MINISTRY OF HEALTH

MEDICAL SERVICES COMMISION

PAYMENT SCHEDULE

September 30, 2026

MSC PAYMENT SCHEDULE INDEX

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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.

[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.**

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.

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.

“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
- 99985 – referral by the BC Cancer Screening Program
- 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

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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 Fee Items

00099 General Services
00199 Family Medicine
00299 Dermatology
00399 Internal Medicine
00499 Neurology
00599 Pediatrics
00699 Psychiatry
00999 Diagnostic Procedures
01499 Critical Care
01799 Physical Medicine and Rehabilitation
01899 Emergency Medicine
01999 Anesthesiology
02599 Otolaryngology
02999 Ophthalmology
03999 Neurosurgery
04999 Obstetrics and Gynecology
06999 Plastic Surgery
07999 General Surgery/Cardiac Surgery
08699 Diagnostic Radiology
08899 Miscellaneous Diagnostic Ultrasound
08999 Urology
09899 Nuclear Medicine
30999 Clinical Immunology and Allergy
31999 Rheumatology
32199 Respirology
32299 General Internal Medicine
33199 Cardiology

33299 Endocrinology and Metabolism
33399 Gastroenterology
33499 Geriatric Medicine
33599 Hematology and Oncology
33699 Infectious Diseases
33899 Nephrology
33999 Occupational Medicine
43999 Palliative Medicine
59999 Orthopaedics
77799 Vascular Surgery
78999 Cardiac 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
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, 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. Services related to motor vehicle accidents (e.g. visits, procedures, counselling, consultations) are no longer the responsibility of Insurance Corporation of BC (ICBC).
2. ICBC-related physician reports remain billable to ICBC via report or invoice using the applicable ICBC fee codes (see Doctors of BC ICBC Fee Guide).
3. ICBC claim numbers and a “yes” code in the Teleplan MVA field are not required.
4. If the patient is from another province, use the normal out-of-province billing process as noted in C. 11. Reciprocal Claims.
5. When the patient has no MSP coverage, the medical practitioner should bill the patient directly.
6. If the MVA is work-related, WorkSafeBC (WSBC) should be billed under their procedures.

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 child or stepchild
    c) a parent or stepparent,
    d) a parent of a spouse,
    e) a grandparent,
    f) a grandchild,
    g) a sibling, or
    h) a spouse of a person referred to in paragraph (b) to (g).

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 all fees, to compensate physicians for the work they do with patients regardless of the location at which the services are delivered. 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 BCP does not apply to Alternative Payments Program (APP) or Longitudinal Family Payment (LFP) payment models, form fees, or to primary health program payments such as the Provincial Attachment System (PAS) and Community Longitudinal Family Physician (CLFP) payments.

BCP does not apply to radiology, anesthesiology, pathology and nuclear medicine fees for services delivered in or for Agency facilities.

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.

D. TYPES OF SERVICES

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D. 1. Telehealth Services

“Telehealth Service” is defined as a medical practitioner delivered health service provided to a patient, through the use of video technology or telephone. "Video technology" means the recording, reproducing and broadcasting of live visual images utilizing a direct interactive video link with a patient. Services which are designated as telehealth services are payable by MSP. Consultations, office visits, and non-procedural interventions where there is no telehealth fee may be claimed under the face-to-face fee with a claim note record that the service was provided via telehealth. 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;
  - registered nurse, for palliative care, to palliative medicine physician;
  - podiatrist, for orthopaedic or rheumatology 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 Subsequent Consultation

A subsequent consultation for the same diagnosis may be payable as the applicable full consultation when an interval of at least six months has passed since the consultant has last provided an insured service for the patient. All referrals include a potential implicit re-referral for the same problem unless a re-referral is specifically excluded. A subsequent consultation must comply with MSC Payment Schedule D. 2. in all respects with the exception that it does not have to be specifically requested via an explicit (new) re-referral.

The potential implicit re-referral may be activated, if medically appropriate, to allow the patient and consultant to schedule and conduct one or more subsequent consultations for the same problem, unless explicitly excluded by either of the following:

i) The referring practitioner's referral letter specifically disallows an implicit re-referral by stating: "This referral is for one consultation only and does not include a re-referral" or similar language, OR
ii) The referring practitioner disallows the implicit re-referral via written response to the consultant within 14 days of receiving notification by the consultant of the scheduled date for a subsequent consultation.

Notification by the consultant of the scheduling of any subsequent consultation must be provided to the referring practitioner at least 30 days before the scheduled date and must conform to all other College of Physicians and Surgeons of BC Guidelines and Standards.

Any additional subsequent consultations must follow the same rules. Another implicit re-referral potentially exists following any subsequent consultation unless the referring practitioner has explicitly excluded it as described above. A subsequent consultation may not be billed if the implicit re-referral has been disallowed.

If the referring practitioner is no longer in practice a subsequent consultation may be performed if medically appropriate, but the consultant must document the unavailability of the original referring practitioner and their advice to the patient to obtain a new referring and/or primary care provider.

D. 2. 4. 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. 5. 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. 6. 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. 7. 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. 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. 11. 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. 12. 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. Any use of dermoscopy and/or any other diagnostic technology (e.g.: use of Artificial Intelligence) is included within the visit and/or consultation.

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 is payable for the second and third stage of labour only. It is not payable for standby time or the first stage of labour. Start and end times must be entered in both the billing claim and the patient’s chart.

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)	79.08
01201	Night (call placed and service rendered between 2300 hours and 0800 hours)	111.05
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours)	79.08

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	72.69
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	99.40
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	72.69

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.

P01210 Evening(1800 hours to 2300 hours) – 44.86% of surgical (or assistant) fee
- minimum charge 66.32
- maximum charge for surgeries under two hours 457.46
- maximum charge for surgeries of two hours or longer 1,246.00

P01211 Night (2300 hours to 0800 hours) – 72.02% of surgical (or assistant) fee
- minimum charge 93.12
- maximum charge for surgeries under two hours 734.42
- maximum charge for surgeries of two hours or longer 2,000.00

P01212 Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 44.86% of surgical (or assistant) fee
- minimum charge 66.32
- maximum charge for surgeries under two hours 457.46
- maximum charge for surgeries of two hours or longer 1,246.00

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 hrs, surgical surcharges are payable provided the major portion of surgical time is after 1800 hrs.

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

iv) Claim must state start and end time of surgery.

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	72.69
01216	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	99.40
01217	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	72.69

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
B00011	Intravenous medications	16.61	
	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	6.76	
	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	17.65	
Y00014	Intra-articular medications by injection – hip	28.98	
	Notes:		
	i) For the initial injection, this fee code is payable at 100% in addition to a consultation or visit.		
	ii) One injection per hip is payable at 100% on the same date of service.		
	iii) For subsequent injections within 30 days, only the injection fee is payable.		
	iv) For subsequent injections within 30 days, if the visit and injections(s) are for unrelated conditions, the visit is payable at 100% and injection(s) at 50%.		
	v) For subsequent injections beyond 30 days, both a subsequent visit fee and the injection(s) are payable at 100%.		
Y00015	Intra-articular medications by injection - tendons, bursae, and all other joints	19.27	
	Notes:		
	i) For the initial injection, this fee code is payable at 100% in addition to a consultation or visit.		
	ii) One injection per site up to a maximum of 3 injections are payable at 100% on the same date of service.		
	iii) For subsequent injections within 30 days, only the injection fee is payable.		
	iv) For subsequent injections within 30 days, if the visit and injections(s) are for unrelated conditions, the visit is payable at 100% and injection(s) at 50%.		
	v) For subsequent injections beyond 30 days, both a subsequent visit fee and the injections(s) are payable at 100%.		
00016	Intrathecal medications by injection	37.87	
00024	Vein dissection for intravenous therapy *(Not paid in the immediate pre and post-operative phase of surgery)*	39.70	
00019	Venesection for polycythaemia or phlebotomy - procedural fee	35.73	

		$	Anes. Level
00018	Autologous ascitic infusion	52.61	
00017	Insertion of central venous pressure catheter	26.63	
B00030	Diagnostic skin tests (Schick, Dick, TB., and Frei.)	10.07	

Blood Transfusions

00020	Administered outside hospital	71.48	
00021	Administered in hospital	40.79	
00022	Serum transfusion	28.47	
00023	With vein dissection - extra	59.08	

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	543.29	
33751	Repeat blood dialysis - physician in charge	204.17	

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	137.35	

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

33708	Subsequent hospital visits	49.41	
33756	Reinsertion of peritoneal catheter after 10 days from initial insertion	53.40	

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	53.40	

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) <u>Peritoneal Dialysis:</u>

77380	Insertion of permanent catheter, procedural fee only	194.99	3

		$	Anes. Level
33723	Performance of initial peritoneal dialysis chronic or acute renal failure, to include consultation and two weeks' care	406.46	
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	53.40	

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	64.56	

***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 and Injections

PB10051	Injection	16.61	

Notes:

i) Payable for and intramuscular or subcutaneous injection administered to a patient of any age.

ii) Payable at 100% per injection.

iii) Payable to a maximum of 3 units per patient, per physician, on the same day. Services which exceed the maximum will be given independent consideration when a claim note record is submitted.

iv) Payable in addition to 10052 and 10053.

v) When an injection is provided as part of a visit, it is included in the visit fee and is not payable as 10051.

vi) Not payable for immunizations. Immunizations are payable as 10052 (Adult) or 10053 (Pediatric).

PB10052	Adult Immunization (per vaccine administered)	16.61	

Notes:

i) Payable for immunization of a patient 19 years or older.

ii) Payable at 100% per vaccine administered (any route). A combination vaccine is payable as a single service.

iii) Payable to a maximum of 6 vaccines per patient, per physician, on the same day. Services which exceed the maximum will be given independent consideration when a claim note record is submitted.

iv) When an immunization is provided on the same day as another in-person service:

a. The immunization is included in the visit fee and not payable as 10052, except for the immunizations described in (b).

b. 10040 is payable for influenza, pneumococcal, pertussis, or COVID-19 immunization provided in addition to a visit in a clinic or the patient's home.

v) Not payable for an immunization required for travel, employment, or emigration.

