepatic also)	55.07
08583	Direct post-operative cholangiogram or pyelogram	59.39
08584	Removal of biliary calculi, by Burhenne technique or equivalent, including necessary cholangiogram and fluoroscopy (excluding procedural fee)	62.06

Total Fee $

Genito-Urinary System

08590	K.U.B.	33.88
08591	Pyelogram - intravenous	76.33
08593	Pyelogram - retrograde or antegrade	50.73
08594	Intravenous pyelogram with voiding cystourethrogram	100.36
08595	Cystogram or retrograde urethrogram (not including catheterization)	50.73
08596	Hystero-salpingogram (excluding injection)	82.54
08597	Pelvimetry	69.73
08599	Voiding cystourethrogram	83.86

Miscellaneous

08575 Video fluoroscopy - 50 percent to be added to fee items 08572 and 08573

Notes:

i) Applicable to the following indications only: complicated oesophageal motility, aspiration, abnormal swallowing, dysphagia or webs.

ii) A note record of the indication is required.

08601	Radiographic study of sinus, fistula, etc., with contrast media, including injection and fluoroscopy, if necessary	63.78
08602	Body section radiography - applies to all tomographic procedures (including polytomography when done in one plane) per plane series, including orthopantogram	48.32
08603	Bone age - whatever method	35.50
08604	Bone survey - first anatomical area	33.88
08605	- each subsequent anatomical area	17.08
08606	Arthrogram, shoulder (excluding injection of contrast)	36.46
08607	Arthrogram, hip (excluding injection of contrast)	33.52
08608	Arthrogram, knee (excluding injection of contrast)	71.94
08609	Arthrogram, ankle (excluding injection of contrast)	33.52
08631	Arthrogram - wrist (excluding injection of contrast)	33.52
08637	Arthrogram - elbow (excluding injection of contrast)	33.52
08610	Mammography - unilateral	97.53
08611	- bilateral	136.67

Notes:

i) Indications for Unilateral Mammograms:

a) New symptoms within one year of a previous bilateral mammogram.

b) Work-up of an abnormal screening mammography.

c) Short term follow up of an abnormality, within one year of a previous bilateral mammogram.

d) Follow-up of surgery/radiotherapy, within one year of a previous bilateral mammogram.

e) Absence of other breast.

f) Visualization for fine wire localization or stereotactic biopsy.

ii) All other requests for mammograms should be bilateral. However, there may be instances where a bilateral mammogram is requested inappropriately and is converted to a unilateral mammogram.

08615	Cerebral angiography - unilateral	130.07
08616	- bilateral	223.14
08617	Peripheral angiography (arteriography and venography) - unilateral.	67.32

		Total Fee $
08618	- bilateral	100.36
08620	Aortography (aortography plus peripheral angiography)	172.93

The entry “thoracic or abdominal angiogram” is intended to include the following:

Thoracic aortogram	Renal arteriogram
Mediastinal angiogram	Celiac arteriogram
Angiocardiogram	Messenteric arteriogram
Retrograde aortogram	Pelvic arteriogram
Pulmonary arteriogram	Splenoportogram
Coronary arteriogram	Superior or inferior vena cavogram
Bronchial arteriogram	Pelvic venogram
Lumbar aortogram	Ascending lumbar venography, etc.
Ilio-femoral arteriogram	

Thoracic or abdominal angiogram (cine or videotape surcharge not applicable)

08626	- using multiple sequential views - non-selective	132.14
08627	- using multiple sequential views - selective	130.07
*08628	Interpretation of submitted films - per examination	16.30

Note: *This item to be charged only in those situations where a third party requests a second written radiological opinion and is payable only when medically required.*

*08629	Radiologist performing fluoroscopy for various clinical procedures	39.20

Notes:

i) Applicable only when no other radiology fees billed for procedure for which fluoroscopy is performed.

ii) May be billed when fluoroscopy is used as the only imaging method during a procedure such as: small bowel biopsy, insertion of pacemaker; orthopaedic manipulation, foreign body localization, or fluoroscopically-guided lumbar puncture, biopsy, injection or aspiration.

iii) This item may be billed only in facilities, either hospital or non-hospital, which are accredited to perform fluoroscopy

*08630	Percutaneous transluminal angioplasty	305.53

Radiology Assistant Fee:

*08632	- first hour or fraction thereof	108.34
*08633	- each 15 minutes or fraction thereof after one hour	27.10

Note: *08632 and 08633 may be applicable:*

i) when a radiology assistant is required in conjunction with 00738, 00979, 00980, 00981, 00982, 00995, 00997, and 00998, 10913, 10914 and 10915;

ii) in lieu of 08629 performed in conjunction with endoscopic retrograde cholangiopancreatography (ERCP).

