MINISTRY OF HEALTH

MEDICAL SERVICES COMMISSION

PAYMENT SCHEDULE

March 31, 2023

MSC PAYMENT SCHEDULE INDEX

(To go directly to the applicable section of the Payment Schedule, click on the Section heading listed below)

GENERAL PREAMBLE TO THE PAYMENT SCHEDULE

A. 1. PURPOSE OF THE GENERAL PREAMBLE

The General Preamble to the Medical Services Commission (MSC) Payment Schedule (the "Schedule") complements the specialty preambles in the Schedule. The intention is that, together, the preambles assist medical practitioners in appropriate billing for insured services. Not every specialty requires a specific preamble; several are governed exclusively by the General Preamble. Every effort has been made to avoid confusion in the structure and language of the preambles; if, however, there is an inadvertent conflict between a fee item description, a specialty preamble and the General Preamble, the interpretation of the fee item description and/or the specialty preamble shall prevail.

The Schedule is the list of fees approved by the MSC and payable to physicians for insured medical services provided to beneficiaries enrolled with the Medical Services Plan (MSP). The preambles provide the billing rules under which the fees are to be claimed; these rules are a roadmap designed to clarify the use of the Schedule.

A. 2. INTRODUCTION TO THE GENERAL PREAMBLE

All benefits listed in the Schedule, except where specific exceptions are identified, must include the following as part of the service being claimed; payment for these inherent components is included in the listed fees:

i) Direct face-to-face encounter with the patient by the medical practitioner, appropriate physical examination when pertinent to the service and on-going monitoring of the patient's condition during the encounter, where indicated.

ii) Any inquiry of the patient or other source, including review of medical records, necessary to arrive at an opinion as to the nature and/or history of the patient's condition.

iii) Appropriate care for the patient's condition, as specifically listed in the Schedule for the service and as traditionally and/or historically expected for the service rendered.

iv) Arranging for any related assessments, procedures and/or therapy as may be appropriate, and interpreting the results, except where separate listings are applicable to these adjunctive services. (Note: This does not preclude medical practitioners rendering referred "diagnostic and approved laboratory facility[1]" services from billing for interpretation of diagnostic or laboratory test results).

v) Arranging for any follow-up care which may be appropriate.

vi) Discussion with and providing advice and information to the patient or the patient's representative(s) regarding the patient's condition and recommended therapy, including advice as to the results of any related assessments, procedures and/or therapy which may have been arranged. No additional claims may be made to the Plan for such advice and discussion, nor for the provision of prescriptions (including completion of Pharmacare required Special Authority requests or Pharmacare Plan G forms) and/or diagnostic and laboratory requisitions, unless the patient's medical condition indicates that the patient should be seen and assessed again by the medical practitioner in order to receive such advice.

vii) Making and maintaining an adequate medical record of the encounter that appropriately supports the service being claimed. A service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit under the Plan.

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[1] **The *Laboratory Services Act* came into force on October 1, 2015. Reference should be made to the Laboratory Services Payment Schedule for definitions and a schedule of laboratory fees.**

The General Preamble is divided into four interdependent sections:

B. Definitions
C. Administrative Items
D. Types of Services

B. DEFINITIONS

Please note that definitions of specific types of medical assessments and services are provided in the corresponding section of the General Preamble.

"Age categories"

Premature Baby	-2,500 grams or less at birth
Newborn or Neonate	-from birth up to, and including, 27 days of age
Infant	-from 28 days up to, and including, 12 months of age
Child	-from 1 year up to, and including, 15 years of age

Notes:
a) for pediatric specialists – up to and including 19 years of age
b) for psychiatrists – up to and including 17 years of age

"Antenatal visit"

Pregnancy-related visits from the time of confirmation of pregnancy to delivery
Same as prenatal

"CPSBC"

College of Physicians and Surgeons of British Columbia

"Diagnostic Facility"

Means a facility, place or office principally equipped for prescribed diagnostic services, studies or procedures, and includes any branches of a diagnostic facility

"Emergency department physician"

Either a medical practitioner who is a specialist in emergency medicine or a medical practitioner who is physically and continuously present in the Emergency Department or its environs for a scheduled, designated period of time

"Family Physician"

A medical practitioner who is registered with the College of Physicians and Surgeons of British Columbia as a Family Physician

"Health care practitioner"

Any of the following persons entitled to practice under an enactment:

a) a chiropractor
b) a dentist
c) an optometrist
d) a podiatrist
e) a midwife
f) a nurse practitioner
g) a physical therapist
h) a massage therapist
i) a naturopathic physician or
j) an acupuncturist

“Holiday”

New Year’s Day, Family Day, Good Friday, Easter Monday, Victoria Day, Canada Day, B.C. Day, Labour Day, National Day of Truth and Reconciliation, Thanksgiving Day, Remembrance Day, Christmas Day, Boxing Day

The list of dates designated as holidays will be issued annually by MSP

“Hospital”

An institution designated as a hospital under Section 1 of the BC Hospital Act - except in Parts 2 and 2.1, means a non-profit institution that has been designated as a hospital by the minister and is operated primarily for the reception and treatment of persons:

a) suffering from the acute phase of illness or disability,
b) convalescing from or being rehabilitated after acute illness or injury, or
c) requiring extended care at a higher level than that generally provided in a private hospital licensed under Part 2.

“Medical practitioner”

A medical practitioner as entitled to practice under the Medical Practitioners Regulations to the Health Professions Act

“Microsurgery”

Surgery for which a significant portion of the procedure is done using an operating microscope for magnification. Magnification by other than an operating microscope is not microsurgery

“MSC”

Medical Services Commission: A statutory body, reporting to the Minister, consisting of 9 members appointed by the Lieutenant Governor in Council as follows:

a) 3 members appointed from among 3 or more persons nominated by the Doctors of BC (formerly known as British Columbia Medical Association or BCMA);
b) 3 members appointed on the joint recommendation of the minister and the Doctors of BC to represent beneficiaries;
c) 3 members appointed to represent the government.

See Preamble C. 2. for additional details

“MSP”

Medical Services Plan

“No charge referral”

Notifying MSP of a referral is usually done by including the practitioner number of the physician to who the patient is being referred on your FFS claim. If no FFS claim is being submitted, a “no charge referral” is a claim submitted to MSP under fee item 03333 with a zero dollar amount.

“Palliative care”

Care provided to a terminally ill patient during the final 6 months of life, where a decision has been made that there will be no aggressive treatment of the underlying disease, and care is directed to maintaining the comfort of the patient until death occurs.

“Practitioner”

a) a medical practitioner, as defined above, or
b) a health care practitioner who is registered with the Medical Services Plan

“Prefixes to fee codes”

Note: These prefixes to fee services codes should not be submitted when billing

B designates services included in the visit fee.
C designates fee items for which it is not required to indicate by letter the need for a certified surgeon to assist at surgery (see fee item 70019).
G designates fee items which originated from the Joint Clinical Committees and have been transferred to the MSC Payment Schedule.
H designates listings which are administered through the Claims payment system but are not funded through the medical practitioners’ Available Amount.
P designates fee items approved on a provisional basis and awaiting further review.
S designates fee items for which a surgical assistant’s fee is not payable.
T designates fee items approved on a temporary basis and awaiting further information.
V designates surgical fee items that are exempt from the post-operative general preamble rule (D. 5. 1.). Therefore, fee item 71008 can be billed for post- operative care within the first 14 post-operative days in hospital.
Y designates office or hospital visit on the same day is billable in additional to the procedure fee.

“Referral”

A request from one practitioner to another practitioner to render a service for a specific patient; typically the service is one or more of a consultation, a laboratory service, diagnostic test, specific surgical, or medical treatment.

Referring practitioner:

Notify MSP of a referral by including the MSP practitioner number of the physician being referred to in the **“**Referred to Field**”** on your fee for service (FFS) claim. If no FFS claim is being submitted, a claim record for a “no charge referral” may be submitted to MSP under fee item 03333 with a zero dollar amount. If the referring physician does not have a MSP practitioner number (e.g.: alternative payment practitioner), a written request for the referral must be sent to the practitioner being referred to and a copy retained in the patient’s clinical record.

Referred to practitioner:

Notify MSP that a referral has been made to you by including the MSP practitioner number of the referring physician in the “Referred by Field” on your FFS claim.

On occasion, a MSP practitioner’s number is not available (e.g.: alternative payment practitioner), for these rare cases the following generic numbers have been established:

- 99957 – referral by retired/deceased/moved out of province physician
- 99991 – referral by a chiropractor to an orthopaedic specialist
- 99992 – referral by an optometrist to an ophthalmologist and referral by an optometrist to a neurologist
- 99993 – referral by a salaried, sessional or contract physician
- 99994 – referral by a dentist
- 99996 – referred by public health for a TB x-ray
- 99997 – referred by a primary care organization
- 99998 – referred by an Out of Province physician

The generic numbers may be used in place of the MSP practitioner number. The name of the physician should be documented in the note field in the FFS claim and a record of the referral must be retained in the patient's clinical record.

"Specialist"

A medical practitioner who is a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada; and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty.

"Third party"

A person or organization other than the patient, his/her agent, or MSP that is requesting and/or assuming financial responsibility for a medical or medically related service

"Transferral"

The transfer of responsibility from one medical practitioner to another for the care of patient, temporarily or permanently.

This is distinguished from a referral, and does not provide the basis for billing a consultation; the exception is that, when the complexity or severity of illness necessitates that accepting the transferral requires an initial chart review and physical examination, a limited or full consultation may be medically necessary and is requested by the transferring medical practitioner.

"Time categories"

- 12-month period – any period of twelve consecutive months
- Calendar year – the period from January 1 to December 31
- Day – a calendar day
- Fiscal year – from April 1 of one year to March 31 of the following year
- Month – a calendar month
- Week – any period of 7 consecutive days
- Calendar week – from Sunday to Saturday

"Uninsured service"

- A service that is not a benefit as defined by the MSC

C. ADMINISTRATIVE ITEMS

Index to Administrative Items

C. ADMINISTRATIVE ITEMS

C. 1. Fees Payable by the Medical Services Plan (MSP)

A Payment Schedule for medical practitioners is established under Section 26 of the *Medicare Protection Act* and is referred to in the Master Agreement between the Government of the Province of British Columbia and the Medical Services Commission (MSC) and the Doctors of BC. The fees listed are the amounts payable by the Medical Services Plan (MSP) of British Columbia for listed benefits. "Benefits" under the Act are limited to services which are medically required for the diagnosis and/or treatment of a patient, which are not excluded by legislation or regulation, and which are rendered personally by medical practitioners or by others delegated to perform them in accordance with the Commission's policies on delegated services.

Services requested or required by a "third party" for other than medical requirements are not insured under MSP. Services such as consultations, laboratory investigations, anesthesiology, surgical assistance, etc., rendered solely in association with other services which are not benefits also are not considered benefits under MSP, except in special circumstances as approved by the Medical Services Commission (e.g.: Dental Anesthesia Policy).

C. 2. Setting and Modification of Fees

The tri-partite Medical Services Commission (MSC) manages the Medical Services Plan (MSP) on behalf of the Government of British Columbia in accordance with the *Medicare Protection Act* and Regulations. The MSC is the body that has the statutory authority to set the fees that are payable for insured medical services provided to beneficiaries enrolled with the Medical Services Plan (MSP). The MSC Payment Schedule is the official list of fees for which insured services are paid by MSP.

The Doctors of BC maintains and publishes the Doctors of BC Fee Guide. The Guide mirrors the MSC Payment Schedule, with some exceptions including recommended private fees for uninsured services.

The process for additions, deletions or other changes to the MSC Payment Schedule, are made in accordance with the Master Agreement. Medical practitioners who wish to have modifications to the MSC Payment Schedule considered should submit their proposals to the Doctors of BC Tariff Committee through the appropriate Section. The Government and the Doctors of BC have agreed to consult with each other prior to submitting a recommendation to the MSC. If both parties agree, in writing, to a revision, MSC will adopt the recommendation as part of the MSC Payment Schedule as long as the service is medically necessary and consistent with the requirements of the *Medicare Protection Act* and Regulations and it agrees with the estimated projected cost that will result from the revision. In the case where there is no agreement between Government and the Doctors of BC, both parties may make a separate recommendation to the MSC and the MSC will determine the changes, if any, to the MSC Payment Schedule.

Usually, the earliest retroactive effective date that may be established for a new or interim fee code, is April 1st of the current fiscal year. For services not listed in the MSC Payment Schedule, please refer to the following sections C. 3. & C. 4.

C. 3. Services Not Listed in the Schedule

Services not listed in the MSC Payment Schedule must not be billed to MSP under other listings. These services should be billed under the appropriate miscellaneous fee as described in section C. 4.

On recommendation of the Doctors of BC Tariff Committee and agreed to by Government, interim listings may be designated by the MSC for new procedures or other services for a limited period of time to allow definitive listings to be established.

However, prior to establishment of a new or interim fee code, an individual or the section may request special consideration to bill for a medically required service not currently listed by following the procedure under Miscellaneous Services (C. 4.).

C. 4. Miscellaneous Services

This section relates to services not listed in the MSC Payment Schedule that are:

- new medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature;
- unusually complex procedures, for established but infrequently performed procedures;
- for unlisted “team” procedures, or
- for any medically required service for which the medical practitioner desires independent consideration to be given by MSP

Claims under a miscellaneous fee code will be accepted for adjudication only if the following criteria are fulfilled:

- An estimate of an appropriate fee, with rationale for the level of that fee
- Sufficient documentation of the services (such as the operative report) to substantiate the claim.

The Medical Services Plan will review the fee estimate proposed and the supporting documentation and by comparing with the service provided with comparable services listed in the MSC Payment Schedule, determine the level of compensation. While an application for a new fee item is in process (as per Section C. 2.), MSP will pay for the service at a percentage of a comparable fee until the new fee item is effective. Should it be determined that a new listing will not be established due to the infrequency of the unlisted service, payments will be made at 100% of the comparable service.

Miscellaneous (...99) Fee Items

00099	General Services
00199	Family Medicine
00299	Dermatology
00399	General Internal Medicine
00499	Neurology
00599	Pediatrics
00699	Psychiatry
00999	Diagnostic Procedures
01499	Critical Care
01799	Physical Medicine
01899	Emergency Medicine
01999	Anesthesia
02599	Otolaryngology
02999	Ophthalmology
03999	Neurosurgery
04999	Obstetrics & Gynecology
06999	Plastic Surgery
07999	General Surgery/Cardiac Surgery
08699	X-ray
08899	Miscellaneous Diagnostic Ultrasound
08999	Urology
09899	Nuclear Medicine
30999	Clinical Immunology and Allergy
31999	Rheumatology
32199	Respirology
33199	Cardiology

33299 Endocrinology and Metabolism
33399 Gastroenterology
33499 Geriatric Medicine
33599 Hematology and Oncology
33699 Infectious Diseases
33899 Nephrology
33999 Occupational Medicine
59999 Orthopaedics
77799 Vascular Surgery
79199 Thoracic Surgery

If a medical practitioner wishes to dispute the adjudication of a claim submitted under a miscellaneous fee, please refer to section C. 12. on Disputed Payments.

C. 5. Inclusive Services and Fees

If it is not medically necessary for a patient to be personally reassessed prior to prescription renewal, specialty referral, release of diagnostic or laboratory results, etc., claims for these services must not be made to MSP regardless of whether or not a medical practitioner chooses to see his/her patients personally or speak with them via the telephone.

The completion of Pharmacare required Special Authority requests or Pharmacare Plan G forms is part of a visit, consultation, or service and as a consequence, no charge will be made for its completion.

Some services listed in the MSC Payment Schedule have fees which are specifically intended to cover multiple services over extended time periods. Examples are most surgical procedures, the critical care per diem listings and some obstetrical listings. The preambles and Schedule are explicit where these intentions occur.

When, because of serious complications or coincidental non-related illness, additional care is required beyond that which would normally be recognized as included in the listed service, MSP will give independent consideration to claims for this additional care, if adequate explanation is submitted with the claim.

C. 6. Medical Research

Costs of medical services (such as examinations by medical practitioners, laboratory procedures, other diagnostic procedures) which are provided solely for the purposes of research or experimentation are not the responsibility of the patient or MSP. However, it is recognized that medical research may involve what is generally considered to be accepted therapies or procedures, and the fact that a therapy or procedure is performed as part of a research study or protocol does not preclude it from being a service insured by MSP. In the situation where therapies or procedures are part of a research study, only those reasonable costs customarily related to routine and accepted care of a patient's problem are considered to be insured by MSP; additional services carried out specifically for the purposes of the research are not the responsibility of MSP.

Experimental Medicine

New procedures and therapies not performed elsewhere and which involve a radical departure from the customary approaches to a medical problem, are considered to be experimental medicine. Services related to such experimental medicine are not chargeable to MSP.

New therapies and procedures which have been described elsewhere may or may not be deemed to be experimental medicine for the purposes of determining eligibility for payment by MSP.

Until new procedures or therapies are proven by peer-reviewed studies and adopted by the medical community, they are experimental. Services related to such experimental medicine are not the responsibility of the Medical Services Plan.

Coverage:

- Associated costs for any routine follow up care and diagnostic procedures related to experimental medicine are the responsibility of the patient.
- Care related to complications of any treatment, including experimental medicine, is covered by the Medical Services Plan. Care may include direct telephone consultation with physicians as required and clinical services provided directly to patients. Physician claims are billed under existing mechanisms through the Medical Services Plan Fee-for-Service system (see the MSC Payment Schedule for further information).

Process:

Where such a new therapy or procedure is being introduced into British Columbia and the medical practitioners performing the new therapy or procedure wish to have a new fee item inserted in to the fee schedule to cover the new therapy or procedure, the process to be used is as follows:

An application for a new fee item related to the new therapy or procedure will be submitted by the appropriate section(s) of the Doctors of BC to the Doctors of BC Tariff Committee for consideration, with documentation supporting the introduction of this item into the payment schedule. The Doctors of BC Tariff Committee will advise the Medical Services Commission whether or not this new therapy constitutes experimental medicine. If the Tariff Committee considers that the item is experimental, it will not be considered an insured service and will not be introduced into the fee schedule. If the Medical Services Commission, on the advice of Tariff Committee, determines that the new therapy or procedure is not experimental medicine, the fee item application will be handled in the usual manner for a new fee.

When a new therapy or procedure is being performed outside British Columbia, a patient or patient advocate may request that the services associated with this new therapy or procedure be considered insured services by MSP. The situation will be reviewed by the Medical Services Commission utilizing information obtained from various sources, such as medical practitioners, the Doctors of BC or evidence based research. If it is determined that the new therapy or procedure is experimental, then the cost of medical services provided for this type of medical care will not be the responsibility of MSP. If it is considered that the therapy or procedure is not experimental, the cost of medical services associated with this treatment will be in part or in whole the responsibility of MSP.

If the procedures are accepted as no longer being experimental, they may be added into the MSC Payment Schedule, if approved by the MSC after the appropriate review process has been followed (see section C. 3.)

C. 7. MSP Billing Number

A billing number consists of two numbers - a practitioner number and a payment number. The practitioner number identifies the practitioner performing and taking responsibility for the service. The payment number identifies the person or party to whom payment will be directed by the Medical Services Plan (MSP). Each claim submitted must include both a practitioner number and payment number.

C. 8. Group Practice, Partnerships, and Locum Tenens

The *Medicare Protection Act* requires that each medical practitioner will charge for his/her own services. For MSP and WorkSafeBC (WSBC) billings this requires the use of the individual's personal practitioner number. This includes members of Group Practices, Partnerships and Locum Tenens.

Non compliance may impact the level of benefits a medical practitioner may accrue under the Benefits Subsidiary Agreement.

Exceptions to this rule are hospital-based Diagnostic Imaging, and where specifically allowed by the MSC.

C. 9. Assignment of Payment

An “Assignment of Payment” is a legal agreement by which an attending practitioner designates payment for his/her services to another party. In this circumstance, the designated party may use the attending practitioner’s practitioner number in combination with its own payment number when submitting claims to MSP. To authorize MSP to make payment to a designated party, the attending practitioner must complete and file an “Assignment of Payment” form. However, even though the payment has been assigned, the responsibility for the clinical service and its appropriate billing remains with the practitioner whose practitioner number is used.

C. 10. Adequate Medical Records of a Benefit under MSP

Except for referred “diagnostic facility” services and approved laboratory facility services, a medical record is not considered adequate unless it contains all information which may be designated or implied in the MSC Payment Schedule for the service. Another medical practitioner of the same specialty, who is unfamiliar with both the patient and the attending medical practitioner, would be able to readily determine the following from that record at hand:

a. Date and location of the service.
b. Identification of the patient and the attending medical practitioner.
c. Presenting complaint(s) and presenting symptoms and signs, including their history.
d. All pertinent previous history including pertinent family history.
e. The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient’s problem(s).
f. Identification of the extent of the physical examination including pertinent positive and negative findings.
g. Results of any investigations carried out during the encounter.
h. Summation of the problem and plan of management.

For referred “diagnostic facility” services, but not including approved laboratory facility services an adequate medical record must include:

a. Date and location of patient encounter or specimen obtained.
b. Identification of the patient and the referring practitioner.
c. Problem and/or diagnosis giving rise to the referral where appropriate.
d. Identification of the specific services requested by the referring practitioner.
e. Identification of specific services performed but not specifically requested by the referring practitioner, and identification of the medical practitioner who authorized the additional services.
f. Original requisition or a copy or electronic reproduction of the requisition, in which the method for copying or producing an electronic reproduction must be approved by the Commission, the nature of the copy or electronic reproduction must comply with the intent relative to the form and content of the standard diagnostic requisition, and must be auditable to the original source document.
g. Where a requisition is submitted electronically, the electronic ordering methods must be approved by the Commission employing guidelines established jointly by MSP and Doctors of BC.
h. Where a written requisition was never submitted by the referring practitioner, the diagnostic person who recorded the verbal requisition must be identified. The requisitions must be retained for 6 years.
i. Results of all services rendered, and interpretation where appropriate. These data must be retained for 6 years.

C. 11. Reciprocal Claims

All Provinces, and Territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid Provincial Health Registration Card. Claims can be submitted electronically and details of this process may be obtained by contacting MSP. However, the services listed below are exempt from this agreement and should be billed directly to the non-resident patient.

Medical Practitioner Services Excluded under the Inter-Provincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims

1. Surgery for alteration of appearance (cosmetic surgery)
2. Gender-reassignment surgery
3. Surgery for reversal of sterilization
4. Routine periodic health examinations including routine eye examinations (including PAP tests for screening only)
5. In-vitro fertilization, artificial insemination
6. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
7. Services to persons covered by other agencies; Armed Forces, WorkSafe BC, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries)
8. Services requested by a “Third Party”
9. Team conference(s)
10. Genetic screening and other genetic investigation, including DNA probes
11. Procedures still in the experimental/developmental phase
12. Anesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make enquires of that home province after direct payment to the BC medical practitioner.

C. 12. Disputed Payments

Remittance statements issued by MSP should be reviewed carefully to reconcile all claims and payments made. Claims may have been adjusted in adjudication and explanatory codes should designate the reason(s) for any adjustments. If a medical practitioner is unable to agree with an adjustment, the account should be resubmitted to MSP together with additional information for reassessment. Further disagreement with the payment should be referred to the Doctors of BC Reference Committee for review and subsequent recommendation to the Commission.

C. 13. Extra Billing and Balance Billing

“Extra Billing” means billing an amount over the amount payable for an insured service (a “benefit”) by MSP. Extra billing is not allowed under the *Medicare Protection Act* except for services rendered by medical practitioners who are not “enrolled” with MSP (i.e. no services are covered by MSP) and then only for those services which are rendered outside of hospitals and community care facilities.

“Balance billing” denotes the practice of medical practitioners who are opted in under MSP billing MSP for the MSP fee and the patient for the amount of the difference between the payment made by MSP for an insured service and the fee for that service listed in the Doctors of BC Fee Guide, under the heading “Non-MSP-Insured Fees”. Except as defined by differential billing for non-referred patients above, balance billing is not permitted under the *Medicare Protection Act.*

C. 14. Differential Billing for Non-Referred Patients

If a specialist attends a patient without referral from another practitioner authorized by the Medical Services Commission to make such referral, the specialist may submit a claim to MSP for the

appropriate family physician visit fee and in addition may charge the patient a differential fee. This is not considered “extra billing.”

The maximum amount the patient may be charged is the difference between the amount payable under the Family Medicine Payment Schedule for the service rendered, and the amount payable under the Payment Schedule to the specialist had the patient been referred.

C. 15. Missed Appointments

Claims for missed appointments must not be submitted to MSP. Billing the patient directly for such missed appointments would not be considered extra billing.

C. 16. Payment for Specialist Consultations/Visits and specialty-restricted items

To be paid by MSP, ICBC or WorkSafeBC for specialist consultations, visit items and/or other specialty-restricted fee items listed in the specialty sections of the Payment Schedule, one must be a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty.

A specialist recognized in more than one specialty by the College of Physicians and Surgeons of British Columbia should bill consultation and referred items under the specialty most appropriate for the condition being diagnosed and/or treated for that referral/treatment period.

C. 17. Motor Vehicle Accident (MVA) Billing Guidelines

1. All cases directly relating to an MVA which ICBC Insurance coverage applies should be identified as such by a “yes” code in the Teleplan MVA field.
2. All such cases should be coded “MVA” regardless of whether seen in an office visit, emergency, diagnostic, lab or x-ray facility. Surgery or procedures performed in regard to these cases should also be identified.
3. Where possible, please attach an ICBC claim number to each coded MVA in your Teleplan billing.
4. In cases where a visit or procedure was occasioned by more than one condition, the dominant purpose must be related to an MVA to code it as such.
5. If the patient is from another province, use the normal out-of-province billing process.
6. In those instances in which the patient has no MSP coverage, the medical practitioner should bill the patient or ICBC directly. Medical practitioners have the choice of either billing the uninsured patient directly at the Doctors of BC recommended rate and having the patient recover the costs from ICBC (see Doctors of BC Fee Guide), or billing ICBC for the MSP amount.
7. If the MVA is work-related, WorkSafeBC (WSBC) should be billed under their procedures.
8. Medical Practitioners are accountable for proper MVA identification and are subject to audit.

C. 18. Guidelines for Payment for Services by Trainees, Residents and Fellows

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the supervising medical practitioner shall be identified to the patient at the earliest possible moment. No fees may be charged in the name of the supervising staff physician for services rendered by a trainee, resident or fellow prior to the identification taking place. Moreover, the supervising staff physician must be available in person, by telephone or videoconferencing in a timely manner appropriate to the acuity of the service being supervised.

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of trainees, residents, fellows or other members of the team, the total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of the other team members. For example:

a) If an anesthesiologist is supervising two rooms simultaneously, the anesthetic intensity/complexity units should only be billed for one of the two cases.

b) If a surgeon is operating in one room while his/her resident is operating in a second room, charges should only be made for the case the surgeon performs.

c) In psychotherapy where direct supervision by the staff physician may distort the psychotherapeutic milieu, the staff physician may claim for psychotherapy when a record of the psychotherapeutic interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff physician should not exceed the lesser of the time spent by the resident in the psychotherapeutic interview or the staff physician in the supervision of that interview.

d) For hospital visits and consultations rendered by the resident in the name of the staff physician, the staff physician should only charge for services on the days when actual supervision of that patient's care takes place through a physical visit to the patient by the staff physician and/or a chart review is conducted with detailed discussion with the other members of the health team within the next weekday workday.

e) The supervising physician may not bill for out-of-office hours premiums or continuing care surcharges unless he/she complies with the explanatory notes for out-of-office hours premiums in the Payment Schedule/Fee Guide and personally attends the patient.

f) In order to bill for a supervised service the physician must review in person, by telephone or videoconferencing the service being billed with the trainee, resident or fellow and have signed off within the next weekday workday on the ER record, hospital chart, office chart or some other auditable document.

C. 19. Services to Family and Household Members

1. Services are not benefits of MSP if a medical practitioner provides them to the following members of the medical practitioner's family:

   a) a spouse,
   b) a son or daughter,
   c) a step-son or step-daughter,
   d) a parent or step-parent,
   e) a parent of a spouse,
   f) a grandparent,
   g) a grandchild,
   h) a brother or sister, or
   i) a spouse of a person referred to in paragraph (b) to (h).

2. Services are not benefits of MSP if a medical practitioner provides them to a member of the same household as the medical practitioner.

C. 20. Delegated Procedures

Procedures which are generally and traditionally accepted as those which may be carried out by a nurse, nurse practitioner or a medical assistant in the employ of a medical practitioner may, when so performed, only be billed to MSP by the medical practitioner when the performance of the procedure is under the "direct supervision" of the medical practitioner or a designated alternate medical practitioner with equivalent qualifications. Direct supervision requires that during the procedure, the medical

practitioner be physically present in the office or clinic at which the service is rendered. While this does not preclude the medical practitioner from being otherwise occupied, s/he must be in personal attendance to ensure that procedures are being performed competently and s/he must at all times be available immediately to improve, modify or otherwise intervene in a procedure as required in the best interest of the patient. Billing for these procedures also implies that the medical practitioner is taking full responsibility for their medical necessity and for their quality. Any exceptions to this rule are subject to the written approval of MSP.

"Procedures" in this context do not include such "visit" type services as examinations/ assessments, consultations, psycho-therapy, counselling, telehealth services, etc., which may not be delegated.

The foregoing limitations do not apply to approved procedures rendered in approved "diagnostic facilities", as defined under the Medicare Protection Act and Regulations, or to services rendered in approved laboratory facilities, as defined under the Laboratory Services Act and Regulation and which are subject to accreditation under the Diagnostic Accreditation Program.

C. 21. Diagnostic Facility Services

Diagnostic Facility Services are defined under the Medicare Protection Act as follows:

"Medically required services performed in accordance with protocols agreed to by the Commission, or on order of the referring practitioner, who is a member of a prescribed category of practitioner, in an approved diagnostic facility by, or under the supervision of, a medical practitioner who has been enrolled, unless the services are determined by the Commission not to be benefits."

The Medical Services Commission designates, from time to time, certain diagnostic procedures as "diagnostic facility" services under the MSC Payment Schedule. Currently, the following services are considered "diagnostic facility" services for purposes of the MSC Payment Schedule:

The services, studies, or procedures of diagnostic radiology, diagnostic ultrasound, nuclear medicine scanning, pulmonary function, computerized axial tomography technical fee (CT, CAT), magnetic resonance imaging (MRI), positron emission tomography (PET), and electro diagnosis (including electrocardiography, electroencephalography, and polysomnography) are not payable by MSP for services rendered to hospital in-patients, "day surgery" patients, or emergency department patients.

The venepuncture and dispatch listings in the Payment Schedule (00012) apply only to those situations where this sole service is provided by a facility or person unassociated with any other bloodwork services provided to that patient. Fee items 00012 cannot be billed or paid to a medical practitioner if any other bloodwork assays are performed or if the specimen is sent to an associated facility.

C. 22. Appliances/Prostheses/Orthotics

The costs of prostheses, orthotics and other appliances are not covered under MSP. Such devices, where insertion in hospital is medically/surgically required and where the devices are embedded entirely within tissue, may be covered under an institutional budget.

C. 23. Accompanying Patients

When it is medically essential that a medical practitioner accompany a patient to a distant hospital, MSP allows payment at the rates listed in the Payment Schedule for the travelling time spent with the patient only. Out-of-office hours premiums may also be applicable in accordance with the guidelines. Payment is based on a return trip and not applicable to layover time. Claims should be submitted with details under fee code 00084. Claims for travel, board and lodging are not payable by MSP. Medical practitioners 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.

C. 24. Salaried and Sessional Arrangements

Fee for Service claims for any physician service(s) that is funded under a service contract, or compensated for under a sessional or salaried payment arrangement, must not be billed to MSP. When physicians who receive compensation under a service contract, sessional payment or salaried arrangement are billing for an unrelated service, the appropriate location code and facility code should be included on all fee for service claims.

C. 25. WorkSafeBC (WSBC)

A detailed description of WorkSafeBC (WSBC) fees, preamble, and policies is contained in the WorkSafeBC section of the Doctors of BC Fee Guide. The fees listed under "MSP and WSBC Fee" have been accepted by the WorkSafeBC through negotiated agreements as the basis for their Fee Guide. WorkSafeBC supplies its own reporting and billing forms. To facilitate payment, WorkSafeBC requires the practitioner to include their MSP payment number on all forms.

MSP is currently processing claims on behalf of WorkSafeBC as its agent. The Doctors of BC and WorkSafeBC agree that MSP Teleplan is the only acceptable manner of billing WorkSafeBC for services billable through MSP.

C. 26. BC Transplant Society

With the exception of medical practitioners paid by the BC Transplant Society under an alternate payment plan, all medical practitioner services associated with cadaveric organ recovery (“organ donation”) are payable on a fee-for-service basis through the MSP. For the purpose of payment of these services, the donor’s PHN will remain valid after legal brain death until such time as the donor’s organs have been successfully harvested. A note record should accompany the account stating “organ donor”.

C. 27. Business Cost Premium

The Business Cost Premium (BCP) is to provide improved compensation for physicians who are responsible for some or all of the rent, lease, or ownership costs (either directly or indirectly) of a community-based office. The BCP is a percentage premium paid on eligible fees for in-person, face-to-face services, to compensate physicians for the work they do with patients in their office. Physicians must be entitled to receive and retain payment for the eligible fees directly from MSP (i.e. payments assigned to Health Authorities are not eligible for the premium).

The current BCP eligible services are:

i) Consultations
ii) Visits
iii) Complete examinations, and
iv) Counselling

The percentage values and the daily maximum amounts of the BCP are based on the location the eligible service is rendered:

i) City of Vancouver: 5% of eligible fees up to a maximum BCP payment of $60 per day per physician.

ii) Metro Vancouver (excluding the City of Vancouver) and Greater Victoria: 4% of eligible fees up to a maximum BCP payment of $48 per day per physician.

iii) Other communities (outside Greater Vancouver and Greater Victoria) not eligible for the Rural Retention Premiums: 3% of eligible fees up to a maximum BCP payment of $36 per day per physician.

To receive the BCP:

i) The physician is responsible for some or all of the lease, rental, or ownership costs of that community-based office, and
ii) The community-based facility in which the eligible services are provided must be in an eligible location and have a unique Facility Number registered with MSP, and
iii) The physician must be registered with MSP as a physician practicing at that Facility, and
iv) The correct Facility Number must be entered on each claim where the eligible service is rendered.

List of eligible BCP fee items:

00062	00064	00100	00101	00110	00120	00121	00122	00206	00207
00210	00214	00307	00310	00311	00312	00313	00314	00315	00407
00410	00411	00440	00450	00457	00460	00485	00486	00487	00488
00491	00492	00507	00510	00511	00512	00513	00514	00515	00550
00551	00552	00553	00554	00590	00597	00607	00610	00611	00613
00614	00622	00623	00625	00626	00627	00630	00631	00632	00633
00635	00636	00638	00639	00663	00664	00665	00666	00667	00668
00669	00670	00671	00672	00673	00674	00675	00676	00677	00678
00679	00680	00681	01013	01015	01016	01107	01115	01116	01400
01402	01707	01710	01712	01713	01714	01715	02007	02010	02011
02012	02215	02507	02510	02511	02512	02513	02514	02515	02517
02519	03007	03010	03011	03315	04007	04010	04012	04190	04191
04194	04717	06007	06010	06012	07007	07010	07012	07807	07810
07812	07815	08007	08010	08012	12100	12101	12110	12120	13013
13014	13015	13070	13075	13501	13502	13503	13763	13764	13765
13766	13767	13768	13679	13770	13771	13772	13773	13774	13775
13776	13777	13778	13779	13780	13781	14044	14045	14046	14047
14048	14090	14091	14094	14545	14560	15300	15301	15310	15320
16100	16101	16110	16120	17100	17101	17110	17120	18100	18101
18110	18120	22118	25013	30007	30010	30011	30012	31007	31010
31012	31014	31050	31060	32007	32010	32012	32014	32207	32210
32212	32307	33007	33010	33012	33013	33014	33015	33207	33210
33212	33213	33214	33215	33307	33310	33312	33313	33314	33315
33401	33402	33403	33404	33407	33410	33412	33413	33414	33415
33440	33442	33447	33507	33510	33512	33513	33514	33515	33520
33522	33527	33607	33610	33612	33613	33614	33615	33620	33645
33707	33710	33712	33713	33714	33715	33907	33910	33912	51005
51007	51010	51012	51015	66015	71010	71015	71017	77007	77010
77012	77015	78763	78764	78765	78766	78767	78768	78769	78770
78771	78772	78773	78774	78775	78776	78777	78778	78779	78780
78781	79007	79010	79012	83000	94007	94010	94012		

D. TYPES OF SERVICES

Index to Types of Services

D. 1. Telehealth Services

“Telehealth Service” is defined as a medical practitioner delivered health service provided to a patient via live image transmission of those images to a receiving medical practitioner at another approved site, through the use of video technology. "Video technology" means the recording, reproducing and broadcasting of live visual images utilizing a direct interactive video link with a patient. If the sending and/or receiving medical practitioner are not in a Health Authority approved site, the medical practitioner is responsible for the confidentiality and security of all records and transmissions related to the telehealth service. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those services which are designated as telehealth services are payable by MSP. Other services/procedures require face-to-face encounters. Telehealth services do not include teleradiology or tele-ultrasound, which are regulated by their specific Sectional Preambles.

Telehealth services are payable only when provided as defined under the specific Preamble pertaining to the service rendered (e.g.: telehealth consultation - see Preamble D. 2.) to a patient with valid medical coverage. Patients must be informed and given opportunity to agree to services rendered using this modality, without prejudice.

Notwithstanding the above, "telehealth examination" means an examination of a patient by the consultant at the receiving site using "telehealth services" as defined above but does not include the "face-to-face encounter" requirements referred to under Preamble A. 2.

In those cases where a specialist service requires a family physician at the patient’s site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate in the "Referred by" field that a request was made for a family physician assisted assessment.

Where a receiving medical practitioner, after having provided a telehealth consultation service to a patient, decides s/he must examine the patient in person, the medical practitioner may claim a subsequent visit.

Where a telehealth service is interrupted for technical failure, and is not able to be resumed within a reasonable period of time, and therefore is unable to be completed, the receiving medical practitioner should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.

Video technology services are generally payable once per patient/per day/per medical practitioner. Any exceptions to this policy must comply with all Payment Schedule criteria for multiple visits. Information regarding the medical necessity and times of service should accompany claims.

Compensation for travel, scheduling and other logistics is the responsibility of the Regional Health Authority. Rural Retention fee-for-service premiums are applicable to telehealth services and are payable based on the location of the receiving medical practitioner in eligible RSA communities.

The College of Physicians and Surgeons of British Columbia have confirmed that in this province, licensure is defined by the location of the medical practitioner. However, other jurisdictions may have other definitions. BC medical practitioners providing care via telehealth to patients outside the province must abide by the regulations set in the patient's home province.

See the appropriate Section for specific fee items and further criteria.

D. 2. Consultation

D. 2. 1. General

A consultation applies when a medical practitioner, or a health care practitioner*, in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a medical practitioner competent to give advice in this field.

* "Health care practitioner" in this context is limited to the following:
  - chiropractor, for orthopaedic consultations;
  - midwife, for obstetric or neonatal consultations;
  - nurse practitioner;
  - optometrist, for ophthalmology consultations;
  - optometrist, for neurology consultations for suspected optic neuritis or amaurosis fugax or anterior ischemic optic neuropathy (AION) or stroke or diplopia;
  - oral/dental surgeon, for diseases of mastication;
  - registered nurse or registered psychiatric nurse, for addiction medicine or psychiatry consultations for substance use conditions;
  - podiatrist, for orthopaedic consultations.

The referring practitioner is expected to provide the consulting physician with a letter of referral that includes the reason for the request and the relevant background information on the patient. The referring practitioner is also required to notify MSP of the referral by including the practitioner number of the specialist to who the patient is being referred on their associated FFS claim. If no FFS claim is being submitted, a "no charge referral" claim under fee item 03333 is to be sent to MSP.

The service includes the initial services of a consultant necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring practitioner. A consultation must not be claimed unless the attending practitioner specifically requested it, and unless the written report is rendered. It is expected that a written report will be generated by the medical practitioner providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable.

Additional criteria apply to certain types of specialty specific consultations. These are described in the Sectional Preambles and/or the notes to the specific fee codes.

D. 2. 2. Restrictions

i) A consultation for the same diagnosis is not normally payable as a full consultation unless an interval of at least six months has passed since the consultant has last billed a visit or service for the patient. A limited consultation may be payable within the six month interval, if medically necessary and a consultation has been specifically requested.

ii) For consultations and/or other specialty limited services to be paid by MSP, the medical practitioner rendering the service must be certified by or be a Fellow of the Royal College of Physicians and Surgeons of Canada, and be so recognized by the College of Physicians and Surgeons of British Columbia. No other specialist qualifications will be recognized by MSP

and payments for visits and examinations rendered by licensed physicians not so qualified will be made on the basis of fees listed in the Family Medicine Section of this MSC Payment Schedule.

Exceptions to this limitation will only be made in cases of geographic need, as recommended by the College of Physicians and Surgeons of BC.

D. 2. 3. Limited Consultation

A limited consultation requires all of the components expected of a full consultation for that specialty but is less demanding and normally requires substantially less of the medical practitioner's time than a full consultation.

It is expected that the limited consultation, when medically necessary and specifically requested, will be billed as part of continuing care, and that a full consultation is not billed simply because of the passage of time.

A new and unrelated diagnosis can be billed as a full consultation without regard to the passage of time since the consultant has last billed any visit or service for the patient.

D. 2. 4. Special Consultation

Specific additional conditions may apply to specific types of consultation, as designated in the Preamble to the pertinent section of the MSC Payment Schedule and/or the notes to the specific listings.

D. 2. 5. Continuing Care by Consultant

Once a consultation has been rendered and the written report submitted to the referring practitioner, this aspect of the care of the patient normally is returned to the referring practitioner. However, if by mutual agreement between the consultant and the referring practitioner, the complexities of the case are felt to be such that its management should remain for a time in the hands of the consultant, the consultant should claim for continuing care according to the MSC Payment Schedule pertaining to the pertinent specialty.

Where the care of this aspect of the case has been transferred, except for a patient in hospital, the referring practitioner generally should not charge for this aspect of the patient's care unless and until the full responsibility is returned to him/her. For hospitalized patients, supportive care may apply.

Continuing care by a specialist (following consultation) normally is paid at the pertinent specialist rates. However, continuing care requires that a written update of the patient's condition and care be appropriately reported to the referring practitioner at least every six months, until the responsibility for this aspect of the patient's care is returned to the Primary Care practitioner.

D. 2. 6. Referral and Transferral

A referral is defined as a request from one practitioner to another practitioner to render a service with respect to a specific patient. Such service usually would be a consultation, a laboratory procedure or other diagnostic test, or specific surgical/medical treatment.

When the medical practitioner to whom a patient has been referred makes further referrals to other medical practitioners, it is the usual practice that the original referring medical practitioner be informed of these further referrals.

A transferral, as distinguished from a referral, involves the transfer of responsibility for the care of the patient temporarily or permanently. Thus, when one medical practitioner is going off call or leaving on holidays and is unable to continue to treat his/her cases, medical practitioners who are substituting for

that medical practitioner should consider that the patients have been temporarily transferred (not referred) to their care.

The medical practitioner to whom a patient has been transferred normally should not bill a consultation for that patient. However, when the complexity or severity of the illness requires that the medical practitioner accepting the transfer reviews the records of the patient and examines the patient, a limited or full consultation may be billed when specifically requested by the transferring medical practitioner.

A new consultation is not allowed when a group or physicians routinely working together provide call for each other.

D. 3. Visits and Examinations

In addition to the general requirements contained in the Introduction to the General Preamble - Section A. 2., the following definitions apply. As well, please note when services are provided for simple education alone, including group education sessions (e.g.: asthma, cardiac rehabilitation and diabetic education) such services are not appropriately claimed under fee-for-service listings.

D. 3. 1. Complete Examination

i) A complete physical examination shall include a complete detailed history and physical examination of all parts and systems with special attention to local examination where clinically indicated, adequate record of findings and, if necessary, discussion with patient. The above should include complaints, history of present and past illness, family history, personal history, functional inquiry physical examination, differential diagnosis and provisional diagnosis.

ii) Routine or periodic complete physical examination (check up) is not a benefit under MSP. This includes any associated diagnostic procedures or approved laboratory facility services unless significant pathology is found. The physician should advise the diagnostic or approved laboratory facility of the patient's responsibility for payment.

D. 3. 2. Partial Examination

A visit for any condition(s) requiring partial examination or history includes both initial and subsequent examination for same or related condition(s). A partial examination includes a history of the presenting complaint(s), appropriate enquiry and examination of the affected part(s), region(s) and/or system(s) as medically required to make a diagnosis, exclude disease and/or assess function.

D. 3. 3. Counselling

Counselling is defined as the discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress, including the management of malignant disease. Counselling, to be claimed as such, must not be delegated and must last at least 20 minutes.

Counselling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the counselling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counselling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns. Nor are the counselling codes generally applicable to the explanation of the results of diagnostic tests or approved laboratory facility services.

Not only must the condition be recognized as difficult by the medical profession, but the medical practitioner's intervention must of necessity be over and above the advice which would normally be appropriate for that condition. For example, a medical practitioner may have to use considerable

professional skill counselling a patient (or a patient's parent) who has been newly diagnosed as having juvenile diabetes, in order for the family to understand, accept and cope with the implications and emotional problems of this disease and its treatment. In contrast, if simple education alone including group educational sessions (e.g.: asthma, cardiac rehabilitation and diabetic education) is required, such service could not appropriately be claimed under the counselling listings even though the duration of the service was 20 minutes or longer. It would be appropriate to apply for sessional payments for group educational sessions. Unless the patient is having significant difficulty coping, the counselling listings normally would not be applicable to subsequent visits in the treatment of this disease.

Other examples of appropriate claims under the counselling listings are Psychiatric Care, the counselling that may be necessary to treat a significant grief reaction, and conjoint therapy and/or family therapy for significant behavioural problems.

MSP payment of counselling under the counselling listings is limited to four sessions per year per patient unless otherwise specified. Subsequent counselling is payable under the other visit listings. Counselling by telephone is not a benefit under MSP.

D. 3. 4. Group Counselling

The group counselling fee items found in the Family Medicine and various specialty sections of the Schedule apply only when two or more patients are provided counselling in a group session lasting 60 minutes or more. The group counselling fee items are not applicable when there is a discussion with the patient in the presence of a caregiver, spouse, or relative when the patient is the only person requiring medical care. In those situations, only the applicable individual counselling fee item could be billed, using the patient's MSP personal health number.

Group counselling fee items are not billable for each person in the group. Claims should be submitted under the Personal Health Number of only one of the beneficiaries, with the names of the other patients attending the session listed in the note record. Only patients with valid MSP coverage should be included. Times should be included with billings for group counselling fee items.

D. 4. Hospital and Institutional Visits

D. 4. 1. Hospital Admission Examination

An in-hospital admission examination (fee item 00109 or 13109) may be claimed when a patient is admitted to an acute care hospital for medical care rendered by a family physician. The service also may be applicable when a medical practitioner is required to perform an admission examination prior to a hospital service being delivered by a health care practitioner (e.g.: a dental surgeon). The hospital admission examination listing is not applicable when a patient has been admitted for surgery or when a patient is admitted for care (other than directive care) rendered by a specialist. This service is applicable only once per patient per hospitalization and is in lieu of a "hospital visit" on the day it is rendered. This item is intended to apply in lieu of fee items 00108 or 13008 on the first in-patient day. However, if extra visits are medically required because of the nature of the problem, 00108 or 13008 may be billed in addition. An explanation of the reasons for the additional charges should accompany the claim.

This service includes all of the components of a complete examination and may not be claimed if either of these two services has been claimed by this medical practitioner, within the week preceding the patient's admission to hospital. If the MSC Payment Schedule listing for a hospital admission examination is not applicable, the service may be billed under the appropriate "hospital visit" listings.

D. 4. 2. Subsequent Hospital Visit

A subsequent hospital visit is the routine monitoring and/or examination(s) that are medically required following a patient's admission to an acute care hospital. Payments for subsequent hospital visits are usually limited to one per patient per day for a period up to 30 days. However, it is not the intent of the

Schedule that subsequent visit fees be claimed for every day a patient is in hospital unless the visits are medically required and unless a medical practitioner visits the patient each day.

If it is medically required for a patient to be visited more than once per day at any time, or daily beyond the initial 30 day period (e.g.: if the patient is in one of the Intensive Care wards), an explanation should be submitted with the claim and independent consideration will be given.

D. 4. 3. Surgery by a Visiting Doctor

If a surgeon operates outside of his/her geographical area, (for example as part of an outreach program or other such circumstances), and because of this, s/he is unable to render the usual post-operative care, the medical practitioner who performs this service for the patient may claim for necessary hospital visits at the usual frequency, as described under Preamble D.4.2. Claims for such post-operative care should be accompanied by a written explanation or an electronic note record. No such claims, however, should be made if the hospital at which the post-operative care is being rendered is within the same metropolitan area or within 32 km of the surgeon's home or office.

D. 4. 4. Long-Stay Hospitalization

For long stays in an acute care hospital including discharge planning and holding units because of serious illness extending beyond 30 days, claims for subsequent hospital visits greater than two visits per patient per week should include an explanation, and will be given independent consideration.

D. 4. 5. Directive Care

Directive care refers to those subsequent hospital visits rendered by a consultant in cases in which the responsibility for the case remains in the hands of the attending practitioner but for which a consultant is requested by the referring physician to give directive care in hospital during the acute phase. Payments for directive care are limited to two visits per patient per week (Sunday to Saturday), even when there is no interval between visits, for each consultant requested to render directive care by the referring practitioner.

D. 4. 6. Concurrent Care

For those medical cases where the medical indications are of such complexity that the concurrent services of more than one medical practitioner are required for the adequate care of a patient, subsequent visits should be claimed by each medical practitioner as required for that care. To facilitate payment, claims should be accompanied by an electronic note record, and independent consideration will be given. For patients in I.C.U. or C.C.U. this information in itself is sufficient.

D. 4. 7. Supportive Care

Where a case has been referred and the referring medical practitioner no longer is in charge of the patient's care but for which continued liaison with the family and/or reassurance of the patient is necessary while the patient is hospitalized, supportive care may be claimed by the referring medical practitioner. Payments for supportive care are limited to one visit for every day of hospitalization for the first ten days and, thereafter, one supportive care visit for every seven days of hospitalization.

D. 4. 8. Newborn Care in Hospital

Newborn care in hospital is the routine care of a well baby up to 10 days of age and includes an initial complete assessment and examination and all subsequent visits as may be appropriate, including instructions to the parent(s) and/or the patient's representative(s) regarding health care. Newborn well baby care in hospital normally is not payable to more than one medical practitioner for the same patient. However, when a well baby is transferred to another hospital (because of the mother's state of health), separate claims for newborn care when rendered by a different medical practitioner at each hospital may be made.

D. 4. 9. Long-Term-Care Institution Visits

When visits are required to patients in long-term-care institutions (such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities, whether or not any of these facilities are situated on the campus of an acute care facility) claims may be made to a maximum of one visit every two weeks. It is not sufficient, however, for the medical practitioner simply to review the patient's chart. A face-to-face patient/medical practitioner encounter must be made. For acute concurrent illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation.

D. 4. 10. Palliative Care

The Palliative Care listings are applicable to the visits for palliative care delivered to patients with any life-limiting illness with life expectancy of up to 6 months, when the focus of care is palliative rather than treatment aimed at cure. These listings only apply where aggressive treatment of the underlying disease process is no longer taking place and care is directed instead to maintaining the comfort of the patient until death occurs.

Claims for these listings should be billed continuously from time of determination of patient's palliative status, for a period not to exceed 180 days prior to death. Under extenuating circumstances palliative listings billed beyond 180 days will be given independent consideration upon receipt of an explanatory note record.

The listings are applicable to patients in acute care hospitals, hospice facilities or other institutions whether or not the patient is in a designated palliative care unit. The palliative care listings do not apply when unexpected death occurs after long hospitalization for a diagnosis unrelated to the cause of death.

D. 4. 11. Sub Acute Care

Sub acute care is payable twice per week under fee items 00108, 13008. If more services or concurrent care is required an explanatory note record should accompany the claim submission. Independent consideration will be given to these claims.

D. 4. 12. Emergency Department Examinations

Emergency department examinations are designated by various intensity levels of emergency department care. These fee codes apply only to those circumstances where either specialists in emergency medicine or other medical practitioners are physically and continuously present in the Emergency Department or its environs for an arranged designated period of time. For complete details, please refer to the Emergency Medicine section of the MSC Payment Schedule.

D. 4. 13. House Calls

i) A house call is considered necessary and may be billed only when the patient cannot practically attend a physician's office due to a significant medical or physical disability or debility and the patient's complaint indicates a serious or potentially serious medical problem that requires a medical practitioner's attendance in order to determine appropriate management;

ii) A house call may be initiated by the patient, the patient's advocate, or the physician when planned proactive care is determined to be medically necessary to manage the patient's condition;

iii) If a house call is determined to be necessary and is rendered any day of the week between 0800 and 2300 hours, the house call should be billed as a home visit (use 00103);

iv) If the house call is initiated and rendered between 2300 and 0800 hours, the visit may be billed as an out-of-office visit with the night call-out charge (01201).

v) A house call provided for patient convenience should be billed as an out-of-office visit (12200, 13200, 15200, 16200, 17200 or 18200) without a service charge;

vi) The above also applies to house calls rendered by medical practitioners taking call for other medical practitioners;

vii) As practicality dictates, the necessity and detail and the time of the call should be documented in the patient's clinical record.

D. 5. Surgery

D. 5. 1. General

The fees for surgery, unless otherwise specifically indicated, include the surgical procedure itself and in-hospital post-operative follow-up, including removal of sutures and care of the operative wound by the surgeon or associate. Unless otherwise specifically indicated, the normal post-operative period included in the surgical fee is 14 days and the surgery fees include all concomitant services necessary to perform the listed service (including preparation of the operative site, incision, exploration, review of the results of diagnostic tests and approved laboratory facility services rendered during the surgery, closure, and pre and post-operative discussion with the patient and/or patient's family).

When unusual circumstances require that additional medical services are provided in the in-hospital 14 days following a surgical procedure over and above the concomitant services necessary to perform the operative procedure, the additional services performed are not part of the inclusive fee for the surgical procedure and may be billed separately. A note record is required.

D. 5. 2. Operation Only

For listings designated "operation only" the in-hospital, 14 day post-operative visits may be claimed in addition to the surgical procedure, with the exception of the visit(s) made on the day of the procedure.

D. 5. 3. Multiple Surgical Procedures

i) When two or more similar procedures (including bilateral procedures) are performed under the same anesthetic, or when two or more procedures are performed in the same general area, whether through the same incision, an extension of that incision or through separate incisions, the procedure with the greater listed fee may be claimed in full and the fees for the additional procedure are reduced to 50 percent, unless otherwise indicated by the Schedule. However, additional incidental surgery performed en passant (i.e. surgery which would not have been performed in the absence of the primary procedure, such as an appendectomy during abdominal surgery, or incidental cystectomy during gynecological surgery) is considered to be included in the fee for the planned procedure and may not be charged.

ii) When two or more different procedures are performed through separate incisions under the same anesthetic, and repositioning or redraping of the patient or more than one separately draped surgical operating field is medically/surgically required (because of the nature of the procedure and/or the safety of the patient), the procedure with the greater listed fee may be claimed in full and the fees for the additional such procedures are reduced to 75 percent, unless otherwise indicated by the Payment Schedule.

iii) Procedures which are listed as “extra” in the Payment Schedule may be claimed at the full listed fee even when performed with other surgical procedures, unless otherwise indicated in the Payment Schedule.

iv) When two procedures are performed under the same anesthetic by two surgeons and both procedures are or should be within the competence of either one of the operators within the specialty or specialities, the total surgical fee claimed should be no more than that which would be payable if both procedures had been performed by one surgeon, plus one assistant’s fee.

v) Except where team fees are specifically listed in the Payment Schedule or where a team fee reasonably could be expected to apply, when two procedures are performed under the same anesthetic by two surgeons whose different specialty skills are required to perform both procedures, each surgeon may claim his/her specific services as if they were performed in isolation from the other surgeon. These surgeons are not eligible for assistant fees for assisting each other, however, unless each of the surgical procedures takes place consecutively instead of concurrently.

vi) Where a surgical procedure is performed in stages under separate anesthetics and where there is no specific staged procedure listing in the Payment Schedule, the maximum fee applicable to the complete procedure is 150 percent of the listed fee. However, for emergency surgery followed by a definitive surgical procedure for the same problem (e.g.: cholecystostomy followed by cholecystectomy at a later date) each procedure may be claimed at the full listed fee.

vii) Surgical procedures which are abandoned before completion will be given independent consideration and paid in accordance with the services performed.

viii) Additional surgery performed to correct an intra-operative injury(ies) which result from the complicated nature of the disease or significant pathology may be billed at 50%. When submitting a claim for a repair of an intra-operative injury, it must be supported by an explanation in a note record or an operative report. If the repair is performed by another surgeon, it may be billed at 100%.

D. 5. 4. Surgical Assist

i) Time, for the purposes of fee codes 00193, 00198, 07920, 70019 and 70020 is calculated at the earliest time of medical practitioner/patient contact in the operating suite.

ii) Where a medical practitioner renders surgical assistance at two operations under the same anesthetic but for which repositioning or redraping of the patient or more than one separately draped surgical operating field is medically/surgically required, separate assistants’ fees may be claimed for each operation, except for bilateral procedures, procedures within the same body cavity, or procedures on the same limb.

iii) If, in the interest of the patient, the referring medical practitioner is requested by the patient or the surgeon to attend but does not assist at the procedure, attendance at surgery may be claimed as a subsequent hospital visit.

iv) The specialist’s assistant listings apply only to surgical procedures having unusual technical difficulties identified and documented by the primary surgeon **in a detailed note record** as necessitating the services of a certified surgical assistant. The general assistant listings are applicable to all other situations where surgical assistance is necessary. (Also see Preamble B. Definitions, Prefixes to Fee Codes).

v) Where surgery is abandoned, independent consideration will be given to the fee applicable to the assistant, to a maximum of 50 percent of the listed assistant fee for the intended procedure.

vi) Surgical fee modifiers are excluded from the calculation for total operative fee(s) for which surgical assist fees are based.

D. 5. 5. Cosmetic Surgery

The guidelines for MSP coverage of surgery for alteration of appearance are listed under Preamble D. 9. For cosmetic surgery not covered by MSP, the anesthetic and assistants' fees also are not covered. In addition, hospitalization charges are not insured for cosmetic surgical procedures not covered by MSP.

D. 6. Fractures and Other Trauma

a. When multiple procedures for multiple fractures and/or soft tissue injuries are done by the same surgeon, through different incisions, the largest fee should be charged at 100% and all subsequent fees at 75%. In cases of dissociated injuries for which the presence of one impedes the progress of another, or in the case of multiple major fractures (e.g.: a fractured femur and tibia in the same limb), a full fee for each (to a maximum of 3) may be charged provided that adequate clinical evidence to support this charge is rendered with the account.

b. Open (compound) fractures: primary wound management fee(s) may be charged in addition to the fracture fee and will be paid at the same percentage as applies to the fracture fees. These wound management fee items are exempt from the 14 day rule (D.5.1). Secondary wound management fees may also be charged and are exempt from the 14 day rule (D.5.1). These primary and secondary Wound Management fees are only applicable where fee items have been designated in a section's schedule of fees for specific open fractures or specified primary or secondary wound management of fractures.

c. Open reduction of fracture or dislocation when necessary - 50% extra may be charged if a fee for open reduction is not listed.

d. Formation and application of moulded casts or splints may be charged in full in addition to procedure and visit fees with the following exceptions:

- formation and application of a cast or splint at the time of the initial orthopedic procedure charged is included in the procedure;
- in the minority of cases when application of a cast or splint is the sole purpose of a visit, a visit fee may not be charged.

Fees for formation and application of moulded casts or splints are payable only when performed by the medical practitioner. Multiple casts (e.g.: bilateral leg casts) are paid at 100%.

e. Open reduction of old malunited fracture - may be billed at an additional 25% of the listed fee unless a specific fee item exists.

f. External Skeletal Fixation with closed reduction - may be billed at an additional 25% of the listed fee unless a specific fee item exists.

D. 7. Diagnostic and Selected Therapeutic Procedures

a. The listings under the "Diagnostic Procedures and Selected Therapeutic Procedures" section of the MSC Payment Schedule may be claimed in addition to a consultation or other assessment/visit, when performed during that visit.

If, however, the procedure takes place on a subsequent visit arranged to perform the procedure, then that visit may not be claimed in addition to the procedure unless the fee code for the latter is prefixed by the letter "Y".

A subsequent visit fee will be paid in addition to the procedure if more than thirty (30) days has elapsed between the initial visit or service and the diagnostic procedure.

b. Diagnostic procedures may be claimed in addition to surgical procedures, when applicable.

c. For multiple diagnostic procedures performed at the same sitting, the procedure having the largest fee may be claimed in full and the remaining procedure(s) at 50 percent of the listed fee(s), unless otherwise specifically indicated in the Payment Schedule.

d. When two diagnostic/therapeutic procedures are performed by separate medical practitioners at the same sitting and both procedures are or should be within the competence of either medical practitioner, the total fee claimed should be no greater than that which would be payable if both procedures had been performed by one medical practitioner, plus one assistant's fee (if applicable).

e. When a medical practitioner performs a diagnostic procedure, s/he must be allowed to appropriately perform a full or limited consultation for which s/he charges and is paid, regardless of what consultations and procedures have been performed by other specialists or sub-specialists. The consultation would require a written report in addition to the report of the diagnostic procedure.

   If the diagnostic procedure is done on an initial visit, and the initial visit is for the specific purpose of performing the diagnostic procedure, and this visit occurs on an out-patient basis in a procedure facility (including endoscopy suites and cardiac catheterization suites), then a limited consultation would normally be billed rather than a full consultation.

f. Procedures designated as "extra" will be paid at 100 percent for the first "extra" and 50 percent for any additional procedures designated as "extra". Should all procedures be designated as "extra" then the first procedure will be deemed a regular procedure and payment for the first subsequent "extra" will be at 100 percent and all others at 50 percent.

D. 8. Minor Diagnostic and Therapeutic Procedures

a. Minor Diagnostic and Therapeutic Procedures are defined as procedures which have a fee value that is less than that of the office visit.

   Note: To determine the service with the greatest value when a tray fee is applicable, the amount of the tray fee will be added to the value of the procedure fee in the calculation process.

b. When minor diagnostic or therapeutic procedures are performed in conjunction with an assessment/visit (not a consultation) either the visit or the procedure may be claimed, but not both. Includes fee items identified as "isolated procedures".

c. When the performance of a minor diagnostic or therapeutic procedure is the primary purpose of the visit (excluding home visits), the fee listed for the procedure includes the associated assessment.

d. If in the course of a visit for a specific complaint, one or more procedures are performed which are unrelated to the purpose of the visit (e.g.: URI and laceration repair), the service having the largest fee may be claimed in full and the remaining service(s) at 50 percent of the listed fee(s), unless otherwise specifically indicated in the MSC Payment Schedule.

e. For two or more minor diagnostic or therapeutic procedures listed in the "General Services" section of the Payment Schedule and performed together at the same sitting, each applicable fee may be claimed in full.

D. 9. Surgery for Alteration of Appearance

D. 9. 1. General

a. Surgery to alleviate significant physical symptoms or to restore or improve function to any area altered by disease, trauma or congenital deformity normally is a benefit under MSP. Surgery solely to alter or restore appearance is not a benefit of MSP except under the circumstances listed in the following policy.

b. In establishing this policy, it has been recognized that:
   - peer acceptance in our society often is influenced disproportionately by the face,
   - children are especially susceptible to emotional trauma caused by physical appearances,
   - some procedures traditionally have been accepted as benefits of Health Insurance Plans in spite of the obvious cosmetic nature of these procedures.

c. Emotional, psychological or psychiatric grounds are not considered sufficient reason for MSP coverage of surgery for alteration of appearance except in children and under exceptional circumstances in adults.

   On request of the attending medical practitioner, exceptions may be made on an independent consideration basis if the proposed surgery is to alter a significant defect in appearance caused by disease, trauma or congenital deformity, and if the surgery is essential to obtain employment as documented by the attending physician and by an employer with regard to a specific job.

d. Surgery to revise or remove features of physical appearance which are familial in nature is not a benefit of MSP.

e. Within the context of this policy, the word "disease" does not include the normal sequelae of aging. Surgery to alter changes in appearance caused by aging is not a benefit of MSP.

f. Within the context of this policy, the word "trauma" includes trauma due to treatment such as surgery, radiation, etc.

g. As the phrase “reasonable period of convalescence” is imprecise, independent consideration will be given to more complex cases or extenuating circumstances.

h. Authorization from MSP is not required for all surgery to alter appearance. It is required only for those categories of procedures for which some cases may not be a benefit under MSP policy.

i. Authorization required and obtained remains valid for a period of up to two years, after which a new authorization will be required.

   Where authorization has been denied or has not been obtained when required for a surgical procedure, the associated consultations, anesthesiology and surgical assistance also are not covered by MSP. Hospitalization costs also will remain the patient’s responsibility.

D. 9. 2. Surface Pathology

All references in Payment Schedule relating to the size of a lesion, tumour, laceration, scar, etc. is based upon the measurements of the actual lesion, tumour, laceration, scar, etc and not upon the measurements of the incision. Documentation of the size should be noted in the patient’s chart. For cases of excision or re-excision for malignancies the measurement shall be based upon the length of the required incision.

D. 9. 2. 1. Trauma Scars

a. **Neck or Face**

- Includes non-hair bearing areas of the scalp.
- Repair of all significant and unsightly such scars, including acne scars, is a benefit of MSP.
- Repair procedures will depend upon the lesion but may include excision, revision, dermabrasion, etc. Rhytidectomy procedures to remove scar prominence, however, are not a benefit of MSP.
- Implantation of collagen, etc. to restore contour, or chemical abrasion to reduce hyperpigmentation are not benefits of MSP except in those rare cases where the pitting or the pigmentation is so severe that a generally acceptable result would not be possible without these procedures.
- MSP authorization for repair of such scars is required.

b. **Scars in other Anatomical Areas**

- Repair of scars which interfere with function or which are significantly symptomatic (pain, local irritation, etc.) is a benefit of MSP.
- Scars with no significant symptoms or functional interference:
  (i) Repair is a benefit if such repair is carried out within a reasonable period of convalescence, or is part of a pre-planned post-traumatic (including post surgical) staged process. MSP notification must be included as part of the planning process in the latter case.
  (ii) Other post-traumatic scar revision is not a benefit of MSP.
  (iii) Revision of acne scars other than on the face or neck is not a benefit of MSP.
- MSP authorization is required for all scar repair procedures.

D. 9. 2. 2. Keloids and Hypertrophic Scars

a. **Head or Neck**

- The repair of all significant and unsightly scars, such as keloids, is a benefit of MSP.
- Repair procedures may include excision and/or injection.

b. **Excision of keloids in other areas**

- Not a benefit of MSP unless significantly symptomatic or there is functional impairment.

D. 9. 2. 3. Tattoos

a. **Face and Neck**

- Excision or destruction of all significant and unsightly tattoos is a benefit of MSP
- Authorization is not required, but adjudication of repair procedures will be identical to that for scars in these areas.

b. **Other Anatomical Areas**

- Normally not a benefit of MSP

D. 9. 2. 4. Benign Skin Lesions

Surgical, physical or chemical removal of benign lesions of the skin, including that done by dermabrasion or chemical peel, unless the diagnosis is specifically defined as an approved indication, in article D. 9. 2. 4. a. is not a benefit of MSP.

Examples of benign lesions that are not insured include but are not limited to the following: benign naevi, seborrhoeic keratosis, common warts (verrucae), lipomata, uncomplicated benign dermal and/or epidermal cysts, telangiectasias and angiomata of the skin, skin tags, acrochordons, fibroepithelial polyps, papillomata, neurofibromata, dermatofibromata.

a. **Exceptions**

Destructive therapies of benign skin lesions are insured services when the treatment is medically necessary. Examples of medical necessity include but are not limited to the following indications:

- genital warts (condylomata acuminate)
- plantar warts
- viral induced cutaneous tumours in the immune compromised patient
- inflamed dermal and epidermal cyst
- dysplastic naevi
- lentigo maligna
- congenital naevi
- actinic (solar) keratosis
- atypical pigmented naevi
- lesions which cause significant pathophysiologic dysfunction

b. When a patient presents with a surface pathology, the initial visit and or consultation and/or pathologic examination of a tissue specimen, when one is submitted, is regarded as medically necessary to establish the diagnosis, and therefore, is an insured service.

D. 9. 2. 5. Hair Loss

a. **Scalp or Neck**

(i) Post-traumatic:

- Repair to the area of traumatic hair loss is a benefit of MSP only if carried out within a reasonable period of convalescence.
- MSP authorization is required.

(ii) Other Etiology:

- Not a benefit of MSP

(iii) Usual repair procedures may include skin shifts or flaps, skin grafts, or hair plugs.

b. **Other Anatomical Areas**

- Not a benefit of MSP

D. 9. 2. 6. Epilation of Hair

- Not a benefit of MSP

D. 9. 2. 7. Redundant Skin

a. Excision of redundant skin for elimination of wrinkles, etc. is not a benefit of MSP.

b. Blepharoplasty is not a benefit of MSP unless there is documented evidence of medical necessity such as a visual field defect caused by the redundant eyelid skin and which meets the BCMA/MSC guidelines for significant defect.

c. MSP authorization is required.

D. 9. 3. Sub-Surface Pathology

D. 9. 3. 1. Congenital deformities

a. **Face or neck**

Repair is a benefit of MSP except for:

- surgery to revise or remove features which are familial in nature;
- surgery to correct ear abnormalities in patients who are sixteen years of age or over.
- MSP authorization is required, other than recognized craniofacial disorders and cleft lip.

b. **Other Anatomical Areas**

- Normally not a benefit of MSP if surgery is for alteration of appearance only.

D. 9. 3. 2 Post-Traumatic Deformities

- Reconstructive procedures are a benefit at the acute stage; within a reasonable period of convalescence; or if part of a pre-planned staged process of repair.
- Repair procedures may include bone revision, tissue shifts and grafts, prosthesis implantation, etc.
- MSP authorization is required for repairs beyond the acute stage.

D. 9. 3. 3. Deformities resulting from local disease (such as loss or distortion of bone, muscle, connective tissue, adipose tissue, etc.).

a. **Head or Neck**

- Reconstructive procedures for significant abnormalities are a benefit at the acute stage; during a chronic disease process; within a reasonable period of convalescence, or if part of a planned staged process of repair initiated during one of these periods.
- Repair procedures normally could include tissue grafts, flaps, shifts or cell-assisted lipotransfer, bone revision, prosthesis insertion, etc.
- Face lifts, modified face lifts, brow lifts, etc. are not a benefit of MSP if skin, only, is involved in the procedure. However, a repair such as ptosis repair or face lift with underlying slings is a benefit of MSP if the procedure is to correct significant deformity following stroke, cancer, 7th nerve palsy, etc.
- MSP authorization is required for repair of deformities resulting from local disease.

b. **Other Anatomical Areas**

- Not a benefit of MSP if the correction is for appearance, only.

D. 9. 3. 4. Breast Surgery

a. **Augmentation Mammoplasty**

- This procedure is a benefit of MSP unilaterally or bilaterally for a female patient with breast aplasia.
- It is a MSP benefit unilaterally for a female patient with a severely hypoplastic breast when the other breast is not also hypoplastic.
- A "balancing" augmentation mammoplasty may be allowed on an independent consideration basis for correction of unilateral hypoplasia when performed in association with approved contralateral reduction mammoplasty.
- MSP authorization is required.

b. **Post-Mastectomy Reconstruction**

- Unilateral or bilateral breast reconstruction, including cell-assisted Lipotransfer, is a benefit of MSP when the procedure is subsequent to total or partial mastectomy or prophylactic mastectomy.
- Authorization is not required but the reason for the reconstruction must accompany the claim.

c. **Reduction Mammoplasty**

- Reduction Mammoplasty is a benefit for female patients only, where there is significant associated symptomatology such as intertrigo, neck or back pain or shoulder grooving. Ptosis and/or size are not sufficient grounds for MSP coverage of reduction mammoplasty. Mastopexy is not normally covered by MSP.
- Unilateral reduction mammoplasty may be a benefit of MSP if there is gross disproportion present, or in association with approved unilateral augmentation mammoplasty or post mastectomy reconstruction of the contralateral breast.
- MSP authorization is required.

d. **Male Mastectomy**

- This procedure is a benefit of MSP for gynecomastia.
- MSP authorization is not required.

e. **Accessory breasts or accessory nipples**

- Excision of such accessory tissue is a benefit of MSP.
- The appropriate fee item normally would be from the skin tumour excision listings.
- Authorization is not required.

D. 9. 3. 5. Excision of excess fatty tissue

- This is a benefit of MSP only if there is significant associated symptomatology such as intertrigo, pain or excoriations.
- When performed for alteration of appearance, the removal of redundant skin and fat from the abdomen, extremities, etc. is not a benefit of MSP.
- There must be clinical evidence of substantial hyperplasia of adenomatous breast tissue.
- MSP authorization is required.

D. 9. 4. Gender Affirming Surgery

Prior approval is required for gender affirming surgery before the surgery is considered to be a MSP benefit. Approval for surgery requires a medical assessment by qualified medical assessors who have recognized and demonstrable expertise in the treatment of gender dysphoria.

Treatment for gender dysphoria refers to the guidelines provided by the World Professional Association for Transgender Health, Standards of Care.

If MSP coverage has not been approved for the gender affirming surgery, any medical consultation(s), anesthesiology and surgical assistance services related to the surgery, will not be eligible for MSP funding.

D. 9. 5. Complications and Revisions

a. The treatment of medical or surgical complications resulting from surgery for alteration of appearance and/or function is a benefit of MSP if medically necessary whether or not the original surgery was covered by MSP.

b. Revision of surgery for alteration of appearance, because of undesirable results, is a benefit of MSP only if the original surgery was a benefit and if the revision either is part of a pre-planned staged process or occurs within a reasonable period of convalescence. Correction of the effects on appearance which are due to complications is a benefit of MSP if it is carried out within a reasonable period of convalescence. MSP authorization is required.

D. 10. Out-of-Office Premiums

The out-of-office premium is an additional fee that may be billed for services initiated and rendered within designated time limits. These premiums are applicable to eligible insured medical services provided to MSP beneficiaries and can be billed by both Family Physicians and Specialists.

For complete details, please refer to the Out-of-Office Hours Premiums section of the MSC Payment Schedule.

OUT-OF-OFFICE HOURS PREMIUMS

(Applicable to Family Physicians and Specialists)

Explanatory Notes

a) The out-of-office hours premium listings apply only to those services initiated and rendered within the designated time limits. They apply to visits to a physician's office only if the office is officially closed during the designated time period.

b) Call-out charges apply only when the physician is specially called to render emergency or non-elective services and only when the physician must travel from one location to another to attend the patient(s).

c) The call-out charge applies only to the first patient examined or treated on any one special visit. A call-out charge is applicable to each special call-out whether or not a previous call-out charge has been billed for the same patient on the same day.

For example, a physician may provide a consultation during out-of-office hours for which a call-out charge is applicable. The physician may then perform an operation on the same patient at a different time during out-of-office hours. If the physician was specially called, on separate occasions, to render both services and was required to travel from one location to another for both services, it would be appropriate to bill a call-out charge for the consultation and a call-out charge for the operation in addition to the regular fees for the services and any applicable continuing care operative and non-operative surcharges.

d) Within the foregoing guidelines, the call-out charges are also applicable to the attending surgeon post-operatively even though the visit itself may not be chargeable as described in Preamble D. 5. 1.

e) The operative continuing care surcharge applies also to surgical assistant fees.

f) The “home visit” (00103) and "emergency visit when specially called" listings (00111, 00112, 00115, 00205, 02005, 02505, 00305, 00405, 03005, 04005, 00505, 00605, 01705, 06005, 07005, 07805, 08005, 30005, 31005, 32005, 33005, 33205, 33305, 33405, 33505, 33605, 33705, 77005, 79005, 94005) are not payable in addition to the out-of-office hours premium. Neither are emergency visits payable to the attending surgeon (or his/her substitute) within 10 post-operative days from a surgical procedure (except "operation only" procedures).

g) The non-operative continuing care surcharge applies to delivery only (not standby time or first stage of labour). State continuous time spent with the patient during second or third stages of labour only.

h) These items are not applicable to full or part-time emergency physicians, or physicians designated by a hospital emergency room as the on duty/on site physician. Those physicians are referred to the Emergency Medicine Section of the Payment Schedule.

i) Call-out charges and continuing care surcharges are also applicable when called from home to provide labour epidural insertions, or to provide subsequent resuscitative care under fee code 01088.

j) The non-operative continuing care surcharge is payable to family physicians, medical specialists and surgical specialists when non-operative services are provided. Continuing care surcharges are payable to radiologists and nuclear medicine physicians only when the primary service to which the continuing care surcharges apply are payable by MSP on a fee-for-service basis.

k) The following applies in the event that a consultation or visit is followed by surgery: 1) the non-operative continuing care surcharge applies to the consultation or visit, and 2) the operative continuing care surcharge applies to the surgery.

l) Physicians providing anesthetic services may be eligible for continuing care surcharges even if the service is initiated before 1800 hours. That portion of anesthetic services rendered within the designated times are eligible for continuing care surcharges if they fulfil the requirements described in the Anesthetic Continuing Care Surcharges section.

Call-Out Charges

		$
	- Extra to consultation or other visit, or to procedure if no consultation or other visit charged.	
01200	Evening (call placed between 1800 hours and 2300 hours and service rendered between 1800 hours and 0800 hours)	72.53
01201	Night (call placed and service rendered between 2300 hours and 0800 hours)	101.86
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours)	72.53

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 evaluations. 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	66.69
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	91.18
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	66.69

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 practitioners or to on site practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.

$

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 anesthesiology and/or requiring at least 45 minutes of surgical time.

01210 Evening (1800 hours to 2300 hours) 44.57% of surgical (or assistant) fee
- minimum charge 64.32
- maximum charge 443.67

01211 Night (2300 hours to 0800 hours) 71.55% of surgical (or assistant) fee
- minimum charge 90.32
- maximum charge 623.05

01212 Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) 44.57% of surgical (or assistant) fee
- minimum charge 64.32
- maximum charge 443.67

Notes:

i) When surgery commences within evening time period (1800 – 2300 hrs) and continues into night time period (2300 – 0800 hrs), 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, surcharges are applicable to the entire surgical time.

iv) Claim must state time surgery commenced.

These items are not applicable to full or part time emergency practitioners, designated by a hospital emergency room as the on duty/on site physician and billing under the Emergency Medicine Section of the Payment Schedule.

(c) ANESTHESIOLOGY - Anesthesiology services are eligible for continuing care surcharges 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 anesthesiology evaluations. Payment is based on one half hour of care or major portion thereof. Therefore, the first surcharge is payable after 45 minutes of continuous care when a call-out charge is applicable. If a call-out charge is not applicable then the first continuing care surcharge is payable after 15 minutes of continuous care as long as the anesthetic service is rendered within the designated times.

Applicable also, without the 30 minute time lapse and with timing continuing, to immediately subsequent patients seen on the same call-out, under the following conditions:

i) as an emergency;
ii) to provide subsequent resuscitative care under fee code 01088;
iii) to provide labour epidural insertion under fee code 01102.

Surcharges do not apply to time spent standing by unless code 01112 is payable and are based on the amount of time providing care, regardless of the number of patients attended or services provided.

		$
01215	Evening (service rendered between 1800 hours and 2300 hours) - per half hour or major part thereof	66.69
01216	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	91.18
01217	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	66.69

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 on site practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.

iv) When emergency services commence prior to 1800 hours (weekday) and extend beyond 1800 hours, anesthetic surcharges are applicable to the time after 1800 hours. Timing begins at 1800 hours and surcharge payments are based on one half hour of care or major portion thereof. Therefore, the 01215 surcharge in these cases is payable after 15 minutes of continuous care (i.e. 1815 hours).

v) When emergency anesthetic services commence prior to 0800 hours and continue after 0800 hours, anesthetic surcharges are only applicable to the time prior to 0800 hours.

vi) Anesthetic surcharges are applicable to services associated with elective surgery which, because of intervening emergency surgery, extends into or commences within the designated times.

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
B00010	Intramuscular injections, including immunizations for patients 19 years or older	11.37	
	Notes:		
	i) Payable per injection.		
	ii) Up to 3 injections per patient on the same date of service are billable at 100%.		
	iii) When performed in conjunction with a visit, the injection is included in the visit fee.		
	iv) Not payable for immunizations required for travel, employment, and emigration.		
	iv) *Not payable on the same day as 10010-10029.*		
B00034	Subcutaneous injections, including desensitization treatments and immunizations for patients 19 years or older	11.37	
	Notes:		
	i) Payable per injection.		
	ii) Up to 3 injections per patient on the same date of service are billable at 100%.		
	iii) When performed in conjunction with a visit, the injection is included in the visit fee.		
	iv) Not payable for immunizations required for travel, employment, and emigration.		
	v) Not payable on the same day as 10010-10029.		
B00011	Intravenous medications	12.81	
	The following test is not payable to laboratories, vested interest laboratories and/or hospitals:		
00012	Venepuncture and dispatch of specimen to laboratory, when no other blood work performed	5.99	
	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 a medical practitioner.		
	ii) Where a blood specimen is taken by physician's office and dispatched to another unassociated physician's office or to an approved laboratory, 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%.		
B00013	Intra-arterial medications	16.08	
Y00014	Intra-articular medications by injection – hip (initial injection)	25.65	
Y00015	- tendons, bursae, and all other joints (initial injection)	17.05	
	(subsequent injections, injection fee only, includes visit fee)		
00016	Intrathecal medications by injection	33.86	

		$	Anes. Level
00024	Vein dissection for intravenous therapy *(Not paid in the immediate pre and post-operative phase of surgery)*	36.96	
00019	Venesection for polycythaemia or phlebotomy - procedural fee	31.65	
00018	Autologous ascitic infusion	48.07	
00017	Insertion of central venous pressure catheter	23.88	
B00030	Diagnostic skin tests (Schick, Dick, TB., and Frei.)	8.93	

Blood Transfusions

00020	Administered outside hospital	62.51
00021	Administered in hospital	37.27
00022	Serum transfusion	24.89
00023	With vein dissection - extra	52.84

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.*

Dialysis Fees

(A) Acute renal failure

a) <u>Hemodialysis</u>:

33750	Blood dialysis - physician in charge	531.27
33751	Repeat blood dialysis - physician in charge	199.65

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.

33752	Blood dialysis - fee for cut down by surgeon to be charged in addition to items 33750 or 33751	134.31

b) <u>Peritoneal dialysis</u>:

33708	Subsequent hospital visits	48.32
33756	Reinsertion of peritoneal catheter after 10 days from initial insertion	52.22

Note*: Item 00081 not to be charged in addition to item33723.*
Where an initial peritoneal dialysis is performed and for various reasons, hemodialysis 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) <u>Hemodialysis</u>:

33758	Performance of hemodialysis - fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis, for each dialysis	52.22

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.*

		$	Anes. Level
	b) <u>Peritoneal Dialysis:</u>		
77380	Insertion of permanent catheter, procedural fee only	190.68	3
33723	Performance of initial peritoneal dialysis chronic or acute renal failure, to include consultation and two weeks' care	397.47	
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	52.22	

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

33761	Supervision of home dialysis - per week	63.13	

***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.*

Immunizations

B00010	Intramuscular-injections, including immunizations for patients 19 years or older	11.37	

Notes:

i) Payable per injection.

ii) Up to 3 injections per patient on the same date of service are billable at 100%.

iii) When performed in conjunction with a visit, the injection is included in the visit fee.

iv) Not payable for immunizations required for travel, employment, and emigration.

v) *Not payable on the same day as 10010-10029.*

B00034	Subcutaneous injections, including desensitization treatments and immunizations for patients 19 years or older	11.41	

Notes:

i) Payable per injection.

ii) Up to 3 injections per patient on the same date of service are billable at 100%.

iii) When performed in conjunction with a visit, the injection is included in the visit fee.

iv) Not payable for immunizations required for travel, employment, and emigration.

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Immunizations for Patients 18 Years of Age or Younger

Notes:

i) Payable per immunization.

ii) Payable in full with an office visit to a maximum of 4 immunizations per patient per day.

iii) Not payable on the same day as B00010, B00034.

iv) Not payable for immunizations required for travel, employment and emigration.

		$	Anes. Level
10010	Tdap-IPV or DTaP-IPV (Diphtheria, Tetanus, Pertussis, Polio)	5.45	
10011	DTaP-IPV-Hib (Diphtheria, Tetanus, Pertussis, Polio, Hib)	5.45	
	***Note**: Not payable with 10010 or 10018 on the same day, same patient.*		
10012	Td (Tetanus, Diphtheria)	5.45	
10013	Td/IPV (Tetanus, Diptheria, Polio)	5.45	
	***Note:** Not payable with 10012 or 10019 on the same day, same patient.*		
10014	TdaP (Tetanus, Diphtheria, Pertussis)	5.45	
	***Note:** Not payable with 10013 on the same day, same patient.*		
10015	Influenza (Flu)	5.45	
10016	Hepatitis A	5.45	
10017	Hepatitis B ……	5.45	
10018	Haemophilus influenza type b (Hib)	5.45	
	***Note**: Not payable with 10011 on the same day, same patient.*		
10019	Polio (IPV)	5.45	
	***Note:** Not payable with 10010, 10011 or 10013 on the same day, same patient.*		
10020	Meningococcal C Conjugate (Men-C)	5.45	
10021	Meningococcal Quadrivalent Conjugate (Groups A,C,Y, W-135)	5.45	
10022	MMR (Measles, Mumps, Rubella)	5.45	
10030	MMR/V (Measles, Mumps, Rubella and Varicella)	5.45	
10023	Pneumococcal Conjugate (PCV13)	5.45	
10024	Pneumococcal Polysaccharide (PPV23)	5.45	
10025	Rabies	5.45	
10026	Varicella (Chickenpox)	5.45	
10027	DTap-HB-IPV-Hib (Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib)	5.45	
	***Note:** Not billable with fee items 10010,10011,10012, 10013, 10014,10017, 10018.*		
10028	HPV (Human Papillomavirus)	5.45	
10029	Rotavirus	5.45	

Substance Use Disorder Care

13013	Assessment for Induction of Opioid Agonist Treatment (OAT) for Opioid Use Disorder Initial assessment requires complete medical history, substance use history and appropriate targeted physical examination. If assessment and induction are done on the same day, withdrawal assessment using COWS or SOWS and administration of first dose of OAT included – per 15 minutes or greater portion thereof	43.23	

Notes:

i) Payable to a maximum of 4 units per patient/per day/per intended induction.

ii) Payable only to the physician who intends to provide or share management of the patient's OAT induction for opioid use disorder.

iii) Start and end times must be entered in both the billing claim and the patient's chart.

iv) No other visit fees billable same day except 13014, 14018 and 14077. 13014, 14018 and 14077 payable in addition to 13013 only when not performed concurrently.

v) Payable for assessment for change of OAT with induction to a different medication.

vi) May not be repeated within 30 days by the same physician.

vii) This service payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day).

		$	Anes. Level
13014	Management of OAT Induction for Opioid Use Disorder This fee is payable for individual interactions with the patient during the first three days of OAT induction for opioid use disorder within the limits described in the following notes	20.21	

Notes:

i) Billable in addition to 13013 or a same day visit fee (in-person, telephone or video conference) with a physician when not performed concurrently.
ii) Billable up to 3 times on day of first dose of OAT.
iii) Billable up to 2 times on day 2 of OAT induction.
iv) Billable once only on day 3 of OAT induction.
v) May be provided in-person, by telephone, or by video conference.
vi) May be billed when delegated to a nurse (LPN, RN, NP) employed within the eligible physician practice.
vii) Start time must be entered in both the billing claim and patient's chart.

00039	Management of Maintenance Opioid Agonist Treatment (OAT) for Opioid Use Disorder Management of ongoing maintenance Opioid Agonist Treatment for Opioid Use Disorder	23.67	

Notes:

i) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.
ii) 00039 is the only fee payable for any medically necessary service associated with maintenance opioid agonist treatment for opioid use disorder. This includes but is not limited to the following:
a) At least one visit (in-person, telephone or video conference) per month with the patient after induction/stabilization on opioid agonist treatment is complete.
b) At least one in-person visit with the patient every 90 days. Exceptions to this criterion will be considered on an individual basis.
c) Supervised urine drug screening and interpretation of results.
d) Simple advice/communication with other allied care providers involved in the patients OAT.
iii) Claims for treatment of co-morbid medical conditions, including psychiatric diagnoses other than substance use disorder, are billable using the applicable visit of service fees. Counselling and visit fees related only to substance use disorder are not payable in addition.
iv) This fee is payable once per week per patient regardless of the number of services per week for management of OAT maintenance.
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 are actively supervising the patient's continuing use of opioid agonist medications for treatment of opioid use disorder.
vi) *This payment stops when the patient stops opioid agonist treatment.*

15039	Point of Care (POC) testing for opioid agonist treatment	12.89	

Notes:

i) Restricted to patients in opioid agonist treatment.
ii) Maximum billable: <u>26 per annum, per patient</u>.
iii) 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 is in treatment for opioid use disorder. Accordingly, confirmatory testing should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management.
iv) This fee includes the adulteration test.
v) Only POC urine testing kits that have met Health Canada Standards are to be used.

		$	Anes. Level
15040	Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone	12.89	

Notes:

i) Not billable for patients in opioid agonist treatment.

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.

00040	Stomach lavage and gavage	26.38	
B00041	Ultrasound treatments	8.68	
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)	2.78	

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

00043	Anticoagulation therapy by telephone	7.00	

Hyperbaric Chamber

Notes:

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

ii) Start and end times must be entered in both the billing claims and the patient's chart.

00025	Where no other fee is charged - physician in chamber - 1st ½ hour	81.83	7
00026	- each additional 15 mins	42.02	
00027	- physician outside chamber - 1st ½ hour	55.73	5
00028	- each additional 15 mins	29.59	
00046	Additional charge to pertinent medical, anesthetic or surgical fee, per hour	28.44	

Eye Bank Services

00050	Enucleation of eye(s) for use in corneal transplant	138.67	

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.

00051	Corneal tissue processing	375.66	

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.			
00062	Initial "in-care" or adoption examination of a well baby or child (with report) (fee for each doctor)	77.58	
00064	Subsequent "in-care" or adoption examination by same doctor within six months	34.90	
00065	Investigation, with completion of B.C. Mental Health Act Forms 3, 4 or 6 (fee per doctor)	103.82	
00066	Completion of B.C. Mental Health Act Forms 3, 4 or 6, on previously assessed or treated cases	46.66	
00067	Investigation with cancellation of B.C. Mental Health Act Forms 4 or 6, and subsequent voluntary treatment status	46.54	

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.

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 ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	106.12	
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	63.67	

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 106.13

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.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

00084 Accompanying patient(s) to a distant hospital, where medically required - per ½ hour or major portion thereof.....223.06

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.

iv) Start and end times must be entered in both the billing claims and the patient's chart.

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 (10087, 10088, and 10089) 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 comorbidities, 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^o) burn $\geq$ 10% and full thickness (3^o) burn
- Electrical or lightning burn
- Chemical burn or Inhalation injury
- Burn injury in patients with significant comorbidities
- 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
10087	Trauma Team Leader - Initial Assessment, Secondary Survey and Support	301.88	

Notes:

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

10088	Trauma Team Leader – Tertiary Assessment (after 24 hrs. and before 72 hrs.)	104.00	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10089.
iii) Not paid unless 10087 has been previously claimed (on same PHN).
iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
v) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.
vi) Payable to only one physician for one patient, per facility, per day.

10089	Trauma Team Leader Subsequent Hospital Visit (Days 3 – 15 inclusive)	78.72	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10088.
iii) Not paid unless 10087 has been previously claimed (on same PHN).
iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
v) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.
vi) Payable to only one physician for one patient, per facility, per day.

Percutaneous Radiofrequency Neurotomies:

Notes:

i) Must be performed under medical imaging guidance (fluoroscopy or CT) with image capture.
ii) Must be performed by qualified physicians working in approved facilities.
iii) If neurotomies are performed in more than one anatomical region, the first branch in the second anatomical region will be paid at 50%.
iv) Includes anesthesia, sedation, or blocks if performed by the same physician.

Cervical:

P34101	- first branch	240.00	
P34102	- second branch	120.00	
P34103	- third to sixth branch (per branch)	60.00	

		$	Anes. Level
	Thoracic:		
P34104	- first branch	200.00	
P34105	- second branch	100.00	
P34106	- third to sixth branch (per branch)	50.00	
	Lumbar:		
P34107	- first branch	200.00	
P34108	- second branch	100.00	
P34109	- third to sixth branch (per branch)	50.00	
	Sacral:		
P34110	- unilateral	330.00	
P34111	- bilateral	550.00	

Tray Service Fee

00044 Mini Tray Fee 5.25

Notes:

i) 00044 is applicable to fee items 00190, 00217, 00744 and 14560 only.

00080 Minor Tray - is defined as the use of sterile tray suitable for cautery, cryotherapy, dilation or similar procedure 10.51

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 31.53

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 Doctors of BC Tariff Committee.

iii) Tray fees are not applicable when the service is performed at a funded facility (e.g.: 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
S00748	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
S02154	Ectropion/Entropion - complicated, including neoplasms and plastic repair - requires both repair and associated lid shortening and/or skin grafting
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
P04405	Removal of a vaginal cyst situated above the introitus (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)
06027	Repair of torn (split) earlobe (simple)
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
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
06131	Accessory Auricle (operation only)
06156	Periperhal nerve: transplant of neuroma
06182	Ganglia of tendon sheath or joint
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
S07464	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
S10761	Esophagogastroduodenoscopy (EGD) , including collection of specimens by brushing or washing, per oral - procedural fee
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee
	<u>Excision - Diagnostic, Percutaneous</u>:
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
	<u>Excision - Diagnostic:</u>
S11730	Tibial Metaphysis (Distal), Ankle and Foot Needle biopsy, under GA
	<u>Excision - Diagnostic, Percutaneous:</u> 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)
13623	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic – face (operation only)
13632	Removal of nail - with destruction of nail bed (operation only)
13633	Wedge excision or Vandenbos procedure of one nail (operation only)
13650	Hemorrhoid Thrombotic, Enucleation (operation only)
14540	Insertion of IUD
P14542	Insertion of subdermal contraceptive implant
P14543	Removal of subdermal contraceptive implant
	Local tissue shifts: Advancements, rotations, transpositions, "Z" plasty, etc:
20221	Single or multiple flaps under 2 cm in diameter used in repair of a defect (except for special areas as in 20225) (operation only)
20222	Single
20223	Multiple
20224	- with free skin graft to secondary defect
20225	Eyebrow, eyelid, lip, ear, nose - single

	Full-thickness grafts:
20226	Eyelid, nose, lips, ear
20227	Finger, more than one phalanx
20228	Sole or palm
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only
S33373	Colonoscopy with flexible colonoscope - biopsy
33374	Colonoscopy with flexible colonoscope – 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
S61250	- Volume less than 20 ml
S61251	- Volume between 21-60 ml
61252	- Volume greater than 60 ml
	Trunk, Arms and Legs
S61310	Resulting in repair less than 5 cm (operation only)
S61311	Resulting in a repair 5 - 10 cm (operation only)
	Face, scalp, neck, genitalia, hands, feet, axilla
S61313	Resulting in repair less than 5 cm (operation only)
S61314	Resulting in repair 5 -10 cm (operation only)
	Eyelids, ears, lips, nose, mucous membrane, eyebrow
S61316	Resulting in repair less than 2 cm (operation only)
S61317	Resulting in repair 2 - 4 cm (operation only)
S61318	Resulting in repair greater than 4 cm (operation only)
	Advancement flap fees - Nose, Lids, Lips or Scalp:
61324	- Up to 2 cm (operation only)
61325	- 2.1 to 5 cm (operation only)
61327	- 5.1 to 10 cm (operation only)
	Advancement flap fees - Other areas:
61326	- 2.1 to 5 cm (operation only)
61328	- 5.1 to 10 cm (operation only)
61329	- defects more than 10 cm (such as a thoracic abdominal flap)
	Rotations, transpositions, Z-plasty, Limberg or V-Y type flaps
	Trunk
61330	Defect up to 40 cm^2
61331	Defect 40 cm^2 to 100 cm^2
61332	Defect greater than 100 cm^2
	Arms, legs and scalp
61333	Defect up to 6 cm^2
61334	Defect 6 cm^2 to 19 cm^2
61335	Defect greater than 19 cm^2

	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck
61336	Defect up to 6 cm^2
61337	Defect 6 cm^2 to 19 cm^2
61338	Defect greater than 19 cm^2
	Ears, eyelids, lips and nose
61339	Defect up to 6 cm^2
61340	Defect 6 cm^2 to19 cm^2
61341	Defect greater than 19 cm^2
	Revision of Graft
61342	Revision, less than 2 cm
61343	Revision, between 2 and 5 cm
61344	Revision, greater than 5 cm
	Full-thickness grafts:
61350	Trunk (2 to 19 cm^2) (operation only)
61351	Arms, legs, scalp (2 to 19 cm^2)
61352	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm^2)
61353	Ears, eyelids, lips and nose (2 to 19 cm^2)
S61354	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
S61300	- up to 5 cm – other than face, simple closure (operation only)
S61301	- up to 5 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)
S61302	- 5.1 to 10 cm - other than face, simple closure (operation only)
S61303	- 5.1 to 10 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)
61360	Eyebrow ptosis repair- simple skin excision- non-cosmetic – unilateral
61361	Eyebrow ptosis repair – simple skin excision – non-cosmetic – bilateral
	Extensor - primary or secondary repair
61368	- 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 Tumours or Scars
V70116	Removal of tumour (including intraoral) or scar revision – 2 to 5 cm (operation only)
V70117	Removal of tumour (including intraoral) or scar revision – 5.1 cm to 10cm
	Local tissue shifts: Advancements, rotations, transpositions, “Z” plasty, etc.
V70119	Single flap under 2cm in diameter used in repair of a defect (except for special areas as in V70124 (operation only)
V70120	Single flap for lesion greater than 2cm
V70121	Single flap for lesion greater than 2cm with free skin graft to secondary defect
V70122	Multiple flap for lesion greater than 2cm

V70123	Multiple flap for lesion greater than 2cm with free skin graft to secondary defect
V70124	Eyebrow, eyelid, lip, ear, nose – single
	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)
71690	Hemorrhoid(s); – 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
77046	Ultrasound directed (with image capture) foam sclerotherapy – initial
77047	Ultrasound directed (with image capture) foam sclerotherapy – repeat
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 injections
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
01124	Periperhal nerve block - single
01125	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
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)
20231	Biopsy, not sutured
20232	Biopsy, not sutured, multiples same sitting, maximum of four (extra)
61291	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)
71689	Hemorrhoid(s); (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

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES

These listings cannot be correctly interpreted without reference to the Preamble.
Letter prefix **Y** - Office or hospital visits on same day - extra to procedure fee

		$	Anes. Level
(a)	**Diagnostic procedures involving visualization by instrumentation**		
S00700	Bronchoscopy or bronchofibroscopy - procedural fee	122.00	4
S00702	Bronchoscopy with biopsy - procedural fee	210.00	4
10700	Endobronchial cautery - extra ***Notes:*** *i) To a maximum of 3 lesions.* *ii) Second and third lesion payable at 50%.* *iii) Payable only with 00700 or 00702 and 10702, 10703, 00736.* *iv) Not payable with 10739 or 02450.*	77.00	6
10702	Endobronchial cryotherapy - extra ***Notes:*** *i) To a maximum of 3 lesions.* *ii) Second and third lesion payable at 50%.* *iii) Payable only with 00700 or 00702 and 10700, 10703, 00736.* *iv) Not paid with 10739, 02450 and 02422.*	77.00	6
10703	Transbronchial needle aspiration (TBNA) ***Notes:*** *i) To a maximum of 3 separate stations or lesions.* *ii) Second and third station or lesion payable at 100%.* *iii) Payable with 00700, 00702 or 10739 and 10700, 10702, 00736.* *iv) Paid at 100% with other diagnostic procedures.*	70.00	6
S00719	Thoracoscopy	331.00	7
S00701	Direct laryngoscopy - procedural fee ***Notes:*** *i) 00701 is not payable with 00907, 00908, and 00909.* *ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.*	37.70	5
S00717	Micro-laryngoscopy - procedural fee ***Note:*** *00717 to be charged at 50% if performed with a surgical procedure (not payable in addition to fee items 02423, 02428 or 02429).*	75.39	5
SY00907	Endoscopic flexible or rigid examination of the nose and nasopharynx - procedure only	33.07	3
SY00908	- procedure and biopsy	52.89	3
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy ***Notes:*** *i) 00909 is not payable with 00700, 00701, 00702, 00907, and 00908.* *ii) Payable only to certified Otolaryngologists.*	44.30	3
S00704	Cystoscopy to include dilation and panendoscopy - procedural fee	95.37	2
S00705	Cystoscopy with catheterization of ureters (with kidney function test and injection of solution for pyelogram) to include dilation and panendoscopy - procedural fee	111.51	2

		$	Anes. Level
	Upper Gastrointestinal System:		
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	116.63	3
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	97.14	3
S10763	Initial esophageal, gastric or duodenal biopsy	15.00	3
	Notes: *i) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs.* *ii) First biopsy paid at 100%, second and third at 50%.*		
S10764	Multiple biopsies for differential diagnoses of Barrett's Esophagus, H pylori, Eosinophiic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma	43.58	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to S10763 at 100%.* *iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.*		
SY10750	Transnasal esophagogastroduodenoscopy (TGD), procedural fee	116.63	
	***Note**: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.*		
10708	Video capsule endoscopy using M2A capsule - professional fee:	256.63	
	Notes: *i) Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have ruled out other causes.*		
	Lower Gastrointestinal System:		
SY00715	Sigmoidoscopy (with biopsy) - procedural fee	37.98	2
SY10714	Proctosigmoidoscopy, rigid; diagnostic	35.40	2
SY00716	Sigmoidoscopy, flexible; diagnostic	76.09	2
SY00718	- with biopsy	77.34	2
S10730	Colonoscopy, flexible colostomy - single or multiple	240.14	4
S10731	Colonoscopy, flexible, proximal to splenic flexure; diagnostic with or without collection of specimen(s) by brushing or washing	231.61	2
S10732	- with removal of foreign body	272.07	2
S10733	- with control of bleeding, any method	303.99	2
	Notes: i) **Proctosigmoidoscopy** is the examination of the rectum and sigmoid colon. ii) **Sigmoidoscopy** is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon. iii) **Colonoscopy** is the examination of the entire colon, from the rectum to the caecum, and may include the examination of the terminal ileum.		
S00710	Mediastinoscopy or anterior mediastinotomy (combined 50% extra) - procedural fee	196.39	4

(b) (i) Diagnostic procedures utilizing radiological equipment

		$	Anes. Level
	The following fees are separate from the fees for the radiological part of this examination and should be charged by the attending physician or by the radiologist who performs the procedure, e.g.: instrumentation or injection of contrast materials:		
S00722	Operative arteriography - procedural fee	75.51	
S00721	Myelogram - procedural fee	44.19	2
S00723	Sialogram (per duct) or galactograms (per blast) - procedure fee for injection	48.85	2
S00724	Presacral air insufflation - procedural fee	39.17	2
S00727	Salpingogram - procedural fee	77.95	2
S00728	Orthodiagram - procedural fee	11.87	2
S00729	Fluoroscopy of chest by internist or pediatrician - procedural fee	11.11	
S00730	Catheterization of bronchi for bronchogram - procedural fee ***Note:*** *When performed in conjunction with a bronchoscopy (s00700), both fees are to be paid in full.*	27.48	4
S00732	Voiding cysto-urethrogram - procedural fee	19.74	2
S00733	Venogram, intraosseous, or intravenous - procedural fee	59.58	2
S00734	Lymphangiography or lymphography ***Note:*** *Only payable with imaging capture such as x-ray, fluoroscopy and MRI.*	130.97	
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	67.00	4
10739	Endobronchial Ultrasound (EBUS) ***Notes:*** *i) Not payable with 00700, 00702, 02450, 10700 or 10702.* *ii) Fee item 10703 and 00736 payable in addition.*	387.16	6
S00743	Localizing of non-palpable breast lesion	125.53	2
S00811	Joint injection, aspiration or arthrogram, under radiological guidance ***Note:*** *If joint injection, aspiration and/or arthrogram are done at the same time, under radiological guidance, only S00811 X 1 per joint is billable.*	53.31	2
S00826	Biopsy of pancreas - percutaneous	101.44	2
S00857	Percutaneous trans-hepatic cholangiogram (included in S00980)	113.54	2
S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	276.74	2
10735	Rectal endoscopy utilizing ultrasound (radial/linear) ***Note:*** *Includes mucosal biopsy*	153.99	
10740	Upper GI endoscopy utilizing radial ultrasound	256.63	
10741	Upper GI endoscopy utilizing linear ultrasound ***Notes:*** *i) 10740 and 10741 are payable only when done in publicly funded acute care facilities.* *ii) 10741 payable at 50% when done subsequent to 10740 (same patient/same day)*	256.63	
10742	Upper GI endoscopy utilizing radial/ linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 – per lesion ***Notes:*** *i) Payable with 10740 or 10741 only* *ii) First biopsy paid at 100%. Second and third biopsies payable at 50%.*	51.33	

		$	Anes. Level
10743	Upper GI endoscopy utilizing radial/linear ultrasound - with injection of one of more of any of the following – metastases, nodes, masses, or celiac plexus-extra	153.99	
	Note: *Payable with 10740 or 10741 only.*		
10744	Upper GI endoscopy utilizing radial/linear ultrasound - with drainage of pseudocyst (including stent insertion if performed) – extra	205.32	
	***Note**: Payable with 10740 or 10741 only.*		

(b) (ii) Therapeutic procedures utilizing radiological equipment

S00738	Removal of biliary calculi by Burhenne technique	206.05	4
S00746	Reduction of intussusception using hydrostatic pressure, procedural fee	97.49	4
	***Note**: Fee item 08576 is payable in addition, when performed.*		
S00921	Varicocele and/or uterine artery embolization – unilateral	464.98	3
S00925	Varicocele and/or uterine artery embolization - bilateral	674.52	3
	Notes:		
	i) Fee items 00921 and 00925 include all angiographies necessary to perform the procedure.		
	ii) Fee item 08617 or 08618 payable in addition when service rendered in out-patient department.		
	iii) Interventional radiology consultation is payable with 00921 and 00925.		
S00977	Antegrade pyelogram (not billable in conjunction with 00978, 00979)	106.23	2
S00978	Percutaneous nephrostomy, procedural fee	301.15	2
S00979	Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation, procedural fee	401.45	2
S00980	Transhepatic biliary drainage procedure (includes 00857)	425.44	3
S00981	Therapeutic radiological embolization	425.44	3
S00982	Percutaneous transluminal angioplasty	405.54	2
	Notes:		
	i) Includes one step procedure involving inflation and deployment of a stent.		
	ii) 10919 payable following angioplasty with stent insertion.		
S00983	Percutaneous abdominal abscess drainage by catheter insertion	277.00	2
S00984	Exchange of previously inserted catheter or tract dilatation for percutaneous biliary or renal drainage	126.89	2
S00989	Extra-corporeal shock wave lithotripsy	136.64	4
S00994	Extra-corporeal shock wave biliary lithotripsy - procedural only	167.11	4
	Notes:		
	i) 00994 generally is applicable to common bile duct stones, only.		
	ii) 00994 is applicable to stones in the gall bladder only where cholecystectomy is contraindicated because of the medical condition of the patient. For other cases, Clause C. 6. of the Preamble to the Payment Schedule applies.		