P10053	Pediatric Immunization (per vaccine administered) (extra)	6.54	

Notes:

i) Payable for an immunization of a patient under 19 years of age.

ii) Payable at 100% per vaccine administered (any route). A combination vaccine is payable as a single service.

iii) Payable at 100% in addition to a visit.

iv) Payable to a maximum of 6 vaccines per patient, per physician, on the same day. Services which exceed the maximum will be given independent consideration when a claim note record is submitted.
v) Not payable for an immunization required for travel, employment, or emigration.

		$	Anes. Level
10040	Add-on Adult Respiratory Immunization (per vaccine administered) (extra)	6.54	

Notes:
i) Payable for one or more of the following respiratory immunizations for a patient 19 years or older: influenza (using ICD-9 code V048), pneumococcal (using ICD-9 code V05), pertussis (using ICD-9 code V036), COVID-19 (using ICD-9 code C19) and RSV (using ICD-9 code 33C).
ii) Payable to a maximum of 4 vaccines per patient, per physician, on the same day.
iii) Payable at 100% in addition to an in-person service provided in a clinic or a patient's home on the same date of service.
iv) If the primary purpose of the service is for other immunizations, bill fee item 10052.

COVID-19

10046	Assessment for COVID-19 therapeutics: This fee is payable for patient care related to COVID-19 treatment, including patient assessment, prescribing of COVID 19 therapeutics, completion of relevant documentation and forms, and arranging for treatment. May be provided either in-person and/or by telehealth – per 15 minutes or greater portion thereof	50.37	

Notes:
i) Payable to a maximum of 60 minutes (4 units) per patient/per day.
ii) Start and end times of the assessment must be entered in both the billing claim and the patient's chart.
iii) Payable in addition to any visit or consult fee on the same day if medically required, provided the visit does not take place during a time interval that overlaps. Start and end times of the visit must be entered in the billing claim and the patient's chart.
iv) Other services such as patient management and conference fees are payable in addition on the same day by the same physician, provided it does not take place during a time interval that overlaps. Start and end times of the other service must be entered in the billing claim and the patient's chart.

Substance Use Disorder Care

P13013	Assessment for Substance Use Disorder or OAT Induction Includes complete medical history, including substance use history, and an appropriate targeted physician examination. In the case of Opioid Agonist Treatment (OAT) induction, if assessment and induction are done on the same day, withdrawal assessment using appropriate clinical scales and administration of first dose of OAT are included- per 15 minutes or greater portion thereof	50.35	

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 substance use disorder.
iii) Payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day).
iv) Payable for assessment for change of OAT with discussion of transition to a different OAT medication.

v) *Start and end times must be entered in both the billing claim and the patient's chart.*
vi) *No other visit fees billable same day except 13014, 13024, 14018 and 14077. 13014, 13024, 14018 and 14077 are payable in addition to 13013 only when not performed concurrently.*

		$	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	23.32	

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.
iv) *Start time must be entered in both the billing claim and patient's chart.*

P13023	Management of Substance Use Disorder A monthly fee payable to the physician responsible for the continuous management of a patient's substance use disorder, other than opioid use disorder. Applicable only to patients with a documented diagnosis of substance use disorder	26.20	

Notes:
i) Payable only to the physician or physicians responsible for the provision of continuous care management of the patient's substance use disorder.
ii) Applicable only to patients with a confirmed diagnosis of substance use disorder, the effects of which are significant enough to require active monitoring and management.
iii) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.
iv) First payable after 30 days of care, including at least one physician visit service (office, telephone, video, home, facility visits). If the required physician visit was provided by a physician associated with a different payee number, a note record is required with this explanation.
v) This fee is payable once every 31 days per patient.
vi) The physician must have at least one visit service (office, telephone, video, home, facility visits) with the patient every 90 days.
vii) Visit services are payable in addition.
viii) Payable monthly as long as the patient requires ongoing management of their substance use disorder.
ix) Claim must include ICD-9 code specific to the substance use disorder.

P13024	Outpatient Management of Alcohol Withdrawal Applicable only to patients with a documented diagnosis of alcohol use disorder	26.20	

Notes:
i) Payable only to the physician or physicians responsible for the provision of outpatient management of alcohol withdrawal.
ii) Payable in addition 13013 or a same day visit fee (in-person, telephone or video)
iii) Payable once daily for up to 5 consecutive days, per patient, beginning on the day of the first dose of medication.
iv) May be provided in-person, by telephone, or by video.
v) May be delegated to a nurse (LPN, RN, NP) employed within the eligible physician practice.

		$	Anes. Level
P00039	Management of Opioid Use Disorder A weekly fee payable to the physician responsible for the continuous management of a patient's opioid use disorder. Applicable only to patients with a documented diagnosis of opioid use disorder	26.75	

Notes:

i) Payable only to the physician or physicians responsible for the provision of continuous care management of the patient's opioid use disorder.
ii) Applicable only to patients with a confirmed diagnosis of opioid use disorder, the effects of which are significant enough to require active monitoring and management.
iii) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.
iv) This fee is payable once per week per patient regardless of the number of services per week for management of the patient's opioid use disorder.
v) First payable after one full week of care, including at least one physician visit service (office, telephone, video, home, facility visits).
vi) The physician must have at least one visit service (office, telephone, video, home, facility visits) with the patient every 90 days.
vii) Visit services are payable in addition.
viii) Payable weekly as long as the patient requires ongoing management of their opioid use disorder.

15039	Point of Care (POC) testing for opioid agonist treatment	15.11	

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	Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone	15.11	

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	26.98	
00042	Mileage, per kilometre one way (in the country beginning 8 kilometres from town centre, in the city from the boundary the city)	2.85	

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

00043	Anticoagulation therapy by telephone	10.08	

		$	Anes. Level

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	83.68	7
00026	- each additional 15 mins.	42.98	
00027	- physician outside chamber - 1st ½ hour	56.99	5
00028	- each additional 15 mins.	30.26	
00046	Additional charge to pertinent medical, anesthetic or surgical fee, per hour	29.09	

Eye Bank Services

00050 Enucleation of eye(s) for use in corneal transplant 146.37
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 396.50
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.

Certificates, etc.

00062	Initial "in-care" or adoption examination of a well baby or child (with report) (fee for each doctor)	88.13
00064	Subsequent "in-care" or adoption examination by same doctor within six months	39.64
00065	Investigation, with completion of B.C. Mental Health Act Forms 3, 4.1, 4.2 or 6 (fee per doctor)	117.94
00066	Completion of B.C. Mental Health Act Forms 3, 4.1, 4.2 or 6, on previously assessed or treated cases	53.00
00067	Investigation with cancellation of B.C. Mental Health Act Forms 4.1, 4.2 or 6, and subsequent voluntary treatment status	52.87

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.*	119.97	
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.*	71.88	

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 ..... ***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.*	119.82	
00084	Accompanying patient(s) to a distant hospital, where medically required - per ½ hour or major portion thereof..... ***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.*	250.72	

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	308.71	

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.)	106.35	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10089.
iii) Not paid unless 10087 or 01871 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)	80.50	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10088.
iii) Not paid unless 10087 or 01871 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) Limit of 6 branches in total for all anatomical regions when performed on the same day. Claims received over this limit will be given independent consideration upon receipt of an explanatory note record.
v) Maximum of 6 branches in total for any one region in any 6-month period. Claims received over this limit will be given independent consideration upon receipt of an explanatory note record.
vi) Includes anesthesia, sedation, or blocks if performed by the same physician.

		$	Anes. Level
Cervical:			
34101	- first branch	245.43	
34102	- second branch	122.72	
34103	- third to sixth branch (per branch)	61.36	
	Thoracic:		
34104	- first branch	204.53	
34105	- second branch	102.26	
34106	- third to sixth branch (per branch)	51.14	
	Lumbar:		
34107	- first branch	204.53	
34108	- second branch	102.26	
34109	- third to sixth branch (per branch)	51.14	
	Sacral:		
34110	- unilateral	337.47	
34111	- bilateral	562.45	

Tray Service Fee

00044 Mini Tray Fee 7.12

Note: *00044 is applicable to fee items 00190, 00217, 00744, 04681,13640, 14560 and 14562 only.*

00080 Minor Tray - is defined as the use of sterile tray suitable for cautery, cryotherapy, dilation or similar procedure 14.24

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 42.70

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 Esophagogastroduodenoscopy 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	Lavage or debridement of sino-nasal tract or cavity – unilateral (operation only)

02325	Lavage or debridement of sino-nasal tract or cavity – 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	Marsupialization of a Bartholin's cyst under general anesthesia or procedural sedation (operation only)
04312	Resection of labia minora (operation only)
04317	Biopsy Vulva, lesion <2 cm
04330	I&D of Bartholin’s cyst with insertion of Word catheter (operation only)
04405	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
TY08206	Intravesical treatment instillation
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)
13631	Nail removal (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)
04682	Initial Pessary Fitting
04683	Pessary Maintenance
06028	Abscess, web space (operation only)
06271	Alveolar fracture (operation only)
07678	Abscess - Perianal, I & D, superficial (operation only)
TY08339	Intracavernosal penile injection for test dosing
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)
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

00044	Mini Tray Fee
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
P04681	Vaginal Speculum Examination Procedure (extra)
14560	Routine pelvic examination including Papanicolaou smear
14562	Office Vaginal Speculum Exam (exam)