Total Fee $

Bone Mineral Densitometry Using DEXA Technology

T08688 Bone density - single area 66.43
T08689 Bone density - second area 45.44
T08696 Bone density - whole body 119.62

Notes:

i) Please refer to the May 1, 2011 Guideline "Osteoporosis: Diagnosis, Treatment and Fracture Prevention" to determine if service is payable by MSP. Claims for males and females <50 require written explanation indicating risk factor.

ii) Altering patient care requires one of the following:
- *a) prescribing bisphosphonates (ie: fosomax)*
- *b) weaning patient off glucocorticosteriods (ie: prednisone)*
- *c) adequate ongoing monitoring (in cases of primary hyperparathyroidism)*

iii) Not payable for following indications:
- *a) chronic back pain*
- *b) kyphosis*
- *c) menopause*
- *d) routine bone density screening*

iv) Additional areas paid to a maximum of one, except for unusual circumstances, which must be accompanied by written explanation.

v) Repeat scans are not billable within three years of a previous scan, except for indications outlined in the guidelines, which must be accompanied by written explanation.

vi) Claims for whole body bone density must be accompanied by written explanation of need.

vii) Includes any lumbar and/or hip radiographs taken as a part of the procedure. Medically necessary lumbar and/or hip radiographs for other disease processes may be billed when accompanied by written explanation.

viii) Restricted to certified radiologists or nuclear medicine physicians and individuals who have received approval from the College of Physicians and Surgeons of BC (CPSBC) to perform these tests, and the tests are provided in a DAP accredited and MSC approved facility.

Computerized Tomography

Professional Fees:

*08690 Head scan - without contrast 44.31
*08691 - with contrast 61.81
*08692 - double scan or 2 planes 79.83
*08693 Body scan - one region without contrast 88.44
*08694 - one region with contrast 97.75
*08695 - double scan or two regions 133.63
P83090 Cardiac CT/CT Coronary Angiography, Professional fee 150.00

Notes:

i) Paid once daily per patient.

ii) Includes cardiac gating and 3D imaging post-processing, cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts and requires imaging without contrast material followed by contrast materials.

iii) Includes supervision of oral beta blockers and/or IV injection.

iv) Paid only for a minimum of a 64-detector CT scanner.

v) Restricted to Radiologists with a minimum of Level 2 CCTA; or other duly qualified Specialists with a minimum of Level 2 CCTA who also meet the American College of Radiology standards of competency in Performing and Interpreting Diagnostic Computed Tomography, and Performance of (Adult) Thoracic Computed Tomography.

Total Fee $

vi) Paid only for the following indications:
- *a) Diagnosis of obstructive CAD in symptomatic patients with an intermediate pre-test likelihood of CAD; or symptomatic patients with equivocal/inclusive stress test results.*
- *b) Assessment of patency or course of coronary bypass grafts.*
- *c) Exclusion of obstructive CAD in low risk patients who require invasive coronary angiography.*
- *d) Identification or definition of the course of anomalous coronary arteries.*
- *e) Assessment of LV or RV size, volume, and function when alternative imaging modalities are unavailable or inconclusive.*
- *f) Assessment of pulmonary venous anatomy before and after pulmonary vein isolation for arterial fibrillation. Assessment of coronary venous anatomy prior to cardiac resynchronization therapy.*
- *g) Assessment of cardiac and extra-cardiac structures (e.g.: aorta, pericardium, and cardiac masses) and non-cardiac structures (e.g.: lungs, pleura, spine, mediastinal structures (esophagus, lymph nodes), ribs and chest musculature.*

vii) Not paid for coronary calcium scoring.
viii) Not paid with 08693, 08694 or 08695.
ix) Not paid with a consult or a visit on the same day.

P83096 CT Colonography, Professional fee (extra) 60.00

Notes:
i) Paid only as a diagnostic procedure, only in circumstances where optical colonoscopy is not technically possible, or clinically unsafe.
ii) Restricted to Radiologists.
iii) Restricted to referrals by Gastroenterologists, General Surgeons and General Internal medicine specialist.
iv) Rural GP's (in RSA communities) can refer patients for this procedure in communities where a specialist referral is not available.
v) Paid on out-patients only.
vi) Paid in addition to 08695, same patient, same day.
vii) Maximum one per patient per day.