		$	Anes. Level
10320	Insertion of permanent pleural drainage catheter	235.00	5
	Notes: *i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter* *ii) Not paid with S32031, 00749, 00759, 07924 and 08646.*		
10321	Removal permanent pleural drainage catheter	72.00	2
	***Note**: Not paid with S32031, 00749, 00759, 07924 and 08646.*		
00995	Embolization of brain and spinal cord AVM's	2,098.46	3
	Notes: *i) Tolerance testing (e.g.: super selective Amytal test) performed during embolization is included.* *ii) Includes functional testing in the awake patient.*		
S00997	Detachable balloon embolization	1,312.16	3
	Notes: *i) To include all balloons placed during the procedure.* *ii) Repeat procedures billable at 100%.*		
00998	Embolization of head, neck and spinal vascular lesions	1,618.27	3
	Notes: *i) 00995, 00997 and 00998 include the consultations associated with the procedure performed, preparation of the embolizing agent(s) and catheter(s), catheterization(s) and follow-up care of the patient by the radiologist.* *ii) 00995, 00997 and 00998 are billable only by physicians with appropriate training in interventional neuroradiology.* *iii) 00995, 00997 and 00998 are payable once per day, regardless of the number of embolizations or catheterizations performed, or balloons inserted.* *iv) 00995 and 00998 include:* *a) Diagnostic angiograms done during the procedure.* *b) Angiograms performed as a separate procedure before or after the embolization are billable.* *c) Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted embolization procedure. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of $1,700. Claims must be accompanied by written details of vessels injected.* *d) Repeat procedures performed by the same physician and done within 30 days of the original procedure will be paid at 75% of the original fee.* *v) Includes 10913 if performed on same day as 00995, 00997 or 00998.*		
10900	Abdominal aortic aneurysm repair using endovascular stent graft – second operator	509.83	
	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.*		
10901	Percutaneous image guided catheter directed thrombolysis of peripheral vein/artery	589.66	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.* *iii) Start and end times must be entered in both the billing claims and the patient's chart.*		

		$	Anes. Level
10902	Peripherally inserted image-guided central Venous catheter line (PICC)	112.32	2
	Notes: *i) Not applicable if performed via other than peripheral access.* *ii) Includes placement, venogram/angiogram, and all medically required image guidance.* *iii) May not be delegated.*		
10903	Percutaneous hemodialysis graft thrombolysis	589.66	2
	Notes: *i) Includes declotting and treatment of underlying cause of access failure.* *ii) Includes angioplasty and all necessary Imaging and intervention.*		
10904	Percutaneous transcatheter arterial chemo-embolization (TACE)	589.66	3
	Notes: *i) Fee is per session/sitting, regardless of number of lesions treated.* *ii) Includes all associated imaging necessary to complete procedure.*		
10905	Cerebral intra-arterial thrombolysis and/or thrombectomy	1,312.16	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) Not payable with fee item 00998.*		
10906	Image-guided percutaneous vertebroplasty - first level	365.04	4
10907	- each additional level (to a maximum of 3)	84.25	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.*		
10908	Percutaneous image-guided tumour ablation – first lesion	530.20	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, 50% for second lesion and 50% for third lesion.* *iii) Includes all CT and ultrasound guidance necessary to complete the procedure.* *iv) Paid at 50% if repeated within 30 days.*		
10909	Percutaneous intravascular/intracorporeal medical device/ foreign body removal	393.12	3
	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.*		
10911	Selective salpingography/fallopian tube recanalization (FTR)	393.12	2
	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.*		

		$	Anes. Level
10912	Transjugular liver/renal biopsy	393.12	2

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%.

10913	Cerebral arterial balloon occlusion tolerance test	798.88	5

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) Included in payment for endovascular obliteration of an aneurysm using the GDC technique (FI 10915), or embolization (fee items: 00995, 00997, 00998) if performed on the same day.

10914	Percutaneous balloon angioplasty for cerebral vasospasm	1,026.79	9

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.
iv) Medically necessary extra cranial angioplasty and stenting required to enable access for balloon angioplasty payable at 50% of 00982
v) Radiological assists are payable under fee items 08632 and 08633.
vi) 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.
vii) Not payable with fee item 10905.

10915	Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique	1,997.22	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) Multiple aneurysms paid as follows: 2nd – 50 percent; 3rd – 25 percent (to a maximum of three aneurysms).
v) Radiological assists are payable under fee items 08632 and 08633.
vi) Fee item 08629 not payable in addition.
vii) 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.

		$	Anes. Level
10916	Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations – up to 4 hours procedural time	1,174.82	5
10917	– after 4 hours (extra to 10916)	293.72	

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 end times must be entered in both the billing claims and the patient's chart.

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	469.94	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) Includes necessary post-operative visits by physician performing procedure.

iv) Compression sclerotherapy listings (fee items 77050 – 77060) not payable with 10918.

10919	Intravascular stent placement – extra	129.56	

Notes:

i) Includes all diagnostic imaging associated with stent placement.

ii) Payable when follows angioplasty procedure (S00982) where stent is not initially deployed.

iii) For non-Vascular surgery, placement of second stent in a different site is payable at 50%.

iv) When 10919 is combined with another vascular surgery, multiple stents will be paid on anatomical named vessels as follows: 100% for the first and 50% for the second, to a maximum of 2 stents.

v) When 10919 is performed with 77113 or 77114 as an isolated endovascular procedure, multiple stents will be paid on anatomical named vessels as follows: 100% for the first, 50% for the second and 25% for the third, to a maximum of 3 stents.

vi) Procedures repeated within 30 days are payable at 50%.

vii) Not payable for Coronary stent placement.

viii) When done with 77177 (EVAR), payable to either the primary or the second operator.

When performed with percutaneous angioplasty for the following anatomical named vessels

Upper extremity vessels
Right brachial artery
Right radial artery
Right ulnar artery
Left brachial artery
Left radial artery
Left ulnar artery

Lower extremity vessels
Anterior tibial artery
Posterior tibial artery

Peroneal artery
Tibioperoneal trunk
Right common femoral artery
Right superficial femoral artery
Right profunda femoral artery
Right popliteal artery
Left common femoral artery
Left superficial femoral artery
Left profunda femoral artery
Left popliteal artery

Intra abdominal vessels
Abdominal aorta
Celiac axis
Hepatic artery
Splenic artery
Superior mesenteric artery
Inferior mesenteric artery
Right common iliac artery
Right external iliac artery
Right internal iliac artery
Left common iliac artery
Left external iliac artery
Left internal iliac artery
Right renal artery
Left renal artery

Thoracic vessels
Ascending thoracic aorta
Transverse thoracic aorta
Descending thoracic aorta
Brachiocephalic artery
Right common carotid artery
Right subclavian artery
Right vertebral artery
Left common carotid artery
Left subclavian artery
Left vertebral artery

Cervical vessels
Right common carotid artery
Right internal carotid artery
Right external carotid artery
Left common carotid artery
Left internal carotid artery
Left external carotid artery

		$	**Anes. Level**
10920	Intracorporeal stent placement – extra	129.56	

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) 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.*
- *vi) Placement of second stent in non-contiguous site payable at 50%.*

		$	Anes. Level
10921	Transjugular Intrahepatic Porto-systemic shunt (TIPS)	1,113.42	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) Radiological assists are payable under fee items 08632 and 08633.

10922	Embolization in the management of Epistaxis without vascular lesion or tumour	628.08	3

Notes:

i) Includes the procedure performed, preparation of the embolic agent(s), catheter(s), catheterization(s), and follow-up care of the patient by the radiologist.
ii) Billable only by physicians with appropriate training in interventional radiology.
iii) Payable once per day, regardless of the number of embolizations or catheterizations performed, or balloons inserted.
iv) 10922 include:
  a) Diagnostic angiograms done during the procedure.
  b) Angiograms performed as a separate procedure before or after the embolization are billable.
  c) Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted embolization procedure. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of $1,700. Claims must be accompanied by written details of vessels injected.
  d) Repeat procedures performed by the same physician and done within 30 days of the original procedure will be paid at 75% of the original fee.
v) Includes 10913 if performed on same day.

(c) Needle Biopsy Procedures

These biopsies include only those done by needle. Biopsies involving the incision of skin or mucous membrane or involving total or partial removal of a lesion are regarded as surgical procedures, i.e. biopsy of breast, brain, larynx, skin, facial skin, lymph nodes, prostate, etc.:

S00739	Percutaneous lung or mediastinal biopsy - procedure fee	111.09	2
S00740	Liver biopsy - procedural fee	109.61	2
S00741	Splenic biopsy - procedural fee	109.61	2
S00742	Renal biopsy - procedural fee	111.09	2
S00744	Thyroid biopsy - procedural fee	73.65	2
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	49.15	2
S00747	Prostate biopsy - procedural fee	32.47	2
S00748	Bone biopsy under local/regional anesthetic	63.99	
S00749	Parietal pleural, including thoracentesis - procedural fee	131.00	2
S00844	Biopsy of salivary gland, fine needle or core needle	54.02	3

(d) Puncture procedure for obtaining body fluids (when performed for diagnostic purposes)

SY00750	Lumbar puncture - in a patient 13 years of age and over	55.28	2

Note: *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*

		$	Anes. Level
SY00570	Lumbar puncture in a patient 12 years of age and younger ***Note:*** *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*	82.92	2
S00751	Pericardial puncture - procedural fee	252.53	3
S00752	Cisternal puncture - procedural fee	38.41	2
S00753	Marrow aspiration - procedural fee	43.77	2
S00755	Artery puncture - procedural fee	6.41	2
SY00757	Joint aspiration - procedural fee (not in addition to Y00014 or Y00015) - other joints	12.03	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	86.00	2
S00760	- (abdominal) - procedural fee	25.88	2
S00761	Cyst or bursa - procedural fee	14.65	2

(e) Allergy, patch and photopatch tests

S00762	Scratch test, per antigen ***Note:*** *Minor tray fees may be paid in addition if a minimum of 16 antigens are used.*	1.06	
S00763	- children under 5 years of age, per antigen ***Note:*** *Minor tray fees may be paid in addition of a minimum of 14 antigens are used.*	2.32	
S00764	Intracutaneous test, per test	2.15	
S00765	Annual maximum (to include scratch or intracutaneous tests) for each physician - per patient	34.40	
S00767	Patch testing (extra) (annual maximum, 80 tests), per test	1.96	
S00768	Photopatch test - per test	5.66	
S00769	- annual maximum	56.69	

(f) Examination under anesthesia when done as independent procedure

S00770	Pelvic examination under anesthesia when done as an independent procedure - procedural fee	204.56	2
S00771	Retinal examination under anesthesia - procedural fee	20.08	3

(g) Gynecological

S00775	Hydrotubation ***Note:*** *When 00775 is done in conjunction with laparoscopy, fee included in laparoscopy fee.*	45.92	
S00776	Fetal scalp sampling	103.13	
S00782	Needle aspiration of Pouch of Douglas - procedural fee	36.40	2
S00783	Huhner's test - procedural fee	45.92	
S00784	Cervix punch biopsy - procedural fee	19.81	2
S00785	Endometrial biopsy - procedural fee ***Note:*** *Includes pap smear if required.*	45.92	2
S00786	Pelvic examination with needle aspiration of Pouch of Douglas under anesthesia when not followed by a surgical procedure by the same surgeon	47.09	2
S00787	Transabdominal amniocentesis	90.47	2
S00790	Antepartum fetal heart monitoring (not to be charged for intrapartum fetal heart monitoring nor when done in conjunction with a consultation) - professional fee	18.15	
S00794	Chorionic villus sampling ***Note****: Includes ultrasound guidance of the villus biopsy.*	124.40	2

		$	Anes. Level
S00807	Diagnostic hysteroscopy - not payable in addition to a D&C	156.58	2
S00808	Diagnostic hysteroscopy with biopsy(s), includes D&C	209.46	2
S00815	Laparoscopically directed biopsies and/or lysis of adhesions – extra	64.21	4
S00819	Diagnostic vaginoscopy under GA	156.58	2
	Notes: *i) Payable only for premenarchal patients unless medical necessity provided in the note record.* *ii) Not billable in addition to hysteroscopy.*		

(h) Urological

S00802	Urethrogram	39.53	2
	Cysto-ureterogram:		
S00792	- technical fee	12.52	2
S00793	- professional fee	6.26	
S00799	Transurethral ureterorenoscopy to include C&P	158.13	2
S00800	Transurethral ureterorenoscopy with x-ray control - C & P included	384.37	2
S00803	Loopogram	54.70	
S00866	Dynamic cavernosometry and cavernosography	79.05	2
	Note: *Interpretation of x-ray is included in technical portion and is not billable in addition to procedure.*		
S00878	Cystometry, to include pelvic floor EMG	66.24	
S00874	Urethral profilometry (water or gas)	19.77	
S00875	Uroflowimetry (with sphincter EMG with or without pharmacologic manipulation)	31.64	
S00876	Video uro-dynamics (full study), includes S00874, S00875 and S00878	200.16	

(i) Miscellaneous

S00774	Secretion pancreazymin stimulation test	86.88	
S00780	Schirmer's Test (included in fee Item 02015)	13.15	
SY00789	Peritoneal lavage	85.74	2
S00797	Oesophageal motility test	176.15	
S00788	- technical fee	74.35	
S00798	- professional fee	101.79	
S00818	Oesophageal pH study for reflux, extra		
	- professional fee	41.00	
S00817	- technical fee	13.00	
S00809	Retrograde pancreatography	216.54	3
S00869	Manometry; anal - adult	101.37	2

(j) Cardio-vascular Diagnostic Procedures -procedural fees

S00801	Intra-arterial cannulation - with multiple aspirations - procedural fee	22.10	
S00810	Right heart catheterization, by duly qualified specialist	165.44	4
S00812	Selective angiocardiogram, extra, by duly qualified specialist	55.52	4
S00813	Ergonovine provocative testing for coronary artery spasm	79.14	4
S00814	Dye dilution studies, extra, by duly qualified specialist	55.52	4
S00816	Hydrogen ion study	28.96	2
S00830	Trans-septal left heart catheterization, by duly qualified specialist	235.58	4
S00839	Direct intracoronary streptokinase thrombolysis	361.78	4
	Note: *When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).*		

		$	Anes. Level
S33131	Diagnostic cardiac catheterization	333.75	4

Notes:

i) Restricted to Cardiologists and Pediatric Cardiologists.
ii) Not payable with 33132, 33133, 33134 and/or 00842.
iii) Include arterial access, arterial pressure measurements and interpretations, direct coronary artery cannulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, and interpretation of aortic valve pullback gradient hemodynamics.

S33132	Diagnostic cardiac catheterization with advanced arterial assessment	483.26	4

Notes:

i) Restricted to Cardiologists and Pediatric Cardiologists.
ii) Not payable with 33131, 33133, 33134 and/or 00842.
iii) Applies to per patient, not per vessel or lesion when advanced arterial assessment is performed.
iv) Include arterial access, arterial pressure measurements and interpretations, direct coronary artery cannulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, interpretation of aortic valve pullback gradient hemodynamics, and advanced assessment of the coronary artery with Fractional Flow Reserve (FFR), intravascular ultrasound (IVUS), and/or optical coherence tomography (OCT).

Percutaneous coronary interventions:

S33133	Percutaneous coronary intervention with diagnostic cardiac catheterization	563.36	4

Notes:

i) Restricted to Cardiologists and Pediatric Cardiologists.
ii) Includes balloon inflation (angioplasty), stent insertion, and/or diagnostic cardiac catheterization.
iii) *Not payable with 33131, 33132, and/or 33134.*
iv) Name of vessel must be provided in the note record.
v) When temporary pacemaker insertion is performed in addition, 33030 to be paid at 50%.

S33134	Percutaneous coronary intervention alone	375.53	4

Notes:

i) Restricted to Cardiologists and Pediatric Cardiologists.
ii) Includes balloon inflation (angioplasty), stent insertion.
iii) Payable when 33131 or 33132 had been performed by a different practitioner as part of the same procedure.
iv) Not payable with 33131, 33132, 33133 when is performed by the same practitioner.
v) Name of vessel must be provided in the note record.
vi) When temporary pacemaker insertion is performed in addition, 33030 to be paid at 50%.

S00842	Percutaneous coronary intervention – for additional vessel(s), per vessel	189.01	

Notes:

i) Only payable in addition to 33133 or 33134.
ii) When temporary pacemaker insertion is performed in addition it will be payable at 50% of listed fee(s).
iii) Maximum of 5 named vessels per patient.
iv) Name of vessel(s) must be provided in the note record.

Percutaneous coronary intervention anatomical named vessels: (Including Coronary artery bypass graft to vessels below):

Right coronary:

- *Right coronary artery*
- *Right posterior descending artery*
- *Right posterior atrioventricular artery*
- *First right posterolateral artery*

- *Second right posterolateral artery*
- *Acute marginal artery*
- *Inferior septal artery*

Left coronary:

- *Left main coronary artery*
- *Left anterior descending artery*
- *First diagonal artery*
- *Second diagonal artery*
- *Ramus artery*
- *Circumflex artery*
- *First obtuse marginal artery*
- *Second obtuse marginal artery*
- *Third obtuse marginal artery*
- *Left atrioventricular artery*
- *First left posterolateral artery*
- *Second left posterolateral artery*
- *Left posterior descending artery*
- *First septal artery*

		$	Anes. Level
S00843	Selective arteriography or venography of any abdominal branch by catheter extra: - for first branch (each additional branch 50% extra)	100.98	2
S00847	Selective arteriography of any thoracic aortic branch (excluding coronaries) extra - for first branch (each additional branch 50% extra)	163.73	2
S00871	Pulse tracing, including interpretation: - intravascular, including both arterial and venous	55.52	
	Portal pressures:		
S00880	- hepatic vein wedge pressure, by duly qualified specialist	65.89	
S00881	- percutaneous splenic portal pressure	52.73	2
S00898	Balloon septostomy	338.65	7
	Aortogram:		
S00890	- abdominal - procedural fee	116.28	2
S00897	- thoracic - procedural fee (extra except when part of a retrograde left heart catheterization)	167.15	2
	Arteriogram-procedural fee:		
S00892	- carotid percutaneous; unilateral	114.91	3
S00891	- carotid percutaneous; bilateral	172.79	3
S00893	- femoral or axillary	88.98	2
S00894	- cerebral, by dissection	193.71	3
S00853	Superior venacavogram, by indirect means	24.26	2
S00854	Inferior venacavogram	116.28	2
S00855	Selective catheterization of branches of inferior vena cava or iliac system - first branch	90.31	2
S00856	- others	60.04	2
S00888	Ventriculogram, when no ventricular access device is present (i.e. ventricular reservoir, VP shunt, or drain)	256.42	3
S00889	Ventriculogram through previously placed ventricular access device, drain, or catheter	128.22	3
S00896	Pulmonary arteriography	141.15	3
S00885	Digital angiography - peripheral injection	46.99	2
S00919	Impedance plethysmography - professional component	6.89	
S00920	Impedance plethysmography - technical component	34.55	

		$	Anes. Level
	Cardiology Assist Fees:		
00845	For first hour or fraction thereof	171.21	
00846	After one hour, for each 15 minutes or fraction thereof	42.81	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

(k) Electrodiagnosis

Items under:

Intensity duration curve - each muscle.
Electromyograph - each muscle.
Motor nerve conduction study - each nerve.
Sensory nerve conduction study - each nerve.
Tetanic simulation test - each muscle.

Bill according to:

S00900	Schedule A - extensive examination (eight or more items)	121.85	
S00901	Schedule B - limited examination (four to seven items)	81.49	
S00902	Schedule C - short examination (one to three items)	40.61	
S00923	Technical fee for electrodiagnostic testing	20.39	
S00905	Daily measurements of nerve conduction thresholds in facial palsy	6.35	
S00906	- maximum per course	44.15	
S00914	Insertion of sphenoidal electrodes temporal lobe epilepsy, E.E.G.: recording	43.61	
S00915	Intra-carotid injection of sodium amytal, speech localization test	98.01	2
S00926	Seizure activation with intravenous activating agents associated with insertion of sphenoidal and/or orbital electrodes	147.86	2
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests	57.26	
S00927	Decamethonium test - for attendance at, and follow-up observation if necessary	34.34	
S00944	Tilt table testing with continuous ECG monitoring and automatic BP recording - total fee	290.15	
S00947	- professional fee	178.57	
S00948	- technical fee	111.59	

Notes:

i) Applicable only for investigation for diagnosis of neurally mediated syncope.
ii) Physician must be present throughout duration of procedure.
iii) Includes testing before and if necessary, after pharmacological provocation.
iv) Requires backup resuscitation equipment and materials.
v) Routine ECG not billable in addition.
vi) Restricted to facilities licensed to perform cardiac electrophysiological testing.

Polysomnogram:

	Overnight home oximetry (continuous recording of oxygen and pulse)		
S00910	- professional fee	28.30	
S00911	- technical fee	15.62	

Note: *Fee items 00910 and 00911 are limited to Category III pulmonary function diagnostic facilities and/or polysomnography diagnostic facilities with the established personnel qualifications for such facilities.*

S11915	Polysomnography, standard – professional fee	167.45	
S11916	Polysomnography, standard – technical fee	387.02	

		$	Anes. Level
S11917	Polysomnography, two-night – professional fee	251.10	
S11918	Polysomnography, two-night – technical fee	774.04	
S11919	Multiple Sleep Latency Test (MSLT) - professional fee	83.70	
S11920	Multiple Sleep Latency Test (MSLT) - technical fee	193.51	
S11925	Four channel home polysomnography – professional fee	83.61	
S11926	Four channel home polysomnography – technical fee	83.86	

(I) Pulmonary Investigative and Function Studies

S00930	Peak expiratory flow rate	5.57	
	***Note**: Fee item S00930 payable when performed in physicians' office (not restricted to an accredited facility).*		
	Diagnostic Procedures:		
S00928	Simple screening spirometry with FVC, FEV(i), and FEV(i)/FVC ratio using a portable apparatus without bronchodilators	13.00	
S00929	Simple screening spirometry as above but before and after bronchodilators	19.00	
	Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume:		
S00931	- professional fee	15.00	
S00932	- technical fee	14.18	
	Spirometry – forced expiratory spirogram to include FVC, FEV(i) and FEV(i)/FVC ratio, MMEFR, etc.:		
S00933	- without bronchodilators - professional fee	12.00	
S00934	- without bronchodilators - technical fee	11.11	
S00935	- before and after bronchodilators - professional fee	13.50	
S00936	- before and after bronchodilators - technical fee	14.18	
	Spirometry - flow volume loops:		
S00937	- without bronchodilators - professional fee	12.00	
S00938	- without bronchodilators - technical fee	18.20	
S00940	- before and after bronchodilators - professional fee	15.00	
S00941	- before and after bronchodilators - technical fee	26.92	
	Diffusion Studies with Carbon Monoxide:		
S00942	- at rest or exercise - professional fee	16.00	
S00943	- technical fee	12.87	
	Detailed Pulmonary Function Studies:		
S00945	- professional fee (includes S00931, S00935 and S00942)	42.50	
S00946	- technical fee (includes S00932, S00936 and S00943)	40.29	
	***Note**: Fee items S00931-S00936, S00942, S00943 will be paid at 100%.*		
	Exercise Studies:		
	***Note:** No more than one exercise study item may be billed for a single patient on any one day without written explanation.*		
	Progressive exercise test with at least three workloads, measuring ventilation and electrocardiographic monitoring:		
S00950	- professional fee	25.00	
S00951	- technical fee	32.59	
	Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, and electrocardiographic monitoring:		
S00954	- professional fee	93.00	
S00955	- technical fee	59.06	

		$	Anes. Level
	Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space:		
S00956	- professional fee	109.46	
S00957	- technical fee	70.32	
	Testing for exercise-induced asthma by serial flow measurements:		
S00958	- professional fee	22.35	
S00959	- technical fee	32.95	

Miscellaneous Pulmonary Tests:

	Plethysmography and airway resistance:		
S00964	- professional fee	14.00	
S00965	- technical fee	26.92	
	Inhalation challenge - assessed by serial flow measurements, per day:		
S00968	- professional fee	40.00	
S00969	- technical fee	36.41	
	Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:		
SY11964	- professional fee	20.57	
SY11965	- technical fee	44.36	

Notes:

i) Restricted to Respirologists.

ii) Maximum of one assessment per patient per day.

iii) Annual maximum four per year. Two additional tests will be considered if accompanied by a note record.

iv) Not payable in addition to bronchoscopy 00700, 00702.

	Precipitin tests - one or more antigens:		
S00970	- professional fee	11.16	
S00971	- technical fee	27.05	
	$C0_2/0_2$ responsiveness of respiratory centres by steady state test or rebreathing test:		
S00972	- professional fee	20.00	
S00973	- technical fee	11.11	
	Inspiratory and expiratory muscle strength		
S00974	- professional fee	14.00	
S00975	- technical fee	12.72	
S11960	Oximetry at rest, with or without oxygen - professional fee	5.00	
S11961	- technical fee	5.10	
S11962	Oximetry at rest and exercise, with or without oxygen - professional fee	12.00	
S11963	- technical fee	15.94	

(m) Evoked Response Procedures

S00985	Brainstem auditory evoked response; supra threshold testing for integrity of brainstem function	48.66	
S00986	Somatosensory evoked response - upper extremity	37.08	
S00987	- upper and lower extremity	64.10	
S00988	Visual evoked response	71.89	

		$	Anes. Level
(n)	**Orthopaedic Diagnostic Procedures**		
	Shoulder Girdle, Clavicle and Humerus		
	Incision - Diagnostic, Percutaneous:		
S11200	Arthroscopy shoulder joint	298.77	2
	Incision Diagnostic Open:		
11215	Arthrotomy shoulder joint or bursa	186.72	2
	Excision - Diagnostic, Percutaneous:		
S11230	Needle biopsy under GA	186.72	2
S11232	Arthroscopy - biopsy, shoulder	242.74	2
	Excision - Diagnostic, Open:		
11245	Biopsy, open	242.74	2
	Elbow, Proximal Radius and Ulna		
	Incision - Diagnostic, Percutaneous:		
S11300	Arthroscopy elbow joint	268.43	2
S11302	Aspiration bursa, tendon sheath.	23.23	2
	Incision - Diagnostic, Open:		
11315	Arthrotomy elbow joint	186.72	2
	Excision - Diagnostic, Percutaneous:		
S11330	Needle biopsy under GA	186.72	2
S11332	Arthroscopy and biopsy	296.44	2
	Excision - Diagnostic, Open:		
11345	Open - biopsy	242.74	2
	Note: *Not billable with other procedures on the same joint.*		
	Hand and Wrist		
	Incision - Diagnostic, Percutaneous:		
S11400	Arthroscopy wrist joint	287.62	2
S11402	Aspiration bursa, synovial sheath, etc	23.23	2
	Incision - Diagnostic, Open:		
11415	Arthrotomy wrist joint - isolated procedure	186.72	2
11416	Arthrotomy MP, PIP, DIP joints - isolated procedure	186.72	2
	Excision - Diagnostic, Percutaneous:		
S11430	Needle biopsy, under GA	186.72	2
S11432	Arthroscopy and biopsy, wrist /hand joint(s)	186.72	2
	Excision - Diagnostic, Open:		
11445	Open biopsy, hand or wrist	242.74	2
	Pelvis, Hip and Femur		
	Incision - Diagnostic, Percutaneous:		
S11500	Arthroscopy hip joint	518.18	3
S11501	Aspiration hip joint	23.23	2
S11502	Aspiration bursa, tendon sheath	11.63	2
	Incision - Diagnostic, Open:		
11515	Arthrotomy hip joint	298.77	3
	Excision - Diagnostic, Percutaneous:		
S11530	Needle biopsy, under GA	186.72	2
S11532	Arthroscopy and biopsy, hip	518.18	3

		$	Anes. Level
	Excision - Diagnostic, Open:		
11545	Arthrotomy and biopsy, hip	242.74	3
11546	Biopsy open, soft tissue or bone	242.74	2

Femur, Knee Joint, Tibia and Fibula

	Incision - Diagnostic Percutaneous:		
S11600	Arthroscopy knee joint	214.73	2
S11602	Aspiration bursa, tendon sheath or other peri-articular structures	23.23	2
	Incision - Diagnostic Open:		
11615	Arthrotomy knee joint	242.74	3
	Excision - Diagnostic, Percutaneous:		
S11630	Needle biopsy, under GA	186.72	2
S11632	Arthroscopy - biopsy	214.73	2
	Excision - Diagnostic, Open:		
11645	Biopsy, open	242.74	2

Tibial Metaphysis (Distal), Ankle and Foot

	Incision - Diagnostic, Percutaneous:		
S11700	Arthroscopy ankle joint / subtalar joint	186.72	2
S11702	Aspiration bursa, tendon sheath.	23.23	2
	Incision - Diagnostic, Open:		
11715	Ankle joint,	186.72	2
11716	Subtalar joint	186.72	2
11717	Midtarsal joint	186.72	2
11718	Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint.	186.72	2
	Excision - Diagnostic:		
S11730	Needle biopsy, under GA	186.72	2
11745	Open biopsy, under GA	242.74	2

Vertebra, Facette and Spine

	Excision - Diagnostic, Percutaneous:		
S11830	Needle biopsy - soft tissue/bone - thoracic spine, under GA	214.73	2
S11831	Needle biopsy - soft tissue/bone - lumbar spine, under GA	186.72	2
	Excision - Diagnostic, Open:		
11845	Biopsy, with GA	242.74	3
	Note: *Not payable with definitive spinal surgery*		

CRITICAL CARE

Complete understanding of the following paragraphs is essential to appropriate billing of the critical care fees. Members of the team billing the Critical Care Payment Schedule cannot be receiving other payments (e.g.: fees, alternative or sessional payments) for the clinical care of the patient.

Preamble

Adult and Pediatric Critical Care

These listings do not apply to the non-ventilated stable patients admitted to a special care unit for routine post-op care, or for nursing care reasons, cardiac or other monitoring. The Critical Care Payment Schedule is intended to be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment, such as ventilatory support, haemodynamic support including vasoactive medications, or prolonged resuscitation.

Day 1 billing is to be used only when more than 2 hours of bedside care is provided. (If 01411 – 01413 billed in isolation, a total of 2 hours care on the first day is required. If critical and ventilatory care is billed conjointly by the team, then each component must be a minimum of 1 hour of care). Day 1 is defined as starting at 0000 hours. If a patient is seen after 2200 hours, the physician may bill emergency care services, (00081/00082) or a major consultation fee with resuscitation services, (00081), or a major consultation fee with additional visits when appropriate. Day 2 billing would start at 0000 hours the next day. Standby time is not allowed.

It is recognized that a team of physicians often manages complicated problems in the Intensive Care Unit. The schedule is a team fee and individual members of the team who share a common call rotation may not bill separately. The original physician or physicians providing initial bedside care will be designated physician or physicians in charge, i.e. if it is a single physician then the comprehensive or critical care item may be billed when appropriate. If two physicians are involved then the critical care item and ventilatory support item may be billed, if the other requirements are met. Critical care billing no longer applies when the services indicated in the listings are no longer required. If the patient has been discharged from the unit and is readmitted within 48 hours with the same or a similar problem, billing would continue from where it was stopped. After 48 hours, billing would usually start at Day 2 rates. If problem is totally different, Day 1 rates will apply regardless of time admitted both within or after 48 hours (a note record is required).

Since these listings are intended to cover all required services for critically ill patients, no other physician except the Primary Care Physician (who may bill for daily or supportive care) may bill for the care of the patient on the same day, except for:

- Consultation fee to a specialist outside the team when requested (service not within the competence or specialty of a team member). Follow-up visits may be billed only if the physician is involved in the active care of the patient.

- TPN when ordered by a physician not part of the critical care team.

- Medical management of Extra Corporeal Membrane Oxygenation (ECMO) should be billed as a miscellaneous fee, and will be paid in equity with the Critical Care daily fees (1411/21/31/41), starting at Day 1.

- The Critical Care team member who performs ECMO cannot concurrently bill the daily fees on the same patient. Another physician on the team may concurrently bill the appropriate Adult and Pediatric Critical Care daily fees on that patient.

- Continuous Renal Replacement Therapy (CRRT, also referred to as dialysis) and MARS (Molecular Adsorbents Recirculating System) may be paid in

addition to Critical Care daily fees to the same physician or to another member of the Critical Care Team. For the CCM Physician, these fees will be paid at 75% of fee item 33750, 33751, 33752 and 33758, and will follow the billing rules under these dialysis fees.

- Dialysis, when supervised by a physician not part of the Critical Care Team, will be paid at 100%.

- In exceptional circumstances other physicians may be called in to perform specific procedures usually managed by the critical care team, i.e. anesthesiologist (not a member of the team) called to insert a difficult arterial line when no one else is capable of performing the procedure. That physician may bill the procedure fee but a consultation fee would not be applicable.

A note record is required explaining the need for services outside the critical care team.

Subsequent Major surgical procedures rendered by a physician who is on the team billing under the critical care schedule are payable at 75% (operation only procedures payable at 100%) and should be billed accordingly.

Postoperative surgical care is included in the surgeon's fee. Critical care fees are not applicable for services rendered to routine, stable patients who are simply recovering from surgery. The following is applicable for members of the critical care team, in cases where the patient requires critical care following surgery:

(a) Services rendered to unstable, critically ill non-elective post-surgical patients who meet normal Day 1 criteria should be billed at Day 1 rates.

(b) Services rendered to high risk and unstable patients, (particularly after emergency surgery) who warrant ICU care but who do not meet the requirement of two hours of direct critical care management on their first day in ICU, should be billed using the appropriate consultation and procedural item(s). Subsequent day, Day 2 rates are applicable.

(c) Where the patient requires critical care following uncomplicated elective surgery, the critical care fees may be billed by the critical care team utilizing Day 2 rates. The operating surgeon(s) may bill the critical care fee guide but the preceding major surgical procedure will be reduced to 75%.

(d) The critically ill patient, who, following elective surgery, has an unusual and unexpected problem, can be billed as Day 1. A note record is required.

Critically ill patients are occasionally transferred from one hospital to another. Under such circumstances the original intensive care team may bill for the day of the patient's transfer, if appropriate. First day rates would apply to the receiving intensive care team if more than two hours of bedside care are provided. This does not apply to intra-hospital transfers. Please also provide in a "note record" the statement that "patient transferred from _____ Hospital".

Physicians required to be in attendance during the transporting of a patient from a critical care area to an outside institution may claim the appropriate fee (e.g.: 00084).

These Critical Care listings only apply to physicians who are directly involved in the bedside care of patients as defined in the "Preamble to the Payment Schedule".

“C. 18. Guidelines for Payment for Services by Trainees, Residents and Fellows

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the supervising medical practitioner shall be identified to the patient at the earliest possible moment. No fees may be charged in the name of the supervising staff physician for services rendered by a trainee, resident or fellow prior to the identification taking place. Moreover, the supervising staff physician must be available in person, by telephone or videoconferencing in a timely manner appropriate to the acuity of the service being supervised.

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of trainees, residents, fellows or other members of the team, the total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of the other team members. For example:

a) If an anesthesiologist is supervising two rooms simultaneously, the anesthetic intensity/complexity units should only be billed for one of the two cases.

b) If a surgeon is operating in one room while his/her resident is operating in a second room, charges should only be made for the case the surgeon performs.

c) In psychotherapy where direct supervision by the staff physician may distort the psychotherapeutic milieu, the staff physician may claim for psychotherapy when a record of the psychotherapeutic interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff physician should not exceed the lesser of the time spent by the resident in the psychotherapeutic interview or the staff physician in the supervision of that interview.

d) For hospital visits and consultations rendered by the resident in the name of the staff physician, the staff physician should only charge for services on the days when actual supervision of that patient's care takes place through a physical visit to the patient by the staff physician and/or a chart review is conducted with detailed discussion with the other members of the health team within the next weekday workday.

e) The supervising physician may not bill for out-of-office hours premiums or continuing care surcharges unless he/she complies with the explanatory notes for out-of-office hours premiums in the Payment Schedule/Fee Guide and personally attends the patient.

f) In order to bill for a supervised service the physician must review in person, by telephone or videoconferencing the service being billed with the trainee, resident or fellow and have signed off within the next weekday workday on the ER record, hospital chart, office chart or some other auditable document.”

Out-Of-Office Hours Call-out charges and Surcharges and emergency visit fees are not payable in addition to this schedule, as historically, these fees are included in the critical care fees.

CRITICAL CARE

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Referred Cases

01400 Consultation: to consist of examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report (not for ICU patients) 322.21
Note: *Restricted to Critical Care physicians.*

01402 Repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee (not for ICU patients) 152.26
Note: *Restricted to Critical Care physicians.*

Continuing care by consultant:

01408 Subsequent hospital visit (not for patients in an ICU) 159.47
Note: *Restricted to Critical Care physicians.*

01469 Direction of care/end of life Assessment 247.51
Notes:
i) Restricted to Critical Care physicians who have not treated the patient in the previous seven days.
ii) This fee includes an examination, review of history, laboratory. X-ray findings necessary to write a report as well as any and all meetings with family and ICU team required to formulate and perform end-of-life and/or direction of care, e.g.: withdrawal of life-sustaining measures and filling out forms for comfort care orders.
iii) Patient must be in ICU with life threatening illness.
iv) Not intended for use for advance-care planning.
v) Limited to one assessment per patient per ICU admission.

Telehealth Service with Direct Interactive Video Link with the Patient:

01470 Telehealth Consultation: to consist of examination, review of history, laboratory,X-ray findings and additional visits necessary to render a written report (not for ICU patients) 322.21
Note: *Restricted to Critical Care physicians.*

01472 Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee (not for ICU patients) 152.26
Note: *Restricted to Critical Care physicians.*

Miscellaneous

P01450 Adult and Pediatric Critical Care 1st day modifier – extra 42.87
Notes:
i) Restricted to Critical Care physicians.
ii) Payable only in addition to 01411, 01412, or 01413 by the same practitioner.

01455 Adult and Pediatric Critical Care modifier (2nd day onward) – extra 7.26
Notes:
i) Restricted to Critical Care physicians.
ii) Payable only in addition to 01421, 01422, 01423, 01431, 01432, 01433, 01441, 01442, or 01443 by the same practitioner.

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Adult and Pediatric Critical Care

1. CRITICAL CARE – includes provision in an Intensive Care Area of all aspects of care of a critically ill patient excluding ventilatory support and includes initial consultation and assessment, family counselling, emergency resuscitation, intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, pressure infusion set and pharmacological agents, insertion of arterial C.V.P., Swan-Ganz or urinary catheters and nasogastric tubes, defibrillation, cardio version and usual resuscitative measures, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 1 hour of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in ICU's for example, routine post-op monitoring, or patients admitted for ECG monitoring or observation alone.

Physician-in-charge is the physician(s) daily providing the above.

01411	1st day	340.05
01421	2nd to 7th day (inclusive) per diem	170.52
01431	8th day to 30th day	117.75
01441	31st day onward	135.47

2. VENTILATORY SUPPORT - includes provision of ventilatory care including initial consultation and assessment of the patient, family counselling, cut-down, pressure infusion, insertion arterial & CVP, Swan-Ganz, tracheal toilet, endotracheal intubation, intravenous lines, artificial ventilation and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, end tidal CO_2, transcutaneous blood gas application and assessment and maximum inspiratory pressure monitoring and non-invasive metabolic measurements. There is an expectation of at least 1 hour of bedside care on Day 1. This is the fee to use when one physician is providing the ventilatory care and another physician, the critical care. This service may also be billed by a physician other than the operating surgeon or associate, for critical care required in addition to postoperative care by the surgeon.

Physician-in-charge is the physician(s) daily providing the above.

01412	1st day	294.96
01422	2nd to 7th day (inclusive) per diem	161.06
01432	8th day to 30th day	123.38
01442	31st day onward	110.89

3. COMPREHENSIVE CARE - These fees apply to intensive care physicians who provide complete care, both Critical Care and Ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment and subsequent examinations of the patient, family counselling, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, arterial and/or venous catheters, insertion of a Swan-Ganz catheter, pressure infusion sets and pharmacological agents, insertion of C.V.P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric tubes, securing and interpretation of blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 2 hours of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in the ICU's or patients admitted for ECG monitoring and observations.

Physician-in-charge is the physician(s) daily providing the above.

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01413	1st day	507.54
01423	2nd to 7th day (inclusive) per diem	256.61
01433	8th day to 30th day	142.11
01443	31st day onward	147.80

If ventilatory support only is provided, claims should then be made under Ventilatory Support. Comprehensive Care fees do not apply. Other physicians should then charge Critical Care fees, if applicable, or the appropriate consultation, visit or procedure fees.

Neonatal Intensive Care

These listings may be used for patients receiving neonatal intensive care and are intended for use by the Neonatologist or Pediatrician (or Team) in charge of the patient. These listings may be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment such as ventilatory support, haemodynamic support including vasoactive medications or prolonged resuscitation. They are to be billed only on sick or preterm infants requiring intensive care. They are also for infants who are more than 28 days old, who have neonatal problems related to prematurity, etc. These listings do not apply to non-ventilated stable patients admitted to a special care unit for routine post-op care. These fees are not for the infant who is stable and only requiring a period of observation. Neither are they for the infant who needs a short course of prophylactic antibiotics. It would be unusual to bill these fees on an infant whose period of care in the NICU lasted less than 48 hours Consultation and visit fees would be appropriate.

These neonatal intensive care fees only apply to physicians who are directly involved in the bedside care of patients in the Critical Care Areas. “Preamble to the Payment Schedule” applies:

“C. 18. Guidelines for Payment for Services by Trainees, Residents and Fellows

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the supervising medical practitioner shall be identified to the patient at the earliest possible moment. No fees may be charged in the name of the supervising staff physician for services rendered by a trainee, resident or fellow prior to the identification taking place. Moreover, the supervising staff physician must be available in person, by telephone or videoconferencing in a timely manner appropriate to the acuity of the service being supervised.

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of trainees, residents, fellows or other members of the team, the total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of the other team members. For example:

a) If an anesthesiologist is supervising two rooms simultaneously, the anesthetic intensity/complexity units should only be billed for one of the two cases.

b) If a surgeon is operating in one room while his/her resident is operating in a second room, charges should only be made for the case the surgeon performs.

c) In psychotherapy where direct supervision by the staff physician may distort the psychotherapeutic milieu, the staff physician may claim for psychotherapy when a record of the psychotherapeutic interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff physician should not exceed the lesser of the time spent by the resident in the psychotherapeutic interview or the staff physician in the supervision of that interview.

d) For hospital visits and consultations rendered by the resident in the name of the staff physician, the staff physician should only charge for services on the days when actual

supervision of that patient's care takes place through a physical visit to the patient by the staff physician and/or a chart review is conducted with detailed discussion with the other members of the health team within the next weekday workday.

e) The supervising physician may not bill for out-of-office hours premiums or continuing care surcharges unless he/she complies with the explanatory notes for out-of-office hours premiums in the Payment Schedule/Guide to Fees and personally attends the patient.

f) In order to bill for a supervised service the physician must review in person, by telephone or videoconferencing the service being billed with the trainee, resident or fellow and have signed off within the next weekday workday on the ER record, hospital chart, office chart or some other auditable document."

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included are: family counselling, emergency resuscitation, insertion of arterial, venous, Swan-Ganz, CVP or urinary catheters, intravenous lines, interpretation of blood gases, insertion of nasogastric tubes, infusion of pharmaceutical agents including TPN, endotracheal intubation and artificial ventilation and all other necessary respiratory support. Exchange transfusion is not included in these fees and not all infants requiring an exchange transfusion are critically ill.

Out-Of-Office Hours Call-out Charges may still apply for special calls back to the hospital and may be billed in conjunction with a no charge visit. If a patient is discharged from the unit for more than 48 hours and is readmitted, second day rates again apply. If the patient is re-admitted within 48 hours of discharge, billing continues under fee code billed at discharge, unless acuity level changes. If a patient changes acuity level up or down then the appropriate second day rate applies. A note record is required indicating the change in acuity level. Fee item 00505 (Emergency Visit) may not be billed by the person claiming these fees.

Call-out charges are billable with the neonatal critical care fee items. Historically, these have not been included in the neonatal fees and may be billed separately.

Members of the team billing the Neonatal Guide cannot be receiving other payments (e.g.: fees, alternative or sessional payments) for the clinical care of the patient.

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	LEVEL A - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all necessary procedures.	
01511	Day 1	636.75
01521	Day 2 - 10	254.68
01531	Day 11 onward	169.83
	LEVEL B - Infants in a Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive and requiring IV therapy or parenteral alimentation but without ventilator support.	
01512	Day 1	466.99
01522	Day 2 - 10	169.83
01532	Day 11 onward	126.18

		$
	LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.	
01513	Day 1	403.28
01523	Day 2 - 10	124.63
01533	Day 11 onward	104.16

EMERGENCY MEDICINE

Preamble

1) The following listings apply only to examinations rendered by the emergency physician designated by the medical staff who is on hospital Emergency Department duty and on-site. Other physicians (e.g.: on call) who choose to attend their patients in the Emergency Department but who are not the designated emergency physicians as defined above, shall not bill these listings but shall refer to other sections of the Payment Schedule for billing the appropriate examinations. The physicians working in hospital Emergency Departments that are covered on a call-in basis as opposed to an on-site basis shall not bill these listings but shall refer to the section of Family Medicine. Physicians working in diagnostic treatment centers or freestanding emergency clinics should also refer to the listings in the section of Family Medicine. Call-in fees (i.e. 00112) or call-out charges for patients seen in the Emergency Department are not applicable to emergency physicians while on duty and on-site in the hospital Emergency Department. These fees, in addition to continuing care non-operative surcharges, are only appropriate for the Emergency Physician providing on-call Trauma Team Leader Services.

2) Separate day, evening, night and weekend/statutory holiday listings are defined as follows:

Day fee items (01811, 01812, 01813):	0800 to 1800 hrs, weekdays
Evening fee items (01821, 01822, 01823):	1800 to 2300 hrs, weekdays
Night fee items (01831, 01832, 01833):	2300 to 0800 hrs
Saturday, Sunday or Statutory Holiday fee items (01841, 01842, 01843):	0800 to 2300 hrs

Time Care Starts:

Care starts when you pick up the chart and begin reviewing the patient's past history within the hospital's computer system or the information provided by the patient or other health care providers and subsequently document this review OR when you begin your interaction with the patient. Start time must be accurately entered on the claims and documented in the patient's chart, as this determines the correct time listings to submit.

The billing period time is NOT determined by:

- When the majority of care is provided
- When the patient checks in at Triage or is registered

Example:

If you start to see a patient at 07:58 hrs, this is a night fee item patient, (fee items are 01831, 01832 or 01833). If you see a patient at 17:57 hrs, this is either a day fee item patient (fee items are 01811, 01812 or 01813) or a weekend/statutory holiday fee item patient (fee items are 01841, 01842 or 01843). Times between patients should be reasonable for levels billed. For example, it is reasonable that you may see a patient and begin care at 07:58 and bill a night fee item for this care. It is not reasonable that you can initiate care on multiple patients in the two minutes preceding the change to a day (or lower) fee item.

3) Emergency Department visit listings are further categorized into three levels of complexity.

LEVEL I (01811, 01821, 01831, 01841)

Evaluation and treatment of a single and/or simple condition affecting a single body system, which requires:

- An abbreviated and/or focused documented history
- Review of relevant labs and/or X-rays
- Organization or guidance of any follow-up required

Examples of Level I:

- INR check
- Single joint injuries – ankle, foot, knee, shoulder or non-displace uncomplicated fractures
- Balanoposthitis
- Radial head subluxation
- Simple uncomplicated adult UTI, acute otitis externa or media
- Simple sore throat with the absence of systemic and/or lower respiratory tract symptoms
- Corneal abrasion, conjunctivitis
- Localized rash in the absence of systemic symptoms

These patients often do not require observation and/or reassessment nor do they present with features that are potentially serious and/or indicative of systemic disease.

Examples NOT Level I: which would require a more thorough evaluation and warrant Level II:

- Concussion
- Low impact head trauma on blood thinners
- Open fracture
- Acute glaucoma, retinal detachment, central artery occlusion
- Mastoiditis
- Localized and/or generalized rash with fever and/or systemic symptoms

However, medical complexity, socioeconomic factors, mental illness, behavioural actions of these patients that led to increased time and effort by the physician should be clearly documented if a Level II is billed for a patient that otherwise would have been a Level I.

LEVEL II (01812, 01822, 01832, 01842)

Pertains to the evaluation of a new or existing medical condition that necessitates:

- An appropriate detailed history and pertinent physical exam including documentation of at least two systems
- Review of labs, ECG & imaging where required
- Initiation of appropriate therapy
- Organization or guidance of any follow-up required
- Includes observation and/or reassessment of patients within 2 hours, but does not preclude another physician billing another level fee or resuscitation code with appropriate documentation if the patient deteriorates or a change in treatment is required and the initial billing physician is no longer available.

LEVEL III (01813, 01823, 01833, 01843)

Pertains to evaluation of patients with serious and/or complex medical problem(s) where the emergency condition necessitates a detailed history and appropriate physical examination by the emergency room physician. These patients may require prolonged observation, continuous therapy and/or multiple reassessments. Documentation of the findings shall include:

- The chief complaint(s)
- History of past and present illness
- Relevant personal, family and social history
- Physical examination with special attention to local examination relevant to the present complaint
- Review and interpretation of relevant laboratory, imaging and ECG studies
- Initiation of therapy provided
- Includes observation and/or reassessment of patients within 3 hours, but does not preclude another physician billing another level fee or resuscitation code with appropriate documentation if the patient deteriorates or a change in treatment is required and the initial billing physician is no longer available
- Discussion with the patient and/or family and/or family physician and/or specialist(s) including organization or guidance of any follow-up required

This level of care shall also pertain to the management of a life threatening illness/injury which requires immediate evaluation and emergent treatment by the emergency physician but does not meet the criteria of the Emergency Medicine Resuscitation fee and hence does not require constant care by the emergency physician.

4) If a patient that required Level I, II, or III care, after their initial work-up and/or treatment deteriorates, to the point of requiring active resuscitation they are also eligible for the Emergency Medicine Resuscitation fee item in addition to the initial level fee items.

5) **Emergency Medical Consultations:**

a. A specialist emergency medicine consultation (fee item 01810) only applies to certified emergency physicians either by the Royal College of Physicians and Surgeons of Canada (FRCPC) or the Canadian College of Family Physicians (CCFP-EM).

b. An emergency medicine consultation (billed as 01810) applies only when a patient is referred by another physician or nurse practitioner (other than an emergency physician or nurse practitioner within the same institution's department) who has seen and examined the patient and, because of the complexity, obscurity or seriousness of the problem, the referring physician or nurse practitioner has requested a consultation. Exception: If the consulting physician is an emergency physician who is a designated on-call Trauma Team Leader they may bill emergency medicine consultations if called in by the on-site emergency physician at the same institution.

c. An emergency medicine consultation shall include a detailed history and appropriate physical examination, review of previous medical records, discussion with family, friends or witnesses when appropriate, evaluation of appropriate laboratory, imaging and ECG findings and report of opinions and recommendations clearly documented and accessible by the referring physician.

d. A copy of the Emergency Department chart does not constitute a consultation report unless it is within the Electronic Medical Record and section c. above has been satisfied.

e. A consultation cannot be charged for the routine transfer of care to the emergency physician or for the provision of treatment for a stable medical condition.

f. A consultation does not apply in cases of self referral by patients who present themselves to the Emergency Department or are brought by persons acting on their behalf.

g. If a consultation is charged in addition to the Emergency Resuscitation fee, the consultation fee can be paid but shall constitute a half-hour of time spent with patient.

h. No service charges (i.e. call-out charges, non-operative surcharges) may be billed in addition to the emergency medicine consultation fee, except for Trauma Team Leaders, with a note record.

6) **Transfer of care:**

The transfer of care between emergency physicians at the change of shift shall not generate a new visit or consultation fee. However, in the event of a significant deterioration in a patient's status that medically requires both a new examination and/or modification of the treatment plan, then the appropriate visit fee item may be claimed. This does not preclude the second physician from billing a resuscitation code if the patient has declined to the point of requiring this type of care. The assessment and/or modification of the treatment plan must be documented in the medical record and the time of the intervention should be noted on the billing claims.

7) An appropriate level fee is billable in addition to a procedural fee whether the diagnostic code is the same or different. The greater fee is paid at 100% and the lesser fee(s) are paid at 50%.

EMERGENCY MEDICINE

The following listings cannot be correctly interpreted without reference to the Preambles.

		$	Anes. Level
01810	Emergency medicine consultation	130.28	
	Level I emergency care:		
01811	- day	36.78	
01821	- evening	43.13	
01831	- night	64.67	
01841	- Saturday, Sunday or Statutory Holiday	52.00	
	Level II emergency care:		
01812	- day	77.53	
01822	- evening	90.31	
01832	- night	127.80	
01842	- Saturday, Sunday or Statutory Holiday	108.00	
	Level III emergency care:		
01813	- day	98.07	
01823	- evening	112.47	
01833	- night	163.63	
01843	- Saturday, Sunday or Statutory Holiday	135.00	

Fractures:

01850 and 01851 can only be billed by the emergency physician working within the Emergency Department and requires documentation of the history including mechanism, focused physical exam and a discussion with patient (or guardian) about temporary immobilization for comfort and arranging orthopaedic follow up as required. Cannot be billed in addition to a visit or Emergency Medicine Level I, II, or III fee items. Must be performed in the Emergency Department (location code E).

01850	Clavicle	105.60	2
01851	Fibula - shaft or malleolus - not requiring reduction	91.34	

Dislocations:

Must be performed in the Emergency Department (location code E).

01860	Temporo-mandibular joint, dislocation – closed reduction	68.95	3
01861	Patella - closed reduction	66.05	2
01862	Toe - closed reduction	49.54	2

Resuscitation:

01870	Emergency Medicine Resuscitation fee: Treatment of acute life-threatening, limb organ saving emergency that requires constant bedside care – per 5 minutes or part thereof	27.70	

Notes:

i) Applicable only to emergency physicians designated by the medical staff who are on hospital Emergency Department duty and designated on-site. Not applicable to on call Emergency physicians. (see Emergency Medicine Preamble).

ii) Includes endotracheal intubation, cricothyrotomy, vascular access (including intraosseous), invasive monitoring, chest tube drainage, and pacemaker insertion and/or other procedures which are central to the resuscitation for

acute life-threatening, limb or organ saving emergencies.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

iv) If multiple patients are resuscitated, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed for each individual patient OR for concurrent services the majority of time may be claimed on one patient; while a minimum of one unit must be claimed on all other patients. No more than 12 units may be claimed within a 60 minute period.

v) When a consultation is charged in addition to the resuscitation fee, for billing purposes, the consultation shall constitute a half hour of the time spent with the patient. Start and end times for the consultation must also be entered in both the billing claims and the patient's chart.

vi) Emergency Level fees and other procedure fees not considered central to the resuscitation for acute life-threatening, limb or organ saving which are not included in Note ii), by the same practitioner on the same day are payable if not performed concurrently. Start and end times for these fees must also be entered in both the billing claims and the patient's chart.

vii) Out-of-office hours premiums are not applicable.

		$	Anes. Level
01871	Trauma Team Leader Resuscitation fee: Treatment of acute life-threatening, limb or organ saving emergency that requires constant bedside care – per 5 minutes or part thereof	27.70	

Notes:

i) Applicable only to Trauma Team Leaders on contract with a Health Authority to provide on call Trauma Team Leader Services and where the contract does not include provision of this service. Not applicable for General Surgery Trauma Team Leaders.

ii) Includes endotracheal intubation, cricothyrotomy, vascular access (including intraosseous), invasive monitoring, chest tube drainage, and pacemaker insertion and/or other procedures which are central to the resuscitation for acute life-threatening, limb or organ saving emergencies.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

iv) If multiple patients are resuscitated, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed for each individual patient OR for concurrent services the majority of time may be claimed on one patient; while a minimum of one unit must be claimed on all other patients. No more than 12 units may be claimed within a 60 minute period.

v) When a consultation is charged in addition to the resuscitation fee, for billing purposes, the consultation shall constitute a half hour of the time spent with the patient. Start and end times for the consultation must also be entered in both the billing claims and the patient's chart.

vi) Emergency Level fees and other procedure fees not considered central to the resuscitation for acute life-threatening, limb or organ saving which are not included in Note ii), by the same practitioner on the same day are payable if not performed concurrently. Start and end times for these fees must also be entered in both the billing claims and the patient's chart.

vii) Out-of-office hours premiums are applicable if physician is specially called to render emergency or non-elective services and only when the physician must travel from one location to another to attend the patient(s). Claims must be submitted with a note record.

FAMILY MEDICINE

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

Note: Cosmetic Surgery - Physicians should be familiar with the Guidelines for Cosmetic Surgery in the Preamble prior to referring patients for surgery for alteration of appearance. Where it is clear at the time of referral that the proposed surgery for alteration of appearance would not qualify for coverage under MSP, the consultation also would not be covered.

Note: Daily Volume Payment Rules Applying to Designated Office Codes

(i) The codes to which these rules apply are as follows:

Office visits: 12100, 00100, 15300, 16100, 17100, 18100
Office counselling: 12120, 00120, 15320, 16120, 17120, 18120
Office complete examinations: 12101, 00101, 15301, 16101, 17101, 18101

(ii) The total of all billings under the codes listed in i) that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. When such a daily total exceeds 50 the practitioner's payment on these codes for that day will be discounted. Moreover, when a daily total exceeds 65, a further payment discount will be made.

Daily Ranges *(for an individual practitioner for any single calendar day)*	**Discount Rate**	**Payment Rate**
0 to 50	0%	100%
51 to 65	50%	50%
66 and greater	100%	0%

(iii) Payment discounts will not be applied to services rendered in communities that are/were receiving NIA premiums as of December 15, 2002.

(iv) Payment discounts will not be applied to services designated by the physician as being the responsibility of ICBC, (designate by checking the MVA indicator on the claim), or services that are the responsibility of Worksafe BC.

(v) Services will be assessed and payment/discounts will be applied to services in the order in which they are received and accepted for payment by MSP.

Billing For In-Office and Out-of-Office Visits

The following definitions must be adhered to when preparing MSP billings for consultation, complete examination, office visit and individual counselling services (both in and out-of-office listing).

IN-OFFICE FEE ITEMS: 12110, 00110, 15310, 16110, 17110, 18110, 12100, 00100, 15300, 16100, 17100, 18100, 12101, 00101, 15301, 16101, 17101, 18101, 12120, 00120, 15320,16120, 17120, and 18120 apply to consultation, visit, complete examination and counselling services provided in offices, clinics, outpatient areas of hospitals, diagnostic treatment centers and similar locations.

OUT-OF-OFFICE FEE ITEMS: 12210, 13210, 15210, 16210, 17210, 18210, 12200, 13200, 15200, 16200, 17200, 18200, 12201, 13201, 15201, 16201, 17201, 18201, 12220, 13220, 15220, 16220, 17220, and 18220 apply to consultation, visit, complete examination and counselling services provided in either a patient's home, at the scene of an illness or accident, in a hospital

in-patient area, palliative care facility, long term care institution or in a hospital emergency department, unless the circumstance of the service is specifically covered by the definition of either fee item 00103, 00108, 00109, 13109, 00127, 00128, 13028, 00111, 00112, 00114, 00115, 00113, 00105, 00123, 13228 or one of the 01800 series.

WorkSafeBC and ICBC Services

In cases where a visit or procedure was occasioned by more than one condition, the dominant purpose must be related to an MVA or WorkSafeBC issue to code it as such. If medically necessary, an assessment of an unrelated condition can also be billed to MSP by Family Physicians.

		$	Anes. Level

Consultations

FP Consultations apply when a medical practitioner (FP or Specialist), or a health care practitioner (see General Preamble D. 2. 1.), in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a family physician competent to give advice in this field. A consultation must not be claimed unless it was specifically requested by the attending practitioner. The service consists of the initial services of the FP consultant, including a history and physical examination, review of x-rays and laboratory findings, necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring practitioner. Consultations will not apply if the referred patient has been attended by the consulting family physician or another family physician in the same group during the preceding six months.

12110	Consultation - in office: (age 0-1)	85.40
00110	Consultation - in office: (age 2 - 49)	77.63
15310	Consultation – in office (age 50 - 59)	85.40
16110	Consultation - in office: (age 60 - 69)	89.28
17110	Consultation - in office: (age 70 - 79)	100.91
18110	Consultation - in office: (age 80+)	116.11

00116 Special in-hospital consultation 164.96

Notes:

i) This item applies to consultations on in-hospital patients of an acute or extended care (or when the patient is in the ER with a complex problem as described below and a decision has been made to admit), who are referred to a family physician by a certified specialist (FRCP, FRCS or CCFP-EM) for advice about and/or the continuing care of complex problems for which the management is complicated and requires extra consideration. Examples of such problems include (but are not restricted to) the assessment of terminal illness, the planning of activation/rehabilitation programs and the management of patients with AIDS.

ii) This item is not applicable to the transfer of care in uncomplicated cases. It also will not apply if the referred patient has been attended by the consulting family physician or another family physician in the same group during the preceding six months.

12210	Consultation – out of office (age 0 – 1)	102.48
13210	Consultation – out of office (age 2 - 49)	93.16
15210	Consultation – out of office (age 50 - 59)	102.48
16210	Consultation – out of office (age 60 - 69)	107.14
17210	Consultation – out of office (age 70 - 79)	121.10
18210	Consultation – out of office (age 80+)	139.76

Complete Examinations

For any condition seen requiring a complete physical examination and detailed history (to include tonometry and biomicroscopy when performed).

Notes:

i) A complete physical examination shall include a complete detailed history and detailed physical examination of all parts and systems with special attention to local examination where clinically indicated, adequate recording of findings and if necessary, discussion with patient. The above should include complaints, history of present and past illness, family history, personal history, functional inquiry, physical examination, differential diagnosis, and provisional diagnosis.

ii) Routine or periodic physical examination (check-up) is not a benefit under MSP. This includes any associated diagnostic or laboratory procedures unless significant pathology is found. Advise the diagnostic or approved laboratory facility of patient's responsibility for payment.

iii) Complete examination fee codes are not to be charged for in-hospital admission examinations. Fee code 00109 or 13109 may apply in this circumstance. See Preamble and listing restrictions.

		$	Anes. Level
12101	Complete examination - in office (age 0-1)	76.83	
00101	Complete examination - in office (age 2-49)	69.85	
15301	Complete examination – in office (age 50 – 59)	76.83	
16101	Complete examination - in office (age 60-69)	80.32	
17101	Complete examination - in office (age 70-79)	90.80	
18101	Complete examination - in office (age 80+)	104.79	

Note: *Items 12101, 00101, 15301, 16101, 17101 and 18101 are subject to the daily volume payment rules described earlier in this section.*

12201	Complete examination - out of office (age 0-1)	92.20	
13201	Complete examination - out of office (age 2-49)	83.82	
15201	Complete examination - out of office (age 50-59)	92.20	
16201	Complete examination - out of office (age 60-69)	96.39	
17201	Complete examination - out of office (age 70-79)	108.95	
18201	Complete examination - out of office (age 80+)	125.74	

Visits

For any condition(s) requiring partial or regional examination and history - includes both initial and subsequent examination for same or related condition(s).

Note*: Visit fee codes are not to be charged for in-hospital admission examinations. Fee code 00109 or 13109 may apply in this circumstance. See Preamble and listing restrictions.*

12100	Visit - in office (age 0-1)	34.90
00100	Visit - in office (age 2-49)	31.72
15300	Visit – in office (age 50-59)	34.90
16100	Visit - in office (age 60-69)	36.47
17100	Visit - in office (age 70-79)	41.22
18100	Visit - in office (age 80+)	47.59

Note: *Fee items 12100, 00100,15300, 16100, 17100, and 18100 are subject to the daily volume payment rules described earlier in this section.*

13070	In office assessment of an unrelated condition(s) in association with a WorkSafe BC service	16.49

Notes:

i) Paid only when services are provided for an unrelated illness occurring in conjunction with a WorkSafeBC insured service.

ii) Unrelated service must be initiated by patient.

iii) The unrelated condition(s) must justify a stand-alone visit.

iv) Only paid once per patient per day, per insurer, and includes all other unrelated problems.

v) Not paid if a procedure for the same or related condition is paid for same patient on same day, same practitioner.

vi) The visit for each payer must be fully and adequately documented in chart.

vii) Paid only to Family Physicians.

		$	Anes. Level
13075	In office assessment of an unrelated condition(s) in association with an ICBC service	16.49	

Notes:

i) Paid only when services are provided for an unrelated illness occurring in conjunction with an ICBC insured service.
ii) Unrelated service must be initiated by patient.
iii) The unrelated condition(s) must justify a stand-alone visit.
iv) Only paid once per patient per day, per insurer, and includes all other unrelated problems.
v) Not paid if a procedure for the same or related condition is paid for same patient on same day, same practitioner.
vi) The visit for each payer must be fully and adequately documented in chart.
vii) Paid only to Family Physicians.

12200	Visit - out of office (age 0-1)	41.87
13200	Visit - out of office (age 2-49)	38.07
15200	Visit – out of office (age 50-59)	41.87
16200	Visit - out of office (age 60-69)	43.87
17200	Visit - out of office (age 70-79)	49.48
18200	Visit - out of office (age 80+)	57.09

***Note**: For fee items 12200, 13200, 15200, 16200, 17200 and 18200, see notes following fee item 00108.*

Family Medicine Group Medical Visit

A Group Medical Visit provides medical care in a group setting. A requirement of a GMV is a 1:1 interaction between each patient and the attending physician. While portions of the GMV may be delegated to other allied health providers, the physician must be physically present at the GMV for the majority of each time interval billed and assumes clinical responsibility for the patients in attendance. Because this is a time based fee, concurrent billing for other services during the time intervals billed for GMV is not permitted.

Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction. Physicians can also benefit by reducing the need to repeat the same information many times and free up time for other patients. Appropriate patient privacy is always maintained and typically these benefits result in improved satisfaction for both patients and physicians.

The Group Medical Visit is not appropriate for advice relating to a single patient. It applies only when all members of the group are receiving medically required treatment (i.e. each member of the group is a patient). Family Medicine Group Medical Visits are not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns other than in the context of the individual medical condition.

Fee per patient, per 1/2 hour or major portion thereof:

13763	Three patients	25.95
13764	Four patients	20.95
13765	Five patients	18.01
13766	Six patients	16.03
13767	Seven patients	14.62
13768	Eight patients	13.57
13769	Nine patients	12.71
13770	Ten patients	12.06
13771	Eleven patients	10.56

13772	Twelve patients	9.93
13773	Thirteen patients	9.20
13774	Fourteen patients	9.03
13775	Fifteen patients	8.66
13776	Sixteen patients	8.41
13777	Seventeen patients	8.06
13778	Eighteen patients	7.88
13779	Nineteen patients	7.60
13780	Twenty patients	7.41
13781	Greater than 20 patients (per patient)	7.14

Notes:

i) A separate claim must be submitted for each patient.

ii) When a patient attends a group visit, it should be noted in his or her chart, along with the start and end times.

iii) A separate file should be maintained which documents all participants in each group visit.

iv) Claim must include start and end times.

v) Not payable to physicians working under salary, service contract or sessional arrangements, and whose duties would otherwise include provision of care.

vi) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per patient per day.

vii) Where group medical visits with a patient extend beyond two and one-half (2 ½) hours in any seven (7) day period, a note-record is required.

viii) Service is not payable with other consultation, visit or complete examination services, for the same patient, on the same day.

ix) Concurrent billings for any other MSP services for any patient during the time interval for which the GMV fee is billed will not be paid.

x) Where two physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate per patient for the reduced group size. Each claim should indicate "Group medical visit" and also identify the other physician.

Counselling - Individual

For a prolonged visit for counselling (minimum time per visit – 20 minutes)

Notes:

i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) per patient per year (see Preamble D. 3. 3.)

ii) Start and end time must be entered in both the billing claims and patient's chart.

iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

		$	Anes. Level
12120	Individual counselling - in office (age 0-1)	62.43	
00120	Individual counselling - in office (age 2-49)	56.76	
15320	Individual counselling – in office (age 50-59)	62.43	
16120	Individual counselling - in office (age 60-69)	65.26	
17120	Individual counselling - in office (age 70-79)	73.77	
18120	Individual counselling - in office (age 80+)	85.12	

Note: *Items 12120, 00120, 15320, 16120, 17120 and 18120 are subject to the daily volume payment rules described earlier in this section.*

12220	Individual counselling - out of office (age 0-1)	74.90	
13220	Individual counselling - out of office (age 2-49)	68.09	
15220	Individual counselling – out of office (age 50 – 59)	74.90	
16220	Individual counselling - out of office (age 60-69)	78.31	
17220	Individual counselling - out of office (age 70-79)	88.54	
18220	Individual counselling - out of office (age 80+)	102.15	

Counselling - Group

For groups of two or more patients.

00121	- first full hour	160.99	
00122	- second hour, per 1/2 hour or major portion thereof	80.50	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

<u>Telehealth Service with Direct Interactive Video Link with the Patient:</u>

These fee items cannot be interpreted without reference to the Preamble D. 1.

In-Office

P13036	Telehealth GP in-office Consultation	82.43	
P13037	Telehealth GP in-office Visit	34.44	
P13038	Telehealth GP in-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes)	58.90	

Notes:

i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) per patient per year (see Preamble D. 3. 3.)

ii) Start and end time must be entered into both the billing claims and patient's chart.

iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

		$	Anes. Level
	Telehealth FP in-office Group Counselling For groups of two or more patients		
P13041	- First full hour	86.94	
P13042	- Second hour, per ½ hour or major portion thereof	43.50	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Out-of-Office

For the billing of the GP Telehealth out-of-office fees 13016, 13017, 13018, 13021 and 13022, out-of-office shall mean that the physician providing the service is physically present in a Health Authority approved facility. The name of the facility and the results of the Telehealth service must be recorded in the patient chart.

P13016	Telehealth GP out-of-office Consultation	109.02	
P13017	Telehealth GP out-of-office Visit	41.10	
P13018	Telehealth GP out-of-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes)	75.32	

Notes:

i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) per patient per year (see Preamble D. 3. 3.)

ii) Start and end time must be entered into both the billing claims and patient's chart.

iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

	Telehealth FP out-of-office Group Counselling For groups of two or more patients		
P13021	- First full hour	87.46	
P13022	- Second hour, per ½ hour or major portion thereof	43.76	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

13020	Telehealth Family Physician Assistant – Physical Assessment as requested by receiving specialist: - for each 15 minutes or major portion thereof	43.23	

Notes:

i) Applicable only if the family physician is required at the referring end to assist with essential physical assessment, without which the specialist service would be ineffective.

ii) Applies only to period spent during consultation with specialist.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

Substance Use Disorder Care

13013	Assessment for Induction of Opioid Agonist Treatment (OAT) for Opioid Use Disorder Initial assessment requires complete medical history, substance use history and appropriate targeted physical examination. If assessment and induction are done on the same day, withdrawal assessment using COWS or SOWS and administration of first dose of OAT included – per 15 minutes or greater portion thereof	43.23	

Notes:

i) Payable to a maximum of 4 units per patient/per day/per intended induction.

ii) Payable only to the physician who intends to provide or share management of the patient's OAT induction for opioid use disorder.
iii) Start and end times must be entered in both the billing claim and the patient's chart.
iv) No other visit fees billable same day except 13014, 14018 and 14077. 13014, 14018 and 14077 payable in addition to 13013 only when not performed concurrently.
v) Payable for assessment for change of OAT with induction to a different medication.
vi) May not be repeated within 30 days by the same physician.
vii) This service payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day).

		$	Anes. Level
13014	Management of OAT Induction for Opioid Use Disorder This fee is payable for individual interactions with the patient during the first three days of OAT induction for opioid use disorder within the limits described in the following notes	20.21	

Notes:
i) Billable in addition to 13013 or a same day visit fee (in-person, telephone or video conference) with a physician when not performed concurrently.
ii) Billable up to 3 times on day of first dose of OAT.
iii) Billable up to 2 times on day 2 of OAT induction.
iv) Billable once only on day 3 of OAT induction.
v) May be provided in-person, by telephone, or by video conference.
vi) May be billed when delegated to a nurse (LPN, RN, NP) employed within the eligible physician practice.
vii) Start time must be entered in both the billing claim and patient's chart.

00039	Management of Maintenance Opioid Agonist Treatment (OAT) for Opioid Use Disorder	23.67	
	Management of ongoing maintenance Opioid Agonist Treatment for Opioid Use Disorder		

Notes:
i) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.
ii) 00039 is the only fee payable for any medically necessary service associated with maintenance opioid agonist treatment for opioid use disorder. This includes but is not limited to the following:
a) At least one visit (in-person, telephone or video conference) per month with the patient after induction/stabilization on opioid agonist treatment is complete.
b) At least one in-person visit with the patient every 90 days. Exceptions to this criterion will be considered on an individual basis.
c) Supervised urine drug screening and interpretation of results.
d) Simple advice/communication with other allied care providers involved in the patients OAT.
iii) Claims for treatment of co-morbid medical conditions, including psychiatric diagnoses other than substance use disorder, are billable using the applicable visit of service fees. Counselling and visit fees related only to substance use disorder are not payable in addition.
iv) This fee is payable once per week per patient regardless of the number of services per week for management of OAT maintenance.
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 are actively supervising the patient's continuing use of opioid agonist medications for treatment of opioid use disorder.
vii) This payment stops when the patient stops opioid agonist treatment.

		$	Anes. Level
15039	FP Point of Care (POC) testing for opioid agonist treatment	12.89	

Notes:

i) Restricted to patients in opioid agonist treatment.
ii) Maximum billable: 26 per annum, per patient.
iii) 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 is in treatment for opioid use disorder. Accordingly, confirmatory testing should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management.
iv) This fee includes the adulteration test.
v) Only POC urine testing kits that have met Health Canada Standards are to be used.

15040 FP Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone 12.89

Notes:

i) Not billable for patients in opioid agonist treatment.
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.

Miscellaneous Visits

13501 MAiD Assessment Fee – Assessor Prescriber
Includes all requirements of a MAiD assessment, including review of medical records, patient encounter and completion of the MAiD Assessment Record (Prescriber). The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof 43.24

Notes:

i) Maximum payable is 135 minutes (9 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.
ii) Start and end time for the assessment must be entered in both the billing claim and patient's chart.
iii) Additionally, start and end time for the patient encounter must be entered in the patient's chart.
iv) Only one service for 13501 or 13502 may be performed by video conference.

13502 MAiD Assessment Fee – Assessor
Includes all requirements of a MAiD assessment, including review of medical records, patient encounter and completion of the MAiD Assessment Record (Assessor). The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof 43.24

Notes:

i) Maximum payable is 105 minutes (7 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.
ii) Start and end time for the assessment must be entered in both the billing claim and patient's chart.
iii) Additionally, start and end time for the patient encounter must be entered in the patient's chart.

iv) Not payable with 13501 by same physician.
v) Only one service for 13501 or 13502 may be performed by video conference.

		$	Anes. Level
13503	Physician witness to video conference MAiD Assessment – Patient Encounter Physician must be in personal attendance with the patient for the duration of the patient encounter with the Assessor or Assessor Prescriber. Billable only for time spent witnessing the patient – Assessor encounter. Includes completion of any required documentation – per 15 minutes or greater portion thereof	43.24	

Notes:
i) Maximum payable is 105 minutes (7 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.
ii) Start and end time for the witnessed encounter must be entered in both the billing claim and patient's chart.
iii) Not payable with 13501 or 13502 by same physician.

13504	MAiD Event Preparation and Procedure	283.85	

Notes:
i) Payable only to Assessor Prescriber.
ii) Includes all necessary elements: establishment of IV, administration of meds, pronouncement of death.
iii) Includes pharmacy visits for procedures provided in facilities with on-site pharmacies.
iv) Fee 13505 billable in addition for procedures provided in facilities with no on-site pharmacy.
v) A same day visit fee is payable in full in addition under fee item 00103 (home) or out of office visit fee items 12200, 13200, 15200, 16200, 17200, and 18200 (all other locations). Fee items 00108, 13008, 00127 and 00114 are not payable.

13505	MAiD Medication Pick-up and Return	126.72	

Notes:
i) Paid only in addition to 13504.
ii) Payable only when MAiD procedure takes place in a location where there is no on-site pharmacy.
iii) Not payable when time for medication pick-up and return has been compensated under a different payment modality.

13015	HIV/AIDS Primary Care Management – in or out of office - per half hour or major portion thereof	85.95	

Notes:
i) When performed in conjunction with visit, counselling, consultations or complete examinations, only the larger fee is billable.
ii) Only applicable to services submitted under diagnostic codes 042, 043 and 044.
iii) Services that are less than 15 minutes duration should be billed under the appropriate visit fee item.
iv) Start and end times must be entered in both the billing claims and the patient's chart.

Home Visits

00103	Home visit (service rendered between 0800 and 2300 hours – any day) - any day	116.09	

Note: *Additional patients seen during same house call are to be billed under the applicable out of office visit fee items (12200, 13200, 15200, 16200, 17200, 18200)*

		$	Anes. Level

FP Facility Visit Fees

Please read the entire facility listings as some visits are restricted to community based FP's with active or associate/courtesy hospital privileges.

00109 Acute care hospital admission examination 81.61

Notes:

i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a FP with active hospital privileges. It is not applicable when a patient has been admitted for surgery or for "continuing care" by a certified specialist.

ii) This item is intended to apply in lieu of fee item 00108 on the first in-patient day, for that patient.

iii) Fee item 00109 is not applicable if fee item 12101, 00101, 15301, 16101,17101, 18101, 12201, 13201, 15201, 16201, 17201, or 18201 has been billed by the same physician within the week preceding the patient's admission.

iv) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108. The claim must include the time of each visit and a statement of need included in a note record.

v) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

vii) Limit of one hospital admission (00109 or 13109) payable per patient per hospitalization.

00108 Hospital visit..... 31.93

Notes:

i) Billable by FP's with active hospital privileges for daily attendance on the patients they have most responsibility for.

ii) Essential emergent or non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108. The claim must include the time of each visit and a statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record. This note is not applicable to hospitalists.

00128 Supportive care hospital visit..... 27.52

Notes:

i) Referring physician may charge one supportive care hospital visit for each day hospitalized during the first ten days of hospitalization and thereafter one visit for every seven days hospitalized (Preamble D. 4. 7.).

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

		$	Anes. Level
00127	Palliative care patient facility visit	54.20	

Notes:

i) This item is applicable to the visits for palliative care delivered to patients with any life-limiting illness with life expectancy of up to 6 months, when the focus of care is palliative rather than treatment aimed at cure. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.

ii) This item may be billed for necessary visits rendered for a period not to exceed 180 days prior to death and is applicable to patients in an acute care hospital, nursing home or palliative care patient facility, whether or not the patient is in a palliative care unit. Under extenuating circumstances, for visits that exceed 180 days, a note record must be submitted.

iii) Palliative care patient visit fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

iv) The chemotherapy listings (33581, 33582, 33583, 00578, 00579, and 00580) may not be billed when palliative care patient facility visit fees are being billed.

v) Essential non-emergent additional palliative care patient facility visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00127. The claim must include the time of each visit and a statement of need included in a note record.

vi) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent palliative care patient facility visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

Community Based FP Hospital Visits

The following eligibility rules apply to all community based FP hospital visit fees.

Physician Eligibility:

- Payable only to FPs who maintain an active family practice in the community, accepting the role of being Most Responsible Physician (MRP) for the longitudinal coordinated care of their patients.
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months.
- Not payable to physicians who are employed by, or who are under contract, whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

		$	Anes. Level

Community Based FP with Active Hospital Privileges

Active privileges signify the physician has the authority to write orders, whereas courtesy/associate privileges permit the FP to write progress notes in charts, but not orders.

13109 Community based FP: Acute care hospital admission examination 103.16

Notes:

i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a community based FP with active hospital privileges. It is not applicable when a patient has been admitted for surgery or for "continuing care" by a certified specialist.

ii) This item is intended to apply in lieu of fee item 13008 on the first in-patient day, for that patient.

iii) Fee item 13109 is not applicable if fee item 12101, 00101, 15301, 16101, 17101, 18101, 12201, 13201, 15201, 16201, 17201, or 18201 has been billed by the same physician within the week preceding the patient's admission.

iv) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 13008. The claim must include the time of each visit and a statement of need included in a note record.

v) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

vi) Limit of one hospital admission (00109 or 13109) payable per patient per hospitalization.

13338 Community based FP, first facility visit of the day bonus, extra (active hospital privileges) (for routine, supportive or palliative care).....49.84

Notes:

i) Paid only if 13008, 13028, 00127 paid the same day.

ii) Limit of one payable for the same physician, same day, regardless of the number of facilities attended.

iii) Not payable same day for same physician as 13339.

13008 Community based FP: hospital visit (active hospital privileges).....54.20

Notes:

i) Additional visits are not payable on same day to same physician for the same patient, except as set out in the notes ii) and iii).

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included a note record.

iii) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

		$	Anes. Level
13028	Community based FP: supportive care hospital visit (active hospital privileges)	36.01	

Notes:

i) Referring physician may charge one hospital visit for each day hospitalized during the first ten days of hospitalization and thereafter one visit for every seven days hospitalized (Preamble D. 4. 7). A written record of the visit must appear in either the patient's hospital or office chart.

ii) Essential non-emergent additional visits to a hospitalized patient by the physician providing supportive care for diagnosis unrelated to the admission diagnosis, during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

13011	Hospital at Home Visit	64.64	

Notes:

i) Payable only for patients admitted for care under the Hospital at Home program.

ii) Additional visits are not payable on same day to same physician for the same patient, except as set out in the notes iii) and iv).

iii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 13011. The claim must include the time of each visit and a statement of need included a note record.

iv) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in the note record.

v) Call-out charges apply under fee items 01200, 01201, 01202 only when the physician is specially called to render emergency or non-elective services and only when the physician must travel from one location to another to attend the patient and may include continuing care fee charges 01205, 01206, 01207 if applicable.

13012	Hospital at Home FP Conference with Allied Care Provider and/or Physician – per 15 minutes or greater portion thereof	43.23	

Notes:

i) Payable only for patients admitted for care under the Hospital at Home program.

ii) Payable for two-way collaborative conferencing, either by telephone, videoconferencing or in-person, between the Family Physician and an allied care provider and/or a physician.

iii) Conferencing cannot be delegated. No claim may be made where communication is with a proxy for either provider.

iv) Details of care conference must be documented in the patient's chart as well as information on clinical discussion and decisions made.

v) Not payable for simple advice to a non-physician allied care provider about the patient or where the primary purpose of the call is to:

a. Book an appointment
b. Arrange for an expedited consultation or procedure
c. Arrange for laboratory or diagnostic investigations
d. Convey the results of diagnostic investigations
e. Arrange a hospital bed for a patient.

vi) Payable in addition to any visit fee on the same day if medically required and does not take place during a time interval that overlaps with the patient conference (i.e. Visit time is separate from conference time).
vii) Payable to a maximum of 2 units (30 minutes) per patient on any single day.
viii) If multiple patients are discussed, the billings must be for consecutive, non-overlapping time periods.
ix) Start and end times must be included with the claim and documented in the patient chart. If conferencing takes place as a series of separate phone calls, use the start time of the first call and calculate the "end time" based on total time spent conferencing.
x) Not payable in addition to PG14018 or PG14077 on same day to same physician for the same patient.
xi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

		$	Anes. Level

Community Based FP with Courtesy or Associate Hospital Privileges

13339 Community based FP, first facility visit of the day bonus, extra, (courtesy/associate privileges) 49.84

Notes:
i) Only payable if 13228 paid the same day.
ii) Limit of one payable for the same physician, same day, regardless of the number of facilities attended.
iii) Not payable same day for same physician as 13338.

13228 Community based FP: hospital visit (courtesy/associate privileges)..... 30.09

Notes:
i) Payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.
ii) Payable for patients in acute, sub-acute care or palliative care.
iii) Not payable with any other visit fee including 00108, 13008, 00109, 13109, 00114, 00115, 00113, 00105, 00123, 00127, 12200, 13200, 15200, 16200, 17200, 18200, 12201, 13201, 15201, 16201, 17201, 18201, 00128, 13028, 13015, 12220, 13220, 15220, 16220, 17220, 18220, 00121, 00122, 12210, 13210, 15210, 16210, 17210, 18210, 00116, 00112, 00111.
iv) If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable.
v) A written record of the visit must appear in either patient's hospital or office chart.
vi) If a hospitalist or FP member of an Unassigned In-Patient Care Network, is providing FP care to the patient, the community based FP with courtesy or associate hospital privileges may bill 13228.
vii) Note vi) also applies to Community based FPs with active hospital privileges at a hospital other than the one to which the patient is admitted.

		$	Anes. Level

On-call On-site Hospital Visits

These listings should be used when a physician, located in the hospital or Emergency Department, is called to see a patient in either the Emergency Department or elsewhere in the hospital.

00113	Evening (between 1800 hours and 2300 hours)	51.93	
00105	Night (between 2300 hours and 0800 hours)	72.17	
00123	Saturday, Sunday or Statutory Holiday	51.93	

Note: *For services rendered between 0800 hours and 1800 hours weekdays bill appropriate visit or procedure fee. Out-of-office hours premiums are not chargeable in addition to emergency department fees. Claim must state time call placed.*

Long-Term Care Facility Visits

00114	One or multiple patients, per patient	36.54	
13334	Community based FP, long term care facility visit - first visit of the day bonus, extra	49.84	

Notes:

i) Paid only if 00114 paid the same day.

ii) Limit of one payable for the same physician, same day, regardless of the number of long term care facilities attended.

00115	Nursing home visit – one patient, when specially called and patient seen between hours of 0800 hrs and 2300 hrs – any day. The visit must take place within 24 hours of receiving the request from the Nursing home.	116.45	

(*See Preamble Clause D. 4. 9., for long-stay patients).*

Emergency Visits

00112	Emergency visit (call placed between hours of 0800 and 1800 hours) – weekdays	116.09	

Notes:

i) This item to be charged only when one must immediately leave home, office, or hospital to render immediate care. Call to hospital emergency department while at hospital, bill under appropriate on-call on-site hospital visit listings or procedure.

ii) Claim must state time service rendered.

The following are examples of situations explaining when it would be appropriate to bill under fee item 00112:

Example 1: *Physician is called by patient with non-urgent condition. Physician agrees to meet the patient later in the day at the hospital.*

Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

Example 2*: Physician is called to assess a patient at the hospital. Due to the urgent nature of the patient's condition, the physician must leave his/her office immediately.*

Fee item 00112 is applicable, as all the criteria are met.

Example 3*: Physician is visiting patients at the hospital during the daytime. She/he is called to attend a patient in the emergency ward. Due to the urgent nature of the patient's condition, the physician must attend the patient immediately.*

Fee item 00112 is not applicable, as the physician remained at the same site.

***Example 4**: The physician is called at home regarding a patient. She/he asks the patient to meet him/her at the office later in the day for assessment.*

Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

		$	Anes. Level
00111	An emergency home (or scene of accident) visit for an acutely ill or injured patient immediately followed by a trip to hospital to arrange for emergency admission and to include immediate associated hospital visit	117.46	

Telephone Advice

13000 Telephone advice to a Community Health Representative in First Nation's Communities 18.28

Notes:

i) Applicable only to medically required calls to physician for medical advice initiated by and provided to Community Health Representative.

ii) Not billable if a Community Health Nurse is available in the Community.

13005 Advice about a patient in Community Care 18.28

Notes:

i) This fee may be claimed for advice by telephone, fax or in written form about a patient in community care in response to an enquiry initiated by an allied care provider specifically assigned to the care of the patient.

ii) Community Care comprises long-term care facilities (such as nursing homes, intermediate care, extended care, rehabilitation, chronic care, or convalescent care) as well as patients receiving home nursing care, home support or palliative care at home.

iii) Allied care providers are trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: nurses, nurse practitioners, mental health workers, midwives, psychologists, clinical counsellors, school counsellors, social workers, registered dieticians, physiotherapists, occupational therapists, and pharmacists. Not all allied care providers are College-certified.

iv) Claims should be submitted under the personal health number of the patient and should indicate the time of day the request for advice was received.

v) Dates of services under this item should be documented in the patient's record together with the name and position of the enquiring allied health care worker and a brief notation of the advice given. Alternatively the original of a fax or a copy of written advice will suffice to document these services.

vi) This fee may not be claimed in addition to visits or other services provided on the same day by the same physician for the same patient with the exception of 14076.

vii) This fee may be billed to a maximum of one per patient per physician per day.

viii) This fee may not be claimed for advice in response to enquiries from a patient or their family.

ix) Not payable to physicians who are employed by or who are under contract to a facility, working under salary, service contract or sessional arrangements whether on duty or on call when these duties would otherwise include provision of this care.

Obstetrical Care

14090 FP Prenatal visit - complete examination 86.94

14091 FP Prenatal visit - subsequent examination 37.20

Notes:

i) Restricted to Family Physicians

ii) Uncomplicated prenatal care usually includes a complete examination followed by monthly visits to 32 weeks, then visits every second week to 36 weeks, and weekly visits thereafter to delivery. In complicated pregnancies, charges for additional visits will be given independent consideration upon explanation.

iii) Where a patient transfers their total ongoing uncomplicated prenatal care to another physician, the second physician also may charge a prenatal visit complete examination and subsequent examinations, as rendered. To facilitate payment the reason for transfer should be stated with the claim. Temporary substitution of one physician for another during days off, annual vacation, etc. should not be considered as a patient transfer.

iv) Other than during prenatal or postnatal visits, it is proper to charge separately for all visits (including counselling) for conditions unrelated to the pregnancy, under appropriate fee items listed elsewhere. The reason for the charges should be clearly spelled out when submitting claim.

v) Other than procedures, services for the care of unrelated conditions, during a prenatal or postnatal visit are included in the prenatal (14091) or postnatal visit fee (14094). Procedures rendered for unrelated conditions are chargeable as set out in Preamble D. 8. d.

		$	Anes. Level
14094	FP Postnatal office visit	37.20	

Notes:

i) Restricted to Family Physicians

ii) 14094 may be billed in the six weeks following delivery (vaginal or caesarean section).

iii) Not payable to the physician performing caesarean section.

14199	Management of prolonged second stage of labour, per 30 minutes or major portion thereof.	85.47	

Notes:

i) This item is billable in addition to the delivery fee only when the second stage of labour exceeds two hours in length.

ii) Not payable with 04000, 04014, 04017, 04018, or 04085.

iii) Timing ends when constant personal attendance ends, or at the time of delivery.

iv) Start and end times must be entered in both the billing claims and the patient's chart.

14104	Delivery and postnatal care (1-14 days in-hospital)	588.41	

Notes:

i) Care of newborn in hospital (see item 00119).

ii) Repair of cervix is not included in fee item14104. Charge 50% of listed fee when done on same day as delivery.

iii) When medically necessary additional post-partum office visit(s) are payable under fee item 14094 or 04194.

14105	Management of labour and transfer to higher level of care facility for delivery	245.04	

Notes:

i) This fee includes all usual hospital care associated with the confinement and provided by the referring physician.

ii) May be claimed by the referring physician when the referring physician intended to conduct the delivery providing the following conditions are met:

a) The referring physician attended the patient during active labour and provided assessment of the progress of labour, both initial and on-going.

b) Active labour is defined as:"regular painful contractions, occurring at least once in five minutes, lasting at least 40 seconds, accompanied by either spontaneous rupture of the membranes, or full cervical effacement and dilatation of at least two centimeters."

c) There is a documented complication warranting the referral such as foetal distress or dysfunctional labour (failure to progress).

d) Where the referring physician must transfer the patient to another facility.

iii) Not payable with assessment or visit fee or 14104, 14109 and generally 14199 (provide details if claiming for 14199 in addition).

iv) OOOHP Continuing Care Surcharges do not apply to maternity services in the first stage of labour only.

v) When medically necessary additional post-partum office visit (s) are payable under fee item 14094 or 04194

		$	Anes. Level
14108	Postnatal care after elective caesarean section(1-14 days in-hospital) ***Note***: *When medically necessary additional post-partum office visit(s) are payable under fee item 14094 or 04194*	121.06	
14109	Primary management of labour and attendance at delivery and postnatal care associated with emergency caesarean section (1-14 days in-hospital) ***Notes***: *i) Surgical assistant is extra to fee items 14108 and 14109.* *ii) When medically necessary additional post-partum office visit(s) are payable under fee item 14094 or 04194*	490.12	
14545	Medical abortion ***Note:*** *Includes all associated services rendered on the same day as the abortion, including the consultation whenever rendered, required components of Rh factor, associated services including counselling rendered on the day of the procedure, and any medically necessary clinical imaging.*	165.47	
15120	Pregnancy test, immunologic - urine	11.72	

Infant Care

00118	Attendance at caesarian section (if specifically requested by surgeon for care of baby only) ***Note:*** *Not payable if a pediatrician is present at the caesarean section to care for the baby.*	91.09	
00119	Routine care of newborn in hospital	93.11	

Gynecology

14540	Insertion of intrauterine contraceptive device (operation only) ***Note****: Includes Pap smear if required.*	43.28	2
14541	Removal of intrauterine device (IUD) -operation only ***Note****: Not payable with a pap smear (14560) or IUD insertion (14540).*	31.72	
14560	Routine pelvic examination including Papanicolaou smear (no charge when done as a pre and postnatal service) ***Note:*** *Services billed under this code must include both a pelvic examination and Pap smear.*	31.72	
P14542	Insertion of subdermal contraceptive implant	51.92	
P14543	Removal of subdermal contraceptive implant	66.35	

Urology

Y13655	FP vasectomy bonus associated with bilateral vasectomy ***Notes***: *i) Restricted to Family Physicians.* *ii) Maximum of 25 bonuses per calendar year per physician.* *iii) Payable only when fee item S08345 billed in conjunction.* *iv) Maximum of one bonus per vasectomy per patient.*	21.57	

		$	Anes. Level

Surgical Assistance

13194	First Surgical Assist of the Day	89.09	

Notes:

i) Restricted to Family Physicians.

ii) Maximum, of one per day per physician, payable in addition to 00195,00196, 00197 or 00193.

Total operative fee(s) for procedure(s):

00195	- less than $317.00 inclusive	134.22	
00196	- $317.01 to 529.00 inclusive	189.24	
00197	- over $529.00	261.76	
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	28.52	

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 anesthesic, 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.

Open Heart Surgery:

00193	Non-CVT-certified surgical assistance at open-heart surgery, per quarter hour or major portion thereof	30.89	

Notes:

i) The same fee applies equally to all assistants (first, second, etc.).

ii) Start and end times must be entered in both the billing claims and the patient's chart.

Anesthesia

13052	Anesthetic evaluation - non-certified anesthesiologist	55.93	

Note: *See Anesthesia Preamble regarding Pre-Anesthetic Evaluation Fees.*

		$	Anes. Level

Minor Procedures

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)	31.72	
	Notes: *i) Payable to non-dermatologists only.* *ii) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."*		
13660	Metatarsal bone - closed reduction (operation only)	53.11	2
13600	Biopsy of skin or mucosa (operation only)	52.24	2
13601	Biopsy of facial area (operation only)	52.24	2
	Note: *Punch or shave biopsies which do not require sutures are not to be charged under fee items 13600 or 13601.*		
13605	Opening superficial abscess, including furuncle - operation only	44.76	2
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	35.84	
	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	66.76	2
13612	Extensive laceration greater than 5 cm (maximum charge 35 cm) - operation only - per cm	13.40	2
	Note: *Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	66.76	2
13621	- additional lesions removed at the same sitting (maximum per sitting, five) each (operation only)	33.39	
	Notes: *i) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."* *ii) Fee items 13620 and 13621 are not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13623	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - face (operation only)	90.04	
	Note: *i) Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13624	Removal of extensive scars – 5 cm or more – per cm over 5 cm (in addition to 13623 or 13620)	8.62	
	Notes: *i) Payment for scar revision based on length of scar, not length of incision.* *ii) A note record is required for scars >30 cm.* *iii) Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13622	Localized carcinoma of skin proven histopathologically (operation only)	73.75	2
13630	Paronychia - operation only	35.75	2
13631	Removal of nail - simple operation only	35.75	2

		$	Anes. Level
13632	- with destruction of nail bed (operation only)	72.34	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	63.83	2
13650	Enucleation or excision of external thrombotic hemorrhoid (operation only)	52.44	2
Y10710	In office Anoscopy	7.96	

Notes:

i) Anoscopy is the examination of the anus and anal sphincter, for evaluating patients with anal and/or peri-anal symptoms (pain or bleeding), or used as an adjunct to the DRE.

ii) Not payable in addition to 00715, 00716, 00718, 10714, 10731, 10732 or 10733.

iii) Restricted to Family Physicians.

		$	Anes. Level

Tests Performed in a Physician's Office

The following tests, when performed in physicians' offices, are accepted for payment by the Medical Services Plan of British Columbia. These tests are not payable to laboratories, vested interest laboratories and/or hospitals.

00012	Venepuncture and dispatch of specimen to an approved laboratory facility, when no other blood work performed	5.99	
	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 a medical practitioner.* *ii) Where a blood specimen is taken by physician's office and dispatched to another unassociated physician's office or to an approved laboratory facility, the original physcian'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%.*		
15132	Candida Culture	6.67	
15133	Examination for eosinophils in secretions, excretions and other body fluids	7.14	
15134	Examination for pinworm ova	5.85	
15136	Fungus, direct microscopic examination, KOH preparation	8.39	
15100	Glucose - semiquantitative (dipstick analysed visually or by reflectance meter)	3.70	
15137	Hemoglobin cyanmethemoglobin method and/or haematocrit.	3.12	
15000	Hemoglobin - other methods	1.62	
	***Note**: 15137 and 15000 - see the Laboratory Services Payment Schedule for additional hematology information.*		
15110	Occult blood – feces	5.37	
	***Note:** Applies only to guaiac methods.*		
15120	Pregnancy test, immunologic - urine	11.72	
30015	Secretion smear for eosinophils	7.29	
15138	Sedimentation rate	2.51	
15139	Sperm, Seminal examination for presence or absence	14.78	
15140	Stained smear	7.40	
15141	Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination	5.69	
15130	Urinalysis - Chemical or any part of (screening)	2.19	
15131	Urinalysis - Microscopic examination of centrifuged deposit	4.15	
15142	Urinalysis - Complete diagnostic, semi-quant and micro	5.65	
15143	White cell count only (see the Laboratory Services Payment Schedule for additional information)	6.48	
	The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:		
93120	E.C.G. tracing, without interpretation, (technical fee)	16.97	

Investigation

00117	Interpretation of electrocardiogram by non-internist	10.41	

No Charge Referral

03333	Use this code when submitting a claim for a "no charge referral."		

General Practice Services Committee (GPSC) Initiated Listings

Preamble

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. These fees were previously administered by the General Practice Services Committee (GPSC). Note that the GPSC Preamble governs the GPSC initiated listings in this section, however, the GPSC Preamble does not apply to the rest of the MSP fee listings.

Unless otherwise identified in the individual fee description, physicians are eligible to bill the following incentive payments if they are:

1. A Family Physician who has a valid BC MSP practitioner number;
2. Currently in family practice in BC as a community longitudinal family physician;
3. The most responsible physician/provider for the majority of their patients' longitudinal primary medical care.

Unless otherwise identified in the individual fee description, physicians are NOT eligible to bill GPSC Incentives if:

1. They are working under an Alternate Payment/Funding model as defined below and their duties would otherwise include provision of this care; and
2. They have billed any specialty consultation fee in the previous 12 months.

Additional detailed eligibility requirements are identified in each section.

Definitions in GPSC Initiated Listings:

(1) Physicians

Community Longitudinal Family Physician (CLFP)
For the purpose of GPSC incentives, a family physician is working as a "Community Longitudinal Family Physician" (CLFP) when they do all of the following:

- Assume the role of Most Responsible Physician/Provider (MRP) for a known panel of patients.
- Confirm patient-physician relationship with their patients through a standardized conversation or "compact", as outlined in PG14070.
- Provide, or coordinate delivery of, longitudinal full scope family medicine primary care services to a patient panel that is inclusive of patients of diverse demographics and medical needs.
- Work in community settings such as physician offices or health care clinics where patients are seen in person. CLFP may also provide some virtual services to their patient panel via telephone, video or other virtual care modality. CLFP may also provide some services to patient panel in facility settings such as hospitals, long term care, hospices, assisted living, or group homes.
- Maintain the comprehensive longitudinal medical records of each patient on patient panel.

A family physician is not considered to be working as a CLFP while they are working solely in one or more of the following health care settings:

- Episodic care settings such as (but not limited to) walk-in clinics, urgent care centres, and hospitals, where physician does not assume the role of MRP for patients.
- Virtual care settings where patient care is delivered via telephone, video, or other virtual care modalities.

- Focused practices serving a specific patient population or providing sub-specialty services such as (but not limited to) maternity care, palliative care, sports medicine, chronic pain, and addiction care.
- Facility settings such as (but not limited to) hospitals, long term care, hospices, assisted living, or group homes.

Family Physician with Consultative Expertise
GPSC defines a Family Physician with Consultative Expertise as: “A family physician who has consultative expertise and provides consultative services or support to colleagues through a health authority supported or approved program. Examples of health authority supported programs include (but are not limited to) mental health, addictions, palliative, chronic pain, and emergency medicine.

Locum Tenens
For the purpose of its incentives, GPSC defines a locum tenens as a physician with appropriate accreditation who substitutes on a temporary basis for another physician who is away from practice.

Most Responsible Physician/Provider (MRP)
For the purpose of its incentives, the GPSC defines “Most Responsible Physician/Provider” (MRP) as a physician who takes responsibility for directing and coordinating the ongoing care and management of a patient. This includes coordinating clinical services delegated to other providers, ensuring cross coverage when MRP is unavailable, and coordinating referrals to specialty care when needed.

(2) Allied Care Providers

Allied Care Provider
For the purposes of incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Nurses; Nurse Practitioners; Mental Health Workers; Midwives; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.
Note: *Not all allied care providers are College-certified.*

College-certified Allied Care Provider
Allied Care Providers who are College-certified are governed by a provincial regulatory college or body. Specific GPSC incentives may require ACPs to be College-certified for the delegation of tasks, whereas other GPSC incentives may not require ACPs to be College-certified to undertake delegated tasks. Fee notes will clearly indicate whether the ACP must be College-certified to be delegated tasks.

Allied Care Provider “Employed by” a Physician Practice
For the purposes of its incentives, GPSC defines Allied Care Providers (ACPs) “employed by” a physician practice as ACPs who are employed by a physician practice and paid out of practice earnings to work directly within the practice team, with no cost recovery either directly or indirectly from a third party (e.g.: Health Authority, Division of Family Practice, Ministry of Health, etc.), unless otherwise specified.

Allied Care Provider “Working Within” a Physician Practice Team
For the purpose of its incentives, GPSC defines Allied Care Providers (ACPs) “working within” a physician practice team as ACPs who work as part of an FP practice’s team to support the ongoing care of its patients. The costs of an ACP “working within” the practice team may be paid either by the physician practice or by a third party (directly or indirectly). ACPs employed by a Health Authority are considered to be “working within” the practice team if they are assigned to work with an FP practice to support the longitudinal care of its patients. By contrast, ACPs not assigned to work with an FP practice and who provide episodic services to patients on a referral basis such as through Specialized Health Authority Programs or in stand-alone chronic disease clinics are not considered to be “working within” the physician practice team.

(3) Payment Models

Alternative Payment/Funding Model:
For the purposes of these fees Alternative Payment/Funding Model means an Alternative Payment Arrangement or Alternative Funding contract between an entity (e.g.: Ministry of Health, Health Authority or other organization) and an individual physician or physician clinic. An Alternative Payment Arrangement or Alternative Funding contract may or may not be governed by the Physician Master Agreement. If services supported and paid through GPSC incentives are already included in an Alternative Payment/Funding Model contract, GPSC incentives are not billable in addition. Private agreements between physicians to pool FFS billings and pay out physicians in a mutually acceptable way (e.g.: per day, per shift, per hour, etc.) are not considered as an Alternative Payment/Funding Model.

(4) Miscellaneous

Assisted Living:
For the purpose of its incentives when referring to assisted living, GPSC utilizes the ministry definition as found at:https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living

Care Plan
For the purpose of its incentives, when referring to a care plan, GPSC requires documentation of the following core elements in the patient's chart, as follows:

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face to face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Face to Face:
For the purpose of its incentives, GPSC defines "face to face" to mean in in-person.

Living in Community
For the purpose of its incentives, GPSC considers patients living in group homes to be living in community.

Patient's Medical Representative:
For the purpose of its incentives, GPSC defines Patient's Medical Representative as outlined in the "Health Care (Consent) and Care Facility (Admission) Act".

Representative means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative.

Temporary Substitute decision makers (Alternate Representative) in listed order, of the following who is available and qualifies under subsection 16(2):

(a) the adult's spouse
(b) the adult's child
(c) the adult's parent
(d) the adult's brother or sister
(d.1) the adult's grandparent
(d.2) the adult's grandchild
(e) anyone else related by birth or adoption to the adult
(f) a close friend of the adult
(g) a person immediately related to the adult by marriage

Patient self-management

Patient self-management can be defined as the decisions and behaviours that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. There are a variety of publicly available tools that FPs can provide to patients, to help build the patients' skills and confidence to manage their chronic conditions.

Patient Panel

For the purpose of its incentives, the GPSC defines a "patient panel" as the group of patients for which a family physician has assumed the role of MRP, and has confirmed their ongoing patient-physician relationship.

(5) Reciprocal Claims

All Provinces, and Territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid Provincial Health Registration Card. There are some services excluded under the Inter-Provincial Agreements as per the MSC Payment Schedule Preamble C. 11 regarding Reciprocal Claims.

Claims for GPSC fees must first meet the GPSC Preamble and fee criteria and may then be billed through the MSP claims system (with the exception of Quebec) as follows:

(a) GPSC fees payable for services provided to residents of other provinces (with the exception of Quebec) are:

- PG14021, PG14022, PG14023 FP with Consultative Expertise Fees
- PG14018 FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise
- PG14019 FP Advice to a Nurse Practitioner/Registered Midwife Fee
- PG14004, PG14005, PG14008, PG14009 FP Obstetrical Premiums
- PG14063 Palliative Care Planning
- H14088 FP Unassigned In-patient Care Fee

(b) GPSC fees payable for services provided to residents of Alberta or Yukon by a physician who has successfully submitted and met the requirements of 14070/14071/14072:

- PG14075 FP Frailty Complex Care Planning and Management Fee
- PG14076 FP Patient Telephone Management Fee
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
- PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Fees

- PG14029 Allied Care Provided Practice Code
- PG14033 Complex Care Planning & Management
- PG14043 Mental Health Planning Fee
- PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management Fees
- PG14066 Prevention/Personal Health Risk Assessment
- PH14041 CLFP New Patient Intake Fee

(c) GPSC fees payable for services provided to residents of Alberta or Yukon by a physician who is a MRP Family Physician under Alternate Payment/Funding Model Programs:

- PG14250, PG14251, PG14252, PG14253 Chronic Disease Management Fees
- PG14029 Allied Care Provider Practice Code
- PG14276 Patient Telephone Management Encounter Code

1. Community Longitudinal Family Physician Portals (PG14070, PG14071)

Submitting code PG14070 provides access to the following fee codes:

- PG14075 FP Frailty Complex Care Planning and Management Fee
- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee

In addition to the fees below:

- PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Fees (Behind portal as of April 1, 2020)
- PG14033 Complex Care Planning & Management Fee – 2 Diagnoses (Behind portal as of April 1, 2020)
- PG14043 Mental Health Planning fee (Behind portal as of April 2, 2020)
- PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management Fees (Behind portal as of April 1, 2020)
- PG14063 Palliative Care Planning (Behind portal as of April 1, 2020)
- PG14066 Prevention/Personal Health Risk Assessment (Behind portal as of April 1, 2020)
- PH14041 CLFP New Patient Intake Fee (Behind portal as of April 1, 2020)

Submitting PG14070 signifies that:

- You are a community longitudinal family physician (as defined in the GPSC Preamble), with an office from which you provide in-person medical services to a known panel of patients;
- You are the MRP for the majority of the patient's longitudinal primary medical care, providing continuous comprehensive coordinated family practice services to your patients, and will continue to do so for the duration of that calendar year;
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'Compact'; and
- You are able to produce a list of active patients for whom you are the MRP.

Family Physician-Patient 'Compact'
The standardized wording of the Family Physician-Patient 'Compact' was developed in consultation with physicians and members of the Patient Voices Network. The GPSC believes this compact appropriately describes the relationship between a FP and their patients. The compact states:

As your family doctor I, along with my practice team, agree to:

- Provide you with the best care that I can
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:

- Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s)
- Name me as your family doctor if you have to visit an emergency facility or another provider
- Communicate with me honestly and openly so we can best address your health care needs

		$
PG14070	Community Longitudinal Family Physician Portal Code	0.00

The Community Longitudinal Family Physician Portal should be submitted once at the beginning of each calendar year by CLFP who maintain a comprehensive longitudinal practice OR at any time during the year when the CLFP begins their comprehensive longitudinal practice. Successful submission of PG14070 allows access to fees listed in the notes below during the calendar year.

Submit fee item PG14070 Community Longitudinal Family Physician Portal Code using the following "Patient" demographic information:

PHN:	9753035697
Patient Surname:	Portal
First name:	GPSC
Date of Birth:	January 1, 2013
ICD-9 code:	780

Notes:

i) Submit once per calendar year per physician.

ii) Submission provides access to the following fee codes:

- *PG14075 FP Frailty Complex Care Planning and Management Fee*
- *PG14076 FP Patient Telephone Management Fee*
- *PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
- *PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees*
- *PG14033 Complex Care Planning & Management Fee – 2 Diagnoses*
- *PG14043 Mental Health Planning fee*
- *PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management Fees*
- *PG14063 Palliative Care Planning Fee*
- *PG14066 Personal Health Risk Assessment (Prevention) Fee*
- *PH14041 CLFP New Patient Intake Fee*

iii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.

iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Locum Community Longitudinal Family Physician Portal

The Locum Community Longitudinal Family Physician Portal Code (PG14071) provides access to the following incentive fee codes:

- PG14075 FP Frailty Complex Care Planning and Management Fee
- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
- PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees (Behind portal as of April 1, 2020)
- PG14033 Complex Care Planning & Management Fee – 2 Diagnoses (Behind portal as of April 1, 2020)
- PG14043, PG14044, PG14045, PG14046, PG14047, PG14048 Mental Health Planning & Management Fees (Behind portal as of April 1, 2020)
- PG14063 Palliative Care Planning (Behind portal as of April 1, 2020)
- PG14066 Personal Health Risk Assessment/Prevention (Behind portal as of April 1, 2020)

These fees are accessible by a locum tenens when working on a temporary basis for a CLFP who is away from practice. As per the GPSC Preamble, a locum tenens is defined as a physician with appropriate credentials who substitutes on a temporary basis for another physician who is away from practice.