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	138.87	4
S00702	Bronchoscopy with biopsy - procedural fee	218.67	4
10700	Endobronchial cautery - extra	80.08	6
	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.*		
10702	Endobronchial cryotherapy - extra	80.08	6
	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.*		
10703	Transbronchial needle aspiration (TBNA)	72.47	6
	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.*		
S00719	Thoracoscopy	351.12	7
S00701	Direct laryngoscopy - procedural fee	73.82	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.*		
S00717	Micro-laryngoscopy - procedural fee	147.62	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).*		
SY00907	Endoscopic flexible or rigid examination of the nose and nasopharynx - procedure only	33.81	3
SY00908	- procedure and biopsy	54.09	3
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy	45.30	3
	Notes: *i) 00909 is not payable with 00700, 00701, 00702, 00907, and 00908. ii) Payable only to certified Otolaryngologists.*		
S00704	Cystoscopy to include dilation and panendoscopy - procedural fee	97.53	2
S00705	Cystoscopy with catheterization of ureters (with kidney function test and injection of solution for pyelogram) to include dilation and panendoscopy - procedural fee	153.40	2

		$	Anes. Level
	Upper Gastrointestinal System:		
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	119.27	3
	Note: *Not payable with 33341.*		
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	120.07	3
	Note: *Not payable with 33341.*		
S10763	Initial esophageal, gastric or duodenal biopsy	15.15	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	44.56	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	119.27	
	Note*: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.*		
10708	Video capsule endoscopy using M2A capsule - professional fee:	262.44	
	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	38.83	2
SY10714	Proctosigmoidoscopy, rigid; diagnostic	36.20	2
SY00716	Sigmoidoscopy, flexible; diagnostic	77.81	2
SY00718	- with biopsy	79.09	2
S10730	Colonoscopy, flexible colostomy - single or multiple	234.43	4
S10731	Colonoscopy, flexible, proximal to splenic flexure; diagnostic with or without collection of specimen(s) by brushing or washing	234.35	2
S10732	- with removal of foreign body	278.22	2
S10733	- with control of bleeding, any method	310.87	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	208.31	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	127.71	
S00721	Myelogram - procedural fee	46.58	2
S00723	Sialogram (per duct) or galactograms (per blast) - procedure fee for injection	51.50	2
S00724	Presacral air insufflation - procedural fee	41.30	2
S00727	Salpingogram - procedural fee	82.17	2
S00729	Fluoroscopy of chest by internist or pediatrician - procedural fee	11.36	
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.*	28.96	4
S00732	Voiding cysto-urethrogram - procedural fee	20.81	2
S00733	Venogram, intraosseous, or intravenous - procedural fee	62.82	2
S00734	Lymphangiography or lymphography ***Note:*** *Only payable with imaging capture such as x-ray, fluoroscopy and MRI.*	138.06	
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	69.68	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.*	399.81	6
S00743	Localizing of non-palpable breast lesion	132.33	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.*	56.19	2
S00826	Biopsy of pancreas - percutaneous	103.74	2
S00857	Percutaneous trans-hepatic cholangiogram (included in S00980)	119.68	2
S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	291.74	2
10735	Rectal endoscopy utilizing ultrasound (radial/linear) ***Note:*** *Includes mucosal biopsy*	157.47	
10740	Upper GI endoscopy utilizing radial ultrasound	262.44	
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)*	262.44	
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%.*	52.49	

		$	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	157.47	
	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	209.97	
	Note*: Payable with 10740 or 10741 only.*		
	Transient Elastography (TE)		
T33395	- professional fee	25.00	
T33396	- technical fee	25.00	
	Notes:		
	i) Payable only to physicians with completion of additional recognized training in Transient Elastography interpretation and performance.		
	ii) Requires an elevated pre-test probability of hepatic fibrosis, based on identifiable risk factors or clinical indicators.		
	iii) Interpretation of clinical findings and their application to the patient's care plan must be clearly documented in the patient's chart.		
	iv) Payable once per patient in a consecutive 12-month period. Additional claims within this period will be given independent consideration when submitted with an explanatory note record.		

(b) (ii) Therapeutic procedures utilizing radiological equipment

S00738	Removal of biliary calculi by Burhenne technique	217.21	4
S00746	Reduction of intussusception using hydrostatic pressure, procedural fee	102.76	4
	Note*: Fee item 08576 is payable in addition, when performed.*		
S00921	Varicocele and/or uterine artery embolization – unilateral	490.15	3
S00925	Varicocele and/or uterine artery embolization - bilateral	711.07	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)	111.97	2
S00978	Percutaneous nephrostomy, procedural fee	317.46	2
S00979	Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation, procedural fee	423.19	2
S00980	Transhepatic biliary drainage procedure (includes 00857)	448.48	3
S00981	Therapeutic radiological embolization	448.48	3
S00982	Percutaneous transluminal angioplasty	427.50	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	292.00	2

		$	Anes. Level
S00984	Exchange of previously inserted catheter or tract dilatation for percutaneous biliary or renal drainage	133.75	2
S00989	Extra-corporeal shock wave lithotripsy	144.05	4
S00994	Extra-corporeal shock wave biliary lithotripsy - procedural only	176.17	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.

iii) Not payable with 33342 or 33345.

10320	Insertion of permanent pleural drainage catheter	242.68	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	86.51	2

***Note**: Not paid with S32031, 00749, 00759, 07924 and 08646.*

S00995	Embolization of brain and spinal cord AVM's	2,212.12	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	1,383.23	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	1,705.91	3

Notes:

i) S00995, 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) S00995, 00997 and 00998 are billable only by physicians with appropriate training in interventional neuroradiology.

iii) S00995, 00997 and 00998 are payable once per day, regardless of the number of embolizations or catheterizations performed, or balloons inserted.

iv) S00995 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 S00995, 00997 or 00998.

10900	Abdominal aortic aneurysm repair using endovascular stent graft – second operator	521.36	

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
10901	Percutaneous image guided catheter directed thrombolysis of peripheral vein/artery	621.60	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.

10902	Complex peripherally inserted image-guided central venous catheter line (PICC)	136.07	2

Notes:
i) Restricted to Radiologists.
ii) Not applicable if performed via other than peripheral access as required for complex PICC placements.
iii) Includes placement, venogram/angiogram, and all medically required image guidance.
iv) May not be delegated.

10323	Simple peripherally inserted image-guided central venous catheter line (PICC)	84.36	

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	621.60	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)	621.60	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	1,383.23	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	384.81	4
10907	- each additional level (to a maximum of 3)	88.82	4

Notes:
i) Payable only when rendered on in-patient or day-care basis in acute care facility.
ii) Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating.
iii) Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure.

		$	Anes. Level
10908	Percutaneous image-guided tumour ablation – first lesion	558.91	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	414.41	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)	414.41	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.

10912	Transjugular liver/renal biopsy	414.41	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	842.15	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: S00995, 00997, 00998) if performed on the same day.

10914	Percutaneous balloon angioplasty for cerebral vasospasm	1,082.41	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.*

		$	Anes. Level
10915	Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique	2,105.39	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.*

10916	Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations – up to 4 hours procedural time	1,238.45	5
10917	– after 4 hours (extra to 10916)	309.63	

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	495.40	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	136.59	

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	136.59	

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)	1,173.73	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	662.11	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.:

		$	Anes. Level
S00739	Percutaneous lung or mediastinal biopsy - procedure fee	117.10	2
S00740	Liver biopsy - procedural fee	115.55	2
S00741	Splenic biopsy - procedural fee	115.55	2
S00742	Renal biopsy - procedural fee	117.10	2
S00744	Thyroid biopsy - procedural fee	79.32	2
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	56.20	2
S00747	Prostate biopsy - procedural fee	33.21	2
S00748	Bone biopsy under local/regional anesthetic	73.17	
S00749	Parietal pleural, including thoracentesis - procedural fee	136.23	2
S00844	Biopsy of salivary gland, fine needle or core needle	55.25	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 ***Note:*** *Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.*	61.83	2
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.*	92.73	2
S00751	Pericardial puncture - procedural fee	258.25	3
S00752	Cisternal puncture - procedural fee	40.49	2
S00753	Marrow aspiration - procedural fee	44.76	2
S00755	Artery puncture - procedural fee	7.15	2
SY00757	Joint aspiration - procedural fee (not in addition to Y00014 or Y00015) - other joints	16.54	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	103.74	2
S00760	- (abdominal) - procedural fee	27.29	2
S00761	Cyst or bursa - procedural fee	16.54	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.*	1.08
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.*	2.37
S00764	Intracutaneous test, per test	2.20
S00765	Annual maximum (to include scratch or intracutaneous tests) for each physician - per patient	35.18
S00767	Patch testing (extra) (annual maximum, 80 tests), per test	2.00
S00768	Photopatch test - per test	8.81
S00769	- annual maximum	88.07

(f) Examination under anesthesia when done as independent procedure

S00770	Pelvic examination under anesthesia when done as an independent procedure - procedural fee	255.79	2
S00771	Retinal examination under anesthesia - procedural fee	21.19	3

(g) Gynecological

S00775	Hydrotubation ***Note:*** *When 00775 is done in conjunction with laparoscopy, fee included in laparoscopy fee.*	52.98

		$	Anes. Level
S00776	Fetal scalp sampling	106.15	
S00782	Needle aspiration of Pouch of Douglas - procedural fee	37.47	2
S00783	Huhner's test - procedural fee	47.26	
S00784	Cervix punch biopsy - procedural fee	20.38	2
S00785	Endometrial biopsy - procedural fee	47.26	2
	Note: *Includes cervical cancer screening, if clinically indicated.*		
S00787	Transabdominal amniocentesis	105.98	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	18.68	
S00794	Chorionic villus sampling	128.03	2
	Note*: Includes ultrasound guidance of the villus biopsy.*		
S00807	Diagnostic hysteroscopy - not payable in addition to a D&C	204.63	2
S00808	Diagnostic hysteroscopy with biopsy(s), includes D&C	255.79	2
S00815	Laparoscopically directed biopsies and/or lysis of adhesions – extra	66.09	4
	Note: *Not paid with 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048.*		
S00819	Diagnostic vaginoscopy under GA	255.79	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	50.66	2
	Cysto-ureter ogram:		
S00792	- technical fee	13.20	2
S00793	- professional fee	6.61	
S00799	Transurethral ureterorenoscopy to include C&P	161.71	2
S00800	Transurethral ureterorenoscopy with x-ray control - C & P included	393.06	2
S00803	Loopogram	57.66	
S00866	Dynamic cavernosometry and cavernosography	80.84	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	67.74	
S00874	Urethral profilometry (water or gas)	20.22	
S00875	Uroflowimetry (with sphincter EMG with or without pharmacologic manipulation)	32.36	
S00876	Video uro-dynamics (full study), includes S00874, S00875 and S00878	206.31	