Total Fee $

Interventional Radiology

Note: *The following fees are specific to physicians' professional fees for the following services:*

83000 **Interventional Radiology Consultation**: To include pertinent patient history, regional physical examination, review of laboratory and radiological findings and generation of a written report.....80.82

Notes:

i) Payable only to physicians with appropriate training in interventional radiology.

ii) Payable only when rendered in acute care public facilities.

iii) Must be initiated by written request by another physician.

iv) Payable only when interventional radiological procedure requires extensive discussion and review of all available data.

v) Includes all patient visits necessary.

vi) Payable when patient is referred for any of the following interventional radiological procedures, regardless if procedure is performed or is scheduled and subsequently cancelled.:

- *a) Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery (10901)*
- *b) Varicocele and/or uterine artery embolization -unilateral/bilateral (00921/00925)*
- *c) Percutaneous image-guided tumor ablation(10908)*
- *d) Percutaneous transcatheter arterial chemoembolization (TACE)(10904)*
- *e) Cerebral arterial balloon occlusion tolerance test (10913)*

vii) Payable if one of the following procedures is planned but cancelled subsequent to the consultation:

- *a) Percutaneous nephrostomy (00978)*
- *b) Percutaneous nephrostomy with dilation of tract (00979)*
- *c) Transhepatic biliary drainage procedure (00980)*
- *d) Therapeutic radiological embolization (00981)*
- *e) Percutaneous transluminal angioplasty (00982)*
- *f) Percutaneous abdominal abscess drainage by catheter insertion (00983)*
- *g) Embolization fee codes T00995, T00997, T00998*
- *h) Abdominal aortic aneurysm repair using endovascular stent graft – second operator (T10900) – Payable to Radiologists only*
- *i) Complex diagnostic Neuroangiography*
- *j) Percutaneous hemodialysis graft thrombolysis (10903)*
- *k) Cerebral intra-arterial thrombolysis (10905)*
- *l) Percutaneous intravascular/intracorporeal medical device/foreign body removal (10909)*
- *m) Selective salpingography/fallopian tube recanalization (10911)*
- *n) Transjugular liver or renal biopsy (10912)*
- *o) Image-guided percutaneous vertebroplasty (10906)*
- *p) Intravascular stent placement (10919)*
- *q) Intracorporeal stent placement (10920)*
- *r) Percutaneous balloon angioplasty for cerebral vasospasm (10914)*
- *s) Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique (10915)*
- *t) Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance (10918)*

viii) Repeat consultation not applicable for same condition, same patient within 6 months.

		$	Anes. Level

Telehealth Service with Direct Interactive Video Link with the Patient:

83070 Telehealth Interventional Radiology Consultation: To include pertinent patient history, regional physical examination, review of laboratory and radiological findings and generation of a written report 80.82

Notes:

i) Payable only to physicians with appropriate training in interventional radiology.

ii) Payable only when rendered in acute care public facilities.

iii) Must be initiated by written request by another physician.

iv) Payable only when interventional radiological procedure requires extensive discussion and review of all available data.

v) Includes all patient visits necessary.

vi) Payable when patient is referred for any of the following interventional radiological procedures, regardless if procedure is performed or is scheduled and subsequently cancelled.

- *a) Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery (10901)*
- *b) Varicocele and/or uterine artery embolization -unilateral/bilateral (00921/00925)*
- *c) Percutaneous image-guided tumor ablation(10908)*
- *d) Percutaneous transcatheter arterial chemoembolization (TACE) (10904)*
- *e) Cerebral arterial balloon occlusion tolerance test (10913)*

vii) Payable if one of the following procedures is planned but cancelled subsequent to the consultation:

- *a) Percutaneous nephrostomy (00978)*
- *b) Percutaneous nephrostomy with dilation of tract (00979)*
- *c) Transhepatic biliary drainage procedure (00980)*
- *d) Therapeutic radiological embolization (00981)*
- *e) Percutaneous transluminal angioplasty (00982)*
- *f) Percutaneous abdominal abscess drainage by catheter insertion (00983)*
- *g) Embolization fee codes T00995, T00997, T00998*
- *h) Abdominal aortic aneurysm repair using endovascular stent graft – radiology component (T10900)*
- *i) Complex diagnostic Neuroangiography*
- *j) Percutaneous hemodialysis graft thrombolysis (10903)*
- *k) Cerebral intra-arterial thrombolysis (10905)*
- *l) Percutaneous intravascular/intracorporeal medical device/foreign body removal (10909)*
- *m) Selective salpingography/fallopian tube recanalization (P10911)*
- *n) Transjugular liver or renal biopsy (10912)*
- *o) Image-guided percutaneous vertebroplasty (10906)*
- *p) Intravascular stent placement (10919)*
- *q) Intracorporeal stent placement (10920)*
- *r) Percutaneous balloon angioplasty for cerebral vasospasm (10914)*
- *s) Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique (10915)*
- *t) Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance (10918)*

viii) Repeat consultation not applicable for same condition, same patient within 6 months.