The host CLFP must have submitted PG14070 in the same calendar year. The locum tenens and host FP should discuss and mutually agree which of the services accessed through the Community Longitudinal Family Physician Portal may be provided and billed by the locum. However, locums have their own annual allotment of PH14067 (FP Brief Clinical Conference with Allied Care Provider and/or Physician), PG14076 (FP Patient Telephone Management Fee) and PG14078 (FP Patient Email/Text/Telephone Medical Advice Relay Fee), and PH14067 (FP Brief Clinical Conference with Allied Care Provider and/or Physician).

Submitting PG14071 signifies that:

- You are providing community longitudinal family practice services to the patients of host physicians, and will continue to do so for the duration of any locum coverage for a family physician who has submitted PG14070.

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PG14071	Locum Community Longitudinal Family Physician Portal Code The Locum Community Longitudinal Family Physician Portal Code may be submitted by the FP who provides locum coverage for Family Physicians who have submitted PG14070. PG14071 should be submitted once at the beginning of the calendar year or prior to the start of the first locum for a host FP who has submitted PG14070 in the same calendar year. Once processed by MSP, the locum may access the fees listed in note ii) below. Submit fee item PG14071 Locum Community Longitudinal Family Physician Portal Code using the following “Patient” demographic information: PHN: 9753035697 Patient Surname: Portal	0.00

First name: GPSC
Date of Birth: January 1, 2013
ICD-9 code: 780

Submission of this code signifies that:

- You are providing continuous comprehensive coordinated family practice services to the patients of the host physician who has submitted PG14070 and will continue to do so for the duration of locum coverage.

Notes:

i) Submit once per calendar year at the beginning of the year or prior to the first locum for a family physician who has submitted PG14070 in the same calendar year.

ii) Submission provides access to the following fee codes:

- *PG14075 FP Frailty Complex Care Planning and Management Fee*
- *PG14076 FP Patient Telephone Management Fee*
- *PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
- *PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees*
- *PG14033, PG14075 Complex Care Planning & Management Fees*
- *PG14043, PG14044, PG14045, PG14046, PG14074, PG14048 Mental Health Planning and Management Fees*
- *PG14063 Palliative Care Planning Fee; and*
- *PG14066 Personal Health Risk Assessment (Prevention)*

iii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.

iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

2. Long Term Care Portal

Effective January 1, 2021, family physicians who have a focused practice in long term care facilities and are not working as a Community Longitudinal Family Physician (as defined in the GPSC Preamble) in a community-based physician office or clinic will not be eligible to submit the Community Longitudinal Family Physician Portals (PG14070, PG14071).

They may submit the Long Term Care Portal Code (PG14072) to access the following fee codes:

- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
- PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Fees

		$
PG14072	Long Term Care Portal Code	0.00

The Long Term Care Portal Code should be submitted once at the beginning of each calendar year by family physicians who have a focused practice in long term care facilities and is not working as a Community Longitudinal Family Physician (as defined in the GPSC Preamble) in a community-based physician office or clinic.

When a family physician first begins a long term care focused practice, the Long Term Care Portal Code should be submitted when the focused practice

begins. Successful submission of PG14072 allows access to fees listed in the notes below during the calendar year.

Submit fee item PG14072 Long Term Care Portal Code using the following "Patient" demographic information:

PHN:	9753035697
Patient Surname:	Portal
First name:	GPSC
Date of Birth:	January 1, 2013
ICD-9 code:	780

Notes:

i) Submit once per calendar year per physician.

ii) Submission provides access to the following fee codes:

- *PG14076 FP Patient Telephone Management Fee*
- *PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
- *PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Fees*

iii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.

iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

3. Chronic Disease Management Incentives-Fee For Service (PG14050, PG14051, PG14052, PG14053, PG14029)

The GPSC Chronic Disease Management Incentives compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full twelve-month period. Guideline-informed care includes consideration of the patient's goals, values and comorbidities.

To confirm an ongoing doctor-patient relationship, there must be at least 2 visits billed over the previous 12 months. Visits provided by a locum or colleague covering for the MRP FP may be counted toward these 2 visits however, an electronic note indicating the locum or colleague coverage must be submitted with the claim. Patients in long-term care facilities are eligible when active chronic disease management is clinically appropriate.

When a new FP assumes the practice of another FP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fees are billable on the anniversary date of the previous billing, provided the new FP has continued to provide guideline-informed care for these patients. To demonstrate continuity, if some of the required visits have been provided by the previous FP, an electronic note should be submitted at the time of the CDM submission by the new FP, indicating they have taken over the practice of the previous FP and there has been continuity of care over 12 months. Documentation in the patient chart of the provision of patient self-management supports as part of the patient's chronic disease management is expected.

PG14050, PG14051, PG14052, PG14053 are payable to MRP FPs who have submitted PG14070 or PG14071, or FP's who have submitted PG14072.

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PG14050 Incentive for MRP Family Physicians -
- annual chronic care incentive (diabetes mellitus) 125.78

Notes:

i) Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully

submitted PG14071 on the same or a prior date in the same calendar year.
ii) Payable to Family Physicians who have successfully submitted PG14072.
iii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.
iv) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (PG14076) or
2. a group medical visit (13763-13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.
vi) Claim must include the ICD-9 code for diabetes (250).
vii) Payable once per patient in a consecutive 12 month period.
viii) Payable in addition to fee items PG14051 or PG14053 for same patient if eligible.
ix) Not payable once PG14063 has been billed and paid.
x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

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PG14051 Incentive for MRP Family Physicians
- annual chronic care incentive (heart failure) 125.78

Notes:
i) Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.
ii) Payable to Family Physicians who have successfully submitted PG14072.
iii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.
iv) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (PG14076) or
2. a group medical visit (13763-13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.
vi) Claim must include the ICD-9 code for congestive heart failure (428).
vii) Payable once per patient in a consecutive 12 month period.
viii) Payable in addition to items PG14050 or PG14053 for the same patient if eligible.
ix) Not payable once PG14063 has been billed and paid.
x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

PG14052 Incentive for MRP Family Physicians
- annual chronic care incentive (hypertension).....50.31

Notes:
i) Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.
ii) Payable to Family Physicians who have successfully submitted PG14072.
iii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.
iv) This item may only be billed after one year of care has been provided

including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (PG14076) or
2. a group medical visit (13763-13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").

v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.
vi) Claim must include the ICD-9 code for hypertension (401).
vii) Payable once per patient in a consecutive 12 month period.
viii) Not payable if PG14050 or PG14051 paid within the previous 12 months.
ix) Not payable once PG14063 has been billed and paid.
x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

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PG14053 Incentive for MRP Family Physicians
- annual chronic care incentive (Chronic Obstructive Pulmonary Disease-COPD) 125.78

Notes:

i) Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.
ii) Payable to Family Physicians who have successfully submitted PG14072.
iii) Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.
iv) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (PG14076) or
2. a group medical visit (13763-13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.
vi) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).
vii) Payable once per patient in a consecutive 12 month period.
viii) Payable in addition to fee items PG14050, PG14051 or PG14052 for the same patient if eligible.
ix) Not payable once PG14063 has been billed and paid
x) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

Allied Care Provider Code (PG14029)

To support team based care, College-certified Allied Care Providers (ACPs) may provide one of the two visits required for billing GPSC chronic disease management incentives. Visits provided by the College-certified ACP can be in person (PG14029) or by telephone (PG14076).

PG14029 Allied Care Provider Practice Code 0.00

Notes:

i) Applicable only for in-person medical services (office, home or LTC) provided by a College-certified allied care provider working within the family physician's practice team where the family physician has accepted responsibility for the provision of the care. (See Preamble definition of "working within" and "College-certified ACP").

ii) Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14077 or PH14067.

iii) Billable on patients receiving guideline informed care who will be eligible for one of the chronic disease management incentives (CDM).

5. Complex Care Planning and Management Fees (PG14033, PG14075)

There are two Complex Care Planning and Management Incentives: PG14033 and PG14075.

Both PG14033 and PG14075 are available only to MRP Family Physicians who have submitted PG14070 or PG14071. PG14033 and PG14075 are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing calendar year.

Only one Complex Care Planning and Management Incentive may be billed for an individual patient in any given calendar year, even if the patient meets eligibility requirements for both PG14033 and PG14075. When patients meet eligibility requirements for both Complex Care Incentives, choose either PG14033 or PG14075 - whichever best reflects the cause of their medical complexity.

To be eligible for either of the Complex Care Planning and Management Fees, the effects of the patient's condition(s) should be significant enough to warrant the development of a management plan. In other words, eligibility is not based solely on the individual diagnoses. Consideration should be given to the overall clinical impact of the diagnoses on the patient.

		$
PG14033	Complex Care Planning and Management Fee - 2 Diagnoses The Complex Care Planning and Management Fee is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions. It is payable upon the completion and documentation of a care plan in the patient's chart.	316.95

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

PG14033 Complex Care Planning & Management Fee- 2 Diagnoses

The Complex Care Planning and Management Fee-2 Diagnoses was developed to compensate FPs for the management of complex patients living in their home or assisted living, who have documented confirmed diagnoses of 2 eligible conditions from at least 2 of the 8 categories listed below.

Eligible Complex Care Condition Categories:

1) Diabetes mellitus (type 1 and 2)
2) Chronic Kidney Disease
3) Heart failure
4) Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)
5) Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g.: TIA, Migraine)
6) Ischemic heart disease, excluding the acute phase of myocardial infarct
7) Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.)
8) Chronic Liver Disease with evidence of hepatic dysfunction.

If a patient has more than 2 of the eligible conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

Notes:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.

ii) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions as listed in Table 1.

iii) Payable once per calendar year per patient on the date of the complex care planning visit.

iv) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14033.

v) Minimum required total planning time 30 minutes. The majority of the planning time must be spent face to face between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").

vi) Chart documentation must include:
1. the care plan;
2. total planning time (minimum 30 minutes); and
3. physician face to face planning time (minimum 16 minutes).

vii) PG14018, PG14077, or PH14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14033.

viii) PG14050, PG14051, PG14052, PG14053 payable on same day for same patient, if all other criteria met.

ix) Not payable once PG14063 has been billed and paid.

x) PG14043, PG14063, PG14076 and PG14078 not payable on the same day for the same patient.

xi) Maximum daily total of 5 of any combination of PG14033 and PG14075 per physician.

xii) PG14075 is not payable in the same calendar year for same patient as PG14033.

xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.

xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Diagnostic codes submitted with PG14033 billing must be from Table 1. If the patient has multiple comorbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

Table 1: Complex Care Diagnostic codes (PG14033)

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Dysfunction)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Dysfunction)
I428	Ischemic Heart Disease	Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Dysfunction)
H250	Heart Failure	Diabetes
H430	Heart Failure	Cerebrovascular Disease
H585	Heart Failure	Chronic Kidney Disease
H573	Heart Failure	Chronic Liver Disease (Hepatic Dysfunction)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease
D573	Diabetes	Chronic Liver Disease (Hepatic Dysfunction)
C585	Cerebrovascular Disease	Chronic Kidney Disease
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Dysfunction)
K573	Chronic Kidney Disease	Chronic Liver Disease (Hepatic Dysfunction)

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PG14075 Complex Care Planning and Management Fee - Frailty 316.95

The Complex Care Planning and Management Fee- Frailty is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for eligible patients of any age with documented frailty from any cause. Frailty is defined as requiring assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL). The effect of the frailty on the patient must be significant enough to warrant the development of a management plan.

Patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for PG14075.

Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community	Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care
Meal preparation	Mobility in bed
Ordinary housework	Transfers

Managing finances	Locomotion inside and outside the home
Managing medications	Dressing upper and lower body
Phone use	Eating
Shopping	Toilet use
Transportation	Personal hygiene
	Bathing

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

Notes:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.

ii) Payable only for patients who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living, the effects of which are significant enough to warrant the development of a management plan.

iii) Claim must include the diagnostic code V15.

iv) Payable once per calendar year per patient on the date of the complex care planning visit.

v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14075.

vi) Minimum required total planning time 30 minutes. The majority of the planning time must be face to face between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, be on different dates and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").

vii) Chart documentation must include:
1. the care plan;
2. total planning time (minimum 30 minutes); and
3. physician face to face planning time (minimum 16 minutes).

viii) PG14018, PG14077, or PH14067 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for PG14075.

ix) Maximum daily total 5 of any combination of PG14033 and PG14075 per physician.

x) PG14075 not payable once PG14063 has been billed.

xi) PG14033 is not payable in the same calendar year for same patient as PG14075.

xii) PG14043, PG14063, PG14076, PG14078 not payable on the same day for the same patient.

xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.

xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

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6. Prevention Fee (PG14066)

PG14066 Personal Health Risk Assessment (Prevention).....50.31
This fee is payable to the family physician who is most responsible for the majority of the patient's longitudinal primary medical care and who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, tobacco use, physically inactive,

unhealthy eating**,** or at risk for substance use disorder). The FP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative.

PG14066 is payable only to MRP Family Physicians who have submitted PG14070 or PG14071.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

The Ministry of Health website contains: The current Lifetime Prevention Schedule and the BC Prevention Guidelines.

Notes:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.

*ii) Payable only for patients with one or more of the following risk factors: Tobacco Use/Smoking, unhealthy eating, physical inactivity, medical obesity**,** or at risk for substance use disorder.*

iii) Diagnostic code submitted with PG14066 must be one of the following: Tobacco use/Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783), at risk for substance use disorder (V82).

iv) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.

v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under PG14066.

vi) PG14077 or PH14067 payable on same day for same patient if all criteria met.

vii) PG14033, PG14043, PG14063, PH14002, PG14076 and PG14078 not payable on the same day for the same patient.

viii) Payable to a maximum of 100 patients per calendar year, per physician.

ix) Payable once per calendar year per patient.

x) Not payable once PG14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

xi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

7. Mental Health Planning Fee (PG14043)

This fee is payable upon the completion and documentation of a care plan (as defined in the GPSC Preamble) in the patient's chart for patients with a confirmed eligible mental health diagnosis when the effect on the patient is significant enough to warrant the development of a care plan. This is not intended for patients with short-lived mental health symptoms (e.g.: normal grief, life transitions).

The Mental Health Planning Fee requires a face to face visit with the patient and/or the patient's medical representative and the physician.

PG14043 is payable only to Family Physicians who have submitted PG14070 or PG14071. The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing year.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

		$
PG14043	FP Mental Health Planning Fee	100.62

Notes:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.

ii) Payable only for patients with documentation of a confirmed eligible mental health diagnosis the effects of which are significant enough to warrant the development of a care plan. Eligible diagnoses are listed in Table 1. Not intended for patients with short lived mental health symptoms.

iii) Payable once per calendar year per patient. Not intended as a routine annual fee.

iv) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14043.

v) Minimum required total planning time 30 minutes. The majority of the planning time must be face to face between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) or another physician working within the eligible physician practice team. See Preamble definition of "working within" and "College-certified ACP").

vi) Chart documentation must include:
1. The care plan;
2. Total planning time (minimum 30 minutes); and
3. Physician face to face planning time (minimum 16 minutes).

vii) PG14077 or PH14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for PG14043.

viii) PG14044, PG14045, PG14046, PG14047, PG14048, PG14033, PG14063, PG14075, PG14076 and PG14078 not payable on the same day for the same patient.

ix) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Table 1

The following list of eligible diagnoses and ICD-9 codes is to be used when billing the Mental Health Planning Fee:

CATEGORY	DIAGNOSIS	ICD-9
Anxiety Disorders	Anxiety Disorders	300, 308, 50B
Bipolar and Related Disorders	Bipolar	296
	Cyclothymia	301.13
Depressive Disorders	Depressive disorders	311
Dissociative Disorder	Dissociative Disorders	300
Eating Disorders	Eating Disorders	307, 307.1
Gender Dysphoria	Gender Dysphoria	302
Impulse Control Disorders	Impulse Control Disorders	312
Neurocognitive Disorders	Delirium	293
	Dementia	290, 331, 331.0, 331.2
Neurodevelopmental disorders	Attention Deficit Disorder	314
	Autism Spectrum Disorder	299.0
	Pervasive Developmental Disorder	299.0
Obsessive-Compulsive & Related Disorders	Obsessive-Compulsive Disorder	300
	Body Dysmorphic Disorder	300.7
Schizophrenia and other Psychotic Disorders	Schizophrenia and other Psychotic Disorders	293, 295, 297, 298
Sexual Dysfunction	Sexual Dysfunction	302
Sleep Disorders	Sleep wake disorders: Insomnia/ hypersomnolence/ narcolepsy	307.4, 347
	Parasomnias	307.4
	Breathing-Related Sleep Disorders	780.5
Somatic Symptom & Related Disorders	Factitious Disorder	300, 312
	Pain Disorder with Affective Symptoms	338
	Somatic Symptom Disorder	300.8
	Conversion Disorder	300.1
Substance Use Disorders	Substance Use Disorder: Alcohol	303
	Substance Use Disorder: Drugs	304

CATEGORY	DIAGNOSIS	ICD-9
Trauma and stressor related disorders	Adjustment Disorders	309
	Post-Traumatic Stress Disorder	309

8. Mental Health Management Fees (PG14044, PG14045, PG14046, PG14047, PG14048)

		$
PG14044	FP Mental Health Management Fee age 2 - 49	56.76
PG14045	FP Mental Health Management Fee age 50 - 59	62.43
PG14046	FP Mental Health Management Fee age 60 - 69	65.26
PG14047	FP Mental Health Management Fee age 70 - 79	73.77
PG14048	FP Mental Health Management Fee age 80+	85.12

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients. The four MSP counselling fees (any combination of in-person or telehealth counselling) must first have been paid in the same calendar year.

Notes:

i) Payable only to:
- *a. MRP Family Physicians who have successfully submitted and met the requirements of PG14070 in the same calendar year.*
- *b. Locum Family Physicians who are covering for such a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year;*

ii) Payable a maximum of 4 times per calendar year per patient.

iii) Not payable unless the four in-person or telehealth counselling fees have already been paid in the same calendar year in any combination.

iv) For a prolonged visit for counselling (minimum time per visit – 20 minutes) (see Preamble D.3.3.)

v) Start and end times must be included with the claim and documented in the patient chart.

vi) Counselling may be provided face to face or by videoconferencing.

vii) PG14077 or PH14067, payable on same day for same patient if all criteria met.

viii) PG14043, PG14076, PG14078 not payable on same day for same patient.

ix) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

x) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

9. Palliative Care Planning Fee (PG 14063)

This fee is payable upon the development and documentation of a care plan as described in the GPSC Preamble, for patients who in the FP's clinical judgement have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to 6 months, and who consent to the focus of care being palliative.

Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy. This fee requires a face to face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent.

PG14063 is payable only to Family Physicians who have submitted PG14070 or PG14071 in the same calendar year.

This fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the patient.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

		$
PG14063	FP Palliative Care Planning Fee	100.62

Notes:

i) Payable only to Family Physicians who have successfully submitted and met the requirements for PG14070. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.

ii) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.

iii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).

iv) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new FP who is assuming the ongoing palliative care for the patient.

v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under PG14063.

vi) Minimum required total planning time 30 minutes. The majority of the planning time must be spent face to face between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").

vii) Chart documentation must include:
1. the care plan;
2. total planning time (minimum 30 minutes); and
3. physician face to face planning time (minimum 16 minutes).

viii) PG14077 or PH14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14063.

ix) Not payable if PG14033 or PG14075 has been paid within 6 months.

x) Not payable on same day as PG14043, PG14076 or PG14078.

xi) PG14050, PG14051, PG14052, PG14053, PG14250, PG14251, PG14252, PG14253, PG14033, PG14066, PG14075 not payable once Palliative Care Planning fee is billed and paid.

xii) The GPSC Mental Health Initiative Fees (PG14043, PG14044, PG14045, PG14046, PG14047, PG14048) are still payable once PG14063 has been billed provided all requirements are met, but are not payable on same day.

xiii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

10. FP Email, Text & Telephone Fees: Medical Advice to Patients (PG14076, PG14078)

		$
PG14076	FP Patient Telephone Management Fee	20.12

Notes:

i) Payable only to:
- *a. MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or*
- *b. Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or*
- *c. Family Physicians who have successfully submitted and met the requirements for PG14072 in the same calendar year; or*
- *d. Family Physicians Registered in a Maternity Network, or FP Unassigned In-patient network on a prior date.*

ii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician. Alternatively, this fee may be billed when delegated to or a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed by the eligible physician practice (see GPSC Preamble for definition of allied care provider "employed by" a physician practice and "College-certified ACP").

iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

iv) Not payable for prescription renewal alone.

v) Not payable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

vi) Payable to a maximum of 1500 services per physician per calendar year.

vii) Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14077, PH14067, PG14018, PG14050, PG14051, PG14052, PG14053, 13005.

viii) Not payable to physicians who are employed or under contract to a facility or working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

PG14078 FP Email/Text/Telephone Medical Advice Relay 7.04

PG14078 is payable for 2-way communication of medical advice from the MRP Family Physician to eligible patients, or the patient's medical representative, via email/text or telephone relay. This fee is not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

Notes:

i) Payable only to:
- *a. MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or*
- *b. Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or*
- *c. Family Physicians who have successfully submitted and met the requirements for PG14072 in the same calendar year; or*
- *d. Family Physicians Registered in a Maternity Network, or FP Unassigned In-patient network on a prior date.*

ii) Email/Text/Telephone Relay Medical Advice requires 2-way relay/ communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. Alternatively, the task of relaying the physician's advice may be delegated to any allied care provider or MOA working within the physician practice (see GPSC Preamble for definition of allied care provider "working within" a physician practice team).

iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided,

modality of communication and confirmation the advice has been received.

iv) *Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.*

v) *Payable to a maximum of 200 services per physician per calendar year.*

vi) *Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of PG14077 or PH14067.*

11. Conferencing and Advice Fees (PG14077, PH14067, PG14018, PG14019)

FP Conference with Allied Care Provider and/or Physician - per 15 minutes or greater portion thereof

PG14077 pays for two-way case conferencing about a patient with at least one allied care provider or physician. The fee is billable regardless of where the patient is located or how the conference occurs. Time spent talking to the patient or family member does not count towards conferencing time under PG14077.

As start and end times must be submitted, consider:

a) If conferencing takes place as a series of separate phone calls, use the start time of the first call and calculate the "end time" based on total time spent conferencing.

b) If billing a same day out-of-office hour's visit fee code (which also requires start/end times), the time submitted must either be before or after the PG14077 start/end time.

		$
PG14077	FP Conference with Allied Care Provider and/or Physician - per 15 minutes or greater portion thereof	43.23

Notes:

i) *Payable only to:*
   - a. *MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or*
   - b. *Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or*
   - c. *Family Physicians who have successfully submitted and met the requirements for PG14072 in the same calendar year; or*
   - d. *Family Physicians registered in a Maternity Network, or FP Unassigned In-patient network on a prior date.*

ii) *Payable for two-way collaborative conferencing, either by telephone, videoconferencing or in-person, between the Family Physician and an allied care provider and/or a physician.*

iii) *Conferencing cannot be delegated. No claim may be made where communication is with a proxy for either provider.*

iv) *Details of care conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.*

v) *Conference to include the clinical and social circumstances relevant to the delivery of care.*

vi) *Not payable for situations where the purpose of the call is to:*
   - a. *Book an appointment*
   - b. *Arrange for an expedited consultation or procedure*
   - c. *Arrange for laboratory or diagnostic investigations*
   - d. *Convey the results of diagnostic investigations*
   - e. *Arrange a hospital bed for a patient.*

vii) *When multiple patients are discussed, billing must be for consecutive non-overlapping time periods. Each individual patient conference must meet the time requirement of 15 minutes or greater portion thereof. For brief clinical conferences, fee code PH14067 is payable if all criteria are met.*

viii) Payable in addition to any visit fee on the same day if medically required, provided that the visit does not take place during a time interval that overlaps with the conference (i.e. Visit time must be separate from conference time).
ix) Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.
x) Start and end times must be included with the claim and documented in the patient chart.
xi) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility, or communications which occur as part of regular work flow within a physician's community practice.
xii) Not payable for simple advice to a non-physician allied care provider about a patient in a facility.
xiii) Not payable in addition to PH14067 or PG14018 on the same day for the same patient by the same physician.
xiii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

FP Brief Clinical Conference with Allied Care Provider and/or Physician

PH14067 is payable for two-way case conferencing about a patient with at least one allied care provider or physician. The fee is billable regardless of where the patient is located or how the conference occurs. Time spent talking to the patient or family member is not billable as PH14067.

PH14067 should not be billed for conferencing activities that can be billed as 13005 or PG14077. Eligible physicians are advised to bill:

- 13005 for advice by telephone, fax, or in written form about a patient in community care given in response to an enquiry initiated by an allied health care worker.
- PG14077 for two-way conferencing about a patient with at least one allied care provider or physician per 15 minutes or greater portion thereof.

GPSC fees cannot be correctly interpreted without reading the GPSC Preamble.

		$
PH14067	FP Brief Clinical Conference with Allied Care Provider and/or Physician	18.22

Notes:
i) Payable only to:
a. MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or
b. Locum Family Physicians who are covering for such a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or
c. Family Physicians who have successfully submitted and met the requirements for PG14072 in the same calendar year; or
d. Family Physicians registered in a Maternity Network, or FP Unassigned In-patient network on a prior date.
ii) Payable for two-way collaborative conferencing, either by telephone, videoconferencing or in-person, between the Family Physician and an allied care provider and/or a physician
iii) Conferencing cannot be delegated. No claim may be made where communication is with a proxy for either provider.
iv) Details of clinical discussion and decisions made must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference and their role(s) in care.

v) *Not payable for situations where the purpose of the call is to:*
   a. book an appointment
   b. arrange for laboratory or diagnostic investigations
   c. convey the results of diagnostic investigations;
   d. arrange a hospital bed for a patient
vi) *Payable in addition to any visit fee on the same day if medically required, provided the visit does not take place during a time interval that overlaps with the conference (i.e. Visit time must be separate from conference time).*
vii) *Payable to a maximum of 150 per physician per calendar year.*
viii) *Payable to a maximum of 1 per patient per physician per day.*
ix) *Not payable in addition to PG14077 or PG14018 on the same day for the same patient by the same physician.*
x) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

FP Urgent Telephone Advice from a Physician with Consultative Expertise

PG14018 is billable when the severity of the patient's condition justifies urgent advice (within 2 hours of request) from a Specialist or Physician with Consultative Expertise (as defined in the GPSC Preamble), in order to develop and implement a plan to keep the patient stable in their current environment. The intent of PG14018 is to improve the management of patients with acute needs, and reduce unnecessary ER or hospital admissions/transfers. This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

		$
PG14018	FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise	43.23

14018 is payment for telephone advice that is needed on an urgent basis (within 2 hours of request) from a Specialist or Family Physician with Consultative Expertise (as defined in the Preamble). Includes the creation, documentation, and implementation of a plan for the care of patients with acute needs (i.e. requiring attention within the next 24 hours) and communication of that plan to the patient or patient's representative.

Notes:
i) *Payable to the FP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or family physician with consultative expertise (as defined in the GPSC Preamble) regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.*
ii) *Conversation must take place within two hours of the FP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, email).*
iii) *Fee Includes:*
   a. *Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*
   b. *Developing, documenting and implementing a plan to manage the patient safely in their care setting.*
   c. *Communication of the plan to the patient or the patient's representative.*
   d. *The plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*
iv) *Not payable in addition to PG14077 or PH14067 on the same day for the same patient by the same physician.*

v) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.
vi) Include start time in time fields when submitting claim.
vii) Not payable for situations where the primary purpose of the call is to:
a. Book an appointment
b. Arrange for transfer of care that occurs within 24 hours
c. Arrange for an expedited consultation or procedure within 24 hours
d. Arrange for laboratory or diagnostic investigations
e. Convey the results of diagnostic investigations
f. Arrange a hospital bed for the patient
g. Obtain non-urgent advice for patient management (i.e. advice that is not required within the next 2 hours).
viii) Limited to one claim per patient per physician per day.
ix) Out-of-Office Hours Premiums may not be claimed in addition.
x) Maximum of 6 (six) services per patient, per practitioner, per calendar year.
xi) Payable in addition to a visit on the same date.

FP – Advice to Nurse Practitioner/Registered Midwife Fee

The intent of PG14019 is to support collaboration between nurse practitioners, registered midwives and community family physicians. This fee is billable when providing advice by telephone or in person to a Nurse Practitioner who is an independent practitioner providing care to patients under their MRP care. This fee is not billable for providing advice to a NP when the patient is attached to a FP. This fee is also billable when providing advice by telephone or in person to a Registered Midwife who is an independent practitioner providing maternity care to patients under their MRP care.

		$
PG14019	FP Advice to a Nurse Practitioner/Registered Midwife Fee–Telephone or In Person	43.23

Notes:
i) Payable to:
a. the FP who provides advice by telephone or in person in response to a request from a Nurse Practitioner (NP) in independent practice on patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care; or
b. the FP who provides advice by telephone or in-person in response to a request from a Registered Midwife in independent practice on patients for whom the Midwife has accepted the responsibility of being the Most Responsible Provider for that patient's maternity care.
ii) Excludes advice to an NP about patients who are attached to the FP; excludes advice to a Registered Midwife about patients being cared for in a shared care model with a FP.
iii) Payable for advice regarding assessment and management by the NP/midwife and without the responding physician seeing the patient.
iv) Not payable for written communication (i.e. fax, letter, email).
v) A chart entry, including advice given and to whom, is required.
vi) NP/Midwife Practitioner number required in referring practitioner field when submitting fee through Teleplan.
vii) Not payable for situations where the purpose of the call is to:
a. Book an appointment
b. Arrange for transfer of care that occurs within 24 hours
c. Arrange for an expedited consultation or procedure within 24 hours
d. Arrange for laboratory or diagnostic investigations
e. Convey the results of diagnostic investigations
f. Arrange a hospital bed for the patient.
viii) Limited to 1 (one) claim per patient per day with a maximum of 6 (six) claims per patient per calendar year.
ix) Limit of 5 (five) PG14019 units may be billed by a FP on any calendar day.
x) Not payable in addition to another service on the same day for the same patient by same FP.
xi) Out-of-Office Hours Premiums may not be claimed in addition.

xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

12. Family Physicians with Consultative Expertise Fees (PG14021, PG14022, PG14023

FP with Consultative Expertise Telephone Advice Fees (PG14021, PG14022, PG14023) support tele/videoconferencing between FP's with Consultative Expertise and other Family Physicians, Specialists or Allied Care Providers for the purpose of improving patient care.

The GPSC Preamble defines Family Physicians with Consultative Expertise as:

GPSC defines a Physician with Consultative Expertise as: "A family physician who has consultative expertise and provides consultative services or support to colleagues through a health authority supported or approved program". Examples of health authority supported programs include (but are not limited to) mental health, addictions, palliative, chronic pain and emergency medicine.

Eligibility for FP with Consultative Expertise Telephone Advice Fees:
In addition to meeting the definition of FP with Consultative Expertise listed above and in the GPSC Preamble, the following criteria must be met:

- Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- Service may be provided when physician is located in office or hospital.
- Telephone advice must be related to the field in which the FP provides consultative services or support.

		$
PG14021	FP with Consultative Expertise Telephone/video Advice - Initiated by a Specialist, Family Physician, or Allied Care Provider, Response within 2 hours	60.37

Notes:

i) Payable to a FP with consultative expertise (as defined in the GPSC Preamble) for two-way telephone/video communication regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Conversation must take place within two hours of the initiating provider's request. Not payable for written communication (i.e. fax, letter, email).

iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iv) Not payable for situations where the purpose of the call is to:
- *a. Book an appointment*
- *b. Arrange for transfer of care that occurs within 24 hours*
- *c. Arrange for an expedited consultation or procedure within 24 hours*
- *d. Arrange for laboratory or diagnostic investigations*
- *e. Convey the results of diagnostic investigations*
- *f. Arrange a hospital bed for the patient.*

v) Not payable to provider initiating call.

vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).

vii) Limited to one claim per patient per physician per day.

viii) A chart entry including advice given and to whom, is required.

ix) Start times must be included with the claim and documented in the patient chart.

x) Not payable in addition to another service on the same day for the same patient by same physician.

xi) Out-of-Office Hours Premiums may not be claimed in addition.

xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

xiii) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note record specifying the type of provider).

		$
PG14022	FP with Consultative Expertise Telephone/video Advice - Initiated by a Specialist, Family Physician or Allied Care Provider, response within one week – per 15 minutes or portion thereof	43.23

Notes:

i) Payable to a FP with Consultative Expertise (as defined in the GPSC Preamble) for two-way telephone/video communication regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Conversation must take place within 7 days of initiating provider's request. Initiation may be by phone or referral letter.

iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iv) Not payable for situations where the purpose of the call is to:
- *a. Book an appointment*
- *b. Arrange for transfer of care that occurs within 24 hours*
- *c. Arrange for an expedited consultation or procedure within 24 hours*
- *d. Arrange for laboratory or diagnostic investigations*
- *e. Convey the results of diagnostic investigations*
- *f. Arrange a hospital bed for the patient.*

v) Not payable to provider initiating call.

vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).

vii) Limited to two services per patient per physician per week.

viii) A chart entry, including advice given and to whom, is required.

ix) Start and end times must be included with the claim and documented in the patient chart.

x) Not payable in addition to another service on the same day for the same patient by same physician.

xi) Out-of-Office Hours Premiums may not be claimed in addition.

xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

xiii) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note record specifying the type of provider.)

PG14023	FP with Consultative Expertise - Patient Telephone/video Management/Follow-Up	20.12

Notes:

i) This fee applies to two-way telephone/video communication between the FP with Consultative Expertise (as defined in the GPSC Preamble) and patient, or a patient's representative. Not payable for written communication (i.e. fax, letter, email).

ii) Access to this fee is restricted to patients having received a prior consultation, office visit, hospital or ER visit, diagnostic procedure or surgical procedure from the same physician, within the 6 months preceding this service.

iii) Telephone/video management requires two-way communication between the patient and physician on a clinical level; the fee is not billable for administrative tasks such as appointment notification.

iv) No claim may be made where communication is with a proxy for the physician (e.g.: office support staff).

v) Each physician may bill this service 4 (four) times per calendar year for each patient.

vi) This fee requires chart entry as well as ensuring that patient understands and acknowledges the information provided.

vii) Not payable in addition to another service on the same day for the same patient by the same physician.

viii) Out-of-Office Hours Premiums may not be claimed in addition.

ix) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

13. Family Physician Obstetrical Premiums (PG14004, PG14005, PG14008, PG14009) and Maternity Care Risk Assessment (PH14002)

The following fees are payable to B.C.'s eligible family physicians. The purpose of the payment is to encourage family physicians to continue to provide obstetrical care, giving women the benefit of choice and longitudinal care. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

PH14002, PG14004, PG14005, PG14008, and PG14009 are payable only to family physicians who have submitted PG14070 or PG14071 in the same calendar year, or who are registered in a Maternity Network.

		$
PH14002	Maternity Care Risk Assessment This fee is payable to a CLFP who is the patient's MRP, OR a family physician who will be providing the majority of the patient's maternity care and is registered in a Maternity Network. This fee is payment for the increased time, intensity and complexity required to undertake a Maternity Care Risk Assessment with a pregnant patient based on the BC Antenatal Record, including the review of gestationally appropriate screening interventions, pregnancy risks, and patient comorbidities. This fee requires a face-to-face visit. A Maternity Care Risk Assessment includes, but is not limited to the following: • Reviewing history including present pregnancy, medical history, family history, lifestyle/social concerns, and medications/supplements. • Screening for use of alcohol, tobacco, cannabis and other substances. • Informed consent discussion of options for prenatal genetic screening, discussion of results, and follow up testing as appropriate for the patient's age, gestational age and local resources available. ***Notes:*** *i) Payable only to:* *a. MRP family physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or* *b. Locum family physicians who are covering for a MRP family physicians when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or* *c. Family physicians registered in a Maternity Network* *ii) Payable once per pregnancy per patient except in the case where a patient transfers their total ongoing prenatal care to another physician, the second physician also may charge a Maternity Care Risk Assessment, as rendered. To facilitate payment, the reason for transfer should be stated with the claim. Temporary substitution of one physician for another physician (e.g. days off, vacation) is not be considered as a patient transfer* *iii) Payable to a maximum of two per patient per pregnancy.* *iv) Payable in addition to a visit fee (home or office) on the same day if medically required provided the visit does not take place during a time interval that overlaps with the face-to face planning included under PH14002.* v) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.* *vi) PG14033, PG14043, PG14063, PG14066, PG14076 and PG14078 not payable on the same day for the same patient.*	50.00
PG14004	Obstetric Delivery Incentive for Family Physicians– associated with vaginal delivery and postnatal care *Notes:* *i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:*	375.40

a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
b. Registered in a Maternity Network on a prior date.

ii) Payable only when fee item 14104 billed in conjunction.
iii) Maximum of one incentive under fee time PG14004, PG14008, PG14009 per patient delivered.
iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

$

PG14005 Obstetric Delivery Incentive for Family Physicians – associated with management of labour and transfer for delivery to a higher level of care facility.....156.34

Notes:

i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:
a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
b. Registered in a Maternity Network on a prior date.

ii) Payable only when fee item 14105 billed in conjunction.
iii) Payable in addition to PG14004 or PG14009 when billed and paid to a different FP attending delivery in the receiving hospital.
iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

PG14008 Obstetric Delivery Incentive for Family Physicians– associated with postnatal care after elective caesarean-section.....77.23

Notes:

i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:
a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
b. Registered in a Maternity Network on a prior date.

ii) Payable only when fee item 14108 billed in conjunction.
iii) Maximum of one incentive under fee item PG14004, PG14008, PG14009 per patient delivered.
iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

PG14009 Obstetric Delivery Incentive for Family Physicians – associated with attendance at delivery and postnatal care associated with emergency caesarean section 312.70

Notes:

i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:
a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
b. Registered in a Maternity Network on a prior date.

ii) Payable only when fee item 14109 billed in conjunction.
iii) Maximum of one incentive under fee item PG14004, PG14008, PG14009 per patient delivered.
iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

14. Maternity Network Initiative (H14010)

Eligible family physicians can receive a quarterly payment each quarter ending March 31, June 30, September 30 & December 31, to cover the costs of group/network activities for their shared care of obstetric patients (both assigned and unassigned obstetric patients).

To support conferencing with other health care providers and communication with patients, registration in a Maternity Network allows access to FP Conferencing Incentive PG14077 or PH14067 and FP Patient telephone/advice Incentives PG14076 and PG14078. As part of the GPSC In-patient Initiative, members of Maternity Networks are eligible to bill the Unassigned In-patient Care fee H14088 for unassigned pregnant patients for whom they are the Most Responsible Physician (MRP). Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned.

Note: Claims received for processing before the date of service or with a date of service other than the last day in a quarter will be refused.

Registration in a Maternity Network provides access to the Obstetrical Delivery Incentives for Family Physicians (PG14004, PG14005, PG14008, and PG14009).

		$
H14010	Maternity Care Network Initiative Payment	2,100.00 per quarter

Eligibility:
To be eligible to be a member of the network, you must, for the three-month period up to the payment date:

- *Be a family physician in active practice in BC;*
- *Have hospital privileges to provide obstetrical care;*
- *Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care). Refer to the Maternity Network Registration Form found on the GPSC website at gpscbc.ca;*
- *Co-operate with other members of the network so that one member is always available for deliveries;*
- *Make patients aware of the members of the network and the support specialists available for complicated cases;*
- *Accept a reasonable number of referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy; the referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care);*
- *Share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic prenatal record;*
- *Each doctor must schedule at least four deliveries in each six month period of time (April to September, October to March); and*
- *The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day).*

Billing Information for Maternity Care Network Initiative Payment:

PHN:	9824870522
Patient Last name:	Maternity
Patient First name/initial:	G
Date of Birth:	November 2, 1989
Diagnostic code:	V26
For Date of service use:	Last day in a calendar quarter
Billing Schedule:	Last day of the month, per calendar quarter

15. GPSC Incentives for In-patient Care (H14086, H14088)

The GPSC In-patient Initiative was developed to recognize and better support the continuous relationship with a family physician (FP) that can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. An important aspect of such continuous care is the coordination of care through the in-patient journey as well as in transitions between hospital and community FP offices. There are two separate levels of incentives aimed at better supporting and compensating FPs who provide this important aspect of care. This initiative will support family physicians who:

a. Provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned In-patients); and may also
b. As part of a network, provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned In-patients).

To participate in the GPSC In-patient Initiative, it is expected that these FPs agree to the following expectations:

A. They are members of the active or equivalent medical staff category and have hospital privileges in the identified acute care hospital.

B. That their on-call colleagues (Network) are also members of the active or equivalent medical staff category and have hospital privileges.

C. That they will:
- Coordinate and manage the care of hospitalized patients (assigned and/or unassigned), admitted under them as the MRP.
- Provide supportive care when their hospitalized patient is admitted under a specialist as MRP.
- See all acute patients under their MRP care on a daily basis and document a progress note in the medical record.
- Work with the interdisciplinary team, as appropriate, to develop a care plan and a plan for discharge.
- When care is transferred to another physician, ensure that this is documented in the medical record and ensure there is a verbal or written handover plan provided to the accepting physician.
- Ensure availability through their network to expedite discharges of patients daily during the normal working day which includes early morning, daytime, and early evening.
- On weekends ensure the covering physician is made aware of those discharges that could occur over the weekend.
- Provide a discharge note to an unassigned in-patient for their FP or communicate directly with the FP on discharge.
- Respond to requests from members of the interdisciplinary in-patient care team by phone as per hospital bylaws.
- The Network Call Group will accept responsibility for their newly admitted in-patients on a 24/7/365 basis. The MRP shall assess and examine the patient, document findings and issue applicable orders as soon as warranted by the patient's needs, but in any case no longer than 24 hours after accepting the transfer. Utilization needs within the facility may dictate that the patient must be seen sooner.

D. The non-clinical services include the already existing expectations of FPs as outlined in the Health Authority Medical Staff bylaws, rules and regulations, and policies. The health authority, the Department of Family Practice, the Division of Family Practice (where it exists) and the In-patient Care Networks could reasonably expect that all parties would participate in discussions which could include:
- The orderly transitions of MRP status between specialists and generalists.
- Participating in the orderly discharge planning of generally more complicated patients.
- Patient safety concerns that come up in local hospitals.
- Identifying and providing input into "local hassle factors" that would need to be examined and resolved at a local level between the local division of family practice and health authorities.
- Participate in utilization management within the hospital.

- Patient care improvement discussions that would reasonably be covered under the improved FP hospital care incentives.

FP Assigned Inpatient Care Network (H14086)

The FP Assigned Inpatient Care Network initiative was designed to support community Family Physicians who continue to accept Most Responsible Physician (MRP) status to provide care to their own patients who have been admitted to hospital. The Assigned In-patient Network payment is for FPs who provide in-patient care services for their own and colleagues' patients (assigned). Maternity patients are not included under the Assigned In-patient Network if the FP is also participating in a GPSC Maternity Care Network because those patients are counted as part of that incentive.

		$
H14086	FP Assigned Inpatient Care Network Initiative	2,100.00

Eligibility:
To be eligible to be a member of a FP Assigned Inpatient Care Network, you must meet the following criteria:

- *Be a Family Physician in active practice in B.C.*
- *Have active hospital privileges.*
- *Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing inpatient care – see below).*
- *Submit a completed Assigned Inpatient Care Network Registration Form.*
- *Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.*
- *Each doctor must provide MRP care to at least 24 admitted patients over the course of a year; networks may average out this number across the number of members.*

This network incentive is payable in addition to visit fees, but is inclusive of time spent in associated Quality Improvement activities necessary to maintain privileges such as M and M rounds as well as time spent on network administration, etc.

Exemptions for communities where it may be difficult to achieve the minimum volume of MRP inpatient cases will be considered by the GPSC Inpatient Care Working Group.

The FP Assigned In-patient Care Network Incentive is payable for participation in the network activities for the majority of the following calendar quarter (50% plus 1 day). Once your registration in the network has been confirmed, submit fee item H14086 FP Assigned in-patient care network fee using the following billing specifics:

Billing Schedule: First day of the month, per calendar quarter (i.e. January 1, April 1, July 1, October 1) and is paid for the subsequent quarter ICD-9 code: 780

Your location will determine which PHN# to use:

Fraser Health Authority PHN# 9752 590 548 Patient Surname: Assigned First Name: FHA Date of birth: January 1, 2013	Interior Health Authority PHN# 9752 590 587 Patient Surname: Assigned First Name: IHA Date of birth: January 1, 2013
Northern Health Authority PHN# 9752 590 509 Patient Surname: Assigned First Name: NHA Date of birth: January 1, 2013	Vancouver Coastal Health Authority PHN# 9752 590 523 Patient Surname: Assigned First Name: CVHA Date of birth: January 1, 2013
Vancouver Island Health Authority PHN# 9752 590 516	

Patient Surname: Assigned First Name: VIHA Date of birth: January 1, 2013

FP Unassigned Inpatient Care Fee (H14088)

The term “Unassigned Inpatient” is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted.

The FP Unassigned Inpatient Care Fee is designed to provide an incentive for Family Physicians to accept Most Responsible Physician (MRP) status for an unassigned patient’s hospital stay. It is intended to compensate the Family Physician for the extra time and intensity required to evaluate an unfamiliar patient’s clinical status and care needs when the patient is admitted and is only billable once per hospital admission.

This fee is restricted to Family Physicians actively participating in an FP Unassigned Inpatient Care Network or an FP Maternity Network. This fee is billable through the MSP Teleplan system and is payable in addition to the hospital visit (00109, 13109, 13008, 13011, 00127) or delivery fee.

		$
H14088	FP Unassigned Inpatient Care Fee	150.00

Notes:

i) Payable only to Family Physicians who have submitted a completed FP Unassigned Inpatient Care Network Registration Form and/or an FP Maternity Network Registration Form.

ii) Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.

iii) Payable once per unassigned patient per in-hospital admission in addition to the hospital visit (00109, 13109, 13008, 13011, 00127) or delivery fee.

iv) Not payable to physicians who are employed or under contract to a facility or working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

16. CLFP New Patient Intake Fee (PH14041)

PH14041	CLFP New Patient Intake Fee	15.00

Payable in addition to a visit fee for confirming the addition of a new patient to the physician’s panel where the longitudinal doctor-patient relationship has been confirmed through a standardized conversation or ‘compact’.

By billing PH14041, the FP commits to assuming the role of Most Responsible Provider (MRP) for the patient.

Notes:

i) Payable to the family physician who will be most responsible for the majority of the patient’s longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Not payable to locum physicians.

ii) Must be billed within the first 3 months of the MRP onboarding the new patient into their ongoing care.

iii) A visit must have been provided by the billing physician on the same day or within 3 months prior to the billing of 14041.

iv) Payable to a maximum of 1 per patient per calendar year.

v) Not payable to physicians working under an Alternative Payment/Funding model which is inclusive of the activities included in this fee.

$

P13013 Assessment for Induction of Opioid Agonist Treatment (OAT) for Opioid Use Disorder
Initial assessment requires complete medical history, substance use history and appropriate targeted physical examination. If assessment and induction are done on the same day, withdrawal assessment using COWS or SOWS and administration of first dose of OAT included – per 15 minutes or greater portion thereof ..... …….42.97

Notes:

i) Payable to a maximum of 4 units per patient/per day/per intended induction.
ii) Payable only to the physician who intends to provide or share management of the patient's OAT induction for opioid use disorder.
iii) Start and end times must be entered in both the billing claim and the patient's chart.
iv) No other visit fees billable same day except 13014, 14018, 14077 and 14067. 13014, 14018, 14077, and 14067 payable in addition to 13013 only when not performed concurrently.
v) Payable for assessment for change of OAT with induction to a different medication.
vi) May not be repeated within 30 days by the same physician.
vii) This service payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day).

13012 Hospital at Home FP Conference with Allied Care Provider and/or Physician – per 15 minutes or greater portion thereof ..... …..43.23

Notes:

i) Payable only for patients admitted for care under the Hospital at Home program.
ii) Payable for two-way collaborative conferencing, either by telephone, videoconferencing or in-person, between the Family Physician and an allied care provider and/or a physician.
iii) Conferencing cannot be delegated. No claim may be made where communication is with a proxy for either provider.
iv) Details of care conference must be documented in the patient's chart as well as information on clinical discussion and decisions made.
v) Not payable for simple advice to a non-physician allied care provider about the patient or where the primary purpose of the call is to:
a. Book an appointment
b. Arrange for an expedited consultation or procedure
c. Arrange for laboratory or diagnostic investigations
d. Convey the results of diagnostic investigations
e. Arrange a hospital bed for a patient.
vi) Payable in addition to any visit fee on the same day if medically required and does not take place during a time interval that overlaps with the patient conference (i.e. Visit time is separate from conference time).
vii) Payable to a maximum of 2 units (30 minutes) per patient on any single day.
viii) If multiple patients are discussed, the billings must be for consecutive, non-overlapping time periods.
ix) Start and end times must be included with the claim and documented in the patient chart. If conferencing takes place as a series of separate phone calls, use the start time of the first call and calculate the "end time" based on total time spent conferencing.
x) Not payable in addition to PG14018, ~~or~~ PG14077, or 14067 on same day to same physician for the same patient.
xi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

ANESTHESIOLOGY

Anesthesiology Preamble

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

Intensity and Complexity Index

Intensity/Complexity Level	Fee Code	$ (per 15 minutes or part thereof)
2	01172	36.64
3	01173	36.75
4	01174	36.75
5	01175	41.87
6	01176	43.75
7	01177	43.75
8	01178	49.82
9	01179	50.00
10	01180	50.00
11	01181	50.00

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

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

1. Pre-Anesthetic Evaluation Fees

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

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

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

2. Consultations

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

b) 01115 applies to two situations:

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

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

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

d) 01116 applies to two situations:

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

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

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

f) Continuing care items 01107, 01108 and 01109 cannot be billed with any other listings.

3. Anesthetic Procedural Fees

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

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

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

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

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

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

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

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

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

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

4. Anesthetic Procedural Fee Modifiers

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

b) 01059, 01065, 01070, 01071, 01072, 01077, 01082, 01084, 01093, 01096, 01164, 01165, 01166, 01168 and 01192 are fixed fees which are paid in addition to the anesthetic procedural fee. They are not included in the anesthetic procedural fee for the application of 01080.

c) 01169 is a time-based fee modifier which is paid in addition to the anesthetic procedural fee. It is not included in the anesthetic procedural fee for the application of 01080.

d) 01080 is a multiplier and applies only to the anesthetic procedural fee. When 01080 is applicable, multiply the total anesthetic procedural fee [including routine P.A.R. care as is 3. d) i)] by 15%.

e) 01080 can only be used once per case, even if it qualifies more than once (e.g.: ASA 5E cardiac surgical case with an I.A.B.P. lasting 12 hours will be paid at 15%).

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

5. Resuscitation Fees

These fees refer to resuscitation by anesthesiologist.

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

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

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

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

6. Diagnostic and Therapeutic Anesthetic Fees

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

b) Consultations will be paid where appropriate.

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

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

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

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

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

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

7. Acute Pain Management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Obstetric Analgesia Fees (Epidural Analgesia in Labour)

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

9. An anesthesiologist's continuous attendance

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

10. Payment of two anesthesiologists

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

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

11. Payment of anesthetic when performed by the surgeons

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

12. Anesthetic fees not included in the schedule

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

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

c) Anesthesiologists will not normally perform simultaneous services. In the rare event where a life-threatening emergency presents to an anesthesiologist already in attendance at one service, AND a second anesthesiologist is not immediately available, AND a delay to await the arrival of a second anesthesiologist would pose an unacceptable risk of adverse outcome to the second patient, SO THAT, in the judgment of the attending physicians and the attending anesthesiologist has no option other than performing two services simultaneously, THEN the attending anesthesiologist may perform two services simultaneously and may bill the full fee for both services until the second anesthesiologist arrives. Written explanation to the payment agency is required. This does not apply to simultaneous services of a less than life-threatening nature or where one of the two services is conducted or supervised by a resident or intern or student.

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

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

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

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

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

ii) 01112 is applicable where the attendance of the anesthesiologist is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and where the anesthesiologist is in constant attendance. For example, this applies to the situation where an anesthesiologist is requested to be present at delivery for the purpose of neonatal resuscitation. If resuscitation is necessary, then 01112 stops at the time of delivery and 01090 commences.

13. Anesthetic for non-insured dental procedures

Preface:

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

Policy:

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

- children requiring extensive dental rehabilitation and could not be otherwise managed/treated due to the length of time for the treatment and the dental treatment is scheduled to last more than one hour; or
- the patient has a severe mental or physical disability that precludes the performance of the dental procedure(s) under local anesthetic; or
- there is a demonstrated medical contra-indication (e.g.: allergy) to local anesthetic precluding the performance of the dental procedure(s) under local anesthetic; or
- there is difficulty with access to the airway precluding the performance of the dental procedure(s); or
- the presence of dental disease adds a significant risk of complication(s) to a planned major surgical procedure, medical treatment, or post-operative care such as for cancer treatment

and/or the patient's presenting medical condition is severe enough to preclude the performance of the dental procedure(s) under local anesthetic; or

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

Notes:

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

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

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

ANESTHESIOLOGY

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

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Visit / Evaluation

01107 Office visit 56.75
Note: *Not paid with other listings.*

01108 Hospital visit (weekday) 50.74
Notes:
i) Not paid with other listings.
ii) Applies only on weekdays, excluding statutory holidays.
iii) Out-of-Office Hour Premiums are not applicable.

P01109 Hospital visit (Saturday, Sunday, or statutory holiday) 88.62
Notes:
i) Not paid with other listings.
ii) Applies only on Saturday, Sunday, or statutory holidays.
iii) Out-of-office Hour Premiums are not applicable.

01151 Pre-anesthetic evaluation (applies to standard pre-anesthetic evaluation) 60.85
Note: *Applicable to certified anesthesiologists only.*

Referred Cases

Consultations:

01015 **Consultation by a certified specialist in Anesthesia:** Because of the complexity, obscurity and/or seriousness of the case. Includes appropriate history and physical examinations, review of radiological and laboratory findings and a written report. 132.71

01115 **Repeat or limited consultation by a certified specialist in Anesthesia:** To apply where a consultation is repeated for the same condition/problem within six months by the same consultant, or where, in the judgment of the consultant, the consultative service does not warrant 01015. To include appropriate history and physical examination, review of radiological and laboratory findings and a written report. 76.14

01016 **Consultation by a certified specialist in Anesthesia:** For diagnostic opinion and/or therapeutic management of complicated chronic pain, and/or related problems. To include comprehensive history and physical examination, review of radiological and laboratory findings and a written report. If followed by a diagnostic or therapeutic nerve block the consultation may be charged in addition to the nerve block fees on the first occasion. 201.75

01116 **Repeat or limited consultation by a certified specialist in Anesthesia:** To apply for a diagnostic opinion and/or therapeutic pain management where a consultation is repeated for the same condition/problem within six months by the same consultant, or where in the judgment of the consultant, the consultative service does not warrant a 01016. ..... 100.86
Notes:
i) 01016, 01116 do not apply to evaluation of pain during confinement.
ii) Fee item 01116 plus a nerve block would be payable for the initial re-referral at the same sitting.

iii) In cases where the consultant sets down a treatment plan that requires the patient to return to follow-up nerve blocks for the same condition, only the nerve block is payable.

iv) In some cases, a single nerve block will be performed at the initial consultation and no further nerve blocks are planned at that time. The course of treatment is to monitor the effectiveness of the first block. If, however, the patient is re-referred for further blocks within 6 months, then a follow-up consultation (01116) plus the nerve block is payable.

Telehealth Service with Direct Interactive Video Link with the Patient:

01155 Telehealth Anesthesiology Consultation: By a certified specialist in Anesthesiology because of the complexity, obscurity and/or seriousness of the case. Includes appropriate history and an appropriate physical examination, review of pertinent radiological and laboratory findings and a written report 132.71

Anesthetic Procedural Fee Modifiers

01059 Prone position 35.50

01065 Patients under 1 year of age 61.10
Note: *Not to be billed in addition to 01168.*

01070 Controlled hypotension in neurosurgical anesthetic to lower mean blood pressure to 60 mm Hg or less, or the appropriate safe lower limit 61.13

01071 Thoracic epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up 54.28

01072 Lumbar epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up. 41.75

01077 Pulmonary artery catheterization 55.60

01082 Axillary catheter insertion during anesthetic, to include initial injection and/or infusion set-up 24.26

01084 Intrapleural catheter insertion during anesthetic, to include initial injection and/or infusion set-up 27.93

01093 Spinal cord monitoring (interpretation of SSEP during anesthetic) 40.76

01096 Retrobulbar/peribulbar block administered by an anesthesiologist in conjunction with an anesthetic 34.04

01164 Patients 70 – 79 years of age 20.38

01165 Patients 80 years of age and over 41.56

01166 Sitting position where there is a danger of venous air embolism 61.13

01168 Neonates (less than 42 gestational weeks and/or 4000 grams or less) 122.20

01192 Awake intubation by any means in the patient with a suspected or proven difficult airway 61.13
Note: *Applicable only when airway score is 3 or 4.*

01169 BMI ≥ 35 - per 15 minutes or part thereof 10.00
Notes:
i) Restricted to certified specialists in Anesthesiology.
ii) Payable only when fee items 01172, 01173, 01174, 01175, 01176, 01177, 01178, 01179, 01180, 01181, 01005, 01106, 01110, or 01111 are also payable.
iii) Applicable to all patients ≥ 19 years of age with a BMI ≥ 35 and to all patients < 19 years of age with a BMI ≥ 97th percentile adjusted for age and gender.
iv) The patient's BMI must be provided in the claim note record and documented on the patient's anesthetic record.

		$
01080	In the following cases an additional 15% of the procedural fee will be paid: a) All patients (except cardiac surgery patients) who have an incapacitating, systemic disease which is a constant threat to life, or who are not expected to survive for 24 hours, i.e. ASA 4 or 5. b) Cardiac surgery patients who have emergency surgery, i.e. ASA 4E or 5E. c) Cardiac or transplant surgery patients who require an IABP or mechanical assist device. d) All cases where the surgical time as noted on the OR record is 8 hours or more. This includes cardiac surgery.	

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

Diagnostic and Therapeutic Anesthetic Fee Items

The anesthetic fee is for professional services. Consultations (fee items 01016, 01116, and 01013) when requested, will be charged in addition. Anesthetic evaluation (fee item 01151), or Continuing Care items (fee items 01107, 01108 and 01109) will not be charged in addition. These fees are for diagnostic and therapeutic procedures not associated with surgery.

01022	Nerve plexus	135.49
01124	Peripheral nerve block - single	64.17
01125	Peripheral nerve block - multiple	96.97
01035	Gasserian ganglion	254.41
	Epidural Blocks:	
01135	Lumbar	150.36
01036	Thoracic	228.03
01037	Cervical	263.12
01138	Caudal blocks	150.36
	Nerve Root or Facet Blocks:	
	Cervical:	
01140	- single	183.13
01141	- multiple	244.17
	Thoracic:	
01142	- single	167.72
01143	- multiple	223.60
	Lumbar:	
01144	- single	152.31
01145	- multiple	203.09

Note: *Fee items 01140, 01141, 01142, 01143, 01144 and 01145 must be performed under medical imaging guidance (ultrasound, fluoroscopy or CT) with image capture.*

	Subarachnoid (Spinal) Blocks:	
01032	Subdural (spinal)	160.01
01034	Differential spinal	213.36

		$
	Sympathetic Nerves:	
01040	Stellate ganglion	117.92
01042	Paravertebral (lumbar sympathetic)	193.87
01044	Coeliac plexus	269.84
	Permanent Cryosection and/or Neurolysis:	
01146	Major plexus or nerve root	352.86
01147	Single peripheral nerve	166.87
01148	Multiple peripheral nerves	223.60
01149	Epidural or subarachnoid neurolysis	397.04
01150	Gasserian ganglion neurolysis	397.04
	Injection Tendon Sheath, Ligaments, Trigger Points:	
01156	Single injection	60.75
01157	Multiple injections	76.20
01159	IV injection for diagnosis and/or therapeutic management of chronic pain syndromes - local anesthetic only	60.75
01160	IV injections for diagnosis and/or therapeutic management of chronic pain syndromes –ketamine only	121.52

Resuscitation by an Anesthesiologist

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

01088 Resuscitation by an anesthesiologist, requiring continuous bedside care - per 15 minutes or part thereof 83.73

Notes:

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

ii) Consultation not paid in addition.

01090 Neonatal resuscitation by an anesthesiologist - per 15 minutes (or part thereof) 83.73

Notes:

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

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

iii) Consultation not paid in addition.

01091 Intubation requested by attending physician, with no responsibility for subsequent care. 176.01

Notes:

i) Applicable to removal and reinsertion of ET tube.

ii) Consultation not paid in addition.

01094	Pulmonary artery catheter placement (not associated with an anesthetic).	167.09
01095	Intra-arterial catheter placement - isolated procedure	34.46
00017	Insertion of central venous pressure catheter	23.88

Acute Pain Management

See Anesthesia Preamble for application and limitations.

		$
01013	Consultation by a certified specialist in anesthesia for assessment of the patient for post operative acute pain management, when the consultation is requested after admission and either prior to surgery or within 24 hours following the end of surgery, to include review of the relevant history and physical examination, X-ray and laboratory findings, and a written report.	101.03
01026	Thoracic epidural catheter insertion, to include initial injection and/or infusion set up	228.03
01025	Lumbar or caudal epidural catheter insertion, to include initial injection and/or infusion set up	150.36
01050	Repeat injection via indwelling epidural catheter to a maximum of 4 per day - per injection ***Note:*** *Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.*	60.85
01073	Hospital visit for supervision of epidural infusion to a maximum of 2 per day - per visit ***Note****: Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.*	40.57
01074	Axillary catheter insertion, to include initial injection and/or infusion set up	72.55
01075	Repeat injections via indwelling axillary catheter to a maximum of 4 per day – per injection ***Note****: Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.*	60.85
01076	Hospital visit for supervision of axillary catheter infusion to a maximum of 2 per day - per visit ***Note:*** *Where more than two visits per day are necessary, an explanatory note in the claim note record is required.*	40.57
01007	Intrapleural catheter insertion, to include initial injection and/or infusion set up	83.54
01019	Repeat injections via indwelling intrapleural catheters to a maximum of 4 per day - per injection ***Note:*** *Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.*	60.85
01021	Hospital visit for supervision of intrapleural infusion to a maximum of 2 per day - per visit ***Note:*** *Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.*	40.57
01011	Patient controlled analgesia (PCA) - first day only (to include set up)	21.79
01012	Hospital visit for supervision of patient controlled analgesia during second and subsequent days, to a maximum of 2 visits per day - per visit ***Notes:*** *i) Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.* *ii) 01012 is not payable on the same day as 01011.*	40.57
01186	Major peripheral nerve block - single	45.85
01187	Major peripheral nerve block - multiple	69.28

$

Obstetric Analgesia Fees

01102 Insertion of epidural catheter. To include initial injection and/or set-up of infusion for analgesia during labour. 127.43

Supervision of Labour Epidural Analgesia

01047 Medical Supervision of Labour Epidural Analgesia: Daytime (Monday to Friday, 0800-1800 hrs), per 5 minutes (or major portion thereof) 9.57

01048 Medical Supervision of Labour Epidural Analgesia: Evening (Monday to Friday, 1800-2300 hours), and Weekends (Saturday & Sunday, 0800-2300 hours) and Statutory Holidays (0800-2300 hours), per 5 minutes (or major portion thereof) 14.38

01049 Medical Supervision of Labour Epidural Analgesia: Night (Monday to Sunday, 2300-0800 hours), per 5 minutes (or major portion thereof) 19.16

Notes:

i) Fees are payable to the same physician concurrently with services provided to other patients, including concurrent payment of fee items 01047, 01048, 01049 for more than one patient.

ii) The fee items 01047, 01048, 01049 are payable to a maximum of 48 units per patient, per maternity.

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

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

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

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

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

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

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

Miscellaneous Anesthetic Procedural Fees

01005 Anesthesia for Magnetic Resonance Imaging (MRI) or CT scanning - per 15 minutes or part thereof 37.30
Note: *Intended to apply only to very heavy sedation, general anesthesiology and/or ventilatory assistance associated with MRI or CT scanning.*

01105 Anesthesia for cataract surgery – per one minute increment..... 2.00
Note: *This item applies to fee codes S02188, S02190, S02192, S02196, and S22191.*

01106 Anesthesia for electroconvulsive therapy - per 15 minutes or part thereof..... 41.90

01110 Anesthesia for dental procedures (all procedures unless otherwise listed) - per 15 minutes or part thereof 36.64

		$
01111	Anesthesia for emergency relief of acute upper airway obstruction (above the carina) - per 15 minutes or part thereof	83.73

Notes:

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

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

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

01112	Anesthetic attendance - per 15 minutes or part thereof	36.64

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

01158	Epidural blood patch	181.82

Transplant Surgery

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

DERMATOLOGY

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

		$	Anes. Level

Referred Cases

00210 **Consultation:** To include history and dermatological examination, with review of any previous X-ray and laboratory findings and written report 79.36

00214 **Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy when necessary, extra) 50.56
Note: *Punch and shave biopsies are included in consultation or visit fees.*

Continuing care by consultant:

00204 Directive care 30.75
00207 Subsequent office visit 31.76
00208 Subsequent hospital visit 30.75
00209 Subsequent home visit 63.28
00205 Emergency visit when specially called out of office 105.43
(not paid in addition to out-of-office-hours premiums)
Note: *Claim must state time service rendered.*

Telehealth Service with Direct Interactive Video Link with the Patient:

20210 Telehealth Consultation: To include history and dermatological examination, with review of any previous X-ray and laboratory findings and written report 79.36

20214 Telehealth repeat or limited consultations: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy when necessary, extra) 50.56
Note: *Punch and shave biopsies are included in consultation or visit fees.*

20207 Telehealth subsequent office visit 31.76
20208 Telehealth subsequent hospital visit 30.75

P20310 Initial Teledermatology Assessment using store and forward technology: To include history and physical findings through one or more photos, with review of any previous X-ray and laboratory findings and written report to the referring physician 78.71
Notes:
i) Restricted to Dermatologists.
ii) Referral is required.
iii) Not payable within 6 months of a consultation, visit, or initial Teledermatology assessment by the same practitioner.
iv) Not paid with another service on the same day by the same practitioner.

		$	Anes. Level
P20314	Repeat Teledermatology Assessment using store and forward technology: To include history and physical findings through one or more photos, with review of any previous X-ray and laboratory findings and written report to the referring physician	40.65	

Notes:

i) Restricted to Dermatologists.
ii) Referral is required.
iii) Payable within 6 months of a consultation, visit, or initial Teledermatology assessment by the same practitioner.
iv) Not paid with another service on the same day by the same practitioner.

Special Examinations

00206	For primary systemic diseases with cutaneous manifestations, to include complete history and physical examination, review of X-ray and laboratory findings, and a written report	179.96	

Special Therapy

00217	Treatment of skin disorders and lesions other than: ultraviolet, x-ray, grenz ray: such as cryosurgery, electrosurgery, etc., - extra (operation only)	14.81	

Notes:

i) Payable to specialists certified in Dermatology only.
ii) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."

00218	Curettage and electrosurgery of skin carcinoma proven histopathologically (operation only)	61.38	
00219	For each additional lesion – to a maximum of two additional lesions per day (operation only)	30.69	

** These items are subject to the general regulations covering surgical procedures.*

00222	Psoralen Ultra Violet A treatment: - whole body	20.33	
00223	- partial body.	20.33	

Note: *Both 00222 and 00223 include an office visit and have a maximum of 40 treatments per year.*

00224	Ultra Violet B treatment, whole or partial body - includes office visit	20.33	
00235	Pulsed laser surgery of the face and/or neck, treatment area less than 50 cm^2 (operation only)	67.92	3
00236	Pulsed laser surgery of the face and/or neck, treatment area greater than or equal to 50 cm^2, or treatment of the eyelids with eye shield insertion (operation only)	101.87	3
00237	Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia	56.08	

Notes:

(a) Only the following conditions qualify for payment under 00235, 00236, 00237:

i) Port wine stains involving the face and/or neck.
ii) Complicated superficial haemangiomas:
- lesions interfering with function (vision, breathing or feeding).
- lesions which are ulcerated, bleeding, or prone to infections where standard wound care has failed.
iii) Facial naevus of Ota.

iv) Disfiguring facial pigmentary anomalies (eg: segmental or systematized).

(b) Only the following types of lasers qualify for payment under 00235, 00236, 00237:

i) Pulsed dye laser
ii) Q-Switched Ruby laser
iii) Q-Switched YAG laser

(c) Restricted to Dermatology and Plastic Surgery.

		$	Anes. Level
00019	Venesection for polycythaemia or phlebotomy - procedural fee	31.65	

Surgical Procedures and Repairs

Mohs' microscopically controlled excision:

00225	Initial cut, including debulking	346.71
00226	One or more additional cuts, extra	300.32
00227	Special overhead and technical component, extra	323.29

Notes:

i) 00225, 00226, 00227 are billable only for complicated epithelial cancer and only by physicians specially qualified in this technique.

ii) 00226, 00227 are billable only once, whether or not excision of the lesion extends to the subsequent day.

iii) 00227 is not billable if the surgery is performed in a hospital setting.

iv) Closure of the resulting defect by undermining and advancement flaps is included in the above fees. If more complicated closure is medically necessary, bill as an extra under appropriate listings for skin grafts.

Skin Grafts

Additional procedures, other than skin grafts, are extra; e.g.: bone or tendon grafts, inlay grafts, etc

Notes:

1. *The medical necessity for a single or multiple flap occurs when a defect cannot be closed by elevating or undermining the edges and suturing subcutaneous tissue and skin. An advancement flap does not qualify for these listings unless the repair involves at least one level of deep sutures and each edge of the lesion is undermined a distance equal to or greater than:*
   (a) 1 cm - nose, ear, eyelid, lip
   (b) 1.5 cm - other face and neck
   (c) 3 cm - rest of body

   These listings are only to be used where the dissection meets the criteria above, whether the advancement involves one or both sides of the wound. If the wound can be closed in a straight line, five cm or less in length, a tissue advancement flap should not ordinarily be required.
2. *When fee items 20222, 20223 or 20225 are done under local anesthesia, an operative note, and/or diagram or clinical record that describes the procedure may be required by MSP to justify claims.*
3. *The medical record of the patient must explain the medical necessity for the use of these listings.*
4. *Fee item 20222 should rarely be used for an excision of tumour of skin or subcutaneous tissue or scar up to five cm when excised under local anesthetic.*
5. *Fee items 20221 to 20228 are restricted to services provided by Dermatologists and/or MOHS surgeons.*

		$	Anes. Level
	Local tissue shifts: Advancements, rotations, transpositions, "Z" plasty, etc:		
20221	Single or multiple flaps under 2 cm in diameter used in repair of a defect (except for special areas as in 20225) (operation only)	203.96	2
20222	Single	315.48	2
20223	Multiple	569.41	2
20224	- with free skin graft to secondary defect	647.63	2
20225	Eyebrow, eyelid, lip, ear, nose - single	296.52	3
	Note: *Repair of torn earlobe to be claimed under 06027.*		

Free Skin Grafts (including mucosa)

Full-thickness grafts:

20226	Eyelid, nose, lips, ear	310.50	2
20227	Finger, more than one phalanx	296.52	2
20228	Sole or palm	296.52	2

Tumours of the Skin:

13600	Biopsy of skin or mucosa (operation only)	52.24	2
13601	Biopsy of facial area (operation only)	52.24	2
	Note: *Punch or shave biopsies which do not require sutures are not to be charged under fee items 13600 or 13601.*		
20231	Biopsy, not sutured	26.85	
20232	Biopsy, not sutured, multiples same sitting, maximum of four (extra)	13.42	
	Notes: *i) Restricted to Dermatologists.* *ii) Paid at 100% in addition to 00207, 00210 or 00214 only.*		
13605	Opening superficial abscess, including furuncle - operation only	44.76	2
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	66.76	2
13621	- additional lesions removed at the same sitting (maximum per sitting, five) each (operation only)	33.39	
	Notes: *i) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."* *ii) Fee items 13620 and 13621 are not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13622	Localized carcinoma of skin, proven histopathological (operation only)	73.75	
06146	Lip shave - vermilionectomy	399.13	3

Diagnostic Procedures

Allergy, patch and photopatch tests:

S00762	Scratch test, per antigen	1.06	
	Note: *Minor tray fees may be paid in addition if a minimum of 16 antigens are used.*		

		$	Anes. Level
S00763	- children under 5 years of age, per antigen	2.32	
	Note: *Minor tray fees may be paid in addition if a minimum of 14 antigens are used.*		
S00764	Intracutaneous test, per test	2.15	
S00765	Annual maximum (to include scratch or intracutaneous tests) for each physician - per patient	34.40	
S00767	Patch testing (extra) (annual maximum, 80 tests) per test	1.96	
S00768	Photopatch test, per test	5.66	
S00769	- annual maximum	56.69	
15136	Fungus, direct microscopic examination KOH preparation	8.39	

OPHTHALMOLOGY

Guidelines for Billing Eye Examinations

Guide to Payments under the Medical Services Plan of B.C. (MSP) for insured services of consultations and eye examinations by Ophthalmologists to insured patients as agreed to by Section of Ophthalmology, B.C.M.A.

1. Consultations:

(a) The definition of a consultation as outlined in Clause D. 2. of the Preamble to the schedule is applicable to ophthalmologists; an ophthalmologic referral is defined as a referral by a medical practitioner or optometrist to an ophthalmologist for a problem beyond refraction.

(b) The account from the ophthalmologist to MSP must include the name of the referring medical practitioner, the appropriate diagnosis and/or symptoms.

(c) A "no charge" referral will be acceptable to MSP to permit payment of the consultative fee where the referring medical practitioner did not carry out an examination of the patient but s/he indicated definite symptoms of which s/he was aware and which were beyond his/her scope.

(d) A consultative fee may be paid to the consultant where a patient is “referred” on a “no charge” basis for an "eye examination" and the consultant in his/her examination finds significant eye pathology, so indicates and completes a written report to the referring medical practitioner. (Note: MSP reserves the right to request a copy of the written report to assist in its determination of any specific account.)

(e) A consultative fee will not be paid where there is a “no charge” referral and the ophthalmologist does not find significant pathology in s/he examination or h/she does not provide satisfactory information regarding pathology s/he has found.

(f) A consultation fee will not be paid if no reference is made to referral received by MSP from the referring medical practitioner, as it will be assumed that no referral was intended.

(g) The deliberate seeking of referrals by an ophthalmologist is not condoned. Ophthalmologists who severely limit their practice to one area or areas of ophthalmology and who do not accept patients for routine eye examinations are to be considered consulting ophthalmologists only. It is the responsibility of these physicians to ensure that referring physicians and patients are aware that they do not accept patients for routine eye examinations; patients would be advised to seek such services elsewhere.

(h) It is the responsibility of the ophthalmologist and the referring medical practitioner to make the system work.

2. Eye Examinations (Item 02015)

(a) MSP, by law, includes as insured services, services rendered by a medical practitioner that are medically required by the patient.

(b) A specific time frequency will not be used as a guide to evidence of medical requirement for an eye examination; if in the opinion of the examining doctor the service was medically required s/he will submit an account to MSP. MSP will accept the account from the examining doctor as evidence of medical requirement, but the Commission (or peer review committees), reserves the right in a specific patient pattern of frequency of services, or physician pattern of practice to require additional information to clearly determine any question.

(c) Where a patient demands or requests services that are beyond medical requirement in the opinion of the examining doctor the patient is responsible for payment of such service.

(d) Where in the judgment of the attending physician the service rendered does not warrant the full 02015 fee, a lesser fee may be charged. It should be kept in mind that in non-referred cases fee item 02015 should not be used where it is more appropriate for the service rendered to be billed as a family medicine office visit.

3. Deinsurance of Routine Eye Examinations

A routine eye examination is not a benefit for individuals 19 – 64 years of age when not associated with an ocular or systemic disease or condition, trauma or injury, or if the patient is using medication which could reasonably be expected to cause a change in refractive status. Exceptional circumstances may be given independent consideration when supported by documentation.

An eye examination is still an insured service if medically required. Medically required eye examination may include the following:

- Ocular disease, trauma or injury
- Systemic diseases associated with significant ocular risk (e.g.: diabetes)
- Medications associated with significant ocular risk.

4. Rural Retention Program Premium Adjustments

The Rural Retention Program applies a fee premium based on a community's isolation points. This fee premium is adjusted for Ophthalmology fee codes by a factor of 1.273.

OPHTHALMOLOGY

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

** See fee item 02012.*

		$	Anes. Level

Clinical Examinations

Referred Cases:

02010 **Consultation:** To include history, eye examination, review of X-rays and laboratory findings and in addition where indicated and necessary, any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test and keratometry, in order to prepare and render a written report. 99.26

02011 **Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six months of the last visit to the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee..... 48.83

02012 **Special consultation:** To apply when a ophthalmologist, neurologist, pediatric neurologist or a neurosurgeon refers a patient to an ophthalmologist for special examination, or when an ophthalmologist refers a patient to another ophthalmologist where a decision regarding medical or surgical treatment is complicated and requires extra consideration, judgement and implementation of specialized knowledge and experience. This item should include any or all eye examinations marked with an asterisk, when indicated and necessary to prepare a written report..... 135.53
Note: *Where referred for emergency surgery and surgery is performed within 3 days from date consultation requested, charge an ordinary consultation.*

Continuing care by consultant:

02007 Subsequent office visit..... 36.14
02008 Subsequent hospital visit..... 48.72
02009 Subsequent home visit 60.27
02005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums)..... 89.84
Note: *Claim must state time service rendered.*

Telehealth Service with Direct Interactive Video Link with the Patient:

22010 Telehealth Consultation: To include history, eye examination, review of X-rays and laboratory findings and any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test, keratometry, where indicated and necessary to prepare written report..... 99.26

22011 Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit to the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee 48.83

22007 Telehealth subsequent office visit 36.14
22008 Telehealth subsequent hospital visit 48.72

		$	Anes. Level

Basic Eye Examination

Eye Examinations (included in consultation or visit fee when applicable)

(When two or more examinations are performed on the same subsequent visit, the major exam is to be charged in full and the lesser exam to be charged at 50%. UP TO A MAXIMUM OF THREE).

02015*	Eye examination to include measurement of refractive error, ophthalmoscopy, and any or all of biomicroscopy, tonometry, eye-balance test, keratometry where indicated	50.86	
	Note: *Fee items 02015, 02018 and 02019 are payable to certified ophthalmologists only.*		
02014	Complete orthoptic evaluation with written report to include history, sensory assessment, motor evaluation in all cardinal gaze situations, and any or all of Hess Screen, Troposcope and Visuscope where indicated	60.87	
	Note*: Item 02014 includes 02007 and 02017.*		
02017*	Oculo-motor function tests	34.51	
02018*	Biomicroscopy	31.95	
02019*	Tonometry	31.95	
02020*	Ophthalmo-dynamometry	28.61	
02028	Examination for low visual aid at low-vision clinic	49.50	
02038*	Keratometry	15.63	
02040	Retinoscopy, keratometry, tonometry, indirect fundoscopy, fundus photography and prosthetic fitting under general anesthetic	133.06	3
02048	Exophthalmometry	13.45	
22016	Pachymetry – extra (when billed with other eye examinations)	10.21	

Notes:

i) Payable once per lifetime for patients with glaucoma or elevated IOP(> 24 mm Hg.). Other diagnoses limited to once per year per patient

ii) Repeats within one year for other diagnoses must be substantiated by diagnostic code or note record.

iii) Not payable for post-refractive (Lasik) patients.

iv) Included in daily limit for eye examinations per day per patient.

Diagnostic Examinations

Notes:

All eye examination fees cover both eyes unless otherwise indicated.

Do not bill professional or technical fee separately to the Plan: for institutional information only.

22046	Posterior segment contact lens examination	11.20	2
22047	Anterior segment gonioscopy	15.01	2

Notes:

i) Fee items 22046 and 22047 are not payable with 02011, 02012, 22113-22117, 02116, or for non-contact lens examination of posterior segment.

ii) Fee items 22046 and 22047 are not payable together.

02025	Fluorescein angiography of retina with interpretation	106.96	
02026	- professional fee	26.90	
02027	- technical fee	80.07	
02030	Electro-retinogram	94.19	
02031	- professional fee	34.98	
02032	- technical fee	59.20	
02034	Dark adaptation, per eye	21.39	

		$	Anes. Level
02035	Colour vision assessment (to include a screening test and at least one quantitative test of hue discrimination)	41.04	
02036	- professional fee	26.91	
02037	- technical fee	14.14	
02039	Fundus photography (limitations - glaucomatous, disc changes, tumour progression and potentially progressive retinal disease)	13.40	
02041	Limited visual field examination: i.e. tangent screen, autoplot arc perimeter, or single level automated test such as OCTOPUS program 3 or 7 or equivalent)	32.59	
	Notes:		
	i) Gross field testing (e.g.: confrontation testing) is included in the consultation, visit or eye examination fee.		
	ii) Fee includes examination of both eyes whether at one time or two separate visits.		
	iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 120 days without written justification.		
02042	Quantitative perimetry examination: one of: (a) Full field manual perimetry such as 2 or 3 isopters on Goldman perimeter or equivalent, with spot checks between isopters and kinetic plotting of scotomata; or (b) limited area manual static threshold perimetry such as 2 or 3 half-meridians at 2 degree intervals to 30 degrees from fixation, or 30 to 50 static threshold points in any arrangement; or (c) automated testing at 2 or 3 threshold related luminance levels (such as OCTOPUS program 33 or 34 or equivalent); or (d) automated testing of periphery only (such as OCTOPUS program 41 or equivalent)	45.70	
	Notes:		
	i) 02042 includes 02041.		
	ii) Fee includes examination of both eyes whether at one time or two separate visits.		
	iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 120 days without written justification.		
02043	Comprehensive quantitative perimetry examination (oculus visual fields): more extensive examination than under fee item 02042 - comprehensive automated static perimetry with multilevel threshold testing (such as OCTOPUS programs 31 and 32, or 31 and 41, or SQUID programs 310, 311, 410, or 411, or programs of equivalent information)	63.32	
	Notes:		
	i) 02043 includes 02042, 02041.		
	ii) Fee includes examination of both eyes whether at one time or two separate visits.		
	iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 120 days without written justification.		
02044	Electro-oculogram	76.33	
02045	- professional fee	26.91	
02047	Dacryocystogram	62.57	

		$	Anes. Level
02049	Potentiometry	31.31	
22023	10 or 24 hour diurnal tension curve	35.27	

***Note**: Fee items 02018 and 02019 are not billable in addition to 22023 if the physician is required to perform a final intraocular pressure measurement and microscopic assessment of the anterior segment and a review of the trend of the previous hourly pressures taken. This is considered as included in the fee for 22023.*

02067	Manual retinal nerve fibre layer photography and neuro-retinal rim assessment	65.18	
02068	- professional fee	12.52	
02069	- technical fee	52.65	

Notes:

i) Fee items 02067 - 02069 include examination of both eyes whether at one time or two separate visits.

ii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

22067	Computerized retinal nerve fibre layer photography and neuro-retinal assessment (e.g.: Heidelberg, GDX)	55.54	
22068	- professional fee	12.52	
22069	- technical fee	43.02	

Notes:

i) Requires both qualitative and quantitative assessments.

ii) Includes examination of both eyes whether at one time or two separate visits.

iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

iv) Includes 02007, 02018, 02019.

22075	Computerized Corneal Topography	58.70	
22076	- professional fee	15.92	
22077	- technical fee	42.78	

Notes:

i) Payable for post-operative corneal transplant assessment, maximum six per year per patient. In cases of problematic corneal transplant or unresolved astigmatism, additional tests may be paid, if accompanied by the following code (9968).

ii) This fee includes both eyes, whether at one time or two separate visits.

iii) Payable for corneal thinning disorders, including keratoconus and pellucid marginal degeneration, where progressive astigmatic change greater than 1 diopter in a year has been documented, corneal epithelial or stromal scarring, where the visual central axis of the cornea is affected. Payable once per year per patient. In cases where there is documented progression of any of these conditions, additional tests may be paid, if accompanied by the following code (V80).

iv) Not payable for pre- or post-operative cataract patients except where there is documented evidence of irregular astigmatism resulting from the cataract surgery.

v) Payable with following fee items if medically necessary: 02015, 02018, 02019, 22169, 02010 and 02012.

vi) Note record or letter must be submitted to document evidence of results derived from CCT when billing eye exams.

vii) Keratometry (02038) not payable in addition.

viii) Not an insured benefit when used in association with laser refractive surgery or assessment for same.

		$	Anes. Level
S00780	Schirmer's Test (included in Fee Item 02015)	13.15	
S00771	Retinal examination under anesthesia - procedural fee (when done as an independent procedure)	20.08	3
22050	Specular Microscopy – total fee	78.13	
22051	Specular Microscopy – professional fee	20.39	
22052	Specular Microscopy – technical fee	57.74	

Notes:

i) Paid for post-operative corneal transplant assessment, maximum 6 per patient, per each 12 month period.

ii) Daily maximum of 1 per patient/day.

iii) In cases of corneal failure or rejection, additional tests may be paid, if accompanied by a note.

iv) This fee includes specular microscopy for one eye.

v) Not paid for pre- or post-operative cataract patients.

vi) Paid once prior to intraocular surgery when affected by:
- o Fuchs corneal dystrophy
- o Bullous keratopathy
- o Iridocorneal endothelial syndrome
- o Posterior polymorphous corneal dystrophy
- o Other causes of endothelial disease, prior to surgical intervention that could damage endothelial cells (e.g.: secondary IOL insertion).

vii) 22050 (total fee) and 22052 (technical fee) paid only when service performed in a physician's office.

Ultrasound and Axial Measurement Examinations

Preamble: "Real-time ultrasound fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision."

22399 Measurement of axial length of eye – by any method (to be billed only if patient proceeds to eye surgery/procedure as indicated below): 64.34

Notes:

i) Eligible indications for billing 22399 include:
- *a) Intraocular lens (IOL) implant surgery following cataract removal.*
- *b) Any procedure where a peribulbar or retrobulbar injection is needed and risk of eyeball perforation by the injection needle is a potential danger such as:*
  - *i. any ocular surgery requiring local anesthetic with peri or retro-bulbar block, e.g.: Ptyregium surgery, corneal transplant, retinal surgery.*
  - *ii. Retrobulbar injection of therapeutic agents.*
- *c) Axial or pathological myopia-serial assessments.*
- *d) Diagnosis of conditions where axial myopia is a diagnostic criteria (e.g.: Marfan's).*
- *e) Posterior staphyloma-serial assessments.*
- *f) Pre-operative assessment for radioactive plaque implant - Brachytherapy for ocular melanoma.*

ii) Provide indication in note record when non-IOL implant indicated A-scan is performed.

iii) Claims for IOL implant patients should indicate either:
- *R/L eye for cataract surgery -on wait list or*
- *R/L eye for cataract surgery (with the surgery date indicated).*

iv) Limited to once per year, per eye. A note record indicating the need for additional scans is required.

		$	Anes. Level
08641	Ophthalmic B scan (immersion and contact):	101.17	

Notes

i) No additional charge for second eye when both eyes examined concurrently.
ii) 08641 includes 22399 when done at the same sitting.
iii) Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.

Fitting of Contact Lenses

22056	Contact lens bandage - unilateral	79.83	
02058	Contact Lens - aphakia - unilateral	266.12	
	Note: *Fee item 02058 includes follow-up visits for three months.*		
22059	Contact lens - keratoconus - unilateral	266.12	

Surgical Fees

Note: *Unless otherwise noted, all fees apply to single eye.*
Second eye is billable as per operative surgical fee Preamble, clause D. 5. 3.

Special Therapy

S02108	Beta radiation	20.74	
S02109	Injections – subconjunctival (operation only)	22.36	
	Note: *Not to be billed at the time of any intra-ocular surgery.*		
S02110	Placement of radioactive plaque	1,002.34	5
	Note: *Fee item S02110 involves 3 surgeries over a span of 3 weeks. The fee includes the 3 procedures. The anesthesiologist may bill for each procedure.*		
S02073	Botulinum toxin injections for blepharospasm associated with dystonia (including benign essential blepharospasm) or VII nerve disorders in patients 12 years of age or older - unilateral or bilateral	136.66	
S02075	Botulinum toxin injections for entropion	74.69	
S02076	Botulinum toxin injections for strabismus in patients age 12 or older	207.99	

Lacrimal Apparatus

S02111	En bloc micro-dissection lacrimal gland for tumour with excision by lateral approach with levator dissection	1,119.48	6
S02118	Two or three snip procedure (operation only)	47.95	3
S02120	Punctum dilation and syringing sac	25.54	3
S22121	Duct probing - under general anesthesia - unilateral or bilateral	176.44	3
	Note: *Not to be billed with S02123 on the same eye.*		
S02122	- under local anesthesia (operation only)	25.54	3
S02123	Insertion of Quickert tube	206.18	3
S02129	Insertion of Lester Jones tube	423.43	3
S02119	Dacryocystostomy - under local anesthesia (operation only)	35.29	3
S02112	Dacryocystectomy with unroofing of bony lacrimal canal and removal of lacrimal duct for tumour	1,058.61	4
S02126	Dacryocystorhinostomy	560.17	3
	Note*: Not to be billed with S02123 on the same eye.*		
S02127	Repair of canaliculi	494.00	3

		$	Anes. Level
	Orbit		
S02132	Retrobulbar injection (operation only)	90.93	2
	Note: *Not to be paid in addition to intra-ocular surgery.*		
S02133	Enucleation or evisceration	529.70	4
S02134	Orbit - enucleation with insertion of complicated implant (e.g.: dermis fat graft and/or scleral wrapped porous implant).	776.31	4
S02135	Exenteration of orbit	1,008.31	4
S22136	Biopsy or excision of anterior orbital tumour	352.88	4
S22140	Orbital exploration (posterior route) - to biopsy posterior orbital tumour or to fenestrate optic nerve sheath	1,129.17	6
	Note*: Not payable with fee item S22138.*		
S22138	Posterior orbitotomy for removal of posterior orbital tumour not involving the orbital apex or optic nerve	1,411.49	6
	Note: *Not payable with fee item S22140.*		
S02144	Aspiration needle biopsy of orbit under scan control	135.62	3
S02101	Posterior orbitotomy with microscopic dissection for lesions of optic nerve or orbital apex	1,764.34	7
S02145	Orbital exenteration with en bloc resection of bony orbital walls - Ophthalmologist	1,679.65	7
	Note: *Fee from Neurosurgeon and Plastic Surgeon in addition.*		
	Orbital decompression:		
S22141	- 1 wall	635.16	6
S22142	- 2 wall	980.91	6
S22143	- 3 wall	1,411.49	6
	Note*: Orbital decompression is not paid in addition to fee items S22140 or S22138.*		
	Eyelids		
	Note: *For removal of foreign bodies from surface of eye, the appropriate fee item to charge in non-referred cases is one 13610, 13611 or 06063. For properly referred cases it is expected the ophthalmologist will charge only the consultation fee.*		
S02103	Minor lid repair (operation only)	88.57	3
S02104	Major lid reconstruction (one or two stage)	882.17	3
	Note: *Includes rotation or transposition of flaps and/or skin grafting if required to reconstruct defect, and/or canalicular reconstruction, and/or (in one-stage procedure) frozen section controlled excision of tumour if performed.*		
S02105	Two-stage reconstruction with micrographic tumour excision	1,470.29	3
	Note: *Includes resection of tumour with micrographic control, cross lid flaps, skin grafts and subsequent division of transposition flaps.*		
S02106	Microscopic repair of trichiasis including muscular graft or mucosal membrane graft	582.57	3
S02107	Repair of eyelid margin defect, requiring layered closure.	352.88	3
S02146	Trichiasis - epilation, forceps (operation only)	22.36	3
S02147	- electric (operation only)	64.38	3
S02148	Cryotherapy of eyelids for trichiasis or tumour (operation only)	117.64	3
S02149	Meibomian gland evacuation (operation only)	22.36	
S02150	Chalazion excision (operation only)	78.90	3

		$	Anes. Level
S02152	Tarsorrhaphy (operation only)	116.92	3
S02153	Ectropion/Entropion - Ziegler or simple procedure - involves simple skin incision but does not require associated lid shortening or skin grafting (operation only)	56.35	3
S02154	Ectropion/Entropion - complicated, including neoplasms and plastic repair - requires both repair and associated lid shortening and/or skin grafting	334.98	3
S02155	Ptosis repair - frontalis sling using synthetic material	294.05	3
S02159	- frontalis sling using autologous material	547.30	3
S02160	- levator resection	537.77	3
S02158	Fasanella Servat	265.00	3
S02166	Lid elevation and scleral graft for lower lid retraction	470.48	3
S02100	Graded Muellerectomy with levator recession under local anesthesiology	470.48	3
S02156	Excision of tumour of lid margin or conjunctiva – benign (operation only)	88.57	3
S02157	Excision of benign tumour of lids (operation only)	38.32	3
	Note: *The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D.9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."*		

Eye Muscles

S02161	Strabismus - one or two muscles	374.20	3
S02162	- three or more muscles	529.31	3
S22165	- five or more muscles	764.54	4
S02163	- complicated re-operation	588.12	4
S22166	Adjustable suture fee - extra to strabismus surgery	176.44	
S22167	Prism adaptation therapy and/or amblyopia therapy correction of fusional disturbances and/or amblyopia	138.39	
	Note: *Billable at full value, only during pre-/post-operative period in association with strabismus surgery (S02161, S02162, S 02163, S22165). Minimum of three visits required to bill single fee.*		

Cornea and Sclera

S22171	Pterygium excision with mucous membrane graft.	420.13	4
S22172	Complicated pterygium excision (re-operation) or cancer excision, with mucous membrane graft	604.99	4
	Note: *Record of previous pterygium surgical excision (operative report or referral letter) must be available on request.*		
S02167	Cautery or cryotherapy of corneal ulcer (operation only)	31.83	3
S02171	Pterygium or limbus tumour excision (operation only)	126.95	3
S02172	Gundersen-type flap	294.05	3
	Keratoplasty:		
S02173	- lamellar	850.60	3
S02175	- penetrating	851.47	4
S02168	- complicated re-operation	956.76	4
	Note: *S02168 applicable only when there is previous anterior segment surgery (with record) or major anterior segment trauma to same eye.*		

		$	Anes. Level
S22169	Suture removal at slit lamp following keratoplasty (operation only)	22.15	4

Notes:

i) S02168, S02173, S02175 include all suture removals within the normal 42 day post-operative period. After 42 days, bill under S22169.

ii) S22169 is not billable with an office visit, but is billable at 50% with other procedures.

Collagen Cross-Linking for Keratoconus

S22175	Professional fee	404.61	
S22176	Technical fee	505.77	

Notes:

i) Paid only for Keratoconus.

ii) In order to be eligible for the procedure, patients age 25 or older must show progression of greater than 1 Dioptre change in refractive astigmatism or a greater than one line loss of corrected acuity documented over a minimum of two examinations. Patients under the age of 25 with Keratoconus do not need to show progression.

iii) CXL may not be claimed in association or in relationship with refractive surgery for shape improvement.

iv) Includes: both corneal pachymetry (pre and post), corneal de-epithelization, all the isometric riboflavin drops, any other drops, the technician's time, use of the UV-A light.

v) When performed in a publicly-funded facility, the technical fee is not paid.

vi) Second eye paid at 50% if performed the same day. Post refractive ecstasia is not a benefit.

S02174	Suture of cornea and/or sclera - with or without iridectomy - simple	309.98	4
S02169	- complicated	701.33	4

Glaucoma/Iris/Anterior Chamber

S22070	Molteno implant (includes phase 1 and phase 2)	1,072.16	5

Note: *Includes placement of scleral graft if indicated.*

S02176	Sclerotomy - posterior with or without insufflation of gas - isolated procedure	131.46	4
S02177	Glaucoma - peripheral iridectomy - isolated procedure	345.26	4
S02178	- filtering procedure, non-microscopic	598.26	4
S02180	- goniotomy	543.84	4
S02183	- goniotomy, repeat within 3 months	225.87	4
S02184	- cyclodialysis	334.98	4
S22185	- cycloablative procedures	309.98	4
S02187	- filtering procedure, microscopic	644.24	4
S22187	- complicated trabeculectomy	939.34	4

Note: *For use in cases with at least one previous glaucoma filtering operation (S02187 or S22070) or multiple previous intraocular surgeries.*

S02189	Iridocyclectomy via scleral flap dissection	631.00	4
S02197	Surgical evacuation of a hyphema	518.72	4

		$	Anes. Level
	Cataract/Lens		
S02188	Cataract - linear extraction, congenital, traumatic or senile	279.16	
S22191	- capsulotomy (needling or discission) - isolated procedure	208.26	
	Pediatric cataract extraction		
22188	- 0 to 7 years	1,122.62	
22189	- 8 to 16 years	748.41	
S02190	Primary intraocular lens implantation to include repositioning of lens within the 42 day post-operative period - extra	73.47	
S02192	Secondary intraocular lens implantation to include repositioning of lens within the 42 day post-operative period	481.75	
S02196	Surgical repositioning of implant lens ***Note:*** *For non-surgical repositioning use visit fees.*	225.87	
	Retinal Procedures		
S02181	Foreign body intraocular - magnetic extraction - isolated procedure	620.22	4
S02182	- non-magnetic extraction - isolated procedure	750.18	4
S02090	Intravitreal injection of vitreous paracentesis ***Note****: Not to be billed with S02199 or S02194.*	134.43	4
S02091	Paracentesis, anterior chamber	134.23	4
S02092	Intravitreal biopsy (microbiology, cytology) or intraocular tumour needle biopsy	215.18	4
S02194	Buckling procedure ***Notes:*** *i) Includes cryopexy, and/or laser and/or fluid gas injection, and/or paracentesis, and/or fluid drainage.* *ii) Not to be billed with S02199.*	807.76	5
S02195	Diathermy or cryopexy for retinal tear or other retinal disorder ***Note:*** *Not to be billed in addition to S02199 or S02194.*	226.99	5
S02198	Anterior vitrectomy ***Note****: S02198 is intended for cases of vast complication requiring removal of membranes from the anterior segment as a result of prior surgery or injury. It is not intended in conjunction with elective cataract removal and/or primary lens implantation.*	349.55	4
S02199	Posterior vitrectomy with 2 or 3 port infusion cutting device. Includes membrane peel and/or dissection	910.84	5
	Extras to posterior vitrectomy, where appropriate: A maximum of two of the following fee items (S22199 - S22203) may be billed at 100% in addition to S02199. Fee items S02174 or S02169 may be billed at 50% in substitution for one of the above, where applicable:		
S22199	Fluid/gas exchange and silicone injection if required with posterior vitrectomy (operation only)	67.23	5
S22200	Panretinal endolaser greater than 200 burns when done with a posterior vitrectomy	207.26	5
S22201	Scleral buckle done with posterior vitrectomy (operation only)	56.01	5
S22202	Intra-ocular lens removal and/or lensectomy when done with a posterior vitrectomy (operation only)	56.01	5
S22203	Removal of intra-ocular foreign body at the time of posterior vitrectomy	224.07	5

		$	Anes. Level
S22196	Pneumato retinopexy with air or gas - isolated procedure ***Note**: Includes cryopexy or laser.*	387.65	5
S22195	Removal of buckle material or sponge ***Note**: Not paid with any other fee item on the same eye.*	173.65	5
S22197	Additional gas (C3F8 or SF6) or air injection ***Note:** Payable within 42-day post-operative period following buckling procedure, vitrectomy, or pneumato retinopexy.*	99.69	5
S22198	Repair of scleral laceration and cryopexy and/or gas injection with scleral buckle – isolated procedure	981.42	5

Laser Procedures

S02072	Laser interferometry	32.49	4
S22113	Laser iridotomy per eye (operation only)	117.64	4
S22114	Laser trabeculoplasty per eye ***Note:** If laser trabeculoplasty (22114) to the same eye is done at multiple sittings within 6 weeks of the initial treatment, then subsequent treatments will be included in the original fee*	128.40	
S22115	YAG laser capsulotomy per eye (operation only)	106.44	4
S22116	Retinal photocoagulation - left	128.40	4
S22117	Retinal photocoagulation - right	128.40	4
S02116	Panretinal photocoagulation - defined as greater than 700 burns maximum fee for one eye for any 6 month period ***Notes:*** *i) All laser procedures include all follow-up visits in the six-week post-operative period except for fee item S22118 which is limited to one visit.* *ii) Laser procedures include fee items 22046 and 22047.* *iii) Where laser procedures are performed on both eyes at the same sitting, both shall be paid at 100%.* *iv) Repeat billing for retinopathy of prematurity (babies under 6 months) is permitted, to a maximum of two billings per eye in 6 month period. A note record is required if more than 2 repeats are needed.*	524.72	4
S22118	Laser follow-up visit ***Notes:*** *i) Can be billed once only during six weeks following laser treatment.* *ii) Includes examination of lasered site and may include refraction and vision check, and intra-ocular pressure check.*	33.20	
S22125	Photodynamic therapy for age-related wet macular degeneration – professional fee ***Note:** Payable to Retinal Physicians certified in PDT treatment only.*	279.77	
00094	YAG laser tray service fee ***Notes:*** *i) Applicable to fee items S22113 and S22115 only.* *ii) Hospitals and physicians who use hospital based YAG lasers are not eligible to bill this fee.*	65.66	

OTOLARYNGOLOGY

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

		$	Anes. Level

Referred Cases

02510 **Consultation:** To include history, detailed examination of the ear, nose, and throat, review of X-ray and laboratory findings, and written report 78.65

02511 Consultation with pure tone audiogram 94.26

02514 **Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee 45.81

02512 **Special consultation for dizziness**: To apply where a patient has been referred by an Otolaryngologist or a Neurologist or a Neurosurgeon and to include all special examinations and an appropriate neurological assessment and a written report 166.27

02513 Consultation for management of malignancy 108.85

Notes:

i) Payable to the surgeon in charge.

ii) Not payable for minor or superficial skin malignancies.

iii) Applicable to new malignancy or recurrence of malignancy in remission.

02515 Otolaryngic Allergy Consultation: To include a detailed history and appropriate physical exam with review of laboratory and other relevant investigations, plus appropriate otolaryngic allergy testing, management and additional visits necessary to render a written report 145.14

Notes:

i) Restricted to Otolaryngologists who have completed advanced training in Otolaryngic Allergy through the AAOA.

ii) Appropriate diagnostic allergy skin testing is a requirement for billing 02515.

iii) Skin scratch and patch testing fee items (00762, 00763, 00764, 00765, 00767) are not payable in addition.

02517 Consultation for management of complex laryngeal disorder 137.56

Notes:

i) To apply where a patient has been referred by another Otolaryngologist, Neurologist or Respirologist.

ii) To include self-assessment, perceptual analysis, aerodynamic measures and acoustic analysis.

Continuing care by consultant:

02507 Subsequent office visit 36.97

02508 Subsequent hospital visit 24.41

02509 Subsequent home visit 48.92

02505 Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) 122.35

Note: *Claim must state time service rendered.*

		$	Anes. Level
02215	Pre-Operative Assessment	77.84	

Notes:

i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.

ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.

iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.

iv) Maximum of one pre-operative assessment per patient per procedure.

v) Only paid to the surgeon who performs the procedure.

Telehealth Service with Direct Interactive Video Link with the Patient:

25010	Telehealth consultation: To include history, detailed examination of the ear, nose, and throat, review of X-ray and laboratory findings, and written report	78.65	
25012	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	45.81	
25007	Telehealth subsequent office visit	36.97	
25013	Telehealth consultation for management of malignancy	108.85	

Notes:

i) Payable to the surgeon in charge.

ii) Not payable for minor or superficial skin malignancies.

iii) Applicable to new malignancy or recurrence of malignancy in remission.

Miscellaneous

02519	Complex Laryngeal Disorder Conference Fee - per 15 minutes or greater portion thereof	30.35	

Notes:

i) Restricted to Otolaryngology.

ii) Restricted to laryngeal pathology.

iii) Payable only if 02517 (consult for management of complex laryngeal disorder) has been paid for the same patient by the same practitioner in the previous 6 months.

iv) Requires interdisciplinary team meeting with at least one allied health professional.

v) Maximum of four paid per patient, per day.

vi) Maximum of eight paid per patient, per calendar year.

vii) The results of the assessment, as well as the names and roles of those who participated in the meeting must be documented in patient's chart, and result communicated to Family Physician or referring physician.

viii) Start and end times must be entered in both the billing claims and patient's chart.

ix) Not paid to physicians who are employed by, or who are under contract to a facility; or physician working under salary, service contract, or sessional arrangements.

x) Consult or visit on the same day paid in addition if medically required and does not take place concurrently with the conference fee.

		$	Anes. Level

Special Examinations

The following fees, except for items 02520 and 02521, apply when these special otolaryngological examinations are carried out by or under the supervision of a certified otolaryngologist.