(i) Miscellaneous

S00774	Secretion pancreazymin stimulation test	86.88	
S00780	Schirmer's Test (included in fee Item 02015)	13.89	
S00797	Oesophageal motility test	180.13	
S00788	- technical fee	76.03	
S00798	- professional fee	104.09	
S00818	Oesophageal pH study for reflux, extra - professional fee	42.72	
S00817	- technical fee	15.59	

		$	Anes. Level
S00809	Retrograde pancreatography	221.44	3
S00869	Manometry; anal - adult	103.67	2

(j) Cardio-vascular Diagnostic Procedures -procedural fees

S00801	Intra-arterial cannulation - with multiple aspirations - procedural fee	22.60	
S00810	Right heart catheterization, by duly qualified specialist	169.19	4
S00812	Selective angiocardiogram, extra, by duly qualified specialist	56.77	4
S00813	Ergonovine provocative testing for coronary artery spasm	80.93	4
S00814	Dye dilution studies, extra, by duly qualified specialist	56.77	4
S00816	Hydrogen ion study	29.61	2
S00830	Trans-septal left heart catheterization, by duly qualified specialist	263.46	4
S00839	Direct intracoronary streptokinase thrombolysis	395.89	4
	Note: *When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).*		
S33131	Diagnostic cardiac catheterization	349.16	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	494.19	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	583.44	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	384.02	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%.

		$	Anes. Level
S00842	Percutaneous coronary intervention – for additional vessel(s), per vessel	193.28	

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*

S00843	Selective arteriography or venography of any abdominal branch by catheter extra: - for first branch (each additional branch 50% extra)	106.45	2
S00847	Selective arteriography of any thoracic aortic branch (excluding coronaries) extra - for first branch (each additional branch 50% extra)	172.59	2
	Pulse tracing, including interpretation:		
S00871	- intravascular, including both arterial and venous	56.77	
	Portal pressures:		
S00880	- hepatic vein wedge pressure, by duly qualified specialist	69.46	
S00881	- percutaneous splenic portal pressure	55.60	2
S00898	Balloon septostomy	378.73	7
	Aortogram:		
S00890	- abdominal - procedural fee	122.58	2
S00897	- thoracic - procedural fee (extra except when part of a retrograde left heart catheterization)	176.21	2
	Arteriogram-procedural fee:		
S00892	- carotid percutaneous; unilateral	121.14	3
S00891	- carotid percutaneous; bilateral	182.16	3
S00893	- femoral or axillary	93.79	2
S00894	- cerebral, by dissection	204.19	3

		$	Anes. Level
S00853	Superior venacavogram, by indirect means	25.57	2
S00854	Inferior venacavogram	122.58	2
S00855	Selective catheterization of branches of inferior vena cava or iliac system - first branch	95.21	2
S00856	- others	63.28	2
S00888	Ventriculogram, when no ventricular access device is present (i.e. ventricular reservoir, VP shunt, or drain)	262.23	3
S00889	Ventriculogram through previously placed ventricular access device, drain, or catheter	131.12	3
S00896	Pulmonary arteriography	148.80	3
S00885	Digital angiography - peripheral injection	49.54	2
S00919	Impedance plethysmography - professional component	7.05	
S00920	Impedance plethysmography - technical component	35.33	
	Cardiology Assist Fees:		
00845	For first hour or fraction thereof	175.08	
00846	After one hour, for each 15 minutes or fraction thereof	43.78	

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)	130.77	
S00901	Schedule B - limited examination (four to seven items)	87.47	
S00902	Schedule C - short examination (one to three items)	43.59	
S00923	Technical fee for electrodiagnostic testing	20.85	
S00905	Daily measurements of nerve conduction thresholds in facial palsy	6.81	
S00906	- maximum per course	47.39	
S00915	Intra-carotid injection of sodium amytal, speech localization test	105.19	2
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests	61.58	
S00927	Decamethonium test - for attendance at, and follow-up observation if necessary	36.24	
S00944	Tilt table testing with continuous ECG monitoring and automatic BP recording - total fee	296.72	
S00947	- professional fee	182.61	
S00948	- technical fee	114.11	

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
	Polysomnogram:		
	Overnight home oximetry (continuous recording of oxygen and pulse)		
S00910	- professional fee	29.48	
S00911	- technical fee	16.64	
	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	174.28	
S11916	Polysomnography, standard – technical fee	402.47	
S11917	Polysomnography, two-night – professional fee	261.17	
S11918	Polysomnography, two-night – technical fee	804.93	
S11919	Multiple Sleep Latency Test (MSLT) - professional fee	87.04	
S11920	Multiple Sleep Latency Test (MSLT) - technical fee	201.24	
S11925	Four channel home polysomnography – professional fee	86.94	
S11926	Four channel home polysomnography – technical fee	87.21	

(I) Pulmonary Investigative and Function Studies

S00930	Peak expiratory flow rate	6.22	
	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	13.79	
S00929	Simple screening spirometry as above but before and after bronchodilators	20.78	
	Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume:		
S00931	- professional fee	17.28	
S00932	- technical fee	14.75	
	Spirometry – forced expiratory spirogram to include FVC, FEV(i) and FEV(i)/FVC ratio, MMEFR, etc.:		
S00933	- without bronchodilators - professional fee	13.21	
S00934	- without bronchodilators - technical fee	12.48	
S00935	- before and after bronchodilators - professional fee	15.24	
S00936	- before and after bronchodilators - technical fee	14.86	
	Spirometry - flow volume loops:		
S00937	- without bronchodilators - professional fee	13.21	
S00938	- without bronchodilators - technical fee	18.93	
S00940	- before and after bronchodilators - professional fee	15.76	
S00941	- before and after bronchodilators - technical fee	28.00	
	Diffusion Studies with Carbon Monoxide:		
S00942	- at rest or exercise - professional fee	17.04	
S00943	- technical fee	13.38	
	Detailed Pulmonary Function Studies:		
S00945	- professional fee (includes S00931, S00935 and S00942)	44.29	
S00946	- technical fee (includes S00932, S00936 and S00943)	41.90	
	Note*: Fee items S00931-S00936, S00942, S00943 will be paid at 100%.*		

		$	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.*		
	Progressive exercise test with at least three workloads, measuring ventilation and electrocardiographic monitoring:		
S00950	- professional fee	27.03	
S00951	- technical fee	33.89	
	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	98.64	
S00955	- technical fee	61.41	
	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	114.33	
S00957	- technical fee	73.13	
	Testing for exercise-induced asthma by serial flow measurements:		
S00958	- professional fee	22.86	
S00959	- technical fee	33.69	
	Miscellaneous Pulmonary Tests:		
	Plethysmography and airway resistance:		
S00964	- professional fee	14.74	
S00965	- technical fee	28.00	
	Inhalation challenge - assessed by serial flow measurements, per day:		
S00968	- professional fee	42.20	
S00969	- technical fee	37.85	
	Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:		
SY11964	- professional fee	21.40	
SY11965	- technical fee	46.13	
	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	12.44	
S00971	- technical fee	30.17	
	$C0_2/0_2$ responsiveness of respiratory centres by steady state test or rebreathing test:		
S00972	- professional fee	21.30	
S00973	- technical fee	11.54	
	Inspiratory and expiratory muscle strength		
S00974	- professional fee	16.77	
S00975	- technical fee	13.23	

		$	Anes. Level
S11960	Oximetry at rest, with or without oxygen - professional fee	6.22	
S11961	- technical fee	5.30	
S11962	Oximetry at rest and exercise, with or without oxygen - professional fee	12.54	
S11963	- technical fee	16.59	

(m) Evoked Response Procedures

S00985	Brainstem auditory evoked response; supra threshold testing for integrity of brainstem function	52.22	
S00986	Somatosensory evoked response - upper extremity	43.55	
S00987	- upper and lower extremity	75.29	
S00988	Visual evoked response	75.88	

(n) Orthopaedic Diagnostic Procedures

Shoulder Girdle, Clavicle and Humerus

	Incision - Diagnostic, Percutaneous:		
S11200	Arthroscopy shoulder joint	305.53	2
	Incision Diagnostic Open:		
11215	Arthrotomy shoulder joint or bursa	190.94	2
	Excision - Diagnostic, Percutaneous:		
S11230	Needle biopsy under GA	190.94	2
S11232	Arthroscopy - biopsy, shoulder	248.23	2
	Excision - Diagnostic, Open:		
11245	Biopsy, open	248.23	2

Elbow, Proximal Radius and Ulna

	Incision - Diagnostic, Percutaneous:		
S11300	Arthroscopy elbow joint	274.51	2
S11302	Aspiration bursa, tendon sheath.	23.76	2
	Incision - Diagnostic, Open:		
11315	Arthrotomy elbow joint	190.94	2
	Excision - Diagnostic, Percutaneous:		
S11330	Needle biopsy under GA	190.94	2
S11332	Arthroscopy and biopsy	303.15	2
	Excision - Diagnostic, Open:		
11345	Open - biopsy	248.23	2

Note: *Not billable with other procedures on the same joint.*

Hand and Wrist

	Incision - Diagnostic, Percutaneous:		
S11400	Arthroscopy wrist joint	294.13	2
S11402	Aspiration bursa, synovial sheath, etc	23.76	2
	Incision - Diagnostic, Open:		
11415	Arthrotomy wrist joint - isolated procedure	190.94	2
11416	Arthrotomy MP, PIP, DIP joints - isolated procedure	190.94	2