		$	Anes. Level
10901	Percutaneous image guided catheter directed thrombolysis of peripheral vein/artery	565.73	2

Notes:

i) Includes any medically necessary angiographies, any necessary imaging all necessary catheter repositioning and ongoing assessment and care throughout the patient's active treatment phase.

ii) Payable at 100% for the first 12 hours of care and 50% for each additional 12 hours of care up to 36 hours.

10902	Peripherally inserted image-guided central Venous catheter line (PICC)	107.76	2

Notes:

i) Interventional Radiology consultation not payable in addition, regardless of when rendered.

ii) Not applicable if performed via other than peripheral access.

iii) Includes placement, venogram/angiogram, and all medically required image guidance.

iv) May not be delegated.

10903	Percutaneous hemodialysis graft thrombolysis	565.73	2

Notes:

i) Includes declotting and treatment of underlying cause of access failure.

ii) Includes angioplasty and all necessary Imaging and intervention.

iii) An interventional radiology consultation is not payable unless the procedure is cancelled.

10904	Percutaneous transcatheter arterial chemo-embolization (TACE)	565.73	3

Notes:

i) Fee is per session / sitting, regardless of number of lesions treated;

ii) Includes all associated imaging necessary to complete procedure;

iii) Interventional Radiology consultation is payable.

10905	Cerebral intra-arterial thrombolysis	1,258.87	5

Notes:

i) Payable once only, regardless of number of arterial territories treated.

ii) Includes all diagnostic and superselective angiograms performed during procedure and immediate post procedure CT scans.

iii) An Interventional radiology consultation not payable unless the procedure is cancelled.

10906	Image-guided percutaneous vertebroplasty – first level	350.21	4
10907	- each additional level (to a maximum of 3)	80.82	4

Notes:

i) Payable only when rendered on in-patient or day-care basis in acute care facility;

ii) Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating;

iii) Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure;

iv) An interventional radiology consultation is not payable unless the procedure is cancelled.

10908	Percutaneous image-guided tumour ablation – first lesion	508.67	3

Notes:

i) Payable only for non-resectable liver, kidney, lung tumours, colorectal metastases and osteoid osteoma;

ii) Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 75% for second lesion and 25% for third lesion;

		$	Anes. Level
	iii) Includes all CT and ultrasound guidance necessary to complete the procedure; *iv) Paid at 50% if repeated within 30 days;* *v) Interventional Radiology consultation is payable.*		
10909	Percutaneous intravascular/intracorporeal medical device/foreign body removal ***Notes:*** *i) All angiography, angioplasty and/or intravascular stenting included;* *ii) If a second or third medical device / foreign body is removed, payable at 50% each, to a total maximum of three;* *iii) Interventional Radiology consultation is not payable unless the procedure is cancelled.*	377.15	3
10911	Selective salpingography / fallopian tube recanalization (FTR) ***Notes:*** *i) Hysterosalpingogram not payable in conjunction with the procedure;* *ii) Paid at 2/3 of the fee if unilateral;* *iii) FTR is not an insured benefit when used to correct scarring of the fallopian tubes after reversal of tubal ligation;* *iv) Any imaging related to the procedure is inclusive.* *v) An interventional radiology consultation is not payable unless the procedure is cancelled.*	377.15	2
10912	Transjugular liver/renal biopsy ***Notes:*** *i) Ultrasound guidance, venous puncture, central access catheter are included in the fee;* *ii) Payable only for uncorrectable coagulopathy;* *iii) The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day;* *iv) If repeated within 6 months, payable at 50%;* *v) An interventional radiology consultation not payable unless the procedure is cancelled.*	377.15	2
10913	Cerebral arterial balloon occlusion tolerance test ***Notes:*** *i) Payable for procedures performed on cerebral, carotid or vertebral arteries;* *ii) Radiological assists payable under fee items 08632 and 08633;.* *iii) Includes all neurological exams done in association with the procedure, any diagnostic angiography done immediately prior to or during the procedure and any necessary imaging performed at the time of the procedure;* *iv) Payable once per day, regardless of the number of balloon catheters inserted;* *v) Repeats within 30 days included in payment for original procedure.* *vi) Consultations payable in addition;* *vii) Included in payment for endovascular obliteration of an aneurysm using the GDC technique (FI 10915), or embolization (fee items : T00995, T0099, T00998) if performed on the same day.*	766.44	5
10914	Percutaneous balloon angioplasty for cerebral vasospasm ***Notes:*** *i) Includes all neurological exams done in association with the procedure, diagnostic cerebral angiography done during the procedure and any necessary imaging performed at the time of the procedure;* *ii) Includes catheterization of any and all cerebral arteries.* *iii) Payable once per day regardless of number of vascular territories or times treated.*	985.09	9