Note: *When two or more special examinations are performed by a specialist Otolaryngologist on the same visit, the major examination is to be charged in full and the lesser examinations to be charged at 50%, up to a maximum of three examinations (not to include an audiogram [AC and BC] if done as a part of a consultation). No charge will be made for an office visit in addition to these special examinations when examination is done as an adjunct to a consultation.*

	Hearing tests:		
02520	Audiogram - pure tone (AC and BC)	15.44	
02521	Audiogram - speech (SRT,PB, MCL)	16.85	
02525	Impedance test	9.04	
02531	Impedance test, including contralateral reflex	17.79	
02532	PI-PB test	6.24	
02533	Play audiometry	24.10	
02534	Free field audiometry	24.10	
02536	Brain stem evoked response audiometry	47.21	
02541	Electrocochleography	51.42	
02539	Brain stem evoked response audiometry with electrocochleography	68.22	
	***Note**: Only one additional specialist examination can be billed in addition to this item.*		
	Vestibular tests:		
02526	Cold calorics test	11.11	
02527	Bithermal test	24.10	
02528	E.N.G. (Electronystagmography)	47.54	
	***Note:** To control the total cost involved in extensive patient investigation, the following recommendation applies: Vestibular tests performed on a subsequent visit should have a maximum fee limitation equal to the value of fee item 02528 to be paid directly in lieu of return visit.*		
	Functional tests:		
02530	Stenger	24.10	
02542	Measurement of autoacoustic emissions	32.14	
	Miscellaneous tests:		
	***Note**: See also SY00907, SY00908 under Diagnostic Procedures*		
02538	Laryngostroboscopy	84.80	
02535	Maxillary sinus endoscopy via canine fossa, with or without biospy	116.87	3

Ear

	Removal of foreign body or aerating tubes from ear - simple	per visit	
02221	Microscopic debridement, foreign body removal, or aural polyp removal	27.11	2
02223	- under general anesthesia (operation only)	63.76	2
	***Note:** 02221 and 02223 are not payable with 02254, 02274, 02228, and 02229.*		
02206	Removal of ear canal osteoma (operation only)	82.94	2
02209	Removal of obstructing exostosis of the ear canal	484.78	3

		$	Anes. Level
02210	Paracentesis of the ear drum (operation only)	44.65	2
02233	Transmastoid facial nerve decompression - vertical and horizontal segment	1,127.78	4
02234	- vertical segment	586.86	4
02224	Transcanal labyrinthotomy transmastoid for posterior semicircular canal occlusion.	218.88	4
02241	Labyrinthectomy - drill out of petrous bone.	574.07	4
02242	Microsurgical repair and reconstruction soft tissue atresia, external ear canal – complete ***Note:*** *Includes skin grafting or flap.*	796.06	3
02243	Repair atresia external ear canal, complete, bony	1,058.85	3
02244	Repair stenosis external ear canal, bony	612.35	3
02245	Microsurgical repair and reconstruction soft tissue stenosis - external ear canal ***Note:*** *Includes skin grafting or flap.*	663.38	3
02231	Microsurgical revision and reconstruction, soft tissue stenosis - external ear ***Note:*** *Includes skin grafting or flap.*	530.69	3
02247	Mastoidectomy - partial, canal wall up (Cortical)	612.35	3
02248	Radical mastoidectomy	778.18	4
02249	Stapes-reconstruction	612.35	3
02250	- mobilization of	357.19	3
02246	- reconstruction with laser	663.38	3
02251	Myringoplasty repair of drum – without exploration of middle ear	191.35	3
02239	Tympanotomy - with ossicular chain reconstruction	357.19	3
02252	Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of tympanotomy)	446.51	3
02264	- with ossicular chain reconstruction	676.13	3
02276	- lateral graft, homograft tympanic membrane ***Note****: Applicable to adhesive otitis media or total perforation.*	676.13	3
02238	Tympanoplasty with excision of bony canal stenosis – microscopic open ***Notes:*** *i) Requires drilling out of bony canal stenosis in conjunction with repair of tympanic membrane perforation.* *ii) Not payable with fee item 02253 or 02273.* *iii) Includes fee item 02244 or 02252.*	832.28	3
S02277	Tympanoplasty with excision of middle ear cholesteotoma - first 90 minutes ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	507.54	3
S02278	Tympanoplasty with excision of middle ear cholesteotoma - each additional 15 minutes or greater portion thereof (to a maximum of 16 units) ***Notes:*** *i) Restricted to Otolaryngologists.* *ii) If the cholesteatoma extends into the mastoid, bill fee items 02253 or 02273 only.* *iii) Not payable with fee items 02252, 02253, 02264, 02273, or 02276.* *iv) Start and end times must be entered in both the billing claims and the patient's chart.*	50.76	3

		$	Anes. Level
02253	Tympanomastoidectomy - Complete, canal wall down, including tympanoplasty	1,033.35	3
02265	- partial, canal wall down (atticotomy)	612.35	3
02263	Trans-tympanic polyneurectomy	331.68	3
	Myringotomy with insertion of aerating tube:		
02254	- unilateral (operation only)	82.94	2
02274	- bilateral (operation only)	127.57	2
	Myringotomy with insertion of aerating tube, under GA		
02228	- unilateral (operation only)	103.09	2
02229	- bilateral (operation only)	157.79	2
02255	Exploratory tympanotomy	236.02	2
02261	- with chemical control, tac procedure, cryosurgical control, ultrasound	389.10	3
02266	Myringoplasty - paper patch or synthetic (operation only)	44.65	2
02256	Endolymphatic shunt, any procedure	867.48	6
02259	Excision of glomus - by tympanotomy approach	676.13	3
02260	- where extensive dissection is required	1,039.57	6
02269	Implantable bone conductor	469.68	4
02267	Conchal cartilage graft	318.91	3
02268	Intra-cochlear implant	1,383.29	4
C02225	Middle Fossa Approach for Repair of Superior Canal Dehiscence ……	920.76	5
	Note: *To include approach and plugging or repair of canal.*		
02270	Transmastoid - posterior semicircular canal occlusion or repair of superior canal dehiscence	1,383.29	4
	Note: *i) Includes mastoidectomy ii) For management of posterior canal positional vertigo and superior canal dehiscence to include approach and plugging or resurfacing of canal.*		
02271	Transmastoid microsurgical removal of facial neuroma via extended facial recess approach.	1,990.13	5
	Notes: *i) Includes resection and removal of tumour with facial nerve preservation. ii) Payable only to certified Otolaryngologists.*		
02272	Transmastoid microsurgical removal of middle ear/mastoid tumour.	1,194.08	5
	Notes: *i) Requires extensive dissection, ossicular disarticulation and reconstruction, and extended facial recess approach to the hypotympanum. ii) Applicable to tympanomastoid glomus and facial nerve tumours requiring resection of the facial nerve.*		
02273	Microsurgical tympanomastoidectomy - complete, canal wall up.	1,127.78	5
	Note*: Includes tympanoplasty and ossicular reconstruction.*		

Nose and Sinuses

	Removal of foreign body from nose: - simple	per visit	
02301	Removal of foreign body from nose- complicated with anesthetic (operation only)	63.76	3
	Cauterization of septum - chemical	per visit	
02303	Cauterization of septum – electric (operation only)	38.25	3
	Cryosurgical treatment of turbinates:		
02298	- unilateral	153.09	3
02299	- bilateral	191.35	3

		$	Anes. Level
	Turbinectomy:		
02304	- unilateral (operation only)	95.67	3
02305	- bilateral	140.31	3
02306	Submucous resection of septum	165.83	3
	Naso-antral window:		
02307	- single (operation only)	114.81	3
02308	- double	178.61	3
02309	Radical antrostomy	318.91	3
02310	- with closure of alveolar fistula	459.27	4
	Intranasal ethmoidotomy to include polypectomy, posterior:		
02360	- unilateral	357.19	3
02361	- bilateral	548.56	3
	Intranasal ethmoidotomy, anterior:		
02362	- unilateral	191.35	3
02363	- bilateral	318.91	3
02357	Endoscopic sinus surgery: Functional endoscopic sinus surgery in children under 14 years of age.	318.93	
	Notes: *i) Extra to fee items 02307, 02308, 02360, 02361.* *ii) Payable at an additional 50% of the applicable surgical fee.*		
02315	External radical fronto-ethmoidectomy	586.86	4
	Electrocoagulation of turbinates:		
02317	- one side (operation only)	51.03	3
02318	- both sides (operation only)	76.53	3
02319	Trephining frontal sinus	255.15	3
02321	Sinus sphenoidotomy (intranasal)	267.90	3
	Removal of nasal polypi:		
S02322	- unilateral (operation only)	102.06	3
S02323	- bilateral	165.83	3
	Antral lavage:		
02324	- unilateral (operation only)	33.58	3
02325	- bilateral (operation only)	50.35	3
	Choanal atresia, definitive repair of:		
02326	- unilateral	484.78	3
02327	- bilateral	676.13	4
	Choanal atresia; perforation of:		
02328	- unilateral	165.83	3
02329	- bilateral	229.62	4
02336	Laser revision of choanal stenosis	132.68	4
	Submucous turbinectomy:		
02330	- unilateral	165.83	3
02331	- bilateral	255.15	3
	Lateral rhinotomy and excision tumour:		
02332	- benign	586.86	3
02333	Lateral rhinotomy and/or medial maxillectomy for excision of nasal tumour	625.11	3
	Notes: *i) To include open or endoscopic techniques* *ii) Not payable for polyps.*		
02334	Transantral ethmoidectomy	484.78	3
02335	Transantral ligation, internal maxillary artery	510.30	6

		$	Anes. Level
02337	Ligation of anterior and posterior ethmoid arteries	318.91	6
02338	Removal of angiofibroma-nasal pharynx	739.92	6
02342	Maxillectomy with exenteration of ethmoid	803.71	5
02339	Palatal fenestration	257.82	3
02343	Septal reconstruction	382.72	3
02341	Posterior nasal packing - to include balloon control of epistaxis (operation only)	63.76	3
02346	- with trans-oral gauze pack, under local, topical, or general anesthesiology (operation only)	99.49	3
02345	Drainage of abscess or haematoma of septum (operation only)	114.81	3
02347	External osteoplastic frontal flap operation	931.30	4
02364	Nasal fracture - simple reduction (operation only)	63.76	3
S02365	- reduction and splinting (operation only)	127.57	3
06123	- comminuted nasal fractures – transosseous wire plate fixation	307.05	3
02348	Operative closure of oral-nasal fistula	357.19	3
02349	Operative closure of nasal septal perforation	510.30	3
02358	Revision endoscopic frontal sinusotomy, with or without C arm	464.38	3
02359	Revision endoscopic intranasal spheno-ethmoidotomy (anterior, middle and posterior cells including sphenoid).	530.69	3
25100	Laser photocoagulation of hereditary hemorrhagic telangiectasia lesions of nasal cavities (HHT)	446.09	6

Notes:

i) Not payable with fee items 00907, 00908, 00909, 00235, 00236, 00237, 02303, 02317, 02318, 02341 and 02346.

ii) Includes payment for any and all HHT sites treated by laser. Not for use on external non-symptomatic lesions.

iii) Payable for treatment of one or both nasal cavities at the same sitting regardless of the number of lesions treated.

iv) Maximum of five subsequent procedures in a six (6) month period, otherwise support with a written letter.

25300	Endoscopic stereotactic resection of intranasal or sinus tumour - up to 7 hours operating time	1,046.36	6

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

25301	- additional payment after 7 hours operating time	261.58	

Notes:

i) Fee items 25300 and 25301 are payable only when pre-operative radiological imaging indicates either distorted anatomy of the sinuses secondary to disease or injury, or revised complex anatomy resulting from prior surgery, such that without stereotactic guidance, the surgery could not be performed.

ii) Not payable for ethmoid disease, polypectomy or tumours affecting only one sinus.

iii) Includes all surgery necessary to access tumour.

iv) Payable only when rendered in acute-care facility.

v) Time over seven hours is payable under fee item 25301.

vi) Minimum of 3 hours surgery duration required to bill fee item 25300.

vii) Start and end times must be entered in both the billing claims and the patient's chart.

viii) A written report must be submitted with claims billed under these items.

25305	Endoscopic ligation – sphenopalatine artery	418.55	6

Notes:

i) Not payable in addition to fee item 02336.

ii) Includes diagnostic endoscopy performed on same day as surgery.

iii) Not payable in addition to endoscopic tumour excision surgery.

		$	Anes. Level
25310	Endoscopic trans-nasal repair of CSF leak from anterior skull base	976.07	8

Notes:

i) Includes harvest of any tissue needed for the repair, including closure of any donor site.

ii) Includes complete sphenoethmoidectomy or frontal sinusotomy or sinus trephine if required.

iii) Iatrogenic injuries payable at 50%.

25315	Primary frontal sinusotomy	232.29	3

Notes:

i) Requires direct visualization of frontal sinus recess/ostium

ii) Not to be billed in uncomplicated anterior ethmoidotomy

iii) Frontal sinus disease must be present to bill this item.

iv) Payable at 100% with fee items 02360, 02361, 02362, or 02363.

Rhinoplasty

02351	Nasal refracture requiring lateral osteotomies	357.19	3
02352	Reconstruction of nasal tip, ala, and columella	420.98	3
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma).	563.88	3
02354	Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture, and reconstruction of nasal tip, without skin grafting	612.35	3
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and external reconstruction of nasal tip without skin grafting.	776.17	3

Throat

	Incision of peritonsillar abscess:		
02447	- under local anesthetic (operation only)	95.00	4
02444	- under general anesthetic (operation only)	128.81	6
	Tonsillectomy:		
02403	- under local anesthesia	257.70	4
02445	- adult or child over the age of 14 years	250.73	4
02446	- child age 14 years and under (to include neonate)	224.46	4
02413	Operative control of post-tonsillectomy or post-adenoidectomy haemorrhage requiring local or general anesthetic	263.45	6
02399	Cryotherapy of tonsils and oral lesions (operation only)	114.81	3
02442	Adenoidectomy - adult or child over 14 years (operation only)	128.81	4
02443	- child 14 years and under (neonate included)	158.22	4
02448	Retropharyngeal abscess or hematoma - drainage under local anesthetic (operation only)	127.57	4
02406	Retropharyngeal abscess or hematoma - requiring lateral pharyngotomy	315.73	6
02408	Removal of tumour from larynx or trachea	191.35	5
02409	Uvulo-palato-pharyngoplasty for obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy	420.98	5

Notes:

The following two indications are requirements:

i) Patient is unable to use Continuous Positive Airway Pressure (CPAP). This may be due to:

a) Failure to adapt to the wearing of a mask of any kind after a trial of at least 30 days supervised by a qualified sleep therapist.

b) Failure of CPAP to improve symptoms directly related to OSA after CPAP delivery has been optimized by a titration Polysomnogram (PSG).

ii) Patient has, on level 1 Polysomnography in a certified sleep lab, an Apnea Hyponea Index (AHI) of 15 or greater. (Home sleep studies (level 2 or 3 PSG) may be substituted for level 1 PSG only if they are done through a certified sleep lab.)

		$	Anes. Level
02410	Thyrotomy (including cordectomy)	510.30	5
02431	Hemilaryngectomy	1,447.59	6
02432	Supraglottic laryngectomy	1,575.30	6
02433	Vocal cord implant - injection	318.91	5
02434	- external approach	637.88	5
02436	Arytenoid adduction	812.06	5
	Notes: *i) Payable only to certified Otolaryngologists. ii) Includes fee item 02434.*		
02414	Repair laryngo-tracheal stenosis - to include skin grafting, stenting, and associated endoscopy	1,441.57	8
02449	Rigid oesophagoscopy for removal of foreign body	191.35	4
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	255.15	6
02422	- in a child under the age of 3 years	380.57	6
02418	Repair of fractured larynx – external approach	829.22	8
02420	Dilation of trachea (operation only)	152.64	5
02421	- repeat within one month (operation only)	152.43	5
02425	Arytenoidectomy	637.88	5
02437	Transphenoidal removal of pituitary tumour or hypophysectomy - two surgeons - otolaryngologist	1,233.76	8
02438	Trans-oral cricopharyngeal myotomy	420.98	5
02424	Tracheoesophageal puncture and insertion of voice prosthesis following laryngectomy	357.19	5
02440	Bilateral micro-transposition of submandibular salivary ducts when done with or without a microscope.	338.35	4
02441	O.R. standby fee for the ENT surgeon in the operating room for management of acute airway obstruction (for example, epiglottitis, allergic laryngeal edema, malignancy).	298.53	11
	Note*: 02441 is not payable when tracheostomy is performed by the same surgeon at the same time. Bill under fee item 02407.*		
02451	Excision of congenital cyst or fistula from neck	420.98	4
02452	Sialolithotomy - simple, in duct (operation only)	63.76	3
02453	- complicated, in gland	191.35	3
02454	Alveolectomy	191.35	3
02455	Excision of submandibular gland	318.91	4
02456	Salivary fistula - plastic to Stensen's duct	420.98	4
02457	Tongue tie - under general anesthetic (operation only)	82.94	3
02458	Local excision tongue - under general anesthetic	165.83	3
02459	Excision cystic hygroma	548.56	4

Laryngeal Endoscopy and Surgery

02412	Biopsy of larynx and/or cauterization (including laryngoscopy) (operation only)	127.57	5
02419	Direct or indirect laryngoscopy with foreign body removal	153.09	5
02423	Micro-laryngoscopy - with removal of non-pedunculated malignancy or extensive submucosal lesion	445.46	5
02428	Micro-laryngoscopy - with biopsy of larynx and/or cauterization	178.61	5

		$	Anes. Level
02429	Micro-laryngoscopy and removal of tumour from larynx or trachea	204.12	5
	Microsurgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:		
02430	- first procedure	445.46	6
02435	- subsequent procedure, each	445.46	6
	Notes:		
	i) Maximum of 5 subsequent procedures in 6 month period, otherwise support with written letter.		
	ii) Microsurgery treatment with CO_2 laser other than removal of tumour(s) of larynx or trachea - bill under miscellaneous item 02599 with operative report.		

Skull Base Procedures

02262	Translabyrinthine approach for neurosurgical access exposure, closure with microscope	2,429.48	8
02610	Middle cranial fossa approach without petrosectomy - for trauma, neoplasm resection, nerve section/decompression	1,423.90	8
	Notes:		
	i) Includes exposure, removal and closure with microscope.		
	ii) May include extra-dural resection of lesion by Otolaryngologist.		
02612	Middle cranial fossa approach – petrosectomy	1,929.76	8
02613	Middle cranial fossa approach – petrosectomy - procedure lasting longer than 8 hours.	2,412.08	8
	Notes:		
	i) 02612 and 02613 to include exposure, extra-dural removal and closure with microscope.		
	ii) Start and end times must be entered in both the billing claims and the patient's chart.		
02614	Retrolabyrinthine approach for neurosurgical access - exposure, closure with microscope	2,206.00	8
02618	Repair of CSF leak following skull base approach with mastoid obliteration - to include exposure, dissection and closure with microscope	1,400.00	8
02622	Infra-temporal fossa approach to skull base - Otolaryngology fee.	2,224.40	8
02623	Infra-temporal fossa approach to skull base - Otolaryngology fee for procedure lasting longer than 8 hours.	2,582.14	8
	Notes:		
	i) 02622 and 02623 to include exposure and closure with microscope.		
	ii) May include extra-dural resection of lesion by Otolaryngologist.		
	iii) Time is based on the cumulative time spent by the Otolaryngologist on the procedure.		
	iv) Start and end times must be entered in both the billing claims and the patient's chart.		

Diagnostic Procedures

S00701	Direct laryngoscopy - procedural fee	37.70	5
	Notes:		
	i) 00701 is not payable with 00907, 00908, and 00909.		
	ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.		

		$	Anes. Level
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	97.14	3
S00717	Micro-laryngoscopy - procedural fee	75.39	5
	Note: *00717 to be charged at 50% if performed with a surgical procedure (not payable in addition to fee items 02423, 02428 or 02429).*		
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	49.15	2
SY00907	Endoscopic flexible or rigid examination of the nose and nasopharynx - procedure only	33.07	3
SY00908	- procedure and biopsy	52.89	3
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy	44.30	3
	Notes: *i) 00909 is not payable with 00700, 00701, 00702, 00907, and 00908.* *ii) Payable only to certified Otolaryngologists.*		

Major Head and Neck Surgery

Note: *The following procedures will be paid at 100% of the listed fees for each item when done as a team, or where two surgeons are involved. If more than one of the listed procedures is performed by the same physician, the greater procedure will be paid at 100% and all lesser procedures will be paid at 75%. Procedures when done in combination with fee item 06220 by a single surgeon will be paid at 75%.*

02279	Resection base of tongue and/or tonsil and soft palate	1,926.37	6
02281	Conservative radical neck dissection	1,255.22	6
	Note: *Includes radical neck dissection with full dissection and sparing of entire accessory nerve and generally sternomastoid muscle and internal jugular vein.*		
02470	Radical neck dissection	1,056.28	6
02471	Subtotal parotidectomy - with complete facial nerve dissection	842.01	4
02472	Total parotidectomy - with nerve dissection for malignancy or deep lobe tumour	969.55	4
02407	Tracheostomy	390.00	5
	Note: *Not applicable to cricothyrotomy puncture.*		
02411	Laryngectomy total	1,659.94	6
02431	Hemilaryngectomy	1,447.59	6
02432	Supraglottic laryngectomy	1,575.30	6
C02473	Laryngo-pharyngo-oesophagectomy - primary excision only	1,900.00	6
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon	637.88	5
C02474	Transoral maxillectomy with skin graft	1,056.25	5
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy	1,926.37	7
02477	Contralateral suprahyoid dissection	484.78	5
02600	Complete temporal bone resection, ENT fee	2,412.31	8
02601	Temporal bone resection for neoplasm, subtotal and lateral, to include mastoidectomy and excision of external auditory canal	1,506.13	8
02275	Glossectomy - subtotal with either division of mandible or transcervical resection	1,056.22	6

		$	Anes. Level
02280	Otolaryngological component of cranio facial resection for tumour of ethmoid or frontal sinus or orbit (in conjunction with a neurosurgeon (- see also fee code 03065)	2,412.31	8
	Note: *02280 includes rhinotomy, ethmoidectomy, cribriform plate, and orbital exenteration*		
02478	Glossectomy - partial for carcinoma	369.96	6
C02479	Transpalatal maxillectomy, ethmoidectomy, and sphenoidectomy	1,320.23	6
C02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy	1,320.23	7

GENERAL INTERNAL MEDICINE

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

		$	Anes. Level

Referred Cases

There are now referred cases fee items for both Internal Medicine and General Internal Medicine. Where there is no specific fee item listed under General Internal Medicine use applicable Internal Medicine fee.

Internal Medicine:

00310	**Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	168.39
00312	**Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	81.35
00314	Prolonged visit for counselling (maximum, four per year) ***Notes:*** *i) See Preamble, Clause D. 3. 3.* *ii) Start and end times must be entered in both the billing claims and the patient's chart.*	55.38
	Group counselling for groups of two or more patients:	
00313	- first full hour	113.42
00315	- second hour, per 1/2 hour or major portion thereof	56.67
	Note: *Start and end times must be entered in both the billing claims and the patient's chart.*	
	Continuing care by consultant:	
00306	Directive care	72.19
00307	Subsequent office visit	53.73
00308	Subsequent hospital visit	29.07
00309	Subsequent home visit	51.88
00305	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	114.98
	Telehealth Service with Direct Interactive Video Link with the Patient:	
32270	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	168.39
32272	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	81.35
32276	Telehealth directive care	72.19
32277	Telehealth subsequent office visit	53.73
32278	Telehealth subsequent hospital visit	29.07

		$	Anes. Level

General Internal Medicine:

Note: *Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.*

32210 **Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.....206.36

32212 **Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee 90.68

00311 **Complex Consultation** - 3 medical conditions 285.81

Notes:

i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

ii) For hospital in-patients, paid once per patient per hospital admission.

iii) Written consultation report includes advice or recommendations for treatment regarding 3 or more of the conditions listed in note iv), below.

iv) Payable for patients that have 3 or more of the following listed chronic diseases. Exceptions to this rule could be made if the patient has two diagnoses from this list and one alternative diagnosis not on the list can be submitted with correspondence/note record, outlining the medical necessity. Each case will be reviewed on an independent consideration basis. (Diagnostic codes in brackets):

Septicemia (038)
Other HIV infection (044)
DM including complications (250)
Disorders of Lipid Metabolism (272)
Thyroid disorders (246)
Purpura, thrombocytopenia and hemorrhagic conditions (287)
Anemia, unspecified (285.9)
Senile dementia, presenile dementia (290)
Acute confusional state (293)
Congestive Heart Failure (428)
Diseases of the aortic and mitral valve (396)
Essential hypertension (401)
Coronary atherosclerosis (414)
Neoplasm of uncertain behaviour of other and unspecified sites. "Not for minor or superficial skin malignancies." (238)
Cardiac dysarrhythmias (427)
Cerebral atherosclerosis (437)
Asthma allergic bronchitis (493)
Emphysema (492)
Other bacterial pneumonia (482)
Non infective enteritis and colitis (557.1)
GI hemorrhage (578)
Chronic liver diseases and cirrhosis of the liver (571)
CRF (585)
ARF (584)
Disorders of fluid, electrolyte and acid base balance (276)
Syncope (780.2)
Venous thrombosis and embolism (453)
Pulmonary fibrosis (515)
Rheumatoid Arthritis (714)
Systemic Lupus Erythematosus (710)

		$	Anes. Level
	Continuing care by consultant:		
32206	Directive care	85.64	
P32207	Subsequent office visit	80.00	
PG32307	Subsequent follow-up office visit, complex patient – 3 medical conditions	98.88	

Notes:

i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

ii) Payable only if 00311 or 32271 paid within the previous 6 months.

iii) Payable for patients that have 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart.

32208	Subsequent hospital visit	50.38	
PG32308	Subsequent hospital visit, complex patient – 3 medical conditions	67.29	

Notes:

i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

ii) Payable only if 00311 or 32271 paid within the previous 6 months.

iii) Payable for patients that have 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart.

iv) Payable only for an admitted patient.

v) Payable for ongoing inpatient follow up care, for each day hospitalized during the first ten days of hospitalization, thereafter bill 32208.

vi) The total of all daily billing under this fee item that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. Daily totals will be paid as follows:

- 1-15 visits paid at 100%

- 16 or more visits paid at 50%.

Telehealth Service with Direct Interactive Video Link with the Patient:

32370	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	206.36	
32372	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	90.68	
32271	Telehealth Complex Consultation - 3 medical conditions	285.81	

Notes:

i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

ii) Limited to one per patient in a 6 month period.

iii) Written consultation report includes advice or recommendations for treatment regarding 3 or more of the conditions listed in note iv), below.

iv) Payable for patients that have 3 or more of the following listed chronic diseases. Exceptions to this rule could be made if the patient has two diagnoses from this list and one alternative diagnosis not on the list can be submitted with correspondence/note record, outlining the medical necessity. Each case will be reviewed on an independent consideration basis. (Diagnostic codes in brackets):

Septicemia (038)
Other HIV infection (044)
DM including complications (250)
Disorders of Lipid Metabolism (272)

Thyroid disorders (246)
Purpura, thrombocytopenia and hemorrhagic conditions (287)
Anemia, unspecified (285.9)
Senile dementia, presenile dementia (290)
Acute confusional state (293)
Congestive Heart Failure (428)
Diseases of the aortic and mitral valve (396)
Essential hypertension (401)
Coronary atherosclerosis (414)
Neoplasm of uncertain behaviour of other and unspecified sites. "Not for minor or superficial skin malignancies." (238)
Cardiac dysarrhythmias (427)
Cerebral atherosclerosis (437)
Asthma allergic bronchitis (493)
Emphysema (492)
Other bacterial pneumonia (482)
Non infective enteritis and colitis (557.1)
GI hemorrhage (578)
Chronic liver diseases and cirrhosis of the liver (571)
CRF (585)
ARF (584)
Disorders of fluid, electrolyte and acid base balance (276)
Syncope (780.2)
Venous thrombosis and embolism (453)
Pulmonary fibrosis (515)
Rheumatoid Arthritis (714)
Systemic Lupus Erythematosus (710)

		$	Anes. Level
32376	Telehealth directive care	85.64	
P32377	Telehealth Subsequent office visit	80.00	
PG32367	Telehealth subsequent follow-up office visit, complex patient – 3 medical conditions	98.88	

Notes:

i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

ii) Payable only if 00311 or 32271 paid within the previous 6 months.

iii) Payable for patients that have 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart.

32378	Telehealth subsequent hospital visit	50.38	

Examinations by Certified Internist

00322	Internists' part in cardioangiogram, per hour or fraction thereof	46.76	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

33037	Replacement transfusion - hepatic failure to include two weeks' care after transfusion	287.85	

Note*: Consultation and necessary hospital visits prior to initial transfusion extra*

00343	Cardiac screening (maximum, three a month within manufacturer's guarantee and one a week beyond manufacturer's guarantee)	4.67	
00344	- professional fee	2.34	
00345	- technical fee	2.34	
33032	Pacemaker standby and/or placement of the endocardial catheter (operation only)	80.06	4
33033	Generator placement and venous cutdown	263.32	4

Adult Critical Care

Please refer to the Critical Care Section of the Payment Schedule for Preamble rules and billing guidelines applicable to appropriate billing of the critical care fees.

1. CRITICAL CARE - includes provision in an Intensive Care Area of all aspects of care of a critically ill patient excluding ventilatory support and includes initial consultation and assessment, family counselling, emergency resuscitation, intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, pressure infusion set and pharmacological agents, insertion of arterial C.V.P., Swan-Ganz or urinary catheters and nasogastric tubes, defibrillation, cardio version and usual resuscitative measures, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 1 hour of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in ICU's for example, routine post-op monitoring, or patients admitted for ECG monitoring or observation alone.

		$	Anes. Level
	Physician-in-charge is the Physician(s) daily providing the above.		
01411	1st day	340.05	
01421	2nd to 7th day (inclusive) per diem	170.52	
01431	8th to 30th day	117.75	
01441	31st day onward	135.47	

2. VENTILATORY SUPPORT - includes provision of ventilatory care including initial consultation and assessment of the patient, family counselling, cut-down, pressure infusion, insertion arterial & CVP, Swan-Ganz, tracheal toilet, endotracheal intubation, intravenous lines, artificial ventilation and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, end tidal CO_2, transcutaneous blood gas application and assessment and maximum inspiratory pressure monitoring and non-invasive metabolic measurements. There is an expectation of at least 1 hour of bedside care on Day 1. This is the fee to use when one physician is providing the ventilatory care and another physician, the critical care. This service may also be billed by a physician other than the operating surgeon or associate, for critical care required in addition to postoperative care by the surgeon.

   Physician-in-charge is the physician(s) daily providing the above.

01412	1st day	294.96	
01422	2nd to 7th day (inclusive) per diem	161.06	
01432	8th to 30th day	123.38	
01442	31st day onward	110.89	

3. COMPREHENSIVE CARE -These fees apply to intensive care physicians who provide complete care, both Critical Care and Ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment and subsequent examinations of the patient, family counselling, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, bronchoscopy, chest tubes, lumbar puncture, cut-downs, arterial and/or venous catheters, insertion of a Swan-Ganz catheter, pressure infusion sets and pharmacological agents, insertion of

C.V.P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric tubes, securing and interpretation of blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device). There is an expectation of at least 2 hours of bedside care on Day 1. These fees are not chargeable for services rendered to stabilized patients in the ICU's or patients admitted for ECG monitoring and observations.

		$	Anes. Level
	Physician-in-charge is the physician(s) daily providing the above.		
01413	1st day	507.54	
01423	2nd to 7th day (inclusive) per diem	256.61	
01433	8th to 30th day	142.11	
01443	31st day onwards	147.80	

If ventilatory support only is provided, claims should then be made under Ventilatory Support. Comprehensive Care fees do not apply. Other physicians should then charge Critical Care fees, if applicable, or the appropriate consultation, visit or procedure fees.

Injections

00017	Insertion of central venous pressure catheter	23.88
00018	Autologous ascitic infusion	48.07

Blood Transfusions

00021	Administered in hospital	37.27

Dialysis Fees

Acute renal failure

<u>Peritoneal dialysis</u>:

33756	Reinsertion of peritoneal catheter after 10 days from initial insertion	52.22

Note*: Item 00081 not to be charged in addition to item 33723.*
Where an initial peritoneal dialysis is performed and for various reasons, hemodialysis initiated within next 48 hours, the subsequent service should be charged under item 33758 plus item 33756 for the insertion of catheter.

Chemotherapy

a) Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.
b) Hospital visits are not payable on the same day.
c) Visit fees are payable on subsequent days, when rendered.
d) A consultation, when rendered, is payable in addition to fee item 33581, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.
e) The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.

		$	Anes. Level
33581	**High intensity cancer chemotherapy**: To include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis	203.27	
	Note: *This service is not payable more frequently than once every 28 days. The following treatments fall into this category:* *a) chemotherapy for acute leukemia.* *b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment.* *c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna.* *d) chemotherapy using DTIC in a dose exceeding 100 mg/m2.* *e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen).* *f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).*		
33582	**Major Cancer Chemotherapy:** To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents	119.21	
	Note*: This service is not payable more than once every 7 days.*		
33583	**Limited Cancer Chemotherapy:** To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line	68.11	
	Note: *This item is not payable more than once every 7 days. Neither is it to be billed for routine IV push administration of 5-flourouracil as a single agent.*		

Diagnostic Procedures

Cardio-vascular Diagnostic Procedures – procedural fee

S00839	Direct intracoronary streptokinase thrombolysis	361.78	4
	Note: *When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).*		

Pulmonary Investigative and Function Studies

S00930	Peak expiratory flow rate	5.57	
	Note: *Fee item 00930 payable when performed in physicians' office (not restricted to an accredited facility).*		

Diagnostic Procedures:

S00928	Simple screening spirometry with FVC, FEV(i), and FEV(i)/FVC ratio using a portable apparatus without bronchodilators	13.00	
S00929	Simple screening spirometry as above but before and after bronchodilators	19.00	

		$	Anes. Level
Exercise Studies:			
	Note: *No more than one exercise study item may be billed for a single patient on any one day without written explanation.*		
	Testing for exercise-induced asthma by serial flow measurements:		
S00958	- professional fee	22.35	
S00959	- technical fee	32.95	
	Precipitin tests-one or more antigens:		
S00970	- professional fee	11.16	
S00971	- technical fee	27.05	
Puncture Procedures for Obtaining Body Fluids **(when performed for diagnostic purposes)**			
S00753	Marrow aspiration - procedural fee	43.77	2
S00755	Artery puncture - procedural fee	6.41	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	86.00	2
Miscellaneous			
00319	Insertion of central catheter for total parenteral nutrition (operation only)	56.81	2

CARDIOLOGY

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

		$	Anes. Level

Referred Cases

33010 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 171.46

33012 **Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee 85.73

33014 Prolonged visit for counselling (maximum, four per year) 60.66

Notes:

i) See Preamble, Clause D. 3. 3.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

Group counselling for groups of two or more patients:

33013 - first full hour 93.55

33015 - second hour, per 1/2 hour or major portion thereof 46.75

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Continuing care by consultant:

33006 Directive care 64.27

33007 Subsequent office visit 64.92

33008 Subsequent hospital visit 57.46

33009 Subsequent home visit 42.80

33005 Emergency visit when specially called 94.84
(not paid in addition to out-of-office-hours premiums)
Note: *Claim must state time service rendered.*

Telehealth Service with Direct Interactive Video Link with the Patient:

33110 Telehealth consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 171.46

33112 Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant that consultative services do not warrant a full consultative fee 85.73

33114 Telehealth prolonged visit for counselling (maximum four per year) 60.66

Notes:

i) See Preamble, Clause D. 3. 3.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

33106 Telehealth directive care 64.27

33107 Telehealth subsequent office visit 64.92

33108 Telehealth subsequent hospital visit 57.46

		$	Anes. Level
	Telehealth Single chamber permanent programmable pacemaker testing		
33126	- professional fee	46.24	
33153	- technical fee	23.12	
	Telehealth Dual chamber permanent programmable pacemaker testing		
33128	- professional fee	69.36	
33154	- technical fee	46.24	

Notes:

i) 33126,33153,33128,33154 include telehealth office visit or an office visit and necessary ECG.

ii) May be billed by any qualified physician who performs this service from a location in BC.

iii) Paid only on outpatients.

Miscellaneous

33020	Supervision of patient in a Cardiac Rehabilitation program - per week	62.41	

Notes:

i) Payable only for patients enrolled at a Health Authority approved Cardiac Rehabilitation Program.

ii) Payable only to cardiologists with fellowship training in cardiac rehabilitation working at Health Authority approved Cardiac Rehabilitation programs.

iii) Payable once per week and includes all services and multiple encounters, necessary for management and supervision of patient while patient is actively enrolled in a comprehensive cardiac rehabilitation program.

iv) Visits by primary cardiologist may be billed for reasons unrelated to cardiac rehabilitation.

Remote Monitoring Cardiac Devices

	Remote Monitoring of Single chamber implantable cardiac devices		
33174	- professional fee	46.24	
33175	- technical fee	23.12	

Notes:

i) For the virtual or telephone assessment of single chamber implantable cardiac devices with virtual or telephone connection with patient.

ii) Includes a telehealth, virtual or telephone assessment, necessary ECG and/or heart rhythm assessment including device interrogation.

iii) May be billed by any qualified physician who performs this service from a location in BC.

iv) Paid only on outpatients.

	Remote Monitoring of Dual chamber implantable cardiac devices		
33176	- professional fee	69.36	
33177	- technical fee	46.24	

Notes:

i) For the virtual or telephone assessment of dual chamber implantable cardiac devices with virtual or telephone connection with patient.

ii) Includes a telehealth, virtual or telephone assessment, necessary ECG and/or heart rhythm assessment including device interrogation.

iii) May be billed by any qualified physician who performs this service from a location in BC.

iv) Paid only on outpatients.

		$	Anes. Level
Examinations by Certified Cardiologist			
33016	Electrocardiogram and interpretation - office, each	24.52	
33017	- home, each	34.10	
33018	Electrocardiogram - professional fee	8.58	
Y33025	Cardioversion (operation only)	88.90	2
	Note: *The procedural fee does not include the consultation fee or follow-up daily visits. If more than one cardioversion is performed on any patient in a single day, this is to be treated as a special case and a written report should accompany the account.*		
	Single chamber permanent programmable pacemaker testing		
33026	- professional fee	46.24	
33053	- technical fee	23.12	
	Dual chamber permanent programmable pacemaker testing		
33028	- professional fee	69.36	
33054	- technical fee	46.24	
	Note: *33026, 33053, 33028, 33054 include office visit and necessary ECG, and may be billed by any qualified physician.*		
33030	Temporary right ventricular pacemaker catheter placement, using external battery pack - cardiologist or other qualified physician	176.07	4
33031	Left ventricular pacing lead insertion–transvenous approach (as part of new cardiac resynchronization device implantation or upgrade from current conventional pacing or AICD system (extra)	456.79	4
	Notes*:* *i) This fee includes hookup. If optimization of device is performed post operatively, 33028 and 33054 may be billed as extras.* *ii) Venogram (00733) performed on same day by same practitioner is included.* *iii) Additional leads payable under S78031, to a maximum of three.* *iv) Restricted to qualified cardiac implantation specialists.* *v) Maximum of one per patient per day.*		
33032	Pacemaker standby and/or placement of the endocardial catheter (operation only)	80.66	4
33033	Generator placement and venous cutdown	263.32	4
33034	Graded exercise test (performance and interpretation)	77.66	
33035	- professional fee	46.06	
33036	- technical fee	31.58	
	Notes: *i) This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer or pharmaceutical agents, with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and post exercise records must be obtained.* *ii) When a 12-lead cardiogram is done on the same day as the graded exercise test, it is included in Item 33034.* *iii) A graded exercise tolerance test may be repeated once within one year to assess the functional capacity of the patient after recovery from coronary bypass surgery and to assess the effect of therapy where exercise has produced a serious ventricular rhythm disturbance. In all other circumstances, where graded exercise tests are repeated within one year, a letter of explanation for the need will accompany the account to the Plan, except in conjunction with thallium myocardial scans where a graded exercise test may be performed and charged with each scan.*		

iv) Where the exercise stress test (33034, 33035, 33036) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent.

		$	Anes. Level
33037	Replacement transfusion - hepatic failure to include two weeks' care after transfusion ..... 287.85 ***Note**: Consultation and necessary hospital visits prior to initial transfusion extra.*		
	Scanning of 24 hour electrocardiogram:		
33047	- professional fee.. .....66.13		
33048	- technical fee 24.81		
	Technical fee for scanning:		
33049	**LEVEL 1:** Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing edited trend analysis, and/or edited graphic or alpha-numeric hourly summary of data 54.16		
33063	**LEVEL 2:** Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data 40.61		
33065	**LEVEL 4:** (i) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adaptor that feeds the information to the standard ECG machine. (ii) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly summary of heart rate, minimum and maximum R-R intervals, premature beats, and ventricular complexes of abnormal width.....13.57		

Patient Activated Cardiac Event Recorders

33062	Event/unmonitored loop recorders (first strip) - professional fee 36.21		
33069	- each additional strip (per strip).....18.10 ***Note:** Additional strips are limited to two extra strips per patient, per two-week period.*		
33092	Event/unmonitored loop recorder – technical fee.....43.51 ***Notes:*** *i) The following notes apply to fee items 33062, 33069, 33092* *ii) These items are intended to cover a two-week period* *iii) Consultation not paid in addition* *iv) Provide note record when more than one recording billed per patient, per year.* *v) Holter monitor not payable in addition* *vi) An explanatory note is required for second test, same patient.*		

Intracardiac Electrophysiological Mapping

33066	- initial study.....776.20		4
33068	Oesophageal or intra-atrial electro-physiological study 116.03		4

		$	Anes. Level

Electrophysiological Mapping and Ablation

33084	Catheter ablation for atrial fibrillation ***Note:*** *Includes percutaneous right heart catheterization, transseptal left heart catheterization, all diagnostic imaging, ECG's (electrophysiological mapping/ablation fee items 33066, 33085, 33086, and 33087).*	1,718.60	6
33085	Catheter ablation - AV node ***Note:*** *To include diagnostic study (33066).*	948.58	4
33086	Catheter ablation of SVT ***Note:*** *To include diagnostic study (33066).*	1,450.76	4
33087	Catheter ablation of VT ***Note:*** *To include diagnostic study (33066).*	1,718.60	4
33088	Repeat diagnostic EP study ***Note:*** *Not normally to be billed for re-check on the same day.* ***Note****: Follow-up visits are billable in addition to fee items 33085, 33086, 33087 and 33088.*	334.78	4
33089	Catheter ablation - assistants fee (per hour) ***Notes:*** *i) For SVT and/or VT ablation; AV node may be billed with supporting documentation.* *ii) Applicable only to fully qualified cardiologists with 2 years EP training.* *iii) Start and end times must be entered in both the billing claims and the patient's chart.*	139.50	

Interventional Cardiology Procedures

S33073	Percutaneous transcatheter cardiac occluder device closure of ASD – for patients over 18 years of age – composite fee ***Notes:*** *i) Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary angiograms, angiocardiograms, atrial septostomy, HIS bundle recordings, CVP, venous cannulation, infusion of pharmacologic agents,pressure measurement, pressure gradient calculations* *ii) 30 days pre and 48 hour post-operative visits in hospital included.*	713.74	7
S33074	Percutaneous transcatheter cardiac occluder device closure of PFO - for patients over 18 years of age - composite fee ***Notes:*** *i) Includes all necessary diagnostic imaging, right and left heart catheterization,all necessary angiograms, angiocardiograms, atrial septostomy, HIS bundle recordings, CVP, venous cannulation, infusion of pharmacologic agents,pressure measurement, pressure gradient calculations* *ii) 30 days pre and 48 hour post-operative visits in hospital included.*	560.80	7
S33075	Percutaneous balloon valvuloplasty for congenital or rheumatic mitral stenosis (composite fee) ***Notes****:* *i) Includes all necessary catheterizations, angiography (00810, 00812, 00830, 00871, 00888, 00889 and 00898), angiocardiography, atrial septostomy, balloon dilation of atrial septum, any medically necessary diagnostic imaging, CVP, arterial lines, blood pressure measurements, and any pharmacological infusion and studies, blood sampling, blood analysis and interpretations done in association with procedure.* *ii) 30 days pre and 48 hour post-operative visits in hospital included.*	917.67	9

		$	Anes. Level
C33076	Percutaneous balloon valvuloplasty for aortic stenosis (composite fee)……	611.78	9

Notes:

i) Includes all necessary catheterizations, angiography (00801, 00810, 00812, 00871, 00888, 00889, 33030), angiocardiography, intra-arterial cannulation, right heart catheterization, retrograde left heart catheterization, pulse tracing (intravascular), temporary pacemaker, any medically necessary diagnostic imaging (e.g.: Intra-cardiac ultrasound), CVP, arterial lines, blood pressure measurements, and any pharmacological infusion and studies, blood sampling, blood analysis and interpretations done in association with procedure.

ii) 30 days pre and 48 hour post-operative visits in hospital included.

iii) 33131, 33132, 33133, may be payable at 50% if done with this procedure.

iv) If a Cardiology assist is required, may bill Cardiology Assist Fee Items 00845 (first hour or fraction thereof) and 00846 (after one hour, each 15 minutes or fraction thereof) @50%.

33071	Percutaneous endovascular Aortic or Pulmonary Heart Valve Replacement	1,147.10	9

Notes:

i) All diagnostic imaging, all necessary left and right heart catheterizations, arterial or venous cannulation, blood sampling, CVP, pressure or gradient measurements, infusion of pharmacological agents, temporary pacing and pacemaker, and percutaneous balloon valvuloplasty are included.

ii) 30 days pre and 48 hour post-operative in hospital visits included

iii) Cardiac Surgeon (specialty 12) paid under 07917/07920 when assisting for 33071.

iv) Cardiologist (specialty 26) paid under 00845/6 when assisting 33071.

33072	Percutaneous left atrial appendage closure	900.00	7

Notes:

i) Includes all necessary catheterizations, angiography (00801, 00810, 00812, 00871, 00888, 00889, 33030), angiocardiography, intra-arterial cannulation, right heart catheterization, retrograde left heart catheterization, pulse tracing (intravascular), temporary pacemaker, any medically necessary diagnostic imaging (e.g.: Intra-cardiac ultrasound), CVP, arterial lines, blood pressure measurements, and any pharmacological infusion and studies, blood sampling, blood analysis and interpretations done in association with procedure.

ii) 30 days pre and 48 hour post-operative visits in hospital included.

iii) Fee item 33057 is payable when performed by another practitioner.

iv) Cardiologist (specialty 26) paid under 00845/6 when assisting 33072.

Diagnostic Procedures:

Electrodiagnosis

S00944	Tilt table testing with continuous ECG monitoring and automatic BP recording - total fee	290.15
S00947	- professional fee	178.57
S00948	- technical fee	111.59

Notes:

i) Applicable only for investigation for diagnosis of neurally mediated syncope.

ii) Physician must be present throughout duration of procedure.

iii) Includes testing before and if necessary, after pharmacological provocation.

iv) Requires backup resuscitation equipment and materials.

v) Routine ECG not billable in addition.

vi) Restricted to facilities licensed to perform cardiac electrophysiological testing.

		$	Anes. Level
	Diagnostic procedures utilizing radiological equipment:		
	The following fees are separate from the fees for the radiological part of this examination and should be charged by the attending physician or by the radiologist who performs the procedure, e.g.: instrumentation or injection of contrast materials:		
S00729	Fluoroscopy of chest by internist or pediatrician - procedural fee	11.11	
	Puncture Procedure for obtaining body fluids (when performed for diagnostic purposes):		
S00751	Pericardial puncture - procedural fee	252.53	3
	Cardio-vascular Diagnostic Procedures – procedural fees:		
S00801	Intra-arterial cannulation - with multiple aspirations - procedural fee	22.10	
S00810	Right heart catheterization, by duly qualified specialist	165.44	4
S00812	Selective angiocardiogram, extra, by duly qualified specialist	55.52	4
S00813	Ergonovine provocative testing for coronary artery spasm	79.14	4
S00814	Dye dilution studies, extra, by duly qualified specialist	55.52	4
S00816	Hydrogen ion study	28.96	2
PS33131	Diagnostic cardiac catheterization	333.75	4
	Notes: *i) Restricted to Cardiologists and Pediatric Cardiologists.* *ii) Not payable with 33132, 33133, 33134 and/or 00842.* *iii) Include arterial access, arterial pressure measurements and interpretations, direct coronary artery cannulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, and interpretation of aortic valve pullback gradient hemodynamics.*		
S33132	Diagnostic cardiac catheterization with advanced arterial assessment	483.26	4
	Notes: *i) Restricted to Cardiologists and Pediatric Cardiologists.* *ii) Not payable with 33131, 33133, 33134 and/or 00842.* *iii) Applies to per patient, not per vessel or lesion when advanced arterial assessment is performed.* *iv) Include arterial access, arterial pressure measurements and interpretations, direct coronary artery cannulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, interpretation of aortic valve pullback gradient hemodynamics, and advanced assessment of the coronary artery with Fractional Flow Reserve (FFR), intravascular ultrasound (IVUS), and/or optical coherence tomography (OCT).*		
	Percutaneous coronary interventions:		
S33133	Percutaneous coronary intervention with diagnostic cardiac catheterization	563.36	4
	Notes: *i) Restricted to Cardiologists and Pediatric Cardiologists.* *ii) Includes balloon inflation (angioplasty), stent insertion, and/or diagnostic cardiac catheterization.* *iii) Not payable with 33131, 33132 and/or 33134.* *iv) Name of vessel must be provided in the note record.* *v) When temporary pacemaker insertion is performed in addition, 33030 to be paid at 50%.*		

		$	Anes. Level
S33134	Percutaneous coronary intervention alone	375.53	4

Notes:

i) Restricted to Cardiologists and Pediatric Cardiologists.
ii) Includes balloon inflation (angioplasty), stent insertion.
iii) Payable when 33131 or 33132 had been performed by a different practitioner as part of the same procedure.
iv) Not payable with 33131, 33132, 33133 when is performed by the same practitioner.
v) *Name of vessel must be provided in the note record.*
vi) When temporary pacemaker insertion is performed in addition, 33030 to be paid at 50%.

S00842	Percutaneous coronary intervention – for additional vessel(s), per vessel	189.01

Notes:

i) Only payable in addition to 33133 or 33134.
ii) When temporary pacemaker insertion is performed in addition it will be payable at 50% of listed fee(s).
iii) Maximum of 5 named vessels per patient.
iv) Name of vessel(s) must be provided in the note record.

Percutaneous coronary intervention anatomical named vessels:
(Including Coronary artery bypass graft to vessels below):

Right coronary:

- *Right coronary artery*
- *Right posterior descending artery*
- *Right posterior atrioventricular artery*
- *First right posterolateral artery*
- *Second right posterolateral artery*
- *Acute marginal artery*
- *Inferior septal artery*

Left coronary:

- *Left main coronary artery*
- *Left anterior descending artery*
- *First diagonal artery*
- *Second diagonal artery*
- *Ramus artery*
- *Circumflex artery*
- *First obtuse marginal artery*
- *Second obtuse marginal artery*
- *Third obtuse marginal artery*
- *Left atrioventricular artery*
- *First left posterolateral artery*
- *Second left posterolateral artery*
- *Left posterior descending artery*
- *First septal artery*

	Pulse tracing, including interpretation:	
S00871	- intravascular, including both arterial and venous	55.52

Cardiology Assist Fees:

00845	For first hour or fraction thereof	171.21
00846	After one hour, for each 15 minutes or fraction thereof	42.81

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

		$	Anes. Level

Diagnostic Ultrasound

Note: *Real-time ultrasound fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.*

S33057 Trans-esophageal echocardiography - procedure fee 165.45 3

Notes:

i) This procedure fee is intended to cover all aspects of the patient's cardiological care during the performance of the TEE. A consultation may not be billed in addition, except in situations where specifically requested and the physician fulfills all Preamble criteria for billing a consultation.

ii) Trans-thoracic echocardiography may only be billed in addition where medically indicated. Written explanation is required.

33091 Echocardiography - combined two dimensional real time and M-mode 144.20

33093 Level III Echocardiographer Complex Assessment of Previous Echocardiogram (clinical assessment and review, interpretation and written report of submitted echocardiograms) – per patient 252.39

Notes:

i) Payable following a written request from a cardiologist or cardiac surgeon for a clinical assessment, review and interpretation of submitted echocardiograms done on an out-patient basis only, performed in another institution by a different echocardiographer.

ii) A written report and management recommendation must be provided to the referring physician.

iii) Not payable when echocardiograms above are used for comparison purposes with echocardiograms made in the Level III Echocardiographer's facility.

iv) Not payable with a consult, visit or 33091 done on the same day.

v) Payable once per year per patient, unless substantiated in note record.

vi) Payable only on echocardiograms done in publicly-funded hospitals in BC.

vii) Not payable in addition to a consultation rendered within 2 months on the same patient on referral by the same physician for the same diagnosis.

33094 Contrast echocardiography (extra) – technical fee, per vial of contrast 127.45

Notes:

i) Paid only in addition to fee items 33091, 08638 or 08662.

ii) Submit claim on the first patient the vial is used for. No claims should be made on subsequent patients for the same vial.

Diagnostic Ultrasound

Heart

08638 Echocardiography (real time) 101.86

Doppler Studies

Heart

08662 Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis 234.46

Note: *Where the exercise stress test (00530, 00531, 00535, 01730, 01731, 01732, 33034, 33035 and 33036) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent.*

08679 Doppler echocardiography 46.73

CLINICAL IMMUNOLOGY AND ALLERGY

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

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Referred Cases

Notes:

1) These fee items are only payable to specialists qualified by the Royal College Certification in Clinical Immunology and Allergy, or equivalent as approved by the B.C. Society of Allergy and Immunology.

2) Services not related to Clinical Immunology and Allergy should be billed under the appropriate fee listings for the specialty of the physician (see Preamble C.16.).

3) Allergy skin test fees are payable in addition to consultations.

Consultations

30010 **Clinical Immunology and Allergy Consultation**: To include a detailed history and physical examination with review of laboratory investigations, plus appropriate allergy and immunology management and additional visits necessary to render a written report 190.24

30011 **Pediatric Clinical Immunology and Allergy Consultation:** To include a detailed history and physical examination with review of laboratory investigations, plus appropriate allergy and immunology management and additional visits necessary to render a written report 190.70

30012 **Repeat or limited Clinical Immunology and Allergy Consultation:** To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgement of the consultant, the consultative service does not warrant a full consultative fee 94.70

Continuing care by consultant:

30006 Directive care 93.00

30007 Subsequent office visit 40.03

30008 Subsequent hospital visit 22.50

30005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums) 87.57

Note: *Claim must state time service rendered.*

Telehealth Service with Direct Interactive Video Link with the Patient:

30070 Telehealth Clinical Immunology and Allergy Consultation: To include a detailed history and physical examination with review of laboratory investigations, plus appropriate allergy and immunology management and additional visits necessary to render a written report 190.24

		$
30071	Telehealth Pediatric Clinical Immunology and Allergy Consultation: To include a detailed history and physical examination with review of laboratory investigations, plus appropriate allergy and immunology management and additional visits necessary to render a written report	190.70
30072	Telehealth repeat or limited Clinical Immunology and Allergy Consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgement of the consultant, the consultative service does not warrant a full consultative fee	94.70
30076	Telehealth directive care	93.00
30077	Telehealth subsequent office visit	40.03
30078	Telehealth subsequent hospital visit	22.50

Tests Performed in a Physician's Office

30015	Secretion smear for eosinophils	7.29

ENDOCRINOLOGY AND METABOLISM

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

		$	Anes. Level

Referred Cases

33210 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 219.37

33212 Repeat or limited consultation**:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee 105.32

33214 Prolonged visit for counselling (maximum, four per year) 71.74

Notes:

i) See Preamble, Clause D. 3. 3.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

Group counselling for groups of two or more patients:

33213 - first full hour 146.86

33215 - second hour, per 1/2 hour or major portion thereof 73.38

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Continuing care by consultant:

33206 Directive care 61.14

33207 Subsequent office visit 63.84

33208 Subsequent hospital visit 37.65

33209 Subsequent home visit 67.18

33205 Emergency visit when specially called 148.86
(not paid in addition to out-of-office-hours premiums)
Note: *Claim must state time service rendered.*

PG33260 Initial virtual assessment, with patient or representative/family 122.39

Notes:

i) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received.

ii) Restricted to Endocrinology and Metabolism specialists.

iii) Not paid within 6 months of a 33210 (consultation), 33270 (Telehealth consult), or G33260 (virtual assessment~~)~~, for the same diagnosis.

iv) Not payable in addition to another service on the same day for the same patient by the same practitioner.

PG33262 Repeat virtual assessment for same illness within six months of the last visit by the consultant, or where in the judgment of the consultant the service does not warrant an initial assessment fee 61.20

Notes:

i) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received.

ii) Restricted to Endocrinology and Metabolism specialists.

iii) Not payable in addition to another service on the same day for the same patient by the same practitioner.

		$	Anes. Level
33267	Subsequent virtual office visit, requiring a written individualized report to the Family Physician ***Notes:*** *i) Restricted to Endocrinology and Metabolism specialists.* *ii) Maximum 12 per calendar year, per patient.*	39.58	
PG33250	Virtual communication with patient, or representative/family, for medically pertinent matters ***Notes:*** *i) Restricted to Endocrinology and Metabolism specialists.* *ii) Payable for communication with patient or representative/family through telephone or email.* *iii) Maximum 12 per calendar year, per patient.* *iv) Not payable in addition to another service on the same day for the same patient by the same practitioner.*	10.37	
	<u>Telehealth Service with Direct Interactive Video Link with the Patient:</u>		
33270	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	217.81	
33272	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	104.57	
33276	Telehealth directive care	60.70	
33277	Telehealth subsequent office visit	63.39	
33278	Telehealth subsequent hospital visit	37.38	

Miscellaneous

PG33240	Premium for patients 75 years and over, billed in addition to 33210, 33212, 33270, 33272, G33260 or G33262 ***Notes:*** *i) Restricted to Endocrinology and Metabolism specialists.* *ii) Maximum one premium, per patient, per day.*	55.00	
PG33241	Premium for patients 75 years and over, billed in addition to 33207, 33209, 33277, 33267, G33250, GY33255, or GY33256 ***Notes:*** *i) Restricted to Endocrinology and Metabolism specialists.* *ii) Maximum one premium, per patient, per day.*	14.76	
PGY33255	Diabetes injection medication start (insulin or glucagon-like-peptide receptor agonist) ***Notes:*** *i) Paid with endocrinology consultations or visits (33210, G33260, 33206,33207,33208,33209, G33262, 33267).* *ii) Restricted to Endocrinology and Metabolism specialists.* *iii) Maximum one per day, per patient.* *iv) Not paid same day as GY33256.* *v) Payable for insulin or glucagon-like-peptide receptor agonist.*	41.48	

		$	Anes. Level
PGY33256	Insulin pump start	82.95	

Notes:

i) Paid with face-to-face endocrinology consultations or visits (33210, 33206,33207,33208,33209, G33260, G33262 or 33267).
ii) Restricted to Endocrinology and Metabolism specialists.
iii) Maximum one per patient, per day.
iv) Not paid same day as GY33255.

Diagnostic - Miscellaneous

S00744	Thyroid biopsy - procedural fee	73.65	2

GASTROENTEROLOGY

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

		$	Anes. Level
Referred Cases			
33310	**Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	178.78	
33312	**Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	101.14	
33314	Prolonged visit for counselling (maximum, four per year)	54.82	
	Notes: *i) See Preamble, Clause D. 3. 3.* *ii) Start and end times must be entered in both the billing claims and the patient's chart.*		
	Group counselling for groups of two or more patients:		
33313	- first full hour	105.06	
33315	- second hour, per 1/2 hour or major portion thereof	52.78	
	Note: *Start and end times must be entered in both the billing claims and the patient's chart.*		
	Continuing care by consultant:		
33306	Directive care	59.43	
33307	Subsequent office visit	67.10	
33308	Subsequent hospital visit	40.95	
33309	Subsequent home visit	49.22	
33305	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	111.65	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
33360	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	178.78	
33362	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	101.14	
33366	Telehealth directive care	59.43	
33367	Telehealth subsequent office visit	67.10	
33368	Telehealth subsequent hospital visit	40.95	

		$	Anes. Level

Diagnostic procedures involving visualization by instrumentation:

Upper Gastrointestional System:

S10761	Esophagogastroduodenoscopy (EGD) , including collection of specimens by brushing or washing, per oral - procedural fee	116.63	3
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	97.14	3
S10763	Initial esophageal, gastric or duodenal biopsy	15.00	3

Notes:
i) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs.
ii) First biopsy paid at 100%, second and third at 50%.

S10764	Multiple biopsies for differential diagnoses of Barrett's Esophagus, H pylori, Eosinophiic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma	43.58	3

Notes:
i) Paid only once per endoscopy.
ii) Paid only in addition to S10763 at 100%.
iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.

SY10750	Transnasal esophagogastroduodenoscopy (TGD), procedural fee	116.63	

***Note**: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.*

Lower Gastrointestinal System:

SY00715	Sigmoidoscopy (with biopsy) - procedural fee	37.98	2
SY00718	Sigmoidoscopy, flexible – with biopsy	77.34	2
10708	Video capsule endoscopy using M2A capsule - professional fee:	256.63	

Notes:
i) Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have ruled out other causes.

Upper Gastrointestinal System – Endoscopy (Surgical)

S33321	Removal of foreign material causing obstruction, operation only	101.91	4

Notes:
i) Paid only in addition to S10761 or S10762.
ii) Paid only once per endoscopy.

S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only	116.68	3

Notes:
i) Paid only once per endoscopy.
ii) Paid only in addition to S10761 or S10762.

S33323	Transendoscopic tube, stent or catheter – operation only	101.86	3

Notes:
i) Paid only in addition to S10761 or S10762.
ii) Paid only once per endoscopy.

		$	Anes. Level
S33324	Thermal coagulation – heater probe and laser, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	80.00	3
S33325	Gastric polypectomy, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	60.00	5
S33326	Percutaneous endoscopically placed feeding tube – operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	120.00	3
S33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	50.00	3
S33328	Esophageal dilation, blind bouginage, operation only ***Note:*** *Repeats within one month paid at 100%.*	57.25	3
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only ***Note:*** *Repeats within one month paid at 100%.*	109.02	3
S33335	SBE or DBE (balloon assisted) enteroscopy ***Notes:*** *i) Not paid with 10761, 33373, or 33374.* *ii) Examination of the terminal ileum using a SBE/DBE is not billable under this fee item.* *iii) Billable only by specialist who are credentialed to bill fee item 10708.*	302.25	3
	The following fees are only paid in addition to S33335:		
S33336	- with biopsy (single or multiple) – extra	28.71	
S33337	- removal of polyp – extra	50.38	
S33338	- each additional polyp (maximum of 10) – extra	12.09	
S33339	- with fulguration or coagulation, by any means of one or more lesions – extra	40.30	

Endoscopic Retrograde Cholangiopancreatography (ERCP)

	Endoscopic Retrograde Cholangiopancreatography (ERCP); to include biopsies or brushings:		
V33341	- with papillotomy or sphincterotomy	447.05	3
V33342	- with stone extraction	530.07	3
V33343	- with biliary stenting	435.25	3
V33344	- with balloon dilatation of biliary stricture	434.25	3
V33345	- with stone extraction requiring lithotripsy	555.62	3
33346	Insertion of naso-biliary drainage tube - operation only	103.49	3
33347	Replacement of a duodenal biliary stent – operation only	172.45	3

		$	Anes. Level

Diagnostic procedures utilizing radiological equipment

The following fees are separate from the fees for the radiological part of this examination and should be charged by the attending physician or by the radiologist who performs the procedure, e.g.: instrumentation or injection of contrast materials:

10735	Rectal endoscopy utilizing ultrasound (radial/linear) ***Note:*** *Includes mucosal biopsy.*	153.99	
10740	Upper GI endoscopy utilizing radial ultrasound	256.63	
10741	Upper GI endoscopy utilizing linear ultrasound	256.63	

Notes:
- *i) 10740 and 10741 are payable only when done in publicly funded acute care facilities.*
- *ii) 10741 payable at 50% when done subsequent to 10740 (same patient/same day)*

10742	Upper GI endoscopy utilizing radial/linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 – per lesion	51.33	

Notes:
- *i) Payable with 10740 or 10741 only*
- *ii) First biopsy paid at 100%. Second and third biopsies payable at 50%.*

10743	Upper GI endoscopy utilizing radial/linear ultrasound - with injection of one of more of any of the following – metastases, nodes, masses, or celiac plexus-extra **Note:** *Payable with 10740 or 10741 only.*	153.99	
10744	Upper GI endoscopy utilizing radial/linear ultrasound - with drainage of pseudocyst (including stent insertion if performed) – extra ***Note****: Payable with 10740 or 10741 only.*	205.32	

Diagnostic – Miscellaneous

S00809	Retrograde pancreatography	216.54	3

Miscellaneous

	Colonoscopy with flexible colonoscope:		
S33373	- biopsy	235.15	2
33374	- removal polyp	283.50	2
P07375	Complex polypectomy (extra) ***Notes:*** *i) Restricted to General Surgeons and Gastroenterologists.* *ii) Only for resection of a polyp with one or more of the followings:* *-large (≥ 20mm) non-pedunculated colorectal polyp/lesion* *-involving the appendiceal orifice, ileocecal valve, or dentate line* *-recurrent or previously attempted resection* *-complex polyp/lesion as determined by multidisciplinary committee* *iii) Requires 60 minutes or more of slated endoscopy time.* *iv) Not to be performed at index/diagnostic colonoscopy unless specifically referred for complex polypectomy.*	175.00	

v) Complete removal after submucosal injection and piecemeal resection or endoscopic mucosal resection.
vi) May not be claimed for pedunculated polyps.
vii) Payable only in addition to 10730, 10731, 10761, 00716, 00718, or 33373.
viii) Not payable in conjunction with 33374, 07464, 07465, 10714, 00715.
ix) Second complex polypectomy on the same day for the same patient will be paid at 50%.

		$	Anes. Level
33394	Assistant fee for PEG procedure	112.47	

Note: *33326, 33394 may be billed by any qualified physician.*

GERIATRIC MEDICINE

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

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Referred Cases

33410 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.....205.00

33412 **Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee.....117.00

33401 Comprehensive geriatric consultation: limited to patients aged 65 years and over: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care 297.20

Notes:

i) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to, the following:

- *Assessment and management of medical condition(s)/ syndrome(s) in patients 65 yrs and over.*
- *Assessment of failure to thrive and frailty.*
- *Mobility decline and falls.*
- *Polypharmacy, review of medication tolerability/response and compliance issues.*
- *Incontinence.*
- *Co-management with geriatric psychiatry, particularly where there is significant medical instability.*
- *Elder abuse/neglect, caregiver stress.*
- *Assessment/monitoring of functional status including issues of competency and "living at risk".*

ii) Minimum time requirement for service is 65 minutes clinical assessment time.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

33402 Geriatric reassessment subsequent to comprehensive consultation - limited to patients aged 65 years and over 120.00

Notes:

i) See 33401 note i) for billing criteria.

ii) Minimum time requirement for service is 20 minutes.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

iv) Payable once per hospital admission unless note record provided to indicate medical necessity for additional reassessments.

v) Payable up to twice per month per patient only when service rendered in out-patient setting unless note record provided to indicate medical necessity for additional reassessments.

33403 Comprehensive cognitive consultation – for dementia or cognitive problems: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care.....297.20

Notes:

i) Applicable only when written report includes at least two aspects of complexity. The focus here is the cognitive impairment and how it is affecting the patient's ability to function. Common clinical syndromes include, but are not limited to the following:

- *Assessment of dementia, using some form of formal cognitive measurement, as well as integrating reports from family/homemakers/Home Health.*
- *Behavioural/affective issues in dementia management.*
- *Management of common psychiatric syndrome in the elderly, including depression, anxiety, insomnia, psychosis, bipolar disorder.*
- *Substance abuse disorders.*
- *Assessment/monitoring of functional status including issues of competency and "living at risk".*
- *Issues identified in 33401 may enter into the picture.*

ii) Minimum time requirement for service is 65 minutes clinical assessment time.
iii) Start and end times must be entered in both the billing claims and the patient's chart.

$

33404 Geriatric reassessment subsequent to comprehensive consultation - for dementia or cognitive problems.....120.00

Notes:
i) See 33403 note i) for billing criteria.
ii) Minimum time requirement for service is 20 minutes.
iii) Start and end times must be entered in both the billing claims and the patient's chart.
iv) Payable once per hospital admission unless note record provided to indicate medical necessity for additional reassessments.
v) Payable up to twice per month per patient only when service rendered in out-patient setting unless note record provided to indicate medical necessity for additional reassessments.

33440 Complex consultation – for 2 or more conditions: To consist of examination review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care.....270.05

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to, the following:
- *Septicemia*
- *Other HIV infection*
- *DM including complications*
- *Disorders of Lipid Metabolism*
- *Thyroid disorders*
- *Purpura, thrombocytopenia and hemorrhagic conditions*
- *Anemia, unspecified*
- *Senile dementia, presenile dementia*
- *Acute confusional state*
- *Congestive Heart Failure*
- *Diseases of the aortic and mitral valve*
- *Essential hypertension*
- *Coronary atherosclerosis*
- *Neoplasm of uncertain behaviour of other and unspecified sites. "Not for minor or superficial skin malignancies."*
- *Cardiac dysarrhythmias*
- *Cerebral atherosclerosis*
- *Asthma allergic bronchiti*
- *Emphysema*
- *Other bacterial pneumonia*
- *Non infective enteritis and colitis*
- *GI hemorrhage*

- *Chronic liver diseases and cirrhosis of the liver*
- *CRF*
- *ARF*
- *Disorders of fluid, electrolyte and acid base balance*
- *Syncope*
- *Venous thrombosis and embolism*
- *Pulmonary fibrosis*
- *Rheumatoid Arthritis*
- *Systemic Lupus Erythematosus*

		$
33442	Repeat or limited complex consultation – for 2 conditions: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	135.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) See 33440 note ii) for billing criteria.

33414	Prolonged visit for counselling (maximum, four per year)	53.21

Notes:
i) See Preamble, Clause D. 3. 3.
ii) Start and end times must be entered in both the billing claims and the patient's chart.

Group counselling for groups of two or more patients:

33413	- first full hour	99.46
33415	- second hour, per 1/2 hour or major portion thereof	49.68

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Continuing care by consultant:

33406	Directive care	50.00
33446	Comprehensive or complex directive care	72.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations.

33407	Subsequent office visit	55.00
33447	Comprehensive or complex subsequent office visit	88.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Payable only following comprehensive (33401, 33473), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations.

33408	Subsequent hospital visit	44.00
33448	Comprehensive or complex subsequent hospital visit	45.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations.

33409	Subsequent home visit	140.00

		$
33405	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	122.15

Telehealth Service with Direct Interactive Video Link with the Patient:

33470	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	205.00
33472	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	117.00
33421	Telehealth Comprehensive geriatric consultation - limited to patients aged 65 years and over: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care	297.20

Notes:

i) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to, the following:

- *Assessment and management of medical condition(s)/ syndrome(s) in patients 65 yrs and over.*
- *Assessment of failure to thrive and frailty.*
- *Mobility decline and falls.*
- *Polypharmacy, review of medication tolerability/response and compliance issues.*
- *Incontinence.*
- *Co-management with geriatric psychiatry, particularly where there is significant medical instability.*
- *Elder abuse/neglect, caregiver stress.*
- *Assessment/monitoring of functional status including issues of competency and "living at risk".*

ii) Minimum time requirement for service is 65 minutes clinical assessment time.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

33422	Telehealth Geriatric reassessment - subsequent to comprehensive consultation - limited to patients aged 65 years and over	120.00

Notes:

i) See 33421 note i) for billing criteria.

ii) Minimum time requirement for service is 20 minutes.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

iv) Payable once per hospital admission unless note record provided to indicate medical necessity for additional reassessments.

v) Payable up to twice per month per patient only when service rendered in out-patient setting unless note record provided to indicate medical necessity for additional reassessments.

33473	Telehealth Comprehensive cognitive consultation – for dementia or cognitive problems: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care	297.20

Notes:

i) Applicable only when written report includes at least two aspects of complexity. The focus here is the cognitive impairment and how it is affecting the patient's ability to function. Common clinical syndromes include, but are not limited to the following:

- *Assessment of dementia, using some form of formal cognitive measurement, as well as integrating reports from family/homemakers/Home Health.*
- *Behavioural/affective issues in dementia management.*
- *Management of common psychiatric syndrome in the elderly, including depression, anxiety, insomnia, psychosis, bipolar disorder.*
- *Substance abuse disorders.*
- *Assessment/monitoring of functional status including issues of competency and "living at risk".*
- *Issues identified in 33401 may enter into the picture.*

ii) Minimum time requirement for service is 65 minutes clinical assessment time.
iii) Start and end times must be entered in both the billing claims and the patient's chart.

$

33474 Telehealth Geriatric reassessment subsequent to comprehensive consultation - – for dementia or cognitive problems.....120.00

Notes:
i) See 33473 note i) for billing criteria.
ii) Minimum time requirement for service is 20 minutes.
iii) Start and end times must be entered in both the billing claims and the patient's chart.
iv) Payable once per hospital admission unless note record provided to indicate medical necessity for additional reassessments.
v) Payable up to twice per month per patient only when service rendered in out-patient setting unless note record provided to indicate medical necessity for additional reassessments.

33423 Telehealth Complex consultation – for 2 or more conditions: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care... .....270.05

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to, the following:
- *Septicemia*
- *Other HIV infection*
- *DM including complications*
- *Disorders of Lipid Metabolism*
- *Thyroid disorders*
- *Purpura, thrombocytopenia and hemorrhagic conditions*
- *Anemia, unspecified*
- *Senile dementia, presenile dementia*
- *Acute confusional state*
- *Congestive Heart Failure*
- *Diseases of the aortic and mitral valve*
- *Essential hypertension*
- *Coronary atherosclerosis*
- *Neoplasm of uncertain behaviour of other and unspecified sites. "Not for minor or superficial skin malignancies."*
- *Cardiac dysarrhythmias*
- *Cerebral atherosclerosis*
- *Asthma allergic bronchitis*
- *Emphysema*
- *Other bacterial pneumonia*
- *Non infective enteritis and colitis*
- *GI hemorrhage*

- *Chronic liver diseases and cirrhosis of the liver*
- *CRF*
- *ARF*
- *Disorders of fluid, electrolyte and acid base balance*
- *Syncope*
- *Venous thrombosis and embolism*
- *Pulmonary fibrosis*
- *Rheumatoid Arthritis*
  Systemic Lupus Erythematosus

		$
33424	Telehealth repeat or limited complex consultation – for 2 conditions: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	135.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) See 33423 note ii) for billing criteria.

33476	Telehealth directive care	50.00
33426	Telehealth Comprehensive or complex directive care	72.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations.

33477	Telehealth subsequent office visit	55.00
33427	Telehealth Comprehensive or complex subsequent office visit	88.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations.

33478	Telehealth subsequent hospital visit	44.00
33428	Telehealth Comprehensive or complex subsequent hospital visit	45.00

Notes:
i) Payable only for Geriatric Medicine specialists.
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations.

Miscellaneous

PG33445	Geriatric Care Conference (planning for patient) - per 15 minutes, or greater portion thereof	50.00

Notes:
i) Restricted to Geriatric Medicine.
ii) Requires interdisciplinary team meeting of at least one allied health professional, and may or may not include family members and/or representatives.
iii) Billable after any comprehensive consult or complex (33401, 33403, 33421, 33423, 33440, 33473) or follow up (33402, 33404, 33422, 33424, 33442, 33474) by a Geriatrician in the last 6 months.
iv) Maximum six paid per patient, per sitting.
v) Maximum thirty-two paid per patient, per calendar year.
vi) The results of the conference, as well as the roles/relationships of those who participated in the meeting must be documented in patient's chart, and result

communicated to the Family Physician, Specialist and/or appropriate Health care practitioner involved in the care of the patient.

vii) Claim must state start and end times of this service.

viii) Not payable to physicians for services provided within time periods when working under salary, service contract, or sessional arrangements.

ix) Visit paid in addition, if medically required and does not take place concurrently with the conference. Medically required visits performed consecutive to this fee will be paid.

$

PG33450 Family Conference (planning for patient) - per 15 minutes or greater portion thereof.....45.00

Notes:

i) Restricted to Geriatric Medicine.

ii) One or more family members/representatives must be present.

iii) Billable after any comprehensive consult or complex (33401, 33403, 33421, 33423, 33440, 33473) or follow up (33402, 33404, 33422, 33424, 33442, 33474) by a Geriatrician in the last 6 months.

iv) Maximum of four per patient, per sitting.

v) Annual maximum of eight per patient.

vi) The results of the conference, as well as the names and roles of those who participated in the meeting must be documented in the patient's chart, and result communicated to the Family Physician, Specialist and/or appropriate Health care practitioner involved in the care of the patient.

vii) Claim must state start and end times of this service.

viii) Not payable to physicians for services provided within time periods when working under salary, service contract, or sessional arrangements.

ix) Visit paid in addition, if medically required and does not take place concurrently with the conference. Medically required visits performed consecutive to this fee will be paid.

HEMATOLOGY AND ONCOLOGY

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

		$	Anes. Level
Referred Cases			
33510	**Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	174.00	
33512	**Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	84.24	
33520	Complex Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report for complex patient	270.00	

Notes:

i) Restricted to Hematology and Oncology.

ii) Paid to a maximum of one per patient within six months of the last visit.

iii) Payable only for patients who are being directly managed for one of the following hematologic diseases:

- *Multiple myeloma, excludes monoclonal paraproteinemia/ monoclonal gammopathy of undetermined significance*
- *Acute leukemia excludes chronic lymphocytic leukemia*
- *Hereditary hemolytic anemia*
- *Acquired hemolytic anemia*
- *Aplastic anemia and red cell aplasia*

Or one of the following diseases <u>with qualifying features</u>:

- *Myelodysplastic syndrome or Myelofibrosis requiring chemotherapy, transfusion or growth factor therapy*
- *Coagulation defects requiring factor concentrate, transfusion or other hemostatic therapy*
- *Thrombocytopenia requiring immunosuppressive, transfusion or growth factor therapy*
- *Venous thromboembolism (VTE) / Phlebitis and thrombophlebitis that is:*
    - *unprovoked,*
    - *in a patient with cancer,*
    - *in a pregnant patient, or*
    - *in a patient with a contraindication to anticoagulation.*

33522	Repeat or Limited Consultation, Complex Patient: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	152.00	

Notes:

i) Restricted to Hematology and Oncology.

ii) Payable for complex patients (see notes for Complex Consultation – 33520).

		$	Anes. Level
33514	Prolonged visit for counselling (maximum, four per year)	78.88	

Notes:

i) See Preamble, Clause D. 3. 3.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

Group counselling for groups of two or more patients:

33513	- first full hour	113.76	
33515	- second hour, per 1/2 hour or major portion thereof	56.84	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Continuing care by consultant:

33506	Directive care	84.20	
P33526	Directive care, Complex Patient	110.00	

Notes:

i) Restricted to Hematology and Oncology.

ii) Limited to 2 visits per patient per week (Sunday to Saturday).

iii) Not paid in addition to 33506

iv) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iii of fee item 33520.

33507	Subsequent office visit	56.20	
33527	Subsequent Office Visit, Complex Patient	101.00	

Notes:

i) Restricted to Hematology and Oncology.

ii) Payable for complex patients (see notes for Complex Consultation 33520).

iv) Payment not contingent on whether or not a Complex Consultation or telehealth Complex Consultation was billed in the preceding 6 months.

33508	Subsequent hospital visit	64.48	
33509	Subsequent home visit	52.04	
33505	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums)	145.13	

Note: *Claim must state time service rendered.*

Telehealth Service with Direct Interactive Video Link with the Patient:

33570	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	174.00	
33572	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	84.24	
33540	Telehealth Complex Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report for complex patient	270.00	

Notes:

i) Restricted to Hematology and Oncology.

ii) Paid to a maximum of one per patient within six months of the last visit.

iii) Payable only for patients who are being directly managed for one of the following hematologic diseases:

- *Multiple myeloma, excludes monoclonal paraproteinemia/ monoclonal gammopathy of undetermined significance*
- *Acute leukemia excludes chronic lymphocytic leukemia*

- *Hereditary hemolytic anemia*
- *Acquired hemolytic anemia*
- *Aplastic anemia and red cell aplasia*

Or one of the following diseases with qualifying features:

- *Myelodysplastic syndrome or Myelofibrosis requiring chemotherapy, transfusion or growth factor therapy*
- *Coagulation defects requiring factor concentrate, transfusion or other hemostatic therapy*
- *Thrombocytopenia requiring immunosuppressive, transfusion or growth factor therapy*
- *Venous thromboembolism (VTE) / Phlebitis and thrombophlebitis that is:*
    - *unprovoked,*
    - *in a patient with cancer,*
    - *in a pregnant patient, or*
    - *in a patient with a contraindication to anticoagulation.*

		$	Anes. Level
33542	Telehealth Repeat or Limited Consultation, Complex Patient: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	152.00	

Notes:
i) Restricted to Hematology and Oncology.
ii) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iii of fee item 33520.

P33546	Telehealth Directive care, Complex Patient	110.00	

Notes:
i) Restricted to Hematology and Oncology.
ii) Limited to 2 visits per patient per week (Sunday to Saturday).
iii) Not paid in addition to 33506.
iv) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iii of fee item 33520.

33577	Telehealth subsequent office visit	56.20	
33547	Telehealth Subsequent Office Visit, Complex Patient	101.00	

Notes:
i) Restricted to Hematology and Oncology.
ii) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iv of fee item 33520.
iii) Payment not contingent on whether or not a Complex Consultation or Telehealth Complex Consultation was billed in the preceding 6 months.

Examination by Certified Hematologist and Oncologist

33538	Plasmapheresis – therapeutic	199.65	

Diagnostic Procedures - Needle Biopsy Procedures

S00748	Bone biopsy under local/regional anesthetic	63.99	

Puncture Procedure for obtaining body fluids (when performed for diagnostic purposes)

S00753	Marrow aspiration - procedural fee	43.77	2

		$	Anes. Level

Chemotherapy

a) Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.
b) Hospital visits are not payable on the same day.
c) Visit fees are payable on subsequent days, when rendered.
d) A consultation, when rendered, is payable in addition to fee item 33581, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.
e) The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.

33581 **High intensity cancer chemotherapy:**

To include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis 203.27

Note: *This service is not payable more frequently than once every 28 days.*
The following treatments fall into this category:
a) chemotherapy for acute leukemia.
b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment.
c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna.
d) chemotherapy using DTIC in a dose exceeding 100 mg/m2.
e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen).
f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).

33582 **Major Cancer Chemotherapy:**

To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents 119.21

Note*: This service is not payable more than once every 7 days.*

33583 **Limited Cancer Chemotherapy:**

To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line 68.11

Note: *This item is not payable more than once every 7 days. Neither is it to be billed for routine IV push administration of 5-flourouracil as a single agent.*

INFECTIOUS DISEASES

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

		$	Anes. Level

Referred Cases

33610 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 207.09

33612 **Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee 109.91

33620 Infectious Disease Extended Consultation for complex infectious diseases issues (antibiotic resistant organisms, outbreak management/infection control, tropical disease management), when requested by another Infectious Diseases Specialist, Internist, Internal Medicine Sub-Specialist, Pediatricians and Anesthesiologists. Includes history, physical examination, review of X-rays and additional visits necessary to render a written report 335.29

Notes:

i) Minimum time requirement for service is 75 minutes (actual time spent with patient). Please submit start and stop times in the claim submission and log time in patient's chart.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

iii) If an Infectious Diseases specialist receives a referral by a physician other than the speciality types noted above and the conditions defined within the consultation service are met, a claim may be submitted under 33620 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.

33614 Prolonged visit for counselling (maximum, four per year) 55.95

Notes:

i) See Preamble, Clause D. 3. 3.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

<u>Group counselling for groups of two or more patients:</u>

33613 - first full hour 114.64

33615 - second hour, per 1/2 hour or major portion thereof 57.28

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

<u>Continuing care by consultant:</u>

33606 Directive care 62.64

33607 Subsequent office visit 57.98

33608 Subsequent hospital visit 41.42

33609 Subsequent home visit 52.41

33605 Emergency visit when specially called 116.16
(not paid in addition to out-of-office-hours premiums)
Note: *Claim must state time service rendered.*

		$	Anes. Level
33645	Infectious Disease Care Management of HIV/AIDS - per half hour or major portion thereof	102.36	

Notes:

i) Payable to Infectious Diseases specialists only.

ii) When performed in conjunction with visit, counselling or consultations, only the larger fee is paid.

iii) Only applicable to services submitted under diagnostic codes 042, 043 and 044.

iv) Start and end times must be included on claim, and in patient's chart.

v) Services that are less than 15 minutes should be billed under the appropriate visit fee item.

Telehealth Service with Direct Interactive Video Link with the Patient:

33630	Telehealth Consultation: Shall include a detailed history and physical examination, review of previous medical records, discussion with family, friends or witnesses, evaluation of appropriate laboratory, X-ray and ECG findings and report of opinions and recommendations in writing to the referring physician	207.09	

Note: *Restricted to FRCP Infectious Diseases Physicians.*

33632	Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	109.91	
33640	Telehealth Infectious Disease Extended Consultation for complex infectious diseases issues (antibiotic resistant organisms, outbreak management/infection control, tropical disease management), when requested by another Infectious Diseases Specialist, Internist, Internal Medicine Sub-Specialist, Pediatricians and Anesthesiologists. Includes history, physical examination, review of X-rays and additional visits necessary to render a written report	335.29	

Notes:

i) Minimum time requirement for service is 75 minutes (actual time spent with patient). Please submit start and stop times in the claim submission and log time in patient's chart.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

iii) If an Infectious Diseases specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation service are met, a claim may be submitted under 33640 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.

33636	Telehealth directive care	62.64	
33637	Telehealth subsequent office visit	57.98	
33638	Telehealth subsequent hospital visit	41.42	
33635	Telehealth Infectious Disease Care Management of HIV/AIDS – per half hour or major portion thereof	102.36	

Notes:

i) Payable to Infectious Diseases specialists only.

ii) When performed in conjunction with visit, counselling or consultations, only the larger fee is paid.

iii) Only applicable to services submitted under diagnostic codes 042, 043 and 044.

v) Start and end times must be included on claim, and in patient's chart.

v) Services that are less than 15 minutes should be billed under the appropriate visit fee item.

		$	Anes. Level

Miscellaneous

G33655 Home Parenteral Antibiotic Management Fee, for active antibiotic treatment only 18.78

Notes:

i) Restricted to Infectious Diseases specialists.
ii) This fee may be billed for advice by telephone, fax, email, or in written form.
iii) This fee may be billed to a maximum of one per patient, per physician, per day.
iv) This fee may be billed up to 7 services per calendar week per physician per patient.
v) This fee may not be billed in addition to visits, out-of-office premiums, or other services provided on the same day, by the same physician, for the same patient.
vi) A note record must be included for payment past 42 days.

Minor Procedures

13600 Biopsy of skin or mucosa (operation only) 52.24 2

Note: *Punch or shave biopsies which do not require sutures are not to be charged under fee items 13600 or 13601.*

Diagnostic and Selected Therapeutic Procedures

Puncture procedure for obtaining body fluids (when performed for diagnostic purposes)

SY00750 Lumbar puncture in a patient 13 years of age and over 55.28 2

Note: *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*

S00753 Marrow aspiration - procedural fee 43.77 2

SY00757 Joint aspiration - procedural fee (not in addition to Y00014 or Y00015) - other joints 12.03 2

S00759 Paracentesis - (thoracic) or transtracheal aspiration - procedural fee 86.00 2

S00760 - (abdominal) - procedural fee 25.88 2

Needle biopsy Procedures

S00749 Parietal pleural, including thoracentesis - procedural fee 131.00 2

Allergy, patch and photopatch tests

S00764 Intracutaneous test, per test 2.15

Orthopaedic Diagnostic Procedures

Elbow, Proximal Radius and Ulna

Incision - Diagnostic, Percutaneous:

S11302 Aspiration - bursa, tendon sheath. 23.23 2

		$	Anes. Level
	Hand and Wrist		
	Incision - Diagnostic, Percutaneous:		
S11402	Aspiration bursa, synovial sheath, etc.	23.23	2
	Pelvis, Hip and Femur		
	Incision - Diagnostic, Percutaneous:		
S11501	Aspiration hip joint	23.23	2
S11502	Aspiration bursa, tendon sheath.	11.63	2
	Femur, Knee Joint, Tibia and Fibula		
	Incision - Diagnostic, Percutaneous:		
S11602	Aspiration bursa, tendon sheath or other periarticular structures	23.23	2
	Tests Performed in a Physician's Office		
15136	Fungus, direct microscopic examination, KOH preparation	8.39	

NEPHROLOGY

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

		$	Anes. Level

Referred Cases

33710 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 173.42

33712 **Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee 85.60

33714 Prolonged visit for counselling (maximum, four per year) 52.15

Notes:

i) See Preamble, Clause D. 3. 3.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

Group counselling for groups of two or more patients:

33713 - first full hour 106.78

33715 - second hour, per 1/2 hour or major portion thereof 53.36

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Continuing care by consultant:

33706 Directive care 60.17

33707 Subsequent office visit 49.56

33708 Subsequent hospital visit 48.32

33709 Subsequent home visit 48.85

33705 Emergency visit when specially called 108.26
(not paid in addition to out-of-office-hours premiums)
Note: *Claim must state time service rendered.*

Telehealth Service with Direct Interactive Video Link with the Patient:

33730 Telehealth Consultation: Shall include a detailed history and physical examination, review of previous medical records, discussion with family, friends or witnesses, evaluation of appropriate laboratory, X-ray and ECG findings and report of opinions and recommendations in writing to the referring physician 173.42
Note: *Restricted to FRCP Nephrology Physicians.*

33732 Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee 85.60

33736 Telehealth directive care 60.17

33737 Telehealth subsequent office visit 49.56

33738 Telehealth subsequent hospital visit 48.32

		$	Anes. Level

Dialysis Fees

(A) Acute renal failure

a) Hemodialysis:

33750	Blood dialysis - physician in charge	531.27
33751	Repeat blood dialysis - physician in charge	199.65

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.

33752	Blood dialysis - fee for cut down by surgeon to be charged in addition to items 33750 or 33751	134.31

b) Peritoneal dialysis:

33756	Reinsertion of peritoneal catheter after 10 days from initial insertion	52.22

Note*: Item 00081 not to be charged in addition to item 33723.*
Where an initial peritoneal dialysis is performed and for various reasons, hemodialysis 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) Hemodialysis:

33758	Performance of hemodialysis - fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis, for each dialysis	52.22

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:

33723	Performance of initial peritoneal dialysis, chronic or acute renal failure, to include consultation and two weeks' care	397.47
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	52.22

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

33761	Supervision of home dialysis - per week	63.13

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
Miscellaneous			
33790	Care of renal transplant patient, including immediate preparation and fourteen days post-operative care	1,182.14	
77380	Insertion permanent peritoneal catheter; (procedure fee only)	190.68	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.*	132.26	3

OCCUPATIONAL MEDICINE

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

		$
Referred Cases		
33910	**Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	167.40
33912	**Repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	84.22
	Continuing care by consultant:	
33907	Subsequent office visit	52.16

RESPIROLOGY

These listings cannot be correctly interpreted without reference to the Preamble

		$	Anes. Level

Referred Cases

32010 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 229.31

32012 **Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee 123.59

32014 Prolonged visit for counselling (maximum four per year) 84.10
***Notes**:*
i) See Preamble, Clause D. 3. 3.
ii) Start and end times must be entered in both the billing claims and the patient's chart.

Continuing care by consultant:

32006 Directive Care 75.08
32007 Subsequent office visit 76.09
32008 Subsequent hospital visit 68.07
32005 Emergency visit when specially called 104.18
(not paid in addition to out-of-office hours premiums)
***Note:** Claim must state time service rendered.*

PG32011 Complex Respiratory Medicine Assessment, for patients with advanced multi-system disease, per 15 minutes or greater portion thereof 69.08
Notes:
i) Restricted to Respiratory Medicine specialists who provide care in the following clinics:
Adult Cystic Fibrosis: St. Paul's and Royal Jubilee Hospital
Interstitial Lung Disease: Vancouver General and Saint Paul's
Severe Asthma: Vancouver General, Saint Paul's and Surrey Memorial
Lung Transplant Clinic (includes pre and post lung transplant assessment)
Pulmonary Hypertension: Vancouver General and Saint Paul's.
ii) Maximum of 7 hours per day, per physician.
iii) When consult, repeat or limited consult or visit is charged in addition to G32011, for billing purposes, the consultation fee shall constitute the first ½ hr. and the repeat or limited consult or visit will constitute the first 15 minutes of the time spent with the patient.
iv) Includes time spent in multidisciplinary case conferencing and teleconferencing with other health care providers and/or patients.
v) A written consultation report is required for each patient seen in the clinic.
vi) Start and end times must be included on claims.
vii) Paid to a maximum of one service per patient per visit.

Telehealth Service with Direct Interactive Video Link with the Patient:

32110 Telehealth consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 229.31

		$	Anes. Level
32112	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant that consultative services do not warrant a full consultative fee	123.59	
32114	Telehealth prolonged visit for counselling (maximum four per year) ***Notes**:* *i) See Preamble, Clause D. 3. 3.* *ii) Start and end times must be entered in both the billing claims and the patient's chart.*	84.10	
32106	Telehealth directive care	75.08	
32107	Telehealth subsequent office visit	76.09	
32108	Telehealth subsequent hospital visit	68.07	

Diagnostic Therapeutic Procedures

S32031	Closed drainage of chest– operation only	137.00	4
10320	Insertion of permanent pleural drainage catheter ***Notes:*** *i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter* *ii) Not paid with S32031, 00749, 00759, 07924 and 08646.*	235.00	5
10321	Removal permanent pleural drainage catheter ***Note**: Not paid with S32031, 00749, 00759, 07924 and 08646.*	72.00	2

Diagnostic procedures involving visualization by instrumentation

S00700	Bronchoscopy or bronchofibroscopy - procedural fee	122.00	4
S00702	Bronchoscopy with biopsy - procedural fee	210.00	4
10700	Endobronchial cautery - extra ***Notes:*** *i) To a maximum of 3 lesions.* *ii) Second and third lesion payable at 50%.* *iii) Payable only with 00700 or 00702 and 10702, 10703, 00736.* *iv) Not payable with 10739 or 02450.*	77.00	6
10702	Endobronchial cryotherapy - extra ***Notes:*** *i) To a maximum of 3 lesions.* *ii) Second and third lesion payable at 50%.* *iii) Payable only with 00700 or 00702 and 10700, 10703, 00736.* *iv) Not paid with 10739, 02450 and 02422.*	77.00	6
10703	Transbronchial needle aspiration (TBNA) ***Notes:*** *i) To a maximum of 3 separate stations or lesions.* *ii) Second and third station or lesion payable at 100%.* *iii) Payable with 00700, 00702 or 10739 and 10700, 10702, 00736.* *iv) Paid at 100% with other diagnostic procedures.*	70.00	6

		$	Anes. Level
Diagnostic procedures utilizing radiological equipment			
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	67.00	4
10739	Endobronchial Ultrasound (EBUS)	387.16	6
	Notes: *i) Not payable with 00700, 00702, 02450, 10700 or 10702.* *ii) Fee item 10703 and 00736 payable in addition.*		
Diagnostic Procedures or Endoscopy			
S00818	Oesophageal pH study for reflux, extra - professional fee	41.00	
S00817	- technical fee	13.00	
	Polysomnogram:		
	Overnight home oximetry (continuous recording of oxygen and pulse)		
S00910	- professional fee	28.30	
S00911	- technical fee	15.62	
	Note: *Fee items 00910 and 00911 are limited to Category III pulmonary function diagnostic facilities and/or polysomnography diagnostic facilities with the established personnel qualifications for such facilities.*		
S11915	Polysomnography, standard – professional fee	167.45	
S11916	Polysomnography, standard – technical fee	387.02	
S11919	Multiple Sleep Latency Test (MSLT) - professional fee	83.70	
S11920	Multiple Sleep Latency Test (MSLT) - technical fee	193.51	
S11925	Four channel home polysomnography – professional fee	83.61	
S11926	Four channel home polysomnography – technical fee	83.86	
Pulmonary Investigative and Function Studies			
	Diagnostic Procedures:		
S00928	Simple screening spirometry with FVC, FEV(i), and FEV(i)/FVC ratio using a portable apparatus without bronchodilators	13.00	
S00929	Simple screening spirometry as above but before and after bronchodilators	19.00	
	Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume:		
S00931	- professional fee	15.00	
S00932	- technical fee	14.18	
	Spirometry - forced expiratory spirogram to include FVC, FEV(i) and FEV(i)/FVC ratio, MMEFR, etc.		
S00933	- without bronchodilators - professional fee	12.00	
S00934	- without bronchodilators - technical fee	11.11	
S00935	- before and after bronchodilators - professional fee	13.50	
S00936	- before and after bronchodilators- technical fee	14.18	

		$	Anes. Level
	Spirometry - flow volume loops:		
S00937	- without bronchodilators - professional fee	12.00	
S00938	- without bronchodilators - technical fee	18.20	
S00940	- before and after bronchodilators - professional fee	15.00	
S00941	- before and after bronchodilators - technical fee	26.92	
	Diffusion Studies with Carbon Monoxide:		
S00942	- at rest or exercise - professional fee	16.00	
S00943	- technical fee	12.87	

Detailed Pulmonary Function Studies:

S00945	- professional fee (includes 00931, 00935 and 00942)	42.50	
S00946	- technical fee (includes 00932, 00936 and 00943)	40.29	

***Note**: Fee items 00931-00936, 00942, 00943 will be paid at 100%.*

Exercise Studies:

***Note:** No more than one exercise study item may be billed for a single patient on any one day without written explanation.*

	Progressive exercise test with at least three workloads, measuring ventilation and electrocardiographic monitoring:		
S00950	- professional fee	25.00	
S00951	- technical fee	32.59	
	Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, and electrocardiographic monitoring:		
S00954	- professional fee	93.00	
S00955	- technical fee	59.06	
	Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space:		
S00956	- professional fee	109.46	
S00957	- technical fee	70.32	

Miscellaneous Pulmonary Tests:

S11960	Oximetry at rest, with or without oxygen - professional fee	5.00	
S11961	- technical fee	5.10	
S11962	Oximetry at rest and exercise, with or without oxygen - professional fee	12.00	
S11963	- technical fee	15.94	
	Plethysmography and airway resistance:		
S00964	- professional fee	14.00	
S00965	- technical fee	26.92	
	Inhalation challenge - assessed by serial flow measurements, per day:		
S00968	- professional fee	40.00	
S00969	- technical fee	36.41	

		$	Anes. Level
	Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:		
SY11964	- professional fee	20.57	
SY11965	- technical fee	44.36	
	Notes:		
	i) Restricted to Respirologists.		
	ii) Maximum of one assessment per patient per day.		
	iii) Annual maximum four per year. Two additional tests will be considered if accompanied by a note record.		
	iv) Not payable in addition to bronchoscopy 00700, 00702.		
	$C0_2/0_2$ responsiveness of respiratory centres by steady state test or rebreathing test:		
S00972	- professional fee	20.00	
S00973	- technical fee	11.11	
	Inspiratory and expiratory muscle strength:		
S00974	- professional fee	14.00	
S00975	- technical fee	12.72	

RHEUMATOLOGY

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

		$	Anes. Level

Referred Cases

31010 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 223.09

PG31050 Extended consultation-exceeding 53 minutes (actual physician time spent with patient). To consist of examination, review of history, laboratory, X-ray findings, necessary to initiate care 270.47

Notes:

i) Restricted to Rheumatology.

ii) Applicable to patients with chronic and complex medical needs. Paid with the following diagnostic codes:

- *a. Diffuse Diseases of Connective Tissue (710), Systemic Lupus Erythematosus (710.0), Systemic Sclerosis (710.1), Sicca Syndrome (710.2), Dermatomyositis (710.3), Polymyositis (710.4), Other (710.8), Unspecified (710.9);*
- *b. Rheumatoid Arthritis and other Inflammatory Polyarthropathies (714), Rheumatoid Arthritis (714.0), Felty's Syndrome (714.1), Other Rheumatoid Arthritis with Visceral or Systemic Involvement (714.2), Juvenile Chronic Polyarthritis (714.3), Chronic Postrheumatic Arthropathy (714.4), Other (714.8), Unspecified (714.9);*
- *c. Polyarteritis Nodosa and Allied Conditions (446), Polyarteritis Nodosa (446.0), Acute Febrile Mucocutaneous Lymphnode Syndrome (MCLS) (446.1), Hypersensitivity Angiitis (446.2), Lethal Midline Granuloma (446.3), Wegener's Granulomatosis (446.4), Giant Cell Arteritis (446.5), Thrombotic Microangiopathy (446.6), Takayasu Disease (446.7);*
- *d. Ankylosing Spondylitis and Other Inflammatory Spondylopathies (720), Ankylosing Spondylitis (720.0), Spinal Enthesopathy (720.1), Sacroiliitis, not Elsewhere Classified (720.2), Other Inflammatory Spondylopathies (720.8), Unspecified Inflammatory Spondylopathy (720.9);*
- *e. Psoriasis and Similar Disorders (696), Psoriatic Arthropathy (696.0), Other Psoriasis (696.1), Parapsoriasis (696.2), Pityriasis rosea (696.3), Pityriasis Rubra Pilaris (696.4), Other Unspecified Pityriasis (696.5), Other (696.8).*
- *f. Arthropathy associated with infections (711);*
- *g. Polymalgia rheumatic (725);*

iii) Paid to a maximum of one per patient within six months of the last visit.

iv) Not paid in addition to 31010, 31012, 31006, 31007, 31008, 31110, 31112, 31106, 31107 or 31108.

v) Start and end times must be recorded on claim and in the patient's chart.

vi) Not paid when there is no change in condition from previous assessment.

31012 **Repeat or Limited Consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgement of the consultant, the consultative services do not warrant a full consultative fee 143.00

31014 Prolonged visit for counselling (maximum, four per year) 49.06

***Notes**:*

i) See Preamble, Clause D. 3. 3.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

		$	Anes. Level
	Continuing care by consultant:		
31006	Directive care	104.90	
31007	Subsequent office visit	90.10	
31008	Subsequent hospital visit	51.57	
31005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) ***Note:*** *Claim must state time service rendered.*	97.21	
31015	Rheumatology Management of Complex Joint(s) requiring Aspiration and/or Injection ***Notes:*** *i) Restricted to Rheumatologists.* *ii) For patients with severe degenerative diseases or inflammatory diseases, rheumatoid or psoriatic arthritis. It is not intended for disorders such as bursitis/tendonitis or soft tissue injections.* *iii) Maximum of one service per patient, per day.* *iv) Maximum of four services per patient, per calendar year.*	25.29	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
31110	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	223.09	
31112	Telehealth Repeat or Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee	143.00	
31106	Telehealth directive care	104.90	
31107	Telehealth subsequent office visit	90.10	
31108	Telehealth subsequent hospital visit	51.57	

Miscellaneous

PG31055	Rheumatology Immunosuppressant Review ***Notes:*** *i) Restricted to Rheumatology.* *ii) Applicable only to patients with chronic systemic inflammatory diseases requiring aggressive immunosuppression.* *iii) Applicable only to patients prescribed immunosuppressant medication.* *iv) Not applicable for patients prescribed hydroxychloroquine, chloroquine, or anti-inflammatories.* *v) Annual maximum - one per patient.* *vi) Immunosuppressant tool must be recorded in patients' chart.*	30.00	
PG31060	Multidisciplinary Care Assessment for community-based patients. To consist of assessment, written treatment plan and any other counselling the patient needs for management of their particular diagnosis ***Notes:*** *i) Restricted to Rheumatology.* *ii) For the ongoing management of complex disorders of the musculoskeletal system, where the complexity of the condition requires the continuing management by a rheumatologist. It is not intended for the evaluation and/or management of uncomplicated rheumatologic disorders (e.g.: routine osteoarthritis, bursitis/tendonitis).* *iii) Only paid when a Registered Nurse or Licensed Practical Nurse is present.* *iv) Applicable to patients with rheumatoid arthritis diagnoses or similar*	225.96	

inflammatory disease.

v) *Maximum one per patient in 6 month period.*

vi) *Not paid in addition to 31010, 31012, 31007 or G31050.*

NEUROLOGY

Preamble

Acute Cerebral Vascular Syndrome (Stroke & TIA) Listings:

Acute cerebrovascular syndrome (ACVS) includes acute stroke and TIA. Both are indistinguishable clinically at onset and are acute emergencies. The ACVS fee items have been developed in conjunction with the BCSS and the Section of Neurology, and are intended for services provided by neurologists in the acute management of stroke/TIA. When submitting claims, the appropriate 3 –digit ICD-9 stroke code (431, 433, 434, and 435) must be used, and the patient's initial NIHSS 2-digit code for the billed visit must be appended in the ICD-9 field (i.e. 43412 or 43405). The TIA code (435) may also have an appended score if the billed visit includes the symptomatic phase.

Face-to-Face Services:

These fee items are intended for services rendered at public facilities with adequate diagnostic capabilities (i.e. laboratory services, diagnostic imaging ability including CT scan, ultrasound) to ensure timely patient care.

Telestroke Services

"Telestroke Service" is defined as a Neurologist-delivered health service provided via videoconferencing for a patient referred by a physician at a different site for diagnosis related to acute cerebral vascular syndrome (ACVS).

i) Referral sites must have capability to provide laboratory services, diagnostic imaging ability including CT scan, ultrasound, CT angiography and must be part of a Health Authority approved, publicly-funded Telestroke program.

Consulting sites are defined as a neurologist-delivered health service provided to a patient at a Health Authority approved, publicly-funded Telestroke program.

ii) Telestroke service includes live interactive transmission of sound and full-motion picture information between the referring site (hospital) and an approved consulting site (the location of the Telestroke neurologist) using secure videoconferencing technology as defined in Preamble D. 1. In order for payment to be made, the patient must be in attendance at the referring site at the time of the video capture. Information regarding the start and stop times of service must accompany claims.

In those cases where a neurologist's service requires a family physician at the patient's site to assist with the essential physical assessment, without which the neurologist's service would be ineffective, the neurologist must indicate in the "Referred by" field that a request was made for a family physician assisted assessment.

Where a receiving neurologist, after having provided a Telestroke consultation service to a patient, decides s/he must examine the patient in person, the neurologist should claim the subsequent visit as a limited consultation, unless more than 6 months has passed since the Telestroke consultation.

Telestroke services are payable only when provided as defined under the specific Preamble pertaining to the service rendered (e.g.: Telestroke consultation - see Preamble D. 2.) to a patient with valid medical coverage. Patients or their representative must be informed and given opportunity to agree to services rendered using this modality, without prejudice.

Where a Telestroke service is interrupted for technical failure, and is not able to be resumed within a reasonable period of time, and therefore is unable to be completed, the receiving neurologist should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.

In exceptional circumstances, for facilities targeted in the BCSS phased implementation in the process of implementing Telestroke services, a telephone consultation may be payable in an emergent (i.e. life or death) situation. Telemetry review of diagnostic images is required as an integral aspect of the consultation. A note record is required in these instances.

Compensation for travel, scheduling and other logistics is the responsibility of the Regional Health Authority. Rural Retention fee-for-service premiums are applicable to Telestroke services and are payable based on the location of the receiving medical practitioner in eligible RSA communities.

NEUROLOGY

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

		$	Anes. Level

Referred Cases

00410 **Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 182.41

00411 **Repeat or limited consultation:** Where a consultation for the same illness is repeated within six months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee 121.29

PG00450 Complex Care - Extended Consultation - per 15 minutes or major portion thereof 58.10

Notes:

i) Paid in addition to 00410, 00411, 00470 and 00471, after 45 minutes.

ii) Paid to a maximum of 3 units per patient, during same sitting.

iii) Start and end times must be entered on patient's chart and on claim.

PG00460 Transfer of Care from Pediatrics - Extended Consultation: To consist of an examination, review of history, previous laboratory & X-ray findings, and written report on a patient with a complex and chronic neurologic condition requiring active neurologist support transferring from pediatric to adult care. In addition, specific and special documentation as outlined below must be included in the patient's chart and copies sent with the patient and/or family as appropriate 388.18

Notes:

i) For patients 16 years to 21 years of age.

ii) This fee is payable to a neurologist who accepts the primary responsibility for the neurologic management of a patient transferring from pediatric to adult care, and includes review of ALL necessary data, including birth and developmental assessments.

iii) Paid once per patient in that patient's lifetime.

iv) Not paid with 00410, 00411, 00441, 40441, 00470, 00471 G00450 or 00457.

Continuing care by consultant:

00406 Directive care 90.53

00407 Subsequent office visit 88.11

00408 Subsequent hospital visit 88.25

00409 Subsequent home visit 90.53

00405 Emergency visit when specially called 121.29
(not paid in addition to out-of-office-hours premiums)

Note: *Claim must state time service rendered.*

00457 Complex Care – Extended Visit- per 15 minutes or major portion thereof 40.36

Notes:

i) Paid in addition to 00406, 00407, 00408, 00409, 00476, 00477 or 00478 after 15 minutes.

ii) Paid to a maximum of 2 units per patient, during same sitting.

iii) Start and end times must be entered on patient's chart and claim.