		$	Anes. Level
	Excision - Diagnostic, Percutaneous:		
S11430	Needle biopsy, under GA	190.94	2
S11432	Arthroscopy and biopsy, wrist /hand joint(s)	190.94	2
	Excision - Diagnostic, Open:		
11445	Open biopsy, hand or wrist	265.66	2
	Pelvis, Hip and Femur		
	Incision - Diagnostic, Percutaneous:		
S11500	Arthroscopy hip joint	529.91	3
S11501	Aspiration hip joint	23.76	2
S11502	Aspiration bursa, tendon sheath	11.90	2
	Incision - Diagnostic, Open:		
11515	Arthrotomy hip joint	305.53	3
	Excision - Diagnostic, Percutaneous:		
S11530	Needle biopsy, under GA	190.94	2
S11532	Arthroscopy and biopsy, hip	529.91	3
	Excision - Diagnostic, Open:		
11545	Arthrotomy and biopsy, hip	248.23	3
11546	Biopsy open, soft tissue or bone	248.23	2
	Femur, Knee Joint, Tibia and Fibula		
	Incision - Diagnostic Percutaneous:		
S11600	Arthroscopy knee joint	219.58	2
S11602	Aspiration bursa, tendon sheath or other peri-articular structures	23.76	2
	Incision - Diagnostic Open:		
11615	Arthrotomy knee joint	248.23	3
	Excision - Diagnostic, Percutaneous:		
S11630	Needle biopsy, under GA	190.94	2
S11632	Arthroscopy - biopsy	219.58	2
	Excision - Diagnostic, Open:		
11645	Biopsy, open	248.23	2
	Tibial Metaphysis (Distal), Ankle and Foot		
	Incision - Diagnostic, Percutaneous:		
S11700	Arthroscopy ankle joint / subtalar joint	190.94	2
S11702	Aspiration bursa, tendon sheath.	23.76	2
	Incision - Diagnostic, Open:		
11715	Ankle joint,	190.94	2
11716	Subtalar joint	190.94	2
11717	Midtarsal joint	190.94	2
11718	Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint.	190.94	2
	Excision - Diagnostic:		
S11730	Needle biopsy, under GA	190.94	2
11745	Open biopsy, under GA	248.23	2
	Vertebra, Facette and Spine		
	Excision - Diagnostic, Percutaneous:		
S11830	Needle biopsy - soft tissue/bone - thoracic spine, under GA	219.58	2
S11831	Needle biopsy - soft tissue/bone - lumbar spine, under GA	190.94	2
	Excision - Diagnostic, Open:		
11845	Biopsy, with GA	248.23	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) 329.50
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) 155.70
Note: *Restricted to Critical Care physicians.*

Continuing care by consultant:

01408 Subsequent hospital visit (not for patients in an ICU) 163.07
Note: *Restricted to Critical Care physicians.*

01469 Direction of care/end of life Assessment 253.11
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).....329.50
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) 155.70
Note: *Restricted to Critical Care physicians.*

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Miscellaneous

01450 Adult and Pediatric Critical Care 1st day modifier – extra 43.84
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……. ..... ……...13.38
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.

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	347.74
01421	2nd to 7th day (inclusive) per diem	174.38
01431	8th day to 30th day	133.01
01441	31st day onward	138.53

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	326.60
01422	2nd to 7th day (inclusive) per diem	174.65
01432	8th day to 30th day	134.95
01442	31st day onward	130.11

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.

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

01413	1st day	519.02
01423	2nd to 7th day (inclusive) per diem	262.42
01433	8th day to 30th day	145.33
01443	31st day onward	151.15

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	716.38
01521	Day 2 - 10	288.18
01531	Day 11 onward	193.65
	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	550.09
01522	Day 2 - 10	202.59
01532	Day 11 onward	146.48

LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.

		$
01513	Day 1	474.76
01523	Day 2 - 10	149.74
01533	Day 11 onward	133.50

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	148.42	
	Level I emergency care:		
01811	- day	44.35	
01821	- evening	49.14	
01831	- night	73.67	
01841	- Saturday, Sunday or Statutory Holiday	59.23	
	Level II emergency care:		
01812	- day	93.48	
01822	- evening	102.88	
01832	- night	148.93	
01842	- Saturday, Sunday or Statutory Holiday	123.02	
	Level III emergency care:		
01813	- day	118.23	
01823	- evening	128.14	
01833	- night	186.43	
01843	- Saturday, Sunday or Statutory Holiday	153.80	
	Advice and Patient Management / Follow-Up		
P01880	Emergency Medicine Specialist Patient Management / Follow-Up	44.35	

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) Access to this fee is restricted to patients having been seen within an Emergency Department by the communicating Emergency Medicine specialist physician or another Emergency Medicine specialist physician working within the same Emergency Department, within 14 days preceding this service.

iii) Patient management required two-way communication about the clinical matters between the patient or patient's representative and the physician; this fee is only billable for follow-up deemed necessary and urgent to alter a patient's management plan from a visit within 14 days preceding this service.

iv) Not payable in addition to another service on the same day for the same patient by the same physician.

v) Payable to a maximum of 25 services per practitioner per day.

vi) Requires documentation in the medical record to show that the patient or patient's representative understood and acknowledged the information provided.

P01881 Emergent telehealth advice from an emergency physician when requested by a physician or allied health provider – per 15 minutes or part thereof 60.00

Notes:

i) Payable to FRCP, CCFP-EM and ABEM emergency physicians only for emergent two-way telephone or video communication necessary for the management of a patient when requested by another physician or allied health provider.

ii) Not payable when the only purpose of the call is to:

- *a) Arrange for transfer of care that occurs within 24 hours.*
- *b) Arrange for an expedited consultation or procedure within 24 hours.*
- *c) Arrange for laboratory or diagnostic investigations.*

d) *Convey the results of diagnostic investigations.*
e) *Arrange a hospital bed for the patient.*

iii) *Not payable to provider initiating call.*
iv) *No claim may be made where communication is with a proxy for either provider (for example, ED support staff).*
v) *A chart entry including reason for call, advice given and to whom, is required.*
vi) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*
vii) *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 in the record specifying the type of provider).*
viii) *Maximum of one additional unit of time may be billed if call time exceeds 22 minutes.*
ix) *Maximum of 2 services per patient per day.*
x) *Maximum of 12 services per practitioner per day.*
xi) *Emergent telehealth advice fees apply if patient seen subsequently on the same day by same practitioner.*

		$	Anes. Level

Miscellaneous Visits

P01882 Emergency medicine reassessment 32.33

Notes:

i) Payable for essential additional visits by the same physician to a patient in the emergency department at least two hours after 01810, level II emergency care fee (01812, 01822, 01832, or 1842), out-of-office visit (12200, 13200, 15200, 16200, 17200, 18200), out-of-office consultation (12210, 13210, 15210, 16210, 17210, 18210), or 01882 or three hours after a level III emergency care fee (01813, 01823, 01833, or 01843).
ii) Not payable for observation alone or for review of laboratory results/imaging without further reassessment of the patient and/or modification of the treatment plan.
iii) The claim must include an explanation of the medical necessity for the visit in the note record.

P01883 Trauma-informed comprehensive gynecologic assessment in an Emergency Department (extra) 40.00

Notes:

i) Payable only to emergency physicians.
ii) Payable only in addition to 01810, a level I emergency care fee (01811, 01821, 01831, 01841), a level II emergency care fee (01812, 01822, 01832, 01842), a level III emergency care fee (01813, 01823, 01833, 01843), an out-of-office visit (12200, 13200, 15200, 16200, 17200, 18200) or an out-of-office consultation (12210, 13210, 15210, 16210, 17210, 18210).
iii) Must include a speculum exam documented in the patient's chart.
iv) Not payable with a procedural fee that includes a speculum exam, such as 14541.

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).

		$	Anes. Level
01850	Clavicle	107.99	2
01851	Fibula - shaft or malleolus - not requiring reduction	93.40	

Dislocations:

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

01860	Temporo-mandibular joint, dislocation – closed reduction	70.51	3
01861	Patella - closed reduction	67.55	2
01862	Toe - closed reduction	50.66	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 31.56

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.

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 31.56

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 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 Services

In cases where a visit or procedure was occasioned by more than one condition, the dominant purpose must be related to a 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)	103.02
00110	Consultation - in office: (age 2 - 49)	95.95
15310	Consultation – in office (age 50 - 59)	103.02
16110	Consultation - in office: (age 60 - 69)	107.77
17110	Consultation - in office: (age 70 - 79)	121.20
18110	Consultation - in office: (age 80+)	139.50

00116 Special in-hospital consultation 169.72

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)	118.77
13210	Consultation – out of office (age 2 - 49)	112.88
15210	Consultation – out of office (age 50 - 59)	118.77
16210	Consultation – out of office (age 60 - 69)	124.40
17210	Consultation – out of office (age 70 - 79)	140.34
18210	Consultation – out of office (age 80+)	161.89

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)	82.84	
00101	Complete examination - in office (age 2-49)	77.24	
15301	Complete examination – in office (age 50 – 59)	82.84	
16101	Complete examination - in office (age 60-69)	86.57	
17101	Complete examination - in office (age 70-79)	97.52	
18101	Complete examination - in office (age 80+)	112.93	

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)	98.99	
13201	Complete examination - out of office (age 2-49)	94.48	
15201	Complete examination - out of office (age 50-59)	98.99	
16201	Complete examination - out of office (age 60-69)	103.69	
17201	Complete examination - out of office (age 70-79)	116.98	
18201	Complete examination - out of office (age 80+)	134.96	

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)	41.42	
00100	Visit - in office (age 2-49)	38.61	
15300	Visit – in office (age 50-59)	41.42	
16100	Visit - in office (age 60-69)	43.29	
17100	Visit - in office (age 70-79)	48.76	
18100	Visit - in office (age 80+)	56.47	

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

13070	Assessment of an unrelated condition(s) in association with a WorkSafe BC service	20.06	

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.

viii) May be provided in-person or by telehealth.