		$	Anes. Level

iv) Medically necessary extra cranial angioplasty and stenting required to enable access for balloon angioplasty payable at 50% of 00982
v) Consultation payable only if procedure is cancelled subsequent to consultation.
vi) Radiological assists are payable under fee items 08632 and 08633.
vii) Physician may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted 10914. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100 percent for the first angiogram and 50 percent for subsequent angiograms, to a maximum of 75% of fee item 10914. Claims must be accompanied by written details of vessels injected.
viii) Not payable with fee item 10905 (Cerebral intra-arterial thrombolysis).

10915 Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique 1,916.11 7

Notes:
i) Includes all neurological exams done in association with the procedure, any diagnostic angiography performed at time of procedure and any necessary imaging performed at the time of the procedure;
ii) Includes 10913 when performed on same day;
iii) Separate micro catheterization included if required;
iv) Consultation payable only if procedure is cancelled subsequent to the consultation;
v) Multiple aneurysms paid as follows: 2nd – 50 percent; 3rd – 25 percent (to a maximum of three aneurysms);
vi) Radiological assists are payable under fee items 08632 and 08633;
vii) Fee item 08629 not payable in addition.
viii) Physician may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted 10915. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100 percent for the first angiogram and 50 percent for subsequent angiograms, to a maximum of 75% of fee item 10915. Claims must be accompanied by written details of vessels injected.

10916 Complex diagnostic neuroangiography for the assessment of complex vascular tumors or vascular malformations
– up to 4 hours procedural time 1,127.12 5
10917 – after 4 hours (extra to 10916) 281.79

Notes:
i) Includes injection of six or more intracranial or extracranial vessels in the head, neck and/or spine, or if procedure requires use of microcatheters, injection of four or more vessels.
ii) Start and stop times must be noted in claim submission
iii) This listing is not payable when performed concurrently with other interventional radiology procedures.
iv) Subsequent consecutive interventional radiology procedures are payable at
a) 50% if performed by same operator;
b) 100% if performed by different operator.

10918 Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance 450.85 6

Notes:
i) Payable once per day, regardless of the number of lesions treated on head or neck;
ii) Fee item 08629 not payable in addition.
iii) Consultation payable only if procedure is cancelled subsequent to the consultation.
iv) Includes necessary post-operative visits by physician performing procedure.
v) Compression sclerotherapy listings (fee items 77050 – 77060) not payable with 10918.

		$	Anes. Level
10919	Intravascular stent placement – extra	124.30	

Notes:

i) Includes all diagnostic imaging associated with stent placement.
ii) Payable once only when contiguous vessels are stented and/or where more than one stent is used per site.
iii) Placement of second stent in non-contiguous site payable at 50%.
iv) Procedures repeated within 30 days are payable at 50%.
v) Consultation payable only if procedure is cancelled subsequent to consultation.
vi) Not payable for Coronary stent placement.
vii) When done with 77177, payable to the second operator.

10920	Intracorporeal stent placement – extra	124.30	

Notes:

i) Includes all Diagnostic imaging associated with stent placement.
ii) Includes all associated tract dilation(s).
iii) Second procedure same day payable at 50%.
iv) Removal of stent within 6 months of insertion payable at 50%.
v) Consultation payable only if procedure is cancelled subsequent to the consultation.
vi) Payable only when stents are placed in the same organ and/or where more than one stent is used per site or when repositioning of stent required.
vii) Placement of second stent in non-contiguous site payable at 50%.

10921	Transjugular Intrahepatic Porto-systemic shunt (TIPS)	1,068.21	8

Notes:

i) Includes all medically necessary catheters/guidewires/stenting.
ii) Includes all diagnostic and/or procedural imaging.
iii) 2nd TIPS procedure performed within 24 hours payable at 50%.
iv) Replacement of previously inserted TIPS payable at 50%.
v) Consultation (83000) will be paid in addition regardless if the procedure is performed or is scheduled and subsequently cancelled.
vi) Radiological assists are payable under fee items 08632 and 08633.

Breast

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

Incision

70041	Fine needle aspiration of solid or cystic lesion – operation only	44.60	2
70042	- each additional cyst or lesion (maximum of 3) – operation only	11.16	2

Stereotactic or ultrasound-guided core needle biopsy:

70472	- 1 to 5 core samples – operation only	82.72	2
70473	- 6 to 10 core samples (operation only)	116.76	2