		$	Anes. Level
P00440	Virtual Neurologic Assessment ……..... ***Notes:*** *i) Restricted to Neurology specialists.* *ii) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received.* *iii) Not paid within 6 months of a 00410 (Consultation), 00470 (Telehealth Consultation), or 00440 (Virtual Assessment), for the same diagnosis.* *iv) Not payable in addition to a consult or visit.* *v) Not payable on the same day with fee items 00487, 00488, 00491, 00492, 00900, 00901, 00902, 00441, 40441 by the same practitioner.* *vi) Limited to 8 virtual assessments per practitioner per month.*	119.95	
00441	Face-to-face ACVS Consultation..... To consist of examination, review of history, laboratory, diagnostic imaging, and the rendering of a written report, including required BCSS registry data. ***Notes:*** *i) Applicable for patients seen within 4.5 hours of onset of symptoms for diagnosis of acute cerebral vascular syndrome.* *ii) Also applicable for patients seen within 72 hours of onset of symptoms for relapse prevention (00444).* *iii) Refer to Neurology ACVS Preamble for further information.* *iv) Restricted to Neurologists.* *v) Not billable in conjunction with 00410, 00081, 00082 or 40441 by the same neurologist.*	217.25	
00442	Face-to-face follow-up neurological clinical monitoring and treatment for persisting ACVS: <u>without</u> administration of tPA, per ½ hour or major portion thereof..... ***Notes:*** *i) To be used for the ongoing evaluation, clinical monitoring and treatment of a patient referred for acute cerebral vascular syndrome requiring ongoing care by the neurologist.* *ii) Includes ongoing review of any and all diagnostic imaging.* *iii) Includes sequential scales e.g.: NIHSS, as necessary.* *iv) Not payable with 00410, 00081, 00082 or 00443 by same physician.* *v) Not intended for standby time such as waiting for laboratory results.* *vi) For payment purposes, when immediately subsequent to 00441, the consultation fee constitutes the first half hour of the time spent with the patient.* *vii) Start and end times must be submitted with claim.* *viii) Restricted to Neurologists.* *ix) If billed in addition to 00441, paid at 100%.* *x) Daily Maximum per patient is six (6), unless note record indicates medical necessity for extended service.*	108.63	
00443	Face-to-face follow-up neurological clinical monitoring and treatment for persisting ACVS: <u>with</u> administration of tPA, per ½ hour or major portion thereof ..... ***Notes:*** *i) To be used for the ongoing evaluation, clinical monitoring and treatment of a patient referred for suspected acute cerebral vascular syndrome requiring ongoing care by the neurologist.* *ii) Includes ongoing review/discussion of any and all diagnostic imaging and/or interventional imaging.* *iii) Includes the time required for use and monitoring of tPA by the neurologist.* *iv) Includes sequential scales e.g.: NIHSS, as necessary.* *v) Not payable with 00410, 00081, 00082 or 00442 by same physician.* *vi) Not intended for standby time such as waiting for laboratory results.*	108.63	

vii) *For payment purposes, when immediately subsequent to 00441, the consultation fee constitutes the first half hour of the time spent with the patient.*
viii) *Start and end times must be submitted with claim.*
ix) *Restricted to Neurologists.*
x) *If billed in addition to 00441, paid at 100%.*
xi) *Daily maximum per patient is six (6), unless note record indicates medical necessity for extended service.*

		$	Anes. Level
00444	Face-to-face follow-up ACVS relapse intervention, per ½ hour or major portion thereof	108.63	

Notes:
i) *To be used for the ongoing evaluation, neurological clinical monitoring and treatment of a patient seen within 72 hours of onset of symptoms with referral diagnosis of ACVS with remission (partial or complete) of original symptoms who requires ongoing care by the neurologist.*
ii) *Includes ongoing review of any and all diagnostic imaging.*
iii) *Not payable with 00410 or 00081, 00082 by same physician.*
iv) *Includes sequential scales e.g.: NIHSS, as necessary.*
v) *Not intended for standby time such as waiting for laboratory results.*
vi) *For payment purposes, when immediately subsequent to 00441, the consultation fee constitutes the first half hour of the time spent with the patient.*
vii) *Start and end times must be submitted with claim.*
viii) *Restricted to Neurologists.*
ix) *If billed in addition to 00441, paid at 100%.*
x) *Daily maximum per patient is four (4), unless note record indicates medical necessity for extended service.*

00485	Face-to-face assessment for acute deterioration in status of an MS patient – 1st full half hour. To consist of acute assessment, examination including EDSS, review of history, laboratory testing and diagnostic imaging, and the rendering of a written report	217.25	

Notes:
i) *Restricted to Neurologists.*
ii) *Applicable only for patients seen within 14 days of onset of symptoms. Date of onset of symptoms must be recorded in the medical record.*
iii) *Payable only for patients with established diagnosis of MS (ICD-9 code 340 billed previously by any neurologist).*
iv) *Repeat services payable after 42 days of a previous 00485.*
v) *Maximum two per patient per calendar year.*
vi) *Includes lumbar puncture (00750) if required.*
vii) *Fee item 00486 payable in addition if assessment exceeds 30 minutes.*
viii) *Not payable same day with critical care fee items (01411, 01412, 01413, 00081, 00082 or fee item G00450 or 00410). Only highest priced item will be paid.*
ix) *Start and end times must be submitted with the claim.*

00486	Face-to-face assessment for acute deterioration in status of an MS patient – each additional half hour or major portion thereof	115.33	

Notes:
i) *Paid only with 00485.*
ii) *Maximum of 4 units per face-to-face assessment.*
iii) *Payable for the ongoing assessment, clinical monitoring and treatment of an MS patient with acute deterioration.*
iv) *Start and end times must be submitted with the claim.*

00487	Detailed cognitive assessment by Behavioral Neurologist - extra	50.92	

Notes:
i) *Restricted to practitioners with a subspecialty in Behavioral Neurology.*

ii) Payable for documented MMSE or MOCA or similar standardized cognitive assessment.
iii) Limited to 2 assessments per patient per calendar year.
iv) Limited to 40 assessments per practitioner per month.
v) Minimum time between assessments is 4 months.
vi) Payable only in addition to a consult or visit.

		$	Anes. Level
00488	Detailed cognitive assessment - extra	50.92	

Notes:
i) Restricted to Neurologists.
ii) Practitioners with a subspecialty in Behavioral Neurology must bill 00487.
iii) Payable for documented MMSE or MOCA or similar standardized cognitive assessment.
iv) Limited to 2 assessments per patient per calendar year.
v) Limited to 24 assessments per practitioner per month.
vi) Minimum time between assessments is 4 months.
vi) Payble only in addition to a consult or visit.
vii) Not payable in addition to 00400.

00491	Detailed Parkinson's disease quantitative review for neurologists with a Movement Disorder (MD) fellowship – extra	65.50	

Notes:
i) Restricted to Neurologists with a fellowship in movement disorder.
ii) Must be submitted with ICD-9 for Parkinson's disease (332) and include completion of a Parkinson's Assessment Scale on a complex Parkinson's patient.
iii) Paid only in addition to a consult or visit.
iv) Not payable on the same day with fee items 00487, 00488, 00900, 00901, 00902, 00440, 00441 and 40441 by the same practitioner.
v) Limited to 2 assessments per patient per calendar year.
vi) Limited to 24 assessments per practitioner per month.
vii) Minimum time between assessments is 6 months.

00492	Detailed Parkinson's disease quantitative review – extra	65.50	

Notes:
i) Restricted to Neurologists.
ii) Must be submitted with ICD-9 for Parkinson's disease (332) and include completion of a Parkinson's Assessment Scale on a complex Parkinson's patient.
iii) Paid only in addition to a consult or visit.
iv) Not payable on the same day with fee items 00487, 00488, 00900, 00901, 00902, 00440, 00441 and 40441 by the same practitioner.
v) Limited to 2 assessments per patient per calendar year.
vi) Limited to 4 assessments per practitioner per month.
vii) Minimum time between assessments is 6 months.

<u>Telehealth Service with Direct Interactive Video Link with the Patient:</u>

00470	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	182.41	
00471	Telehealth Repeat or limited consultation: Where a consultation for the same illness is repeated within six months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	121.29	
00476	Telehealth directive care	90.53	
00477	Telehealth subsequent office visit	88.11	
00478	Telehealth subsequent hospital visit	88.25	

		$	Anes. Level

Telestroke Services

40441 Telestroke Consultation ……..... .....217.25
To consist of videoconference examination, review of history, laboratory, diagnostic imaging, and the rendering of a written report, including required BCSS registry data.

Notes:

i) Applicable for patients seen within 4.5 hours of onset of symptoms for diagnosis of acute cerebral vascular syndrome.
ii) Also applicable for patients seen within 72 hours of onset of symptoms for relapse prevention (40444).
iii) Refer to Neurology ACVS Preamble for further information.
iv) Restricted to Neurologists.
v) Not billable in conjunction with 00410, 00081, 00082 or 00441 by the same neurologist.

40442 Follow-up Telestroke neurological clinical monitoring and treatment for persisting ACVS <u>without</u> administration of tPA, per ½ hour or major portion thereof…….....108.63

Notes:

i) To be used for the ongoing evaluation, clinical monitoring and treatment of a patient referred for acute cerebral vascular syndrome requiring ongoing videoconference care by the neurologist.
ii) Includes ongoing review of any and all diagnostic imaging.
iii) Includes sequential scales e.g.: NIHSS, as necessary.
iv) Not payable with 00410, 00081, 00082 or 40443 by same physician.
v) Not intended for standby time such as waiting for laboratory results.
VI) For payment purposes, when immediately subsequent to 40441, the consultation fee constitutes the first half hour of the time spent with the patient during the videoconference.
vii) Start and end times must be submitted with claim.
viii) Restricted to Neurologists.
ix) If billed in addition to 40441, paid at 100%.
x) Daily Maximum per patient is six (6), unless note record indicates medical necessity for extended service.

40443 Follow-up telestroke neurological clinical monitoring and treatment for persisting ACVS: with administration of tPA, per ½ hour or major portion thereof 108.63

Notes:

i) To be used for the ongoing evaluation, clinical monitoring and treatment of a patient referred for suspected acute cerebral vascular syndrome requiring ongoing videoconference care by the neurologist.
ii) Includes ongoing review of any and all diagnostic imaging.
iii) Includes the time required for monitoring of tPA by the neurologist.
iv) Includes sequential scales e.g.: NIHSS, as necessary.
v) Not payable with 00410, 00081, 00082 or 40442 by same physician.
vi) Not intended for standby time such as waiting for laboratory results.
vii) For payment purposes, when immediately subsequent to 40441, the consultation fee constitutes the first half hour of the time spent with the patient during the videoconference.
viii) Start and end times must be submitted with claim.
ix) Restricted to Neurologists.
x) If billed in addition to 40441, paid at 100%.
xi) Daily Maximum per patient is six (6), unless note record indicates medical necessity for extended service.

		$	Anes. Level
40444	Follow-up Telestroke ACVS relapse intervention, per ½ hour or major portion thereof	108.63	

Notes:

i) To be used for the ongoing evaluation, neurological clinical monitoring and treatment of a patient seen within 72 hours of onset of symptoms with referral diagnosis of ACVS with remission (partial or complete) of original symptoms who requires ongoing care by the neurologist.
ii) Includes ongoing review of any and all diagnostic imaging.
iii) Not payable with 00410, 00081, or 00082 by same physician.
iv) Includes sequential scales e.g.: NIHSS. as necessary.
v) Not intended for standby time such as waiting for laboratory results.
vi) For payment purposes, when immediately subsequent to 40441, the consultation fee constitutes the first half hour of the time spent with the patient during the videoconference.
vii) Start and end times must be submitted with claim.
viii) Restricted to Neurologists.
ix) If billed in addition to 40441, paid at 100%.
x) Daily maximum per patient is four (4), unless note record indicates medical necessity for extended service.

Special Examinations

00415	Electroencephalogram and interpretation	127.80	
00416	Electroencephalogram - interpretation	49.18	
00413	- technical fee	78.63	
00417	Electrocorticography	229.48	
00418	Fee for intravenous activating agents when given by a qualified electroencephalographer	22.50	
00419	Electroclinical detailed interpretation of a set of seizures	405.04	
00420	Short study of electroclinical interpretation of seizures - professional component	208.56	
00421	Electrocorticography with functional mapping in awake craniotomy	494.52	
00426	Electroencephalogram - sleep only	157.85	

Note: *Not applicable to the segments of sleep which may occur in the course of recording a standard EEG.*

00427	- professional fee	42.56	
00428	- technical fee	115.31	

Miscellaneous

00424	Botulinum Toxin Injections	118.82	2

Note: *Only applicable to cervical dystonia (spasmodic torticollis) in adults; adductor spasmodic dysphonia; jaw-closing oro-mandibular dystonia or hemifacial spasm; dynamic equinus foot deformity due to spasticity in pediatric cerebral palsy patients, two years or older; focal spasticity, including the treatment of upper limb spasticity associated with strokes in adults.*

00480	DMT (Disease Modifying Treatment) management for active inflammatory disease of the Central Nervous System (CNS)	152.77	

Notes:

i) Payable every 6 months to prescribing Neurologists responsible for continuing care of patients with active CNS inflammatory disease, who are on DMT's.
ii) Under this code the prescribing Neurologist is responsible for all associated drug monitoring, drug related complication management and communication to the patient and care providers with respect to the particular drug.
iii) Payable in addition to face-to-face services and physician-to-physician phone calls.

iv) Includes organization of all treatment plans, drug initiation algorithms, medication review, MRI assessment and lab review (including CSF) if required.
v) Includes monitoring of all investigations for subsequent 6 months, including imaging and lab work, and conversations with allied health professionals as required.
***vi)** Maximum number of services payable per neurologist per month is 40.*

		$	Anes. Level
PG00462	Neurological interpretation and written report of submitted X-ray films (including CT scan, TCD, MRI) – per case	52.48	

Notes:
i) Restricted to Neurologists.
ii) For repeats within 24 hours, a note record must be submitted.
iii) Not paid with a consultation (00410, 00411, 00470, 00471, 00441, 40441) within 2 months of this service on the same patient.
iv) Not paid with specialist telephone services G10001, G10002 or G10003 on the same day for the same patient.
v) Not paid for interpretations rendered to inpatients.
vi) Paid to a maximum of 5 services per Neurologist per month.

Doppler Ultrasound

PG00468	Neurology Outpatient Transcranial Doppler Ultrasound: To consist of static and dynamic insonation and definition of intracranial circulation, within 72 hours of stroke onset. This study is designed to assist with a CVA	118.86	

Notes:
i) Restricted to Neurologists.
ii) Paid for outpatients at provincial stroke prevention clinics.
iii) Billable only in addition to 00441, 00442, 00443, 00444 and with 00410, 00411, 00407, 00409, 00470, 00471, or 00477 for patients with sickle cell disease or subarachnoid hemorrhage.
iv) The physician must be present throughout the study.
v) Start and end times must be entered on the patient's chart and on the claim.
vi) Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation, as indicated by the clinical setting.

PG00469	Neurology Outpatient Transcranial Doppler Ultrasound – Prolonged Study – per 15 minutes or greater portion thereof: To consist of prolonged study, which includes fitting of halo-type head brace or other device, and review of study	29.71	

Notes:
i) Restricted to Neurologists.
ii) Paid for outpatients at provincial stroke prevention clinics.
iii) Paid after 45 minutes of G00468.
iv) The physician must be present throughout the study.
v) Start and end times must be entered on patient's chart and on the claim.
vi) Paid to a maximum of 8 units per patient, per study.
vii) Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation as indicated by the clinical setting.

Electrodiagnosis

		$	Anes. Level
	Items under:		
	Intensity duration curve - each muscle.		
	Electromyograph - each muscle.		
	Motor nerve conduction study - each nerve.		
	Sensory nerve conduction study - each nerve.		
	Tetanic simulation test - each muscle.		
	Bill according to:		
S00900	Schedule A - extensive examination (eight or more items)	121.85	
S00901	Schedule B - limited examination (four to seven items)	81.49	
S00902	Schedule C - short examination (one to three items)	40.61	
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests	57.26	
S00923	Technical fee for electrodiagnostic testing	20.39	
S00905	Daily measurements of nerve conduction thresholds in facial palsy	6.35	
S00906	- maximum per course	44.15	
S00914	Insertion of sphenoidal electrodes, temporal lobe epilepsy, E.E.G.: recording	43.61	
S00915	Intra-carotid injection of sodium amytal, speech localization test	98.01	2
S00926	Seizure activation with intravenous activating agents associated with insertion of sphenoidal and/or orbital electrodes	147.86	2
S00927	Decamethonium test - for attendance at, and follow-up observation if necessary	34.34	

NEUROSURGERY

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

		$	Anes. Level
Referred Cases			
03010	**Consultation:** To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	172.86	
03011	**Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	90.17	
	Continuing care by consultant:		
03007	Subsequent office visit	47.16	
03008	Subsequent hospital visit	29.63	
03009	Subsequent home visit	54.82	
03005	Emergency visit when specially called (not paid in addition to out-of-hours premiums) ***Note:*** *Claim must state time service rendered.*	112.94	
03315	Pre-Operative Assessment ***Notes:*** *i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.* *ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.* *iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.* *iv) Maximum of one pre-operative assessment per patient per procedure.* *v) Only paid to the surgeon who performs the procedure.*	172.86	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
03310	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	172.86	
03312	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	90.17	
03317	Telehealth subsequent office visit	47.16	
03318	Telehealth subsequent hospital visit	29.63	
Diagnostic Procedures			
	Puncture procedures for obtaining body fluids (when performed for diagnostic purposes):		
SY00750	Lumbar puncture in a patient 13 years of age and over ***Note:*** *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*	55.28	2

		$	Anes. Level
Miscellaneous			
03211	Muscle biopsy	55.80	2
S03216	Puncture of ventricular shunt for CSF aspiration (operation only)	36.20	2
S03217	Percutaneous ventricular puncture (operation only)	129.36	2
03227	Neurosurgical interpretation and written report of submitted x-ray films (including CT scan, MRI) ***Note:*** *Not payable in addition to a consultation rendered within 2 months (+/-) on the same patient on referral by the same physician.*	59.43	
Trauma			
03110	Elevation or "attempted" elevation of depressed skull fracture in infant under the age of 1 year by neurosurgeon, using vacuum extractor, (operation only)	142.29	6
03111	Elevation of simple depressed skull fracture	729.98	5
03112	Elevation of compound depressed skull fracture	1,177.67	6
03113	Elevation of compound depressed skull fracture with repair of dura, debridement of cerebral laceration and sinuses	1,867.71	8
03115	Exploration of subdural space for chronic subdural haematoma - unilateral or bilateral	914.11	6
03116	Craniotomy for evacuation of intracranial haematoma (cerebral, subdural, extra-dural or abscess)	1,719.76	8
03118	Craniotomy for repair of CSF leak	1,612.18	8
03126	Re-opening or removal of bone flap	693.26	6
S03165	Insertion of intracranial pressure monitoring device - operation only	296.11	6
Cerebrovascular			
03141	Cerebral re-vascularization procedure with extracranial-intracranial anastomosis	2,222.19	9
03142	Application of Silverstone clamps (operation only)	561.66	5
03136	Craniotomy for intracranial aneurysm or angioma	2,731.29	9
03119	Craniotomy for microvascular decompression of cranial nerve	1,999.53	8
Neuro-oncology			
03129	Craniotomy for tumour	1,701.87	8
03114	Craniotomy and microsurgical removal of tumour of ventricle, brain stem, thalamus, hypothalamus, or basal ganglia	2,909.46	8
03130	Craniotomy for removal of extra-axial brain tumour using operating microscope when procedure is prolonged more than 8 hours (to include operative report) ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	4,490.32	8
03135	Craniotomy or laminectomy using operating microscope when procedure is prolonged more than 8 hours (to include operative report) ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	3,924.59	9

		$	Anes. Level
03222	Craniotomy lasting more than 12 hours and requiring operating microscope	5,337.81	9
	Notes: *i) 03222 is applicable to the principal neurosurgeon who is required to spend more than 12 hours performing this surgery.* *ii) Start and end times must be entered in both the billing claims and the patient's chart.* *iii) Additional neurosurgeons involved in this surgery as assistants should claim the certified surgical assistant's fees.* *iv) Other surgical specialists required because of their specific expertise should claim separately in accordance with Clause D. 5. 3. of the Preamble to the Payment Schedule.*		
03066	Craniotomy for microsurgical resection of extra-axial tumour - extra to 03222, per hour or major portion thereof, after 12 hours	193.16	
	Note: *Start and end times must be entered in both the billing claims and the patient's chart.*		
03133	Craniotomy for removal of extra-axial brain tumour using operating microscope	2,909.46	8
03128	Stereotactic biopsy for intracranial pathology via frame-based or frameless techniques	1,474.65	7
	Note: *Fee item 03189 is not payable in addition.*		
03320	Removal of skull tumour without craniectomy	418.78	6
03131	Transsphenoidal removal of pituitary tumour or hypophysectomy - one surgeon	2,022.48	8
03132	- two surgeons - neurosurgeon	2,019.98	8
02437	- otolaryngologist	1,233.76	8
03189	Stereotactic localization during neurosurgery in association with craniotomy and spinal fusion/stabilization procedures – extra	481.50	
	Note: *Applicable to procedures involving cranium or spine.*		

Skull Base

02262	Translabyrinthine approach for neurosurgical access exposure, closure with microscope	2,429.48	8
02610	Middle cranial fossa approach without petrosectomy - for trauma, neoplasm resection, nerve section/decompression	1,440.32	8
	Notes: *i) Includes exposure, removal and closure with microscope.* *ii) May include extra-dural resection of lesion by Otolaryngologist.*		
02612	Middle cranial fossa approach - petrosectomy	1,929.76	8
02613	Middle cranial fossa approach - petrosectomy - procedure lasting longer than 8 hours	2,412.08	8
	Notes: *i) 02612 and 02613 to include exposure, extra-dural removal and closure with microscope.* *ii) Start and end times must be entered in both the billing claims and the patient's chart.*		
02614	Retrolabyrinthine approach for neurosurgical access - exposure, closure with microscope.	2,206.00	8
02618	Repair of CSF leak following skull base approaches with mastoid obliteration - to include exposure, dissection and closure with microscope.	1,400.00	8

		$	Anes. Level
02622	Infra-temporal fossa approach to skull base - Otolaryngology fee.	2,224.40	8
02623	Infra-temporal fossa approach to skull base - Otolaryngology fee for procedure lasting longer than 8 hours.	2,582.14	8

Notes:
i) 02622 and 02623 to include exposure and closure with microscope.
ii) May include extra-dural resection of lesion by Otolaryngologist.
iii) Time is based on the cumulative time spent by the Otolaryngologist on the procedure.
iv) Start and end times must be entered in both the billing claims and the patient's chart.

03065	Neurosurgical component of cranial facial resection for tumour of ethmoid, frontal sinus or orbit, as a combined procedure with ENT (See also fee code 02280)	1,639.46	7

Note: *Not billable for exposure only.*

03224	Neurosurgical component of microsurgical removal of cerebellar pontine angle tumour	1,885.07	8

Note: *Not billable for exposure only.*

Pediatric Neurosurgery

03183	Microsurgical repair of meningomyelocele	1,754.52	6
03175	Repair of meningocoele or encephalocoele	1,001.39	6
03095	Posterior decompression of Chiari malformation or foramen magnum - no dural repair	1,549.63	8
03096	- with dural repair	1,874.56	8
03097	- with fourth ventricular exploration	2,124.50	8
03121	Cranioplasty	950.12	7
03145	Cranioplasty using autologous bone graft	1,341.20	7
03122	Craniectomy for osteomyelitis or skull tumour	1,061.40	7
03123	- with cranioplasty	1,493.23	7
03124	Linear craniectomy or craniotomy for cranial stenosis - 1st suture	1,032.86	7
03127	- additional sutures to a maximum of 3 - each extra	253.50	7
	Lateral canthal advancement or similar procedure for coronal synostosis		
03137	- unilateral	1,195.69	8
03143	- bilateral	1,280.35	8
03125	Bilateral craniectomies for cranial expansion or delayed treatment of synostosis (patient must be older than 1 year)	1,913.31	8
03146	Morcellation of skull for craniosynostosis	1,745.53	8
03147	Cranial reconstruction for complex deformity in a child	2,480.37	8

Note*: 03147 requires that the procedure take place more than three months after a previous cranial reconstruction procedure. The operation must be bilateral and involve at least two of the major cranial vault bones, namely frontal, parietal and occipital bones.*

03148	Forehead reconstruction, extra to linear craniectomies for craniosynostosis	285.85	
03053	Craniotomy for combined plastic surgical/neurosurgical Cranioplasty - neurosurgical component	685.59	8

		$	Anes. Level
03120	Neurosurgical fee for facial craniotomy reconstruction	1,347.34	9
	Bilateral orbital advancement – intracranial approach for correction of hypertelorism when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61380	Plastic Surgery portion	2,235.25	8
03080	Neurosurgery portion	2,235.25	8
	Unilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61381	Plastic Surgery portion	2,073.65	8
03081	Neurosurgery portion	2,073.65	8
	Bilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61382	Plastic Surgery portion	2,773.64	8
03082	Neurosurgery portion	2,773.64	8

Endoscopy/Hydrocephalus

03181	Shunt for ventricular obstruction	1,011.31	6
03182	- revision	1,011.31	6
03184	Lumbar peritoneal shunt for hydrocephalus.	1,011.31	5
S03188	Ventriculostomy or insertion of external ventricular drain (operation only)	339.44	6
S03240	Implantation of totally implantable ventricular access device (e.g.: Ommaya reservoir) - (operation only)	467.81	6
	Note: *03240 not to be used for external ventricular drain.*		
03036	Ventricular shunt with ventriculoscopic guidance	1,074.87	6
S03037	Removal of ventricular shunt (operation only)…	288.15	6

Notes:

i) Restricted to Neurosurgeons.

ii) Not paid with fee item 03182.

iii) If fee item 03188 is performed under the same anesthetic, pay in accordance with Preamble D. 5. 3.

03038	Stereotactic localization during intracranial shunt procedures – extra……..	380.65	6

Notes:

i) Restricted to Neurosurgeons.

ii) Paid only in addition to 03181, 03182, 03188, 03240, 03030, 03031, 03032, 03033, 03034, 03035, or 03036.

iii) Daily maximum of 1 per patient – if a second procedure is required on the same day, provide note record.

Ventriculoscopic Procedures

Note: *When ventriculoscopy is performed as part of a craniotomy, the ventriculoscopic fee is not payable in addition to the craniotomy fee, unless the ventriculoscopic procedure is done via a separate cranial opening. When a craniotomy is performed as a result of complications arising from a ventriculoscopic procedure, or because of failure of the ventriculoscopic procedure, the ventriculoscopic fee may be billed according to the usual rules in the Payment Schedule (i.e. 50%).*

		$	Anes. Level
03030	Ventriculoscopy	840.73	6
03031	Ventriculoscopy, third ventriculostomy	1,324.72	6
03032	Ventriculoscopy/endoscopy biopsy of intraventricular or intracranial lesion	1,909.66	6
03033	Ventriculoscopic retrieval of foreign body	1,638.85	6
03034	Ventriculoscopy and fenestration of cyst or septum pellucidum, or lysis of adhesions	1,475.45	
03035	Ventriculoscopic resection of intraventricular tumour	2,576.95	6

Epilepsy

03055	Craniotomy with microsurgical cortical resection for epilepsy - under general anesthetic	2,474.42	8
03056	- awake patient	3,249.23	8
03057	Craniotomy with cortical resection for epilepsy	2,149.49	8
03058	Hemispherectomy	2,235.64	8
03059	Craniotomy and microsurgical hemispherotomy for epilepsy	2,592.93	8

Notes:

i) Includes corpus callosum section, disconnection of the cerebral hemisphere.

ii) Requires loupe magnification and/or operating microscope.

iii) Not paid with fee item 03058.

03144	Section of corpus callosum	2,255.16	8
03221	Implantation of vagal nerve stimulator – to include electrodes and stimulator	531.34	4
03223	Replacement of stimulator component of vagal nerve stimulator	221.49	3
03225	Removal of vagal nerve stimulator and electrodes	391.52	4
03235	Intraoperative cortical localization SSEP or stimulation studies G.A. (extra to craniotomy)	235.48	
03236	Insertion of subdural strip electrodes - unilateral [epilepsy surgery, to include burrhole(s)]	1,099.02	8
03237	Removal of subdural strip electrodes - unilateral	471.01	6
03238	Cortical or deep brain localization with SEEP or stimulation in an awake patient (extra to craniotomy)	471.01	
03239	Craniotomy and insertion of subdural grid electrodes with or without additional strip electrodes – unilateral	1,465.22	7

Notes:

i) Operative report or accompanying letter required if billed for other than epilepsy surgery or if billed with 03235.

ii) Fee items 03238 or 03237 not payable in addition.

03241	Re-opening of craniotomy for removal of subdural grid electrodes – unilateral	789.19	6

Note: *Isolated procedure – not payable in addition to other epilepsy surgical listings.*

Spine

Miscellaneous

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

Incision - Therapeutic, Percutaneous:

*58205	Injection/aspiration facet joint	92.97	2

		$	Anes. Level
	Excision - Diagnostic, Percutaneous:		
S11830	Needle Biopsy - soft tissue/bone, thoracic spine, under GA	214.73	2
S11831	Needle Biopsy - soft tissue/bone, lumbar spine, under GA	186.72	2
	Excision - Diagnostic, Open:		
11845	Biopsy, with GA ***Note:*** *Not payable with definitive spinal surgery.*	242.74	3
	Fracture and/or Dislocation (Cervical Spine):		
	Cervical		
*58710	Application of Halo	186.72	4
03094	Anterior decompressing craniovertebral junction, using operating microscope	2,947.49	8
03155	Laminectomy for haematoma, tumour or vascular malformation	1,202.45	6
03368	Discogram (operation only)	92.97	2
03369	Abscess or hematoma, extraspinal, under GA (operation only)	186.72	4
03361	Percutaneous discectomy	270.75	3
03367	Removal of spinal instrumentation	863.50	5
03160	Laminectomy for congenital spinal malformation or tethered spinal cord	2,027.87	5
03168	Laminectomy for intradural spinal cord or extra-medullary tumour or vascular malformation by micro-surgical technique	2,213.98	7
S03167	Insertion of skull tongs (operation only)	126.29	4
03169	Fracture of spine without cord injury - open reduction and fusion	686.74	7
03170	- in conjunction with orthopaedic surgeon (operation only)	649.23	
03172	Fracture of spine with cord injury - open reduction and fusion	937.07	7
03173	- in conjunction with orthopaedic surgeon (operation only)	649.23	
03215	Insertion of spinal subarachnoid catheter (operation only)	46.62	2
03231	Repair of spinal CSF leak or pseudomeningocoele	698.96	5

Cervical

Decompression Procedures

	Laminectomy for cervical disc:		
03156	- one level	2,003.94	6
03157	- multiple levels	2,204.84	6
03180	Multiple level laminectomy for cervical cord compression, 3 or more levels	1,430.75	6
03163	Anterior cervical discectomy and fusion - one level	1,429.88	6
03164	- multiple levels	1,936.16	6
03362	Cervical - single level	625.53	6
03363	Cervical - two or more levels	807.58	6
	Vertebral body resection:		
03365	Cervical	1,633.84	6

Instrumented Procedures

	Stabilization - Anterior		
03347	Cervical - stabilization alone (with Neurosurgeon)	504.14	6

		$	Anes. Level
03348	Cervical - with plates and discectomy	1,574.63	6
03349	Cervical - with plates and vertebrectomy	1,769.22	6
	Stabilization - Posterior		
03340	Cervical - simple, single or multiple level (includes Gallie fusion)	541.49	6
03341	Cervical - segmental (includes C1-2 transarticular screws)	1,087.67	6
	Posterior osteotomy with instrumentation		
03354	Cervical	2,836.82	6
	Cervical		
03358	ORIF	1,008.32	7

Thoracic

Decompression Procedures

03166	Removal of thoracic disc	1,918.81	8
03185	Postero-lateral microsurgical thoracic discectomy	1,915.56	8
03174	Trans-thoracic or trans-abdominal removal of thoracic disc; team procedure - Neurosurgeon	1,239.79	8
03179	- Thoracic or General Surgeon	470.49	8

Thoracolumbar

Decompression Procedures

	Laminectomy for lumbar disc:		
03158	- one level	670.94	5
03159	- multiple levels	1,333.43	5
03161	Laminectomy for localized spinal stenosis (two levels or less)	789.13	5
03162	Laminectomy for generalized spinal stenosis (more than two levels)	1,213.99	5
	Posterior lumbar interspinous/interlaminar stabilization/instrumentation (extra)		
03371	- single level (extra)	201.50	
03372	- multiple level (extra)	403.00	

Notes:

i) Paid only in addition to 03158, 03159, 03161 or 03162.

ii) Restricted to Neurosurgery and Orthopaedic surgeons.

	Decompression – Anterior		
	Discectomy with or without Fusion:		
03364	Thoracolumbar- includes decompression	1,442.43	8
	Vertebral body resection:		
03366	Thoracolumbar	1,904.58	8

Instrumented Procedures

	Anterior release/osteotomy:		
03352	Thoracolumbar	1,442.43	8
03353	Thoracolumbar - with anterior instrumentation and correction	1,713.19	8

		$	Anes. Level
03351	Thoracolumbar - instrumentation with anterior release or vertebrectomy ***Note**: 03350 and 03351 are payable in full when done in conjunction with posterior instrumentation and fusion.*	2,449.42	8
	Posterior Instrumentation and Fusion		
03356	Adult	1,769.22	7
03357	Pediatric	1,442.43	7
	Thoracolumbar		
03359	ORIF with segmental fixation alone	1,307.07	7
03360	ORIF with segmental fixation and decompression	1,577.82	7
03342	Thoracolumbar - without instrumentation	490.15	5
03343	Thoracolumbar - simple instrumentation (Harrington or wires or screws, etc.)	774.90	7
03350	Thoracolumbar - approach and stabilization alone (with Neurosurgeon) ***Note**: 03350 and 03351 are payable in full when done in conjunction with posterior instrumentation and fusion.*	952.30	8
03344	Thoracolumbar - segmental instrumentation and spinal fusion	1,251.05	7
03345	Thoracolumbar - segmental instrumentation and fusion with decompression - single level	2,058.13	7
03346	Thoracolumbar - segmental instrumentation and fusion with decompression - multiple levels	2,411.31	7
C03355	Thoracolumbar Spinal Fusion - including posterior osteotomy via Smith-Peterson, pedicle subtraction or vertebral column resection with fusion of greater than four (4) vertebral segments ***Note:** Restricted to Neurosurgery and Orthopaedic surgeons.*	3,526.25	7
03370	Thoracolumbar Spinal Fusion (lasting longer than 6 hours) – per 15 minutes or greater portion thereof (maximum of 16 units per patient) ***Notes:*** *i) Paid only in addition to 03355.* *ii) Surgical start time begins and ends with positioning.* *iii) Start and end times must be entered in both the billing claims and the patient's chart.* *iv) Restricted to Neurosurgery and Orthopaedic surgeons.*	50.79	
	Posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF) (extra)		
03373	single level (extra)	403.00	
03374	multiple level (extra) ***Notes:*** *i) Paid only in addition to 03345, 03346, 03355, 03356 or 03357.* *ii) Restricted to Neurosurgery and Orthopaedic surgeons.*	604.50	

Functional Neurosurgery/Pain

03301	Laminotomy for insertion of spinal stimulator electrode for chronic pain (operation only)	472.93	5
03302	Percutaneous fluoroscopically controlled insertion of spinal stimulator electrode for chronic pain (operation only)	353.75	2

		$	Anes. Level
03303	Implantation of pulse generator or receiver for chronic pain stimulation (operation only)	605.71	3
03304	Implantation of spinal stimulator (complete system), to include implantation of pulse generator/receiver - using percutaneous electrode (operation only)	851.71	3
03305	- using laminotomy electrode (operation only)	951.90	5
03306	Revision of spinal/cranial stimulator pulse generator	605.71	3
03307	Removal of spinal/brain stimulator system	400.79	3
03218	Replacement of spinal subarachnoid catheter access device with infusion pump for spinal subarachnoid infusion (operation only)	462.00	3
03219	Insertion of spinal subarachnoid device reservoir in paraspinal region (operation only) ***Note:*** *03219 to include insertion of spinal subarachnoid catheter.*	391.54	3
03220	Insertion of spinal subarachnoid catheter access device-reservoir/pump in anterior chest wall or abdominal wall (operation only) ***Note:*** *03220 to include insertion of spinal subarachnoid catheter.*	626.46	3
03152	Bischoff's or longitudinal myelotomy	936.10	5
03176	Percutaneous cordotomy	984.04	4
03177	Cordotomy	791.17	5
03178	Operative microsurgical rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic ***Note:*** *Restricted to Neurosurgery and Orthopaedic Surgery.*	932.43	5
03108	Operative facet rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic ***Note:*** *Restricted to Neurosurgery and Orthopaedic Surgery.*	450.00	4
03150	Laminectomy, 03153, 03155 for selective posterior rhizotomy	1,256.01	5
03153	Laminectomy with DREZ lesion for pain	1,408.69	6
03101	Supra or infra orbital nerve avulsion	225.93	3
03102	Decompression of Gasserian ganglion	1,195.79	8
03103	Pre-ganglionic rhizotomy 5th nerve	1,037.96	3
S03104	Percutaneous rhizotomy 5th nerve	1,024.33	3
03106	Posterior fossa exploration with rhizotomy 5th nerve	1,722.07	8
03232	Microsurgical anastomosis of intracranial portion of cranial nerve in conjunction with other craniotomy, with graft. (Extra to craniotomy) ***Note:*** *03232 includes harvesting of graft.*	733.22	
03233	Microsurgical anastomosis of intracranial portion of cranial nerve in conjunction with other craniotomy, without graft. (Extra to craniotomy)	449.18	
03138	Unilateral stereotaxic intracranial procedures	1,195.69	7
03139	Implantation of stimulator	985.00	3
03140	Insertion of intracranial stimulating electrodes	2,450.00	7
03250	Microelectrode recording (MER) – electrophysiological (EP) mapping of the basal ganglia and thalamus, intra-operatively – extra	3,127.23	
	Single Channel Neural Stimulator Implant Testing		
03274	- professional fee	46.08	
03275	- technical fee	23.04	
	Dual Channel Neural Stimulator Implant Testing		
03276	- professional fee	69.11	
03277	- technical fee	46.08	

Notes:

i) Restricted to Neurosurgeons and Neurologists.

ii) 03274, 03275, 03276, and 03277 is included on the same day and for six weeks post-operative of fee item 03140 whether performed by the same or different physician and at any location.

Peripheral Nerve/Microsurgery

		$	Anes. Level
S03196	Exploration, mobilization and transposition	281.48	2
03198	Neurectomy of major nerve	222.43	2
03200	Secondary suture including transposition	575.24	3
03201	Secondary suture of major nerve	437.73	3
03204	Hypoglossal-facial anastomosis	681.78	4
03205	Nerve graft	431.81	3
03207	Microsurgical removal of neoplasm – major peripheral nerve	815.19	3
	Brachial Plexus Surgery		
03045	Brachial plexus exploration for neurolysis, primary repair or tumour removal	1,500.00	3
03046	Post traumatic delayed or repeat exploration in brachial plexus surgery, extra	550.00	3
03047	Intraoperative diagnostic monitoring in brachial plexus surgery, extra	213.42	
03048	Nerve graft done in addition to brachial plexus exploration, extra per graft ***Note:*** *Includes harvesting of graft.*	194.02	
03049	Neurotization in brachial plexus surgery, extra	452.71	
	Microneural Surgery		
	Neurolysis:		
06210	- external	288.08	2
06211	- intraneural	438.94	2
	Microfascicular neurorrhaphy, primary:		
06212	- digital or palmar	350.00	2
06213	- major nerve	614.93	2
	Interfascicular nerve graft (to include harvest of graft):		
06214	- digital or palmar	533.59	2
06215	- major nerve	1,600.00	4
03230	Repeat Neurosurgery ***Notes:*** *i) For neurosurgical procedure repeated within 21 days of initial procedure, full listed fee applies.* *ii) For neurosurgical procedure repeated after 21 days of initial procedure, an additional 25 percent of the listed fee may be claimed for qualifying procedures, under fee item 03230.* *iii) Applicable only to the following neurosurgical procedures:* *<u>Cranial</u>:* *- reoperation for residual or recurrent brain tumour* *<u>Spinal</u>:* *- reoperation for residual or recurrent spinal tumour (intradural or extradural).* *- reoperation for recurrent lumbar disc or spinal stenosis.* *- spinal reoperation for tethering of myelomeningocoele or lipomyelomeningocoele.* *iv) Not applicable to shunt revisions or re-opening of cranial wound for removal of bone flap.* *v) Not applicable to fee items 03130 or 03135.*		

OBSTETRICS AND GYNECOLOGY

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

		$	Anes. Level

Referred Cases

04010	**Consultation:** To include complete history and gynecological examination, review of X-ray and laboratory findings, if required, and a written report or consultation during labour	154.77	
04012	**Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	84.98	
	Continuing care by consultant:		
04007	Subsequent office visit (for gynecology visits only, all pregnant patients and routine prenatal patients billed under fee item 04191)	53.04	
04008	Subsequent hospital visit	50.63	
04009	Subsequent home visit	119.61	
04005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	131.24	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
04070	Telehealth Consultation: To include complete history and gynecological examination, review of X-ray and laboratory findings, if required, and a written report or consultation during labour	154.77	
04072	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	84.98	
04077	Telehealth subsequent office visit (for gynecology visits only)	53.04	
04078	Telehealth subsequent hospital visit	50.63	

Obstetrical Procedures

04038	Repeat intrapartum assessment by consultant at request of primary care physician ***Notes:*** *i) Payable only subsequent to obstetrician's consultation. If consultation rendered same day, must be at least 30 minutes between consultation and repeat evaluation and must be a separate event (i.e. time/situation)* *ii) Charges for delivery payable in addition* *iii) Call-out charges (1200 series) and emergency visits (04005) are not payable in addition.* *iv) Not payable with 04039.*	228.97	

		$	Anes. Level
04039	Management of complicated labour by obstetrician	687.43	

Notes:

i) Requires completion of written record.
ii) Payable only after at least one hour of attendance at bedside.
iii) Start and end times must be entered in both the billing claims and the patient's chart.
iv) Not payable with 04038, 04050, 14104, 14109, or 14199.
v) Payable x 1 only, regardless of multiple gestation.
vi) Payable only for the following conditions:

<u>Fetal conditions:</u>

(a) Abnormal FH tracing requiring scalp pH monitoring, (or attendance at bedside by obstetrician for no less than 60 minutes)
(b) Prematurity <37 completed weeks gestation
(c) Severe IUGR (< 2500 g)
(d) Face or breech presentation
e) Multiple gestation
(f) Congenital anomaly where neonatal morbidity/mortality is an issue and may be affected by labour/delivery process (e.g.: open neural tube defect, body wall defect such as omphalocele, or gastroschisis, congenital; fetal arrhythmia, hydrocephalus)
(g) Hydrops fetalis
(h) Iso-immunization

<u>Placental or amniotic fluid conditions:</u>

(a) Placental abruption
(b) Severe oligohydramnios (AFI<6)
(c) Severe polyhydramnios (AFI>25)

<u>Maternal Conditions:</u>

(a) Cardiovascular disease where the management of labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction, severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrhythmia requiring pharmacological treatment, any lesion with pulmonary hypertension or ventricular dilatation).
(b) Renal disease (e.g.: renal failure, renal transplant)
(c) Pulmonary disease (e.g.: pulmonary fibrosis, severe asthma, cystic fibrosis)
(d) Endocrine disease (e.g.: Addison's disease, clinical hyperthyroidism, Type 1 Diabetes Mellitus)
(e) Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia)
(f) Infectious disease (AIDS, severe pneumonia, systemic sepsis)
(g) Severe pre-eclampsia (attempt made to deliver vaginally)
(h) Maternal obesity – BMI >40.

PG04718	Care of complex antepartum patient prior to transfer to higher level of care facility for delivery	289.06	

***Notes**:*

i) Restricted to Obstetrics and Gynecology specialists.
ii) Not paid with 04038, 04039, 04025, 04050, 04052, 14104, 14105.
iii) Start and end times required in claim submission and patient's chart.
iv) Paid only when time spent stabilizing patient by obstetrician exceeds 60 minutes, and patient is transferred to a higher level of care.
v) Payable on the same date as a Family Physician is paid for 14105.
vi) Payable for pre-eclampsia, preterm labour, and for serious maternal condition(s) that requires stabilization prior to transfer.

04014	Complicated delivery - midcavity surgical delivery (operation only)	464.58	4
04017	Midcavity rotation from OP or OT to OA - surgical delivery (operation only)	567.78	4
04018	Breech vaginal birth (operation only)	603.58	4

***Note:** Fee items 04014, 04017 or 04018 will be paid at 100% for multiple deliveries plus any add on fees (e.g.: 04092) will be paid at 100%.*

		$	Anes. Level
04000	Complicated vaginal delivery - includes shoulder dystocia, premature delivery less than 37 weeks or less than 2500 grams (operation only)	387.12	4

Notes:

i) Complicated delivery fees will be paid at 50% when 14104 is payable to the same physician.

ii) Only one of fee items 04014, 04017, 04018 or 04000 is payable at any one time (for single births).

04022	Repair of complete separation of external sphincter (operation only)	247.75	3

***Note**: Not paid in addition to 04024.*

04023	Repair of extensive cervical and/or vaginal lacerations (operation only)	247.75	3

***Note:** Not paid in addition to 04022 and 04024.*

04024	Repair of 4th degree laceration (operation only)	299.36	3
04026	Manual removal of retained placenta (operation only)	247.75	3

04190	Prenatal visit - complete examination	84.95	
04191	Prenatal visit - subsequent examination	31.81	

Notes:

i) Restricted to Obstetrics and Gynecology specialists.

ii) Uncomplicated prenatal care usually includes a complete examination followed by monthly visits to 32 weeks, then visits every second week to 36 weeks, and weekly visits thereafter to delivery. In complicated pregnancies, charges for additional visits will be given independent consideration upon explanation.

iii) Where a patient transfers their total ongoing uncomplicated prenatal care to another physician, the second physician also may charge a prenatal visit complete examination and subsequent examinations, as rendered. To facilitate payment the reason for transfer should be stated with the claim. Temporary substitution of one physician for another during days off, annual vacation, etc., should not be considered as a patient transfer.

iv) Other than during prenatal or postnatal visits, it is proper to charge separately for all visits (including counselling) for conditions unrelated to the pregnancy, under appropriate fee items listed elsewhere. The reason for the charges should be clearly spelled out when submitting claim.

v) Other than procedures, services for the care of unrelated conditions during a prenatal or postnatal visit are included in the prenatal (04191) or postnatal visit fee (04194), and are not to be billed under fee item 04007. Procedures rendered for unrelated conditions are chargeable as set out in Preamble D. 8. d.

PG04717	Prenatal office visit for complex obstetrical patient	48.32	

Notes:

i) Paid only for the following diagnoses:

a) Fetal conditions:

- *Congenital anomaly where neonatal morbidity/mortality is an issue and may be affected by labour/delivery process (e.g.: open neural tube defect, body wall defect such as omphalocele, or gastroschisis, congenital; fetal arrhythmia, hydrocephalus).*
- *Hydrops fetalis*
- *Iso-immunization*

b) Maternal conditions:

- *Cardiovascular disease where the management of labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction,*

severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrhythmia requiring pharmacological treatment, any lesion with pulmonary hypertension or ventricular dilatation).

- *Renal disease (e.g.: renal failure, renal transplant)*
- *Pulmonary disease (e.g.: pulmonary fibrosis, severe asthma, cystic fibrosis)*
- *Endocrine disease (e.g.: Addison's disease, clinical hyperthyroidism, Type 1 Diabetes Mellitus)*
- *Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia)*
- *Infectious disease (HIV, severe pneumonia, systemic sepsis)*

c) <u>Pregnancy qualifying conditions:</u> hypertension on medication, IUGR with growth less than 10%, oligohydramnios AFI less than 8, hydraminos AFI greater than 23, Type 1 Diabetes Mellitus.

d) <u>Current pregnancy conditions:</u> preterm labour, cervical incompetence, or abruption occurring in this pregnancy; (the high risk antenatal visit fee reverts to 04191 after 36 weeks gestation, multiple gestation.

e) <u>Previous pregnancy conditions:</u> 2 preterm births, or 1 previous preterm birth less than 30 weeks (reverts to 04191 after 36 weeks gestation).

ii) Restricted to Obstetrics and Gynecology specialists.

		$	Anes. Level
04194	Postnatal office visit	31.81	

Notes:

i) Restricted to Obstetrics and Gynecology specialists.

ii) 04194 may be billed in the six weeks following delivery (vaginal delivery or caesarean section).

iii) Not payable to the physician performing the caesarean section.

14199	Management of prolonged second stage of labour, per 30 minutes or major portion thereof.	85.47	

Notes:

i) This item is billable in addition to the delivery fee only when the second stage of labour exceeds two hours in length.

ii) Not payable with 04000, 04014, 04017, 04018, or 04085.

iii) Timing ends when constant personal attendance ends, or at the time of delivery.

iv) Start and end times must be entered in both the billing claims and the patient's chart.

04049	External cephalic version	156.69	

Note: *Administration of IV tocolytic agent and fetal heart monitoring included.*

14104	Delivery and postnatal care (1-14 days in-hospital)	588.41	

Notes:

i) Care of newborn in hospital (see item 00119).

ii) Repair of cervix is not included in fee item 14104. Charge 50% of listed fee when done on same day as delivery.

iii) When medically necessary additional post-partum office visit(s) are payable under fee item 14094.

		$	Anes. Level
04050	Caesarean section - elective	516.22	5
04052	Caesarean section - emergency	578.16	6
04025	Caesarean section- high risk - fetus < 1500g	671.08	6
04106	Caesarean hysterectomy	950.97	8
14108	Postnatal care after elective caesarean section (1-14 days in-hospital) ***Note***: *When medically necessary additional post-partum office visit(s) are payable under fee item 14094.*	121.06	
14109	Primary management of labour and attendance at delivery and postnatal care associated with emergency caesarean section (1 - 14 days in-hospital) ***Notes****:* *i) Surgical assistant is extra to fee items 14108 and 14109.* *ii) When medically necessary additional post-partum office visit(s) are payable under fee item 14094.*	490.12	
04085	Trial of Forceps/Vacuum Delivery ***Notes:*** *i) Payable for a forceps/vacuum assisted vaginal delivery that was unsuccessful.* *ii) Applicable only to mid-pelvis procedures.* *iii) Payable only if followed by an immediate caesarean section.* *iv) Not payable with complicated delivery fees 04000, 04014, 04017, or 04018 (for single births).* *v) Maximum of one payable per pregnancy.*	218.39	4
04092	Multiple births, each additional child - natural birth	166.21	
04093	Multiple births, each additional child - caesarean section… ***Note:*** *Fee item 04093 is paid in full in addition to fee items 04025, 04050, 04052 or 04106.*	84.65	
04107	Supervision of labour and vaginal delivery in a case of previous caesarean section (operation only) ***Note:*** *04107 is a stand-by fee and is not payable in addition to delivery fees (14104, 04000, 04014, 04017, 04018, 04050, 04052, 04025) when done by the same physician*	206.36	5
	Therapeutic abortion (vaginal), by whatever means:		
04111	- less than 14 weeks gestation (operation only)	208.33	2
04110	- 14 to 18 weeks (operation only)	258.02	2
PG04716	Obstetrical surcharge for therapeutic abortion (D&E) at 14 to 18 weeks (extra) ***Note:*** *Paid only with 04110.*	63.35	
S04080	Insertion of Multiple Osmotic Dilators with Paracervical Block, prior to second trimester pregnancy termination ***Notes:*** *i) Paid for gestations over 14 weeks.* *ii) Not paid with 04111 or 01022.* *iii) Paid when performed within 48 hours prior to 04110 or 04114.* *iv) Maximum of two per patient, within 48 hours prior to 04110 and 04114.* *v) When performed within 24 hours prior to 04114, transabdominal amniocentesis (00787) is paid at 100%.* *vi) Amniocentesis (00787) is not paid with 04110.*	157.13	

		$	Anes. Level
04114	Therapeutic abortion by D&E, 18 weeks and over (operation only)	365.74	3
PG04715	Obstetrical surcharge therapeutic abortion (D&E) at 18 weeks and over (extra)	84.46	

Notes:

i) Paid only with 04114.

ii) Restricted to Obstetrics and Gynecology specialists.

04116	Curettage for post-partum haemorrhage (>20 weeks)	260.81	3
04118	Induction or stimulation of labour by oxytocin intravenous drip, where attendance by the physician is readily available - first hour	43.26	
04119	- subsequent hours	29.81	

Notes:

i) Physician must be readily available – response time by telephone is immediate and response time on the unit is within minutes.

ii) Maximum charge for above service to be 10 hours per pregnancy.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

Surgical Fee Modifiers

PG04719	Gynecology surgical surcharge for patients 75 years and older	86.95

Notes:

i) Restricted to Obstetrics and Gynecology specialists.

ii) Fee item G04719 will only be paid once whether single or multiple procedures are performed under the same anesthetic.

iii) Paid with the following surgical procedures: 04701, G04702, G04703, G04704, G04705, G04706, 04707, 04709, 00704, 00705, 00770, 00807, 00808, 00878, 04001, 04003, 04011, 04029, 04032, 04033, 04041, 04042, 04048, 04202, 04203, 04212, 04217, 04218, 04219, 04220, 04223, 04227, 04228, 04229, 04232, 04233, 04301, 04303, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 04401, 04402, 04405, 04406, 04408, 04410, 04411, 04421, 04422, 04424, 04427, 04429, 04500, 04508, 04510, 04512, 04530, 04531, 04551, 04605, 04621, 04622, 04623, 04624, 04628, 04662, 04728, 04729, 07027, 07597, 07634, 08178, 08205, 08232, 08250, 08255, 08257, 08263, 08278, 08282, 08283 or 70120.

iv) Applies to procedures performed in hospital operating room, ambulatory care or office setting.

PG04708	Prolonged laparoscopic surgery, per 15 minutes or major portion thereof (extra)	73.90

Notes:

i) Restricted to Obstetrics and Gynecology.

ii) Payable for significant uterine enlargement due to fibroids, significant adnexal enlargement, presence of significant endometriosis, or significant adhesions.

iii) Fee item 00815 is considered included in G04708.

iv) Paid as an extra to a laparoscopic surgical procedures when surgical time exceeds 2 hours.

v) Not payable if multiple surgical procedures are billed.

vi) Start and end times (for total time of surgery) must be entered on the claim and in the patient's chart.

PG04714	Prolonged surgery – Open procedure per 15 minutes or major portion thereof (extra)	73.90

Notes:

i) Restricted to Obstetrics and Gynecology specialists.

ii) Payable for significant uterine enlargement due to fibroids, significant adnexal enlargement, presence of significant endometriosis, or significant adhesions.

iii) Paid as an extra to an open surgical procedure, when surgical time exceeds 2 hours.
iv) Not payable If multiple surgical procedures are billed (except for 04001 for when a laparoscopic procedure is converted to open).
v) When an open case results from conversion of a laparoscopic procedure, G04714 is paid after 2 hours total surgical time.
vi) Start and end times (for total time of surgery) must be entered on the claim and patient's chart.

		$	Anes. Level

Abdominal Operations

04228	Hysterectomy – total ***Note:*** *Includes salpingectomy/oophorectomy (04003), ovarian cystectomy (04201) and abdominal enterocele repair.*	829.30	5
C04709	Laparoscopic total or supracervical hysterectomy, and/or laparoscopic assisted vaginal hysterectomy (LAVH) (includes oophorectomy and/or salpingectomy) ***Notes:*** *i) Fee items 00815, 04001, 04003, 04041, 04042, 04048, 04202, 04228, 04229, 04232 and 04233 are not paid in addition.* *ii) Fee items 04043, 04044, 04047, 04660, and 04662 are payable in addition, but the maximum payable under these items shall not exceed the value of fee item 04229.* *iii) Other items listed under laparoscopic operations are not payable in addition to this item.* *iv) In cases where conversion to open surgery is necessary, 04001 paid at 50%, plus open procedure.* *v) G04708 will apply after 2 hours.* *vi) Restricted to Obstetrics and Gynecology specialists.*	1010.62	5
04229	Removal of complicated pelvic disease	829.30	6
04203	Myomectomy	516.14	5
04204	Abdominal hysterotomy - with or without sterilization	369.67	5
04206	Suspension of uterus	247.49	4
04208	Ectopic pregnancy removal by salpingotomy or salpingectomy (open procedure)	516.14	5
04003	Oophorectomy and/or salpingectomy (unilateral or bilateral)	369.67	5
04201	Ovarian cystectomy (to include ovary repair) not tubes	461.33	5
04216	Presacral neurectomy	430.79	5
04217	Post-operative haemorrhage - intra-abdominal management	469.40	6
04230	Sterilization, abdominal - open	365.70	4
04605	Vault prolapse - abdominal approach (includes oophorectomy when applicable).	768.79	5
C04707	Laparoscopic sacrocolpopexy, includes oophorectomy and/or salpingectomy ***Notes:*** *i) Fee items 00704, 00705, 00815, 04001, 04003, 04041, 04042, 04408, 04605, 04232, 04233 or G04706 not paid in addition.* *ii) Fee items 04040 and 04047 payable in addition but the maximum payable under these items shall not exceed the value of fee item 04229.* *iii) Other items listed under laparoscopic operations are not payable in addition to this item.* *iv) In cases where conversion to open surgery is necessary, 04001 paid at 50%, plus the open procedure.* *v) G04708 will apply after 2 hours.* *vi) Restricted to Obstetrics and Gynecology specialists.*	1010.62	5

Abdominal Operations for Cancer

		$	Anes. Level
04011	Debulking operation for cancer of ovary or fallopian tubes	1,042.58	6
	Notes: *i) Not applicable to Stage 1 disease. ii) Includes omentectomy and hysterectomy if done.*		
04029	Either omentectomy and/or removal of extrapelvic soft tissue mass - 5 - 10 cm	369.67	5
	Note*: Not to be billed in addition to 04011.*		
04628	Removal of extrapelvic soft tissue mass > 10 cm	523.95	5
04218	Radical abdominal hysterectomy for carcinoma, including partial vaginectomy	1,135.50	6
04212	Pelvic lymphadenectomy	614.02	6
04219	Para-aortic lymphadenectomy - total	614.02	6
04220	- partial	271.93	5
04630	Sentinel lymph node biopsy vulva (SLN-V) – unilateral	488.54	3
04631	Sentinel lymph node biopsy vulva (SLN-V) – bilateral	732.81	3
	Notes: *i) Payable only for the staging of vulvar malignancies and malignant melanoma. ii) SLN component of the combined procedure not payable to surgeons during the training phase.*		
C04640	Laparoscopic Sentinel lymph node biopsy (SLN-L) – unilateral	488.54	3
C04641	– bilateral	732.81	3
	Notes: *i) Payable only for the staging of malignant cervical cancer and endometrial cancer. ii) 04640 paid at 50% with 04212 if ICG dye fails to localize a lymph node. 04641 is not payable with 04212. iii) SLN component of the combined procedure not payable to surgeons during the training phase.*		
P04728	Laparoscopic assisted radical vaginal trachelectomy (LARVT) and sentinel node procedure	1,680.00	6
	Notes: *i) Restricted to Obstetrics and Gynecology specialists. ii) Includes laparoscopy and sentinel node procedures required for patient screening and selection. iii) Includes pelvic lymphadenectomy. iv) Not payable with 04708 and 04714.*		
PC04729	Laparoscopic assisted radical hysterectomy (LARH) (includes oophorectomy and/or salpingectomy)	1,995.00	7
	Notes: *i) Restricted to Obstetrics and Gynecology specialists. ii) Includes sentinel lymph node biopsy. iii) Includes pelvic lymphadenectomy. iv) Not payable with 04708 and 04714.*		
04141	Insertion of intra-peritoneal catheter for chemotherapy under general anesthetic……	320.00	4
	Notes: *i) Restricted to Obstetrics and Gynecology specialists. ii) Includes fee item 04001.*		

		$	Anes. Level
04142	Removal of intra-peritoneal catheter for chemotherapy……	140.00	3

Notes:
i) Restricted to Obstetrics and Gynecology specialists.
ii) For removal of catheter not requiring surgical dissection, use visit fees.

Hysteroscopy – Surgical

Hysteroscopic Division of Intrauterine Adhesions (IUA):
Note: *Payable only for patients with menstrual disturbance, infertility or recurrent pregnancy loss.*

04221	Hysteroscopic division of intrauterine adhesions - simple ***Note:*** *Intended for procedures performed under direct vision, but less than ½ of uterine cavity involved with IUA.*	216.52	2
04222	Hysteroscopic division of intrauterine adhesions - complicated ***Note:*** *Intended for procedures performed under direct vision using either operative hysteroscope and hysteroscopic scissors or rectoscope, and more than ½ of uterine cavity involved with IUA.*	360.87	2
04223	Resection of myoma - includes diagnostic hysteroscopy ***Note:*** *Payable only when done under direct vision.*	469.03	2
04224	Endometrial ablation - includes diagnostic hysteroscopy	469.03	2
04225	Hysteroscopic division of uterine septum	354.51	2
04226	Hysteroscopic tubal occlusion (bilateral)	201.25	

Laparoscopic Operations

Note: The following fee items for individual laparoscopic procedures are billable in addition to fee item 04001.

S04001	Laparoscopy (operation only)	230.69	4
04660	Tubal interruption (sterilization) (operation only)	94.80	4
04662	Removal of foreign body (operation only)	157.80	4
04664	Ectopic pregnancy, removal via scope	352.96	4
	Salpingolysis via laparoscope:		
04034	- unilateral (operation only)	92.65	4
04035	- bilateral (operation only)	178.61	4
04036	Salpingostomy via laparoscope - unilateral (operation only)	193.83	4
04037	Salpingostomy via laparoscope - bilateral	383.65	4
04040	Cautery of endometriosis (operation only)	77.96	4
04041	Oophorectomy and/or salpingectomy – unilateral (operation only)	189.28	5
04042	Oophorectomy and/or salpingectomy – bilateral	374.66	5
04043	Ovarian cystectomy – unilateral	300.55	5
04044	Ovarian cystectomy – bilateral	560.20	5
04045	Ventral suspension of uterus (operation only)	155.89	4
04047	Excision of extensive peritoneal endometriosis including pelvic sidewall dissection and unilateral ureterolysis	438.15	6

		$	Anes. Level
04048	Removal of complicated pelvic disease	598.61	6

Notes:

i) Fee items 04047 and 04048 are composite fees.

ii) When performed together, the fee items for laparoscopic procedures are billable at 100%, except for composite fees, and subject to iii) and iv) below.

iii) When more than one laparoscopic procedures is performed, fee item 04001 is payable once only at 100%.

iv) Maximum billable for multiple laparoscopic operations (listed above) is up to the rate payable for 04229.

Micro-Surgical Operations

04602	Salpingolysis and removal of adhesions – loupes or microscope (unilateral or bilateral)	461.33	5
	Micro salpingostomy:		
04616	- unilateral	635.42	5
04617	- bilateral	825.11	5
04626	Tubo-cornual anastomosis - unilateral (micro-surgical)	919.46	5
04627	Tubo-cornual anastomosis – bilateral (micro-surgical)	1,194.35	5

Notes:

i) Tuboplasty listings are not payable following a previous surgical sterilization and should not be billed to the Plan when a previous sterilization has been performed.

ii) Operative report may be required.

Operations on the Vulva

04300	Incision of hymen - operation only	204.56	2
04301	Excision or marsupialization of a Bartholin's cyst (operation only)	204.56	2
04303	Excision of hydrocele or canal of Nuck	260.22	2
04304	Urethral caruncle - cautery or excision in hospital (operation only)	64.21	2
04305	Venereal warts, cautery or excision - operation only	52.11	
04306	Excision of venereal warts under general anesthesia in hospital (operation only)	204.56	2
04307	Vulvectomy - simple	400.23	3
04309	Varicocele of labium (operation only)	204.06	2
04311	Operation for atresia of vulva or enlargement of vaginal introitus for stenosis (operation only)	204.56	2
04312	Resection of labia minora (operation only)	259.28	2
04317	Biopsy of vulva, excisional lesion < 2 cm	36.57	2
04032	Biopsy of vulva, excisional lesion >/= 2 cm	114.88	2
04316	Vulvovaginoplasty	262.02	2

Note: *This item is payable for genetic females only.*

04318	Radical vulvectomy	929.14	3
	Inguinal and femoral lymphadenectomy:		
04320	- unilateral	412.94	4
04322	- bilateral	722.58	4

04632	Vulvar wide local excision	365.19	3

Notes:

i) Restricted to Obstetrics and Gynecology specialists.

ii) Payable for the wide local excision of the vulva/perineum for pre-invasive and benign disease.

iii) Payable for wide local excision of Paget's disease and/or extensive differentiated VIN or complex VIN3 with suspected malignancy.

		$	Anes. Level
04633	Radical partial/hemi vulvectomy (RPV)	417.66	3
	Notes: *i) Restricted to Obstetrics and Gynecology specialists.* *ii) Payable for the radical excision of vulvar carcninoma.* *iii) Payable for radical excision of verrucous cancers, melanomas, or vulvar soft tissue sarcomas.*		

Operations on the Vagina

04202	Hysterectomy - vaginal	759.34	4
04232	Oophorectomy/ovarian cystectomy and/or adnexectomy (vaginal route), extra to vaginal hysterectomy – unilateral (operation only)	116.32	
04233	Oophorectomy/ovarian cystectomy and/or adnexectomy (vaginal route), extra to vaginal hysterectomy – bilateral	228.72	
04401	Repair of recto-vaginal fistula	680.40	3
04402	Colpotomy with drainage pelvic abscess (operation only)	155.90	2
P04405	Removal of a vaginal cyst situated above the introitus (operation only)	204.78	2
04406	Operation for removal of vaginal septum (operation only)	204.56	2
04408	Vault prolapse following hysterectomy	552.94	4
04410	Post-operative haemorrhage, vaginal management requiring general anesthesiology (operation only)	204.78	5
04033	Vaginectomy for VAIN (partial)	469.40	4
04411	Vaginectomy - Total	627.63	4

Plastic Operations for Genital Prolapse

04227	Cystocele and/or urethrocele repair	419.06	2
04421	Repair of rectocele	419.06	2
04422	Repair of enterocele ***Note****: For concurrent billings of 04421 and 04422, identification of the peritoneal defect and closure of this defect is required or bill only as fee item 04421.*	475.54	2
04424	Complete repair of prolapse (Manchester or Fothergill types)	608.72	3
04427	LeFort's operation	468.54	
04429	Repair of old 3rd degree perineal laceration	470.48	2
04432	Repeat vaginal plastic procedure, extra	156.88	2
04701	Repeat urinary incontinence procedure for cases of a previously failed retropubic or vaginal procedure ***Notes:*** *i) Restricted to Obstetrics and Gynecology specialists.* *ii) Fee items 00704, 00705, 08202, 08282, or 08283 not paid in addition.*	433.03	4
PG04702	Transection or removal of suburethral mesh sling ***Notes:*** *i) Restricted to Obstetrics and Gynecology specialists.* *ii) Fee items 00704, 00705 or 08232 not paid in addition.*	510.47	4
PG04703	Augmented anterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to Arcus Tendinous ***Notes:*** *i) Fee items 00704, 00705 or 04227 not paid in addition.* *ii) Restricted to Obstetrics and Gynecology specialists.*	428.64	2

		$	Anes. Level
PG04704	Augmented posterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to sacrospinous ligament	428.64	2
	Notes: *i) Fee items 04421 or 04422 not paid in addition.* *ii) Restricted to Obstetrics and Gynecology specialists.*		
PG04705	Removal of trans-vaginal placed synthetic mesh where indicated, from anterior or posterior compartment, due to pain or complications	626.50	2
	Notes: *i) Fee items 00704, 00705 are not paid in addition.* *ii) Paid at 50% when done with 04605 or 04408.* *iii) Restricted to Obstetrics and Gynecology specialists.*		
PG04706	Vaginal vault suspension – Apical support procedure	417.97	2
	Notes: *i) Paid for sacrospinous, pre-spinous, iliococcygeal suspension or high, uterosacral ligament plication performed for vault suspension (synthetic or biologic).* *ii) Paid for Stage 3 and Stage 4 prolapse with or without hysterectomy.* *iii) Fee items 00704, 00705, 04408, 04424, 04605 not paid in addition.* *iv) 04227, 04421, 04422, G04703, G04704, paid in addition, as per Preamble D. 5. 3.).* *v) Restricted to Obstetrics and Gynecology specialists.*		

Vaginal Operations on the Cervix and Uterus

S04500	Cervix dilation and curettage (pelvic examination not billable in addition when done as an isolated procedure) (operation only)	207.96	2
04502	Repair of cervix (operation only)	204.56	2
04503	Cryosurgery of cervix (operation only)	104.15	2
04509	Cervical polypectomy (operation only)	31.22	2
04508	Biopsy of cervix under general anesthesiology	204.56	2
04510	Biopsy of cervix, with dilation and curettage (operation only)	204.56	2
04512	Vaginal myomectomy (operation only)	155.89	4
04516	Cervical incompetence - emergency repair	365.70	2
04517	Cervical incompetence - elective repair	262.02	2
04515	Removal of buried cervical ligature under anesthesiology (operation only)	204.56	2
04530	Cauterization of cervix - under general anesthesia (operation only)	204.56	2
S04531	- with dilation and curettage (operation only)	204.56	2
04533	Electric cauterization of cervix in office (operation only)	39.78	
04536	Cone biopsy of cervix with endocervical curettage (dilation and curettage included in the fee)	271.92	2
14540	Insertion of intrauterine contraceptive device (operation only) ***Note****: Includes Pap smear if required.*	43.28	2
04545	Artificial insemination - operation only	33.70	
04551	Cervical stump removal	313.68	3
S00770	Pelvic examination under anesthesia when done as an independent procedure – procedural fee	204.56	2

Laser Vaporization

04620	Cervical neoplasia (operation only)	204.71	2
04621	Vaginal neoplasia with or without general anesthetic (operation only)	204.71	2
04622	Vulvar condylomata (operation only)	204.72	2
04623	Extensive vulvar or vaginal condylomata under general anesthetic	261.74	2
P04624	Vulvar intraepithelial diffuse, multifocal and/or perianal Lesions	419.19	2

		$	Anes. Level

Surgical Assistance

Total operative fee(s) for procedures(s):

00195	- less than $317.00 inclusive	134.22
00196	- $317.01 to 529.00 inclusive	189.24
00197	- over $529.00	261.76
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	28.52

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 anesthesic, 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.

70019	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	256.63

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

70020	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	32.23

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.

Tests Performed in a Physician’s Office

15136	Fungus, direct microscopic examination, KOH preparation	8.39
04699	Fern Test	15.57
15137	Hemoglobin cyanmethemoglobin: method and/or haematocrit	3.12

Note: *See the Laboratory Services Payment Schedule for additional hematology information.*

15000	Hemoglobin - other methods	1.62

Note*: 15137 and 15000 - see the Laboratory Services Payment Schedule for additional hematology information.*

15139	Sperm, Seminal examination for presence or absence	14.78
15141	Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination	5.69
15142	Urinalysis, complete diagnostic, semi-quant and microscopic	5.65
15120	Pregnancy test, immunologic - urine	11.72

		$	Anes. Level

Diagnostic Ultrasound

Preamble: Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.

08651	Obstetrical B scan (14 weeks gestation or over)(for singles) ***Note:*** *Where an obstetrical B scan (08651, 08655 or 86055) has been done within the two weeks immediately prior to an amniocentesis, a repeat obstetrical scan done in conjunction with amniocentesis is not chargeable.*	110.08	
86051	Obstetrical B scan (14 weeks gestation or over) (for multiples – each additional fetus)	81.91	
08655	Obstetrical B scan (under 14 weeks gestation)	82.58	
08652	B scan I.U.D. localization	55.31	
08653	Pelvic B-scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal doppler ***Notes:*** *i) 08653 payable in conjunction with 08658 when specifically requested by the referring physician.* *ii) 08651 and 08655 not billable in conjunction with 08653.*	110.08	
08657	Ultrasonic guidance for chorionic villus sampling	110.68	
04680	Ultrasonic guidance for amniocentesis	172.11	

ORTHOPAEDICS

The following preamble applies to the Orthopaedic fee guide and, if in conflict with, supersedes the general preamble.

1. * Items- Operation Only

Items indicated with a * are operation only items and are exempt from the 14 day in hospital post-op rule (D. 5. 2.).

2. Under general anesthesia or procedural sedation

Procedures so indicated are performed in hospital, under general anesthesia or procedural (conscious) sedation.

Note: The orthopaedic procedure and anesthesia or procedural sedation are not billable by the same physician.

3. ADULT / PEDIATRIC

An adult is an individual over 12 years old.

4. Harvest of Bone Autograft

Bone graft harvested through a separate incision is always charged in full in addition to any other procedural fee(s).

5. Harvest of Skin Autograft

Harvest of skin graft is always paid in full in addition to any other procedural fee(s).

6. Open (Compound) Fractures

Primary wound management fee(s) may be charged in addition to the fracture fee and will be paid at the same percent as applies to the fracture fee(s)

The Secondary Wound Management fee(s) are exempt from the 14 day rule (D. 5. 2.).

Primary and Secondary Wound Management fee(s) are paid for procedures under GA only.

Primary:
Management of the soft tissue component of an open fracture - includes wound excision, debridement, irrigation, implantation of antibiotic beads. Occasionally primary closure/immediate local tissue transfer/skin grafting may be included.

Secondary:
Repeat primary (as above) at a second sitting or return to the operating room for delayed primary closure/closure with skin graft/local skin flap. Includes removal of beads. Does not include muscle flaps or free flaps. These are billed as shown and paid in full.

7. Fasciotomy Wound Management

Fasciotomy wound management fee(s) are for procedures done under GA and are payable within 14 days of the initial procedure.

8. Casts

Formation and application of moulded casts or splints may be charged in full in addition to procedure and visit fees with the following exceptions:

- formation and application of a cast or splint at the time of the initial orthopedic procedure charged is included in the procedure;
- in the minority of cases when application of a cast or splint is the sole purpose of a visit, a visit fee may not be charged.

Fees for formation and application of moulded casts or splints are payable only when performed by the medical practitioner. Multiple casts (e.g.: bilateral leg casts) are paid at 100%.

9. Re-Operation

The treatment of a fracture and/or dislocation or a reconstructive procedure where remanipulation or (re)operation is required is chargeable in full. It is chargeable by the physician providing the initial service only if it is carried out more than five days following the index procedure.

10. Non-Operative Management

Non-operative management of injuries not itemized are chargeable on a per visit basis.

ORTHOPAEDICS

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

		$	Anes. Level

Referred Cases

51010 **Consultation:** (in office or hospital) To include a history and physical examination, review of X-ray and laboratory findings, and a written report 111.54

51012 **Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where, in the judgment of the consultant, the consultative service does not warrant a full consultative fee.....59.52

51015 **Orthopaedic Special Consultation:** Extended consult for complex problems (i.e. oncology, complex trauma, adult cerebral palsy, etc.), when requested by another Orthopaedic Surgeon, Neurosurgeon, Plastic Surgeon or Rehabilitation Physician. Includes history, physical examination, review of X-rays and written report. 160.37
Note: *If an orthopaedic specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation service are met, a claim may be submitted under 51015 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.*

Continuing care by consultant:

51007 Orthopaedic office visit 51.46
51008 Orthopaedic hospital visit 30.70

51005 Pre-Operative Assessment.....111.54
Notes:
i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.
ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.
iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.
iv) Maximum of one pre-operative assessment per patient per procedure.
v) Only paid to the surgeon who performs the procedure.

51009 Pavlic harness – case management; meeting by specific appointment to discuss/plan patient management with parents and/or caregivers - per 15 minutes, or major portion thereof.....46.07
Notes:
i) Restricted to Orthopaedic Surgeons and Pediatricians.
ii) When performed in conjunction with visit, counselling or consultations, only the larger fee is paid.
iii) Services that are less than 15 minutes should be billed under the appropriate visit fee item.
iv) Daily maximum of 3, per patient, per sitting.
v) Service to be billed only on child's Personal Health Number.
vi) Claim must state start and end times, and should be noted in the patient's medical record.
vii) Paid only if the patient has seen the specialist within the preceding 180 days.

		$	Anes. Level
	Telehealth Service with Direct Interactive Video Link with the Patient:		
51110	Telehealth Consultation: To include a history and physical examination, review of X-ray and laboratory findings, and a written report	111.54	
51112	Telehealth Repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where, in the judgment of the consultant, the consultative service does not warrant a full consultative fee	59.52	
51115	Telehealth Orthopaedic Special Consultation: Extended consult for complex problems (i.e. oncology, complex trauma, adult cerebral palsy, etc.), when requested by another Orthopaedic Surgeon, Neurosurgeon, Plastic Surgeon or Rehabilitation Physician. Includes history, physical examination, review of X-rays and written report *Note: If an orthopaedic specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation service are met, a claim may be submitted under 51115 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.*	160.37	
51107	Telehealth Orthopaedic office visit	51.46	

Surgical Assistant

51194	First Surgical Assist of the Day - Orthopaedics ***Notes:*** *i) Restricted to Orthopaedic Surgeons.* *ii) Maximum of one per day per physician, payable in addition to 00195,00196, 00197.*	76.71	
	Total operative fee(s) for procedures(s):		
00195	- less than $317.00 inclusive	134.22	
00196	- $317.01 to 529.00 inclusive	189.24	
00197	- over $529.00	261.76	
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof ***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.*	28.52	
70019	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 ***Note:*** *Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.*	256.63	

		$	Anes. Level
70020	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	32.23	
	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.		

Application of Cast (Includes External Stimulator)

*51016	Short arm (elbow to hand)	23.23	2
*51017	Long Arm (axilla to hand)	23.23	2
*51018	Shoulder spica	86.95	2
*51019	Below knee	23.23	2
*51020	Long leg cylinder	23.23	2
*51021	Long leg	23.23	2
*51022	Hip spica - child	86.95	2
*51023	Hip spica - adult	86.95	2
*51024	Body (shoulder to hips)	86.95	2
S51025	Cast brace	46.49	2

Miscellaneous - Ortho

51030	Orthopaedic interpretation and written report of submitted x-ray films - including CT scan and MRI.	39.38	
	Note: *Not payable in addition to consultation rendered within 2 months on the same patient on referral by the same physician.*		
*51035	Application of skeletal traction (operation only)	93.37	2
*51036	Compartment pressure monitoring - extra	92.97	2
*51037	Harvesting of iliac crest autograft - extra	93.37	2
*51038	Harvesting of skin graft - extra (for orthopaedic procedures only)	102.68	2
	Ilizarov Instrumentation (Any Bone/Joint) To Include Corticotomy:		
51065	Simple construction - lengthening/angular correction with or without lengthening/ Nonunion stabilization/fracture stabilization	1,092.35	3
51066	Complex construction - multiplanar corrections/multiple level lengthening/elevator technique	1,498.46	4
*51067	Extension/revision of frame	214.73	3

Shoulder Girdle, Clavicle and Humerus

	Incision - Diagnostic, Percutaneous:		
S11200	Arthroscopy shoulder joint	298.77	2
SY00757	Aspiration - other joints	12.03	2
	Incision - Diagnostic, Open:		
11215	Arthrotomy shoulder joint or bursa	186.72	2

Shoulder Girdle, Clavicle and Humerus (cont'd)

		$	Anes. Level
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.23	
51040	Aspiration, joint (operation only)	23.23	
*52210	Bursa, I and D, under GA	186.72	2
*52215	Abscess, I and D, under GA	186.72	2
52220	Hematoma, drainage under GA, when sole procedure	242.74	2
	Note: *Payable at 50% in post-op period.*		
*52225	Shoulder joint arthrotomy, I and D	186.72	2
	Incision - Therapeutic, Release:		
52250	Soft tissue release (muscle, tendon)	380.44	2
52255	Major release (shoulder contracture)	541.49	2
	Excision - Diagnostic, Percutaneous:		
S11230	Needle biopsy under GA	186.72	2
S11232	Arthroscopy - biopsy, shoulder	242.74	2
	Excision - Diagnostic, Open:		
11245	Biopsy, open	242.74	2
	Excision - Therapeutic, Endoscopic:		
52305	Removal loose body	287.62	2
52306	Drilling osteochondral defect, with or without loose body.	287.62	2
52307	Pinning osteochondral fragment	350.12	2
52310	Debridement, synovectomy - total or subtotal	410.88	2
	Note: *Includes debridement of articular surface and/or synovium and/or debridement of partial tears of the rotator cuff.*		
52315	Shoulder, abrasion	350.12	2
52320	Excision labrum tear	242.74	2
52325	Stabilization procedure	569.50	2
52330	Endoscopic acromioplasty	410.88	2
52335	Arthroscopic clavicle excision-medial/lateral (extra)	106.57	
	Notes: *i) Paid only with 52330. ii) Not paid with 52505, 52506, 52515, 52516, 52525, 52526, 52535, 52540, 52541, 52545, 52602.*		
	Excision - Therapeutic, Open:		
52355	Bursa, excision, subacromial.	214.73	2
52356	Acromionectomy, acromioplasty, with or without resection of coraco-acromial ligament	350.12	2
52357	Clavicle, excision lateral/medial	214.73	2
52360	Arthrotomy, shoulder: synovectomy, capsulectomy.	406.12	2
52365	Benign soft tissue tumour (sub-fascial)	406.12	2
52370	Bone tumour, benign	406.12	2
*52380	Osteomyelitis, acute, decompression	186.72	2
*52385	Osteomyelitis, debridement with or without reconstruction.	322.10	3
	Note: *52380 and 52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.*		

Shoulder Girdle, Clavicle and Humerus (cont'd)

Introduction and/or Removal, Therapeutic:

52405*	Injection joint	11.63	
52410*	Injection bursa, tendon sheath, other peri articular structures.	11.63	
52415	Removal of internal fixation device(s), with GA	242.15	2
52420*	Removal of internal fixation device(s), without GA (operation only)	70.02	2

Repair, Revision, Reconstruction (Soft Tissue):

When fee items 52505, 52506, 52310, 52517, 52518, 52520, 52521 are performed arthroscopically, the following services are not paid in addition: removal of symptomatic loose body(ies) (52305), drilling of defect and/or micro fracture (52306), pinning of osteochondral fragment (52307), debridement and/or synovectomy (52310), synovial biopsy, shoulder abrasion (52315), excision labral tear (52320), stabilization procedure (52325), endoscopic acromioplasty (52330), and 52555 (tendon transplant).

SLAP/Biceps tenodesis: (Superior Labrum Anterior Posterior) repair (reattachment of the biceps anchor utilizing an anchoring device).

Bankart repair: (reattachment of labrum to the rim of the glenoid).

52505	Rotator cuff repair, simple (to include acromioplasty)	434.15	3
52506	Rotator cuff reconstruction, complex (rotation flap or muscle transfer) (to include acromioplasty)	718.88	4
52515	Acromioclavicular joint stabilization, acute (within six weeks post injury).	270.75	2
52516	Acromioclavicular joint stabilization, chronic (beyond six weeks post injury)	406.12	2
52517	Open or arthroscopic SLAP/Biceps tenodesis repair (reattachment of the biceps anchor utilizing an anchoring device) (isolated procedure)	630.18	3

Notes:
i) Not paid with 52506, 52518, 52519, 52520 and 52521.
ii) Includes 52505, 52550, 52555, 52526, 52535 and 52541.

52518	Open or arthroscopic SLAP/Biceps tenodesis repair and anterior or posterior glenohumeral stabilization and/or Bankart repair (isolated procedure)	914.94	3

Notes:
i) Not paid with 52519, 52520 and 52521.
ii) Includes 52505, 52506, 52550, 52555, 52526, 52535, 52541 and 52517.

52519	Open or arthroscopic SLAP/Biceps tenodesis or Bankart repair, and rotator cuff reconstruction, complex	1,033.99	3

Notes:
i) Not paid with 52520 and 52521.
ii) Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517 and 52518.

52520	Open or arthroscopic SLAP/Biceps tenodesis repair, and Bankart repair including tendon transfer, and Rotator cuff repair	1,349.06	3

Notes:
i) Not paid with 52521.
ii) Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517, 52518 and 52519.

52521	Open or arthroscopic SLAP/Biceps tenodesis repair, and Bankart repair and tendon transfer, and Rotator cuff repair, and anterior glenohumeral stabilization and/or posterior glenohumeral stabilization	1,578.96	3

Note: *Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517, 52518, 52519 and 52520.*

Shoulder Girdle, Clavicle and Humerus (cont'd)

		$	Anes. Level
52525	Shoulder instability: inferior capsular shift	569.50	3
52526	Shoulder instability: Bankart	630.18	3
52535	Shoulder instability: other anterior repairs	459.80	3
52540	Shoulder instability, posterior: glenoid osteotomy	718.88	3
52541	Shoulder instability, posterior: soft tissue	597.51	3
52545	Shoulder instability, revision stabilization (post previous stabilization)	718.88	3
52550	Tendon repair, proximal biceps, pectoralis major	434.15	3
52555	Tendon transfer, transplant	513.50	3
	Repair, Revision, Reconstruction (Bone, Joint):		
	Osteotomy, Malunion/Nonunion with or without Internal Fixation:		
52601	Proximal humerus	718.88	3
52602	Clavicle	513.60	2
	Glenohumeral Joint Arthroplasty:		
52603	Hemi-arthroplasty shoulder	620.86	4
52604	Total shoulder prosthesis	991.26	5
52605	Removal prosthesis shoulder	462.14	3
	Note: *Includes repair of rotator cuff and/or soft tissues.*		
52606	Revision total shoulder arthroplasty to hemi-arthroplasty	802.93	5
52607	Revision total shoulder arthroplasty	1,335.36	5
	Bone Grafting (ie. onlay grafting):		
52651	Proximal humerus	242.74	2
52652	Clavicle	149.38	2
	Fracture and/or Dislocation:		
	Clavicle, Acromion, Coracoid:		
52705	ORIF	436.58	2
52708*	Open injury, primary wound care (operation only)	102.26	2
52709*	Open injury, secondary wound management	186.72	2
52710	Sterno-clavicular joint stabilization	513.60	2
	Notes:		
	i) Restricted to Orthopaedic Surgeons.		
	ii) Not paid with 52357, 52602, 52652, 52705, 52708 or 52709.		
	Scapula:		
52715	ORIF	924.30	3
52718*	Open injury, primary wound care (operation only)	102.26	2
52719*	Open injury, secondary wound management	186.72	2
	Glenohumeral Dislocation - Acute:		
52721*	Closed reduction without GA (operation only)	93.37	2
52722	Closed reduction with GA	242.74	2
52725	Open reduction	406.12	2
	Proximal Humerus:		
52731*	Closed reduction with GA	186.72	2
52732*	Closed reduction with GA, traction/pin	186.72	2
52735	ORIF - two part	541.49	2
52736	ORIF - three or more parts	725.00	2
	Note*: 52735 and 52736 include repair of rotator cuff if required.*		

		$	Anes. Level

Shoulder Girdle, Clavicle and Humerus (cont'd)

52737	Hemiprosthesis and wiring for fracture	802.93	3
52738*	Open injury, primary wound care (operation only)	102.26	2
52739*	Open injury, secondary wound management	186.72	2
	Humerus - Shaft:		
52741	Closed reduction with GA	242.74	2
52742	Closed reduction external fixation	354.78	2
52745	ORIF/intramedullary nailing	569.50	2
52748*	Open injury, primary wound care (operation only)	102.26	2
52749*	Open injury, secondary wound management	186.72	2
	Manipulation: Shoulder Joint:		
S52800*	Manipulation under GA	93.97	2
	Arthrodesis:		
52810	Shoulder joint	952.30	4
52811	Scapula-thoracic joint	746.91	4
	Amputation:		
52980	Shoulder disarticulation	774.90	4
52981	Forequarter	924.30	5
52982	Humeral shaft	541.49	3
52998*	Open injury, primary wound care (operation only)	102.26	3
52999*	Open injury, secondary wound management	186.72	3

Elbow, Proximal Radius and Ulna

	Incision - Diagnostic, Percutaneous:		
S11300	Arthroscopy elbow joint	268.43	2
S11302	Aspiration - bursa, tendon sheath.	23.23	2
SY00757	Aspiration - other joints	12.03	2
	Incision - Diagnostic, Open:		
11315	Arthrotomy elbow joint	186.72	2
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.23	
51040	Aspiration, joint (operation only)	23.23	
*53210	Bursa, I and D (Olecranon, etc.), under GA	186.72	2
*53215	Abscess, I and D, under GA	186.72	2
53220	Hematoma, drainage, under GA, when sole procedure ***Note**: Payable at 50% in post-op period.*	242.74	2
*53225	Elbow joint arthrotomy, I and D	186.72	2
	Incision - Therapeutic, Release:		
53250	Decompression, neurolysis, nerve	242.74	2

Elbow, Proximal Radius and Ulna (cont'd)

		$	Anes. Level
53255	Decompression, neurolysis, submuscular Transposition of nerve	406.12	2
*53260	Fasciotomy, compartment syndrome	214.73	2
*53269	Fasciotomy, secondary wound management	186.72	2
	Excision - Diagnostic Percutaneous:		
S11330	Needle biopsy under GA	186.72	2
S11332	Arthroscopy and biopsy	296.44	2
	Excision - Diagnostic, Open:		
11345	Open - biopsy ***Note**: Not payable with other procedures on the same joint.*	242.74	2
	Excision - Therapeutic, Endoscopic:		
53305	Removal loose body	333.85	2
53310	Debridement, synovectomy - total	642.00	2
	Excision - Therapeutic, Open:		
53355	Bursa/ganglion, excision	214.73	2
53360	Arthrotomy, elbow; open synovectomy with or without radial head resection	406.12	2
53365	Benign soft tissue tumour, subfascial	270.75	2
53370	Bone tumour, benign	270.75	2
53380*	Osteomyelitis - acute, decompression	186.72	2
53385*	Osteomyelitis - debridement, with or without reconstruction.	322.10	2
53386	Radial head resection with or without replacement	242.74	2
	Introduction and/or Removal, Therapeutic:		
53405*	Injection joint	11.63	
53410*	Injection bursa, tendon sheath, other peri articular structures.	11.63	
53415	Removal of internal fixation device(s), with GA	214.73	2
53420*	Removal of internal fixation device(s), without GA (operation only)	70.02	2
	Repair, Revision, Reconstruction (Soft Tissue):		
53505	Elbow instability, chronic	676.86	2
53510	Recurrent dislocating radial head	569.50	2
53515	Triceps tendon, acute	352.44	2
53516	Triceps tendon, fascial reconstruction	406.12	2
53520	Biceps tendon, longhead, tenodesis	270.75	2
53521	Biceps tendon, distal insertion	569.50	2
53530	Tendon transfer, major ***Note**: Includes latissimus/pectoralis to biceps transfer.*	718.88	2
53531	Tendon transfer, minor (steindler or triceps).	434.15	2
53540	Epicondylitis, fascial stripping	214.73	2
	Repair, Revision, Reconstruction (Bone, Joint):		
	Osteotomy, Malunion/Nonunion; with or without internal fixation:		
53601	Humeral shaft	711.89	2
53602	Distal humerus	718.88	2
53603	Radius shaft	595.16	2
53604	Ulna shaft	520.94	2
53605	Radius and ulna shafts	718.88	2

Elbow, Proximal Radius and Ulna (cont'd)

		$	Anes. Level
53606	Epiphysiodesis	270.75	2
53607	Physeal bar excision ***Note:*** *Includes harvest with or without insertion of fat graft, cement or other material.*	448.14	2
	Arthroplasty:		
53641	Interposition/distraction arthroplasty ***Note:*** *Includes harvest and insertion of local fascial graft, application of distraction device and neurolysis, if applicable.*	924.30	3
53642	Total elbow arthroplasty	991.26	3
53643	Revision total elbow arthroplasty ***Note:*** *53642 and 53643 include ligament balancing, neurolysis and nerve transposition.*	1,335.36	3
53644	Osteocapsular arthroplasty (elbow, open or arthroscopic)……. ***Notes:*** *i) Not payable with (11300, 11315, 11332, 11345, 06258, 53250, 53255, 53305, 53310, 53360, 53386, 53641, 53642, 53643, 53800 and 03196).* *ii) Includes: complete synovectomy and diagnostic arthroscopy, removal of loose bodies, excision of prominent osteophytes and heterotopic bone, capsular releases, wound closure, post-operative splint and neurolysis when required.*	924.49	4
	Bone Grafting (ie. onlay grafting):		
53651	Humerus	242.74	2
53652	Radius and/or ulna	242.74	2
53653	Olecranon	149.38	2
	Fracture and/or Dislocation:		
	Humeral Epicondyle:		
53701	Closed reduction, with GA, cast	242.74	2
53702	Closed reduction percutaneous fixation	270.75	2
53705	ORIF	270.75	2
53708*	Open injury, primary wound care (operation only)	102.26	2
53709*	Open injury, secondary wound management	186.72	2
	Distal Humerus: Supracondylar:		
53711*	Closed reduction, with GA, cast/traction	186.72	2
53712	Closed reduction external fixation/percutaneous fixation	430.00	2
53715	ORIF	444.88	2
53718*	Open injury, primary wound care (operation only)	102.26	2
53719*	Open injury, secondary wound management	186.72	2
	Distal Humerus: Intra-articular:		
53721*	Closed reduction, with GA, cast/traction/ and/or percutaneous fixation	186.72	2
53722	Closed reduction external fixation	354.78	2
53725	ORIF - unicondylar/osteochondral	406.12	2
53726	ORIF - bicondylar with or without olecranon osteotomy ***Note:*** *Includes ulnar nerve transposition, if required.*	868.26	2
53727*	Open Injury, primary wound care (operation only)	102.26	2
53728*	Open injury, secondary wound management	186.72	2

Elbow, Proximal Radius and Ulna (cont'd)

		$	Anes. Level
	Olecranon:		
53735	ORIF	416.76	2
53738*	Open injury, primary wound care (operation only)	102.26	2
53739*	Open injury, secondary wound management	186.72	2
	Radial Head/Neck:		
53741	Closed reduction, with GA, cast	242.74	2
53742	Closed reduction percutaneous fixation	270.75	2
53745	ORIF	414.00	2
53748*	Open injury, primary wound care (operation only)	102.26	2
53749*	Open injury, secondary wound management	186.72	2
	Elbow Joint Dislocation:		
53751	Closed reduction, without GA	149.38	2
53752	Closed reduction, with GA	242.74	2
53755	Open reduction	298.77	2
	Radius and Ulna Shaft:		
53761*	Closed reduction, without GA, cast (operation only)	93.37	2
53762	Closed reduction, with GA, cast	298.77	2
53765	ORIF	541.49	2
53768*	Open injury, primary wound care	102.26	2
53769*	Open injury, secondary wound management	186.72	2
	Radius or Ulna Shaft/Monteggia:		
53771	Closed reduction, with GA, cast	270.75	2
53772	Closed reduction external fixation	270.75	2
53775	ORIF	416.76	2
	Notes: *i) Includes closed reduction of associated proximal or distal radial ulnar joint dislocation.* *ii) Cases requiring an open reduction of the associated proximal or distal radial ulnar joint dislocation should be billed as 53765.*		
53778*	Open injury, primary wound care (operation only)	102.26	2
53779*	Open injury, secondary wound management	186.72	2
	Manipulation: Elbow Joint:		
S53800*	Manipulation under GA	93.37	2
	Arthrodesis:		
53810	Elbow joint	718.88	3
	Amputation:		
53980	Elbow	406.12	3
53981	Forearm	406.12	3
53998*	Open injury, primary wound care (operation only)	102.26	3
53999*	Open injury, secondary wound management	186.72	3

Hand and Wrist

		$	Anes. Level
	Incision - Diagnostic, Percutaneous:		
S11400	Arthroscopy wrist joint	287.62	2
S11402	Aspiration bursa, synovial sheath, etc.	23.23	2
SY00757	Aspiration - other joints	12.03	2
	Incision - Diagnostic, Open:		
11415	Arthrotomy wrist joint - isolated procedure	186.72	2
11416	Arthrotomy MP, PIP, DIP Joints – isolated procedure	186.72	2
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.23	
51040	Aspiration, joint (operation only)	23.23	
	Excision - Diagnostic, Percutaneous:		
S11430	Needle biopsy under GA	186.72	2
S11432	Arthroscopy and biopsy, wrist /hand joint(s)	186.72	2
	Excision - Diagnostic, Open:		
11445	Open biopsy, hand or wrist	242.74	2
	Excision - Therapeutic, Endoscopic:		
54305	Removal loose body	242.74	2
54310	Debridement synovectomy, total	324.44	2
54315	Excision triangular fibro cartilage complex (TFCC)	324.44	2
	Excision - Therapeutic, Open:		
54350	Foreign body from wound under GA	214.73	2
54351	Meniscus, radiocarpal	324.44	2
V07055	Ganglia - of the wrist	250.00	2
	<u>Bone Tumour, Benign:</u>		
54372	Carpals, distal radius	324.44	2
54380*	Osteomyelitis, acute, decompression	186.72	2
54385*	Osteomyelitis, debridement with or without reconstruction.	322.10	2
54386	Excision of radial or ulnar styloid ***Note:*** *Not payable with other wrist procedures.*	214.73	2
54387	Proximal row carpectomy ***Note****: Not payable with wrist arthrodesis.*	541.49	2
	Introduction and/or Removal,Therapeutic:		
54405*	Injection joint	23.23	
54410*	Injection bursa, tendon sheath, other peri articular structures.	23.23	
54415	Removal of internal fixation device(s), with GA	214.73	2
54420*	Removal of internal fixation device(s), without GA (operation only)	46.68	2
	Repair, Revision, Reconstruction (Soft Tissue):		
	<u>Ligament:</u>		
54505	Carpal instability: acute	597.51	2
54510	Carpal instability: chronic	658.20	2

Hand and Wrist (cont'd)

		$	Anes. Level
54515	Distal radio-ulnar instability: chronic	487.81	2
	Repair, Revision, Reconstruction (Bone, Joint):		
	Osteotomy, Malunion or Nonunion:		
54601	Distal radius	658.20	2
54602	Distal ulna	340.00	2
	Note: *Darrach resection or limited resection/hemiresection arthroplasties are not payable under this item.*		
54603	Carpal bone (scaphoid)	541.49	2
54604	Epiphysiodesis, epiphysioplasty, radius and/or ulna, or hand	406.12	2
	Arthroplasty Joint		
54631	Ulna, distal excision with or without silastic	242.74	2
54632	Total wrist joint replacement, includes tenosynovectomy & distal ulnar reconstruction	718.88	2
54633	Silastic wrist arthroplasty, includes tenosynovectomy & distal ulnar reconstruction	541.49	2
54634	Removal prosthesis	270.75	2
54635	Revision total wrist arthroplasty	952.30	3
	Bone Grafting (ie. onlay grafting)		
54651	Distal radius and/or ulna	242.74	2
54652	Metacarpal or phalanx (operation only)	121.36	2
	Fracture and/or Dislocation:		
	Radius with or without Ulna - Distal, Fracture		
54701	Closed reduction without GA	252.09	2
54702	Closed reduction with GA	298.77	2
54703	Closed reduction, external or percutaneous fixation	326.77	2
54705	ORIF	518.18	2
54708*	Open injury, primary wound care (operation only)	51.13	2
54709*	Open injury, secondary wound management (operation only)	93.37	2
	Carpal Bone Fracture (Scaphoid)		
54715	Open reduction, internal fixation	434.15	2
	Carpus: Dislocations: with or without Fracture		
54721	Closed reduction without GA	252.09	2
54722	Closed reduction, percutaneous fixation	298.77	2
54725	Open reduction, internal and/or external fixation	597.51	2
54728*	Open injury, primary wound care (operation only)	51.13	2
54729*	Open injury, secondary wound management (operation only)	93.37	2
	Manipulation: Hand/Wrist Joint:		
S54800	Manipulation under GA	93.37	2
	Arthrodesis/Tenodesis:		
54810	Wrist arthrodesis, limited or total	658.20	2
	Amputation:		
06218	Transmetacarpal	254.92	2
06219	Finger, any joint or phalanx (operation only)	254.92	2

Pelvis, Hip and Femur

		$	Anes. Level
	Incision - Diagnostic, Percutaneous:		
S11500	Arthroscopy hip joint	518.18	3
S11501	Aspiration hip joint	23.23	2
S11502	Aspiration bursa, tendon sheath.	11.63	2
	Incision - Diagnostic, Open:		
11515	Arthrotomy hip joint	298.77	3
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.23	
51040	Aspiration, joint (operation only)	23.23	
55210*	Bursa, I and D (trochanteric, etc.), under GA	186.72	2
55215*	Abcess, I and D, under GA	186.72	2
55220	Hematoma, drainage under GA, when sole procedure	298.77	2
	Note: *Payable at 50% in post-op period.*		
55225*	Hip Joint - arthrotomy, I and D	322.10	3
	Incision - Therapeutic, Release:		
55255	Soft tissue release: percutaneous	270.75	2
55270	Minor release hip, one tendon	298.77	2
55275	Major release hip, two or more	406.12	3
	Excision - Diagnostic, Percutaneous:		
S11530	Needle biopsy under GA	186.72	2
S11532	Arthroscopy and biopsy, hip	518.18	3
	Excision - Diagnostic, Open:		
11545	Arthrotomy and biopsy, hip	242.74	3
11546	Biopsy open, soft tissue or bone	242.74	2
	Excision - Therapeutic, Endoscopic:		
55305	Removal loose body	378.11	3
55310	Debridement or synovectomy, total	597.51	3
	Excision - Therapeutic, Open:		
55355	Bursa, excision, trochanteric, etc.	214.73	2
55360	Arthrotomy, hip: open synovectomy, total	569.50	3
55365	Benign soft tissue tumour subfascial	406.12	3
55370	Bone tumour, benign	434.15	3
S55371	Heterotopic bone resection	515.94	3
	Note: *Paid only for heterotopic bone resection which meets the criteria for Brooker Classification III or IV.*		
55380*	Osteomyelitis, acute, decompression	186.72	3
55385*	Osteomyelitis, debridement with or without reconstruction	322.10	3
	Introduction and/or Removal, Therapeutic:		
55405*	Injection joint	11.63	
55410*	Injection bursa, tendon sheath, other peri articular structures.	11.63	
55415	Removal of internal fixation device(s), with GA	242.74	3
55420*	Removal of internal fixation device(s), without GA (operation only)	70.02	3

Pelvis, Hip and Femur (cont'd)

		$	Anes. Level
	Repair, Revision, Reconstruction (Soft Tissue):		
55505	Hip instability: soft tissue repair	653.54	3
55510	Tendon-muscle transfer, hip	658.20	3
55515	Tendon avulsion repair	326.77	3
	Repair, Revision, Reconstruction (Bone, Joint):		
	Osteotomy:		
55601	Pelvis, adult	746.91	6
55602	Pelvis, pediatric	746.91	6
55603	Proximal femur, adult	746.91	4
55604	Proximal femur, pediatric	746.91	4
55605	Femoral shaft, adult	774.90	4
55606	Femoral shaft, pediatric	774.90	4
55607	Multiple for Osteogenesis Imperfecta	891.61	6
	Malunion or Nonunion:		
C55631	Pelvis (including Sacroiliac joint arthrodesis)	1,363.10	4
	Notes: *i) Restricted to Orthopaedic Surgeons. ii) Removal of previously placed hardware to be paid at 50% if removed from a separate incision. iii) Harvesting of bone graft is paid in addition when performed at the same time.*		
55632	Acetabulum	1,848.57	4
55633	Proximal femur (ie. subtrochanteric)	896.29	4
55634	Shaft, femur (includes closed femoral lengthening and open femoral shortening)	774.90	4
55635	Femoral lengthening, open	896.29	4
55636	Femoral shortening, closed	896.29	4
	Bone Grafting (ie. onlay grafting):		
55651	Femur: Intertrochanteric, shaft	270.75	4
55652	Epiphysiodesis, greater trochanter	326.77	4
	Arthroplasty:		
55661	Hip resection arthroplasty	490.15	5
55662	Hemi-arthroplasty hip	635.00	5
55663	Total hip prosthesis	817.65	5
	Revision Total Hip Arthroplasty:		
55671	Components, removal only (isolated procedure)	802.93	5
55672	Exchange of modular component	434.15	5
55673	Revision femur or acetabulum	989.64	6
55674	Revision femur and acetabulum, includes PROSTALAC	1,307.07	6
	Note*: 55673 and 55674 include trochanteric osteotomies if required.*		
55675	Proximal femoral replacement, allograft or custom prothesis and/or acetabular reconstruction with internal fixation	1,633.84	6
	Notes: *i) When a total hip replacement is revised in conjunction with a peri-prosthetic fracture, the revision of the pre-existing femoral fracture may be billed under fee item 55675 for the failed total hip arthroplasty + 50% of 55785 for open reduction and fixation of the fracture of the proximal femur. ii) When fracture of the femur occurs <u>during</u> a revision total hip, the procedure will be paid at the rate for revision total hip, only.*		

Pelvis, Hip and Femur (cont'd)

		$	Anes. Level
	Hip Arthroscopy:		
P55520	Hip arthroscopy with labral debridement +/- microfracture/chondroplasty +/- iliopsoas release	765.12	3
P55521	Hip arthroscopy with labral repair and/or abductor repair, and/or hamstring repair, +/- capsule closure	1,071.16	3
P55522	Hip arthroscopy with femoral and/or acetabular osteoplasty +/- capsule closure	1,071.16	3
P55523	Hip arthroscopy with labral repair and femoral and/or acetabular osteoplasty	1,326.20	4
PC55524	Hip arthroscopy with labral reconstruction and/or ligamentum teres reconstruction	1,479.22	3
	Notes: *The following applies to fee items 55520, 55521, 55522, 55523, and 55524* *i) Restricted to Orthopaedic Surgeons.* *ii) Maximum of one hip arthroscopy payable per patient per day.* *iii) Hip arthroscopies are composite fees and include all necessary procedures. No other procedures involving the hip are payable during the same operation.*		
	Fracture with or without Dislocation:		
	Pelvis: Operative Rx. Unstable:		
55701*	Closed reduction - skeletal traction (operation only)	93.37	3
55702	Closed reduction - external fixation	494.83	4
55705	External fixation and ORIF	1,092.35	5
55706	ORIF - anterior or posterior	765.57	5
55707	ORIF - anterior and posterior	1200.00	5
	Hip: Dislocation, Traumatic (Includes Total Hip Arthroplasty):		
55711*	Reduction hip without anesthetic (operation only)	93.37	2
55712*	Reduction hip, with GA	186.72	2
55715	Open reduction	490.15	4
	Hip: Dislocation, Congenital: Conservative Management:		
55721	Closed reduction under GA, with or without tenotomy	270.75	2
	Hip: Dislocation, Congenital: Operative Management:		
55725	Open reduction	714.22	2
55726	Open reduction and femoral or pelvic osteotomy	1,047.97	4
55727	Open reduction and femoral and pelvic osteotomy	1,318.75	4
	Hip:Fracture Dislocation, (includes lip and/or head fractures):		
55731*	Reduction hip without anesthetic (operation only)	93.97	2
55732*	Reduction hip, with GA	186.72	2
55735	Open reduction	490.15	4
55736	ORIF	952.30	5
55738*	Open injury, primary wound care (operation only)	102.26	2
55739*	Open injury, secondary wound management	186.72	2
	Hip: Acetabulum Fracture (one or two column fractures):		
55741*	Closed reduction	186.72	2
55745	ORIF - one approach	1,325.00	5
55746	ORIF - two approach/extensile approach	1,900.00	6

Pelvis, Hip and Femur (cont'd)

		$	Anes. Level
	Hip:Fracture Femoral Neck or Subcapital:		
55751	Closed reduction, internal fixation	518.18	5
55755	ORIF (with supporting documentation)	830.94	5
55758*	Open injury, primary wound care (operation only)	102.26	
55759*	Open injury, secondary wound management	186.72	2
55760	SCFE insitu fixation	518.18	5
	Hip:Fracture Intertrochanteric with or without Subtrochanteric Extension:		
55761	Reduction internal fixation	653.54	5
55768*	Open injury, primary wound care	102.26	
55769*	Open injury, secondary wound management	186.72	2
	Hip:Fracture Subtrochanteric:		
55771	Internal fixation	891.61	5
55778*	Open injury, primary wound care	102.26	2
55779*	Open injury, secondary wound management	186.72	2
	Femur: Shaft:		
55780*	Closed reduction, without GA, cast/traction (operation only)	121.36	2
55781*	Closed reduction, with GA, cast/traction (operation only)	214.73	2
	Note: *If 55780 or 55781 is followed by an ORIF/IM nailing after 48 hours, both paid in full.*		
55782	Closed reduction, external skeletal fixation	400.00	4
55783	Closed reduction, IM nail	774.90	5
55785	ORIF	774.90	5
55788*	Open injury, primary wound care (operation only)	102.26	2
55789*	Open injury, secondary wound management	186.72	2
	Manipulation: Hip Joint:		
S55800*	Manipulation under GA	93.37	2
	Arthrodesis:		
55810	Hip joint	1,227.71	6
	Amputation:		
55980	Hemicorpectomy	2,446.08	6
55981	Hemipelvectomy	1,363.10	6
55982	Hip Disarticulation	1,036.32	6
55983	Above knee	653.54	4
55984	Knee disarticulation	653.54	4
55985	Revision, amputation, below knee, after 14 days	680.00	3
	Note: *Restricted to Orthopaedic Surgeons.*		
55998*	Open injury, primary wound care	102.26	4
55999*	Open injury, secondary wound management	186.72	4

Femur, Knee Joint, Tibia and Fibula

	Incision - Diagnostic, Percutaneous:		
S11600	Arthroscopy knee joint	214.73	2
SY00757	Aspiration - other joints	12.03	2
S11602	Aspiration bursa, tendon sheath or other periarticular structures	23.23	2

		$	Anes. Level
	Incision - Diagnostic, Open:		
11615	Arthrotomy knee joint	242.74	3
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.23	
51040	Aspiration, joint (operation only)	23.23	
56210*	Bursa, I and D (Prepatellar, etc.), under GA	186.72	2
56215*	Abcess, I and D, under GA	186.72	2
56220	Hematoma, drainage under GA, when sole procedure ***Note**: Payable at 50% in post-op period.*	298.77	2
56225*	Knee Joint - arthrotomy, I and D	186.72	3
	Incision - Therapeutic, Release:		
56250	Decompression, neurolysis, nerve	214.73	2
56260*	Fasciotomy, compartment syndrome	300.00	3
56269*	Fasciotomy, secondary closure wound, with or without Graft	186.72	2

Femur, Knee Joint, Tibia and Fibula (cont'd)

	Soft Tissue Release:		
56270	Minor release knee - tendons only, uni- or bilateral	345.45	2
56275	Major release knee - includes posterior capsulotomy, uni- or bilateral	487.81	3
56280	Knee liberation/major release (post ligament reconstruction)	770.24	3
56285	Quadriceps plasty	625.53	3
56290	Open lateral / medial retinacular release	242.74	2
	Excision - Diagnostic, Percutaneous:		
S11630	Needle biopsy under GA	186.72	2
S11632	Arthroscopy - biopsy	214.73	2
	Excision - Diagnostic, Open:		
11645	Biopsy, open	242.74	2
	Excision - Therapeutic, Endoscopic:		
56315	Resection 'plica' (isolated procedure)	287.62	2
56322	Abrasion debridement, one or more compartments must include substantial debridement of pathologic articular cartilage and includes synovectomy, meniscal trimming and/or chondroplasty, extra - first 15 minutes, or major portion thereof ***Notes:*** *i) Paid only with knee arthroscopy (56305, 56306, 56310, 56315, 56320, 56325 and 56335).* *ii) Not paid to Orthopaedic Surgeon performing a surgical assist.* *iii) Start and end times of debridement must be recorded in the patient's chart and claim submission.*	143.81	2
56323	Abrasion/debridement, extra - each additional 15 minutes, or major portion thereof ***Notes:*** *i) Paid only with 56322.* *ii) Paid to a maximum of two additional units.* *iii) Start and end times of debridement must be recorded in the patient's chart and claim submission.*	71.91	