		$	Anes. Level
12200	Visit - out of office (age 0-1)	49.69	
13200	Visit - out of office (age 2-49)	46.53	
15200	Visit – out of office (age 50-59)	49.69	
16200	Visit - out of office (age 60-69)	52.05	
17200	Visit - out of office (age 70-79)	58.71	
18200	Visit - out of office (age 80+)	67.73	

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

Family Conference

P13121 Family Conference – per 15 minutes or greater portion thereof 50.35

Notes:

i) Restricted to family physicians.

ii) Payable for in-person or telehealth participation in a family conference with one or more family members, representatives, or substitute decision makers.

iii) Payable only for family conferences for the purpose of:
a) Obtaining informed consent for care related to an acute medical event or a significant change in the patient's condition; or
b) Developing and reviewing the patient's care plan, including advanced care planning and goals of care discussions.

iv) Not payable when communication occurs as a part of routine communication with a family member, representative, or substitute decision maker.

v) Payable in addition to a patient visit or 14067/14077 on the same day if clinically required, provided that this service does not take place concurrently with the family conference (i.e., the visit time must be separate from the family conference time).

vi) Payable to a maximum of 2 units per patient per physician per calendar day.

vii) Payable to a maximum of 100 units per physician per calendar year.

viii) Details of the family conference must be documented in the patient's chart, including the participants, their roles, information about the discussion, and decisions made.

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

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.

		$	Anes. Level
	Fee per patient, per 1/2 hour or major portion thereof:		
13763	Three patients	28.34	
13764	Four patients	22.86	
13765	Five patients	19.66	
13766	Six patients	17.51	
13767	Seven patients	15.96	
13768	Eight patients	14.83	
13769	Nine patients	13.89	
13770	Ten patients	12.63	
13771	Eleven patients	11.65	
13772	Twelve patients	10.95	
13773	Thirteen patients	10.23	
13774	Fourteen patients	9.63	
13775	Fifteen patients	9.07	
13776	Sixteen patients	8.81	
13777	Seventeen patients	8.42	
13778	Eighteen patients	8.24	
13779	Nineteen patients	7.95	
13780	Twenty patients	7.60	
13781	Greater than 20 patients (per patient)	7.32	

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) per patient per year (see Preamble D. 3. 3.)

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

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

12120	Individual counselling - in office (age 0-1)	82.84	
00120	Individual counselling - in office (age 2-49)	77.24	
15320	Individual counselling – in office (age 50-59)	82.84	

		$	Anes. Level
16120	Individual counselling - in office (age 60-69)	86.57	
17120	Individual counselling - in office (age 70-79)	97.52	
18120	Individual counselling - in office (age 80+)	112.93	

Note: *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)	98.99	
13220	Individual counselling - out of office (age 2-49)	94.48	
15220	Individual counselling – out of office (age 50 – 59)	98.99	
16220	Individual counselling - out of office (age 60-69)	103.69	
17220	Individual counselling - out of office (age 70-79)	116.98	
18220	Individual counselling - out of office (age 80+)	134.96	

Counselling - Group

For groups of two or more patients.

00121	- first full hour	199.49	
00122	- second hour, per 1/2 hour or major portion thereof	99.75	

Note: *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:

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

13236	Telehealth FP Consultation (age 0-1)	103.02	
13436	Telehealth FP Consultation (age 2-49)	95.95	
13536	Telehealth FP Consultation (age 50-59)	103.02	
13636	Telehealth FP Consultation (age 60-69)	107.77	
13736	Telehealth FP Consultation (age 70-79)	121.20	
13836	Telehealth FP Consultation (age 80+)	139.50	
13237	Telehealth FP Visit (age 0-1)	41.42	
13437	Telehealth FP Visit (age 2-49)	38.61	
13537	Telehealth FP Visit (age 50-59)	41.42	
13637	Telehealth FP Visit (age 60-69)	43.29	
13737	Telehealth FP Visit (age 70-79)	48.76	
13837	Telehealth FP Visit (age 80+)	56.47	
13238	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 0-1)	82.84	
13438	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 2-49)	77.24	
13538	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 50-59)	82.84	
13638	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 60-69)	86.57	
13738	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 70-79)	97.52	
13838	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 80+)	112.93	

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) 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 Group Counselling For groups of two or more patients		
13041	- First full hour	199.44	
13042	- Second hour, per ½ hour or major portion thereof	99.73	

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	50.35	

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

P13013	Assessment for Substance Use Disorder or OAT Induction Includes complete medical history, including substance use history, and an appropriate targeted physician examination. In the case of Opioid Agonist Treatment (OAT) induction, if assessment and induction are done on the same day, withdrawal assessment using appropriate clinical scales and administration of first dose of OAT are included- per 15 minutes or greater portion thereof	50.35	

Notes:
i) Payable to a maximum of 4 units per patient/per day/per assessment or intended induction.
ii) Payable only to the physician who intends to provide or share management of the patient's substance use disorder.
iii) Payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day).
iv) Payable for assessment for change of OAT with discussion of transition to a different OAT medication.
v) Start and end times must be entered in both the billing claim and the patient's chart.
vi) No other visit fees billable same day except 13014, 13024, 14018 and 14077. 13014, 13024, 14018 and 14077 are payable in addition to 13013 only when not performed concurrently.

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	23.32	

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.
ix) Start time must be entered in both the billing claim and patient's chart.

		$	Anes. Level
P13023	Management of Substance Use Disorder A monthly fee payable to the physician responsible for the continuous management of a patient's substance use disorder, other than opioid use disorder. Applicable only to patients with a documented diagnosis of substance use disorder	26.20	

Notes:
i) Payable only to the physician or physicians responsible for the provision of continuous care management of the patient's substance use disorder.
ii) Applicable only to patients with a confirmed diagnosis of substance use disorder, the effects of which are significant enough to require active monitoring and management.
iii) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.
iv) First payable after 30 days of care, including at least one physician visit service (office, telephone, video, home, facility visits). If the required physician visit was provided by a physician associated with a different payee number, a note record is required with this explanation.
v) This fee is payable once every 31days per patient.
vi) The physician must have at least one visit service (office, telephone, video, home, facility visits) with the patient every 90 days.
vii) Visit services are payable in addition.
viii) Payable monthly as long as the patient requires ongoing management of their substance use disorder.
ix) Claim must include ICD-9 code specific to the substance use disorder.

P13024	Outpatient Management of Alcohol Withdrawal Applicable only to patient with a documented diagnosis of alcohol use disorder	26.20	

Notes:
i) Payable only to the physician or physicians responsible for the provision of outpatient management of alcohol withdrawal.
ii) Payable in addition 13013 or a same day visit fee (in-person, telephone or video)
iii) Payable once daily for up to 5 consecutive days, per patient, beginning on the day of the first dose of medication.
iv) May be provided in-person, by telephone, or by video.
v) May be delegated to a nurse (LPN, RN, NP) employed with the eligible physician practice.

P00039	Management of Opioid Use Disorder A weekly fee payable to the physician responsible for the continuous management of a patient's opioid us disorder. Applicable only to patients with a documented diagnosis of opioid use disorder	26.75	

Notes:
i) Payable only to the physician or physicians responsible for the provision of continuous care management of the patient's opioid use disorder.
ii) Applicable only to patients with a confirmed diagnosis of opioid use disorder, the effects of which are significant enough to require active monitoring and management.
iii) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.
iv) This fee is payable once per week per patient regardless of the number of services per week for management of the patient's opioid use disorder.
v) First payable after one full week of care, including at least one physician visit service (office, telephone, video, home, facility visits).

vi) The physician must have at least one visit service (office, telephone, video, home, facility visits) with the patient every 90 days.
vii) Visit services are payable in addition.
viii) Payable weekly as long as the patient requires ongoing management of their opioid use disorder.

		$	Anes. Level
15039	FP Point of Care (POC) testing for opioid agonist treatment	15.11	

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	15.11	

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 (Prescriber) – per 15 minutes or greater portion thereof This fee includes all requirements of a medical assistance in dying (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.	50.35	

Notes:
i) Payable to a maximum of 135 minutes (9 units) for the assessment of patients whose natural death is reasonably foreseeable (Track 1 patients). Services which exceed the maximum will be given independent consideration when an explanatory letter is submitted.
ii) Payable to a maximum of 270 minutes (18 units) for the assessment of patients whose natural death is not reasonably foreseeable (Track 2 patients). "Track 2" must be entered in both the claim note record and the patient's chart. Services which exceed the maximum will be given independent consideration when an explanatory letter is submitted.
iii) Start and end times for the assessment must be entered in both the billing claim and patient's chart.
iv) Additionally, start and end times for the patient encounter must be entered in the patient's chart.
v) Only one service for 13501 or 13502 may be performed by video conference.

		$	Anes. Level
13502	MAiD Assessment (Assessor) – per 15 minutes or greater portion thereof This fee includes all requirements of a medical assistance in dying (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.	50.35	

Notes:

i) Payable to a maximum of 105 minutes (7 units) for the assessment of patients whose natural death is reasonably foreseeable (Track 1 patients). Services which exceed the maximum will be given independent consideration when an explanatory letter is submitted.

ii) Payable to a maximum of 150 minutes (10 units) for the assessment of patients whose natural death is not reasonably foreseeable (Track 2 patients). "Track 2" must be entered in both the claim note record and the patient's chart. Services which exceed the maximum will be given independent consideration when an explanatory letter is submitted.

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

iv) Additionally, start and end times for the patient encounter must be entered in the patient's chart.

v) Not payable in addition to 13501 to the same physician for the same patient.

vi) Only one service for 13501 or 13502 may be performed by video conference.

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	50.35	

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	327.48	

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 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	146.18	

Notes:

i) Payable when a physician picks up medication for a medical assistance in dying (MAiD) event and returns the unused/partially used medications to a pharmacy.

ii) Payable only when a MAiD event takes place in a location that does not have an on-site pharmacy.

iii) Payable only in addition to fee item 13504 or if the claim note record indicates a planned MAiD event did not occur after the physician arrives because:
a. the patient declined to proceed with MAiD, or
b. the patient died before MAiD medication was administered.
iv) Not payable when the time required for medication pick-up and return has been compensated under the Medical Assistance in Dying Travel and Training Assistance Program (MAiDTTAP) or another payment model.

		$	Anes. Level
P13506	MAiD Expert Case Review When death is not reasonably foreseeable. Includes all activities necessary to complete an expert case review including patient assessment when required. The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof	43.67	

Notes:
i) Maximum payable is 105 minutes (7 units).
ii) Payable once per patient, except where patient reapplies as previous MAiD request was declined.
iii) Not payable with 13501 or 13502 by the same physician.
Not payable with a consult or visit on the same day by the same physician.
iv) Start and end time for the assessment must be entered in both the billing claim and patient's chart.

P13507	MAiD Waiver of Final Consent Includes explanation and review of the Waiver of Final Consent with the patient as well as completing the waiver form. May be provided in-person or by videoconference. – per 15 minutes or greater portion thereof	43.67	

Notes:
i) Maximum payable is 60 minutes (4 units) (see note iv. for exception).
ii) Payable only to the Assessor Prescriber who provides the MAiD assessment fee 13501.
iii) Payable in addition to fee 13501.
iv) A second waiver may be paid if the original waiver has expired. If second waiver performed by the same assessor as the first waiver, only one additional unit may be billed.
v) Start and end time must be entered in both the billing claim and patient's chart.

P13508	Oral MAiD extension (extra) For provision of oral MAiD when the procedure takes longer than 90 minutes or conversion to IV MAiD is necessary – per 15 minutes or greater portion thereof	43.67	

Notes:
i) Maximum payable is 90 minutes (6 units).
ii) Only payable when MAiD provision is by oral medication.
iii) Only payable in addition to fee 13504.
iv) Timing begins after 90 minutes has passed since administration of the oral agent.
v) Start and end time must be entered in both the billing claim and patient's chart.
vi) Not other surcharge is payable.

13015	HIV/AIDS Primary Care Management – in or out of office - per half hour or major portion thereof	87.89	

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.

		$	Anes. Level

Home Visits

00103 Home visit 147.69

Notes:

i) Payable for a home visit between 0800 and 2300 hours any day of the week.
ii) Additional patients seen during the same house call are to be billed under the applicable out-of-office visit fee items (12200, 13200, 15200, 16200, 17200, 18200) Please see Preamble D. 4. 12.
iii) Not payable for a patient admitted under a Hospital at Home program.

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 83.46

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

00108 Hospital visit 32.65

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.

		$	Anes. Level
00128	Supportive care hospital visit	35.00	

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.

00127	Palliative Care In-Person Facility Visit	68.00	

Notes:

i) Payable for palliative care provided to a patient with a life-threatening illness whose goals of care are primarily focused on comfort, quality of life, and symptom management rather than curative treatment.

ii) Payable for an in-person visit for a patient in a facility setting when:
- *a. The patient is located in a hospital, long-term care facility, or palliative care facility;*
- *b. The patient has a life expectancy of six months or less; and*
- *c. The focus of care is palliative rather than treatment aimed at cure.*

iii) Payable for visits during the last 180 days of the patient's life. Services which exceed the 180 days prior to death will be given independent consideration when a claim note record is submitted.

iv) For essential and non-emergent care, a subsequent in-person visit on the same calendar day can be billed under fee item 00127 with submission code D. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.

v) For urgent or emergent care when the attending physician is specially called back because the patient's condition has changed requiring the physician's attendance, an in-person visit can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.
- *a. When the physician must immediately leave home, office, or hospital to render care, an additional weekday daytime in-person emergency visit can be billed as fee item 00112, if the billing criteria are met.*
- *b. When the physician is specially called on an evening, nighttime, or weekend to render emergency or non-elective services and must travel from one location to another to attend the patient, call-out charges can be billed under fee items 01200, 01201, 01202 in addition to fee item 00127. Continuing care fee surcharges 01205, 01206, 01207 can be billed if the billing criteria are met.*

vi) When the physician is on-site and called for emergent care, fee items 00113, 00105, or 00123 can be billed.

vii) Chemotherapy fee items (00578, 00579, 00580, 33581, 33582, and 33583) are not payable to the same physician for the same patient on the same day.

viii) Not payable if the patient dies unexpectedly during a hospitalization and was not considered palliative.

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 a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).
- 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.

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 130.00

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).....89.05

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).....68.00

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)	44.31	

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.

Hospital at Home

P13010	Hospital at Home Virtual Visit	56.87

Notes:

i) Payable for a phone or video visit with direct patient interaction for a patient under a Hospital at Home program.

ii) Additional visits are not payable on the same day to the same physician for the same patient, except as indicated in the fee notes below.

iii) For essential and non-emergent care, a subsequent Hospital at Home visit on the same calendar day can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.

d. An additional virtual visit on the same calendar day for a Hospital at Home patient must be billed as fee item 13010 with submission code D.

e. A subsequent in-person visit on the same calendar day for a Hospital at Home patient must be billed under fee item 13011.

iv) For urgent or emergent care when the attending physician is specially called back because the patient's condition has changed requiring the physician's attendance, an in-person visit can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.

a. When the physician must immediately leave home, office, or hospital to render care, an additional weekday daytime in-person emergency visit can be billed as fee item 00112, if the billing criteria are met.

b. When the physician is specifically called on an evening, nighttime, or weekend to render emergency or non-elective services and must travel from one location to another to attend the patient, call-out charges can

be billed under fee items 01200, 01201, 01202 in addition to fee item 13011. Continuing care fee surcharges 01205, 01206, 01207 can be billed if the billing criteria are met.

v) Fee item 00103 (home visit) is not payable for a patient admitted for care under a Hospital at Home program.

		$	Anes. Level
13011	Hospital at Home In-Person Visit	72.43	

Notes:

i) Payable for an in-person visit with direct patient interaction for a patient admitted under a Hospital at Home program.

ii) Additional visits are not payable on the same day to the same physician for the same patient, except as indicated in the fee notes below.

iii) For essential and non-emergent care, a subsequent Hospital at Home visit on the same calendar day can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.

a. An additional in-person visit on the same calendar day for a Hospital at Home patient must be billed under fee item 13011 with submission code D.

b. A subsequent virtual visit on the same calendar day for a Hospital at Home patient must be billed as fee item 13010.

iv) For urgent or emergent care when the attending physician is specially called back because the patient's condition has changed requiring the physician's attendance, an in-person visit can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.

a. When the physician must immediately leave home, office, or hospital to render care, an additional weekday daytime in-person emergency visit can be billed as fee item 00112, if the billing criteria are met.

b. When the physician is specially called on an evening, nighttime, or weekend to render emergency or non-elective services and must travel from one location to another to attend the patient, call-out charges can be billed under fee items 01200, 01201, 01202 in addition to fee item 13011. Continuing care fee surcharges 01205, 01206, 01207 can be billed if the billing criteria are met.

v) Fee item 00103 (home visit) is not payable for a patient admitted under a Hospital at Home program.

13012	Hospital at Home FP Conference with Allied Care Provider and/or Physician – per 15 minutes or greater portion thereof	50.35	

Notes:

i) Payable only for a patient admitted under a 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 the 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) 14018 and 14077 are not payable for a patient admitted under a Hospital at Home program.
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) 89.05

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)..... 33.82

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.

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) 58.64
00105 Night (between 2300 hours and 0800 hours)..... 81.51
00123 Saturday, Sunday or Statutory Holiday 58.64

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.*

		$	Anes. Level

Long-Term Care Facility Visits

Long-term care compensation supports care for patients in long-term care facilities, including proactive, urgent, and emergent care. A documented in-person visit with the patient is required to bill long-term care codes.

Fee-for-service codes are aligned with the Family Practice Services Committee's Long-Term Care Initiative (LTCI) which is designed to improve the quality of care in long-term care facilities.

The LTCI promotes three system-level outcomes:

- Reduced unnecessary or inappropriate hospital transfers
- Improved patient and provider experience
- Reduced cost per patient as a result of a higher quality of care

The five LTCI Best Practice Expectations are:

- Proactive visits to residents
- Meaningful medication reviews
- Completed documentation
- Attendance at interdisciplinary care conferences
- 24/7 availability and on-site attendance when required

P13115 Long-Term Care Admission.....130.00

Notes:

i) Restricted to family physicians.
ii) Payable for an in-person admission visit provided at a long-term care facility for a patient's initial admission to the long-term care facility.
iii) Requires medication reconciliation, care planning, review of the Medical Orders for Scope of Treatment (MOST) form, and documentation.
iv) Payable once per patient per physician.
v) Not payable for admission paperwork completed without an in-person visit.
vi) Not payable for transfer of care to another physician in the same long-term care facility.

00114 Long-Term Care In-Person Visit.....57.00

Notes:

i) Payable for an in-person visit for a patient admitted to a long-term care facility.
ii) Payable to a maximum of one visit every 14 days. Services which exceed the maximum will be given independent consideration when a claim note record is submitted.
iii) Not payable for:
a. review of a patient's chart without an in-person patient interaction, or
b. interaction with the care team without an in-person patient interaction.

00115 Long-Term Care Urgent Assessment.....147.69

Notes:

i) Payable for an in-person urgent assessment between 0800 and 2300 hours any day of the week for a patient admitted to a long-term care facility.
ii) Payable when a physician provides an assessment within 24 hours of request from the long-term care facility.
iii) Relevant details must be documented in the patient's chart, such as the reason for urgency, time of contact, time of attendance to patient, and the person who contacts the physician.
iv) 13334 is not payable in addition to 00115.
v) 13334 is not payable when additional long-term care in-person visits (00114) are done at the same time as an urgent assessment.