		$	Anes. Level
56325	Meniscal repair	450.00	2
	Notes: *i) Includes 56320, debridement of attachment site.* *ii) Not paid for trimming of the meniscus.*		
56330	Abrasion / debridement (isolated procedure)	287.62	2
56335	Lateral or medial release, endoscopic (isolated procedure)	287.62	2
	Excision – Therapeutic, Knee Arthroscopic:		
	Synovial biopsy is included in 56305, 56306, 56356, 56315, 56320, 56325, 56330 and 56322.		
56305	Removal symptomatic loose body ***Note:*** *Not paid for removal of iatrogenic loose body(ies).*	287.62	2
56306	Pinning/drilling osteochondral fragment(s) for osteoarthritic cartilage deficiency ***Note:*** *Includes removal of loose body(ies).*	410.88	2

Femur, Knee Joint, Tibia and Fibula (cont'd)

56310	Synovectomy knee, for diseased synovium, anterior, posterior or complete total	487.92	2
56320	Meniscectomy knee, partial or total for symptomatic meniscal tear	287.62	2
56321	Drilling of defect or microfracture and/or abrasion arthroplasty	287.62	2
	Excision - Therapeutic, Open:		
56353	Ganglion or cyst	214.73	2
56354	Popliteal cyst	298.77	2
56355	Bursa, prepatellar	214.73	2
	<u>Arthrotomy Knee:</u>		
56356	Removal loose body	242.74	3
56357	Pinning/drilling osteochondral fragments	352.44	3
56360	Synovectomy knee, total	464.48	3
56361	Meniscectomy knee	242.74	3
56362	Meniscal repair	375.00	3
56365	Benign soft tissue tumour subfascial	326.77	3
56370	Bone tumour, benign	270.75	3
56380*	Osteomyelitis, acute, decompression	186.72	3
56385*	Osteomyelitis, debridement, with or without reconstruction	214.73	3
56390	Patellectomy	326.77	3
	Introduction with or without Removal, Therapeutic:		
56405*	Injection joint	23.23	
56410*	Injection bursa, tendon sheath, other peri articular structures.	23.23	
56415	Removal of internal fixation device(s), with GA	242.74	2
56420*	Removal of internal fixation device(s), without GA (operation only)	70.02	2
	Repair, Revision, Reconstruction (Soft Tissue):		
	<u>Knee ligament, Instability (with or without arthroscopy)</u>		
56505	One ligament repair/reconstruction, acute or chronic	675.00	3
56510	Posterior cruciate repair/reconstruction, acute or chronic	746.91	3

		$	Anes. Level
56515	Two ligament repair/reconstruction, acute or chronic	800.00	3
56520	Three ligament repair/reconstruction, acute or Chronic (includes PCL)	980.00	3
56525	Revision knee ligament reconstruction (post previous ligament reconstruction)	718.88	3
	Note: *56505 to 56525 include meniscectomy, graft harvest plus use of synthetic device. Meniscus repair is payable in addition at 50%.*		
56528*	Open injury, primary wound care (operation only)	102.26	2
56529*	Open injury, secondary wound care	186.72	2
	Recurrent Subluxation/Dislocation Patella:		
56530	Extensor realignment procedures, soft tissue/bone.	434.15	3
56531	Lateral release, open or endoscopic	242.74	2
56540	Quadriceps tendon rupture, acute (within six weeks post injury)	480.90	2
56541	Quadriceps tendon rupture, chronic (beyond six weeks post injury)	550.00	2
56542	Patellar tendon repair	480.90	2
	Notes: *i) Restricted to Orthopaedic Surgeons.* *ii) Not paid with 56540, 56541 or 56545.*		

Femur, Knee Joint, Tibia and Fibula (cont'd)

56545	Tendon transfer, transplant	326.77	2
	Repair Reconstruction Bone/Joint:		
	Osteotomy and/or Internal Fixation: Arthritis, Malunion or Nonunion		
56601	Distal femur	802.93	3
56602	Proximal tibia	569.50	3
56603	Tibia, shaft, includes fibula	746.91	3
56604	Fibula	270.75	3
	Bone Grafting (ie. onlay grafting)		
56651	Femur	270.75	3
56652	Tibia, with or without fibular osteotomy	270.75	3
56653	Epiphysiodesis	298.77	3
56654	Physeal bar excision	508.83	3
	Arthroplasty: Knee Joint		
56661	Knee replacement unicompartmental	809.23	4
56662	Total knee replacement	817.00	4
56663	Total knee, removal prosthesis knee, includes PROSTALAC	490.15	4
56664	Revision total knee	1,104.00	4
56665	Revision patellar component	406.12	3
C56666	Meniscal Allograft Transplant	1,301.86	5
	Notes: *i) Restricted to Orthopaedic Surgeons.* *II) if the procedure is abandoned after initial diagnostic arthroscopy due to advanced articular chondromalacia or the state of the remnant meniscus, only fee item 11600 would be payable.* *iii) Includes 11600, 11615, 56320, and 56321.*		
	Fracture and/or Dislocation:		
	Metaphysis Femur: Supracondylar		
56701*	Closed reduction, without GA, cast/traction (operation only)	121.36	2
56702*	Closed reduction, with GA, cast/traction	214.73	2
56703	Closed reduction, external fixation / percutaneous fixation	400.00	2

		$	Anes. Level
56704	Closed reduction, IM nail	774.90	5
56705	ORIF	774.90	4
56708*	Open injury, primary wound care (operation only)	102.26	2
56709*	Open injury, secondary wound management	186.72	2
	Metaphysis Femur: Condyle or Intracondylar		
56711*	Closed reduction, without GA, cast/traction (operation only)	93.37	2
56712*	Closed reduction with GA, cast/traction	186.72	2
56713	Closed reduction, external fixation /percutaneous fixation	400.00	2
56715	ORIF - unicondylar	774.90	4
56716	ORIF - bicondylar	1,115.69	4
56718*	Open injury, primary wound care (operation only)	102.26	2
56719*	Open injury, secondary wound management	186.72	2
	Patellar Dislocation		
56725	Open reduction and repair	242.74	2
56728*	Open injury, primary wound care (operation only)	102.26	2
56729*	Open injury, secondary wound management	186.72	2

Femur, Knee Joint, Tibia and Fibula (cont'd)

	Patellar Fractures		
56734	Patellectomy	326.77	2
56735	ORIF	462.14	2
56738*	Open injury, primary wound care (operation only)	102.26	2
56739*	Open injury, secondary wound management	186.72	2
	Tibial Plateau Fractures		
56741*	Closed reduction, with GA, cast/traction	186.72	2
56742	Closed reduction, external fixation with or without minimal internal fixation	400.00	2
56745	ORIF - unicondylar	653.54	3
56746	ORIF - bicondylar	924.30	3
56748*	Open injury, primary wound care (operation only)	102.26	2
56749*	Open injury, secondary wound management	186.72	2
	Tibial Shaft Fractures		
56751*	Closed reduction, without GA, cast/traction (operation only)	93.37	2
56752*	Closed reduction, with GA, cast/traction	214.73	2
56753	Closed reduction, external fixation with or without minimal internal fixation	400.00	2
56754	Closed reduction, IM nail	686.20	3
56755	ORIF	569.50	3
56758*	Open injury, primary wound care (operation only)	102.26	2
56759*	Open injury, secondary wound management	186.72	2
	Fibular Shaft Fractures		
56769*	Open injury, primary/secondary wound care	186.72	2
	Manipulation: Knee Joint:		
S56800*	Manipulation, with GA	93.37	2
	Arthrodesis:		
56810	Knee joint	802.93	3
	Amputation:		
56980	Below knee	650.00	3
56998*	Open injury, primary wound care (operation only)	102.26	3

		$	Anes. Level
56999*	Open injury, secondary wound management	186.72	3

Tibial Metaphysis (Distal), Ankle and Foot

	Incision - Diagnostic, Percutaneous:		
S11700	Arthroscopy - ankle joint / subtalar joint	186.72	2
S11702	Aspiration bursa, tendon sheath.	23.23	2
SY00757	Aspiration - other joints	12.03	2
	Incision - Diagnostic, Open:		
11715	Ankle joint,	186.72	2
11716	Subtalar joint	186.72	2
11717	Midtarsal joint	186.72	2
11718	Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint.	186.72	2

Tibial Metaphysis (Distal), Ankle and Foot (cont'd)

	Incision - Therapeutic, Drainage:		
51039	Aspiration – bursa (operation only)	23.23	
51040	Aspiration – joint (operation only)	23.23	
57210*	Bursa, I and D (Tendo-achilles, etc.), under GA	186.72	2
57215*	Abcess, I and D, under GA	186.72	2
57220	Hematoma, drainage under GA, when sole procedure ***Note:*** *Payable at 50% in post-op period.*	298.77	2
57225*	Ankle/foot Joint, I and D, under GA	186.72	2
	Incision - Therapeutic, Release:		
57250	Decompression, neurolysis, nerve (isolated procedure)	298.77	2
57260*	Fasciotomy, compartment syndrome	214.73	2
57269*	Fasciotomy, secondary closure wound	186.72	2
	<u>Soft Tissue Release: Musculo-tendonous</u>		
57270	Plantar fascia: open release or partial excision, uni- or bilateral	270.75	2
57275	Plantar fasciectomy - total	406.12	2
57280	Achilles tendon lengthening, percutaneous, uni- or bilateral	214.73	2
57285	Posterior hindfoot release	434.15	2
57286	Posteromedial release (club foot /vertical talus)	718.88	2
57290	Tendon lengthening, open	270.75	2
57295	Tenosynovectomy	270.75	2
	Excision – Diagnostic:		
S11730	Needle biopsy under GA	186.72	2
11745	Open biopsy under GA	242.74	2
	Excision - Therapeutic, Endoscopic:		
57305	Removal loose body	287.62	2
57306	Pinning/drilling osteochondral fragments	410.88	2
57310	Synovectomy ankle, total	462.24	2
57330	Abrasion or debridement	287.62	2
	Excision - Therapeutic, Open:		
57354	Ganglion: tendon sheath, or joint	214.73	2
57355	Bursa, excision, achilles.	214.73	2

		$	Anes. Level
57356	Neuroma (ie. sensory, digital, etc.)	214.73	2
57360	Total synovectomy / debridement.	354.78	2
57365	Benign soft tissue tumour	214.73	2
57370	Bone tumour, benign	352.44	2
57371	Tarsal coalition ***Note**: Includes harvesting of interposition material, if required.*	352.44	2
57372	Sesamoidectomy	242.74	2
57373	Excision - accessory navicular	242.74	2
57374	Talectomy	541.49	2
57375	Excision - nail bed, under GA, single or multiple	214.73	2
57380*	Osteomyelitis, acute, decompression	186.72	2
57385*	Osteomyelitis, debridement with or without reconstruction.	322.10	2

Tibial Metaphysis (Distal), Ankle and Foot (cont'd)

Introduction and/or Removal, Therapeutic:

57405*	Injection joint	11.63	
57410*	Injection bursa, tendon sheath, other peri articular structures.	11.63	
57415	Removal of internal fixation device(s), with GA	214.73	2
57420*	Removal of internal fixation device(s), without GA (operation only)	46.68	2

Repair, Revision, Reconstruction (Soft Tissue):

<u>Ankle Instability: Capsule or Ligament Repair</u>

57505	Acute ligament repair - medial and/or lateral	242.74	2
57510	Reconstruction for ankle instability	470.00	2

<u>Tendon Muscle Repair</u>

57515	Tendo achilles repair - acute (within six weeks post injury)	352.44	2
57516	Tendo achilles repair - chronic (beyond six weeks post injury)	541.49	2
57520	Flexor tendon repair, ankle or foot, single or multiple	352.44	2
57525	Extensor tendon(s), without GA (operation only)	121.36	2
57526	Extensor tendon, single, under GA	242.74	2
57527	Extensor tendon, multiple, under GA	336.10	2
57535	Repair/reconstruction of tendon sheath	380.44	2

<u>Tendon Muscle Transfer, Transplant, Tenoplasty</u>

57550	Tendon transfer	434.15	2
57555	Jones' procedure	326.77	2

Repair, Revision, Reconstruction (Bone, Joint):

<u>Osteotomy/Malunion</u>

57601	Distal tibial	648.87	2
57602	Malleolus: lateral and/or medial	434.15	2
57603	Calcaneal osteotomy (not to include Hagelund's)	520.99	2
57604	Midtarsal osteotomy	597.51	2
57605	Metatarsals: base, shaft, neck	352.44	2
57606	Phalanges, open osteotomy	242.74	2

<u>Osteotomy/Nonunion</u>

57631	Distal tibial	541.49	2
57632	Malleolus: lateral and/or medial	326.77	2
57633	Tarsals	380.44	2
57634	Metatarsals: base, shaft, neck	214.73	2
57635	Phalanges	214.73	2

		$	Anes. Level
57636	Epiphysiodesis	298.77	2
57637	Physeal bar excision	406.12	2
	Bone Grafting (ie. onlay grafting)		
57651	Distal tibia	242.74	2
57652	Malleolus - medial and/or lateral-tarsals, metatarsals, phalanges	149.38	2
	Arthroplasty: Ankle Joint		
57661	Total ankle prothesis	991.26	3
57662	Revision total ankle	1,335.36	3
57663*	Removal of total ankle arthroplasty	186.72	3

Tibial Metaphysis (Distal), Ankle and Foot (cont'd)

	Metatarsal Phalangeal Joint: Arthroplasty		
57671	Excision arthroplasty great toe (Keller's cheilectomy)	270.75	2
57672	Resection/soft tissue reconstruction	298.77	2
57673	Distal metatarsal osteotomy	298.77	2
57674	Proximal metatarsal osteotomy with distal realignment.	434.15	2
57675	Implant arthroplasty	288.77	2
57676	Interphalangeal joint arthroplasty, single or multiple	270.75	2
57677	Minor forefoot reconstruction (lesser toes).	380.44	2
57678	Major forefoot reconstruction - (includes excision arthroplasty,stabilization with or without implant, includes great toe)	595.16	2
	Fracture and/or Dislocation:		
	Ankle Fracture: Intra-articular Tibial Metaphysial (PILON)		
57701*	Closed reduction, with GA, cast/traction	186.72	2
57702	Closed reduction, external fixation with or without percutaneous fixation, with or without minimal internal fixation, with or without ORIF distal fibula	490.15	2
57705	ORIF (include fibular fracture)	896.29	2
57708*	Open injury, primary wound care (operation only)	102.26	2
57709*	Open injury, secondary wound management	186.72	2
	Ankle (Malleolar) Fracture		
57711*	Closed reduction without GA, application of cast (operation only)	93.37	2
57712*	Closed reduction, with GA, application of cast	270.75	2
57713	Closed reduction, external fixation/percutaneous fixation	270.75	2
57715	ORIF - one malleolus ***Note:*** *Injuries requiring opposite side soft tissue repairs (i.e. deltoid ligament repair with lateral malleolar fracture ORIF) are payable under 57716.*	352.44	2
57716	ORIF - two or more	406.12	2
57718*	Open injury, primary wound care (operation only)	102.26	2
57719*	Open injury, secondary wound management	186.72	2
	Hindfoot/Midfoot/Lisfranc Dislocation with or without Fracture		
57721*	Closed reduction without GA, cast (operation only)	93.37	2
57722*	Closed reduction, with GA, cast	186.72	2
57723	Closed reduction, fixation	298.77	2
57725	Open reduction with or without internal fixation	520.00	2
57728*	Open injury, primary wound care (operation only)	102.26	2
57729*	Open injury, secondary wound management	186.72	2
	Os Calcis Fracture		
57732*	Closed reduction, with GA, cast	186.72	2

		$	Anes. Level
57733	Closed reduction, fixation	298.77	2
57735	ORIF	670.00	2
57738*	Open injury, primary wound care (operation only)	102.26	2
57739*	Open injury, secondary wound management	186.72	2
57749*	Open injury, secondary wound management	186.72	2

Tibial Metaphysis (Distal), Ankle and Foot (cont'd)

	Talus Fracture		
57741*	Closed reduction, without GA, cast (operation only)	93.37	2
57742*	Closed reduction, with GA, cast	186.72	2
57743	Closed reduction, fixation	326.77	2
57745	ORIF	550.00	2
57748*	Open injury, primary wound care (operation only)	102.26	2
	Tarsal Fracture		
57751*	Closed reduction, without GA, cast (operation only)	93.37	2
57752*	Closed reduction, with GA, cast	186.72	2
57753	Closed reduction, fixation	298.77	2
57755	ORIF	326.77	2
57758*	Open injury, primary wound care (operation only)	102.26	2
57759*	Open injury, secondary wound management	186.72	2
	Note: *Multiple tarsal fractures are payable under hind/mid foot Lisfranc dislocation with or without fracture items 57721 to 57729.*		
	Metatarsal Fractures		
57761	Closed reduction, fixation	270.75	2
57765	ORIF - one	298.77	2
57766	ORIF - two or more	352.44	2
57768*	Open injury, primary wound care (operation only)	102.26	2
57769*	Open injury, secondary wound management	186.72	2
	Metatarso-Phalangeal Dislocation		
57771*	Closed reduction, without GA, cast, single or multiple (operation only)	93.37	2
57772*	Closed reduction, with GA, cast, single or multiple	186.72	2
57773	Closed reduction, fixation, single or multiple	214.73	2
57775	ORIF	298.77	2
57778*	Open injury, primary wound care (operation only)	102.26	2
57779*	Open injury, secondary wound management	186.72	2
	Phalangeal Fracture		
57781	Closed reduction, fixation, single or multiple	270.75	2
57785	ORIF	298.77	2
57788*	Open injury, primary wound care (operation only)	51.13	2
57789*	Open injury, secondary wound management (operation only)	93.37	2
	Interphalangeal Dislocations with or without Fracture		
57791*	Closed reduction, without GA, cast, single or multiple (operation only)	46.68	2
57792*	Closed reduction, with GA, cast, single or multiple	186.72	2
57793	Closed reduction, fixation, single or multiple	270.75	2
57795	Open reduction with or without fixation	298.77	2
57798*	Open injury, primary wound care (operation only)	51.13	2

		$	Anes. Level
57799*	Open injury, secondary wound management (operation only)	93.37	2
	Manipulation: Ankle/Foot:		
S57800*	Manipulation, with GA	93.37	2

Tibial Metaphysis (Distal), Ankle and Foot (cont'd)

	Arthrodesis:		
57810	Tibiocalcaneal	597.51	2
57811	Pantalar	840.26	2
57812	Ankle joint	718.88	3
57813	Subtalar joint/triple	800.00	2
57814	Midtarsal joint	615.00	2
57815	Tarso-Metatarsal joints	658.20	2
57816	Metatarsophalangeal	410.00	2
57817	Interphangeal, single or multiple	270.75	2
	Amputation:		
57980	SYME	532.14	2
57981	Midtarsal	490.15	2
57982	Transmetatarsal	406.12	2
57983	Single metatarsal/ray resection	354.78	2
57984	Toe	186.72	2
57998*	Open injury, primary wound care (operation only)	51.13	2
57999*	Open injury, secondary wound management (operation only)	93.37	2

Vertebra, Facette and Spine

	Incision - Diagnostic, Percutaneous:		
SY00757	Aspiration - other joints	12.03	2
	Incision - Therapeutic, Percutaneous:		
58205*	Injection/aspiration facet joint	92.97	2
	Incision - Therapeutic, Drainage:		
51039	Aspiration – bursa (operation only)	23.23	
	Excision - Diagnostic, Percutaneous		
S11830	Needle biopsy - soft tissue/bone - thoracic spine, under GA	214.73	2
S11831	Needle biopsy - soft tissue/bone - lumbar spine, under GA	186.72	2
	Excision - Diagnostic, Open:		
11845	Biopsy, with GA ***Note**: Not payable with definitive spinal surgery.*	242.74	3
	Excision - Therapeutic, Open:		
	<u>Decompression - Posterior</u> Laminectomy:		
03155	- for hematoma, tumour or vascular malformation	1,202.45	6
03161	- for localized spinal stenosis (two levels or less)	789.13	5
03162	- for generalized spinal stenosis (more than two levels)	1,213.99	5
03160	- for congenital spinal malformation or tethered spinal cord	2,027.87	5
03180	Multiple level laminectomy for cervical cord compression, three or more levels	1,430.75	6

		$	Anes. Level
	Introduction and/or Removal, Therapeutic:		
S03167	Insertion of skull tongs (operation only)	126.29	4

Vertebra, Facette and Spine (cont'd)

	Fracture and/or Dislocation (Cervical Spine):		
	Cervical		
S03167	Insertion of skull tongs (operation only)	126.29	4
58710*	Application of Halo	186.72	4

Musculoskeletal Oncology

51051	Resection of subfascial malignant soft tissue tumour, simple	597.51	5
51052	Resection of subfascial malignant soft tissue tumour, complex (involvement of neuro/vascular structures)	1,279.05	6
51053*	Resection of malignant bone tumour limb, limb sparing.	1,083.01	6
51054	Reconstruction of skeletal defect following excision	1,092.35	6
51055	Resection of malignant girdle tumour, scapula	1,083.01	6
51056*	Resection of malignant girdle tumour, pelvis and/or sacrum.	1,624.50	6
51057	Reconstruction of shoulder/pelvis or sacrum	1,092.35	6
51058	Resection of malignant tumour, rotation plasty	2,175.33	6

Note: *Fee items 51053 to 51058. Reconstruction items are payable in full with the resection, if applicable.*

Minor Procedures

13610	Minor laceration or foreign body - not requiring anesthesia - operation only	35.84	

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	- requiring anesthesia - operation only	66.76	2
13630	Paronychia - operation only	35.75	2
13631	Removal of nail - simple operation only	35.75	2
13632	- with destruction of nail bed (operation only)	72.34	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	63.83	2

Peripheral Nerve

S03196	Exploration, mobilization and transposition	281.48	2
03198	Neurectomy of major nerve	222.43	2
S06258	Exploration of peripheral nerve and neurolysis	254.74	2

Note: *Multiple neurolyses are paid in accordance with Preamble Clause D. 5. 3. to a maximum of four Neurolyses per sitting.*

Spine

03152	Bischoff's or longitudinal myelotomy	936.10	5
03153	Laminectomy with DREZ lesion for pain	1,408.69	6
03155	Laminectomy for haematoma, tumour or vascular malformation	1,202.45	6
	Laminectomy for cervical disc:		

		$	Anes. Level
03156	- one level	2,003.94	6
03157	- multiple levels	2,204.84	6
	Laminectomy for lumbar disc:		
03158	- one level	670.94	5
03159	- multiple levels	1,323.50	5
03160	Laminectomy for congenital spinal malformation or tethered spinal cord	2,027.87	5
03161	Laminectomy for localized spinal stenosis (two levels or less)	789.13	5
03162	Laminectomy for generalized spinal stenosis (more than two levels)	1,213.99	5
03168	Laminectomy for intradural spinal cord or extra-medullary tumour or vascular malformation by micro-surgical technique	2,213.98	7
03180	Multiple level laminectomy for cervical cord compression, 3 or more levels	1,430.75	6
03163	Anterior cervical discectomy and fusion - one level	1,429.88	6
03164	- multiple levels	1,936.16	6
03166	Removal of thoracic disc	2,349.45	8
03185	Postero-lateral microsurgical thoracic discectomy	1,915.56	8
S03167	Insertion of skull tongs (operation only)	126.29	4
03169	Fracture of spine without cord injury - open reduction and fusion	686.74	7
03231	Repair of spinal CSF leak or pseudomeningocoele	698.96	5

Skin Grafts

Note: *Additional procedures, other than skin grafts, are extra; e.g.: bone or tendon grafts, inlay grafts, etc.*

Local tissue shifts: *Advancements, rotations, transpositions, "Z" plasty, etc.*

	Hand and Wrist, Incision; Open:		
06051	Finger tip (operation only)	310.00	2
06050	Regions of major joints and hands - early	440.00	2
	Hand and Wrist, Excision; Therapeutic, Open:		
V07055	Ganglia - of the wrist	250.00	2

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)	550.00	5
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	294.65	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	117.87	
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	261.93	4
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	130.96	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	288.10	4

		$	Anes. Level
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	144.06	
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 ***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.* *iii) Applicable with or without anesthesia.*	78.57	
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) ***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.*	125.72	4

PEDIATRICS

		$	Anes. Level

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

Referred Cases

00510 **Consultation:** To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 241.36

00550 **Extended Consultation –** exceeding 53 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 331.08

Notes:

i) Applicable to patients with chronic and complex medical needs.

ii) Not payable in addition to 00510, 00511, 00512, 00551, 50510, 50511, 50512, 50515 or 50516.

iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

00551 **Extended Consultation** – exceeding 68 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report..... 393.05

Notes:

i) Applicable to patients with chronic and complex medical needs.

ii) Not payable in addition to 00510, 00511, 00512, 00550, 50510, 50511, 50512, 50515 or 50516.

iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

00511 **Consultation** — for complex behavioural, developmental or psychiatric condition in a child**:** To consist of a physical and neurological examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report..... 452.52

Notes:

i) Not to be billed when no change in condition from previous assessment.

ii) Minimum time requirement for service is 1.5 hours – with at least 60 minutes being face-to-face time with patient.

iii) Start and end times for the face-to-face time must be entered in both the billing claims and the patient's chart.

iv) Developmental delays include, but are not limited to: non verbal learning disability, developmental reading disability, developmental coordination disability, developmental writing disability, dsycalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.

v) Includes collection of data from collateral sources and formal screening, as appropriate.

00590 Antenatal Consultation to consist of an appropriate examination, review of history, laboratory imaging studies, and additional visits necessary to render a written report 141.41

***Note**: Payable in cases of prematurity or fetal anomaly.*

00512 **Repeat or limited consultation:** Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee..... 103.39

		$	Anes. Level
00585	Diabetic Ketoacidosis (DKA) – 1st day management – in hospital	461.81	

Notes:
i) Restricted to Pediatrics.
ii) Day 1 billing is to be used only when more than 2 hours of bedside care is provided.
iii) This fee includes all consultations, visits or critical care fees.

00514	Prolonged visit for counselling	90.32	

Notes:
i) The Plan will pay up to four such visits per year. (see Clause D. 3. 3. of the Preamble)
ii) Start and end times must be entered in both the billing claims and the patient's chart.

Group counselling for groups of two or more patients:

00513	- first full hour	125.40	
00515	- second hour, per 1/2 hour or major portion thereof	62.69	

Note:
i) Start and end times must be entered in both the billing claims and the patient's chart.

Continuing care by consultant:

00506	Directive care	104.16	
00507	Subsequent office visit	91.04	
00552	Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient)	103.20	

Notes:
i) Applicable to patients with chronic and complex medical needs.
ii) Includes review of extensive documentation regarding the patient.
iii) Not payable in addition to 00507, 00553, 00554, 50507, 50517, 50518, or 50519.
iv) For time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.

00553	Extended subsequent office visit – exceeding 23 minutes (at least 20 minutes spent with patient)	158.48	

Notes:
i) Applicable to patients with chronic and complex medical needs.
ii) Includes review of extensive documentation regarding the patient.
iii) Not payable in addition to 00507, 00552, 00554, 50507, 50517, 50518 or 50519.
iv) For time spent with the patient, start and end times must be submitted with claim and recorded in the patient's chart.

00554	Extended subsequent office visit – exceeding 38 minutes (at least 30 minutes spent with patient)	230.94	

Notes:
i) Applicable to patients with chronic and complex medical needs.
ii) Includes review of extensive documentation regarding the patient.
iii) Not payable in addition to 00507, 00552, 00553, 50507, 50517, 50518, or 50519.
iv) For the time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.

		$	Anes. Level
00597	Antenatal follow-up visit ***Note**: Payable in cases of prematurity or fetal anomaly.*	37.28	
00508	Subsequent hospital visit	104.16	
00509	Subsequent home visit	153.94	
00505	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) ***Notes:*** *i) Claim must state time service rendered.* *ii) For premature care or intensive care of a newborn (see Clauses D. 4. 5., D. 4. 6., D. 4. 7., and D. 4. 8. of the Preamble).*	127.35	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
50510	Telehealth Consultation: To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	241.36	
50515	Telehealth Extended Consultation – exceeding 53 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report ***Notes:*** *i) Applicable to patients with chronic and complex medical needs.* *ii) Not payable in addition to 00510, 00511, 00512, 00550, 00551, 50510, 50511, 50512, or 50516.* *iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.*	331.08	
50516	Telehealth Extended Consultation – exceeding 68 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report ***Notes:*** *i) Applicable to patients with chronic and complex medical needs.* *ii) Not payable in addition to 00510, 00511, 00512, 00550, 00551, 50510, 50511, 50512, or 50515.* *iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.*	393.05	
50511	Telehealth Consultation for complex behavioural, developmental or psychiatric condition in a child: To consist of a physical and neurological examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report ***Notes:*** *i) Not to be billed when no change in condition from previous assessment.* *ii) Minimum time requirement for service is 1.5 hours.* *iii) Start and end times must be entered in both the billing claims and the patient's chart.* *iv) Developmental delays include, but are not limited to: non-verbal learning disability, developmental reading disability, developmental coordination, disability, developmental writing disability, dsycalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.* *v) Includes collection of data from collateral sources and formal screening, as appropriate.*	452.52	

		$	Anes. Level
50512	Telehealth repeat or limited consultation: Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	103.39	
50514	Telehealth prolonged visit for counselling ***Notes:*** *i) The Plan will pay up to four such visits per year. (see Clause D. 3. 3. of the Preamble)* *ii) Start and end times must be entered in both the billing claims and the patient's chart.*	90.32	
50506	Telehealth directive care	104.16	
50507	Telehealth subsequent office visit	91.04	
50517	Telehealth Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient) ***Notes:*** *i) Applicable to patients with chronic and complex medical needs.* *ii) Includes a review of extensive documentation regarding the patient.* *iii) Not payable in addition to 00507, 00552, 00553, 00554, 50507, 50518, or 50519.* *iv) For time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.*	103.20	
50518	Telehealth Extended subsequent office visit – exceeding 23 minutes (at least 20 min. spent with patient) ***Notes:*** *i) Applicable to patients with chronic and complex medical needs.* *ii) Includes a review of extensive documentation regarding the patient.* *iii) Not payable in addition to 00507, 00552, 00553, 00554, 50507, 50517, or 50519.* *iv) For time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.*	158.48	
50519	Telehealth Extended subsequent office visit – exceeding 38 minutes (at least 30 min. spent with patient) ***Notes:*** *i) Applicable to patients with chronic and complex medical needs.* *ii) Includes a review of extensive documentation regarding the patient.* *iii) Not payable in addition to 00507, 00552, 00553, 00554, 50507, 50517, or 50518.* *iv) For time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.*	230.94	
50508	Telehealth subsequent hospital visit	104.16	

Miscellaneous

50571	Pediatric evening surcharge (service rendered between 1800 hours and 2300 hours)	34.21	
50572	Pediatric Saturday, Sunday, and Statutory Holiday surcharge (service rendered between 0800 hours and 2300 hours)	34.21	
50573	Pediatric night surcharge (service rendered between 2300 hours and 0800 hours) ***Notes:*** *i) Restricted to Pediatrics and Pediatric Cardiology.* *ii) Payable only in addition to fee items 00510, 00550, 00551, 00585, 01511, 01512, and 01513.*	105.51	

iii) Payable only in addition to out-of-office premiums (01200, 01201, 01202, 01205, 01206, 01207)
iv) Not applicable to full or part-time onsite practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.

00545 Pediatric Case Conference – a formal, scheduled session/meeting to discuss/plan medical management of patients with serious and complex pediatric problems. Payable only when coordination of care and two-way collaborative conference with community agency representative and/or health care provider is required e.g.: psychologists, counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry – per ¼ hour or major portion thereof.....78.64

Notes:
i) Patient must be 18 years of age or younger.
ii) For services related to:
a) psychiatric disorders
b) developmental disorders
c) major chronic disease
d) pre-transplant (concerning donor/recipient assessment*)*
e) end of life
f) multiple medical handicaps
iii) Maximum of one hour may be claimed per patient per day.
iv) Not to exceed a maximum of four hours per patient per year.
v) The case conference must last at least 15 minutes to submit a claim.
vi) The results of the case conference must be recorded in the patient's chart along with the start and end times of the conference, as well as the names and job titles of the other participants at the meeting.
vii) This fee is not payable to physicians who are employed or who are under contract to a facility, agency or program (ie: Ministry of Children and Families' FAS, autism and child abuse or neglect assessments, HEAL, health authorities) who otherwise would have attended the conference as a requirement of their employment with the facility, agency or program.
viii) This fee is payable when the care conference occurs in person, by phone, or by videoconference.
ix) A visit or consult may be payable for the same patient on the same day as a case conference, provided the two items are consecutive, not concurrent, and start and end times are provided for both. A note record must be submitted for consults and patient management conferences occurring on the same day.
x) It may not be claimed unless the pediatrician has a pre-existing relationship with the patient.
xi) Not payable within 3 months of fee item 00511 without a note record explaining the medical necessity.
xii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed under the PHN of each patient for the specific time period.
xiii) Start and end times must be included in time fields.

Special Procedures

00525 Insertion of intra-arterial infusion line in infants - extra to consultation 95.69
00523 Exchange transfusion - procedural fee.....458.60

Notes:
i) Charge full fee for all repeat transfusions.
ii) Normally an assistant for exchange transfusion is not required. However, in those exceptional cases when an assistant is required, an explanation of need must accompany the account to the payment agency.
iii) Paid at 50% when billed in conjunction with critical care codes.
iv) Not applicable to replacement of blood with saline for hyperviscosity syndrome.

		$	Anes. Level
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	57.24	
	Electrocardiogram and interpretation:		
00527	- office (each)	34.94	
00528	- home (each)	48.57	
	Electrocardiogram:		
00529	- professional fee	12.23	
	The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:		
93120	E.C.G. tracing, without interpretation, (technical fee)	16.97	
	Graded exercise test:		
00530	- technical fee	43.12	
00535	- professional fee	62.91	
00531	- total fee	106.05	
	Note: *The notes following fee items 33034, 33035 and 33036 in the Cardiology section of this Schedule apply to items 00530, 00531, and 00535.*		
00532	Electrocardiogram and interpretation for children under 2 years of age	57.24	
00533	- interpretation	13.43	
00534	- technical fee	43.81	
00539	Rectal suction biopsy in children	106.34	
00540	24 hour intraoesophageal pH study in children (to include probe and monitoring)	245.54	
SY00541	Pediatric urethral catheterization in child under 5 years – isolated procedure	19.91	

Notes:

i) Procedure not payable if delegated to a non-physician.

ii) Not payable with critical care listings or diagnostic urological procedures (e.g.: voiding cystourethrogram.)

iii) Restricted to Pediatricians.

Chemotherapy

a) Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.

b) Hospital visits are not payable on the same day.

c) Visit fees are payable on subsequent days, when rendered.

d) A consultation, when rendered, is payable in addition to fee item 00578, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.

e) The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.

00578	High Intensity Cancer Chemotherapy for patients 16 years of age and under: To include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis	243.26	

Notes: *This service is not payable more frequently than once every 28 days.*

The following treatments fall into this category:

a) chemotherapy for acute leukemia.

		$	Anes. Level
	b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment. *c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna.* *d) chemotherapy using DTIC in a dose exceeding 100 mg/m2.* *e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen).* *f) Chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol.)*		
00579	Major Intensity Cancer Chemotherapy for patients 16 years of age and under: To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents	187.96	
	***Note**: This service is not payable more frequently than once every 7 days.*		
00580	Limited Intensity Cancer Chemotherapy for patients 16 years of age and under: To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line	110.56	
	***Note:** This service is not payable more frequently than once every 7 days. Neither is it to be billed for routine IV push administration of 5-flourouracil as a single agent.*		

Diagnostic Procedures

	Puncture procedures for obtaining body fluids (when performed for diagnostic purposes):		
SY00750	Lumbar puncture in a patient 13 years of age and over	55.28	2
	***Note:** Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*		
SY00570	Lumbar puncture in a patient 12 years of age and younger	82.92	2
	***Note:** Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*		
S00755	Artery puncture - procedural fee	6.41	2
S00571	Pediatric Oesophagogastroduodenoscopy in a patient 16 years of age and under	199.00	3
	***Note:** Restricted to Pediatricians.*		
S00572	Pediatric colonoscopy with flexible colonoscope – patients 16 years of age and under	364.86	2
	Notes: *i) Includes biopsies, removal of polyps, collection of specimens by brushing or washing, control of bleeding, removal or foreign body, if required.* *ii) Restricted to Pediatricians.*		
S50520	Pediatric right heart catheterization – patients 0 – 6 years of age	358.82	4
	***Note:** Restricted to BC Children's Hospital.*		

		$	Anes. Level
S50521	Pediatric right heart catheterization – patients 7 – 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	269.10	4
S50522	Pediatric myocardial biopsy for ages 0-16 years of age, extra ***Notes:*** *i) Payable once per session, regardless of number of biopsies performed.* *ii) Payable only to Pediatric Cardiologists at BC Children's Hospital.* ***iii)*** *Only paid in addition to fee item S50520 or S50521.*	103.08	
S50527	Pediatric retrograde left heart catheterization, extra – patients 0 – 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	286.99	4
S50528	Pediatric retrograde left heart catheterization, extra – patients 7 – 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	215.22	4
S50530	Pediatric trans-septal left heart catheterization – patients 0 – 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	386.73	4
S50531	Pediatric trans-septal left heart catheterization – patients 7 – 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	290.05	4
S50539	Pediatric percutaneous transluminal coronary angioplasty – patients 0- 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	816.85	4
S50540	Pediatric percutaneous transluminal coronary angioplasty – patients 7- 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	612.64	4
S50541	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 0 – 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	430.62	4
S50542	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 7– 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	322.96	4
S50545	Pediatric therapeutic radiological embolization – patients 0 – 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	749.01	3
S50546	Pediatric therapeutic radiological embolization – patients 7 – 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	561.78	3
50550	Percutaneous cardiac stenting in pediatric patients (0 – 18 years of age) - composite fee (operation only) ***Notes:*** *i) Applicable to placement of stents in vena cava, pulmonary or coronary arteries and veins and aorta.* *ii) Includes all necessary diagnostic imaging, right and left heart catheterization,all necessary angiograms and/or angioplasty, coronary or elsewhere and stent implantation to include any declotting or treatment of underlying cause of access failure.* *iii) Not payable with fee items 00898 and 00871. This composite also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance.* *iv) Payable to Pediatricians only.*	1,050.37	7

		$	Anes. Level
	v) Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.		
50551	Additional stents – extra	221.14	
	Notes:		
	i) Must be inserted into a differently named, non-contiguous vessel (provide information in note record).		
	ii) Maximum payable is 2 additional stents.		
50555	Percutaneous transcatheter cardiac occluder device closure of ASD in pediatric patients (0 – 18 years of age) – composite fee (operation only)	1,050.37	7
	Notes:		
	I) Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary angiograms and/or angioplasty, coronary or elsewhere and stent implementation to include any declotting or treatment of underlying cause of access failure.		
	ii) Not payable with fee item 00871. This composite fee also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance.		
	iii) Payable to Pediatricians only.		
	iv) Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.		

Neonatal Intensive Care

Please refer to the Critical Care Section of the Payment Schedule for Preamble rules and billing guidelines applicable to appropriate billing of the critical care fees.

These listings may be used for patients receiving neonatal intensive care and are intended for use by the Neonatologist or Pediatrician (or Team) in charge of the patient. These listings may be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment such as ventilatory support, haemodynamic support including vasoactive medications or prolonged resuscitation. They are to be billed only on sick or preterm infants requiring intensive care. They are also for infants who are more than 28 days old, who have neonatal problems related to prematurity, etc. These listings do not apply to non-ventilated stable patients admitted to a special care unit for routine post-op care. These fees are not for the infant who is stable and only requiring a period of observation. Neither are they for the infant who needs a short course of prophylactic antibiotics. It would be unusual to bill these fees on an infant whose period of care in the NICU lasted less than 48 hours Consultation and visit fees would be appropriate.

These neonatal intensive care fees only apply to physicians who are directly involved in the bedside care of patients in the Critical Care Areas. “Preamble to the Payment Schedule” applies:

“C. 18. Guidelines for Payment for Services by Trainees, Residents and Fellows

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the supervising medical practitioner shall be identified to the patient at the earliest possible moment. No fees may be charged in the name of the supervising staff physician for services rendered by a trainee, resident or fellow prior to the identification taking place. Moreover, the supervising staff physician must be available in person, by telephone or videoconferencing in a timely manner appropriate to the acuity of the service being supervised.

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of trainees, residents, fellows or other members of the team, the total billings must not exceed the

amount that a medical practitioner could bill in the same time period in the absence of the other team members. For example:

a) If an anesthesiologist is supervising two rooms simultaneously, the anesthetic intensity/complexity units should only be billed for one of the two cases.

b) If a surgeon is operating in one room while his/her resident is operating in a second room, charges should only be made for the case the surgeon performs.

c) In psychotherapy where direct supervision by the staff physician may distort the psychotherapeutic milieu, the staff physician may claim for psychotherapy when a record of the psychotherapeutic interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff physician should not exceed the lesser of the time spent by the resident in the psychotherapeutic interview or the staff physician in the supervision of that interview.

d) For hospital visits and consultations rendered by the resident in the name of the staff physician, the staff physician should only charge for services on the days when actual supervision of that patient's care takes place through a physical visit to the patient by the staff physician and/or a chart review is conducted with detailed discussion with the other members of the health team within the next weekday workday.

e) The supervising physician may not bill for out-of-office hours premiums or continuing care surcharges unless he/she complies with the explanatory notes for out-of-office hours premiums in the Payment Schedule/Fee Guide and personally attends the patient.

f) In order to bill for a supervised service the physician must review in person, by telephone or videoconferencing the service being billed with the trainee, resident or fellow and have signed off within the next weekday workday on the ER record, hospital chart, office chart or some other auditable document."

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included are: family counselling, emergency resuscitation, insertion of arterial, venous, Swan-Ganz, CVP or urinary catheters, intravenous lines, interpretation of blood gases, insertion of nasogastric tubes, infusion of pharmaceutical agents including TPN, endotracheal intubation and artificial ventilation and all other necessary respiratory support.

Exchange transfusion is not included in these fees and not all infants requiring an exchange transfusion are critically ill.

Out-Of-Office Hours Call-out Charges may still apply for special calls back to the hospital and may be billed in conjunction with a no charge visit. If a patient is discharged from the unit for more than 48 hours and is readmitted, second day rates again apply. If the patient is re-admitted within 48 hours of discharge, billing continues under fee code billed at discharge, unless acuity level changes. If a patient changes acuity level up or down then the appropriate second day rate applies. A note record is required indicating the change in acuity level. Fee item 00505 (Emergency Visit) may not be billed by the person claiming these fees.

Call-out charges are billable with the neonatal critical care fee items. Historically, these have not been included in the neonatal fees and may be billed separately.

Members of the team billing the Neonatal Guide can not be receiving other payments (e.g.: fees, alternative or sessional payments) for the clinical care of the patient.

		$	Anes. Level
	LEVEL A - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all necessary procedures.		
01511	Day 1	636.75	
01521	Day 2 - 10	254.68	
01531	Day 11 onward	169.83	
	LEVEL B - Infants in a Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive and requiring IV therapy or parenteral alimentation but without ventilator support.		
01512	Day 1	466.99	
01522	Day 2 - 10	169.83	
01532	Day 11 onward	126.18	
	LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.		
01513	Day 1	403.28	
01523	Day 2 - 10	124.63	
01533	Day 11 onward	104.16	

PSYCHIATRY FEE GUIDE - PREAMBLE

1. Time Units

Some psychiatry fee item descriptions specify nominal time units of 15/30/45/60 minutes. For these listings to be applicable, the psychiatrist must spend at least 12.5 out of each 15 minutes actually engaged in the designated activity for that fee (ie., 25 out of 30 minutes, 37.5 out of 45 minutes, 50 out of 60 minutes). The designated activities are:

Psychiatric Treatment, Family Therapy and Group Psychotherapy

- actual patient/group contact time;
- billing for individual therapy is permitted for only one person within a specified time frame;
- psychiatric treatment or counselling by telephone is not an insured service.
- psychoanalysis is not an insured benefit under the Plan.

Patient Management Conference

- actual meeting time

For all time-based out-patient claims, start and end times must be entered in both the billing claims and the patient's chart. In recognition of the nature of In-patient or Institutional psychiatry, the start time of the first patient seen and the end time of the last patient seen each day must be entered in both the billing claims and the patient's chart. Physicians must ensure that the patient's chart contains enough information about time spent with the patient and how this time was billed to allow independent confirmation that there is no overlap in reimbursement received from different payment modalities (e.g.: FFS, APP).

For example:

If a patient was seen on five occasions for between five and ten minutes at 8:30 (10 min), 9:45 (5 min), 10:00 (5 min), 11:00 (10 min) and 11:30 (5 min), the claim could be appropriately submitted as 1 x 00650 as the total time was 35 minutes. However, any other claims from the same physician for services provided between the hours of 8:30 and 11:35 (all payment modalities) cannot exceed a total of the balance of time of 2 hours and 30 minutes.

Like other specialists with possible Alternative Payment Plan (APP) funding, there must not be any time overlap in fee items billed by psychiatrists under FFS and APP/sessional contract or arrangements (see also General Preamble C. 24.).

2. Psychiatric Treatment

Psychiatric Treatment is defined as a series of medical interventions carried out by a psychiatrist trained to treat mental, emotional, and psychosomatic illness through a relationship with the patient in an individual, group, or family setting, utilizing verbal or non-verbal communication with the patient.

Psychiatric Treatment always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drug and other physical treatments. Psychiatric Treatment/Group Psychotherapy recognizes that the psychological and physical components of an illness are intertwined and that at any point in the disease process psychological symptoms may give rise to, substitute for, or run concurrently with physical symptoms and vice versa.

Family/Conjoint Therapy and Group Psychotherapy are defined as Psychiatric Treatment rendered to a family or other group.

Where a therapy session extends beyond one hour in a day, a written explanation of need is required by the Plan. Typical situations are:

a) patient is from out of town,
b) emergency or like situations,
c) extended time required due to nature of clinical problem (explanation needed in each such case),
d) a particular type of psychiatric therapy is being rendered, requiring extended sessions.

Approval from the Plan will be necessary in each such case.

Psychiatric treatment/psychotherapy sessions in excess of two hours in any one week require an explanation of need to the Plan and approval from the Plan in each such case. Typical situations are:

a) patient is from out of town;
b) emergency or like situation;
c) patient in an acute care facility.

3. Prolonged Time-Intensive Psychiatric Treatment

The BC Psychiatric Association has adopted the following principle:

Due to the unmet demand for psychiatric services, prolonged time-intensive psychiatric treatment must be provided only to the extent that it is justified and cost-effective in the context of limited psychiatric treatment resources and waiting lists.

4. Rural Retention Program Premium Adjustments

The Rural Retention Program applies a fee premium based on a community's isolation points. This fee premium is adjusted for Psychiatric fee codes by a factor of 1.782.

PSYCHIATRY

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

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Referred Cases

Full Consultations

Individual: Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report:

00610	Private office or hospital out-patient	252.38
00611	Extended Adult Psychiatry Consultation > 68 minutes	336.50

Notes:

i) Payable only to patients 18 years of age and older.

ii) Start and end times must be entered in both the billing claims and the patient's chart.

00615	Hospital/institution in-patient or home	252.38
00613	Geriatric consultation (patients 75 years or older)	381.57
00622	**Emotionally disturbed child:** Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian, or other relatives and written report	450.67
00623	**Multiple disturbed family (three or more members)**: Simultaneous diagnostic interviews or examination, including mental status of the members, their interactions, and written report	450.67

Repeat or Limited Consultations

Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee:

00625	Individual (see 00610 and 00615)	133.70
00614	Geriatric (see 00613)	190.79
00626	Emotionally disturbed child (see 00622)	225.34
00627	Multiple disturbed family (see 00623)	225.34

Continuing care by consultant:

Psychiatric Treatment

00607	Office visit to include services such as chemotherapy management and/or minimal psychotherapy	56.23
00608	Hospital visit	56.23
00609	Home visit	75.32
00605	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	147.13

Note: *Claim must state time service rendered.*

Individual (office or hospital out-patient):

00630	- per 1/2 hour	110.48
00631	- per 3/4 hour	165.26
00632	- per 1 hour	219.74

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

		$
	Individual (hospital or institution in-patient or home):	
00650	- per 1/2 hour	110.48
00651	- per 3/4 hour	165.26
00652	- per 1 hour	219.74

Note: *The start time of the first patient seen and the end time of the last patient seen each day must be entered in the billing claims and the patient's chart should have sufficient documentation around the timing of the patient interaction (See Psychiatry Preamble 1.).*

	Family/Conjoint Therapy - (two or more family members):	
00633	- per 1/2 hour	110.48
00635	- per 3/4 hour	165.26
00636	- per 1 hour	219.74
00638	- per 1 ¼ hour	274.67
00639	- per 1 ½ hour	329.61

Notes:

i) Start and end times must be entered in both the billing claims and the patient's chart.

ii) A note record is required for sessions longer than one hour.

Group Psychotherapy

	Fee per patient, per 1/2 hour:	
00663	Three patients	54.86
00664	Four patients	43.01
00665	Five patients	35.91
00666	Six patients	31.17
00667	Seven patients	27.78
00668	Eight patients	25.25
00669	Nine patients	23.27
00670	Ten patients	21.69
00671	Eleven patients	20.40
00672	Twelve patients	19.32
00673	Thirteen patients	18.42
00674	Fourteen patients	17.63
00675	Fifteen patients	16.95
00676	Sixteen patients	16.36
00677	Seventeen patients	15.84
00678	Eighteen patients	15.37
00679	Nineteen patients	14.96
00680	Twenty patients	14.59
00681	Greater than 20 patients (per patient)	14.26

Notes:

i) A separate claim should be submitted for each patient.

ii) Where two co-therapists are involved in a group of eight or more patients, the group should be divided for claims purposes, with each co-therapist claiming the appropriate rate per patient for the reduced group size. Each claim should indicate "co-therapy" and also identify the other co-therapist.

iii) Where a group psychotherapy session extends beyond two hours or involves more than 20 patients, a written explanation of need is required by the Plan.

iv) Start and end times must be entered in both the billing claims and the patient's chart.

		$
	Telehealth Service with Direct Interactive Video Link with the Patient:	
	Full Telehealth Consultations:	
60610	Telehealth individual full consultation: Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report.	252.38
60613	Telehealth Geriatric consultation (patients 75 years or older)	381.57
60622	Telehealth consultation - Emotionally disturbed child: Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian, or other relatives and written report	450.67
	Repeat or Limited Telehealth Consultations:	
	Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	
60625	Telehealth - Individual consultation	133.70
60614	Telehealth - Geriatric consultation	190.79
60626	Telehealth - Emotionally disturbed child	225.34
	Telehealth Psychiatric Treatment:	
60607	Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy	56.23
60608	Telehealth hospital in-patient visit	56.23
	Individual Telehealth Psychiatric Treatment:	
60630	- per 1/2 hour	110.48
60631	- per 3/4 hour	165.26
60632	- per 1 hour	219.74

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

	Family/Conjoint Telehealth Therapy - (two or more family members):	
60633	- per 1/2 hour	110.48
60635	- per 3/4 hour	165.26
60636	- per 1 hour	219.74
60638	- per 1 ¼ hour	272.67
60639	- per 1 ½ hour	329.61

Notes:

i) Start and end times must be entered in both the billing claims and the patients' chart.

ii) A note record is required for sessions longer than one hour.

	Telehealth – Miscellaneous:	
60624	Telehealth Clinical evaluation/ interview of family member/close acquaintance/knowledgeable professional involved in the patient's care – per 15 minute or greater portion thereof	55.24

Notes:

i) When not the direct interactive focus of the interview, the patient may be present (e.g.: child or geriatric patient).

ii) Payable in addition to other services when performed consecutively, not concurrently.

iii) Maximum of one hour (4 units) may be claimed per patient per day.

iv) This fee is payable when the interview occurs in person or by telephone.

v) Start and end times must be included in the time fields.

		$
60645	Telehealth Patient Management Conference - meeting by specific appointment to discuss/plan patient management with third parties, including referring physicians or allied hospital staff (if an inpatient) or relatives, and/or community agency representatives/providers including psychologists, counsellors, case managers, home or specialty-care nurses, social workers or other medical specialists or family practitioners - per 15 minutes or major portion thereof.	55.24

Notes:

i) Not to exceed a maximum of four hours per patient per psychiatrist, per calendar year.
ii) A written record of the meeting must be maintained and/or a report generated by the psychiatrist.
iii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
iv) Not payable unless the patient has been seen by the Psychiatrist in the preceding 180 days.
v) Names and positions of other participants in the Patient Management Conference must be recorded in the patient's chart.
vi) Start and end times must be entered in both the billing claims and the patient's chart.

Miscellaneous

00624	Clinical evaluation/interview of family member/close acquaintance/knowledgeable professional involved in the patient's care – per 15 minutes or greater portion thereof	55.24

Notes:

i) When not the direct interactive focus of the interview, the patient may be present (e.g.: child or geriatric patient).
ii) Payable in addition to other services when performed consecutively, not concurrently.
iii) Maximum of one hour (4 units) may be claimed per patient per day.
iv) This fee is payable when the interview occurs in person or by telephone.
v) Start and end times must be included in the time fields.

00641	Electroconvulsive therapy	92.40
00645	Patient Management Conference - meeting by specific appointment to discuss/plan patient management with third parties, including referring physicians or allied hospital staff (if an inpatient) or relatives, and/or community agency representatives/providers including psychologists, counsellors, case managers, home or specialty-care nurses, social workers or other medical specialists or family practitioners - per 15 minutes or major portion thereof.	55.24

Notes:

i) Not to exceed a maximum of four hours per patient per psychiatrist, per calendar year.
ii) A written record of the meeting must be maintained and/or a report generated by the psychiatrist.
iii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
iv) Not payable unless the patient has been seen by the Psychiatrist in the preceding 180 days.
v) Names and positions of other participants in the Patient Management Conference must be recorded in the patient's chart.
vi) This fee is payable when the case conference occurs in person or by phone.
vii) Start and end times must be entered in both the billing claims and the patient's chart.

PHYSICAL MEDICINE AND REHABILITATION

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

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Referred Cases

01710 **Formal consultation**: To consist of examination, review of history, laboratory, X-ray findings, functional, social, and vocational appraisal, and additional visits necessary to render a written report 208.53

01712 **Repeat or limited consultation:** Where a formal consultation for the same illness is repeated at an interval within six months of the last visit by the consultant 110.93

01714 Prolonged visit for counselling (up to four annually. See Preamble, D. 3. 3.) 80.91
Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Group counselling for groups of two or more patients:

01713 First full hour 144.18
01715 Second hour, per 1/2 hour (or major portion thereof) 72.05
Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Continuing care by consultant:

01706 Directive care 95.74
01707 Office visit 106.60
01708 Hospital visit 71.52
01709 Home visit 150.00
01705 Emergency visit when specially called 107.90
(not paid in addition to out of office hours premiums)
Note: *Claim must state time service rendered.*

Telehealth Service with Direct Interactive Video Link with the Patient:

01770 Telehealth Formal consultation: To consist of examination, review of history, laboratory, X-ray findings, functional, social, and vocational appraisal, and additional visits necessary to render a written report 208.53

01772 Telehealth repeat or limited consultation: Where a formal consultation for the same illness is repeated at an interval within six months of the last visit by the consultant 110.93

01776 Telehealth directive care 95.74
01777 Telehealth office visit 106.60
01778 Telehealth hospital visit 71.52

Miscellaneous:

01728 Biofeedback for neurological and/or muscular retraining 21.33
Notes:
- *i) Payment for this listing is restricted to specialists certified in Physical Medicine.*
- *ii) This service must be performed by the physiatrist and is not payable if simply supervised or delegated.*
- *iii) Treatment sessions must be performed on a one-to-one basis and not in group sessions.*
- *iv) An office visit may not be billed in addition to 01728, or in lieu of 01728.*

		$
01730	Graded exercise test - technical fee	34.07
01731	- professional fee	49.73
01732	- total fee	83.79

Note: *The notes following fee items 33034, 33035 and 33036 in the Cardiology section of this schedule also apply to fee items 01730, 01731 and 01732.*

01721	Family rehabilitation conference where a certified specialist in Physical Medicine and Rehabilitation is involved with two or more members of the family - per 1/2 hour or greater portion thereof, to a maximum of two hours for any one rehabilitative case	90.66

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

PLASTIC SURGERY

Preamble

Complete understanding of the following paragraphs is essential to appropriate billing of the Plastic Surgery fees, but should be interpreted in the context of the General Preamble.

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

Definitions

"Ablation" means destruction of a lesion without excision.

"Advancement flaps" are adjacent tissue transfers based on extensive undermining and layered closure. The medical necessity for a flap or graft occurs when Direct Closure alone would not suffice due to unacceptable wound tension or local distortion. The distances required to be undermined are:

a. 1 cm – nose, ear, eyelid, lip, eyebrow
b. 1.5 cm – other face and neck
c. 3 cm – rest of body

"Complicated blepharoplasty" means skin removal and transgression (and occasional partial excision) of orbicularis oculi muscle, as well as at least one of: manipulation of the orbital septum, removal or repositioning of orbital fat, supratarsal fixation of the pre-tarsal skin to the upper tarsal plate.

"Direct closure" means approximation of wound/skin edges with minimal undermining. Simple ligation of vessels in an open wound is considered included in any wound closure.

"Excision" means a procedure involving removal of skin and/or subcutaneous tissue.

"Functional area" means head, face, neck, shoulder, axilla, elbow, wrist, hand, groin, perineum, knee, ankle, foot and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve).

"Incision" means a simple cut or puncture of skin and/or subcutaneous tissue for the purpose of aspiration, drainage, biopsy or extraction of a foreign body.

"Lesions:"

Benign Lesions

Destructive therapies of benign skin lesions are insured services when the treatment is medically necessary. Examples of medical necessity include but are not limited to the following indications:

i) genital warts (condylomata acuminata)
ii) plantar warts
iii) viral induced cutaneous tumours in the immune compromised patient
iv) inflamed dermal and epidermal cyst
v) dysplastic nevi
vi) lentigo maligna
vii) congenital nevi
viii) actinic (solar) keratosis
ix) atypical pigmented nevi
x) painful neurofibromata

The following are not a benefit of MSP, unless there is medically significant pathophysiological dysfunction:

i) excisions for the listed benign skin lesions
ii) benign nevi
iii) seborrheic keratosis
iv) common warts (verrucae)

v) *lipomata*
vi) *uncomplicated benign dermal and/or epidermal cysts*
vii) *telangiectasias and angiomata of the skin*
viii) *skin tags*
ix) *acrochordons*
x) *fibroepithelial polyps*
xi) *papillomata*
xii) *neurofibromata*
xiii) *dermatofibromata*

Premalignant Lesions:

i) *dysplastic nevus (nevus with dysplastic features, atypical melanocytic hyperplasia, atypical melanocytic proliferation, atypical lentinginous melanocytic proliferation or premalignant melanosis).*
ii) *actinic/solar keratosis*
iii) *chemical and other premalignant keratoses*
iv) *large cell acanthoma*
v) *erythroplasia of Queyrat*
vi) *leukoplakia and other in-situ lesions such as lentigo maligna, melanoma in-situ and Bowen's Disease and squamous cell carcinoma in-situ are considered malignant.*
vii) *locally invasive tumours are considered malignant lesions.*

Cutaneous Malignant lesions:

i) *basal cell carcinoma*
ii) *squamous cell carcinoma*
iii) *malignant melanoma*
iv) *lentigo maligna*
v) *dermatofibrosarcoma protuberans*
vi) *sebaceous carcinoma*
vii) *adnexal carcinoma*
viii) *atypical fibroxanthoma*
ix) *merkel cell carcinoma*
x) *eccrine carcinoma*
xi) *extramammary Paget's disease*
xii) *leiomyosarcoma*
xiii) *primary cutaneous adenocarcinoma*

"Local Flap closure" means skin and subcutaneous tissue is moved locally to close an adjacent defect.

"Minimal undermining" means less than 1 cm on the nose, ear, eyelid, lip; less than 1.5 cm on the rest of the face; or less than 3 cm for the rest of the body.

"Non-functional area" means posterior trunk, anterior trunk, arm (above elbow), forearm (below elbow), thigh, leg (below knee).

"Operation Only," means listings designated as "operation only," the in hospital post-operative visits within 14 days post-op may be claimed in addition to the surgical procedure with the exception of the visit(s) made the day of the procedure.

"Rotations, Transpositions, Z-plasties" are the same as advancement flaps with the addition of extra incisions required to create the shape the flap.

"Simple repair" of an excision means the wound is superficial (i.e. involving primary epidermis or dermis or subcutaneous tissue without significant involvement of deeper structures), and requires direct closure.

"Skin Flaps and Grafts" Unless otherwise noted, these include creation of the defect (debridement of tissue, excision of a lesion) and closure (creation and placement of flap or graft and the care of the donor site). When bone or tendon grafts or inlay grafts are required with skin flaps or grafts, they can be billed in addition.

“Simple blepharoplasty” means simple skin (and possible muscle) removal on the upper lid and involves only skin removal. “Significant blepharochalasia” is defined when the usual field is restricted within 20° of fixation above the horizontal meridian, due to excess upper eyelid skin or brow ptosis.

PLASTIC SURGERY

		$	Anes. Level

Referred Cases

06010	**Major consultation:** To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	98.50	
06012	**Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	48.27	
	<u>Continuing care by consultant</u>:		
06007	Subsequent office visit	25.43	
06008	Subsequent hospital visit	36.71	
06009	Subsequent home visit	80.00	
06005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	104.23	
66015	Pre-Operative Assessment ***Notes:*** *i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.* *ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.* *iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.* *iv) Maximum of one pre-operative assessment per patient per procedure.* *v) Only paid to the surgeon who performs the procedure.*	98.88	
	<u>Telehealth Service with Direct Interactive Video Link with the Patient:</u>		
66010	**Telehealth Major consultation**: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	98.50	
66012	**Telehealth repeat or limited consultation:** To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	48.27	
66007	Telehealth subsequent office visit	25.43	
66008	Telehealth subsequent hospital visit	36.71	

Skin and Subcutaneous Tissues

<u>Biopsy</u>

61291	Biopsy, not sutured	89.10	
61292	Biopsy, not sutured,multiples same sitting, maximum of four (extra) ***Notes:*** *i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.* *ii) Fee items 61291 and 61292 include the visit fee.* *iii) Paid with tray fee 00080 (once per patient per sitting, regardless of number of biopsies performed).*	25.02	

		$	Anes. Level
07025	Temporal artery biopsy (operation only)	155.00	2
07028	Biopsy of sural nerve – operation only	177.27	2
	Excision - Diagnostic, Open:		
11445	Open biopsy, hand or wrist	242.74	2
	Incisional or excisional biopsy, includes suture closure		
13600	Biopsy of skin or mucosa (operation only)	52.24	2
13601	Biopsy of facial area (operation only)	52.24	2
	Note: *Punch or shave biopsies which do not require sutures are not to be charged under fee items 13600 or 13601.*		
	Aspiration		
07041	Aspiration: abdomen or chest (operation only)	76.01	2
	Hand and Wrist Incision - Diagnostic, Percutaneous:		
S11402	Aspiration bursa, synovial sheath, etc	23.23	2
	Abscess – incision and drainage		
	Abscess:		
07059	- deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	81.46	2
07027	- under general anesthesia (operation only)	225.00	2
07061	- deep, post operative wound infection under general anesthesia (operation only)	225.00	2
07045	Anterior closed space abscess - operation only	101.44	2
13605	Opening superficial abscess, including furuncle operation only	44.76	2
	Pilonidal Cyst or Sinus		
70084	- incision and drainage abscess (operation only)	101.36	2
07685	- excision or marsupialization - operation only	277.43	2
	Hand and Wrist Abscess		
06028	Web space abscess - (operation only)	254.92	2
06029	- under general anesthetic (operation only)	290.00	2
06042	Mid palmar, thenar, and dorsal: subaponeurotic space abscess – (operation only)	254.92	2
06197	Acute tenosynovitis - finger - (operation only)	290.00	2
06198	- ulnar or radial bursa – (operation only)	290.00	2
13630	Paronychia - operation only	35.75	2

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)	550.00	5

		$	Anes. Level
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	294.65	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	117.87	
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	261.93	4
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	130.96	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	288.10	4
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	144.06	
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	78.57	
	Notes: *i) Payable when rendered at the bedside but only when performed by a medical practitioner.* *iii) Requires wound assessment and dressing change and may include VAC application.* *iii) 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)	125.72	4
	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.*		

Foreign Body and Minor Laceration

In cases where a foreign body was simply extracted but the wound was not closed bill 13610 (without anesthetic) or 13611 (with anesthetic)

06063	Removal of foreign body - requiring general anesthesia - operation only	250.72	2
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	35.84	
	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	66.76	2

Ablation

Abrasive Surgery

06112	Abrasive surgery - less than quarter face (operation only)	126.70	3
S06113	- between quarter and half-face	246.18	3
S06114	- full face	523.79	3

		$	Anes. Level

Ablation – Cryotherapy, curettage & electrosurgery

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) 31.72

Notes:

i) Payable to non-dermatologists only.

ii) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."

00218 Curettage and electrosurgery of skin carcinoma proven histopathologically (operation only) 61.38

00219 For each additional lesion – to a maximum of two additional lesions per day (operation only) 30.69

* *These items are subject to the general regulations covering surgical procedures.*

Laser Therapy

00235 Pulsed laser surgery of the face and/or neck, treatment area less than 50 cm^2 (operation only) 67.92 3

00236 Pulsed laser surgery of the face and/or neck, treatment area greater than or equal to 50 cm^2, or treatment of the eyelids with eye shield insertion (operation only) 101.87 3

00237 Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia 56.08

Notes:

(a) Only the following conditions qualify for payment under 00235, 00236, 00237:
- i) Port wine stains involving the face and/or neck.
- ii) Complicated superficial haemangiomas:
  - lesions interfering with function (vision, breathing or feeding).
  - lesions which are ulcerated, bleeding, or prone to infections Where standard wound care has failed.
- iii) Facial naevus of Ota
- iv) Disfiguring facial pigmentary anomalies (eg: segmental or systematized).

(b) Only the following types of lasers qualify for payment under 00235, 00236, 00237:
- i) Pulsed dye laser
- ii) Q-Switched Ruby laser
- iii) Q-Switched YAG laser

(c) Restricted to Dermatology and Plastic Surgery.

Special Case – Skin and Soft Tissue

06166 Excision of axillary sweat glands for hyperhidrosis - unilateral 325.14 4

Notes:

i) Direct closure included when open procedure used.

ii) Aggressive removal of apocrine sweat glands by any means.

V07053 Excision of nail bed, complete, with shortening of phalanx 137.99 2

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		$	Anes. Level
	Excision of skin and subcutaneous tissue of hidradenitis suppurativa:		
Note: Direct closure included.			
	Foreign Body:		
	Excision of skin and subcutaneous tissue of hidradenitis suppurative:		
07072	- axillary (operation only)	250.00	2
07075	- inguinal (operation only)	250.00	2
07076	- perianal (operation only)	250.00	2
07082	- perineal (operation only)	250.00	2
	Nail Surgery		
13631	Removal of nail - simple operation only	35.75	2
13632	- with destruction of nail bed (operation only)	72.34	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	63.83	2
	Ganglia		
06182	Ganglia of tendon sheath or joint	182.27	2
	Torn Ear Lobe		
06027	Repair of torn (split) earlobe (simple) (operation only)	118.31	3
	Notes: *i) Single flap only, under 2 cm.* *ii) Paid only for complete tear of lobe through margin.*		

Suture of Lacerations and Minor Traumatic Wounds

Wounds – Simple, or involving minor debridement of traumatic wounds

These fees apply to closure using tissue glue (included), direct closure with sutures (included) but not flap/graft (bill in flap/graft section for composite fee). For primary excision and direct closure of benign (medically necessary) and pre-malignant or malignant lesions, bill 61310 to 61318. These fee items are intended for linear/stellate wounds. In the case of wider degloving/abrasion, it is appropriate to bill 70155 to 70169 if wound debrided but left open or treated with Vacuum Assisted Closure (VAC).

S61300	- up to 5 cm – other than face, simple closure (operation only)	137.54	2
S61301	- up to 5 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)	203.77	2
S61302	- 5.1 to 10 cm - other than face, simple closure (operation only)	244.52	2
S61303	- 5.1 to 10 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)	254.72	2

		$	Anes. Level
S61304	- 10.1 to 15 cm - other than face, simple closure (operation only)	285.29	2
S61305	- 10.1 to 15 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)	356.60	2
S61306	- 15.1 cm or more - other than face, simple closure (operation only)	305.66	2
S61307	- 15.1 cm or more – on face and/or closure in layers (operation only)	407.55	2

Notes:

i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Multiples paid at 50%, to a maximum of 5 lacerations at the same sitting.
iii) Removal of sutures included in any visit fee.
iv) Not paid with skin flap or graft fees. (Per wound. Cannot bill flap and wound closure on same wound, but if one wound requires a flap/graft and second/third wounds require simple layered closure then existing 100%/50% billing applies as per Note ii above).
v) Direct closure paid when the procedure includes at least one deep layer of sutures and cyanoacrylate.
vi) Minor undermining (to help evert wound edges) is considered included.

61308	Laceration(s) under GA – if general anesthetic is used, and when suture of laceration(s) is the sole procedure – extra	203.77	2

Notes:

i) Restricted to Plastic Surgery, Orthopaedics.and Otolaryngology.
ii) Paid in addition to 61300-61307 and 61310-61322.

<u>Wounds - avulsed and complicated (in special areas)</u>

V70150	Complicated lacerations of tongue, floor of mouth	270.50	3
06238	Repair of complicated fingertip injury under digital block or anesthetic (regional/general)	201.05	2

Note: *Requires nail bed repair (includes removal of nail plate, suturing of nail bed laceration and replacement of nail plate) including associated management of distal phalangeal fracture*.

06075	Lips and eyelids	339.41	3
06076	Nose and ear	426.36	3
06077	Complicated lacerations of the scalp, cheek and neck	333.13	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
ii) Lacerations requiring layered closure <u>and</u> key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or
iii) Lacerations into the subcutaneous tissue requiring alignment <u>and</u> repair of cartilage <u>and</u> 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.*

		$	Anes. Level

Lesions and Scars

For medically necessary excision and/or repair of benign, pre-malignant and malignant lesions and scars, by direct closure, and resulting in linear closure:

Notes:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) First paid at 100%, 2nd to 5th – 50%. The maximum payable for benign and pre-malignant lesions is 5 per sitting. If additional (>5) malignant lesions are removed at the same sitting payment will be made at 25% of the listed fee. If more than 10 malignant lesions are removed at the same sitting a copy of the operative and pathology reports is required.
iii) Not paid with excision fees 61320, 61321, 61322.

Trunk, Arms and Legs

S61310	Resulting in repair less than 5 cm (operation only)	122.27	
S61311	Resulting in a repair 5 - 10 cm (operation only)	157.92	
S61312	Resulting in a repair greater than 10 cm (operation only)	234.35	

Face, scalp, neck, genitalia, hands, feet, axilla

S61313	Resulting in repair less than 5 cm (operation only)	169.13	
S61314	Resulting in repair 5 -10 cm (operation only)	224.15	
S61315	Resulting in repair greater than 10 cm (operation only)	275.10	

Eyelids, ears, lips, nose, mucous membrane, eyebrow

S61316	Resulting in repair less than 2 cm (operation only)	178.30	
S61317	Resulting in repair 2 - 4 cm (operation only)	213.97	
S61318	Resulting in repair greater than 4 cm (operation only)	290.38	
61319	For excision of lesion (in hospital), to achieve tumour-free margin with frozen section, (extra)	101.89	

Notes:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Paid once per sitting.
iii) Paid with 61310-61318, 61320-61322 and 61325-61341.

Skin Flaps and Grafts

Excision of Malignant and Pre-malignant Lesions

Note: For excision of malignant and pre-malignant lesions, when the recipient area requires skin flaps, full thickness grafts or split thickness grafts for closure, use the following fee items for excision in addition to the fees for skin flaps or grafts. For defects less than 10 cm^2 (3cm x 3cm), payment is made for closure only.

61320	Area 10-50 cm^2 (minimum 10 cm^2) – extra (operation only)	61.13	2
61321	Area 51-100 cm^2 (minimum 51 cm^2) – extra (operation only)	132.45	2
61322	Area over 100 cm^2 (minimum 101 cm^2) – extra (operation only)	183.40	2

Notes:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Not paid with direct linear closure fees (61310-61318).

		$	Anes. Level

iii) For areas ≥10 cm².
iv) Maximum 3 services paid per patient, per sitting, regardless of number performed.
v) Paid in addition to skin flaps, split-thickness graft or full-thickness grafts (where applicable).
vi) Paid with 61319 (when applicable).

Advancement flap fees

Notes:
i) These fees are for adjacent tissue transfers based on extensive undermining and layered closure. The medical necessity for a flap or graft occurs when direct closure alone would not suffice due to unacceptable wound tension. The distances required to be undermined are:
a. 1 cm (nose, ear, eyelid, lip, eyebrow)
b. 1.5 cm (other face and neck)
c. 3 cm (rest of body)
ii) Fee items 61324 to 61329 are restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
iii) These fees include creation and closure of the defect, except when 61320 to 61322 apply.

	Nose, Lids, Lips or Scalp:		
61324	- up to 2 cm (operation only)	185.44	2
61325	- 2.1 to 5 cm (operation only)	234.35	2
61327	- 5.1 to 10 cm (operation only)	355.27	2
	Other Areas:		
61326	- 2.1 to 5 cm (operation only)	182.38	2
61328	- 5.1 to 10 cm (operation only)	233.47	2
61329	- defects more than 10 cm (such as a thoracic abdominal flap)	393.85	2

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

Notes:
i) These flaps differ from advancement flaps in that they require skin incisions specifically to create the shape of the flap.
ii) Fee items 61330 to 61344 are restricted to Plastic Surgery, Orthopaedics and Otolaryngology.

	Trunk		
61330	Defect up to 40 cm²	243.61	2
61331	Defect 40 cm² to 100 cm²	324.82	2
61332	Defect greater than 100 cm²	423.66	2
	Arms, legs and scalp		
61333	Defect up to 6 cm²	305.76	2
61334	Defect 6 cm² to 19 cm²	346.00	2
61335	Defect greater than 19 cm²	458.84	2
	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck		
61336	Defect up to 6 cm²	305.76	2
61337	Defect 6 cm² to 19 cm²	346.78	2
61338	Defect greater than 19 cm²	469.01	2
	Ears, eyelids, lips and nose		
61339	Defect up to 6 cm²	347.03	2

		$	Anes. Level
61340	Defect 6 cm^2 to19 cm^2	457.92	2
61341	Defect greater than 19 cm^2	509.26	2
	Revision of Graft		
61342	Revision, less than 2 cm	203.01	2
61343	Revision, between 2 and 5 cm	243.61	2
61344	Revision, greater than 5 cm	284.22	2
	Specialized Flaps		
06026	Arterial island flap	353.91	2
06177	Neurovascular pedicle flap	744.43	3
	Flaps from a distance: for defects over 10 cm^2 requiring two stages (e.g.: groin flap, deltopectoral flap or cross leg flap):		
06030	Upper extremity – initial stage (with free skin graft) - over 10 cm^2	591.47	2
06031	– second stage - over 10 cm^2	471.50	2
06032	Lower extremity (plaster cast included) - initial stage - over 10 cm^2	710.26	2
	***Note**: Second stage for lower extremity paid at 50% (of 06032).*		
	Flaps from a distance for defects under 10 cm^2, requiring two stages (e.g.: cross finger flap, thenar flap for digital defects)		
06033	First stage - per operation (skin graft to secondary defect included) - under 10 cm^2	353.91	4
06034	Minor Second stage - per operation - under 10 cm^2	235.39	3
06035	Delaying a flap (operation only) - under 10 cm^2	163.48	3
	Specific areas: **Eyebrow**		
06148	Hair bearing scalp vascular island flap to eyebrow	483.98	3
	Hand		
06171	Syndactyly, local flaps - first cleft	254.92	2
06172	- with skin grafts - first cleft	453.55	2
	<u>Free Skin Grafts (including mucosa)</u>		
	Full-thickness grafts: ***Notes:*** *i) Full thickness fees, 2 to 19 cm^2, include direct closure of donor site.* *ii) Each additional 19 cm^2 or major portion thereof, will be paid at 50%, depending on the anatomic location of the defect.* *iii) Paid to a maximum of 2 additional units.* *iv) Fee items 61350 to 61354 are restricted to Plastic Surgery , Orthopaedics and Otolaryngology.*		
61350	Trunk (2 to 19 cm^2) (operation only)	228.39	2
61351	Arms, legs, scalp (2 to 19 cm^2)	289.29	2
61352	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm^2)	355.27	2
61353	Ears, eyelids, lips and nose (2 to 19 cm^2)	395.89	2
S61354	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)	310.00	2

		$	Anes. Level
	Split-thickness grafts:		
	Note:		
	Non-functional areas include posterior or trunk, anterior trunk, arm (above elbow), forearm (below elbow), thigh, leg (below knee).		
	Functional areas 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)	300.00	2
06047	- 65 sq.cm. (operation only)	432.00	2
06048	- 650 sq.cm.	648.00	2
06049	For each 6.5 sq.cm. over 650 sq.cm. (operation only)	8.00	3
	Note: *Refrigerated graft - 50% of appropriate fee.*		
	Functional areas:		
	Note: *Multiple operations to functional areas [see Preamble, Clause D. 5. 3.].*		
06051	Finger tip (operation only)	310.00	2
06050	Regions of major joints and hands - early	440.00	2
06058	- late - with scar excision graft	523.79	2
06052	Head and neck - 65 sq.cm. or less	440.00	3
06053	- in excess of 65 sq.cm.	648.00	3
06054	- in excess of 195 sq.cm.	1,033.97	3
	Major Flap Procedures		
06151	Decubitus ulcers - excision and treatment of bone, rotation flaps, and skin grafts to secondary defect	866.70	4
61152	Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment	910.00	4
	Note: *To include umbilicoplasty where medically indicated*		
C61156	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving small muscles	444.79	5
	Note*: The following muscle flaps are payable under this item:*		
	i) abductor digiti minimi flap		
	ii) abductor hallucis flap		
	iii) abductor pollicis brevis flap		
	iv) anconeus flap		
	v) extensor digitorum communis flap		
	vi) extensor digitorum longus flap		
	vii) extensor hallucis longus flap		
	viii) first dorsal interosseous flap		
	ix) flexor carpi ulnaris flap		
	x) flexor digitorum brevis flap		
	xi) flexor digitorum longus flap		
	xii) flexor hallucis longus flap		
	xiii) orbicularis oculi flap		
	xiv) orbicularis oris flap.		

		$	Anes. Level
C61157	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving medium muscles	630.91	5

Note: *The following muscle flaps are payable under this item:*

i) brachioradialis flap
ii) coracobrachialis flap
iii) pectoralis minor flap
iv) peroneus brevis flap
v) peroneus longus flap
vi) platysma flap
vii) sartorius flap
viii) serratus flap
ix) sternocleidomastoid flap
x) tibialis anterior flap
xi) tongue flap

C61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	955.00	5

Note: *The following muscle flaps are payable under this item:*

i) biceps femoris flap
ii) deltoid flap
iii) external oblique flap
iv) gastrocnemius flap
v) gluteus maximus flap
vi) gracilis flap
vii) latissimus dorsi flap
viii) pectoralis major flap
ix) rectus abdominus flap
x) rectus femoris flap
xi) soleus flap
xii) trapezius flap
xiii) temporalis flap
xiv) tensor fascia lata flap
xv) triceps flap
xvi) vastus lateralis flap
xvii) vastus medialis flap

Cheeks

06111	Facial paralysis - static slings with simple suspension (unilateral)	650.54	3
06110	- dynamic slings with local functional muscle transfer (unilateral)	785.69	3
06120	Complete repair for facial paralysis, plication of paralyzed muscles, meloplasty, and resection of overactive muscles – bilateral	838.07	3
06129	Combined complete repair as above and rhytidectomy – unilateral	945.41	3

Cell-assisted Lipotransfer for soft defects (Aspiration and Injections)

	Cell-assisted Lipotransfer – Aspiration		
S61250	- Volume less than 20 ml	81.88	3
S61251	- Volume between 21-60 ml	102.34	3
61252	- Volume greater than 60 ml	143.28	3

Notes:

i) Lipoaspiration and lipo injection components are paid together at 100%. Subsequent lipo injection procedures to anatomically discrete sites, completed during the same session, are paid at 50%.
ii) When performed with another procedure (e.g.: breast reduction, mastopexy) during the same date of service, the surgical preamble rules will apply.
iii) As with other medically necessary procedures for alteration of appearance, pre-approval is required.

		$	Anes. Level

iv) These fees are not intended to accompany any liposuction procedures. Lipoaspiration is only to be followed by lipo injection.
v) Restricted to Plastic Surgery.
vi) Aspirate from multiple sites is pooled for a total amount; only one aspirate fee is paid per session, for the aggregate amount.
vii) Volume harvested is the total usable fat cells after processing and does not include the oil or aqueous layers.

	Cell-assisted Lipotransfer – Injection		
	Functional area:		
S61260	- Volume less than 20 ml	122.81	3
S61261	- Volume greater than 20 ml	184.23	3
	Non-functional area:		
S61270	- less than 20 ml	102.34	3
S61271	- 21 to 60 ml	143.28	3
61272	- greater than 60 ml	184.23	3

Notes:
i) For the purpose of cell-assited fat injection, functional area will be restricted to the head and neck, hands, perineum and groin, as well as in the direct vicinity of major joints. The breast is considered a non-functional area for this indication.
ii) Non-functional areas are defined as: posterior or anterior trunk (including breasts), arm (above elbow), forearm (below elbow), thigh, leg (below knee).
iii) Facial subunits such as eyelid and lip are considered part of one aggregate fee for the face. Injections of multiple subunits of the face are still considered one aggregate area, the face.
iv) Bilaterally symmetrical sites, as in breasts or axillary regions are considered separate areas.

Tissue Expansion

06085	Tissue expansion - major areas - breast, scalp and tibial areas, regions of major joints	559.83	3
06086	Tissue expansion - minor areas	351.98	2

Blepharoplasty

06125	Blepharoplasty, simple, non-cosmetic (unilateral)	261.90	3

Notes:
i) Covers simple skin removal on the upper lid, and may include transgression (and occasional partial excision) of orbicularis oculi muscle on the upper eyelid.
ii) Significant blepharochalasis is defined as present when the visual field is restricted to within 20 degrees of fixation above the horizontal meridian.

61025	Blepharoplasty, simple, non-cosmetic (bilateral)	392.82	3

Notes:
i) Covers simple skin removal on the upper lid, and may include transgression (and occasional partial excision) of orbicularis oculi muscle on the upper eyelid.
ii) Significant blepharochalasis is defined as present when the visual field is restricted to within 20 degrees of fixation above the horizontal meridian.

		$	Anes. Level
06126	Blepharoplasty, complicated, non-cosmetic (unilateral)	392.82	3

Notes:

i) Includes not only skin removal, but also transgression (and occasional partial excision) of orbicularis muscle, entry of the septum, removal of fat if necessary, and fixation of the upper lid crease by identifying and attaching the orbicularis to the anterior levator surface.

ii) Significant blepharochalasis is defined as present when the visual field is restricted to within 20 degrees of fixation above the horizontal meridian.

61026	Blepharoplasty, complicated, non-cosmetic (bilateral)	589.27	3

Notes:

i) Includes not only skin removal, but also transgression (and occasional partial excision) of orbicularis muscle, entry of the septum, removal of fat if necessary, and fixation of the upper lid crease by identifying and attaching the orbicularis to the anterior levator surface.

ii) Significant blepharochalasis is defined as present when the visual field is restricted to within 20 degrees of fixation above the horizontal meridian.

Eyebrow ptosis

61360	Eyebrow ptosis repair - simple skin excision- non-cosmetic – unilateral	261.90	
61361	Eyebrow ptosis repair - simple skin excision – non-cosmetic – bilateral	392.82	

Notes:

i) Significant eyebrow ptosis is defined as present when the visual field is restricted to within 20 degrees of fixation above the horizontal meridian.

ii) Includes resection of any amount of forehead skin and upward brow advancement required to correct the functional deficit.

iii) For upper lid skin excess secondary to severe brow ptosis as opposed to primary upper lid skin excess.

iv) Not paid with 06125 or 61025 on the same patient, same date of service.

Tenotomy

Notes:

i) Tenotomy fees paid once per tendon only. Two repairs on the same tendon will be paid as one repair.

ii) Restricted to Plastic Surgery, Family Medicine and Orthopaedics, General Surgery and Emergency Medicine.

	Flexor - primary or secondary repair		
61363	- first tendon	400.00	2
61364	- second to sixth tendon repair (extra)	200.00	2
61365	- seventh to eleventh tendon repair (extra)	100.00	2
61366	– twelfth and over tendon repair (extra)	50.00	2
	Extensor - primary or secondary repair		
61368	- first tendon	250.00	2
61369	- second to sixth tendon repair (extra)	125.00	2
61370	- seventh to eleventh tendon repair (extra)	62.50	2
61371	– twelfth and over tendon repair (extra)	31.25	2
	Tenoplasty - tenodesis, tenovaginitis, shortening or lengthening, stenosing tenosynovitis:		
06186	- one tendon, any location	231.62	2
06187	- two or more tendons	377.06	2
06188	Tenolysis	392.14	2

		$	Anes. Level
06189	- each additional, to a maximum of three (extra) (operation only)	145.44	2
06185	Tendon graft	705.63	2
06203	Tendon transfer in hand and wrist	448.72	2
06204	- each additional, to a maximum of three (extra)	163.48	2
06175	Pollicization	1,150.59	4
06176	Digital transplant	952.71	5
S61230	Needle Aponeurectomy - Dupuytren's Disease	151.13	

Notes:

i) Restricted to Plastic Surgery and Orthopaedics.
ii) Not paid in addition to fee items 06193 and 06194.
iii) Bilateral services paid at 150%.

57270	Plantar Fascia: open release or partial excision, uni- or bilateral	270.75	2
06193	Extensive palmar - fasciectomy involving one or more digits	433.71	2
06194	- with skin grafting	561.51	2

Notes:

i) 06193 and 06194 are applicable only for open techniques which require removal of the disease (operative report may be requested).
ii) Localized, charge under items 61313, 61314, or 61315.

06195	Silastic rod prior to tendon grafting	462.17	3

Cavity grafting

06055	Eye socket	441.02	3
06056	- with mucosa	675.68	3
06057	Nose	393.90	3
06060	Mouth	523.79	3
06061	Lining pedicle flaps	300.67	3
06062	Bone cavity over 7.5 cm in diameter in large bone, e.g.: femur	441.02	4
06065	Bone cavity up to 7.5 cm in diameter in large bone	311.13	3
06064	Bone cavity in small bone, e.g.: hand or foot	254.92	2
06066	Operation for congenital absence of vagina (McIndoe) plastic surgery and care	582.45	4

Burns (with or without general anesthesia - per operation)

General care, severe only:

06083	- first hour	254.92	
06084	- subsequent hour (per hour)	203.93	
	- subsequent visits	per visit	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

Local care:

Minor burns - per visit:

06078	- dressing (in-hospital care only)	57.62	4
06079	- surgical debridement-for each 5% of body surface (operation only)	122.35	5
06080	- subsequent debridement-for each 5% of body surface (operation only)	30.37	5
06081	Surgical excision of burnt tissue prior to immediate skin grafting-for first 5 percent of body surface, extra (operation only)	376.08	5
06082	- for each subsequent 5 percent of body surface, extra (operation only)	203.93	5

		$	Anes. Level
Osteomyelitis			
06087	Incision subperiosteal abscess (operation only)	254.92	2
Regional Mandibulo-Facial			
	Guidelines for compounded facial fractures:		
1)	a. When fractures of the zygoma, the orbital floor and medial wall are compounded into the sinuses, no additional fee should be paid for these fractures.		
	b. When fractures of the maxilla and mandible involve the dento-alveolar tissues, and are compounded, no additional fee should be paid (this would include fractures into the tooth socket where a tooth is lost or a fracture into a partially erupted wisdom tooth, or a diastasis to two teeth at the fracture site where the compounding component does not extend further than the dento-alveolar area).		
2)	Significant external compounding of facial fractures is recognized as a factor which compromises the treatment and possible outcome of patients with these injuries. Treatment of these fractures should be billed at 150% of the pertinent listed fee. Operative notes should accurately describe such an injury to support these billings when submitted to MSP.		
3)	Fractures of the maxilla and mandible with intraoral compounding beyond the dento-alveolar bone, therefore exposing basal bone, complicates treatment and possible outcome. These injuries should be billed at 150% of the listed fee (eg: degloving of the maxilla or mandible).		
	Fracture - mandible:		
06240	Interdental and intermaxillary wiring	445.96	6
06241	Wiring with Gunning splints or dentures	457.87	6
	Open reduction:		
06242	- unilateral	662.31	6
06243	- bilateral	866.25	6
	Open reduction and intermaxillary wiring:		
06244	- unilateral	764.28	6
06245	- bilateral	968.21	6
06246	Removal of sutures, intra-oral splints, etc., under general anesthetic - (operation only)	301.47	4
	Fracture-maxilla (central mid-third):		
06250	Le Fort I - horizontal fractures	968.21	6
06251	Le Fort II - pyramidal fractures	1,070.17	6
06252	Le Fort III - cranio facial dysjunction	1,213.31	6
06253	Open reduction and internal or external craniomaxillary wire suspension with or without intermaxillary fixation	1,111.81	6
	Fracture - Zygomatic (lateral mid-third):		
	Zygomatico-maxillary, including orbital floor		
06260	Temporal elevation (operation only)	328.22	3
06261	Open reduction and interosseous wiring (to include antral packing where necessary)	637.40	4
06262	Reduction via transantral approach and antral packing (operation only)	457.93	4

		$	Anes. Level
	Zygomatic arch:		
06265	Temporal elevation (operation only)	356.42	3
06266	Open reduction and interosseous wiring	446.25	4
	Orbital floor fractures (blow-out fractures):		
06270	Open reduction (to include antral packing where necessary)	743.98	4
	Fracture-alveolus:		
06271	Alveolar fracture - with one tooth extraction (operation only)	128.20	3
06272	- each additional tooth (operation only)	79.71	3
06273	Arch bar fixation of teeth	409.62	3
	Temporo-mandibular joint:		
06280	Meniscectomy	446.25	3
06281	Condylectomy	510.65	3
06282	Arthroplasty	726.12	3
	Mandibular resection:		
06291	Tumours - enucleation, partial, or complete resection	606.54	4
06292	- with bone graft	860.78	4
06293	Bone graft to jaw or face - autologous	541.89	4
06294	- non-autologous	499.88	4

Maxillo-facial

	Osteotomies:		
C06300	Le Fort I - horizontal	1,130.11	6
C06301	Le Fort II - pyramidal	1,399.45	6
C06302	Le Fort III - intracranial	2,907.70	8
C06303	Le Fort III - extracranial	2,476.77	7
	Bilateral orbital advancement – intracranial approach for correction of hypertelorism when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61380	Plastic Surgery portion	2,235.25	8
03080	Neurosurgery portion	2,235.25	8
	Unilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
P61381	Plastic Surgery portion	2,073.65	8
03081	Neurosurgery portion	2,073.65	8
	Bilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61382	Plastic Surgery portion	2,773.64	8
03082	Neurosurgery portion	2,773.64	8
C06310	Unilateral orbital advancement, intracranial approach	2,799.96	8
C06311	Intracranial orbital advancement and correction of hypertelorism	3,123.16	8
C06312	Intracranial correction of hypertelorism	3,769.56	8
C06313	Unilateral orbital expansion by osteotomy for macrophthalmia	3,015.43	8
06314	Canthopexy	564.52	3
C06304	Malar maxillary	1,291.71	6

		$	Anes. Level
	Mandibular - for prognathism, micrognathism, malocclusion, etc.:		
C06305	- unilateral with intermaxillary fixation	806.91	6
C06306	- bilateral with intermaxillary fixation	968.51	6
C06307	Premaxillary set back	806.91	6
C06308	Mandibular osteotomy with rigid internal fixation - unilateral	832.07	6
C06309	- bilateral	1,183.97	6

Nose and Sinuses

	Cryosurgical treatments of turbinates:		
02298	- unilateral	153.09	3
02299	- bilateral	191.35	3
02306	Submucous resection of septum	165.83	3
	Rhinoplasty:		
06109	Removal of hump	238.09	3
06118	Bone graft to nose-autologous	601.15	3
06119	- non-autologous	493.41	3
06115	Forehead rhinoplasty- two operations	917.68	3
	***Note**: Partial forehead rhinoplasties charge under item 61339, 61340, or 61341.*		
02351	Nasal refracture requiring lateral osteotomies	357.19	3
02352	Reconstruction of nasal tip, ala, and columella	420.98	3
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma).	563.88	3
02354	Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture, and reconstruction of nasal tip, without skin grafting	612.35	3
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and external reconstruction of nasal tip without skin grafting.	776.17	3
06116	Composite graft	331.03	3
06117	Rhinophyma	335.05	3
	Fractures:		
06123	Comminuted nasal fractures – transosseous wire plate fixation	307.05	3
06124	Naso-orbital fractures-open reduction and interosseous wiring or transosseous wire plate fixation	533.27	3
02364	Nasal fracture - simple reduction (operation only)	63.76	3
S02365	- reduction and splinting (operation only)	127.57	3

Ears

06131	Outstanding ears - unilateral otoplasty	317.82	3
61031	Outstanding ears - bilateral otoplasty	476.72	3
06132	Microtia or loss of ear - partial - per stage	377.06	3
06133	- total - major stage	938.36	3
06134	- total - minor stage	307.05	3
06130	Accessory auricle (operation only)	254.92	3
06135	Preauricular sinus - simple	254.92	3
06180	- complicated	304.33	3

		$	Anes. Level
Mouth			
06181	Lip adhesion procedure for cleft palate	393.22	3
06146	Lip shave - vermilionectomy	399.13	3
06136	Plastic repair, e.g.: Abbe operation - two stages	641.12	4
06137	Full lip thickness transfer by rotation flap	548.93	4
06139	Unilateral cleft lip	558.04	4
06138	Bilateral cleft lip - complete	1,061.16	4
06144	- incomplete	750.90	4
06140	Wedge resection of lip – vermilion (operation only)	200.57	3
06141	- to sulcus	250.72	3
06142	Pharyngoplasty or pharyngeal flap	542.97	6
06143	Push-back of palate - with pharyngeal flap or similar procedure	750.90	6
06145	Cleft palate	553.74	6
06147	Bone graft to palatal cleft	612.99	4
Orbit			
06153	Bone graft to orbit-autologous	612.99	4
06154	- non-autologous implant	462.17	4
Breast			
	Note: See Preamble regarding cosmetic surgery.		
06150	Reduction mammoplasty for hypermastia - unilateral ***Note:*** *For ptosis, cosmetic only.*	606.68	4
61050	Reduction mammoplasty for hypermastia – bilateral ***Note****: For ptosis, cosmetic only.*	910.15	4
61045	Immediate Breast Reconstruction – extra ***Notes:*** *i) Payable only to Plastic Surgeons.* *ii) Must be performed under the same anesthesia as a mastectomy (07471, 07498, 07472, 07473) done by a different surgeon.* *iii) Paid only in addition to breast reconstruction surgery done by same surgeon.* *iv) Maximum of one whether unilateral or bilateral.*	202.31	
61046	Biologic tissue for breast reconstruction - extra ***Notes:*** *i) Paid only in addition to fee items 06164 or 06165.* *ii) Also payable in addition to fee item 06085 when a patient requires post mastectomy radiation and there is a concern for the long term pliability of the mastectomy flap(s), (BC Cancer Agency registration number must be provided in the note record).* *iii) Paid at 100% for unilateral and 150% for bilateral reconstruction.* *iv) Payable only to Plastic Surgeons.*	303.46	
06085	Tissue expansion - major areas - breast, scalp and tibial areas, regions of major joints	559.83	3
61047	Filling of tissue expander ***Notes:*** *i) Not payable on same day as fee items 06085 and 06086.* *ii) Maximum of 1 per patient per day regardless of number of fills or unilateral/bilateral.* *iii) Not paid with a visit fee.*	43.77	

		$	Anes. Level
C61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	955.00	5

Note: *The following muscle flaps are payable under this item:*

i) biceps femoris flap
ii) deltoid flap
iii) external oblique flap
iv) gastrocnemius flap
v) gluteus maximus flap
vi) gracilis flap
vii) latissimus dorsi flap
viii) pectoralis major flap
ix) rectus abdominus flap
x) rectus femoris flap
xi) soleus flap
xii) trapezius flap
xiii) temporalis flap
xiv) tensor fascia lata flap
xv) triceps flap
xvi) vastus lateralis flap
xvii) vastus medialis flap

61053	Bilateral breast construction in the context of gender affirming surgery, male to female (MtF)	772.73	3

Notes:

i) Requires MSP approval for transgender services.
ii) Patient must meet the clinical criteria for MtF surgery; and unless contraindicated, patient must complete 18 months of hormone therapy
iii) Please refer to Preamble D. 9. 4. Gender Affirming Surgery.

C06159	TRAM Flap reconstruction of mastectomy defect	1,021.77	5

Notes:

i) Includes preparation of site to be grafted, harvesting and insertion of the graft, closure of donor defect, with or without mesh.
ii) Reconstruction of both breasts (bilateral) with <u>two</u> pedicled TRAM flaps is payable at 150%.

C06220	Free flap, including closure of defect at donor site	3,108.09	5

Cell-assisted Lipotransfer for soft defects (Aspiration and Injections)

	Cell-assisted Lipotransfer – Aspiration		
S61250	- Volume less than 20 ml	81.88	3
S61251	- Volume between 21-60 ml	102.34	3
61252	- Volume greater than 60 ml	143.28	3

Notes:

i) Lipoaspiration and lipo injection components are paid together at 100%. Subsequent lipo injection procedures to anatomically discrete sites, completed during the same session, are paid at 50%.
ii) When performed with another procedure (e.g.: breast reduction, mastopexy) during the same date of service, the surgical preamble rules will apply.
iii) As with other medically necessary procedures for alteration of appearance, pre-approval is required.
iv) These fees are not intended to accompany any liposuction procedures. Lipoaspiration is only to be followed by lipo injection.
v) Restricted to Plastic Surgery.

		$	Anes. Level
	vi) Aspirate from multiple sites is pooled for a total amount; only one aspirate fee is paid per session, for the aggregate amount.		
	vii) Volume harvested is the total usable fat cells after processing and does not include the oil or aqueous layers.		
	Cell-assisted Lipotransfer – Injection		
	Non-functional area:		
S61270	- less than 20 ml	102.34	3
S61271	- 21 to 60 ml	143.28	3
61272	- greater than 60 ml	184.23	3
	Notes:		
	i) For the purpose of cell-assited fat injection, functional area will be restricted to the head and neck, hands, perineum and groin, as well as in the direct vicinity of major joints. The breast is considered a non-functional area for this indication.		
	ii) Non-functional areas are defined as: posterior or anterior trunk (including breasts), arm (above elbow), forearm (below elbow), thigh, leg (below knee).		
	iii) Facial subunits such as eyelid and lip are considered part of one aggregate fee for the face. Injections of multiple subunits of the face are still considered one aggregate area, the face.		
	iv) Bilaterally symmetrical sites, as in breasts or axillary regions are considered separate areas.		
	Mastectomy:		
V70478	- for gynaecomastia	305.89	3
61054	Bilateral mastectomy in the context of gender affirming surgery, female to male (FtM) - (to include bilateral subcutaneous mastectomy, nipple-areolar reconstruction and chest wall reconstruction)	1,476.26	3
	Notes:		
	i) For MSP approved, transgender patients meeting the clinical criteria for FtM surgery.		
	ii) Not billable in addition to 07498 (mastectomy, subcutaneous), 06157 (nipple-areolar reconstruction), and 61330, 61331, or 61332 (local tissue shifts, multiple).		
	iii) Otherwise subject to General Preamble rules for multiple surgery.		
	Prosthetic breast replacement in unilateral agenesis or following mastectomy:		
06164	- unilateral	405.66	3
06165	- bilateral	608.76	3
61166	Mastopexy, balancing unilateral (isolated procedure)	606.68	3
61167	Mastopexy, balancing – when performed at same time as contralateral breast surgery	404.45	3
06178	Excision of breast implant and associated pathologic capsule	410.00	2
06179	Excision of breast implant only (operation only)	245.70	2
06157	Nipple-areolar reconstruction	339.52	2
	Note: *This procedure is to result in a pigmented areolar complex using pigmented epithelium.*		
61057	Nipple areolar reconstruction and tattooing	457.84	2
	Notes:		
	i) Fee includes initial tattooing whether done at time of the reconstruction or as a staged procedure, and one additional tattooing		
	ii) Subsequent tattooing is not payable by the Plan.		

		$	Anes. Level
Leg			
06127	Lymphoedema of limbs, excision and grafting - entire leg	700.04	3
06128	- entire lower extremity	1,046.58	3
06167	Treatment of lymphoedema, using the Thompson procedure - upper extremity forearm	353.91	4
06168	- arm	235.39	4
	(Total of $577.96 whether one or two stages.)		
06169	- lower extremity leg	591.48	4
06170	- thigh	591.48	4
	(Total of $1,160.18 whether one or two stages.)		
Microsurgery			
06259	Microsurgical removal of neoplasm – digital or palmar	336.04	2
	Microneural Surgery:		
	Neurolysis:		
06210	- external	288.08	2
06211	- intraneural	438.94	2
	Microfascicular neurorrhaphy, primary:		
06212	- digital or palmar	350.00	2
06213	- major nerve	614.93	2
	Interfascicular nerve graft (to include harvest of graft):		
06214	- digital or palmar	533.59	2
06215	- major nerve	1,600.00	4
03207	Microsurgical removal of neoplasm - major peripheral nerve	815.19	3
	Microvascular Surgery:		
06216	Artery or vein - primary repair (to include operative report) ***Note:*** *If a major artery in trunk, anesthetic IC Level 9.*	675.48	6
C06220	Free flap, including closure of defect at donor site	3,108.09	5
	Microreimplantation:		
C06217	Digit or extremity (to include operative report)	3,108.88	4
61210	Certified Plastic Surgeon Assist – Complex Case (extra) Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof ***Notes:*** *i) Restricted to Plastic Surgery.* *ii) Paid only for assisting microsurgical surgeries; fee items 06217 or 06220.* *iii) Paid in addition to fee items 70020 and 00198.* *iv) Maximum payable is 20 units per surgery.* *v) Any additional assistants, if required, are paid under fee items 00197 and 00198 only.* *vi) This fee is intended for plastic surgeons in active practice to compensate for lost office or operating room time in taking the day to assist a colleague on complex procedures. Fellowship trainees and short term locums (<6 months) are not eligible.* *vii) Start and end times must be entered in both the billing claims and the patient's chart.*	50.58	

		$	Anes. Level
Amputations			
06218	Transmetacarpal	254.92	2
06219	Finger, any joint or phalanx (operation only)	254.92	2
Bone Grafting			
06221	Inlay bone grafting of metacarpal or phalanx	354.92	2
Fractures			
06222	Finger phalanx, requiring reduction (operation only)	126.70	2
06223	Metacarpal requiring reduction (operation only)	126.70	2
61222	CRIF of phalangeal (middle or proximal) or metacarpal fracture	227.73	2
61223	ORIF of phalangeal (middle or proximal) or metacarpal fracture ***Note:*** *Multiple fractures paid in accordance with Preamble D. 6.*	340.00	2
61224	Open (compound) hand fracture – Primary wound management (operation only) ***Notes:*** *i) Includes management of soft tissue component of open fracture, including wound excision, debridement, irrigation, and implementation of antibiotic beads.* *ii) Payable in addition to 06224, 06225, 61223.* *iii) Payable at same percent as applies to fracture fee.* *iv) Payable only when procedure performed in operating room.*	41.11	2
61225	Open (compound) hand fractures – Secondary Wound Management (operation only) ***Notes:*** *i) Repeat primary management of soft tissue component of open fracture, including wound excision, debridement, irrigation, implementation of antibiotic beads at a second sitting or return to the O.R. for delayed primary closure. Not payable in addition to closure with skin grafts and/or local skin grafts.* *ii) Includes removal of beads.* *iii) This listing is exempt from the 14 day rule (D. 5. 2.)* *iv) Payable only when procedure performed in operating room.*	82.15	2
	Distal phalanges open reduction and wiring:		
06224	- first	340.00	2
06225	- each additional (extra) (operation only)	286.00	2
Joints - Interphalangeal or Metacarpophalangeal			
06228	Arthroplasty of metacarpophalangeal or interphalangeal (hand) joint	344.75	2
06229	Arthrodesis of metacarpophalangeal or interphalangeal (hand) joint	344.75	2
06231	Reconstruction of rheumatoid hand joints, multiple, e.g.: synovectomy, intrinsic release, repositioning of extensor tendons, each hand, fee for service, at any one operative session - up to ***Note:*** *Only applicable when performed on more than 2 joints.*	992.21	3
06232	Finger joint prosthesis - first joint	259.64	2
06233	- subsequent joints same sitting – each (operation only)	147.59	2
06234	Synovectomy - of flexor or extensor tendons in wrist and hand for rheumatoid disease	351.20	2

		$	Anes. Level
06235	Intrinsic release	254.92	2
	Dislocations:		
06236	Metacarpophalangeal or interphalangeal joint: - closed reduction (operation only)	125.35	2
06237	- open reduction (operation only)	254.92	2

Nerves

	Peripheral nerve:		
06255	Minor, digital, primary suture or secondary	254.92	2
06256	Repair of palmar nerve	254.92	2
06257	Major, primary suture	403.31	3
S06258	Exploration of peripheral nerve and neurolysis	256.65	2
	Note: *Multiple neurolyses are paid in accordance with Preamble, clause D. 5. 3. to a maximum of four neurolyses per sitting.*		
S03196	Exploration, mobilization and transposition	281.48	2
03198	Neurectomy of major nerve	222.43	2
03200	Secondary suture including transposition	575.24	3
03201	Secondary suture of major nerve	437.73	3
03205	Nerve graft	431.81	3
06156	Transplant of neuroma	254.92	2

Tattooing Surgery (for haemangiomata, vitiligo, lentigines, etc.)

	Facial area:		
S06200	Less than one-quarter of face (operation only)	114.69	3
S06201	One-quarter to one half of face	235.39	3
S06202	Full face	353.91	4
	Nonfacial area:		
06205	Less than 6.5 sq.cm. (operation only)	59.75	2
S06206	Less than 65 sq.cm. (operation only)	118.31	2
S06207	Less than 650 sq.cm.	235.39	2
	Note: *Fee items 06205-06207 are not payable for nipple areolar tattooing.*		

Salivary Gland and Ducts – Excision

07522	Local excision of parotid tumour - without nerve dissection (operation only)	203.62	3

Arteries

	Trauma:		
	Repair of injury of major vessel in extremity:		
77330	- suture	583.75	6
77335	- graft	750.88	6

Elbow, Proximal Radius and Ulna

	Incision - Therapeutic, Release:		
53250	Decompression, neurolysis, nerve	242.74	2
53255	Decompression, neurolysis, submuscular transposition of nerve	406.12	2

		$	Anes. Level
	Repair, Revision, Reconstruction (Soft Tissue):		
53520	Biceps tendon, longhead, tenodesis	270.75	2

Shoulder Girdle, Clavicle and Humerus

	Repair Revision, Reconstruction (Soft Tissue):		
52555	Tendon transfer transplant	513.50	

GENERAL SURGERY

Preamble

General Surgeons billing surgical fee items identified with a "V" prefix are exempt from the post-operative general preamble rule (Preamble D. 5. 1.) and can bill fee item 71008 for post-operative visits (in hospital) during post-op days 1 – 14.

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

		$	Anes. Level

Referred Cases

07010	**Consultation:** To include complete history and physical examination, review of X-ray and laboratory findings, if required, and written report	117.82	
07012	**Repeat or limited consultation**: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	60.00	
	Continuing care by consultant:		
07007	Subsequent office visit	29.50	
07008	Subsequent hospital visit	29.25	
07009	Subsequent home visit	50.00	
07005	Emergency visit when specially called (not paid in addition to out-of-office premiums) (not paid within 10 post-operative days from surgical procedure)	116.00	
	Note: *Claim must state time service rendered.*		
07006	Directive care in emergent surgical conditions - per visit	30.00	
	Notes: *i) Limited to 2 services per calendar week, when medically required, by the patient's condition.* *ii) This item is payable when further resuscitation and assessment is medically required in preparation for surgery and for the management of conditions such as acute pancreatitis which do not invariably progress to surgical intervention.*		
71008	Post-operative visit, in-hospital (1 – 14 days post-operatively)	28.00	
	Notes: *i) Restricted to General Surgeons whose most recent specialty is General Surgery.* *ii) Restricted to surgical fee items with a "V" prefix.* *iii) Do not bill this item for "operation only" procedures, bill 07008 (subsequent hospital visit), or other appropriate fee item.* *iv) For visits outside of the 1 - 14 days time frame bill 07008, or other appropriate item.* *v) Not billable on the day of the procedure.* *vi) Paid once per day per patient.*		

		$	Anes. Level
71015	Pre-Operative Assessment	116.00	

Notes:

i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.
ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.
iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.
iv) Maximum of one pre-operative assessment per patient per procedure.
v) Only paid to the surgeon who performs the procedure.

71010	Complex consultation for management of malignancy	150.00	
71017	Special office visit for new diagnosis or recurrent malignancy	65.00	

Notes:

i) Payable only to the General Surgeon who is the most responsible physician in treatment of the malignancy.
ii) Applicable to new malignancy or recurrence of malignancy in remission.
iii) For histologically confirmed malignancy only.
iv) Not to be billed for non-melanoma skin carcinoma.
v) Only payable when seen by the same practitioner, in consultation, within 365 days prior.

Telehealth Service with Direct Interactive Video Link with the Patient:

70070	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and written report	117.82	
70072	Telehealth repeat or limited consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	60.00	
70077	Telehealth subsequent office visit	29.50	
70078	Telehealth subsequent hospital visit	29.00	
70076	Telehealth directive care in emergent surgical conditions - per visit	30.00	

Notes:

i) Limited to 2 services per calendar week, when medically required, by the patient's condition.
ii) This item is payable when further resuscitation and assessment is medically required in preparation for surgery and for the management of conditions such as acute pancreatitis which do not invariably progress to surgical intervention.

70080	Telehealth Complex consultation for management of malignancy	150.00	
70087	Telehealth Special office visit for new diagnosis or recurrent malignancy	65.00	

Notes:

i) Payable only to the General Surgeon who is the most responsible physician in treatment of the malignancy.
ii) Applicable to new malignancy or recurrence of malignancy in remission.
iii) For histologically confirmed malignancy only.
iv) Not to be billed for non-melanoma skin carcinoma.
v) Only payable when seen by the same practitioner, in consultation, within 365 days prior.

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, ie., 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 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 ..... ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	106.12	
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof ..... ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	63.67	

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 (10087, 10088, and 10089) 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 comorbidities, 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^o) burn ≥ 10% and full thickness (3^o) burn
- Electrical or lightning burn
- Chemical burn or Inhalation injury
- Burn injury in patients with significant comorbidities
- 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.

		$	Anes. Level

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

10087 Trauma Team Leader - Initial Assessment, Secondary Survey and Support 301.88

Notes:

i) Restricted to General Surgeons

ii) Indicated for those patients experiencing any of the Trauma Team Activation Criteria.

iii) Minimum of 2 hours of bedside care required on Day 1 (excluding stand by time).

iv) Start and end times must be entered in both the billing claims and the patient's chart.

v) Payable in addition to the adult and pediatric critical care fees at 100%.

vi) Not paid with any consult, visit or emergency care fees, by the same practitioner on the same date of service.

vii) Paid to only one physician for one patient, per facility, per day.

		$	Anes. Level
10088	Trauma Team Leader – Tertiary Assessment (after 24 hrs. and before 72 hrs.)	104.00	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10089.
iii) Not paid unless 10087 has been previously claimed (on same PHN).
iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
v) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.
vi) Payable to only one physician for one patient, per facility, per day.

10089	Trauma Team Leader Subsequent Hospital Visit (Days 3 – 15 inclusive)	78.72	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10088.
iii) Not paid unless 10087 has been previously claimed (on same PHN).
iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
v) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.
vi) Payable to only one physician for one patient, per facility, per day.

Surgical Fee Modifiers

Notes:

i) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the modifier.
ii) Surgical fee modifiers are excluded from the calculation for total operative fee(s) for which surgical assist fees are based.

07001	Surgical Surcharge (Age 75+)	85.00	

Notes:

i) Payable only to General Surgeons.
ii) Fee item 07001 will be paid only once when multiple procedures are performed under the same anesthetic.
iii) Payable when the following surgical fee items are performed for patients who are age 75 or older: 07027, 07061, 07072, 07075, 07076, 07082, 07108, 07109, 07110, 07111, 07112, 07143, 07147, 07150, 07360, 07363, 07366, 07368, 07402, 07403, 07404, 07405, 07406, 07407, 07408, 07409, 07410, 07411, 07412, 07413, 07414, 07431, 07432, 07433, 07434, 07435, 07436, 07437, 07438, 07440, 07441, 07442, 07443, 07444, 07445, 07446, 07447, 07448, 07449, 07452, 07455, 07460, 07470, 07471, 07472, 07473, 07474, 07475, 07479, 07481, 07482, 07497, 07498, 07516, 07522, 07528, 07536, 07561, 07565, 07567, 07569, 07570, 07578, 07580, 07588, 07589, 07597, 07600, 07601, 07603, 07610, 07623, 07624, 07626, 07627, 07628, 07630, 07632, 07634, 07635, 07636, 07640, 07641, 07643, 07645, 07646, 07647, 07648, 07649, 07650, 07651, 07654, 07658, 07660, 07662, 07663, 07665, 07666, 07672, 07675, 07676, 07677, 07678, 07679, 07683, 07685, 07687, 07689, 07698, 07699, 07703, 07705, 07706, 07707, 07711, 07714, 07725, 07732, 07733, 07740, 07741, 07743, 07744, 07745, 07749, 07756, 07758, 07769, 07771, 07776, 07782, 07789, 07790, 07796, 33321, 33322, 33323, 33324, 33325, 33326, 33329, 33346, 33347, 70084, 70155, 70158, 70159, 70162, 70163, 70165, 70166, 70168, 70169, 70470, 70471, 70473, 70477, 70478, 70479, 70500, 70530, 70531, 70532, 70533, 70534, 70535, 70536, 70538, 70539, 70540, 70541, 70542, 70544, 70545, 70601, 70602, 70603, 70605, 70606, 70607, 70620, 70621, 70622, 70625, 70626, 70627, 70628, 70629, 70630, 70631, 70632, 70633, 70635, 70637, 70639, 70640, 70641, 70642, 70643, 70644, 70645, 70646, 70648, 70649, 70650, 70660, 70665, 70666, 70668, 70671, 70672, 70674, 70676, 70680, 70683, 70694, 70695,

70698, 70700, 70701, 70702, 70703, 70704, 70705, 70712, 70713, 70714, 70715, 70716, 70718, 70720, 70721, 70722, 70725, 70726, 70727, 70728, 70731, 70740, 70742, 70743, 70745, 70747, 70748, 71282, 71290, 71292, 71293, 71380, 71530, 71535, 71536, 71537, 71538, 71539, 71540, 71541, 71542, 71543, 71546, 71548, 71549, 71551, 71606, 71607, 71608, 71609, 71610, 71611, 71612, 71613, 71614, 71615, 71616, 71617, 71618, 71619, 71620, 71621, 71622, 71623, 71624, 71625, 71634, 71635, 71650, 71651, 71681, 71682, 71684, 71686, 71700, 71703, 71704, 71705, 71706, 71708, 71709, 71710, 71712, 71713, 71714, 71716, 71717, 71718, 71719, 71720, 71721, 71722, 71725, 71746, 72572, 72600, 72601, 72602, 72603, 72604, 72605, 72606, 72607, 72608, 72609, 72610, 72620, 72622, 72623, 72624, 72625, 72626, 72631, 72632, 72633, 72634, 72635, 72636, 72640, 72641, 72644, 72647, 72648, 72650, 72651, 72652, 72653, 72656, 72657, 72658, 72659, 72660, 72665, 72666, 72669, 72670, 72671, 72672, 72673, 72683, 72703, 72704, 72705, 72711, 72713, 72714, 72715, 72720, 72721, 72723, 72725, 72726, 72727, 72728, 72729, 72730, 72731, 72732, 72733, 72734, 72735, 72736, 72737, 72739, 72740, 72741, 72743, 72745, 72751, 72755, 72760, 72762, 72763, 72765, 72767, 72769, 72770, 72775, 72788, 72789, 72794, 72795, 72796, 72797, 72798.

P07003 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery performed

- The patient has a Body Mass Index (BMI) greater than 35 for major surgery on the peritoneal cavity, pelvis, retroperitoneum or 40 for major surgery on the neck.
- The surgery is rendered under general anesthesia using either an open technique for the neck, or an open or laparoscopic technique for the peritoneal cavity, pelvis or retroperitoneum.
- The principal surgical technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation nor catheterization.

Notes:

i) Payable only to General Surgeons.

ii) Patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.

iii) Maximum of one surcharge per operation unless two general surgeons perform two synchronous surgeries that are both eligible for the surcharge.

iv) When multiple procedures are performed during the same operation, the surcharge applies to all eligible procedures based on the prorated value according to the surgical preamble for multiple procedures.

v) The surcharge does not apply to surgical fee modifier 07001 (Surgical Surcharge Age 75+) but may be paid in addition.

vi) Payable when the following General Surgery fee items are performed for patients with a BMI greater than 35: 07134, 07360, 07363, 07366, 07368, 07402, 07403, 07404, 07405, 07406, 07407, 07408, 07409, 07410, 07411, 07412, 07413, 07414, 07431, 07432, 07433, 07434, 07435, 07436, 07437, 07438,07440, 07441, 07442, 07443, 07444, 07445, 07446, 07447, 07448, 07449, 07450, 07451, 07452, 07455, 07474, 07475, 07479, 07565, 07566, 07567, 07569, 07570, 07578, 07580, 07588, 07589, 07596, 07597, 07600, 07601, 07603, 07610, 07623, 07624, 07626, 07627, 07628, 07630, 07632, 07633, 07634, 07635, 07636, 07640, 07641, 07643, 07645, 07646, 07647, 07648, 07649, 07650, 07651, 07654, 07655, 07658, 07660, 07662, 07663, 07664, 07672, 07698, 07699, 07703, 07705, 07706, 07707, 07711, 07714, 07732, 07733, 07756, 07758, 07764, 07769, 07776, 70024, 70025, 70501, 70503, 70504, 70505, 70506, 70509, 70511, 70531, 70532, 70533, 70534, 70535, 70536, 70538, 70539, 70540, 70541, 70542, 70544, 70601, 70602, 70603, 70604, 70605, 70606, 70607, 72608, 72609, 72610, 70620, 70621, 70622, 70624, 70625, 70626, 70627, 70628, 70629, 70630, 70631, 70632, 70633, 70635, 70639, 70640, 70641, 70646, 70648, 70649, 70650, 70651, 70660, 70661, 70665, 70666, 70668, 70670, 70671, 70672, 70694, 70695, 70696, 70698, 70700, 70701, 70702, 70703, 70704, 70705, 70710, 70711, 70712, 70713, 70714, 70715, 70716, 70717, 70718, 70720, 70721, 70722, 70725, 70726, 70727, 70728, 70730, 70731, 70748, 71290, 71291, 71292,

		$	Anes. Level

71293, 71380, 71535, 71536, 71537, 71538, 71539, 71540, 71541, 71542, 71543, 71544, 71546, 71547, 71549, 71551, 71606, 71607, 71608, 71609, 71610, 71611, 71612, 71613, 71614, 71615, 71616, 71617, 71618, 71619, 71620, 71621, 71622, 71623, 71624, 71625, 71634, 71635, 71650, 71651, 71698, 71700, 71703, 71704, 71705, 71708, 71709, 71710, 71712, 71713, 71714, 71715, 71716, 71717, 71718, 71719, 71720, 71721, 71722, 71725, 71747, 72572, 72600, 72601, 72620, 72621, 72622, 72623, 72624, 72625, 72626, 72631, 72632, 72633, 72634, 72635, 72636, 72640, 72641, 72644, 72645, 72646, 72647, 72648, 72650, 72651, 72652, 72653, 72654, 72656, 72657, 72658, 72659, 72660, 72662, 72664, 72665, 72666, 72667, 72669, 72670, 72671, 72672, 72673, 72683, 72684, 72703, 72704, 72705, 72713, 72714, 72715, 72720, 72721, 72723, 72725, 72726, 72727, 72728, 72729, 72730, 72731, 72732, 72733, 72734, 72735, 72736, 72737, 72740, 72741, 72745, 72751, 72755, 72760, 72762, 72763, 72765, 72767, 72769, 72770, 72775, 72788, 72789, 72794, 72795, 72796, 72797, and 72798.

vii) Payable when the following General Surgery fee items are performed for patients with a BMI greater than 40: 07361, 07740, 07741, 07743, 07744, 07745, 07771, 07796, 70023, 70500, 70502, 70530, 70545, 70740, 70742, 70743, 70745, 70747, 71530, 71548, 71550, 71706, 71707, 71746, and 71748.

Surgical Assistant or Second Operator

Total operative fee(s) for procedures(s):

00195	- less than $317.00 inclusive	134.22	
00196	- $317.01 to 529.00 inclusive	189.24	
00197	- over $529.00	261.76	
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	28.52	

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.

70019	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	256.63	

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

70020	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	32.23	

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.

		$	Anes. Level
70021	Certified General Surgeon Assist (extra) Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	31.77	

Notes:

i) Restricted to General Surgery.
ii) Paid only in addition to fee item 70020.
iii) Maximum payable is 8 units per surgery.
iv) Any additional assistants, if required, are paid under fee items 00197 and 00198 only.
v) Start and end times must be entered in both the billing claims and the patient's chart.

Second Surgeon

Total or near total oesophagectomy; without thoracotomy (Transhiatal):

with pharyngogastrostomy or cervical oesophagogastrostomy, with or without pyloroplasty:

70503	- secondary surgeon	650.00	

with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

70504	- secondary surgeon	650.00	

Total or near total oesophagectomy;

with thoracotomy; with or without pyloroplasty (3 hole):

70505	- secondary surgeon	650.00	

with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

70506	- secondary surgeon	650.00	

Partial oesophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic oesophagogastrostomy:

(Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.)
with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

70509	- secondary surgeon	650.00	

Partial oesophagectomy, thoraco-abdominal or abdominal approach; with oesophagogastrostomy:

(Includes vagotomy. Includes proximal gastrectomy, pyloroplasty, and splenectomy if required).

with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

70511	- secondary surgeon	650.00	
07702	Fee for second surgeon participating in total correction of cloacal anamolies	507.54	

Note: *When 07700 and 07702 are claimed, assistant's fees are not applicable to either surgeon for assisting the other.*

07593	Fee for second surgeon participating in Pena posterior saggital anoproctoplasty	339.13	

Note: *When 07571 and 07593 are claimed, assistant's fees are not applicable to either surgeon for assisting the other.*

		$	Anes. Level
	Second Operator:		
77025	Synchronous combined bypass graft - extremities	297.96	
77030	- trunk	300.19	
	Note: *Items 77025 and 77030, provide operative report by second operator when requested by MSP.*		

Superficial/Miscellaneous

13605	Opening superficial abscess, including furuncle - operation only	44.76	2
07041	Aspiration: abdomen or chest (operation only)	76.01	2
	Abscess:		
07059	- deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	81.46	2
07027	- under general anesthesia (operation only)	225.00	2
07061	- deep, post operative wound infection under general anesthesia (operation only)	225.00	2
07045	Anterior closed space abscess - operation only	101.44	2
06028	Web space abscess - operation only	254.92	2
06029	- under general anesthetic (operation only)	290.00	2
	Pilonidal Cyst or Sinus:		
70084	- incision and drainage abscess (operation only)	101.36	2
07685	- excision or marsupialization - operation only	277.43	2
	Wounds - simple:		
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	35.84	
	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	- requiring anesthesia - operation only	66.76	2
06063	Removal of foreign body requiring general anesthesia - operation only	250.72	2
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	66.76	2
13621	- additional lesions removed at the same sitting (maximum per sitting, five) - each (operation only)	33.39	
	Notes: *i) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance." ii) Fee items 13620 and 13621 are not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13601	Biopsy of facial area (operation only)	52.24	2
	Note: *Punch or shave biopsies which do not require sutures are not to be charged under fee items 13600 or 13601.*		
13622	Localized carcinoma of skin, proven histopathological (operation only)	73.75	2

Removal of Tumours or Scars

V70116	Removal of tumour (including intraoral) or scar revision – 2 to 5 cm (operation only)	127.72	2
	Note: *For tumours or scars under 2 cm, bill under fee item 13620.*		

		$	Anes. Level
V70117	Removal of tumour (including intraoral) or scar revision – 5.1 cm to 10 cm	261.90	2
V70118	Removal of tumour (including intraoral) or scar revision – greater than 10 cm	452.56	2

Note:
i) 70116, 70117, and 70118 are not billable by Plastic Surgery, Orthopaedics, or Otolaryngology.

V70125	Radical resection of malignant skin or soft tissue tumour measuring 5-10 cm	261.90	2
V70126	Radical resection of malignant skin or soft tissue tumour measuring 10 cm or greater	452.56	2
70127	Closure or radical resection requiring a free split thickness skin graft (extra) - greater than 65 cm^2 on trunk - greater than 25 cm^2 on extremities or head/neck	101.15	

Notes:
i) Restricted to General Surgeons.
ii) Must be performed in an Operating Room (location code E, G, I, or P).
iii) 70127 only paid in addition to 70125 or 70126.

Local tissue shifts: Advancements, rotations, transpositions, "Z" plasty, etc.

Notes:
i) Advancement flaps are defined as adjacent tissue transfers based on undermining and layered closure. The medical necessity for a flap or graft occurs when direct closure alone would not suffice due to unacceptable wound tension or local distortion. The distances required to be undermined are measured from each edge, not the combined distance:
a) 1 cm – nose, ear, eyelid, lip or eyebrow
b) 1.5 cm – other face and neck
c) 3 cm – rest of body
ii) Direct closure means approximation of wound/skin edges with less undermining that defined by an advancement flap.
iii) A Limberg flap for pilonidal sinus repair is considered a single flap.
iv) 70119, 70120, 70121, 70122, 70123, 70124 are not billable by Plastic Surgery, Orthopedics, Otolaryngology or Dermatology.

V70119	Single flap under 2 cm in diameter used in repair of a defect (except for special areas as in V70124) (operation only)	158.38	2
V70120	Single flap for lesion greater than 2 cm	324.74	2
V70121	Single flap for lesion greater than 2 cm with free skin graft to secondary defect	408.56	2
V70122	Multiple flap for lesion greater than 2 cm	571.97	2
V70123	Multiple flap for lesion greater than 2 cm with free skin graft to secondary defect	650.54	2
V70124	Eyebrow, eyelid, lip, ear, nose – single	295.14	3

Note: *Repair of torn earlobe to be claimed under 06027.*

Foreign Body:

Excision of skin and subcutaneous tissue of hidradenitis suppurative:

07072	- axillary (operation only)	250.00	2
07075	- inguinal (operation only)	250.00	2
07076	- perianal (operation only)	250.00	2
07082	- perineal (operation only)	250.00	2

		$	Anes. Level
06166	Excision of axillary sweat glands for hyperhidrosis - unilateral	325.14	4

Notes:
i) Direct closure included when open procedure used.
ii) Aggressive removal of apocrine sweat glands by any means.

Tenotomy:

07073	- congential torticollis (operation only)	304.16	3
V07074	- resection	257.99	3

(Section of transverse carpal ligament - bill under 06258)

Excisional biopsy of lymph glands for suspected malignancy:

70023	- neck (operation only)	240.00	3
V70024	- axilla	240.00	2
70025	- groin (operation only)	240.00	2
13630	Paronychia - operation only	35.75	2
13631	Removal of nail - simple operation only	35.75	2
13632	- with destruction of nail bed (operation only)	72.34	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	63.83	2
V07053	Excision of nail bed, complete, with shortening of phalanx	137.99	2
07025	Temporal artery biopsy (operation only)	155.00	2
07028	Biopsy of sural nerve – operation only	177.27	2
V07055	Ganglia - of the wrist	250.00	2

Wounds

13612	Extensive laceration greater than 5 cm (maximum charge 35 cm) - operation only - per cm	13.40	

Note: *Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*

Wounds - avulsed and complicated:

06075	Lips and eyelids	339.41	3
06076	Nose and ear	426.36	3
06077	Complicated lacerations of the scalp, cheek and neck	333.13	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

ii) Lacerations requiring layered closure <u>and</u> key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or

iii) Lacerations into the subcutaneous tissue requiring alignment <u>and</u> repair of cartilage <u>and</u> 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	270.50	3

		$	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)	550.00	5
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	294.65	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	117.87	
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	261.93	4
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	130.96	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	288.10	4
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	144.06	
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	78.57	
	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.* *iii) 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)	125.72	4
	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.*		
Vascular Access			
00319	Insertion of central catheter for total parenteral nutrition (operation only)	56.81	2
	Broviac type catheter:		
07139	- insertion of	162.55	2
V07140	- insertion of - less than 3 months of age or less than 3 kg	269.03	4
07141	- removal of (operation only)	126.79	2
	Totally implantable venous access port with subcutaneous reserv**oir** (portacath type device):		
07142	- insertion of	255.98	2
V07143	- revision (removal and reinsertion)	350.00	2
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	57.24	
07145	Intra osseous – access (operation only)	101.29	2

		$	Anes. Level
V07134	Peritoneal venous shunt for ascites	390.37	6
V07146	Insertion of inferior vena cava filter; percutaneous placement or cutdown (e.g.: Kimray Greenfield filter)	367.84	2
V07147	Insertion of a peritoneal catheter under general anesthetic	305.89	4
	Notes: *i) Includes fee items 77380, 07600 and 04001 (laparoscopy).*		
S00801	Intra-arterial cannulation - with multiple aspirations - procedural fee	22.10	

Head and Neck

Lips:

06140	Wedge resection of lip – vermilion (operation only)	200.57	3
06141	- to sulcus	250.72	3

Mouth - Excision

	Excision of lesion of tongue with closure anterior 2/3:		
V07789	- with local tongue flap	319.30	3
	Excision, lesion of floor of mouth:		
07790	- benign (operation only)	152.81	3
02457	Tongue tie - under general anesthetic (operation only)	82.94	3
02458	Local excision tongue - under general anesthetic	165.83	3
02275	Glossectomy - subtotal with either division of mandible or transcervical resection	1,056.22	6
02279	Resection base of tongue and/or tonsil and soft palate	1,926.37	6
02478	Glossectomy - partial for carcinoma	369.96	6
C02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy	1,320.23	7

Pharynx and Tonsils

S00701	Direct laryngoscopy - procedural fee	37.70	5
	Notes: *i) 00701 is not payable with 00907, 00908, and 00909.* *ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.*		
	Incision of peritonsillar abscess:		
02447	- under local anesthetic (operation only)	95.00	4
02444	- under general anesthetic (operation only)	128.81	6
	Tonsillectomy:		
02403	- under local anesthesia	257.70	4
02445	- adult or child over the age of 14 years	250.73	4
02446	- child age 14 years and under (to include neonate)	224.46	4
02413	Operative control of post-tonsillectomy or post-adenoidectomy haemorrhage requiring local or general anesthetic	263.45	6
02399	Cryotherapy of tonsils and oral lesions (operation only)	114.81	3
02442	Adenoidectomy - adult or child over 14 years (operation only)	128.81	4

		$	Anes. Level
Salivary Glands and Ducts			
07515	Drainage of abscess; parotid, submaxillary or sublingual (operation only)	202.59	3
07526	Dilation of salivary duct (operation only)	152.38	3
02452	Sialolithotomy - simple, in duct (operation only)	63.76	3
02453	- complicated, in gland	191.35	3
02456	Salivary fistula - plastic to Stensen's duct	420.98	4
	Excision:		
S00844	Biopsy of salivary gland, fine needle or core needle	54.02	3
07516	Excision or marsupialization of sublingual salivary cyst (ranula) (operation only)	203.56	3
07522	Local excision of parotid tumour- without nerve dissection (operation only)	203.62	3
02455	Excision of submandibular gland	318.91	4
02471	Subtotal parotidectomy - with complete facial nerve dissection	842.01	4
02472	Total parotidectomy - with nerve dissection for malignancy or deep lobe tumour	969.55	4
Neck Dissection			
02281	Conservative radical neck dissection ***Note:*** *Includes radical neck dissection with full dissection and sparing of entire accessory nerve and generally sternomastoid muscle and internal jugular vein.*	1,255.22	6
02470	Radical neck dissection	1,056.28	6
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy	1,926.37	7
02477	Contralateral suprahyoid dissection	484.78	5
Head and Neck - Miscellaneous			
02459	Excision cystic hygroma	548.56	4
V07500	Resection of mandible	402.23	5
V07749	Partial maxillectomy for malignancy - fenestration	811.46	5
CV07725	Maxillectomy	1,014.37	5
CV07726	- with exenteration of orbit and skin graft	1,051.77	5
V07796	Excision neurogenic neoplasm neck	1,115.70	5
	Diverticulectomy of hypopharynx or oesophagus, with or without myotomy:		
V70545	- cervical approach	536.76	6
02407	Tracheostomy ***Note****: Not applicable to cricothyrotomy puncture.*	390.00	5
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon	637.88	5

		$	Anes. Level
Breast			
	Incision		
70041	Fine needle aspiration of solid or cystic lesion – operation only	48.20	2
70042	- each additional cyst or lesion (maximum of 3) – operation only	12.07	2
70043	Mastotomy with exploration or drainage of abscess; deep - operation only	150.00	2
V70044	- under general anesthetic	250.00	2
	Excision		
	Biopsy of breast:		
70469	- needle core – operation only	100.00	2
70470	- incisional - operation only	200.00	2
70471	- excisional - operation only	250.00	2
	Stereotactic or ultrasound-guided core needle biopsy:		
70472	- 1 to 5 core samples – operation only	90.89	2
70473	- 6 to 10 core samples (operation only)	128.33	2
V07470	Nipple exploration, with excision of lactiferous duct(s) or papilloma of lactiferous duct (microdochectomy)	277.88	2
V07497	Biopsy or segmental resection of non-palpable breast lesion following radiological fine wire localization	232.60	2
70477	- each additional lesion identified by a radiologic marker	110.42	2
	Mastectomy:		
V70478	- for gynaecomastia	305.89	3
V07471	- simple for benign disease (female only)	340.96	3
V07498	- skin sparing, when performed for reconstruction – unilateral (female only)	650.00	3
V07473	- partial, for malignancy	329.57	3
V07472	- total, for malignancy	474.13	3
V70479	- radical	777.59	3
	Note: *Includes pectoral muscles and complete axillary node dissection.*		
V07475	Partial axillary dissection	237.35	3
V07474	Complete axillary dissection (level II)	507.42	3
79135	Chest wall tumour with rib resection	1,016.71	6
V07479	Sentinel lymph node biopsy (SLN)	474.13	3

Notes:

i) Payable only for the staging of malignant breast disease and malignant melanoma.

ii) Subsequent surgery (07474 or 07475) performed under same anesthetic is payable at 50% of the applicable fee of the lesser item.

iii) Payable only to BCCA validated physicians.

iv) SLN component of the combined procedure not payable to surgeons during the training phase.

		$	Anes. Level
	Oncoplastic breast surgery:		
	Lumpectomy for malignancy with immediate reconstruction of the defect using mammoplasty techniques. Excision of the tumour with planned margins to achieve locoregional control.		
V07481	Oncoplastic breast conserving surgery – Level 1	450.00	4
	Notes:		
	i) Restricted to General Surgeons with appropriate training and/or mentoring.		
	ii) Includes mobilization of breast parenchyma, creation of skin flaps, and layered closure and mammoplasty.		
CV07482	Oncoplastic breast conserving surgery – Level 2	550.00	4
	Notes:		
	i) Restricted to General Surgeons with appropriate postgraduate or post-fellowship training.		
	ii) Includes mobilization of breast parenchyma, creation of skin flaps, rotational flap closure, and nipple areolar complex repositioning.		

Oesophagus

Incision

V70500	Oesophagotomy - cervical approach with removal of foreign body	536.76	5
V70501	- thoracic approach with removal of foreign body	637.58	8
V70502	Cricopharyngeal myotomy - cervical approach	469.34	4

Excision

	Excision of lesion, oesophagus, with primary repair:		
CV70530	- cervical approach	536.76	6
CV70531	- thoracic or abdominal approach; open	777.59	8
CV70532	- thoracic or abdominal approach; laparoscopic or thorascopic	777.59	8
	Total or near total oesophagectomy; without thoracotomy (Transhiatal):		
	With pharyngogastrostomy or cervical oesophagogastrostomy, with or without pyloroplasty:		
V70533	- primary surgeon	2,030.14	8
70503	- secondary surgeon	650.00	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70534	- primary surgeon	2,030.14	8
70504	- secondary surgeon	650.00	
	Total or near total oesophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):		
V70535	- primary surgeon	2,283.91	8
70505	- secondary surgeon	650.00	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70536	- primary surgeon	2,283.91	8
70506	- secondary surgeon	650.00	
V70538	Partial oesophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic oesophagogastrostomy (Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required)	1,634.89	8
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70539	- primary surgeon	1,864.78	8
70509	- secondary surgeon	650.00	

		$	Anes. Level
CV70540	Partial oesophagectomy, thoraco-abdominal or abdominal approach; with esophagogastrostomy	1,430.50	8
	Notes: *i) Includes vagotomy.* *ii) Includes proximal gastrectomy, pyloroplasty, and splenectomy if required.*		
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70541	- primary surgeon	1,673.20	8
70511	- secondary surgeon	650.00	
CV70542	Total or partial oesophagectomy, without reconstruction (any approach), with cervical oesophagostomy (includes gastrostomy)	1,073.50	6
	Diverticulectomy of hypopharynx or oesophagus, with or without myotomy:		
V70545	- cervical approach	536.76	6
V70544	- thoracic approach	653.95	8

Oesophagus - Endoscopy

S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	116.63	3
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	97.14	3
S10763	Initial esophageal, gastric or duodenal biopsy	15.00	3
	Notes: *i) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs.* *ii) First biopsy paid at 100%, second and third at 50%.*		
S10764	Multiple biopsies for differential diagnoses of Barrett's Esophagus, H pylori, Eosinophiic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma	43.58	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to S10763 at 100%.* *iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.*		

Upper Gastrointestinal System – Endoscopy (Surgical)

S33321	Removal of foreign material causing obstruction, operation only	101.91	4
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only	116.68	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to S10761 or S10762.*		
S33323	Transendoscopic tube, stent or catheter – operation only	101.86	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		

		$	Anes. Level
S33324	Thermal coagulation – heater probe and laser, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	80.00	3
S33325	Gastric polypectomy, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	60.00	5
S33326	Percutaneous endoscopically placed feeding tube – operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	120.00	3
S33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	50.00	3
S33328	Esophageal dilation, blind bouginage, operation only ***Note:*** *Repeats within one month paid at 100%.*	57.25	3
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only ***Note:*** *Repeats within one month paid at 100%.*	109.02	3
	Oesophagus – Repair:		
V71530	Cervical oesophagostomy	531.36	5
V71531	Repair tracheo-oesophageal fistula – cervical approach ***Note:*** *71530 and 71531 include gastrostomy.*	2,000.00	6
	Oesophagoplasty, (plastic repair or reconstruction) thoracic approach:		
CV71532	- without repair of tracheo-oesophageal fistula	2,000.00	8
CV71533	- with repair of tracheo-oesophageal fistula	2,250.00	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach) ***Note:*** *C71533 and 71534 include gastrostomy.*	798.45	8
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	920.65	6
V71536	- open	736.52	6
CV71537	Oesophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	791.86	8
V71538	- with gastroplasty - Collis	1,218.09	8
	Plastic operation for cardiospasm; Heller:		
CV71539	- thoracic approach - open	672.58	8
CV71540	- laparoscopic or thorascopic (endoscopy to be billed separately)	840.72	6
CV71541	- with fundoplication - open	940.05	6
CV71542	- with fundoplication - laparoscopic	1,175.07	6

		$	Anes. Level
	Gastrointestinal reconstruction for previous oesophagectomy; for obstructing oesophageal lesion or fistula, or for previous oesophageal exclusion:		
CV71543	- with stomach; with or without pyloroplasty	1,430.50	6
CV71544	- with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	1,673.20	6
CV07536	Direct ligation of oesophageal varices	736.52	7
CV71546	Transection of oesophagus with repair, for oesophageal varices	830.20	6
CV71547	Ligation or stapling at gastro-oesophageal junction for pre-existing oesophageal perforation	1,200.00	6
	Suture of oesophageal wound or injury:		
V71548	- cervical approach	1,268.85	6
CV71549	- transthoracic or transabdominal approach	1,522.60	8
	Closure of oesophagostomy or fistula:		
CV71550	- cervical approach	1,268.85	6
CV71551	- transthoracic or transabdominal approach	1,522.60	8
07528	Placement of gastroesophageal venous compression balloon (e.g.: Minnesota or Blakemore) operation only	202.10	5

Notes:

i) Paid at 100% with 00081.

ii) Paid in addition to S10761 or S10762.

iii) Paid only once per endoscopy.

Diaphragm - Repair

V70601	Repair of para-oesophageal hiatus hernia, transabdominal, with or without fundoplication	1,212.64	6
	For anti-reflux procedures, fundoplications, etc., please see Oesophageal section.		
	Diaphragmatic or other hernia to include fundoplication, vagotomy and drainage procedure where indicated:		
V70602	- open	1,212.64	6
CV70603	- laparoscopic	1,212.64	6
CV70604	Congenital diaphragmatic hernia	1,522.60	9
	Repair diaphragmatic hernia or laceration; thoracic or abdominal approach:		
CV70605	- acute (traumatic)	1,215.00	8
CV70606	- chronic	1,215.00	8
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	800.00	8

Stomach

Incision

V70620	Gastrotomy - with exploration or foreign body removal	505.35	5
V70621	- with suture repair of bleeding ulcer (including duodenal)	674.39	6

		$	Anes. Level
CV70622	- with suture repair of pre-existing oesophagogastric laceration (e.g.: Mallory-Weiss)	702.47	6
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	505.35	5
	Excision		
	Limited or wedge excision:		
V70625	- ulcer or benign tumour of stomach - open	572.21	6
CV72725	- ulcer or benign tumour of stomach - laparoscopic	715.27	6
V70626	- malignant tumour of stomach - open	653.95	6
CV72726	- malignant tumour of stomach - laparoscopic	817.44	6
	Gastrectomy, total:		
CV70627	- with oesophagoenterostomy - open	1,700.00	6
CV72727	- with oesophagoenterostomy - laparoscopic	2,000.00	6
CV70628	- with Roux-en-Y reconstruction - open	1,700.00	6
CV72728	- with Roux-en-Y reconstruction - laparoscopic	2,000.00	6
CV70629	- with formation of intestinal pouch, any type - open	1,700.00	6
CV72729	- with formation of intestinal pouch, any type - laparoscopic	2,000.00	6
	Gastrectomy, partial, distal:		
V70630	- with gastroduodenostomy (Billroth I) - open	1,100.00	6
CV72730	- with gastroduodenostomy (Billroth I) - laparoscopic	1,226.17	6
V70631	- with gastrojejunostomy (Billroth II) - open	1,100.00	6
CV72731	- with gastrojejunostomy (Billroth II) - laparoscopic	1,226.17	6
V70632	- with Roux-en-Y reconstruction - open	1,200.00	6
CV72732	- with Roux-en-Y reconstruction - laparoscopic	1,277.23	6
V70633	- with formation of intestinal pouch - open	1,300.00	6
CV72733	- with formation of intestinal pouch - laparoscopic	1,379.45	6
70634	Vagotomy (extra)	63.86	
V70635	Proximal gastrectomy; thoracic or abdominal approach including oesophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy with or without splenectomy - open	1,202.67	6
CV72735	Proximal gastrectomy; thoracic or abdominal approach including oesophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy with or without splenectomy – laparoscopic	1,503.32	6
PCV70639	Radical gastrectomy including D2 Extended Lymphadenectomy – open or laparoscopic – first 60 minutes	662.77	6

		$	Anes. Level
PCV70640	Radical gastrectomy including D2 Extended Lymphadenectomy – open or laparoscopic – each additional 15 minutes or greater portion thereof	76.47	6

Notes:

i) Restricted to General Surgeons and Thoracic Surgeons.

ii) For curative-intent gastric resection for adenocarcinoma of the stomach.

iii) Payable only for complete dissection of periportal, common hepatic artery, celiac and splenic artery nodal basins as detailed in operative note.

iv) Not billable for D1 lymphadenectomy or palliative intent resections.

v) Not paid with portal lymphadenectomy (70718), total and/or partial gastrectomy.

vi) Start and end times are required in the claim and the patient's chart for the radical gastrectomy and cannot be billed for time performing concurrent procedures.

CV07624	Emergency gastrectomy for continued haemorrhage (accompanied by written report to MSP)	1,200.00	7
V07628	Gastrojejunostomy or pyloroplasty – with vagotomy - with or without gastrostomy	636.64	5
CV07578	Highly selective vagotomy	636.64	5

Stomach – Introduction

V07630	Gastrostomy - open	456.79	5
33394	Assistant fee for PEG procedure	112.47	

Note: *33326, 33394 may be billed by any qualified physician.*

70637	Change of gastrostomy tube (operation only)	45.46	2

Stomach - Other Procedures

V07626	Pyloroplasty	402.23	5
V07627	Gastrojejunostomy - open	558.30	5
CV72737	Gastrojejunostomy - laparoscopic	634.10	5
V07632	Patch or suture of perforated duodenal or gastric ulcer, wound or injury - open	750.00	6
V70641	- laparoscopic	750.00	6
V70642	Gastric restrictive procedure, without gastricbypass, for morbid obesity (includes vertical banded and other gastroplasties)	1,015.07	7
CV72739	Laparoscopic vertical sleeve gastrectomy	1,105.07	7
V70643	Gastric restrictive procedure - with bypass, for morbid obesity; gastroenterostomy - open	1,600.00	7
CV72743	Gastric restrictive procedure - with bypass, for morbid obesity; gastroenterostomy - laparoscopic	1,415.75	7
V70644	- with small bowel reconstruction to limit absorption - ileojejunal bypass	929.80	7
V70645	Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity - open	1,617.25	7
CV72775	Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity – laparoscopic	1,700.00	7

		$	Anes. Level
CV07623	Revision gastrectomy after previous gastrectomy - with or without vagotomy - open	1,217.37	7
CV72723	Revision gastrectomy after previous gastrectomy - with or without vagotomy - laparoscopic	1,521.68	7
V70646	Closure of gastrostomy, surgical	402.33	4
CV07633	Closure of gastro-jejuno-colic fistula	1,140.06	5
CV70649	Closure of gastrocolic fistula	786.78	5

Intestines

V70650	Lysis of intra-abdominal adhesions – first 30 minutes (extra)	152.95	7
70651	- each additional 15 minutes or greater portion thereof (extra)	76.47	

Notes:

i) Restricted to General Surgeons only.
ii) Payable for open procedures only.
iii) Not payable with fee item 07650.
iv) Not payable to same general surgeon doing the surgical assist.
v) Start and stop times for Lysis must be provided in patient chart and claim time field.

V70660	Lysis of intra-abdominal adhesions, laparoscopic – first 30 minutes (extra)	152.95	7
70661	- each additional 15 minutes or greater portion thereof (extra)	76.47	

Notes:

i) Restricted to General Surgeons only.
ii) Not payable with fee item V07650, V70650 or S04001.
iii) Not payable to same general surgeon doing the surgical assist.
iv) Start and stop times for laparoscopic lysis must be provided in patient chart and claim time field.
v) If conversion to open procedure is necessary, bill open procedure plus 50% of laparoscopy fee, 04001.

Incision

V07650	Intestinal obstruction; resection of bands; enterolysis - open	550.00	5

***Note**: Not payable with fee items 70650, 70651, 70660, 70661.*

CV72650	Intestinal obstruction, resection of bands, enterolysis – laparoscopic	627.62	5

Notes:

i) Restricted to General Surgeons.
ii) Not payable with fee items 70650, 70651, 70660, 70661.

V70648	Tube or needle catheter jejunostomy for enteral alimentation, intraoperative any method	507.00	4
V07634	Full thickness repair of iatrogenic intestinal perforation (single)	487.38	5
V07635	Full thickness repair of iatrogenic intestinal perforation (multiple)	639.86	5
PCV71634	Repair of iatrogenic intestinal perforation (single) – laparoscopic	609.23	5
PCV71635	Repair of iatrogenic intestinal perforation (multiple) – laparoscopic	799.83	5
V07654	Intestinal obstruction - plication or insertion of intraluminal tube	570.04	5
V07651	Reduction of volvulus, intussusception, internal hernia, by laparotomy	526.23	5
V71650	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) - open	505.61	5
V71651	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic	586.02	5

Notes:

i) Restricted to General Surgeons.
ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100% plus fee item 04001 at 50%.

		$	Anes. Level
	Excision		
V07636	Resection of small intestine with anastomosis - open	632.10	5
CV72736	Resection of small intestine with anastomosis - laparoscopic	754.18	5
CV72620	- with enterostomy; without anastomosis (does not include separate enterostomies or resections) - open	813.78	5
CV72720	- with enterostomy; without anastomosis (does not include separate enterostomies or resections) - laparoscopic	1,017.22	5
CV71725	Resection of duodenum ***Notes:*** *i) Requires appropriate training or experience in proximal pancreatic surgery.* *ii) Requires complete mobilization of the entire duodenum, including taking down the ligament of Treitz and separating the duodenum from the superior mesentreric vessels.* *iii) For limited resection of the duodenum requiring only Kocherisation bill fee item 07636.* *iv) Includes lymph node biopsies (00745).*	1,469.94	8
V07643	Enteroenterostomy	606.44	5
V07570	Colo-colostomy or entero-colostomy - open ***Note:*** *07570 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.*	802.82	6
CV72770	Colo-colostomy or entero-colostomy – laparoscopic ***Note:*** *CV72770 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.*	1,003.53	6
72621	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy- extra (not applicable to right or left hemicolectomy) (operation only) - open	95.79	6
C72721	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy – laparoscopic – extra (not applicable to right or left hemicolectomy) (operation only) ***Notes:*** *i) Restricted to General surgeons.* *ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100%.*	119.74	6
V72622	Limited resection of colon - open	859.52	6
CV72623	- laparoscopic	984.85	6
V72624	Hemicolectomy; right - open	884.86	6
CV72625	- laparoscopic	1,033.43	6
V72626	Hemicolectomy; left - open	960.62	6
CV72631	- laparoscopic	1,096.80	6
V72632	Sigmoid resection - open	1,011.14	6
CV72633	- laparoscopic	1,141.81	6
V72634	- with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) - open	960.56	6
CV72734	- with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) - laparoscopic	1,078.87	6
CV72635	Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) with or without protective stoma - open	1,515.90	6

		$	Anes. Level
CV72755	Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) with or without protective stoma - laparoscopic	1,617.81	6
V72636	Proctectomy; abdominal and transanal approach; coloanal anastomosis (with or without protective colostomy) - synchronous abdominal portion	1,125.66	7
CV07662	Abdomino-perineal resection - single surgeon - open	1,718.82	7
CV72762	Abdomino-perineal resection - single surgeon - laparoscopic	1,820.21	7
V07663	- synchronous abdominal portion - open	1,314.61	7
CV72763	- synchronous abdominal portion - laparoscopic	1,407.07	7
V07664	Proctectomy, in combination with any abdominal resection – synchronous – perineal portion	505.57	7
CV07569	Colectomy and hemiproctectomy - open	1,088.40	6
CV72769	Colectomy and hemiproctectomy - laparoscopic	1,360.51	6
CV07640	Colectomy - total, abdominal, (without proctectomy) - open ***Note:*** *Includes ileostomy or ileoproctostomy*	1,314.24	6
CV72760	Colectomy - total, abdominal, (without proctectomy) - laparoscopic ***Note:*** *Includes ileostomy or ileoproctostomy.*	1,409.05	6
V07567	Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy - open	1,750.00	6
CV72767	Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy - laparoscopic	1,936.03	6
V07566	Rectal mucosectomy and ileoanal anastomosis	837.43	6
CV07641	Total proctocolectomy - with perineal excision of rectum and ileostomy - single surgeon - open	1,645.83	7
CV72741	Total proctocolectomy - with perineal excision of rectum and ileostomy - single surgeon - laparoscopic	2,057.30	7
V07589	- synchronous - abdominal portion - open	1,317.10	7
CV72789	- synchronous - abdominal portion - laparoscopic	1,646.40	7
V07565	Take-down of pelvic pouch, to include ileostomy - open	1,218.09	5
CV72765	Take-down of pelvic pouch, to include ileostomy - laparoscopic	1,520.89	5
V72640	Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy - open	884.71	6
CV72740	Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy – laparoscopic	985.67	6
72641	Caecostomy, tube for decompression (extra) - open	404.20	5
72601	Caecostomy tube for decompression – laparoscopic (extra) ***Notes:*** *i) Restricted to General Surgeons.* *ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100% plus fee item 04001 at 50%*	377.50	5
	Transanal Minimally Invasive total Mesorectal Excision (TaTME)		
PCV72602	TaTME second surgeon – synchronous perineal portion ***Notes:*** *for second surgeon when performed with synchronous abdominal fees 72604, 72606, 72608, or 72610.*	1,600.00	7
PCV72603	Rectosigmoid resection in combination with a TaTME – single surgeon – open	2,350.00	7
PCV72604	Rectosigmoid resection in combination with a TaTME – synchronous abdominal portion – open	1,000.00	7

		$	Anes. Level
PCV72605	Rectosigmoid resection in combination with a TaTME – single surgeon laparoscopic	2,537.50	7
PCV72606	Rectosigmoid resection in combination with a TaTME – synchronous abdominal portion – laparoscopic	1,250.00	7
PCV72607	Proctocolectomy in combination with a TaTME – single surgeon – open	2,650.00	7
PCV72608	Proctocolectomy in combination with a TaTME – synchronous abdominal portion – open	1,400.00	7
PCV72609	Proctocolectomy in combination with a TaTME – single surgeon - laparoscopic	2,912.50	7
PCV72610	Proctocolectomy in combination with a TaTME – synchronous abdominal portion – laparoscopic	1,750.00	7
	Revision of colostomy, ileostomy:		
V07648	- simple incision or scar, etc.	450.00	4
V07649	- radical; reconstruction with bowel resection	505.42	5
V72644	- with repair of paracolostomy hernia requiring laparotomy	657.12	5
V72645	Continent ileostomy (Koch procedure) - open	1,004.22	6
CV72745	Continent ileostomy (Koch procedure) - laparoscopic	1,255.27	6
V07645	Colostomy or ileostomy – loop - open	505.38	5
CV72715	Colostomy or ileostomy – loop - laparoscopic	511.75	5
V07588	- end - open	505.63	5
CV72788	- end - laparoscopic	589.60	5
72646	- multiple biopsies (e.g.: for Hirschsprung disease) – extra (operation only)	134.49	5
	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction:		
V72647	- single	606.54	5
V72648	- multiple (two or more)	909.55	5
	Closure of loop enterostomy, large or small intestine:		
V07646	- without resection	509.22	4
V07647	- with resection and anastomosis	631.93	5
V72651	Reconstruction Hartmann procedure with or without protective colostomy - open	1,010.79	5
CV72652	- laparoscopic	1,033.43	5
	Closure of fistula; enterovesical, colovesical or colovaginal:		
V72653	- without intestinal and/or bladder resection - open	909.89	5
72654	- with bowel resection (extra to 72653) - open	404.35	5
	Closure of fistula; enterovesical, colovesical or colovaginal:		
CV72683	- without intestinal and/or bladder resection - laparoscopic	981.74	5
72684	- with bowel resection (extra to 72683) - laparoscopic	421.25	5
	Note: *Fee items 72653, 72654, 72683, 72684 includes fee items 08207, 08255, or 04401 if performed by the same surgeon.*		
V07455	Emergency resection of obstructed colon, with lavage and anastomosis	1,011.50	6
V07658	Exteriorization of large bowel lesion (carcinoma, perforation, etc.)	602.52	5

		$	Anes. Level
Meckel's Diverticulum and the Mesentery			
	Excision		
V07655	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	505.22	4
	Suture and Repairs		
V07447	Repair of mesenteric injury	572.71	6
Appendix			
	Incision		
V72660	Incision and drainage of appendiceal abscess, transabdominal ***Note:*** *Not payable in addition to appendectomy listings.*	434.19	4
	Excision		
V72656	Appendectomy - open	480.30	4
V72658	- laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee)	480.30	4
V72657	Appendectomy; perforated with abscess or generalized peritonitis - open	505.30	5
V72659	- laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee)	505.30	5
Rectum			
	Incision		
V07660	Transrectal drainage of pelvic abscess	303.15	2
	Excision		
07665	Biopsy of anorectal wall, anal approach (e.g.: congenital megacolon) – operation only	150.98	2
CV07662	Abdomino-perineal resection - single surgeon - open	1,718.82	7
CV72762	Abdomino-perineal resection - single surgeon - laparoscopic	1,820.21	7
V07663	- synchronous abdominal portion - open	1,314.61	7
CV72763	- synchronous abdominal portion - laparoscopic	1,407.07	7
V07664	Proctectomy, in combination with any abdominal resection - synchronous – perineal portion	505.57	7
	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull through procedure and anastomosis (e.g.: Swenson, Duhamel, or Soave type operation):		
V72662	- synchronous abdominal	1,314.90	7
CV72664	- with subtotal or total colectomy, with multiple biopsies	1,645.83	7
V72665	Proctectomy, partial, without anastomosis, perineal approach	558.30	5
V72666	Altemeier transperineal excision of rectal procidentia with anastomosis ***Notes:*** *i) Includes levator muscle imbrication (70671).* *ii) Sphincteroplasty (70666) is paid in addition if performed through a separate incision.* *iii) Colostomy paid in addition if required.*	677.27	3
72667	Division of stricture of rectum (includes endoscopy) - operation only	252.59	2

		$	Anes. Level
V07580	Excision of rectal tumour by posterior parasacral, transacral or transcoccygeal approach (Kraske)	800.00	5
	Excision of rectal tumour, transanal approach to include operative sigmoidoscopy:		
72669	- 0 to 2.5 cm – operation only	253.59	2
72670	- 2.6 to 5 cm - operation only	304.52	2
72671	- greater than 5 cm -operation only	455.09	2
72672	Electrodesiccation or fulguration of malignant tumour of rectum, transanal - includes endoscopy – operation only	252.68	2
CV72673	Transanal Endoscopic Microsurgical Resection of rectal tumour	917.67	6

Notes:

i) Paid only if a sealed and insufflating operating proctoscope is employed with visualization via an endoscopic camera (not under direct vision).
ii) Not paid with S70683, 72669, 72670 and 72671.
iii) Resection of one additional lesion is payable at 50% only if complete removal, repositioning and reinsertion of the insufflating operating proctoscope is required.
iv) If procedure is converted to open, bill under the appropriate open procedure at 100% and 04001 at 50%.
v) Fee items SY00715, SY10714, SY00716 and SY00718 are included if done at the same time.
v) Restricted to General Surgery.

Repair

V07672	Complete rectal prolapse - transabdominal rectopexy – open	698.70	5

Note: *Paid as a stand-alone procedure with the exception when performed in conjunction with sigmoid resection (72632, 72633) payment will be at 25%.*

CV72572	Complete rectal prolapse – transabdominal rectopexy - laparoscopic	873.38	5

Note: *Paid as a stand-alone procedure with the exception when performed in conjunction with sigmoid resection (72632,72633) payment will be at 25%.*

Rectum – Endoscopy

Notes:

i) **Proctosigmoidoscopy** is the examination of the rectum and sigmoid colon.
ii) **Sigmoidoscopy** is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.
iii) **Colonoscopy** is the examination of the entire colon, from the rectum to the caecum, and may include the examination of the terminal ileum.

SY10714	Proctosigmoidoscopy, rigid; diagnostic	35.40	2

Notes:

i) Proctosigmoidoscopy is the examination of the rectum and sigmoid colon.
ii) Sigmoidoscopy is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.
iii) Colonoscopy is the examination of the entire colon, from the rectum to the caecum, and may include the examination of the terminal ileum.

SY00715	Sigmoidoscopy (with biopsy) - procedural fee	37.98	2
S07460	- with decompression of volvulus – operation only	228.83	2
SY00716	Sigmoidoscopy, flexible; diagnostic	76.09	2
SY00718	- with biopsy	77.34	2
S07461	- with removal of foreign body (operation only)	181.00	2
S07462	- with control of bleeding, any method – operation only	181.00	2

		$	Anes. Level
S07463	- with decompression of volvulus, any method (operation only)	228.83	2
S07464	- with removal of polyp(s) (operation only)	251.02	2
S07465	- with ablation of tumour(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique – operation only	169.75	2
S10730	Colonoscopy, flexible, transabdominal via colostomy - single or multiple	240.14	4
S10731	Colonoscopy, flexible, proximal to splenic flexure; diagnostic with or without collection of specimen(s) by brushing or washing	231.61	2
S10732	- with removal of foreign body	272.07	2
S10733	- with control of bleeding, any method	303.99	2
P07375	Complex polypectomy (extra)	175.00	

Notes:

i) Restricted to General Surgeons and Gastroenterologists.

ii) Only for resection of a polyp with one or more of the followings:
-large (≥ 20mm) non-pedunculated colorectal polyp/lesion
-involving the appendiceal orifice, ileocecal valve, or dentate line
-recurrent or previously attempted resection
-complex polyp/lesion as determined by multidisciplinary committee

iii) Requires 60 minutes or more of slated endoscopy time.

iv) Not to be performed at index/diagnostic colonoscopy unless specifically referred for complex polypectomy.

v) Complete removal after submucosal injection and piecemeal resection or endoscopic mucosal resection.

vi) May not be claimed for pedunculated polyps.

vii) Payable only in addition to 10730, 10731, 10761, 00716, 00718, or 33373.

viii) Not payable in conjunction with 33374, 07464, 07465, 10714, 00715.

ix) Second complex polypectomy on the same day for the same patient will be paid at 50%.

Anus

Repair

V70665	Anoplasty; plastic procedure for stricture - adult	451.50	2
V70666	Sphincteroplasty; anal for incontinence or prolapse; posterior anal repair - adult	451.50	2
V07690	Anoplasty for imperforate anus	602.52	4
70668	Graft (Thiersch operation) for rectal incontinence or prolapse (operation only)	203.93	2
V70670	Sphincteroplasty; anal, for incontinence; Gracilis muscle implant	702.52	3
V70671	Levator muscle imbrication - Park posterior; anal repair	451.50	2
V70672	Implantation of artificial sphincter	1,009.32	4

Note: *70670 to 70672 are not payable together.*

V07452	Repair extra-peritoneal rectum with or without colostomy	962.78	7
70674	Destruction of anal lesion, any method including fulguration anal condylomata - simple - less than 10% perianal skin involvement (operation only)	75.41	2
70680	- complicated - greater than 10% of perianal skin involvement (with operative report) (operation only)	252.69	2
S70683	EUA with or without sigmoidoscopy; with or without biopsy (operation only)	152.95	2

		$	Anes. Level
CV72673	Transanal Endoscopic Microsurgical Resection of rectal tumour	917.67	6

Notes:

i) Paid only if a sealed and insufflating operating proctoscope is employed with visualization via an endoscopic camera (not under direct vision).
ii) Not paid with S70683, 72669, 72670 and 72671.
iii) Resection of one additional lesion is payable at 50% only if complete removal, repositioning and reinsertion of the insufflating operating proctoscope is required.
iv) If procedure is converted to open, bill under the appropriate open procedure at 100% and 04001 at 50%.
v) Fee items SY00715, SY10714, SY00716 and SY00718 are included if done at the same time.
vi) Restricted to General Surgery.

07689	Anal dilation under general anesthetic (operation only)	152.67	2
04401	Repair of recto-vaginal fistula	680.40	3

Incision

70675	Removal of anal seton, other marker (operation only)	28.67	2
V70676	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	389.95	2
07691	Anus imperforate - simple incision (operation only)	303.06	2
07679	Incision and drainage of ischiorectal, intramural, intramuscular or submucosal abscess, under anesthesia – operation only	203.01	2
07678	Incision and drainage, perianal abscess – superficial (operation only)	91.43	2

Excision

07687	Anal fissure, excision under local anesthetic (operation only)	115.00	2
V71681	Sphincterotomy with or without fissurectomy	303.07	2
SV71682	Botox injection for anal fissure	252.34	2

Notes:

i) Payment restricted to General Surgeons.
ii) Tray fee is not paid when the procedure is performed in hospital or publicly-funded facilities (D&T Centres, psychiatric facilities).
iii) Paid to a maximum of four injections per patient per year.

Papillectomy or excision of anal tag or polyp:

71684	- single – extra (operation only)	67.87	2
71686	- multiple – extra (operation only)	123.30	2
71689	Hemorrhoid(s); (e.g.: band ligation) to include proctoscopy (operation only)	80.58	2
71690	Hemorrhoid(s); – infrared photocoagulation to include proctoscopy (operation only)	80.58	2
71691	Hemorrhoid(s) add on fee	16.82	

Notes:

i) Restricted to General Surgeons.
ii) Paid only when service performed in an office (Service location code Q or T), not payable in a public facility.
iii) Paid only with fee item 71689 or 71690.

V07683	Hemorrhoidectomy with or without sigmoidoscopy	268.05	2

Fistula-in-ano (fistulectomy or fistulotomy):

07675	- subcutaneous or submucous – operation only	250.00	2
V07676	- submuscular	337.72	2

		$	Anes. Level
V07677	- multiple or horseshoe, with or without placement of seton	451.50	2
V07666	Fistula-in-ano; second stage; division of sphincter after placement of seton	250.00	2
V71700	Closure of congenital or acquired anal fistula with rectal advancement flap	645.16	2

Liver

Incision

V07402	Hepatotomy for drainage of abscess or cyst; laparoscopic or open - single	434.19	6
V07403	- multiple, including marsupialization	653.95	6
CV71380	Open or Laparoscopic operative liver tumour non-resectional ablation by any means	900.00	7

Notes:

i) Payment restricted to General Surgeons.
ii) Includes all diagnostic imaging required to complete the procedure.
iii) Paid to a maximum of three lesions, 100% for the first and 50% for the second and 25% for the third lesion.
iv) Repeats within 30 days are paid at 50%.
v) Not paid with Fee Item 10908.

Excision

CV07404	Non-anatomic, subsegmental excision of liver mass	1,000.00	7
CV72794	Laparoscopic non-anatomic sub-segmental excision of liver mass	1,141.96	7

Notes:

i) Restricted to General Surgery.
ii) If laparoscopic procedure is converted to open, bill under open procedure (07404) at 100% and 04001 at 50%.
iii) Not for incomplete resection or incision/core biopsy of liver masses.
iv) Only for therapeutic liver resection and not diagnostic excisional biopsy.

Hepatectomy, segmental resection:

Liver resections for metastasis, billed in conjunction with colorectal resections or sarcoma resections, will be paid at 100% of the listed fees, for each item, when done as a team by two general surgeons. Only payable when ICD-9 code is 153, 154, 158 or 171.

The following lists of procedures are eligible for payment as team fees:

Liver resections: 07405, 72795, 07406, 72796, 07407, 72797, 07408, 72798, 07409, 07410, 07411

Colorectal resections: 72622, 72623, 72624, 72625, 72626, 72631, 72632, 72633, 72634, 72734, 72635, 72755, 72636, 07664, 07662, 72762, 07663, 72763, 07569, 72769, 07640, 72760, 07641, 72646, 72740, 07662, 07580

Sarcoma resections: 71290, 71291

Hepatectomy, segmental resection:

CV07405	- one or more, same side	1,200.00	8

Note: *Cholecystectomy is not paid in addition.*

CV72795	Laparoscopic hepatectomy, segmental resection-one or more, same side	1,261.93	8

Notes:

i) Restricted to General Surgery.
ii) If laparoscopic procedure is converted to open, bill under open procedure (07405) at 100% and 04001 at 50%
iii) Cholecystectomy is not paid in addition.

		$	Anes. Level
CV07406	- two or more segments, bilateral lobes	1,600.00	8
	Notes: *i) Surgeon must operate on right and left lobes* *ii) Cholecystectomy is not paid in addition.*		
CV72796	Laparoscopic segmental resection of liver: two or more segments, bilateral lobes	1,800.00	8
	Notes: *i) Restricted to General Surgery.* *ii) If conversion to open is necessary, bill the open procedure (07406) at 100% plus 50% of the laparoscopy fee (04001).* *iii) Surgeon must operate on right and left lobes.* *iv) Cholecystectomy is not paid in addition.*		
CV07407	- total left lobectomy - open	2,000.00	8
	Note: *Cholecystectomy is not paid in addition.*		
CV72797	Laparoscopic total left lobectomy	2,500.00	8
	Notes: *i) Restricted to General Surgery.* *ii) If laparoscopic procedure is converted to open, bill under open procedure (07407) at 100% and 04001 at 50%.* *iii) Cholecystectomy is not paid in addition.*		
CV07408	- total right lobectomy - open	2,000.00	8
	Note: *Cholecystectomy is not paid in addition.*		
CV72798	Laparoscopic total right lobectomy	2,500.00	8
	Notes: *i) Restricted to General Surgery.* *ii) If laparoscopic procedure is converted to open, bill under open procedure (07408) at 100% and 04001 at 50%.* *iii) Cholecystectomy is not paid in addition.*		
CV07409	- extended left lobectomy (includes caudate lobe and at least one portion of right lobe)	2,200.00	8
CV07410	- caudate lobectomy (isolated procedure)	2,100.00	8
CV07411	- extended right lobectomy; 5 or more segments (includes caudate)	2,300.00	8
	Note: *Cholecystectomy is not paid in addition.*		

Liver - Repair (Trauma)

V07412	Hepatorrhaphy; suture of liver wound or injury - simple	609.04	8
V07413	- with packing	644.63	8
CV07440	Resectional debridement of liver	1,268.85	8
CV07441	Hepatic artery ligation, to include resectional debridement where indicated	1,015.07	8
CV07442	Hepatic lobectomy for trauma to include resectional debridement where indicated	2,500.00	9

Biliary Tract

Incision

Choledochotomy or choledochostomy and exploration, drainage or removal of calculus:

V70694	- open	850.00	5
V70695	- laparoscopic	900.00	5
V70696	- with transduodenal sphincteroplasty	950.00	5
V07769	Duodenotomy and sphincteroplasty	1,014.02	5

Cholecystostomy:

		$	Anes. Level
V07698	- open	505.43	5
V70698	- laparoscopic	455.06	5
71698	- percutaneous (operation only)	164.85	2

Biliary Tract – Endoscopy

07780	Biliary endoscopy; intraoperative, choledochoscopy (extra)	202.77	
07781	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen by brushing and/or washing to include biopsy – operation only	202.59	2
07782	- with removal of stone (operation only)	228.06	2
07783	- with dilation of duct stricture with or without stent (operation only)	228.06	2
	Endoscopic Retrograde Cholangiopancreatography (ERCP); to include biopsies or brushings:		
V33341	- with papillotomy or sphincterotomy	447.05	3
V33342	- with stone extraction	530.07	3
V33343	- with biliary stenting	435.25	3
V33344	- with balloon dilatation of biliary stricture	434.25	3
V33345	- with stone extraction requiring lithotripsy	555.62	3
33346	Insertion of naso-biliary drainage tube - operation only	103.49	3
33347	Replacement of a duodenal biliary stent – operation only	172.45	3

Biliary Tract – Excision

	Cholecystectomy:		
V07707	- laparoscopic	536.09	5
V07699	- open	606.62	5
V70700	- open cholecystectomy immediately preceded by attempted laparoscopic cholecystectomy	707.84	5
V70701	- with exploration of CBD (laparoscopic)	1,212.66	5
V70702	- with exploration of CBD (open)	1,212.66	5
V70703	- with choledochoduodenostomy (includes CBD exploration)	1,313.82	5
V70704	- with choledochojejunostomy (includes CBD exploration)	1,313.92	5
V70705	- with transduodenal sphincterotomy or sphincteroplasty (includes CBD exploration)	1,313.82	5
CV70710	Exploration for congenital atresia of bile ducts without repair ***Note**: Includes liver biopsy and/or cholangiography if required.*	1,522.60	5
CV70711	Portoenterostomy (Kasai procedure)	1,584.89	6
	Excision of bile duct tumour or stricture:		
CV70712	- lower (below bifurcation), any repair	1,900.00	6
CV70713	- upper (at or above bifurcation) – one anastomosis	2,200.00	6
CV70714	- upper (at or above bifurcation) – multiple anastomoses	2,500.00	6
	Excision of choledochal cyst (to include cholecystectomy):		
CV70715	- below bifurcation	1,414.54	5
CV70716	- above bifurcation requiring one ductoplasty	1,471.37	5
CV70717	- above bifurcation - multiple anastomoses	1,594.00	5

		$	Anes. Level
CV70718	Portal lymphadenectomy	764.73	4

Notes:

i) Paid as stand-alone procedure or in conjunction with liver resection, bile duct resection, or pancreatectomy for cancer of the liver, pancreas, gallbladder and bile ducts.

ii) Paid only with skeletonization of the hepatic artery and portal vein from the superior duodenum to the liver hilum.

iii) Restricted to General Surgery.

Biliary Tract – Repair

Cholecystoenterostomy:

V07706	- direct (loop)	1,015.07	6
V70720	- with gastroenterostomy	1,218.09	5
V70721	- Roux-en-Y	1,116.58	5
V70722	- Roux-en-Y with gastroenterostomy	1,319.59	5
CV07703	Choledochoduodenostomy	1,116.58	6
V07705	Choledochojejunostomy (anastomosis of extra-hepatic biliary ducts and GI tract)	1,218.09	6
V70725	- with gastrojejunostomy	1,700.00	6
V70726	- Roux-en-Y	1,700.00	6
V70727	- Roux-en-Y with gastrojejunostomy	1,700.00	6
CV70728	Anastomosis of intra-hepatic ducts and GI tract; (Longmyer); Roux-en-Y	1,769.19	6
07561	Placement of choledochal stent (operation only)	172.45	5
CV70730	U-tube hepatico enterostomy	1,769.19	5
CV70731	Primary repair of extra-hepatic biliary duct for injury (including intraoperative), any method	1,421.10	5
V07776	Repair of cholecystenteric fistula	1,000.00	5

Endocrine System

Thyroid – Incision

70740	Incision and drainage of thyroglossal cyst; infected (operation only)	203.93	3
S00744	Thyroid biopsy - procedural fee	73.65	2

Thyroid – Excision

V07740	Thyroid biopsy - open	354.83	4

Total thyroid lobectomy:

V70742	- unilateral, with or without isthmusectomy	587.84	4
V70743	- unilateral, with contralateral subtotal lobectomy including isthmus	728.04	4

Thyroidectomy:

V07743	- total or complete	1,014.42	4
V07741	- subtotal unilateral (local excision of thyroid lesion)	450.00	4
V70745	- subtotal bilateral	706.81	4
V70747	- removal of all remaining thyroid tissue following previous removal of portion of thyroid (completion thyroidectomy)	694.84	4
C70748	Sternal split for substernal thyroid; (extra)	163.48	
V07771	Picking operation; metastatic neck nodes for thyroid carcinoma (with operative report)	1,100.00	5

Endocrine System - Parathyroid

Parathyroidectomy or exploration of parathyroids:

		$	Anes. Level
V07745	- removal of single adenoma	900.00	4
V07744	- subtotal parathyroidectomy	1,014.37	4
V71746	- re-exploration	1,217.10	4
CV71747	- with mediastinal exploration and sternal split ***Note**: Re-exploration is not payable in addition to C71747.*	1,217.17	6
71748	Parathyroid autotransplantation - extra to thyroidectomy and parathyroidectomy procedures (operation only)	101.96	

Endocrine System – Adrenal

CV71703	Adrenalectomy for Pheochromocytoma - open ***Notes:*** *i) Only to be billed if procedure takes longer than three hours. If surgery takes less than three hours, bill item 71704.* *ii) Pathology report to be submitted when billing to confirm Pheochromocytoma.* *iii) Start and end times must be included in patients chart and on claim form.*	1,019.18	8
CV72703	Adrenalectomy for Pheochromocytoma - laparoscopic ***Notes:*** *i) Only to be billed if procedure takes longer than three hours. If surgery takes less than three hours, bill item 72704.* *ii) Pathology report to be submitted when billing to confirm Pheochromocytoma.* *iii) Start and end times must be included in patients chart and on claim form.*	1,273.97	8

Adrenalectomy; any approach:

CV71704	- unilateral - open	804.44	8
CV72704	- unilateral - laparoscopic	1,005.57	8
CV71705	- bilateral - open	1,600.00	8
CV72705	- bilateral - laparoscopic	1,800.00	8

Endocrine System - Carotid Body

Excision of carotid body tumour:

CV71706	- without excision of carotid artery	1,014.37	6
CV71707	- with excision of carotid artery	1,217.37	8

Endocrine System - Pancreas – Incision

V71708	Placement of drains, peripancreatic for acute pancreatitis	1,000.00	2
V71709	Resectional debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis; to include gastrostomy, jejunostomy and cholecystostomy - any approach (operation only)	1,300.00	8

Endocrine System - Pancreas – Excision

71710	Open biopsy of pancreas, any method (fine needle, core, wedge) intraoperative – extra (operation only)	100.00	6
S00826	Biopsy of pancreas - percutaneous	101.44	2
CV71712	Limited excision of pancreatic lesion (e.g.: cyst or adenoma)	1000.00	6

Pancreatectomy, distal subtotal:

CV71713	- with splenectomy and without pancreaticojejunostomy -open	1,300.00	7

		$	Anes. Level
CV72713	- with splenectomy and without pancreaticojejunostomy – laparoscopic	1,520.85	7
	Notes: *i) Restricted to General Surgery.* *ii) Start and end times must be included in patients chart and on claim submission.* *iii) If conversion to open procedure is necessary, bill open procedure plus 50% of laparoscopy fee, 04001.*		
CV71714	- with splenic preservation - open	1,600.00	7
CV72714	- with splenic preservation - laparoscopic	1,277.23	7
	Notes: *i) Restricted to General Surgery.* *ii) Start and end times must be included in patients chart and on claim submission.* *iii) If conversion to open procedure is necessary, bill open procedure plus 50% of laparoscopy fee, 04001.*		
CV71715	- with pancreaticojejunostomy and splenectomy	1,500.00	7
CV71716	- with splenic preservation and pancreaticojejunostomy	1,700.00	7
CV71717	Pancreatectomy, distal, near total with preservation of duodenum	2,400.00	7
CV71718	Excision ampulla of vater	1,062.67	6
CV71719	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochojejunostomy and gastroenterostomy (with or without pancreatojejunostomy)(Whipple procedure)	3,045.21	8
CV71720	- pyloric sparing (Whipple procedure)	3,045.21	8
CV71721	Regional pancreatectomy to include above Whipple procedures with portal vein reconstruction, with portosystemic shunt and with coeliac lymphadenectomy	3,449.82	9
CV71722	Total pancreatectomy with Whipple procedure	2,500.00	8
CV07714	Pancreaticojejunostomy; side-to-side anastomosis (Peustow type procedure) ***Note****: Includes removal of calculi.*	1,400.00	6
	Endocrine System - Pancreas - Repair		
	External drainage, pseudocyst of pancreas:		
V07756	- open	1,000.00	5
V07758	- laparoscopic	1,000.00	5
CV07711	Internal drainage or anastomosis of: pancreatic pseudocyst to gastrointestinal tract – cyst gastrostomy; open (endoscopy payable separately)	964.32	5
CV72711	Internal drainage or anastomosis of pancreatic pseudocyst of GI tract – laparoscopic ***Notes:*** *i) Restricted to General Surgery.* *ii) If conversion to open procedure is necessary, bill open procedure (07711) at 100%, plus 50% of laparoscopy fee, 04001.*	1,114.48	5
CV07732	- transduodenal	1,015.07	5
CV07733	- Roux-en-Y	1,015.07	5

Hernia - Repair

		$	Anes. Level
V71600	Repair inguinal or femoral hernia; under 6 months of age; with or without hydrocoelectomy	406.03	2
V71601	- bilateral	707.68	2
V71602	- incarcerated or strangulated	507.54	3
V71603	Repair inguinal or femoral hernia; age 6 months to 12 years; with or without hydrocoelectomy	379.23	2
V71604	- bilateral	606.64	2
V71605	- incarcerated or strangulated	433.34	3
	Repair inguinal or femoral hernia; greater than age 12:		
V71606	- reducible open	364.12	2
V71607	- reducible laparoscopic	404.42	4
V71608	- incarcerated or strangulated	411.85	3
	Repair recurrent inguinal or femoral hernia; any age:		
V71609	- reducible open	455.15	2
V71610	- reducible laparoscopic	505.52	4
V71611	- incarcerated or strangulated	514.78	3
	Bilateral primary inguinal or femoral hernias greater than age 12, not incarcerated or recurrent:		
V71612	- open	606.63	2
V71613	- laparoscopic	667.08	4
	Repair initial incisional hernia: ***Note**: Lysis of adhesions not payable in addition*.		
V71614	- reducible	596.65	2
V71615	- incarcerated or strangulated	596.65	3
V71616	- using prosthetic mesh	596.65	3
V71623	Laparoscopic initial ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis.	697.44	5
	Repair recurrent incisional hernia:		
V71617	- reducible	608.86	2
V71618	- incarcerated or strangulated	609.16	3
V71624	Laparoscopic recurrent ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis ***Note:** Lysis of adhesions not payable in addition*.	761.21	6
CV71625	Myofascial abdominal wall advancement flaps (component separation procedure) for massive initial or recurrent incisional hernia repair ***Notes:*** *i) For complex and recurrent abdominal wall hernias with or without mesh.* *ii) To include removal of previous mesh, if required.* *iii) If Lysis of adhesions (70650 and 70651) is performed and takes longer than 30 minutes to complete, it is payable in addition after 30 minutes of time.*	866.70	7

		$	Anes. Level
	Repair umbilical hernia:		
V71619	- reducible	343.80	2
V71620	- incarcerated or strangulated	343.80	3
V71621	Repair of hernia with resection of bowel; all performed through same incision	758.16	5
V71622	Repair of hernia with resection of bowel requiring a separate incision	809.05	5
07596	Hernia; incisional; repair following laparotomy (with operative report) – extra (operation only)	125.00	2
V07610	Epigastric	343.80	4
CV70604	Congenital diaphragmatic hernia	1,522.60	9

Pediatric Procedures

	Broviac type catheter:		
07139	- insertion of	162.55	2
V07140	- insertion of - less than 3 months of age or less than 3 kg	269.03	4
07141	- removal of (operation only)	126.79	2
V07571	Pena posterior sagittal anal proctoplasty; primary surgeon	1,150.14	6
07593	Fee for second surgeon participating in Pena posterior sagittal anal proctoplasty ***Note:*** *When 07571 and 07593 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.*	339.13	
V07700	Total correction cloacal anomalies; primary surgeon	2,150.54	6
07702	Fee for second surgeon participating in total correction of cloacal anamolies ***Note:*** *When 07700 and 07702 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.*	507.54	
V07690	Anoplasty for imperforate anus	602.52	4
V07466	Anal stricture; plastic repair; child	450.49	2
	Proctectomy; complete (for congenital megacolon) abdominal and perineal approach with pull through procedure and anastomosis (e.g.: Swenson, Duhamel or Soave type operation):		
V72662	- synchronous abdominal	1,314.90	7
CV07697	Excision sacrococcygeal teratoma	1,522.60	6
	Intestinal strictoplasy (enterotomy and enterorrhaphy) with or without dilation for intestinal obstruction:		
V72647	- single	606.54	5
V72648	- multiple (two or more)	909.55	5
	Omphalocoele or gastroschesis:		
V07615	- permanent repair	613.07	7
V07614	- temporary repair	402.23	7
CV70604	Congenital diaphragmatic hernia	1,522.60	9
V07651	Reduction of volvulus, intussusception; internal hernia by laparotomy	526.23	5
CV72751	Reduction of volvulus, intussusception; internal hernia – laparoscopic ***Notes:*** *i) Restricted to General Surgeons.* *ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100% plus fee item 04001 at 50%.*	657.80	5
V70624	Pyloromyotomy, cutting of pyloric muscle (Fradet-Ramstedt type operation)	505.35	5

		$	Anes. Level
V07552	Aortopexy for tracheomalacia	1,015.07	9
V07653	Atresia of the small bowel	1,522.60	6
V07655	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	505.22	4
CV07692	Repair major ano-rectal anomalies – with concurrent uro-genital malformations via sacral approach	1,522.60	7
V71531	Repair tracheo-oesophageal fistula - cervical approach to include gastrostomy ***Note:*** *71530 and 71531 include gastrostomy.*	2,000.00	6
V07630	Gastrostomy - open	456.79	5
33394	Assistant fee for PEG procedure ***Note:*** *33326, 33394 may be billed by any qualified physician.*	112.47	
CV71532	Oesophagoplasty (plastic repair or reconstruction); thoracic approach - without repair of tracheo-oesophageal fistula	2,000.00	8
CV71533	- with repair of tracheo-oesophageal fistula	2,250.00	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach) ***Note:*** *C71533 and 71534 include gastrostomy.*	804.44	8
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	920.65	6
V71536	- open	736.52	6
V71650	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure)- open	505.61	5
V71651	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic ***Notes:*** *i) Restricted to General Surgeons.* *ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100% plus fee item 04001 at 50%.*	586.02	5

Trauma

Note: *Trauma fee items are to be charged in cases of blunt and/or penetrating abdominal injury. They do not apply to incidental intra-operative injury to abdominal structures.*

SV07150	Insertion of Thoracostomy Tube ***Notes:*** *i) Restricted to General Surgeons and Respirologists* *ii) Must be a French 20 or greater thoracostomy tube.* *iii) Payable once for each chest cavity per day, if performed bilaterally billable at 150%.* *iv) Not payable with 10087, 10088, 10089, 01088, 32031, 00081, and critical care fees.*	250.00	4
S32031	Closed drainage of chest – operation only	137.00	4
07430	Diagnostic peritoneal lavage (catheter) – operation only	102.83	3
V07432	Laparotomy in the trauma patient	454.41	5
V07431	Repair diaphragmatic injury	804.44	8
	Hepatorrhaphy; suture of liver wound or injury:		

		$	Anes. Level
V07412	- simple	609.04	8
V07413	- with packing	644.63	8
CV07440	Resectional debridement of liver	1,268.85	8
CV07441	Hepatic artery ligation, to include resectional debridement where indicated	1,015.07	8
CV07442	Hepatic lobectomy for trauma to include resectional debridement where indicated	2,500.00	9
V07434	Splenic repair, any method	758.60	7
V07433	Laparotomy to include removal of injured spleen	850.00	7
V07435	Repair of lacerations to stomach	750.00	7
V07436	Exploration and mobilization of duodenum and pancreas	644.63	7
V07437	Repair of laceration of duodenum	857.71	7
V07438	Resection and debridement of duodenal injury to include duodenal diverticulisation where indicated	1,522.60	7
V07445	Repair of lacerations to small bowel	572.71	7
V07446	Resection of injured small bowel	644.63	7
V07450	Exteriorization of colonic injury	602.52	7
V07448	Repair of colonic injury with or without colostomy	962.78	7
V07449	Resection of colonic injury	962.78	7
V07452	Repair of extra-peritoneal rectum, with or without colostomy	962.78	7
V07447	Repair of mesenteric injury	572.71	6
V07443	Resection of distal pancreas for trauma	1,268.85	8
V07444	Pancreatico-duodenectomy (Whipple Procedure) for trauma	3,045.21	9
77350	Supra renal aortic crossclamp - extra to abdominal vascular or major trauma cases (operation only)	114.21	

Note: *Operative report required.*

Vascular

Venous

Chronic or Varicose Veins

Note: *Treatment of varicose vein pathology is a benefit under MSP only if the patient is symptomatic with varicose veins of at least 3 mm and has one or more of the following:*

i) Pain, aching, cramping, burning, itching and/or swelling during activity or after prolonged standing severe enough to impair mobility.
ii) Recurrent episodes of superficial phlebitis.
iii) Non-healing skin ulceration.
iv) Bleeding from a varicosity.
v) Stasis dermatitis.
vi) Refractory dependent edema.

77045	Varicose veins, injection, each visit	13.46

Note*: Treatment for cosmetic purposes is not a benefit under MSP.*

77046	Ultrasound directed (with image capture) foam sclerotherapy – initial	171.95
77047	Ultrasound directed (with image capture) foam sclerotherapy – repeat	171.95

Notes:

i) 77046 and 77047 may each be charged only once per patient per leg per lifetime.
ii) One additional repeat per leg may be billed under fee item 77060 in the same 12 month period.
iii) Services in subsequent 12 month periods should be billed in accordance with the notes following fee item 77050 and 77060.

		$	Anes. Level
	Compression sclerotherapy:		
77050	- initial	80.82	2
77060	- repeat	37.87	2
	Notes: *i) 77050 may be charged only once per 12 month period for each leg, and 77060 only twice in the same period.* *ii) If in the same 12 month period following fee item 77046 and 77047, only one additional repeat is payable per leg under fee item 77060.*		
77065	High ligation, long saphenous	223.03	2
V07108	Stripping long saphenous	263.88	2
V07109	Stripping short saphenous	228.30	2
	Multiple ligations and stripping tributaries:		
07110	- 3 to 5 incisions (operation only)	278.91	2
V07111	- 6 or more incisions	304.28	2
V07112	Ligation of 2 or more perforators	278.91	2
77070	Complete fasciotomy with or without multiple ligations ***Note**: For decompression fasciotomy, see 77360.*	319.25	2
77075	Re-exploration of groin and/or popliteal fossa	300.19	2
V07116	Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy)	523.41	3
77077	Excision of ulcer and grafting - add full fee to venous procedures (operation only)	120.28	3
77079	Venous crossover graft for iliac obstruction	609.87	7
	Acute Venous		
77082	Ligation of femoral vein	148.84	2
77084	Ligation or fenestration of inferior vena cava (requires laparotomy)	495.27	5
77086	Thrombectomy for acute ilio-femoral thrombophlebitis	620.60	5
	Portosystemic Shunting		
C77090	Spleno-renal shunt	945.05	8
C77092	Porto-caval shunt	945.05	8
C77094	Mesocaval graft - synthetic	945.05	8
C77096	- autogenous	1,006.21	8

Arterial System

Note: 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.

	Thrombectomy, Embolectomy:		
C77115	Thrombectomy - with or without angioplasty	556.73	5
C77120	Embolectomy - trunk or extremities (subclassified by location and incision)	620.60	5
C77125	- one side	446.10	5
77100	Removal of synthetic graft, without replacement - payable at 100% of the current fee listed for the initial insertion		
77102	Removal of synthetic graft, with replacement at the same site - payable at 50% of the current fee listed for the initial insertion, extra to the Replacement graft		

		$	Anes. Level
77104	Removal of synthetic graft, 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% 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.* *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).*		
	Neck or Thoracic:		
C77130	Bypass graft: (synthetic) and/or thromboendarterectomy - carotid arteries	981.24	8
C77135	- innominate	779.13	5
C77140	- subclavian	846.50	5
C77145	Ligation of carotid artery	255.38	5
	Groin Dissection:		
77180	Resection of abdominal aneurysm - with associated femoral dissection, one or both sides (extra fee to be added to procedure) (operation only) ***Note:** Peripheral aneurysm - charge associated bypass graft procedure.*	124.11	9
C77110	Re-exploration of groin for bleeding or hematoma (operation only)	125.47	4
77112	Redissection of groin (after 21 days), extra ***Note**: Not payable with fee items 77100, 77102, 77104 or 77043.*	132.47	4
	Aorto-iliac: Bypass graft (synthetic or autologous vein) and/or thromboendarterectomy including extension onto femoral artery by either retroperitoneal or trans peritoneal approach ***Note:** Harvest of autologous vein (77280, 77285, 77290, or 77295) paid at 100%.*		
C77150	**–** aorta and/or iliac (unilateral)	892.24	9
C77155	- aorta and/or iliac (bilateral)	1,400.80	9
C77160	- aorto-femoral and/or ilio-femoral (unilateral)	866.39	9
C77165	- aorto-femoral and/or ilio-femoral (bilateral)	1,400.80	9
	Aneurysm: ***Note:** Peripheral aneurysm - charge associated bypass graft procedure.*		
77170	Arteriovenous aneurysm	495.27	9
C77175	Abdominal aneurysm - with grafting	1,397.15	9
C77185	Ruptured aneurysm - with grafting	1,598.26	10
	Mesenteric:		
C77190	Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy	892.23	7
C77195	Superior mesenteric bypass graft (autogenous vein)	892.23	7
	Renal:		
C77200	Renal bypass graft (synthetic) and/or thromboendarterectomy	892.23	7
C77205	Renal bypass graft (autogenous vein)	892.23	7

		$	Anes. Level
	Axillo-Femoral:		
	Axillo-femoral bypass graft and/or thromboendarterectomy		
C77210	- unilateral	979.23	7
C77215	- bilateral	1,269.39	7
	Femoral Crossover:		
C77230	Femoro-femoral crossover bypass graft (synthetic) and/or thromboendarterectomy	930.69	5
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	930.69	5
	Infrainguinal:		
C77240	Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	858.35	5
C77245	- popliteal (endarterectomy)	679.59	5
C77250	- popliteal (synthetic)	620.53	5
C77255	- anterior, posterior tibial, or peroneal	742.29	5
	Bypass graft (autogenous vein):		
C77260	- femoral	859.23	5
C77265	- popliteal	1,072.16	5
C77270	- anterior, posterior tibial or peroneal	1,115.63	5
77275	- in situ vein graft (extra)	257.02	7
77280	- non-ipsilateral long saphenous graft (extra)	254.66	7
77285	- short saphenous graft (extra)	254.66	7
77290	- superficial femoral vein graft (extra)	254.66	7
77295	- arm vein graft (extra)	254.66	7
77300	- A-V fistula with bypass graft in limb salvage (extra)	185.56	7
	Profunda thromboendarterectomy:		
77310	Profunda thromoendarterectomy without patch repair	553.02	5
77315	Profunda thromboendarterectomy with patch repair (synthetic or autologous)	750.88	5
	Notes: *i) If performed with inflow procedure (77175, 77160, 77165, 77210, 77215, 77230, or 77235), payment will be made at 50% for unilateral or 2 x 50% for bilateral.* *ii) If performed with outflow procedure (77240, 77260, 77265, or 77270) payment will be made at 50%.*		
	Trauma:		
	Repair of injury of major vessel in extremity:		
C77330	- suture	583.75	6
C77335	- graft	750.88	6
	Repair of injury of major vessel in trunk:		
C77340	- suture	876.21	9
C77345	- graft	1,168.71	9
77350	Supra renal aortic crossclamp - extra to abdominal vascular or major trauma cases (operation only)	114.21	
	Note: *Operative report required.*		
	Fasciotomy:		
77360	Decompression fasciotomy - subcutaneous	334.57	3
	Note: *77360 includes secondary closure*		

		$	Anes. Level
	Miscellaneous:		
77370	Release of popliteal entrapment syndrome	334.57	3
	Note: *Not to be paid if full femoral popliteal bypass is performed.*		
00722	Arteriography, operative - procedural fee	75.51	
	Second Operator:		
77025	Synchronous combined bypass graft - extremities	297.96	
77030	- trunk	300.19	
	Note: *Items 77025 and 77030, provide operative report by second operator when requested by MSP.*		

Renal Access

77380	Insertion permanent catheter - procedure fee only	190.68	3
77385	Removal by dissection of chronic peritoneal catheter - operation only	132.26	3
	Note: *For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.*		
77395	Creation of internal arterio-venous fistula	414.93	4
77396	Revision of AV fistula	505.58	
	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, 295, 77295, 77300).		
	iv) 77043 not paid with this fee.		
77400	Synthetic AV graft for hemodialysis	707.49	4
	Note: *Not paid with 77295, 77395, 77396 and 77402.*		
77402	Creation of brachiobasilic arteriovenous fistula with vein transposition	707.74	5
	Note: *Not paid with 77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77330, 77395 and 77400.*		
77403	Arm revascularization with distal revascularization and interval ligation (DRIL)	707.73	5
	Note: *Not paid with 77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77300, 77395 and 77396.*		
77405	Thrombectomy of arterio-venous fistula	349.01	3

Sympathectomy

77420	Lumbar sympathectomy - unilateral	371.15	4
77422	Cervical sympathectomy - unilateral	501.87	5
77424	Preganglionic sympathectomy, upper dorsal region - unilateral	458.38	7
77426	Lumbo-dorsal sympathectomy and splanchnicneurectomy - unilateral	458.38	7
	Lumbar sympathectomy - with abdominal procedure:		
77428	- unilateral (extra)	124.12	3
77430	- bilateral (extra)	248.26	

Lymphatic System

V07360	Splenectomy	808.57	6
CV07368	Laparoscopic splenectomy	809.21	6
	Notes:		

		$	Anes. Level
	i) Fee items 07360 or 07434 not payable in addition. *ii) If laparoscopic procedure is converted to open, bill under 07360 at 100% and 04001 at 50%.*		
V07361	TB glands - radical removal	269.03	4
V07363	Radical femoral, inguinal and/or iliac dissection	536.76	5
CV07365	Isolated limb perfusion to include groin dissection and laparotomy	938.97	5
CV07366	Laparotomy and staging of lymphoma to include splenectomy	909.86	6

Lymphoedema - Leg

06127	Lymphoedema of limbs, excision and grafting - entire leg	700.04	3
06128	- entire lower extremity	1,046.58	3

Abdominal Surgery - Miscellaneous

V07603	Resuture abdominal wound evisceration	406.03	5
07451	Thoracic extension of abdominal incision, extra	285.69	8
V07600	Exploratory laparotomy to include biopsy	405.81	5
V07597	Post-operative haemorrhage - intra-abdominal management	379.58	6
V07601	Intra-abdominal abscess - excluding intrahepatic (stand-alone procedure) ***Note:*** *Not paid for post operative hemorrhage (by any approach) which should be billed as fee item 07597.*	434.19	5
V72600	Temporary or delayed abdominal closure for complex abdominal sepsis or abdominal compartment syndrome – with Vacuum Assisted Closure (VAC) system Bogota bag or other temporary abdominal closure system (with or without abdominal exploration and washout) ***Notes:*** *i) Payable only in the operating room or ICU under general anesthesia.* *ii) Repeat services billed at 100%.* *iii) If required over 10 times in a single hospital stay, provide explanation in a note record.* *iv) Not billable in addition to 07600 or 07601.*	376.25	5
S04001	Laparoscopy (operation only)	230.69	4
PV07414	Exploratory laparoscopy with incisional, excisional or core liver biopsy and/or peritoneal washings ***Notes:*** *i) Restricted to General Surgery.* *ii) For excisional biopsy of very small superficial liver lesion(s) forstaging/diagnostic purposes or* *iii) For incisional or core biopsy of a large liver lesion for staging/diagnostic purposes.* *iv) Not for laparoscopy without biopsy (see fee item 04001).*	504.62	6
P07415	Liver biopsy in conjunction with other open or laparoscopic abdominal procedure - extra ***Notes:*** *i) Restricted to General Surgery.* *ii) For excisional biopsy of very small superficial liver lesion(s) forstaging/diagnostic purposes, or* *iii) For incisional or core biopsy of a large liver lesion for staging/diagnostic purposes.*	127.77	
	Removal of indwelling Enteral tubes with or without exploration of tube insertion site:		
S71280	- not requiring anesthesia (operation only)	30.65	

		$	Anes. Level
S71281	- requiring local or regional anesthesia (operation only)	63.06	
S71282	- requiring general anesthesia (operation only)	203.93	2

Diagnostic Procedures or Endoscopy

S71283 - replacement of tube – extra 30.65

Notes:

i) Tray fee is not paid when the procedure is performed in hospital or publicly funded facilities (D&T Centres, psychiatric facilities).

ii) Not paid with Fee Items 07781, 07782, 07783, 70637, 33326, 33341, 33342, 33343 and 33347.

iii) Restricted to General Surgeons.

iv) Paid @ 50% with endoscopy.

CV71290 Resection of retroperitoneal or intra-abdominal soft tissue tumour measuring 10 cm or greater – first 60 minutes ..... 662.77 — 8

C71291 Resection of retroperitoneal or intra-abdominal soft tissue tumour measuring 10 cm or greater – each additional 15 minutes or greater portion thereof 76.47

Notes:

i) Payment restricted to General Surgeons.

ii) Not paid with fee items 51051, 51052, 04029 or 04628.

iii) Start and end times are required in the claim and the patient's chart for the resection of the tumour and cannot be billed for time performing concurrent procedures.

CV71292 Peritonectomy, with or without intraperitoneal chemotherapy – each hour (up to 8 hours) ..... 662.77 — 7

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

CV71293 Peritonectomy, with or without intraperitoneal chemotherapy – each additional 15 minutes or greater portion thereof (maximum of 16 units per patient) ..... 75.60 — 7

Notes:

i) Payment restricted to General Surgeons.

ii) This is an all-inclusive fee, for the day of surgery, under the same anesthetic.

iv) Start and end times are required in the claim and the patient's chart

07764	Cholangiography - operative, extra	80.86	
07710	Pancreatogram - with or without sphincterotomy, done in conjunction with any of the biliary or pancreatic surgical procedures –extra	67.19	
S00869	Manometry; anal - adult	101.37	2
S00797	Oesophageal motility test	176.15	
S00788	- technical fee	74.35	
S00798	- professional fee	101.79	
S00818	Oesophageal pH study for reflux, extra - professional fee	41.00	
S00817	- technical fee	13.00	
S00826	Biopsy of pancreas - percutaneous	101.44	2
S00809	Retrograde pancreatography	216.54	3
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	116.63	3
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	97.14	3

		$	Anes. Level
S10763	Initial esophageal, gastric or duodenal biopsy	15.00	3
	Notes:		
	i) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs.		
	ii) First biopsy paid at 100%, second and third at 50%.		
S10764	Multiple biopsies for differential diagnoses of Barrett's Esophagus, H pylori, Eosinophiic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma	43.58	3
	Notes:		
	i) Paid only once per endoscopy.		
	ii) Paid only in addition to S10763 at 100%.		
	iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.		
S00710	Mediastinoscopy or anterior mediastinotomy (combined 50% extra) - procedural fee	196.39	4
SY00716	Sigmoidoscopy, flexible; diagnostic	76.09	2
SY00718	- with biopsy	77.34	2
	Colonoscopy with flexible colonoscope:		
33373	- biopsy	235.15	2
33374	- removal polyp	283.50	2
S00780	Schirmer's Test (included in fee Item 02015)	13.15	
SY00789	Peritoneal lavage	85.74	2

VASCULAR SURGERY

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

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

Preamble

Complete understanding of the following paragraphs is essential to appropriate billing of the Vascular Surgery fees. These definitions should be interpreted with reference to the General Preamble.

Definitions

Preparation of the operative site

All pre-operative steps involved in reducing the risk of surgical site infection including: the administration of systemic antimicrobial therapy, hair removal with the use of clippers, reducing the endogenous microbial flora at a planned surgical incision site by the application of antiseptic solution, and the draping of the surgical field to minimize operative site contact.

Multiple Surgical Procedures (from General Preamble)

D. 5. 3. Multiple Surgical Procedures

i) When two or more similar procedures (including bilateral procedures) are performed under the same anesthetic, or when two or more procedures are performed in the same general area, whether through the same incision, an extension of that incision or through separate incisions, the procedure with the greater listed fee may be claimed in full and the fees for the additional procedure are reduced to 50 percent, unless otherwise indicated by the Schedule. However, additional incidental surgery performed en passant (i.e. surgery which would not have been performed in the absence of the primary procedure, such as an appendectomy during abdominal surgery, or incidental cystectomy during gynecological surgery) is considered to be included in the fee for the planned procedure and may not be charged.

Open surgical procedures are defined as:

All open surgical procedures required in optimizing perfusion and maximizing durability of the operation. Additional open surgical procedures are not considered preparation of the operative site. Additional open surgical procedures accompanying the first open surgical procedure will be limited to one per anatomically named vessel despite vessel continuity in series or in parallel.

Open vascular surgery with angioplasty and stent

Open surgical procedures are considered separate billable procedures from endovascular procedures in the context of hybrid revascularization. The surgical procedures are paid in accordance with Section D. 5. 3 Multiple Surgical Procedures. Angioplasties (77113, 77114) are billed at 50% of the listed fee for the first and 25% of the listed fee for the second to a maximum of two angioplasties. Simultaneous stenting (10919) on differing anatomical named vessels is to be paid: the first at 100% and the second at 50% to a maximum of two stents.

Isolated angioplasties and stents

When angioplasty 77113 or 77114 is performed as isolated endovascular procedure (not in combination with open surgery or another endovascular surgery), multiple angioplasties done during the same procedure on different anatomical named vessels are paid as follows: the first is paid at 100%, the second

at 50%, the third at 25% to a maximum of 3 endovascular interventions. Simultaneous stenting 10919 on differing anatomical named vessels is to be paid: the first at 100%, the second at 50%, and the third at 25% to a maximum of 3 stents.

In cases of combined endovascular procedures involving 77113 and 77114, the higher 77113 fee may be claimed in full and the lower 77114 fee is reduced to 50%.

Anatomical Named Vessels

One or more angioplasty 77113 or 77114 or stent 10919 per anatomical named vessel will be considered as one angioplasty and stent of that anatomical named vessel despite vessel continuity in series or in parallel with other vessels requiring intervention.

The fee codes include any and all diagnostic imaging required to complete the procedure.

Intraoperative open or percutaneous tibial artery angioplasty 77113 anatomical named vessels

Refers to the following four anatomical named vessels:
Anterior tibial artery
Posterior tibial artery
Peroneal artery
Tibioperoneal trunk

Intraoperative open or percutaneous angioplasty 77114 anatomical named vessels

Refers to angioplasty of the following anatomical named vessels with the exception of the 77113 named vessels as defined above.

Upper extremity vessels
Right brachial artery
Right radial artery
Right ulnar artery
Left brachial artery
Left radial artery
Left ulnar artery

Lower extremity vessels
Right common femoral artery
Right superficial femoral artery
Right profunda femoral artery
Right popliteal artery
Left common femoral artery
Left superficial femoral artery
Left profunda femoral artery
Left popliteal artery

Intra abdominal vessels
Abdominal aorta
Celiac axis
Hepatic artery
Splenic artery
Superior mesenteric artery
Inferior mesenteric artery
Right common iliac artery
Right external iliac artery
Right internal iliac artery
Left common iliac artery
Left external iliac artery

Left internal iliac artery
Right renal artery
Left renal artery

Thoracic vessels
Ascending thoracic aorta
Transverse thoracic aorta
Descending thoracic aorta
Brachiocephalic artery
Right common carotid artery
Right subclavian artery
Right vertebral artery
Left common carotid artery
Left subclavian artery
Left vertebral artery

Cervical vessels
Right common carotid artery
Right internal carotid artery
Right external carotid artery
Left common carotid artery
Left internal carotid artery
Left external carotid artery

VASCULAR SURGERY

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

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

Preamble

Complete understanding of the following paragraphs is essential to appropriate billing of the Vascular Surgery fees. These definitions should be interpreted with reference to the General Preamble.

Definitions

Preparation of the operative site

All pre-operative steps involved in reducing the risk of surgical site infection including: the administration of systemic antimicrobial therapy, hair removal with the use of clippers, reducing the endogenous microbial flora at a planned surgical incision site by the application of antiseptic solution, and the draping of the surgical field to minimize operative site contact.

Multiple Surgical Procedures (from General Preamble)

D. 5. 3. Multiple Surgical Procedures

i) When two or more similar procedures (including bilateral procedures) are performed under the same anesthetic, or when two or more procedures are performed in the same general area, whether through the same incision, an extension of that incision or through separate incisions, the procedure with the greater listed fee may be claimed in full and the fees for the additional procedure are reduced to 50 percent, unless otherwise indicated by the Schedule. However, additional incidental surgery performed en passant (i.e. surgery which would not have been performed in the absence of the primary procedure, such as an appendectomy during abdominal surgery, or incidental cystectomy during gynecological surgery) is considered to be included in the fee for the planned procedure and may not be charged.

Open surgical procedures are defined as:

All open surgical procedures required in optimizing perfusion and maximizing durability of the operation. Additional open surgical procedures are not considered preparation of the operative site. Additional open surgical procedures accompanying the first open surgical procedure will be limited to one per anatomically named vessel despite vessel continuity in series or in parallel.

Open vascular surgery with angioplasty and stent

Open surgical procedures are considered separate billable procedures from endovascular procedures in the context of hybrid revascularization. The surgical procedures are paid in accordance with Section D. 5. 3 Multiple Surgical Procedures. Angioplasties (77113, 77114) are billed at 50% of the listed fee for the first and 25% of the listed fee for the second to a maximum of two angioplasties. Simultaneous stenting (10919) on differing anatomical named vessels is to be paid: the first at 100% and the second at 50% to a maximum of two stents.

Endovascular surgery with angioplasty and stent

When endovascular procedures (e.g., 77177) are performed in combination with open or percutaneous angioplasties, a maximum of one angioplasty (77114) is payable in addition at 50%. One tibial artery angioplasty (77113) may also be payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels to be paid: the first at 100% and the second at 50% to a maximum of two stents.

Isolated angioplasties and stents

When angioplasty 77113 or 77114 is performed as isolated endovascular procedure (not in combination with open surgery or another endovascular surgery), multiple angioplasties done during the same procedure on different anatomical named vessels are paid as follows: the first is paid at 100%, the second at 50%, the third at 25% to a maximum of 3 endovascular interventions. Simultaneous stenting 10919 on differing anatomical named vessels is to be paid: the first at 100%, the second at 50%, and the third at 25% to a maximum of 3 stents.

In cases of combined endovascular procedures involving 77113 and 77114, the higher 77113 fee may be claimed in full and the lower 77114 fee is reduced to 50%.

Anatomical Named Vessels

One or more angioplasty 77113 or 77114 or stent 10919 per anatomical named vessel will be considered as one angioplasty and stent of that anatomical named vessel despite vessel continuity in series or in parallel with other vessels requiring intervention.

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Right ulnar artery
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Left radial artery
Left ulnar artery

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Right superficial femoral artery
Right profunda femoral artery
Right popliteal artery
Left common femoral artery
Left superficial femoral artery
Left profunda femoral artery
Left popliteal artery

Intra abdominal vessels
Abdominal aorta
Celiac axis
Hepatic artery
Splenic artery
Superior mesenteric artery
Inferior mesenteric artery

Right common iliac artery
Right external iliac artery
Right internal iliac artery
Left common iliac artery
Left external iliac artery
Left internal iliac artery
Right renal artery
Left renal artery

Thoracic vessels
Ascending thoracic aorta
Transverse thoracic aorta
Descending thoracic aorta
Brachiocephalic artery
Right common carotid artery
Right subclavian artery
Right vertebral artery
Left common carotid artery
Left subclavian artery
Left vertebral artery

Cervical vessels
Right common carotid artery
Right internal carotid artery
Right external carotid artery
Left common carotid artery
Left internal carotid artery
Left external carotid artery

VASCULAR SURGERY

		$	Anes. Level
Referred Cases			
77010	**Consultation**: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	145.69	
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 consultative fee	89.54	
	Continuing care by consultant:		
77007	Subsequent office visit	42.87	
77008	Subsequent hospital visit	30.90	
77009	Subsequent home visit	44.63	
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 service rendered.*	89.07	
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.*	30.90	
77015	Pre-Operative Assessment ***Notes:*** *i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.* *ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.* *iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.* *iv) Maximum of one pre-operative assessment per patient per procedure.* *v) Only paid to the surgeon who performs the procedure.*	136.64	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
77710	**Telehealth Consultation:** to include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	145.69	
77712	**Telehealth 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 judgement of the consultant the consultative service does not warrant a full consultative fee	89.54	
77707	Telehealth subsequent office visit	42.87	
77708	Telehealth subsequent hospital visit	30.90	

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).

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.

		$	Anes. Level
00081	Emergency care, per ½ hour or major portion thereof ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	106.12	
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof ***Note:*** *Start and end times must be entered in both the billing claims and the patient's chart.*	63.67	

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)	72.53
01201	Night (call placed and service rendered between 2300 hours and 0800 hours)	101.86
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours)	72.53

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	66.69
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	91.18

		$	Anes. Level
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	66.69	

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.

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) – 44.57% of surgical (or assistant) fee - minimum charge	64.32	
	- maximum charge	443.67	
01211	Night (2300 hours to 0800 hours) – 71.55% of surgical (or assistant) fee - minimum charge	90.32	
	- maximum charge	623.05	
01212	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 44.57% of surgical (or assistant) fee - minimum charge	64.32	
	- maximum charge	443.67	

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	134.22
00196	$317.01 to 529.00 inclusive	189.24
00197	Over $529.00	261.76
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	28.52

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.

		$	Anes. Level
	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.		
70019	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	256.63	
	Note: *Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.*		
70020	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	32.23	
	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	300.19	
77030	- trunk	300.19	
	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	44.76	2
07041	Aspiration: abdomen or chest (operation only)	76.01	2
	Abscess:		
07059	- deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	81.46	2
07027	- under general anesthesia (operation only)	225.00	2
07061	- deep, post operative wound infection under general anesthesia (operation only)	225.00	2
07045	Anterior closed space abscess - operation only	101.44	2
06028	Web space abscess - operation only	254.92	2
06029	- under general anesthetic (operation only)	290.00	2
07685	Pilonidal cyst or sinus - excision or marsupialization (operation only)	277.43	2
	Osteomyelitis:		
*52380	Osteomyelitis, acute, decompression	186.72	2
*52385	Osteomyelitis, debridement with or without reconstruction	322.10	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	35.84	
	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.		

		$	Anes. Level
13611	Minor laceration or foreign body - requiring anesthesia - operation only	66.76	2
06063	Removal of foreign body requiring general anesthesia - operation only	250.72	2
13612	Extensive lacerations greater than 5 cm. (maximum charge 35 cm) - operation only - per cm	13.40	2

Note: *Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*

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)	550.00	3
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	294.65	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	117.87	3
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	261.93	
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	130.96	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	288.10	3
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	144.06	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	78.57	

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.

iii) 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)	125.72	4

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	339.41	3
06076	Nose and ear	426.36	3

		$	Anes. Level
06077	Complicated lacerations of the scalp, cheek and neck	333.13	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*

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	270.50	3
	Excisional biopsy of lymph glands for suspected malignancy:		
70023	- neck (operation only)	240.00	3
V70024	- axilla	240.00	2
70025	- groin (operation only)	240.00	2
	Foreign Body:		
	Excision of skin and subcutaneous tissue of hidradenitis suppurative:		
07072	- axillary (operation only)	250.00	2
07075	- inguinal (operation only)	250.00	2
07076	- perianal (operation only)	250.00	2
07082	- perineal (operation only)	250.00	2
06166	Excision of axillary sweat glands for hyperhidrosis - unilateral	325.14	4

Notes:

i) Direct closure included when open procedure used.

ii) Aggressive removal of apocrine sweat glands by any means.

	Tenotomy:		
07073	- congenital torticollis (operation only)	304.16	3
V07074	- resection	257.99	3
	(Section of transverse carpal ligament - bill under 06258)		
13630	Paronychia (operation only)	35.75	2
13631	Removal of nail - simple (operation only)	35.75	2
13632	- with destruction of nail bed (operation only)	72.34	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	63.83	2
V07053	Excision of nail bed, complete, with shortening of phalanx	137.99	2
	Biopsy of nerve or artery:		
07025	Temporal artery biopsy (operation only)	155.00	2
07028	Biopsy of sural nerve (operation only)	177.27	2

		$	Anes. Level

Free Skin Grafts And Myeloplasty

Split-thickness grafts:

Note:
Non-functional areas include posterior or trunk, anterior trunk, arm (above elbow), forearm (below elbow), thigh, leg (below knee).
Functional areas 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)	300.00	2
06047	- 65 sq.cm. (operation only)	432.00	2
06048	- 650 sq.cm.	648.00	2
06049	For each 6.5 sq.cm. over 650 sq.cm. (operation only)	8.00	3

Note: *Refrigerated graft - 50% of appropriate fee.*

Vascular Access

Broviac type catheter:

07139	- insertion of	162.55	2
V07140	- insertion of - less than 3 months of age or less than 3 kg.	269.03	4
07141	- removal of (operation only)	126.79	2

Totally implantable venous access port with subcutaneous reservoir (portacath type device):

07142	- insertion of	255.98	2
77142	Removal of totally implantable access device (e.g.: portacath), operation only	127.95	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)	350.00	2
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	57.24	
07145	Intra osseous - access (operation only)	101.29	2
V07134	Peritoneal venous shunt for ascites	390.37	6
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee	22.10	
00319	Insertion of central catheter for total parenteral nutrition (operation only)	56.81	2

Venous

Chronic or Varicose Veins

Note: *Treatment of varicose vein pathology is a benefit under MSP only if the patient is symptomatic with varicose veins of at least 3 mm and has one or more of the following:*

i) Pain, aching, cramping, burning, itching and/or swelling during activity or after prolonged standing severe enough to impair mobility.
ii) Recurrent episodes of superficial phlebitis.
iii) Non-healing skin ulceration.
iv) Bleeding from a varicosity.
v) Stasis dermatitis.
vi) Refractory dependent edema.

		$	Anes. Level
77045	Varicose veins, injection, each visit	13.46	
	Note: *Treatment for cosmetic purposes is not a benefit under MSP.*		
77046	Ultrasound directed (with image capture) foam sclerotherapy – initial	171.95	
77047	Ultrasound directed (with image capture) foam sclerotherapy – repeat	171.95	
	Notes:		
	i) 77046 and 77047 may each be charged only once per patient per leg per lifetime.		
	ii) One additional repeat per leg may be billed under fee item 77060 in the same 12 month period.		
	iii) Services in subsequent 12 month periods should be billed in accordance with the notes following fee item 77050 and 77060.		
	Compression sclerotherapy:		
77050	- initial	80.82	2
77060	- repeat	37.87	2
	Notes:		
	ii) 77050 may be charged only once per 12 month period for each leg, and 77060 only twice in the same period.		
	ii) If in the same 12 month period following fee item 77046 and 77047, only one additional repeat is payable per leg under fee item 77060.		
77065	High ligation, long saphenous	223.03	2
V07108	Stripping long saphenous	263.88	2
V07109	Stripping short saphenous	228.30	2
	Multiple ligations and stripping tributaries:		
07110	- 3 to 5 incisions (operation only)	278.91	2
V07111	- 6 or more incisions	304.28	2
V07112	Ligation of 2 or more perforators	278.91	2
77070	Complete fasciotomy with or without multiple ligations	319.25	2
	Note: *For decompression fasciotomy, see 77360.*		
77075	Re-exploration of groin and/or popliteal fossa	300.19	2
V07116	Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy)	523.41	3
77077	Excision of ulcer and grafting - add full fee to venous procedures (operation only)	120.28	3
77079	Venous crossover graft for iliac obstruction	609.87	7
	Acute Venous:		
77082	Ligation of femoral vein	148.84	2
77084	Ligation or fenestration of inferior vena cava (requires laparotomy)	495.27	5
77086	Thrombectomy for acute ilio-femoral thrombophlebitis	620.60	5
V07146	Insertion of inferior vena cava filter; percutaneous placement or cutdown (e.g.: Kimray Greenfield filter)	367.84	2
	Portosystemic Shunting:		
C77090	Spleno-renal shunt	945.05	8
C77092	Porto-caval shunt	945.05	8
	Mesocaval graft:		
C77094	- synthetic	945.05	8
C77096	- autogenous	1,006.21	8

		$	Anes. Level

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.

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)	125.47	4
77112	Re-dissection of groin (after 21 days) - extra	132.47	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 open 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:

10900	Abdominal aortic aneurysm repair using endovascular stent graft – second operator	509.83	

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.

		$	Anes. Level
Angioplasty			
S77113	Intraoperative open or percutaneous tibial artery angioplasty	697.42	2
	Notes: *i) Restricted to Vascular Surgeons.* *ii) When 77113 is combined with another open vascular surgery, multiple angioplasties will be paid as follows: 50% for the first and 25% for the second. Payable to a maximum of two angioplasties.* *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%, and third at 25%. Payable to a maximum of three angioplasties.* *iv) Any and all diagnostic imaging required to complete the procedure is considered included.*		
S77114	Intraoperative open or percutaneous angioplasty	589.40	3
	Notes: *i) Restricted to Vascular Surgeons.* *ii) When 77114 is combined with another open vascular surgery, multiple angioplasties will be paid as follows: 50% for the first and 25% for the second. Payable to a maximum of two angioplasties.* *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%, and third at 25%. Payable to a maximum of three angioplasties.* *iv) Any and all diagnostic imaging required to complete the procedure is considered included.* *v) When done with 77177, payable once, to either the primary or second operator*		
Surgical Procedures			
	Thrombectomy, Embolectomy:		
C77115	Thrombectomy - with or without angioplasty	556.73	5
C77120	Embolectomy - trunk or extremities (subclassified by location and incision)	620.60	5
C77125	- one side	446.10	5
	Neck or Thoracic:		
C77130	Bypass graft (synthetic) and/or thrombo-endarterectomy - carotid arteries	981.24	8
77135	- innominate	779.13	5
C77140	- subclavian	846.50	5
C77145	Ligation of carotid artery	255.38	5
	Aortoiliac: Bypass graft (synthetic or autologous vein) and/or thromboendarterectomy including extension onto femoral artery by either retroperitoneal or trans peritoneal approach ***Note:*** *Harvest of autologous vein (77280, 77285, 77290, or 77295) paid at 100%.*		
C77150	**–** aorta and/or iliac (unilateral)	892.24	9
C77155	- aorta and/or iliac (bilateral)	1,400.80	9
C77160	- aorto-femoral and/or ilio-femoral (unilateral)	866.39	9
C77165	- aorto-femoral and/or ilio-femoral (bilateral)	1,400.80	9

		$	Anes. Level
	Aneurysm:		
	Note: *Peripheral aneurysm - charge associated bypass graft procedure.*		
77170	Arteriovenous aneurysm	495.27	9
C77175	Abdominal aneurysm, with grafting	1,397.15	9
77177	Abdominal aortic aneurysm repair using endovascular stent graft – vascular surgery component	1,397.15	9
	Notes:		
	i) In order to bill 77177, 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.		
	iii) When done with 77177, if second operator present, 77114 and 10919 payable to either the primary or second operator.		
C77180	Resection of abdominal aneurysm with associated femoral dissection - one or both sides (extra fee to be added to procedure) (operation only)	124.11	9
	Note: *Peripheral aneurysm - charge associated bypass graft procedure.*		
C77185	Ruptured aneurysm, with grafting	1,598.26	10
	Complex endovascular aneurysm repair:		
P77485	Ruptured endovascular abdominal aneurysm repair (REVAR)	1,997.83	10
	Notes:		
	i) Restricted to Vascular Surgeons.		
	ii) In order to bill 77485. Vascular Surgeons must be present throughout the entire procedure.		
	iii) Limited to repair of the abdominal aorta.		
	iv) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement and temporary pacemaker.		
	v) A maximum of one angioplasty (77114) is payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents.		
	vi) When done with 77485, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator.		
	vii) Certified surgical assistants (70019 and 70020) are not payable with 77485.		
P77487	Emergency endovascular thoracic aorta repair (EEVTAR)	2,282.46	10
	Notes:		
	i) Restricted to Vascular Surgeons and Cardiac Surgeons.		
	ii) In order to bill 77487, Vascular Surgeon or Cardiac Surgeon must be present throughout the entire procedure.		
	iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker.		
	iv) A maximum of one angioplasty (77114) is payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents.		
	v) When done with 77487, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator.		
	vi) Certified surgical assistants (70019 and 70020) are not payable with 77487.		

		$	Anes. Level
P77490	Fenestrated endovascular graft for repair of juxta renal abdominal aortic aneurysm (FEVAR)	1,746.44	10

Notes:

i) Restricted to Vascular Surgeons.

ii) In order to bill 77490, Vascular Surgeon must be present throughout the entire procedure.

iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, temporary pacemaker.

iv) A maximum of two angioplasties (77114) are payable in addition: the first at 50% and the second at 25%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents.

v) When done with 77490, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator.

vi) Certified surgical assistants (70019 and 70020) are not payable with 77490.

P77495	Thoracic endovascular aneurysm repair (TEVAR)	1,997.83	10

Notes:

i) Restricted to Vascular Surgeons and Cardiac Surgeons.

ii) In order to bill 77495, Vascular Surgeon or Cardiac Surgeon must be present throughout the entire procedure.

iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker.

iv) A maximum of one angioplasty (77114) is payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents.

v) When done with 77495, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator.

vi) Certified surgical assistants (70019 and 70020) are not payable with 77495.

P77497	Complex thoraco-abdominal endovascular aneurysm repair (CTAEVAR)	2,095.73	10

Notes:

i) Restricted to Vascular Surgeons.

ii) In order to bill 77497, Vascular Surgeon must be present throughout the entire procedure.

iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker.

iv) A maximum of two angioplasties (77114) are payable in addition: the first at 50% and the second 25%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents.

v) When done with 77497, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator.

vi) Certified surgical assistants (70019 and 70020) are not payable with 77497.

P77500	Second Operator – complex endovascular aneurysm repair	637.29	10

Notes:

i) Restricted to Vascular Surgeons, Cardiac Surgeons and Interventional Radiologists.

ii) Intraoperative angioplasties (77114) and stent placements (10919) are payable in addition to the extent allowed under the primary procedure.

iii) The fee will not be paid to the primary operator.

iv) Paid to the second operator only when the primary operator performs procedures payable under 77485, 77487, 77490, 77495, or 77497.

v) Certified surgical assistants (70019 and 70020) are not payable to the second operator.

		$	Anes. Level
	Mesenteric:		
C77190	Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy	892.23	7
C77195	Superior mesenteric bypass graft (autogenous vein)	892.23	7
	Renal:		
C77200	Renal bypass graft (synthetic) and/or thromboendarterectomy	892.23	7
C77205	Renal bypass graft (autogenous vein)	892.23	7
	Axillo - Femoral:		
	Axillo-femoral bypass graft and/or thromboendarterectomy		
C77210	- unilateral	979.23	7
C77215	- bilateral	1,269.39	7
	Femoral Crossover:		
C77230	Femoro-femoral crossover bypass graft (synthetic) and/ or thromboendarterectomy	930.69	5
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	930.69	5
	Infrainguinal:		
C77240	Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	858.35	5
C77245	- popliteal (endarterectomy)	679.59	5
C77250	- popliteal (synthetic)	620.53	5
C77255	- anterior, posterior tibial or peroneal	742.29	5
	Bypass graft (autogenous vein):		
C77260	- femoral	859.23	5
C77265	- popliteal	1,072.16	5
C77270	- anterior, posterior tibial or peroneal	1,115.63	5
77275	- in situ vein graft, (extra)	257.02	7
77280	- non-ipsilateral long saphenous graft; (extra)	254.66	7
77285	- short saphenous graft; (extra)	254.66	7
77290	- superficial femoral vein graft; (extra)	254.66	7
77295	- arm vein graft; (extra)	254.66	7
77300	- A-V fistula with bypass graft in limb salvage; (extra)	185.56	7
	Profunda thromboendarterectomy:		
77310	Profunda thromoendarterectomy without patch repair	553.02	5
77315	Profunda thromboendarterectomy with patch repair (synthetic or autologous)	750.88	5

Notes:

i) If performed with inflow procedure (77175, 77160, 77165, 77210, 77215, 77230, or 77235), payment will be made at 50% for unilateral or 2 x 50% for bilateral.

ii) If performed with outflow procedure (77240, 77260, 77265, or 77270) payment will be made at 50%.

	Trauma:		
	Repair of injury of major vessel in extremity:		
C77330	- suture	583.75	6
C77335	- graft	750.88	6
	Repair of injury of major vessel in trunk:		
C77340	- suture	876.21	9
C77345	- graft	1,168.71	9

		$	Anes. Level
77350	Supra-renal aortic cross-clamp - extra to abdominal vascular or major trauma cases (operation only)	114.21	
	Note: *Operative report required.*		
V07447	Repair of mesenteric injury	572.71	6
	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.*		
	Operative repair – arteriorraphy – for iatrogenic injury during percutaneous endovascular aortic valve implantation :		
77352	Repair of major vessel in extremity - suture	563.58	6
77353	Repair of major vessel in extremity - graft	724.93	6
77354	Repair of major vessel in trunk - suture	845.95	9
77355	Repair of major vessel in trunk - graft	1,128.31	9
	Fasciotomy:		
77360	Decompression fasciotomy - subcutaneous	334.57	3
	Note: *77360 includes secondary closure.*		
	Tibial Metaphysis (Distal) Ankle and Foot:		
	Incision - Therapeutic, Release:		
57250	Decompression, neurolysis, nerve (isolated procedure)	298.77	2
57260*	Fasciotomy, compartment syndrome	214.73	2
57269*	Fasciotomy, secondary wound closure	186.72	2
	Miscellaneous:		
77370	Release of popliteal entrapment syndrome	334.57	3
	Note: *Not to be billed if full femoral popliteal bypass is performed.*		
S00722	Arteriography, operative - procedural fee	75.51	

Renal Access

77380	Insertion permanent peritoneal catheter; (procedure fee only)	190.68	3
77385	Removal by dissection of chronic peritoneal catheter; (operation only)	132.26	3
	Note: *For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.*		
77395	Creation of internal arterio-venous fistula	414.93	4
77396	Revision of AV fistula	505.58	
	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, 295, 77295, 77300).* *iv) 77043 not paid with this fee.*		
77400	Synthetic AV graft for hemodialysis	707.49	4
	Notes: *i) Not paid with 77295, 77395, 77396 and 77402.*		
77402	Creation of brachiobasilic arteriovenous fistula with vein transposition	707.74	5
	Note: *Not paid with 77260 to 77300 and 77395 and 77400.*		
77403	Arm revascularization with distal revascularization and interval ligation (DRIL)	707.73	5
	Note: *Not paid with 77260 to 77300 and 77395.*		

		$	Anes. Level
77405	Thrombectomy of arterio-venous fistula	349.01	3
	Sympathectomy:		
77420	Lumbar sympathectomy - unilateral	371.15	4
77422	Cervical sympathectomy - unilateral	501.87	5
77424	Preganglionic sympathectomy; upper dorsal region - unilateral	458.38	7
77426	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	458.38	7
	Lumbar sympathectomy with abdominal procedure:		
77428	- unilateral (extra)	124.12	
77430	- bilateral (extra)	248.26	
	Lymphatic System:		
V07361	TB glands - radical removal	269.03	4
V07363	Radical femoral, inguinal and/or iliac dissection	536.76	5
V07360	Splenectomy	808.57	6
CV07366	Laparotomy and staging of lymphoma to include splenectomy	909.86	6
CV07365	Isolated limb perfusion to include groin dissection and laparotomy	938.97	5
	Lymphoedema: Leg		
	Lymphoedema of limbs - excision and grafting:		
06127	- entire leg	700.04	3
06128	- entire lower extremity	1,046.58	3

Abdominal Surgery

	Miscellaneous:		
V07603	Resuture abdominal wound evisceration	406.03	5
07451	Thoracic extension of abdominal incision (extra)	285.69	8
V07600	Exploratory laparotomy to include biopsy	405.81	5

Transplantation

	Implantation of kidney graft:		
77440	Vascular surgeon	836.46	7

Amputation

	Hand and wrist:		
06218	Transmetacarpal	254.92	2
06219	Finger, any joint or phalanx (operation only)	254.92	2
	Pelvis, Hip & Femur:		
55983	Above knee	653.54	4
55980	Hemicorpectomy	2,446.08	6
55981	Hemipelvectomy	1,363.10	6
55982	Hip disarticulation	1,036.32	6
55984	Knee disarticulation	653.54	4
55998*	Open injury, primary wound care	101.50	4
55999*	Open injury, secondary wound management	186.72	4

		$	Anes. Level
	Femur, Knee Joint, Tibia & Fibula:		
56980	Below knee	650.00	3
56998*	Open injury, primary wound care (operation only)	102.26	3
56999*	Open injury, secondary wound management	186.72	3
	Tibial Metaphysis (Distal), Ankle & Foot:		
57981	Midtarsal	486.50	2
57982	Transmetatarsal	406.12	2
57983	Single metatarsal/Ray resection	354.78	2
57980	SYME	526.08	2
57984	Toe	185.33	2
57998*	Open injury, primary wound care (operation only)	51.13	2
57999*	Open injury, secondary wound management (operation only)	93.37	2

Chest Wall Surgery

79125	Cervical rib resection	360.84	5
79130	Trans-axillary resection of first rib	869.08	5

CARDIAC SURGERY

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

		$	Anes. Level

Referred Cases

07810	**Consultation:** To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	193.65	
07812	**Repeat or limited Consultation:** To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	65.10	
	Continuing care by consultant:		
07807	Subsequent office visit	28.85	
07808	Subsequent hospital visit	24.63	
07809	Subsequent home visit	49.62	
07805	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	99.03	
07815	Pre-Operative Assessment ***Notes:*** *i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.* *ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.* *iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.* *iv) Maximum of one pre-operative assessment per patient per procedure.* *v) Only paid to the surgeon who performs the procedure.*	193.65	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
78010	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	193.65	
78012	Telehealth repeat or limited Consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	65.10	
78007	Telehealth subsequent office visit	28.85	
78008	Telehealth subsequent hospital visit	24.63	

Arterial System

07820	Coarctation of aorta	941.63	9
07818	Resection of ascending aortic anuerysm	1,690.88	10
07819	Resection of descending aortic aneurysm	1,690.88	10
07822	Ruptured thoracic aneurysm	1,825.97	11
07826	Resection of aortic arch aneurysm	2,395.05	10
07827	Repair of aortic dissection (thoracic)	1,690.88	10

		$	Anes. Level
07828	Repair of aortic injury (thoracic)	1,690.88	10
07829	Repair of traumatic injury of major intrathoracic vessels	941.63	10

Heart

Heart:

07830	Banding of pulmonary artery	822.92	9
07831	Pericardiotomy - with poudrage	822.92	9
07832	Pericardectomy	822.92	9
07833	Left atrial appendage ligation	597.73	9
	Note: *Not paid in addition to fee items 07910 and 07962.*		
07834	Patent ductus arteriosus	822.92	9
07835	Blalock or Pott's procedure for Tetralogy of Fallot	822.92	9
07836	Blalock-Hanlon procedure	822.92	9
07837	Mitral commissurotomy (closed)	822.92	9
07838	Pulmonary valvulotomy (closed)	822.92	9
07839	Aortic valvulotomy	822.92	9
S07843	Implantation of endocardial pacemaker (ventricular)	414.25	4
S07953	Double lead endocardial pacemaker	541.77	4
S78030	AICD and single ventricular lead	578.55	8
	Note: *Thoracotomy (79045) is paid in addition at 50% when required for incision in chest for RV lead.*		
S78031	- each additional lead, to a maximum of 3 extra leads	210.39	
S07952	Electronic monitoring of pacing and pacemaker function	96.22	
S07844	Implantation or replacement of pulse generator for cardiac pacing	250.28	4
07845	Repair, replacement, adjustment of electrode	253.15	4
	Note: *For implantation of temporary pacemaker, see 33030.*		
07851	Phrenic nerve stimulator	473.55	8
07846	Surgical treatment of cardiac arrest by cardiac massage (operation only)	418.95	11
	Note: *To be supported by explanation, and Clauses D. 5. 3. of the Preamble will apply.*		
07852	Gore-tex modified aorto-pulmonary shunt	941.63	9
78041	Laser Lead Extraction after 30 days, first lead	1,409.88	9
	Notes: *i) Not payable with 07845, 33030, and 33057.* *ii) Includes any and all diagnostic imaging related to the surgery.* *iii) Claims for surgical assistance for laser lead extraction are payable under 00197.*		
78042	Laser Lead Extraction after 30 days, additional leads, to a maximum of two – extra	529.26	9
78043	Debridement of chest wall during laser lead extraction-extra (payable only with 78041)	52.92	9
78044	Wide debridement of chest wall during laser lead extraction - extra (payable only with 78041)	105.87	9
78045	Thoracotomy post cardiac surgery for hemorrhage	751.07	8
	Note: *Must be performed by a Cardiac Surgeon in the Operating Room, under general anesthetic.*		

		$	Anes. Level
Open Heart Surgery			
07824	Resecting aneurysm of the ventricle as an isolated procedure	1,587.14	10
07825	Resecting left ventricular aneurysms in conjunction with another procedure	273.08	10
78051	Minimal Access Mitral or Aortic valve replacement or Mid-cavity CABG (extra) ***Notes:*** *i) Paid at 100% and only paid with 07853, 07854, 07855, 07856, 07857, 07858, 07859, 07860 and 07908.* *ii) Restricted to Cardiac Surgery.*	373.70	
	Mitral valve:		
07853	Commissurotomy	1,422.02	9
07854	Plication	1,422.02	9
07855	Replacement	1,587.14	9
07856	Simple repair ***Note:*** *Restricted to Cardiac Surgery.*	1,587.14	9
78056	Mitral Valve Complex repair – including remodelling Annuloplasty and repair of anterior or posterior leaflet, with or without transposition and/or implantation of chordae/neochordae ***Note:*** *Restricted to Cardiac Surgery.*	1,983.95	9
	Aortic valve:		
07857	Commissurotomy	1,422.02	9
07858	Plication	1,422.02	9
07859	Replacement	1,587.14	9
07860	Aortic root reconstruction with mechanical valved conduit, Homograft, or Xenograft root	3166.64	10
	Tricuspid valve:		
07861	Commissurotomy	1,422.02	9
07862	Replacement	1,587.14	9
07863	Annuloplasty	1,422.02	9
	Multiple valve replacement:		
07864	Two valves	2,395.05	10
07865	Three valves	2,768.96	10
07866	Valved external conduit	2,203.98	10
	Atrial septum defect:		
07867	Secundum - suture	1,422.02	9
07868	- patch	1,422.02	9
07869	Primum	1,587.14	9
07870	Multiple	1,422.02	9
07871	- plus pulmonary stenosis	1,422.02	10
07872	- plus partial anomalous pulmonary drainage	1,587.14	10
	Ventricular septal defect:		
07874	Simple	1,527.12	9
07875	Multiple	1,527.12	9
07876	- plus patent ductus	1,527.12	9
07877	- plus pulmonary hypertension	1,527.12	10

		$	Anes. Level
07878	- plus corrected transposition	1,527.12	10
07879	- plus aortic regurgitation	1,527.12	10
	Subaortic stenosis:		
07881	Fibrous ring	1,422.02	9
07882	Muscular hypertrophy	1,587.14	9
	Pulmonary valve:		
07884	Valvulotomy	1,422.02	9
07885	Infundibulectomy	1,587.14	9
07886	Patch	1,587.14	9
07889	Tetralogy of Fallot	1,587.14	10
07890	- plus outflow patch	1,825.97	10
07893	- with previous anastomosis shunt	1,825.97	10
07898	Transposition	1,974.73	10
07887	Pulmonary arterioplasty with bypass	1,587.14	9
07899	Anomalous pulmonary drainage - total	1,974.73	10
07900	Aorticopulmonary window	1,587.14	10
07901	Ruptured sinus of Valsalva	1,587.14	10
07902	Atrioventricular communis	2,395.05	10
07905	Intracardiac tumours	1,587.14	9
07906	Pulmonary embolectomy with bypass	1,422.02	11
07908	Coronary artery bypass graft (end-to-side or side-to-side) - one artery	1,440.05	9
07909	- each additional artery	273.64	
	Note: *When 7 or more arteries are bypassed, a written explanation must be submitted along with the account.*		
07990	Harvest of arterial conduit for the purpose of coronary revascularization – per conduit (extra)	178.45	
	Notes: *i) Paid with fee items 07908 and 07909 only. ii) Paid to a maximum of two per patient. iii) Restricted to Cardiac Surgery.*		
07910	Complete Cox-Maze procedure to include all right and left atrial lesion sets and pulmonary vein isolation	1,819.71	9
	Note: *Not paid with 33084.*		
07962	Left atrial lesion sets only, with or without pulmonary vein isolation	1,357.73	9
	Note: *Not paid with 33084.*		
07963	Pulmonary vein isolation only	611.78	9
	Note: *Not paid with 33084.*		
07911	Ventricular arrhythmia surgery (must include mapping and ablation and includes aneurysmectomy if necessary)	2,209.66	9
07912	Endocardial mapping	382.12	
07913	Pericardiectomy with bypass	1,422.02	9
07914	Recurrent surgery after 21 days (add to 07824, 07855, 07859, 07860, 07862, 07864, 07865, 07908 and congenital heart operations) - extra	1,025.77	
	Specially Qualified Assistant fees:		
07915	First assistant for operations of $1,033.00, or less	275.83	
07916	Second and third assistant for operations of $1,033.00, or less	161.32	
07917	First assistant for operations over $1,033.00	395.75	
07918	Second and third assistant for operation over $1,033.00	247.53	

		$	Anes. Level
07920	Time, after four hours of continuous surgical assistance for one patient, each 15 minute period or fraction thereof.	21.66	
	Note: *Start and end times must be entered in both the billing claims and the patient's chart.*		

Respiratory System

Pleura and Lung:

S07924	Decompression of traumatic pneumothorax - operation only	38.20	4
S07925	Artificial pneumothorax (operation only)	26.60	4

Ribs and Chest Wall:

07949	Laser therapy for intra-tracheal or intra-bronchial tumour to include endoscopy	454.93	7

Ventricular Assist Device

Notes:

i) Fee items 78061, 78063 and 78065 are paid at 150% for biventricular devices.

ii) Fee items 78062, 78064, 78066 are only paid for devices inserted for 14 days or more.

iii) Not paid with ECMO fee items (78071, 78072 and 78073).

iv) Restricted to Cardiac Surgery.

78061	Uni-ventricular temporary device (i.e. Abiomed Impella 5.0) – transcutaneous	509.83	10
78062	Removal of Abiomed Impella 5.0 (includes artery repair)	356.88	10
78063	Uni-ventricular – temporary device (i.e. Levitronix) – thoracotomy (includes blood vessel repair)	1,733.38	10
78064	Removal of Levitronix device	713.74	10
78065	Uni-ventricular – fully implantable (i.e. Heartmate II or Heartware) includes blood vessel repair	2,956.95	10
78066	Removal of fully implantable device includes blood vessel repair	1,529.46	10
07960	Intra-aortic balloon insertion, removal and care	672.80	8

Extracorporeal Membrane Oxygenator (ECMO):

Notes:

i) Includes cannulating and decannulating, by any method, heart, vein and/or artery and repair of vessels if needed.

ii) Restricted to Cardiac Surgery.

78071	Veno - Arterial (V-A) ECMO insertion – peripheral	611.78	10
78072	Veno - Arterial (V-A) ECMO insertion – central	815.71	10
78073	Veno - Veno (V-V) ECMO insertion – peripheral	407.86	10

Oesophageal Surgery

		$	Anes. Level
	Surgical Assistant:		
70019	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	256.63	
	Note: *Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.*		
70020	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	32.23	
	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.		

Oesophagus - Incision

V70500	Oesophagotomy - cervical approach with removal of foreign body	536.76	5
V70501	- thoracic approach with removal of foreign body	637.58	8
V70502	Cricopharyngeal myotomy - cervical approach	469.34	4

Oesophagus - Excision

	Excision of lesion, oesophagus, with primary repair:		
CV70530	- cervical approach	536.76	6
CV70531	- thoracic or abdominal approach; open	777.59	8
CV70532	- thoracic or abdominal approach; laparoscopic or thorascopic	777.59	8
	Total or near total oesophagectomy; without thoracotomy (Transhiatal):		
	With pharyngogastrostomy or cervical oesophagogastrostomy, with or without pyloroplasty:		
V70533	- primary surgeon	2,030.14	8
70503	- secondary surgeon	650.00	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70534	- primary surgeon	2,030.14	8
70504	- secondary surgeon	650.00	
	Total or near total oesophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):		
V70535	- primary surgeon	2,283.91	8
70505	- secondary surgeon	650.00	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70536	- primary surgeon	2,283.91	8
70506	- secondary surgeon	650.00	
V70538	Partial oesophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic oesophagogastrostomy. (Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.)	1,634.89	8

		$	Anes. Level
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70539	- primary surgeon	1,864.78	8
70509	- secondary surgeon	650.00	
CV70540	Partial oesophagectomy, thoraco-abdominal or abdominal approach; with esophagogastrostomy	1,430.50	8
	Notes: *i) Includes vagotomy.* *ii) Includes proximal gastrectomy, pyloroplasty, and splenectomy if required.*		
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70541	- primary surgeon	1,673.20	8
70511	- secondary surgeon	650.00	
CV70542	Total or partial oesophagectomy, without reconstruction (any approach), with cervical oesophagostomy (includes gastrostomy)	1,073.50	6
	Diverticulectomy of Hypopharynx or Oesophagus:		
V70545	- with or without myotomy - cervical approach	536.76	6
V70544	- with or without myotomy - thoracic approach	653.95	8
	Upper Gastrointestinal System – Endoscopy (Surgical)		
S33321	Removal of foreign material causing obstruction, operation only	101.91	4
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only	116.68	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to S10761 or S10762.*		
S33323	Transendoscopic tube, stent or catheter – operation only	101.86	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33324	Thermal coagulation – heater probe and laser, operation only	80.00	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33325	Gastric polypectomy, operation only	60.00	5
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33326	Percutaneous endoscopically placed feeding tube – operation only	120.00	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		

		$	Anes. Level
S33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only	50.00	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33328	Esophageal dilation, blind bouginage, operation only	57.25	3
	Note: *Repeats within one month paid at 100%.*		
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only	109.02	3
	Note: *Repeats within one month paid at 100%.*		

Oesophagus - Repair

V71530	Cervical oesophagostomy	531.36	5
V71531	Cervical approach - repair tracheo-oesophageal fistula	2,000.00	6
	Note: *71530 and 71531 include gastrostomy.*		
	Oesophagoplasty, (plastic repair or reconstruction) thoracic approach:		
CV71532	- without repair of tracheo-oesophageal fistula	2,000.00	8
CV71533	- with repair of tracheo-oesophageal fistula	2,250.00	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach)	804.44	8
	Note: *C71533 and 71534 include gastrostomy.*		
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	920.65	6
V71536	- open	736.52	6
CV71537	Oesophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	791.86	8
V71538	- with gastroplasty - Collis	1,218.09	8
	Plastic operation for cardiospasm; Heller:		
V71539	- thoracic approach - open	672.58	8
V71540	- laparoscopic or thorascopic (endoscopy to be billed separately)	840.72	6
CV71541	- with fundoplication - open	940.05	6
CV71542	- with fundoplication - laparoscopic	1,175.07	6
	Gastrointestinal reconstruction for previous oesophagectomy; for obstructing oesophageal lesion or fistula, or for previous oesophageal exclusion:		
CV71543	- with stomach; with or without pyloroplasty	1,430.50	6
CV71544	- with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	1,673.20	6
	Suture of oesophageal wound or injury:		
V71548	- cervical approach	1,268.85	6
CV71549	- transthoracic or transabdominal approach	1,522.60	8

		$	Anes. Level
	Closure of oesophagostomy or fistula:		
CV71550	- cervical approach	1,268.85	6
CV71551	- transthoracic or transabdominal approach	1,522.60	8
02449	Rigid oesophagoscopy for removal of foreign body	191.35	4

Diaphragm - Repair

V70601	Repair para-oesophageal hiatus hernia, transabdominal, with or without fundoplication	1,212.64	6
	For anti-reflux procedures, fundoplications, etc., see Oesophageal Section.		
	Diaphragmatic or other hernia to include fundoplication, vagotomy and drainage procedure where indicated:		
V70602	- open	1,212.64	6
CV70603	- laparoscopic	1,212.64	6
CV70604	Congenital diaphragmatic hernia	1,522.60	9
	Repair diaphragmatic hernia or laceration; thoracic or abdominal approach:		
CV70605	- acute (traumatic)	1,215.00	8
CV70606	- chronic	1,215.00	8
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	800.00	8

Trauma

Note: *Trauma fee items are to be charged in cases of blunt and/or penetrating abdominal injury. They do not apply to incidental intra-operative injury to abdominal structures.*

V07431	Repair diaphragmatic injury	804.44	8

Miscellaneous

70023	Excisional biopsy of lymph glands for suspected malignancy – neck (operation only)	240.00	3
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	505.35	5
V07630	Gastrostomy - open	456.79	5
V07648	Revision of colostomy, ileostomy – simple incision or scar, etc.	450.00	4
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	255.15	6
02422	- in a child under the age of 3 years	377.74	6
02420	Dilation of trachea (operation only)	152.64	5
02421	- repeat within one month (operation only)	152.43	5
	Microsurgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:		
02430	- first procedure	442.14	6

		$	Anes. Level
02435	- subsequent procedure, each	445.46	6
	Notes: *i) Maximum of 5 subsequent procedures in 6 month period, otherwise support with written letter.* *ii) Microsurgery treatment with CO_2 laser other than removal of tumour(s) of larynx or trachea - bill under miscellaneous item 07999 with operative report.*		
02407	Tracheostomy	390.00	5
	Note: *Not applicable to cricothyrotomy puncture.*		
C02473	Laryngo-pharyngo-oesophagectomy - primary excision only	1,900.00	6

Thoracic Procedures

S00700	Bronchoscopy or bronchofibroscopy - procedural fee	122.00	4
00702	Bronchoscopy with biopsy - procedural fee	210.00	4
S00719	Thoracoscopy	331.00	7
S00701	Direct laryngoscopy - procedural fee	37.70	5
	Notes: *i) 00701 is not payable with 00907, 00908, and 00909.* *ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.*		
S10761	Esophagogastroduodenoscopy (EGD) , including collection of specimens by brushing or washing, per oral - procedural fee	116.63	3
SP10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	97.14	3
S10763	Initial esophageal, gastric or duodenal biopsy	15.00	3
	Notes: *i) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs.* *ii) First biopsy paid at 100%, second and third at 50%.*		
S10764	Multiple biopsies for differential diagnoses of Barrett's Esophagus, H pylori, Eosinophiic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma	43.58	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to S10763 at 100%.* *iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.*		
S00710	Mediastinoscopy or anterior mediastinotomy (combined 50% extra) - procedural fee	196.39	4
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	67.00	4
S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	276.74	2
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	49.15	2
S00749	Parietal pleural, including thoracentesis - procedural fee	131.00	2
S00751	Pericardial puncture - procedural fee	252.53	3
S00755	Artery puncture - procedural fee	6.41	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	86.00	2

		$	Anes. Level
S00797	Oesophageal motility test	176.15	
S00788	- technical fee	74.35	
S00798	- professional fee	101.79	
S00818	Oesophageal pH study for reflux, extra - professional fee	41.00	
S00817	- technical fee	13.00	

THORACIC SURGERY

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

		$	Anes. Level
Referred Cases			
79010	**Consultation:** To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	145.41	
79012	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (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 consultative fee	65.45	
	Continuing care by consultant:		
79007	Subsequent office visit	29.03	
79008	Subsequent hospital visit	24.75	
79009	Subsequent home visit	49.89	
79005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) ***Note:*** *Claim must state time service rendered.*	99.54	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
79210	**Telehealth Consultation:** To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	145.41	
79212	Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (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 consultative fee	65.45	
79207	Telehealth subsequent office visit	29.03	
79208	Telehealth subsequent hospital visit	24.75	
Lung Surgery			
	Lobe:		
79015	Lobectomy	1,364.74	8
79020	Bronchoplasty (extra to lobectomy)	247.44	9
	Entire Lung:		
79025	Pneumonectomy	1,482.88	9
	Other Lung Operations:		
79030	Segmental resection of lung (operative report required)	1,364.74	8
79035	Thoracotomy, including wedge resection	765.70	8
79036	- each additional wedge resection of lung when done thorascopically, to a maximum of two extra	78.32	
79040	Drainage of lung abscess - operation only	511.76	8

		$	Anes. Level
	Thoracotomy (Miscellaneous):		
S07924	Decompression of traumatic pneumothorax – operation only	38.20	4
79045	Exploratory thoracotomy with or without biopsy or removal of foreign body	774.42	8
79050	Decortication of lung	1,193.92	8
79055	Pleurectomy	765.70	8
79060	Intrathoracic tumour – without lung involvement	1,028.29	8

Airway Surgery

	Trachea:		
79065	Tracheal resection	964.56	10
79070	- with laryngeal release, extra	476.11	10
79075	- with hilar release, extra	476.11	10
02420	Dilation of trachea (operation only)	152.64	5
02421	- repeat within one month (operation only)	152.43	5
02407	Tracheostomy ***Note:*** *Not applicable to cricothyrotomy puncture*	390.00	5
	Bronchus:		
79080	Closure of bronchopleural fistula	953.71	10
79085	Repair of ruptured bronchus	964.56	9
07949	Laser therapy for intra-tracheal or intra-bronchial tumour - to include endoscopy	454.93	7
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	255.15	6
02422	- in a child under the age of 3 years	380.57	6
	Micro-surgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:		
02430	- first procedure	442.14	6
02435	- subsequent procedure, each ***Notes:*** *i) Maximum of 5 subsequent procedures in six (6) month period, otherwise support with written letter.* *ii) Microsurgery treatment with CO_2 laser other than removal of tumour(s) of larynx or trachea, bill under 02599 with operative report*	445.46	6

Mediastinal Surgery

79095	Mediastinal cyst or tumour	1,065.18	8
79100	Thymectomy	795.73	8

Chest Wall Surgery

79105	Rib resection for empyema	498.07	6
79110	Closure of pleurostomy following long term management of empyema with rib section	498.07	6
79115	Pectus excavatum and carinatum	776.56	8
79120	Thoracoplasty	776.56	6
79125	Cervical rib resection	360.84	5
79130	Trans-axillary resection of first rib	869.08	5
79135	Chest wall tumour with rib resection	1,016.71	6

		$	Anes. Level
Diaphragm Surgery			
V70602	Repair of para-oesophageal hiatus hernia transabdominal, with or without fundoplication ***Note:*** *For anti-reflux procedures, fundoplications, etc., please see Oesophageal section (in General Surgery).*	1,212.64	6
	Diaphragmatic or other hernia to include fundoplication, vagotomy and drainage procedure where indicated:		
V70602	- open	1,212.64	6
CV70603	- laparoscopic	1,212.64	6
CV70604	Congenital diaphragmatic hernia	1,522.60	9
	Repair diaphragmatic hernia or laceration; thoracic or abdominal approach:		
CV70605	- acute (traumatic)	1,215.00	8
CV70606	- chronic	1,215.00	8
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	800.00	8
V07431	Repair diaphragmatic injury	804.44	8
	Surgical Assistant:		
70019	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 ***Note:*** *Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.*	256.63	
70020	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 ***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.*	32.23	
Oesophageal Surgery			
	Oesaphagus – Incision		
V70500	Oesophagotomy - cervical approach with removal of foreign body	536.76	5
V70501	- thoracic approach with removal of foreign body	637.58	8
V70502	Cricopharyngeal myotomy - cervical approach	469.34	4
	Oesophagus – Excision		
	Excision of lesion, oesophagus, with primary repair:		
CV70530	- cervical approach	536.76	6
CV70531	- thoracic or abdominal approach; open	777.59	8
CV70532	- thoracic or abdominal approach; laparoscopic or thorascopic	777.59	8

		$	Anes. Level
	Total or near total oesophagectomy; without thoracotomy (Transhiatal):		
	With pharyngogastrostomy or cervical oesophagogastrostomy, with or without pyloroplasty:		
V70533	- primary surgeon	2,030.14	8
70503	- secondary surgeon	650.00	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70534	- primary surgeon	2,030.14	8
70504	- secondary surgeon	650.00	
	Total or near total oesophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):		
V70535	- primary surgeon	2,283.91	8
70505	- secondary surgeon	650.00	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70536	- primary surgeon	2,283.91	8
70506	- secondary surgeon	650.00	
V70538	Partial oesophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic oesophagogastrostomy. [Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.]	1,634.89	8
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70539	- primary surgeon	1,864.78	8
70509	- secondary surgeon	650.00	
CV70540	Partial oesophagectomy, thoraco-abdominal or abdominal approach; with esophagogastrostomy.	1,430.50	8
	Notes: *i) Includes vagotomy.* *ii) Includes proximal gastrectomy, pyloroplasty, and splenectomy if required.*		
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70541	- primary surgeon	1,673.20	8
70511	- secondary surgeon	650.00	
CV70542	Total or partial oesophagectomy, without reconstruction (any approach), with cervical oesophagostomy (includes gastrostomy)	1,073.50	6
	Diverticulectomy of hypopharynx or oesophagus, with or without myotomy:		
V70545	- cervical approach	536.76	6
V70544	- thoracic approach	653.95	8
	Upper Gastrointestinal System – Endoscopy (Surgical)		
S33321	Removal of foreign material causing obstruction, operation only	101.91	4
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		

		$	Anes. Level
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only	116.68	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to S10761 or S10762.*		
S33323	Transendoscopic tube, stent or catheter – operation only	101.86	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33324	Thermal coagulation – heater probe and laser, operation only	80.00	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33325	Gastric polypectomy, operation only	60.00	5
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33326	Percutaneous endoscopically placed feeding tube – operation only	120.00	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only	50.00	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33328	Esophageal dilation, blind bouginage, operation only	57.25	3
	Note: *Repeats within one month paid at 100%.*		
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only	109.02	3
	Note: *Repeats within one month paid at 100%.*		

Oesophagus - Repair

V71530	Cervical oesophagostomy	531.36	5
V71531	Repair tracheo-oesophageal fistula – cervical approach	2,000.00	6
	Note: *71530 and 71531 include gastrostomy.*		
	Oesophagoplasty, (plastic repair or reconstruction) thoracic approach:		
CV71532	- without repair of tracheo-oesophageal fistula	2,000.00	8
CV71533	- with repair of tracheo-oesophageal fistula	2,250.00	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach)	804.44	8
	Note: *C71533 and 71534 include gastrostomy.*		

		$	Anes. Level
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	920.65	6
V71536	- open	736.52	6
CV71537	Oesophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	791.86	8
V71538	- with gastroplasty - Collis	1,218.09	8
	Plastic operation for cardiospasm; Heller:		
CV71539	- thoracic approach - open	672.58	8
CV71540	- laparoscopic or thorascopic (endoscopy to be billed separately)	840.72	6
CV71541	- with fundoplication - open	940.05	6
CV71542	- with fundoplication - laparoscopic	1,175.07	6
	Gastrointestinal reconstruction for previous oesophagectomy; for obstructing oesophageal lesion or fistula, or for previous oesophageal exclusion:		
CV71543	- with stomach; with or without pyloroplasty	1,430.50	6
CV71544	- with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	1,673.20	6
	Suture of oesophageal wound or injury:		
V71548	- cervical approach	1,268.85	6
CV71549	- transthoracic or transabdominal approach	1,522.60	8
	Closure of oesophagostomy or fistula:		
CV71550	- cervical approach	1,268.85	6
CV71551	- transthoracic or transabdominal approach	1,522.60	8
02449	Rigid oesophagoscopy for removal of foreign body	191.35	4
C02473	Laryngo-pharyngo-oesophagectomy – primary excision only	1,900.00	6

Miscellaneous Surgery

70023	Excisional biopsy of lymph glands for suspected malignancy: - neck (operation only)	240.00	3
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	505.35	5
V07630	Gastrostomy – open	456.79	5
S32031	Closed drainage of chest – operations only	137.00	4
79140	Anterior scalenotomy	200.86	3

Diagnostic Procedures

	Thoracic procedures:		
	Procedures involving visualization by instrumentation:		
S00700	Bronchoscopy or bronchofibroscopy - procedural fee	122.00	4
S00702	Bronchoscopy with biopsy - procedural fee	210.00	4
S00719	Thoracoscopy	331.00	7
S00701	Direct laryngoscopy - procedural fee	37.70	5

Notes:

i) 00701 is not payable with 00907, 00908, and 00909.

ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.

		$	Anes. Level
	Upper Gastrointestinal System:		
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	116.63	3
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	97.14	3
S10763	Initial esophageal, gastric or duodenal biopsy	15.00	3
	Notes: *i) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs.* *ii) First biopsy paid at 100%, second and third at 50%.*		
S10764	Multiple biopsies for differential diagnoses of Barrett's Esophagus, H pylori, Eosinophiic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma	43.58	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to S10763 at 100%.* *iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.*		
S00710	Mediastinoscopy or anterior mediastinotomy (combined 50% extra) - procedural fee	196.39	4
	Diagnostic procedures utilizing radiological equipment: The following fees are separate from the fees for the radiological part of this examination and should be charged by the attending physician or by the radiologist who performs the procedure, e.g.: instrumentation or injection of contrast materials:		
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	67.00	4
S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	276.74	2

Needle Biopsy Procedures

These biopsies include only those done by needle. Biopsies involving the incision of skin or mucous membrane or involving total or partial removal of a lesion are regarded as surgical procedures, i.e. biopsy of breast, brain, larynx, skin, facial skin, lymph nodes, prostate, etc.:

S00745	Peripheral or subcutaneous lymph node biopsy - procedure fee	49.15	2
S00749	Parietal pleural, including thoracentesis - procedural fee	131.00	2
	Puncture procedures for obtaining body fluids (when performed for diagnostic purposes):		
S00751	Pericardial puncture - procedural fee	252.53	3
S00755	Artery puncture - procedural fee	6.41	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	86.00	2

		$	Anes. Level
	Miscellaneous:		
S00797	Oesophageal motility test	176.15	
S00788	- technical fee	74.35	
S00798	- professional fee	101.79	
S00818	Oesophageal pH study for reflux, extra - professional fee	41.00	
S00817	- technical fee	13.00	

UROLOGY

Preamble

In cases where conversion to open is necessary, bill the appropriate open fee, plus 50% of 04001.

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

		$	Anes. Level

Referred Cases

***Note**: Consultation and office visit include aspiration of hydrocele/spermatocoele and prostatic massage, if required.*

08010	**Consultation**: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	90.03	
08012	**Repeat or limited consultation:** To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	54.44	
	Continuing care by consultant:		
08007	Subsequent office visit	38.98	
08008	Subsequent hospital visit	42.86	
08009	Subsequent home visit	59.66	
08005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:** Claim must state time service rendered.*	122.90	
	Telehealth Service with Direct Interactive Video Link with the Patient:		
08070	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	90.03	
08072	Telehealth repeat or limited consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	54.44	
08077	Telehealth subsequent office visit	38.98	
08078	Telehealth subsequent hospital visit	42.86	

Surgical Assistance

81194	First Surgical Assist of the Day – Urology ***Notes:*** *i) Restricted to Urology Surgeons.* *ii) Maximum of one per day per physician, payable in addition to 00195, 00196, 00197.*	76.47	

Kidney and Perinephrium

08100	Drainage of perinephric abscess	484.34	5
08117	Nephrolithotomy and/or pyelolithotomy	778.42	5
08118	Nephrolithotomy or pyelolithotomy with X-ray control with or without nephroscopy	843.15	5

		$	Anes. Level
08119	Nephrolithotomy or pyelolithotomy with renal cooling with or without X-ray control with or without nephroscopy	739.23	6
S08123	Extra-corporeal shock wave lithotripsy (ESWL), operation only	222.55	4
08104	Partial nephrectomy	1,350.91	5
08105	Nephrectomy	1,248.95	5
08106	- ectopic kidney	875.87	5
08108	- thoraco-abdominal	1,325.42	8
08109	- radical, with gland dissection	1,274.43	6
C81104	Laparoscopic partial nephrectomy for suspected renal malignancy, with or without ipsilateral adrenalectomy, includes excision of perinephric fat ***Notes:*** *i) Restricted to Urologists.*	1,950.06	5
C81105	Laparoscopic radical nephrectomy for suspected renal malignancy, with or without ipsilateral adrenalectomy, includes excision of perinephric fat ***Notes:*** *i) Restricted to Urologists.* *ii) Not paid with open nephrectomy fee items (08105, 08106, 08108, 08109).*	1,529.46	7
08110	Nephro-ureterectomy to include bladder cuff	1,503.98	6
C81110	Laparoscopic nephroureterectomy (including excision of bladder cuff) ***Note:*** *Not paid with 08105, 08106, 08109, 08110, C81104, C81105.*	1,879.95	6
08112	Open renal biopsy (as an independent procedure)	316.22	5
08113	Symphysiotomy and nephropexy or nephrectomy in horseshoe kidney	434.81	5
08114	Pyeloplasty, including management of aberrant vessels and nephropexy	1,000.47	5
C81114	Laparoscopic pyeloplasty, with or without insertion of ureteral stent, includes management of aberrant vessels and nephropexy, cystoscopy or retrograde pyelogram ***Notes:*** *i) Includes nephrolithotomy (08117) if done at same time.* *ii) Fee item 08155 paid at 75% when retrograde approach is required.* *iii) Not paid with open pyeloplasty (08114).* *iv) Repeat pyeloplasty within three months is included in the original fee.*	1,352.04	7
08116	Ruptured or lacerated kidney - repair or removal	1,264.25	6
PC08120	Renal Autotransplant to include nephrectomy, ex-vivo kidney preparation, autologous renal transplant (stand alone) ***Notes:*** *i) Restricted to Urologists with subspecialty training/credentials in renal transplantation.* *ii) This is an all-inclusive fee, for the day of surgery, under the same anesthetic.* *iii) Same day emergent postoperative complication under different anesthetic may be billed, a note record is required.*	6,379.95	6

Endo-Urology

S08146	Ureteroscopy and basket manipulation of ureteral calculus with or without lithopaxy (operation only)	513.90	3
S08155	Insertion of internal ureteral stent to include C & P and ureteroscopy, (operation only) ***Note****: Additional stents to be paid at 50%*	128.46	3
08168	Nephroscopy and stone removal - to include lithopaxy - operation only ***Note:*** *00800 not payable in addition to 08168.*	618.92	4

		$	Anes. Level
S08185	Endoscopic Treatment of upper Tract Transitional Cell Carcinoma Operation required for suspected upper urinary tract malignancy including biopsy or fulguration of lesions to include retrograde ureteroscopic approach or antegrade percutaneous approach. ***Notes:*** *i) Restricted to Urologists.* *ii) Includes fee items 00704, 00800, 08146, and 08155.* *iii) Not payable with 08168, 08117, 08118, and 08119.* *iv) Bilateral procedures which involve both kideys/ureters are payable at 150%.* *v) Antegrade percutaneous access (00978, 00979) payable at 100% in addition.*	900.00	6

Ureter

S08145	Subureteric endoscopic injection for vesicoureteral reflux (VUR) ***Notes:*** *i) Includes Cystoscopy.* *ii) Includes injection of one or both ureters, whether done at the same time or on two separate days.* *iii) Maximum of 3 injections per lifetime.*	257.87	2
08147	Ureterotomy, ureteral lithotomy, upper and lower	409.61	5
08151	Ureterotomy or removal of stump	755.87	5
	Uretero-vesical reanastomosis:		
08152	- unilateral	866.47	5
08148	- bilateral	1,011.34	5
	Ureteral tailoring:		
08153	- unilateral, extra to 08152 or 08148	232.58	5
08154	- bilateral, extra to 08148	328.66	5
08156	Uretero ureterostomy	662.77	5
08157	Uretero-cutaneous-anastomosis - unilateral	668.09	5
08158	Ureteral sigmoid anastomosis - bilateral	632.05	5
08159	Ureterolysis	600.61	5
08160	Reconstruction lower segment ureter by bladder flap	917.67	5
08161	Transurethral manipulation of ureteral calculus - with recovery of calculus	217.40	3
08163	Uretero-vesical anastomosis in the presence of ureterocele or ureteral duplication	783.72	5

Urinary Diversion and Cystectomy

08170	Preparation of intestinal segment and reanastomosis	515.76	5
08174	Preparation of intestinal segment, reanastomosis, and ureteral transplantation (same surgeon)	911.94	6
08184	Cystectomy, isolated procedure, with or without urethrectomy.	1,238.06	6
08173	Radical cystectomy - with pelvic lymphadenectomy (isolated procedure)	1,938.06	7
08177	Cystectomy and ileal loop diversion (includes preparation of intestinal segment and ureteral transplantation - same surgeon)	2,150.00	6
08178	Radical cystectomy and ileal loop urinary diversion (to include preparation of intestinal segment and ureteral transplantation - same surgeon)	2,852.20	7
08181	Bladder augmentation with bowel segment.	1,213.49	5
08182	Continent urinary diversion ***Note:*** *When a second urologist with expertise in continent diversion performs the continent urinary diversion, both surgeons shall be paid in full.*	1,211.94	6
08183	Radical Cystectomy and continent urinary diversion (includes preparation of intestinal segment and ureteral transplantation -same surgeon)	3,150.00	7

		$	Anes. Level
Bladder			
S08200	Bladder fulguration with cystoscopy	158.13	2
08201	Cystostomy, isolated procedure	220.24	2
S08202	Cystostomy by Trochar, isolated procedure (operation only)	101.96	2
08203	Cystolithotomy	315.89	2
08204	Cystectomy - partial for tumour or diverticulum	711.34	5
S08205	Intravesical botulinum toxin injection(s) ***Notes:*** *i) Restricted to Urologists and approved Urogynecologists.* *ii) To a maximum of 3 services per patient per year.* *iii) Includes fee items 00704, 00705, 08232 and 08200.*	285.00	2
08207	Ruptured bladder repair	713.74	5
08255	Closure of fistula - suprapubic, vesico-vaginal, vesico-rectal, or vesico-sigmoid	713.74	5
PC08355	Tensor fascia lata or abdominal rectus fascia harvest Operation for urinary incontinence or urinary tract reconstruction. To include harvest of tensor fascia lata or abdominal rectus fascia for use as a bladder neck sling. ***Notes:*** *i) Restricted to Urologists and approved Urogynecologists.* *ii) Paid only in addition to fee items 08283, 08255, 08259, 08317, 08268, 04227, 81153, or 81154; the lesser procedure will be paid at 75%.* *ii) Includes cystoscopy.*	800.00	2
	Endoscopy:		
S08250	Transurethral resection of bladder or urethral tumour and adjacent muscle and electrocoagulation, as necessary	321.78	3
S08251	Transurethral resection bladder neck, female	301.30	3
S08257	Transurethral removal of foreign body (excluding ureteric stents) ***Note:*** *Removal of ureteric stents is paid under 00704.*	252.75	3
08253	Y-V vesical neck plasty	643.81	4
S08254	Litholapaxy and removal of fragments	280.41	2
S08256	Transurethral resection of external urinary sphincter	303.07	3
Urethra			
S08232	Periurethral collagen injections ***Notes:*** *i) Includes cystoscopy.* *ii) Applicable to females only.* *iii) Additional training at recognized centre required.*	237.30	2
S08260	Urethrotomy, external or internal	214.95	2
S08261	Urethrostomy	301.70	2
S08262	Meatotomy and plastic repair (operation only)	136.37	2
08263	Urethrectomy, total	353.96	3
S08264	Stricture of urethra - office dilation (operation only)	19.77	
S08265	- dilation in hospital, isolated procedure, with or without anesthesiology (operation only)	49.38	2
08266	- first-stage plastic repair (excluding urethrostomy)	1,070.62	3
08259	- first-stage plastic repair requiring pedicle graft	1,019.64	3

		$	Anes. Level
81159	Buccal mucosa graft harvest, extra	229.42	
	Notes: *i) Restricted to Urologists.* *ii) Paid only with fee item 08259 (stricture of urethra first stage plastic repair).*		
08267	Stricture of urethra - second-stage plastic repair (excluding urethrostomy)	1,019.64	3
08268	Urethral diverticulectomy, male or female	600.02	2
S08269	TUR posterior urethral valves	353.92	2
08283	Retropubic or transvaginal tape (TVT) or transobturator tape (TOT) operation for urinary incontinence	332.03	
C81153	Male suburethral sling, including cystoscopy	713.74	4
	Notes: *i) Daily maximum is one per patient.* *ii) Repeats within 30 days are paid at 50%. A note record is required.*		
81154	Transection or removal of sub-urethral mesh sling	560.47	4
	Notes: *i) Restricted to Urology specialists.* *ii) Fee items 00704, 00705 or 08232 not paid in addition.*		
08272	Urethral fistula (penile excision)	400.89	2
08274	Hypospadias, excluding urethrostomy - first stage, chordee	549.14	2
08275	- second stage (penile)	550.35	2
08276	- penoscrotal	1,011.46	2
08277	- epispadias plastic repair	657.31	2
08278	Suprapubic cystostomy and primary repair of urethra	406.22	3
S08282	Excision prolapse of urethra or caruncle - includes cystoscopy (operation only)	243.07	2
S08271	Catheterization, complex – male patient (operation only)	203.93	
	Notes: *i) Restricted to Urologists and General Surgeons.* *ii) Procedure must involve the use of Filiforms and Followers, or introducers (stylet or catheter guide).* *iii) Not paid in addition to the critical care fees, or diagnostic urological procedures (e.g.: voiding cystourethrogram).*		

Penis

08296	Insertion of semi rigid or self contained inflatable prosthesis following traumatic or surgical injury	611.78	3
08363	Revision of penile prosthesis (includes removal, correction of any mechanical failure, and replacement)	862.64	3
	Note: *08296, 08363: In cases in which impotence is not the direct result of surgery or trauma, then prior authorization should be obtained from the Plan.*		
P08364	Repair of penile fracture or traumatic laceration of cavernous tissue	796.60	2
	Notes: *i) Restricted to Urologists.* *ii) Diagnostic cystoscopy prior to surgery is payable at 100%.*		
08297	Deep dissection of intercrural region, with ligation of deep dorsal and cavernosal veins with or without ligation of crural veins (“venous ligation for impotence”).	404.57	2
	Note: *08297 must be preceded by colour flow Doppler or duplex sonogram.*		
08300	Priapism - saphena-cavernous shunt	569.16	2

		$	Anes. Level
P08366	Emergency Management of Priapism, includes aspiration and irrigation of the corporal bodies and injections into the corporal body (includes distal shunt if necessary) ***Notes:*** *i) Restricted to Urologists.* *ii) Cystoscopy to rule out urethral injury may be paid in addition at 100%.* *iii) May be paid at 100% if entire procedure is repeated on the same day.*	497.00	
S08301	Dorsal slit, isolated procedure (operation only)	111.69	2
S08312	Circumcision - excluding clamp or bell technique (operation only) ***Note:*** *Routine circumcision of the newborn for non medical reasons is not a benefit of the Medical Services Plan.*	204.77	2
08305	Simple amputation of penis	462.03	2
08299	Radical amputation of penis	606.84	2
08306	Clitoral recession	252.82	2
	Excision of inguinal and femoral glands with or without iliac glands:		
08308	- unilateral	917.67	4
08309	- bilateral	1,325.53	4
08307	Excision of Peyronies' plaque, with replacement graft (tissue or synthetic)	796.60	2
P08365	Penile plication for correction of penile curvature for Peyronie's disease ***Notes:*** *ii) Restricted to Urologists.* *iii) Circumcision if required is payable in addition at 50%.*	796.60	2

Prostate

Only one prostatectomy fee item is payable per date of service.

Prostatectomy (including meatoplasty, dorsal slit, urethral dilation, panendoscopy, retrograde pyelography, vasectomy or bladder neck surgery done while patient is under anesthetic for the prostatectomy):

08311	- perineal, suprapubic, retropubic and transurethral approaches	474.92	5
08314	- radical perineal retropubic prostate seminal vesiculectomy ***Note:*** *No charge for repeat prostatectomies done within a period of three months by the same operator, except where radical prostatectomy is subsequently required for cancer.*	1,380.84	7
08318	- radical, to include lymphadenectomy	1,410.23	7
C81305	Laparoscopic radical prostatectomy ***Notes:*** *i) Restricted to Urologists.* *ii) Not paid for repeat prostatectomies done within a period of three months by the same operator, except where radical prostatectomy is subsequently required for cancer.*	2,080.06	7
C81310	Laparoscopic radical prostatectomy, with pelvic lymph node dissection (PLND) ***Note:*** *i) Restricted to Urologists.*	2,396.16	7

		$	Anes. Level
S81311	Holmium laser enucleation of prostate (HoLEP)	948.67	5
	Notes: *i) For bladder outlet obstruction secondary to benign prostate hypertrophy.* *ii) For prostates larger than 60 grams.* *iii) Holmium laser only (not intended for KTP a.k.a. green light).* *iv) Under the same anesthetic, includes meatotomy (S08262), dorsal slit (S08301), urethral dilation (08264, 08265), cystoscopy and panendoscopy (00704), retrograde pyelogram (08593), vasectomy (08345), and transurethral resection of bladder or urethral tumour and adjacent muscle and electrocoagulation (08250).* *v) Fee item 08254 will be paid at 50% when done with HoLEP.*		
08317	Anti-incontinence procedure (artificial urinary sphincter)	771.28	4
S08319	Balloon dilation of prostate (Includes cystoscopy)	227.26	2

Testis

S08329	Simple orchidectomy (operation only)	242.52	2
08330	Orchidectomy via inguinal approach	341.58	2
	Note: *Includes excision of spermatic cord to level of internal inguinal ring*		
08322	Orchidopexy - one or two stages	389.50	2
S08323	Exploration of scrotal contents - unilateral (operation only)	243.25	2
08324	Exploration of undescended testicle, without orchidopexy	262.17	2
08328	Recurrent undescended testis	509.23	2
S08325	Reduction of torsion of testis and spermatic cord repair - bilateral	407.86	2
08326	Ruptured testicle - repair	406.85	2
S08327	Biopsy of testis	151.50	2
08349	Retroperitoneal lymphadenectomy for carcinoma of testis	2,039.27	4
08354	- post chemotherapy	2,319.68	4

Epididymis

S08340	Abscess, incision, complete care (operation only)	195.36	2
S08341	Spermatocoele or hydrocele excision	272.90	2
08342	Epididymectomy - unilateral	279.07	2
S08343	Epididymovasostomy or re-anastomosis of vas - unilateral	778.03	2
	Note: *This item is an insured benefit under the Plan only when a previous vasectomy has not been performed.*		
S08344	Vas cannulation, unilateral or bilateral	126.41	2
S08345	Vasectomy - bilateral (operation only)	101.51	2
08346	Varicocoele - resection	392.06	2
P08370	Sub-inguinal Microsurgical Varicocelectomy	1,043.00	7
	Note: *Restricted to Urologists.*		
08347	Avulsion of penile skin and scrotum - repair	405.11	2
08350	Urethro-vesical neck plasty for congenital incontinence	1,032.76	4
08353	Plastic repair of extrophy and plastic repair of bladder with skin	1,329.95	5

Diagnostic Procedures

S00866	Dynamic cavernosometry and avernosography	79.05	2
	Note: *Interpretation of x-ray is included in technical portion and is not billable in addition to procedure.*		

		$	Anes. Level

Diagnostic Ultrasound

Preamble: Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.

08399 Doppler evaluation of penile blood flow wave from evaluation of dorsal and cavernosal arteries. Blood pressure recordings and calculation of penile brachial index. 47.43

Note: *The Doppler Vascular listings are applicable to hospital-based, accredited and approved ultrasound vascular studies laboratories only.*

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

		$
Head and Neck		
08500	Skull - routine	53.41
08501	Skull - special studies - additional	35.32
08503	Paranasal sinuses	35.32
08504	Facial bones - orbit	35.32
08505	Nasal bones	35.32
08506	Mastoids	53.41
08507	Mandible	35.32
08508	Temporo-mandibular joints	35.32
08509	Salivary gland region.	35.32
08510	Sialogram	55.11
08511	Eye - for foreign body	35.32
08512	- for localization of foreign body - additional	52.88
08513	Dacryocystogram	34.94
08514	Nasopharynx and/or neck, soft tissue - single lateral view	22.93
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).*	52.89
08518	Pre-MRI view(s) of orbits to rule out metallic foreign body	24.29
Upper Extremity		
08520	Shoulder girdle	35.32
08521	Humerus	35.32
08522	Elbow	35.32
08523	Forearm	35.32
08524	Wrist	35.32
08525	Hand (any part)	35.32
08526	Special requested views in upper extremity	17.80
Lower Extremity		
08530	Hip	35.32
08531	Femur	35.32
08532	Knee	35.32
08533	Tibia and fibula	35.32
08534	Ankle	35.32
08535	Foot (any part)	35.32
08536	Leg length films - whatever method	41.59
08537	Special requested additional views for lower extremity	17.80
Spine and Pelvis		
08540	Cervical spine	42.28
08541	Thoracic spine	35.32
08542	Lumbar spine	53.41
08543	Sacrum and coccyx	35.32
08549	Spine - requested additional views (flexion, bending views,etc.) ***Note:*** *This item shall not be used to cover normal oblique projections.*	33.26

		$
08544	Pelvis	35.32
08545	Sacro-iliac joints	35.32
08546	Scoliosis film - single AP or lateral - 14 x 36 film taken at 6 feet (1.85 metres)	46.22
08547	Pelvis and additional requested views (i.e. sacro-iliac joints, hip, etc.)	42.28
08548	Myelogram and/or posterior fossa positive contrast (excluding procedural fee)	104.61

Chest

08550	Thoracic viscera	35.04
08551	Thoracic inlet	35.04
08552	- additional requested views	17.80
08553	Fluoroscopy, when requested	17.93
08554	Ribs - one side	35.32
08555	Ribs - both sides	53.41
08556	Sternum or sterno-clavicular joints	35.32
08557	Sternum and sterno-clavicular joints	53.41

Abdomen

08570	Abdomen	35.32
08571	Abdomen, multiple views	53.41

Gastrointestinal Tracts

08572	Oesophagus only	60.23
08573	Oesophagus, stomach, and duodenum	86.03
08574	Small bowel	86.03
08576	Colon or double contrast air studies	96.96
08577	Hypotonic duodenography	86.03
08578	Pancreatography (excluding procedural fee)	52.63
08579	Glucagon assisted contrast study - in addition to routine fee	37.85

Gall Bladder

08581	Intravenous cholangiogram	76.37
08582	Operative cholangiogram (transhepatic also)	57.41
08583	Direct post-operative cholangiogram or pyelogram	61.91
08584	Removal of biliary calculi, by Burhenne technique or equivalent, including necessary cholangiogram and fluoroscopy (excluding procedural fee)	64.67

Genito-Urinary System

08590	K.U.B.	35.32
08591	Pyelogram - intravenous	79.56
08593	Pyelogram - retrograde or antegrade	52.88
08594	Intravenous pyelogram with voiding cystourethrogram	104.61
08595	Cystogram or retrograde urethrogram (not including catheterization)	52.88
08596	Hystero-salpingogram (excluding injection)	86.03
08597	Pelvimetry	72.97
08599	Voiding cystourethrogram	87.41

$

Miscellaneous

08575 Video fluoroscopy - 50 percent to be added to fee items 08572 and 08573 ..... 43.03

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 66.48

08602 Body section radiography - applies to all tomographic procedures (including polytomography when done in one plane) per plane series, including orthopantogram 50.37

08603 Bone age - whatever method 37.01

08604 Bone survey - first anatomical area 35.32

08605 - each subsequent anatomical area 17.80

08606 Arthrogram, shoulder (excluding injection of contrast) 38.00

08607 Arthrogram, hip (excluding injection of contrast) 34.95

08608 Arthrogram, knee (excluding injection of contrast) 74.99

08609 Arthrogram, ankle (excluding injection of contrast) 34.95

08631 Arthrogram - wrist (excluding injection of contrast) 34.95

08637 Arthrogram - elbow (excluding injection of contrast) 34.95

08610 Mammography - unilateral 104.11

08611 - bilateral 145.91

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 135.56

08616 - bilateral 232.60

08617 Peripheral angiography (arteriography and venography) - unilateral. 70.17

08618 - bilateral 104.61

08620 Aortography (aortography plus peripheral angiography) 180.25

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	137.74
08627	- using multiple sequential views - selective	135.56
*08628	Interpretation of submitted films - per examination	51.57

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	40.86

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	318.46
	Radiology Assistant Fee:	
*08632	- first hour or fraction thereof	112.91
*08633	- each 15 minutes or fraction thereof after one hour	28.26

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).

iii) Start and end times must be entered in both the billing claims and the patient's chart.

Bone Mineral Densitometry Using DEXA Technology

08688	Bone density - single area	69.25
08689	Bone density - second area	47.37
08696	Bone density - whole body	124.68

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 45.95
*08691 - with contrast 64.08
*08692 - double scan or 2 planes 82.76
*08693 Body scan - one region without contrast 91.69
*08694 - one region with contrast 101.35
*08695 - double scan or two regions 138.54
83090 Cardiac CT/CT Coronary Angiography, Professional fee 170.21

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.

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.

83096 CT Colonography, Professional fee (extra) 62.20

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 FP'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.

$

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 103.35

Notes:
i) Payable only to physicians with appropriate training in interventional radiology.
ii) Must be initiated by written request by another physician.
iii) Payable only when patient is referred for an interventional radiological procedure which requires extensive discussion and review of all available data.
iv) Includes all patient visits necessary.
v) Repeat consultation not applicable for same condition, same patient within 6 months.
vi) The IR consultation fee is not applicable for simple biopsies or aspirations or in situations where a consultation is not warranted.
vii) The routine task of obtaining an informed consent for a procedure does not constitute an IR consultation.

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 103.35

Notes:
i) Payable only to physicians with appropriate training in interventional radiology.
ii) Must be initiated by written request by another physician.
iii) Payable only when patient is referred for an interventional radiological procedure which requires extensive discussion and review of all available data.
iv) Includes all patient visits necessary.
v) Repeat consultation not applicable for same condition, same patient within 6 months.
vi) The IR consultation fee is not applicable for simple biopsies or aspirations or in situations where a consultation is not warranted.
vii) The routine task of obtaining an informed consent for a procedure does not constitute an IR consultation.

		$	**Anes. Level**
10901	Percutaneous image guided catheter directed thrombolysis of peripheral vein/artery	589.66	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.
iii) Start and end times must be entered in both the billing claims and the patient's chart.

		$	Anes. Level
10902	Peripherally inserted image-guided central Venous catheter line (PICC)	112.32	2
	Notes: *i) Not applicable if performed via other than peripheral access.* *ii) Includes placement, venogram/angiogram, and all medically required image guidance.* *iii) May not be delegated.*		
10903	Percutaneous hemodialysis graft thrombolysis	589.66	2
	Notes: *i) Includes declotting and treatment of underlying cause of access failure.* *ii) Includes angioplasty and all necessary Imaging and intervention.*		
10904	Percutaneous transcatheter arterial chemo-embolization (TACE)	589.66	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 and/or thrombectomy	1,312.16	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) Not payable with fee item 00998.*		
10906	Image-guided percutaneous vertebroplasty – first level	365.04	4
10907	- each additional level (to a maximum of 3)	84.25	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.*		
10908	Percutaneous image-guided tumour ablation – first lesion	530.20	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, 50% for second lesion and 50% for third lesion.* *iii) Includes all CT and ultrasound guidance necessary to complete the procedure.* *iv) Paid at 50% if repeated within 30 days.*		
10909	Percutaneous intravascular/intracorporeal medical device/foreign body removal	393.12	3
	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.*		
10911	Selective salpingography / fallopian tube recanalization (FTR)	393.12	2
	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.*		

		$	Anes. Level
10912	Transjugular liver/renal biopsy	393.12	2

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%.

10913	Cerebral arterial balloon occlusion tolerance test	798.88	5

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) Included in payment for endovascular obliteration of an aneurysm using the GDC technique (FI 10915), or embolization (fee items: 00995, 00997, 00998) if performed on the same day.

10914	Percutaneous balloon angioplasty for cerebral vasospasm	1,026.79	9

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.
iv) Medically necessary extra cranial angioplasty and stenting required to enable access for balloon angioplasty payable at 50% of 00982
v) Radiological assists are payable under fee items 08632 and 08633.
vi) 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.
vii) Not payable with fee item 10905.

10915	Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique	1,997.22	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) Multiple aneurysms paid as follows: 2nd – 50 percent; 3rd – 25 percent (to a maximum of three aneurysms).
v) Radiological assists are payable under fee items 08632 and 08633.
vi) Fee item 08629 not payable in addition.
vii) 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.

		$	Anes. Level
10916	Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations – up to 4 hours procedural time	1,174.82	5
10917	– after 4 hours (extra to 10916)	293.72	

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 end times must be entered in both the billing claims and the patient's chart.

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	469.94	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) Includes necessary post-operative visits by physician performing procedure.

iv) Compression sclerotherapy listings (fee items 77050 – 77060) not payable with 10918.

10919	Intravascular stent placement – extra	129.56

Notes:

i) Includes all diagnostic imaging associated with stent placement.

ii) Payable when follows angioplasty procedure (S00982) where stent is not initially deployed.

iii) For non-Vascular surgery, placement of second stent in a different site is payable at 50%.

iv) When 10919 is combined with another vascular surgery, multiple stents will be paid on anatomical named vessels as follows: 100% for the first and 50% for the second, to a maximum of 2 stents.

v) When 10919 is performed with 77113 or 77114 as an isolated endovascular procedure, multiple stents will be paid on anatomical named vessels as follows: 100% for the first, 50% for the second and 25% for the third, to a maximum of 3 stents.

vi) Procedures repeated within 30 days are payable at 50%.

vii) Not payable for Coronary stent placement.

viii) When done with 77177 (EVAR), payable to either the primary or the second operator.

When performed with percutaneous angioplasty for the following anatomical named vessels

Upper extremity vessels
Right brachial artery
Right radial artery
Right ulnar artery
Left brachial artery
Left radial artery
Left ulnar artery

Lower extremity vessels
Anterior tibial artery
Posterior tibial artery
Peroneal artery
Tibioperoneal trunk
Right common femoral artery
Right superficial femoral artery
Right profunda femoral artery
Right popliteal artery
Left common femoral artery
Left superficial femoral artery
Left profunda femoral artery
Left popliteal artery

Intra abdominal vessels
Abdominal aorta
Celiac axis
Hepatic artery
Splenic artery
Superior mesenteric artery
Inferior mesenteric artery
Right common iliac artery
Right external iliac artery
Right internal iliac artery
Left common iliac artery
Left external iliac artery
Left internal iliac artery
Right renal artery
Left renal artery

Thoracic vessels
Ascending thoracic aorta
Transverse thoracic aorta
Descending thoracic aorta
Brachiocephalic artery
Right common carotid artery
Right subclavian artery
Right vertebral artery
Left common carotid artery
Left subclavian artery
Left vertebral artery

Cervical vessels
Right common carotid artery
Right internal carotid artery
Right external carotid artery
Left common carotid artery
Left internal carotid artery
Left external carotid artery

		$	Anes. Level
10920	Intracorporeal stent placement – extra	129.56	

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) 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.
vi) Placement of second stent in non-contiguous site payable at 50%.

10921	Transjugular Intrahepatic Porto-systemic shunt (TIPS)	1,113.42	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) Radiological assists are payable under fee items 08632 and 08633.

10922	Embolization in the management of Epistaxis without vascular lesion or tumour	628.08	3

Notes:

i) Includes the procedure performed, preparation of the embolic agent(s), catheter(s), catheterization(s), and follow-up care of the patient by the radiologist.
ii) Billable only by physicians with appropriate training in interventional radiology.
iii) Payable once per day, regardless of the number of embolizations or catheterizations performed, or balloons inserted.
iv) 10922 include:
  a) Diagnostic angiograms done during the procedure.
  b) Angiograms performed as a separate procedure before or after the embolization are billable.
  c) Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted embolization procedure. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of $1,700. Claims must be accompanied by written details of vessels injected.
  d) Repeat procedures performed by the same physician and done within 30 days of the original procedure will be paid at 75% of the original fee.
v) Includes 10913 if performed on same day.

Breast

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

Incision

70041	Fine needle aspiration of solid or cystic lesion – operation only	48.20	2
70042	- each additional cyst or lesion (maximum of 3) – operation only	12.07	2

Stereotactic or ultrasound-guided core needle biopsy:

70472	- 1 to 5 core samples – operation only	90.89	2
70473	- 6 to 10 core samples - (operation only)	128.33	2

		$	Anes. Level
	Post biopsy marker		
83045	Post biopsy radiological marker (clip) placement	150.00	

Notes:

i) Restricted to Radiologists who work at approved Community Imaging Clinics only.

ii) Paid only in addition to 86047; or 86048 when combined with 86047.

iii) Maximum two clips per patient per day, either unilateral or bilateral.

DIAGNOSTIC ULTRASOUND

(Full Fee for all Qualified Physicians)

Preamble: Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.

Diagnostic Ultrasound Telemetry

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

For diagnostic ultrasound 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

Real time ultrasound fees may only be claimed for studies performed by telemetry when:

- the facility currently holds a remote site designation from the Medical Services Commission. (Facilities should recognize that once the volume of services justifies full-time radiologist's coverage remote site designation may be removed.); and,
- the use of telemetry will not negatively affect the existing on-site visit schedules of the radiologists; and,
- the majority of scans will continue to be scheduled when the visiting radiologist is on-site for the purpose of ultrasound supervision.

		$
Head and Neck		
08641	Ophthalmic B scan (immersion and contact technique) ***Notes:*** *i) No additional charge for second eye when both eyes examined concurrently.* *ii) 08641 includes 22399 when done at the same sitting.*	101.17
08642	B scan soft tissues of neck. ***Note:*** *To include thyroid, parathyroid, parotid and submandibular glands.*	68.77
08659	B scan of brain	105.25
Heart		
08638	Echocardiography (real time)	101.86
08644	Ultrasonic guidance for pericardiocentesis	110.08
Thorax		
08645	B scan	86.68
08646	Ultrasonic guidance for thoracentesis	100.51
86047	Breast sonogram, unilateral	70.63
86048	Breast sonogram, additional side ***Notes:*** *i) Additional side payable only when a localized area of interest is present in each breast. Sonography of the additional breast is not billable for comparison purposes only.* *ii) Indications for breast ultrasound:* *- evaluation of mammographic abnormalities;* *- evaluation of palpable masses;* *- evaluation of other localized breast symptoms; evaluation of suspected implant complication;* *- guidance for fine needle aspiration biopsy, core needle biopsy or fine wire localization;* *- follow-up of solid nodules with benign characteristics which are not visible at mammography.*	35.62
Abdomen		
08648	Abdominal B scan, complete	110.10
08649	Renal B scan ***Note:*** *08649 not chargeable when done in conjunction with 08648 and/or 08653.*	86.68
08650	Ultrasonic guidance for biopsy or cyst puncture	126.67
08684	Prostate scan using rectal probe	110.08
Obstetrics and Gynecology		
08655	Obstetrical B scan (under 14 weeks gestation)	82.58
08651	Obstetrical B scan (14 weeks gestation or over)(for singles) ***Note:*** *Where an obstetrical B scan (08651, 08655 or 86055) has been done within the two weeks immediately prior to an amniocentesis, a repeat obstetrical scan done in conjunction with amniocentesis is not chargeable.*	110.08
86051	Obstetrical B scan (14 weeks gestation or over) (for multiples – each additional fetus)	81.91

		$
86055	Obstetrical B Scan less than 14 weeks with Nuchal Translucency measurement (for singles)	126.97

Notes:

i) Limited to one per pregnancy.

ii) Only paid for scan between 11 weeks and 13 weeks and 6 days gestation.

iii) Not paid with 08655.

iv) Not paid for women under 35 years of age, at time of delivery, with the following exceptions:

a. Paid for women with multiple gestation pregnancies.

b. Paid for women who have a history of a previous child or fetus with Down syndrome (trisomy 21), trisomy 8, or trisomy 13.

c. Women who are HIV positive.

d. Women pregnant following invitro fertilization with intracytoplasmatic sperm injection.

86056	Obstetrical B Scan less than 14 weeks with Nuchal Translucency measurement (for multiples – each additional fetus)	95.22
08652	B scan I.U.D. localization	55.31
08653	Pelvic B scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal doppler	110.08

Notes:

i) 08653 payable in conjunction with 08658 when specifically requested by the referring physician.

ii) 08651 and 08655 not billable in conjunction with 08653.

08657	Ultrasonic guidance for chorionic villus sampling	110.68

Extremities

08658	Extremity B-scan	59.60

Notes:

i) Includes, but not restricted to, assessment of tendons, joint effusions, soft tissue masses and foreign body localization, unilateral.

ii) Fee items 08670 or 08664 may be claimed in addition, if applicable.

iii) May be claimed bilaterally if specifically requested by physician, except when billed with 08670 or 08664.

Doppler Studies

Note: *The Doppler Vascular listings are applicable to hospital-based, accredited and approved ultrasound vascular studies diagnostic facility only.*

08660	Abdominal duplex of native or transplant liver and/or kidney	122.55

Peripheral Arterial:

08664	Resting arterial assessment: To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index	60.19

Note: *08664 not chargeable when done in conjunction with 08665 or 08666.*

	Treadmill stress examination with or without ECG monitoring: To include sequential post stress measurement and calculations:	
08665	- with monitoring physician present	106.71
08666	- without monitoring physician present	72.19
08668	Vasospastic assessment: To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis	72.19

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08669	Sympathetic tone response: To include resting arterial assessment plus plethysmography and/or impedence monitoring and or digital wave forms, response to Valsalva manoeuvres or other stimuli	43.96
	Note: *08669 not chargeable when done in conjunction with 08668.*	
	Peripheral Venous:	
08670	Diagnostic facility assessment for deep venous system	44.83
	Heart:	
08662	Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis	234.46
	Note: *Where the exercise stress test (00530, 00531, 00535, 01730, 01731, 01732, 33034, 33035 and 33036) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent.*	
08679	Doppler echocardiography	46.73
	Extracranial:	
	Carotid imaging: To include delineation of extra cranial vessels on both sides of the neck:	
08676	- duplex scanning of neck vessels, to include Doppler flow assessment	122.38
08677	Periorbital assessments; either oculoplethysmography (O.P.G.) or photoplethysmography (P.P.G.), and/or Doppler directional determination with extracranial artery compression manoeuvres	44.83
08678	Subclavian or vertebral assessment including assessment of subclavian steal: to include directional Doppler determination of flow direction in vertebral arteries, with or without arm compression and other manoeuvres	61.42

LABORATORY MEDICINE

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

These fee items may not be billed by Laboratory Medicine physicians who are being compensated under a service contract, sessional or salary agreement with a Health Authority for the same period of time in which the consultation/visit service is rendered. Further, no Laboratory Medicine physician who is being compensated under a service contract, sessional or salary agreement for a full time equivalent shall be entitled to bill these fee items. Special authority must be received from the Doctors of British Columbia before Medical Services Plan will consider honouring accounts submitted for these fee items.

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Consultations and Visits

94010	**Consultation:** To consist of examination, review of history and laboratory findings with a written report	148.82
94012	**Repeat or Limited Consultation:** Where a consultation for same illness is repeated within six (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 consultative fee	82.69
	Continuing care by consultant:	
94006	Directive care	31.44
94007	Subsequent office visit	32.15
94008	Subsequent hospital visit	32.04
94009	Subsequent home visit	63.89
94005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	127.63
	Telehealth Service with Direct Interactive Video Link with the Patient:	
94070	Telehealth Consultation: To consist of examination, review of history and laboratory findings with a written report	148.82
94072	Telehealth Repeat or Limited Consultation: Where a consultation for same illness is repeated within six (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 consultative fee	82.69
94076	Telehealth directive care	31.44
94077	Telehealth subsequent office visit	32.15
94078	Telehealth subsequent hospital visit	32.04
	The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:	
93120	E.C.G. tracing, without interpretation, (technical fee)	16.97

PREAMBLE TO THE NUCLEAR MEDICINE SCHEDULE

Nuclear Medicine Telemetry

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

For nuclear medicine 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

Nuclear Medicine Preamble:

1. A separate fee item for SPECT is not required since SPECT is included in the scan fee when performed. Fee item 09877 (repeat of major scan) should not be billed for SPECT.

2. When medically necessary, the following items are billable with Nuclear Medicine Listings. A note record is required:

   a) Fee item 00016 (intrathecal medications by injection) is billable with fee item 09886 (Cisternography).

   b) Fee item 00015 (Intra-articular medications by injection - tendons, bursae, and all other joints) is billable with fee item 09890 (Therapeutic joint injection with isotope).

3. When required for patient care, and the results are not available, laboratory tests such as a pregnancy test or hematology profile may be requested by a Nuclear Medicine Physician subject to the provisions of the Laboratory Services Payment Schedule.

4. When plain film radiographs are required and not available, these may be requested by a Nuclear Medicine Physician for correlation.

5. Fee item 09866 (Perfusion study [dynamic scan], regional or organ) - this fee item is only billable in addition to the following scans and only when not rendered immediately prior to a scan:

   a) 09824 Testicular imaging - isolated procedure
   b) 09834 Bone Scan (only for indications listed under this fee item)
   c) 95045 RBC (Red Blood Cell) Liver Scan

6. When it is medically necessary to perform an aspiration in addition to a Nuclear Medicine scan, it is appropriate to bill the applicable joint aspiration fee (e.g.: 00757). A note record is required.

7. Fee item 09877 (Repeat of major scan – no additional radionuclide) can only be billed with the following scans if additional (delayed) imaging is performed. Fee item 09877 may not be used for SPECT:

   a) 09806 Parathyroid imaging
   b) 09807 M.I.B.G. imaging (I131-metaiodobenzyl-guanidine)
   c) 09817 Receptor imaging
   d) 09826 Tumour imaging
   e) 09829 Adrenal imaging
   f) 09844 Red cell survival study
   g) 09854 Thallium myocardial scan
   h) 09867 Brain scan, static
   i) 09869 Pancreas scan, static
   j) 09886 Cisternography
   k) 95015 Iodine 131 whole body scan
   l) 95053 Thallium Body Imaging
   m) 95055 Renal imaging with Pharmaceuticals (isolated procedure)
   n) 95060 Renal imaging without pharmaceuticals (isolated procedure)
   o) 95065 White blood cell labelled with radioisotope (if views are performed on separate days or 24 hours apart)
   p) 09834 Bone scan (only if 24 hour views are performed
   q) 09878 Liver clearance of H.I.D.A. (biliary scan) (if 24 hour views are performed)
   r) 95025 Liver clearance of H.I.D.A. with pharmaceutical (if 24 hour views are performed)

NUCLEAR MEDICINE PROCEDURES

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

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Scanning and Localization Procedures

09829	Adrenal imaging (isolated procedure)	445.93
09832	Blood pool joint scan	166.13
	Note: *Not payable with joint scans.*	
09833	Bone marrow scan	171.06
09834	Bone scan	232.50
	Notes:	
	i) Includes SPECT.	
	ii) Fee item 09866 is the only Nuclear Medicine listing payable in addition to a bone scan and is payable only in cases of suspected infection or trauma, possible osteomyelitis, evaluation of reflex sympathetic dystrophy, heterotopic ossification, arthropathy, avascular necrosis, metabolic bone disease, primary bone tumours and insufficiency and stress fractures. Note record indicating reason required when billing 09866 in addition to bone scan.	
09871	Brain scan - regional cerebral blood flow (isolated procedure)	358.49
09867	Brain scan, static	205.81
09805	Carbon-14 glycinecholate breath analysis	117.28
95000	Cardiac first pass	91.09
	Note: *Not paid with 95005.*	
09864	Cardiac scan, static	152.89
95005	Cardiac shunt	103.07
	Note: *Not paid with 95000.*	
09886	Cisternography	341.60
09813	CNS Shunt	175.65
09898	Coronary perfusion with radio particles, per radionuclide	197.92
09897	Coronary administration of radio particles, transcatheter	28.75
09802	Oesophageal motility - utilizing an orally administered radioisotope	206.07
09838	Gallium scan	282.91
09839	- each repeat, with no additional radionuclide	102.59
	Note: *09877 not payable same day.*	
09879	Gastric emptying (liquid)	286.11
09808	Gastric emptying (solid)	249.44
	Note: *If both liquid and solid phases are performed on the same day, charge 09877 for the second test.*	
09859	Gastrointestinal blood loss study	119.62
09895	Gastro-oesophageal reflux	249.44
	Note: *Not payable with 09808 or 09879*	
09858	Gastrointestinal protein loss study	152.89
09848	G.F.R. (In-Vitro)	127.35
09804	G.I. bleeding - red cell label	336.24
	Note: *09859/95045 are not payable with 09804.*	

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95015	Iodine 131 whole body scan	242.01
95020	Joint scan	242.01
	Note: *Not payable with blood pool joint scan.*	
09814	Lacrimal duct scan	147.93
09878	Liver clearance of H.I.D.A. (biliary scan)	270.35
	Note: *Included in 95025 when performed same day.*	
95025	Liver clearance of H.I.D.A. with pharmaceutical	397.70
09850	Liver scan, static	164.61
	Note: *When performed in conjunction with spleen scan, static (09873), bill as 09851 only (liver and spleen scan, static).*	
09851	Liver and spleen scan, static	227.25
09896	Lumbar administration of radionuclide	33.11
95030	Lung quantification	256.86
	Notes: *i) Fee item 95030 not payable with 09868.* *ii) 09855 payable in addition only if both ventilation and perfusion are quantified.* *iii) Provide details in note record if billing associated procedures on same day.*	
09868	Lung scan, static	227.02
	Note: *09866 not paid in addition*	
09816	Lymphoscintigraphy - isolated procedure	298.30
09853	Meckel's localization (ectopic gastric mucosa)	341.13
09807	M.I.B.G. imaging (I131-metaiodobenzyl- guanidine)	967.45
09870	Ocular tumour localization	185.72
09869	Pancreas scan, static	296.86
09806	Parathyroid imaging	413.66
09865	Perfusion study (dynamic scan), regional or organ - when done alone	120.05
09866	Perfusion study (dynamic scan), regional or organ - in addition to major scan	45.63
09835	Plasma volume (with plasma label), total blood volume, and red-cell mass by calculation	36.15
09849	Platelet survival	305.56
	Radioiron:	
09840	- clearance	153.11
09841	- turnover	149.09
09842	- red cell utilization	152.89
09843	- combined study at one time of above three	297.32
09863	Radionuclide cardiac ventriculography	263.25
95040	- with stress	387.62
	Notes: *i) Only one of the following items is payable when requested and rendered with a radionuclide cardiac ventriculography (gated study MUGA) - (fee items 09863, 95040):* *a) Cardiac first pass (fee item 95000),or* *b) Cardiac shunt (fee item 95005), or* *c) Cardiac function studies, dynamic (fee item 09862)* *ii) 95040 includes 09863.*	

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09809	Radionuclide venogram alone	197.63
09817	Receptor imaging - isolated procedure	265.54
95045	RBC (Red Blood Cell) liver scan	290.26
	Note: *09859 is not payable with 95045.*	
09836	Red cell mass determination (with red cell label), to include whole blood and plasma volume by calculation	238.34
09837	Red cell mass (with RBC label) and plasma volume (with plasma label) combined study	159.43
09844	Red cell survival	233.43
95055	Renal imaging with pharmaceuticals (isolated procedure)	340.66
95060	Renal imaging without pharmaceuticals (isolated procedure)	308.58
	Notes:	
	i) Fee items 95055 and 95060 may only be billed together on the same day when renography is performed for the assessment of renovascular hypertension using a one-day protocol. For these instances, a note record stating "renovascular hypertension one day protocol" must be submitted when both items are billed. Payment for other renal imaging studies with pharmaceuticals (e.g.: lasix renogram) will be made under 95055 only.	
	ii) 95055 and 95060 include camera GFR	
	iii) Blood GFR (09848) may be billed on the same day, when required.	
09877	Repeat of major scan - no additional radionuclide - charge 50% of scheduled fee for primary procedure	704.11
95062	Rest myocardial perfusion	269.76
95063	Stress myocardial perfusion	278.70
	Note*: 95062 and 95063, (as well as stress test) are billable same day, if performed.*	
09818	Salivary gland study	181.68
09819	SeCHAT	261.40
09873	Spleen scan, static	152.89
	Note: *When performed in conjunction with liver scan, static (09850), bill as 09851 only (liver and spleen scan, static).*	
09824	Testicular imaging - isolated procedure	173.34
09854	Thallium myocardial scan	416.43
95053	Thallium body imaging	423.37
	Notes:	
	i) Not payable with 09806, 09817, 09854 or 09826.	
	ii) 09877 payable in addition if the patient is brought back for additional imaging the same or next day.	
	Thyroid uptake:	
09820	- single determination	45.47
09821	- double determination	68.77
09823	Thyroid scan (Iodine – 123)	187.36
09825	Thyroid scan (pertechnetate)	74.93
09876	Transfer of radionuclide (CSF to blood)	75.54
09826	Tumour imaging with metabolic or biological imaging agent	1,408.23
	Note*: Includes imaging of the entire torso with tomographic and planar images as indicated*.	
09855	Ventilation lung scan	234.79
	Notes:	
	i) 09868 payable in addition, if applicable.	
	ii) Ventilation-perfusion scan to rule out pulmonary embolism is billable under 09855 and 09868.	
	iii) 09866 not paid in addition.	

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	Vitamin B12 absorption study (e.g.: Schilling test):	
09856	- without intrinsic factor	133.84
09857	- with intrinsic factor	160.76
09852	- with blood radioactive determination	73.63
09860	- with two radionuclides	92.14
09828	Voiding cystography	186.77
95065	White Blood Cell labelled with radioisotope	780.13

Therapeutic Procedures

09890	Joint injection with isotope - therapeutic	759.17
09880	Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (Iodine therapy)	392.02
09881	Treatment for polycythaemia vera with P32 - charge per course of treatment	231.35
09882	Treatment for thyroid cancer - charge per course of treatment	509.49
09883	Treatment for prostate cancer - charge per course of treatment	467.28
09884	Treatment for metastatic carcinoma of bone - charge per course of treatment	300.25

SPECIALIST SERVICES COMMITTEE INITIATED LISTINGS

1. Preamble

The following Specialist Services Committee (SSC) fee items are billable only by Specialists certified by the Royal College of Physicians and Surgeons of Canada.

The objectives of SSC fees are to reduce unnecessary face-to-face encounters, to reduce care gaps, and to provide more timely care from the most appropriate physician, thereby improving patient care.

1. For the purposes of this section, face-to-face services include consultation; office, home or hospital visit; and any diagnostic, therapeutic, anesthetic or surgical procedure with both physician and patient in the same room.

2. SSC fees are not payable for situations where the sole purpose of the communication is to:
    a) book an appointment
    b) arrange for transfer of care that occurs within 24 hours
    c) arrange for an expedited consultation or procedure within 24 hours
    d) arrange for laboratory or diagnostic investigations
    e) inform the referring physician of results of diagnostic investigations
    f) arrange a hospital bed for the patient
    g) renew prescriptions with a pharmacist.

3. For Fee items G10001, G10002, G10003, G10004, refer to section D.1. Telehealth Services of the General Preamble.

4. G10002, G10004, and G10005: All registered and regulated health care providers can serve as referral sources. When advice is requested by an Allied Care Provider not registered with MSP use the generic practitioner number 99987: Advice requested by an Allied Care Provider. (Not applicable to referred case fee items such as consultations or Specialist visits).

5. At minimum, the following is required, and the practitioner is responsible for keeping their practice consistent with any new guidelines which may be published by the Canadian Medical Protective Association (CMPA) and/or the College of Physicians and Surgeons of British Columbia (CPSBC).

    Electronic communication as part of patient care must ensure that security and patient confidentiality are maintained and guarded in the same way that paper records are protected.

    - The CMPA and the CPSBC recommendations regarding the use of electronic communications indicate three major areas of potential liability:
        - Confidentiality/privacy/security
        - Timeliness of Response
        - Clarity of Communication
    - Document consent. Obtain express and informed consent before transmitting patient information. Refer to the CMPA Template for consent to use electronic communications:
    - Document discussion & advice for all communications.
    - The email record should be included in the patient record.
    - Develop clear, written policies around use of email.
    - Communication between providers should clearly identify the most responsible physician (MRP).
    - Information should be encrypted as an attachment, or, at a minimum, password protected. Send password or cryptographic key separately.
    - Use secure communication modalities (i.e. Health authority email addresses) if possible.
    - Email addresses need to be double-checked.

6. SSC fees are payable for face-to-face, telephone, video conference and email communication. Review the individual fee notes which identify their respective eligible communication modality. SSC fees are not eligible for communication by instant message, text or short message service (SMS)

modality.

7. SSC fees are not payable to physicians for services provided within time periods when working on salary, service contract or sessional arrangement.

8. No claim may be made where communication or service is with a proxy for the billing physician.

9. These fees were previously administered by the Specialist Services Committee (SSC). Note that the SSC Preamble governs the SSC initiated listings in this section, however, the SSC Preamble does not apply to the rest of the MSP fees listings.

10. The SSC reserves the right to re-value, modify, suspend or cancel these fee items. Fees will be monitored to ensure that the overall expenditures do not exceed the funds available.

11. Out-of-Office Hours Premiums may not be claimed in addition.

12. G10001, G10002, G10004 and G10005 are not payable for the same patient on the same date of service if adult or pediatric critical care team fees have been paid to the same practitioner or a practitioner who belongs to the same critical care team.

2. SSC Fees **$**

Note: These fees cannot be correctly interpreted without reference to the Preamble for SSC Fees above, and the Eligibilities preceding each set of fee items below.

Specialist Advice Fees PG10001, PG10002, PG10005

Eligibility

The intent is to replace the need for the Specialist to see the patient in person. The consulting Specialist is responsible for ensuring that such communication meets the medical needs of the patient.

Notes:
i) Payable to Specialists for communication regarding assessment and management of a patient but without the consulting physician seeing the patient.
ii) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.
iii) An adequate medical record/chart, including times as specified under each fee item, is required.
iv) Not payable to physician initiating communication.
v) The Specialist is responsible for the confidentiality and security of all records, and electronic transmissions. For video technology, see Section D. 1. of the Preamble.
vi) G10001, G10002, G10005 may not be delegated to resident physicians.

PG10001 Urgent Specialist Advice – Initiated by a Specialist, Family Physician or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request 60.30

Notes:
i) Payable for telephone, video technology or face-to-face communication only. Not payable for written communication (i.e. fax, letter, email).
ii) Document time of initiating request, time of response, as well as advice given and to whom.
iii) Include the practitioner number of the physician or Health Care Practitioner requesting the advice in the "referred by" field when submitting claim.
iv) Not payable in addition to another service on the same day for the same patient by the same practitioner.

v) Limited to one claim per patient per physician per day.
vi) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 180 days.

$

PG10002 Specialist Advice for Patient Management – Initiated by a Specialist, Family Physician, Allied Care Provider, or coordinator of the patient's care. Verbal, real-time response within 7 days of initiating request – per 15 minutes or portion thereof 40.20

Notes:

i) Payable for telephone, video technology or face-to-face communication only. Not payable for written communication (i.e. fax, letter, email.)
ii) Document date of initiating request, date of the response, as well as advice given and to whom.
iii) Document start and end times in the medical record, and in time fields when submitting claim.
iv) Include the practitioner number of the physician or Allied Care Provider requesting advice in the "referred by" field when submitting claim. (For Allied Care Providers not registered with MSP use practitioner number 99987.
v) Not payable in addition to another service on the same day for the same patient by the same practitioner.
vi) Limited to two services per patient per physician per week.
vii) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 30 days.

PG10005 Specialist Email Advice for Patient Management–Initiated by a Specialist, Family Physician or Allied Care Provider. Response within 7 days of request.....10.15

Notes:

i) Payable for email communication only. Maximum 3 services per patient per physician per day.
ii) Document date of request, date of the response, as well as advice given and to whom.
iii) Include the practitioner number of the physician or Allied Care Provider requesting advice in the "referred by" field when submitting claim. (For Allied Care Providers not registered with MSP use practitioner number 99987).
iv) Not payable in addition to another service on the same day for the same patient by same practitioner.
v) Limited to 3 services per patient per physician per day.
vi) Limited to maximum of 12 services per patient per physician per year.
vii) Not payable if there is a paid visit/service for the same condition by the same MD in the previous 30 days.

Specialist Patient Follow-up Fees PG10003, PG10006

Eligibility

The purpose of these fees is for the Specialist to provide advice when the intent of communication is to replace the need for the Specialist to see their own patient in person. The consulting Specialist is responsible for ensuring that appropriate communication is used to meet the medical needs of the patient.

Notes:

i) These fees apply to communication between the Specialist and his/her own patient or patient's representative.
ii) Patient management requires two-way communication about clinical matters between the patient or patient's representative and the physician; the fee is not billable for administrative tasks such as appointment booking or notification.
iii) An adequate medical record/chart entry is required.
iv) Not payable in addition to a different service on the same day for the same patient by the same practitioner.

$

Specialist Patient Follow-up Fees PG10003, PG10006

PG10003 Specialist Patient Management / Follow-up – per 15 minutes or portion thereof.....24.17

Notes:

i) For verbal, real-time telephone and video technology communication (including other forms of electronic verbal communication) only. Not payable for written communication (i.e. fax, letter, email).

ii) Documentation in the medical record to show that the patient understood and acknowledged the information provided.

iii) Include start and end times in the medical record, and in time fields when submitting claim.

iv) Face-to-face service must have been billed for the same patient by the same physician within the preceding 18 months.

PG10006 Specialist Email Patient Management / Follow-up 10.15

Notes:

i) This fee applies to email communication only.

ii) Maximum of 3 services per patient per physician per day.

iii) Maximum of 12 services per patient per physician per calendar year.

iv) Face-to-face service billed for the same patient by the same physician within the preceding 18 months.

Multidisciplinary Conferencing for Complex Patients PG10004

Eligibility

This fee is only billable for a scheduled meeting to discuss and plan medical management of patients with serious and complex problems under extraordinary circumstances that the Specialist cannot manage by him/herself. Payable only when coordination of care is required via a collaborative conference with at least two of the following in addition to the Specialist billing: Specialists, Family Physicians, Allied Care Providers and/or coordinators of the patient's care.

Notes:

i) Includes scheduled face-to-face, telephone or video technology communication regarding assessment, clinical coordination and management of a complex patient.

ii) All Specialists involved in the conference may each independently bill this fee.

iii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed under the PHN of each patient for the specific time period.

iv) Not payable to the same patient on the same date of service as 00545, 00645, 60645, G33445, G10001, G10002, G10003, G10005, G10006, G78717 when claimed by the same practitioner.

v) Not payable to the same patient on the same date of service if adult or pediatric critical care team fees have been paid to the same practitioner or a practitioner who belongs to the same critical care team.

vi) Patient must be complex, with multiple medical needs or complex co-morbidities (two or more distinct but potentially interacting problems), where care needs to be coordinated over a period of time between several health disciplines.

Or a diagnosis of malignancy (excluding non-melanoma skin cancer).

Or one morbidity plus a minimum of one of the following non-medical conditions:

- poor socioeconomic status
- unstable home environment
- dependency on family/caregiver for daily living tasks
- accessibility/mobility issues
- under care of MCFD Protection Services

- received Tertiary or Acute level of care related to psychiatric condition within the previous 6 months
- frail elderly
- >75 years old
- BMI > 35
- high readmission rate

Document complexity in the medical record using the ICD-9 code for one of the major disorders when billing. If patient has non-medical comorbidity use the ICD-9 code M04 when billing.

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Specialist Multidisciplinary Conferencing for Complex Patients PG10004

PG10004 Multidisciplinary Conferencing for Complex Patients
– per 15 minutes; maximum one hour.....46.46

Notes:

i) Each Specialist involved in the case conference must document their contribution to the discussion and its effects on the patient's overall care in the medical record/chart.

ii) Start and end times of the conference must be documented in both the medical record and in time fields when submitting the claim.

iii) The names and job titles of the other participants at the meeting must be documented in the medical record.

iv) Maximum 16 services per patient per physician per calendar year.

v) Maximum of 4 services may be claimed per patient per physician per day.

vi) Case must be complex, as defined in the Eligibility.

vii) Use the ICD-9 code for one of the major disorders when billing.

viii) If patient has non-medical comorbidity (see Eligibility) use the ICD-9 code M04 when billing.

Group Medical Visits PG78763 – PG78781 Inclusive

Eligibility

A Group Medical Visit (GMV) provides medical care in a group setting. A requirement of a GMV is a 1:1 interaction between each patient and the attending physician. Because this is a time-based fee, concurrent billing for other services during the time of the GMV is not permitted. The physician must be physically present at the GMV for the majority of each time interval billed. While portions of the GMV may be delegated to a non-physician staff member the Specialist must be present for a majority of the GMV and assumes clinical responsibility for the patients in attendance.

Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction. Physicians can also benefit by reducing the need to repeat the same information many times and free up time for other patients. Appropriate patient privacy is always maintained and typically these benefits result in improved satisfaction for both patients and physicians.

This fee is not intended for provision of group psychotherapy (00663, 00664, 00665, 00667, 00668, 00669, 00670, 00671, 00672, 00673, 00674, 00675, 00676, 00677, 00678, 00679, 00680, 00681).

Referred Cases **$**

Group Medical Visit applies only when all patients in the group are receiving medically required treatment. These fees are not for efforts to persuade patients to alter diet or other lifestyle behavioral patterns, other than in the context of the individual medical condition.

Fee per patient, per 1/2 hour

PG78763	Three patients	47.40
PG78764	Four patients	37.86
PG78765	Five patients	32.91
PG78766	Six patients	29.28
PG78767	Seven patients	26.71
PG78768	Eight patients	24.78
PG78769	Nine patients	23.27
PG78770	Ten patients	22.01
PG78771	Eleven patients	19.29
PG78772	Twelve patients	18.14
PG78773	Thirteen patients	16.79
PG78774	Fourteen patients	16.49
PG78775	Fifteen patients	15.83
PG78776	Sixteen patients	15.35
PG78777	Seventeen patients	14.71
PG78778	Eighteen patients	14.48
PG78779	Nineteen patients	13.87
PG78780	Twenty patients	13.54
PG78781	Greater than 20 patients (per patient)	13.08

Notes:

i) Submit a separate claim for each patient.

ii) Each patient must have an active referral.

iii) Start and end times required in both the medical record and time fields in the claim.

iv) Not payable with any other services for the same patient on the same day by the same physician.

v) If multiple physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate for only the patients in their own fraction of the group. The claim note and patient chart should specify:

a. Number of people in entire group

b. Number of patients billed by billing physician

c. Of the patients billed by the billing physician, how many were to each insurer

d. Name of any other billing physicians.

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Specialist Discharge Care Plan for Complex Patients PG78717

Eligibility

This fee premium is intended to support clinical coordination leading to effective discharge and community-based management of complex patients. It is to be billed for provision of a care plan for patients who require community support upon discharge, and who are otherwise at risk of readmission.

Notes:

i) Primary health care provider must be notified by phone, fax, or electronic means within 24 hours of admission.

ii) Care Plan must:
- *a. Be developed in consultation with the providers identified in the plan*
- *b. Include record of appropriate clinical information, interventions, co-morbidities and safety risks*
- *c. Include re-referral triggers and description of arranged follow-up care*
- *d. Include expectation of symptom progression/remission and patient progress*
- *e. Be included in the patient's medical record.*

iii) Patient must be complex, with multiple medical needs or complex co-morbidities (two or more distinct but potentially interacting problems), where care needs to be coordinated over a period of time between several health disciplines.

Or a diagnosis of malignancy (excluding non-melanoma skin cancer).

Or one morbidity plus a minimum of one of the following non-medical conditions:

- poor socioeconomic status
- unstable home environment
- dependency on family/caregiver for daily living tasks
- accessibility/mobility issues
- under care of MCFD Protection Services
- received Tertiary or Acute level of care related to psychiatric condition within the previous 6 months
- frail elderly
- > 75 years old
- BMI > 35
- high readmission rate

Document complexity in the medical record using the ICD-9 code for one of the major disorders when billing. If patient has non-medical comorbidity use the ICD-9 code M04 when billing.

PG78717 Specialist Discharge Care Plan for Complex Patients – extra 75.38

Notes:

i) Payable to the Specialist who is the MRP for the majority of the patient's in-hospital care and who writes the care plan, and communicates and oversees its implementation.

ii) Patient must be an in-patient for at least 5 days prior to discharge for the current admission.

iii) The written Discharge Care Plan must be completed and shared with:
- *a. The patient at time of discharge, and*
- *b. The patient's primary health care provider within 24 hours of discharge.*

iv) Document the time the primary health care provider was notified of discharge in the medical record.

v) Payable once per patient per discharge from hospital.

vi) Claim on the day of discharge.

vii) Use the ICD-9 code for one of the major disorders when billing.

viii) If patient has non-medical comorbidity (see Eligibility) use the ICD-9 code M04 when billing.

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Advanced Care Planning PG78720

Eligibility

Advance Care Planning occurs when a capable adult forms his/her beliefs, values and wishes for health care in the event of future incapacity. Advance care planning discussions may take place with family, trusted friends, and/or health care providers.

This fee premium is for a Specialist to discuss advance care planning based on the patient's beliefs, values and wishes for future health care.

Notes:

i) The advance care planning discussion should include sharing information and resources on how a patient can create an advance care plan, including Advance Directives.

ii) An advanced care plan form is required to be completed and added to the patient's medical record, medical chart and the discussion should be summarized in the consultation report including any decisions about the patient's future health care wishes. (The care plan form template is available at: www.sscbc.ca).

iii) The care plan template form must be shared with:
a. The patient, and
b. The patient's primary health care provider.

iv) The message to the patient and the plan must be consistent with the Practice Support Program's End of Life Module resources.

v) Not payable in the same hospital admission during which adult or pediatric critical care (01400 series) or neonatal intensive care (01500 series) fees are claimed.

Specialist Advance Care Planning

PG78720 Specialist Advance Care Planning Discussion – extra.....40.20

Notes:

i) Planning discussions and plan development for patients presenting with:
a. A chronic medical illness or complex co-morbidities, and
b. A deteriorating quality of life or end-stage disease state.

ii) Always payable at 100%.