		$	Anes. Level
13334	Community based FP, long term care facility visit - first visit of the day bonus, extra	89.05	

Notes:

i) Restricted to family physicians.
ii) Payable once per physician per day.
iii) Payable only if one of the following fee items is billed on the same day: 00114, 00127, 13115.

Emergency Visits

00112	Emergency visit (call placed between hours of 0800 and 1800 hours) – weekdays	134.69	

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.

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	134.69	

Telephone Advice

13000	Telephone advice to a Community Health Representative in First Nation's Communities	21.08	

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.

		$	Anes. Level
13005	Advice about a patient in Community Care	21.08	

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	99.69	
14091	FP Prenatal visit - subsequent examination	42.90	

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	42.88	

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.	98.72	

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)	679.70	

Notes:

i) Restricted to Family Physicians.
ii) Care of newborn in hospital (see item 00119).
iii) Repair of cervix is not included in fee item 14104. Charge 50% of listed fee when done on same day as delivery.
iv) When medically necessary additional post-partum office visit(s) are payable under fee item 14094.

P14105	Management of labour and transfer to an alternate facility for delivery	283.05	

Notes:

i) This fee includes all usual hospital care associated with the delivery provided by the referring physician.
ii) May be claimed by the referring physician when they intended to conduct the delivery and when the referring physician:
  a) Attends the patient during active labour, 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 centimetres.
  b) Provides assessment of the progress of labour, as evidenced by documentation in the patient's chart.
  c) Documents the reason for referral in the patient's chart.
  d) Transfers the patient to another facility.
iii) Not payable with an assessment fee, visit fee,14104,14109,04414, 04419 or generally 14199, for the same patient on the same day. (Provide a claim note record if claiming for 14199 in addition.)
iv) 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.

P14106	Additional attendant at an out-of-hospital birth	600.00	

Notes:

i) Restricted to family physicians.
ii) Payable for in-person assistance at an out-of-hospital birth by a physician acting as an additional attendant.
iii) Call-out charges (01200, 01201, 01202) and non-operative continuing care surcharges (01205, 01206, 01207) are payable in addition when appropriate. Non-operative continuing care surcharges are payable only for the second and third stage of labour. Please see the Out-of-Office Hours Premiums Explanatory Note (g) for more information.

iv) Postnatal office visits (14094) and accompanying patient(s) to a distant hospital (00084) are payable in addition.
v) Not payable in addition to 14104, 14105, 14109 or 14199 on the same day to the same physician for the same patient.

		$	Anes. Level
14108	Postnatal care after caesarean section (1-14 days in-hospital)	139.85	
	Notes: *i) Restricted to Family Physicians.* *ii) Postnatal office visits are payable under fee item 14094.* *iii) Not payable in addition to 14109.*		
14109	Primary management of labour, attendance at delivery, and postnatal care associated with emergency caesarean section (1-14 days in-hospital)	566.16	
	Notes: *i) Restricted to Family Physicians.* *ii) Postnatal office visits are payable under fee item 14094.* *iii) Not payable in addition to 14108.*		
14545	Medical abortion	186.90	
	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.*		
15120	Pregnancy test, immunologic - urine	14.09	

Infant Care

00118	Attendance at caesarian section (if specifically requested by surgeon for care of baby only)	104.76	
	Note: *Not payable if a pediatrician is present at the caesarean section to care for the baby.*		
00119	Routine care of newborn in hospital	107.08	

Gynecology

14540	Insertion of intrauterine device (IUD) (operation only)	55.77	2
	Notes: *i) Includes cervical cancer screening, if clinically indicated.* *ii) Not payable in addition to 14541.*		
14541	Removal of intrauterine device (IUD) -operation only	34.31	
	Notes: *i) Not payable in addition to 14540 or 14560.* *ii) Not billable by Family Physicians.*		
14560	Pelvic examination	34.34	
	Notes: *i) Includes cervical cancer screening, if clinically indicated.* *ii) Not billable by Family Physicians.*		
14542	Insertion of subdermal contraceptive implant	58.47	
14543	Removal of subdermal contraceptive implant	74.72	
P14562	Office Vaginal Speculum Exam (extra)	15.15	
	Notes: *i) Restricted to Family Physicians.*		

ii) *Payable at 100% in addition to an in-office service on the same date of service.*
iii) *Payable with a mini tray fee (00044).*
iv) *When the vaginal speculum exam is provided by a physician, this fee must be billed in conjunction with a consultation, visit, counselling, complete examination, prenatal visit or postnatal visit.*
v) *When the vaginal speculum exam is delegated to a College-certified allied care provider employed by a physician practice, this fee can be billed as a stand-alone fee when no physician consultation or visit is provided on the same day to the same patient.*
vi) *Not payable in addition to 00784, 00785, 04509 or 14540.*

		$	Anes. Level
14563	Gynecologic Cervical Block – extra	25.25	

Notes:
i) *Restricted to Family Physicians*
ii) *Payable only when billed with 00784, 00785, 04509, 14540, or 14562 on the same date of service.*
iii) *Payable at 100% in addition to 00784, 00785, 04509, 14540, and 14562.*

Urology

PY13655	FP vasectomy bonus associated with bilateral vasectomy - extra	45.45	

Notes:
i) *Restricted to Family Physicians.*
ii) *Payable only in addition to fee item S08345.*
iii) *Maximum of one bonus per vasectomy procedure.*

Surgical Assistance

13194	First Surgical Assist of the Day	110.67	

Notes:
i) *Restricted to Family Physicians.*
ii) *Maximum of one per physician per day.*
iii) *Payable in addition to 00193, 00195, 00196, 00197, 13197.*

P13003	Body Mass Index Surgical Assist Surcharge – Payable at 25% of the listed surgical assist fee		

Notes:
i) *Payable for any surgical assist provided when the patient has a Body Mass Index (BMI) greater than or equal to 35.*
ii) *Payable for all surgeries for which surgical assist fee codes 00193, 00195, 00196, 00197, and 13197 are billable.*
iii) *The patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.*
iv) *Maximum of one BMI surcharge per operation unless two surgical assistants are providing concurrent surgical assistance during the same surgery.*
v) *Out-of-office hours operative surcharges (01210, 01211 and 01212) are not payable on the BMI surgical assist surcharge.*

<u>Surgical Assistance – surgical assist code based on total operative fee(s) for procedure(s):</u>

00195	- less than $317.00 inclusive	147.95
00196	- $317.01 to 529.00 inclusive	209.92
00197	- $529.01 to $869.00 inclusive	309.31
P13197	- greater than $869.00	450.00

		$	Anes. Level
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	34.10	

Notes:

i) Surgical assist fees are based on the total operative fee(s) for the associated surgical procedure(s). Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s).

ii) When a physician provides surgical assistance for two surgeries at different operative sites under one anesthetic, they may charge a separate surgical assistance fee for each surgery. This applies whether the two surgeries were performed by the same surgeon or by different surgeons. This does not apply to bilateral procedures, procedures within the same body cavity, or procedures on the same limb.

iii) Visit fees are not payable to the same physician on the same day as surgical assistance fees, unless each service is performed at a distinct/separate time. When this occurs, start and end times must be noted on each billing claim.

iv) When a surgical assistant is required for minor surgery, a detailed explanation of the need for the surgical assistant is required in the claim note record.

Open Heart Surgery:

00193	Non-CVT-certified surgical assistance at open-heart surgery, per quarter hour or major portion thereof	34.05	

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	64.41	

Note: *See Anesthesia Preamble regarding Pre-Anesthetic Evaluation Fees.*

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)	35.87	

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)	59.85	2
13600	Biopsy of skin or mucosa (operation only)	59.26	2
13601	Biopsy of facial area (operation only)	59.26	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	50.75	2

		$	Anes. Level
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	40.64	
	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	75.71	2
13612	Extensive laceration greater than 5 cm (maximum charge 35 cm) - operation only - per cm	15.19	2
	Note: *Not billable by Plastic Surgery, pedics or Otolaryngology.*		
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	75.70	2
13621	- additional lesions removed at the same sitting (maximum per sitting, five) each (operation only)	37.87	
	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)	102.12	
	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)	9.77	
	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.* *iv) Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13622	Localized carcinoma of skin proven histopathologically (operation only)	87.72	2
13630	Paronychia - operation only	40.50	2
13631	Removal of nail - simple operation only	40.50	2
13632	- with destruction of nail bed (operation only)	81.96	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	72.32	2
13650	Enucleation or excision of external thrombotic hemorrhoid (operation only)	59.13	2
Y10710	In office Anoscopy	11.71	
	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.*		

		$
P13640	Add-on Procedure (extra)	10.00

Notes:

i) Restricted to Family physicians.

ii) Payable at 100% in addition to an in-person service provided in a clinic or a patient's home on the same date of service.

iii) Payable for one of the following minor procedures:

a) Ear syringing
b) Suture and staple removal
c) Wound care and dressing change
d) Frenotomy
e) Treatment of epistaxis, including nasal packing and silver nitrate
f) Procedures for therapeutic foot care, including symptomatic callus debridement, use of a Dremel for dystrophic toenails, debridement of diabetic foot ulcers, silver nitrate to granulomas. Not payable for foot examination and monofilament testing.

iv) When the procedure is provided by a physician, this fee is payable at 100% in addition to a consultation, visit, counselling, complete examination, prenatal visit or postnatal visit.

v) When the procedure is delegated to a college-certified allied care provider employed by a physician practice, this fee can be billed as a stand-alone fee when no physician consultation or visit is provided on the same day to the same patient.

vi) Payable with a mini tray fee (00044).

vii) Details of the procedure must be documented in a procedure note in the patient's chart.

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.

		$	Anes. Level
00012	Venepuncture and dispatch of specimen to an approved laboratory facility, when no other blood work performed	6.76	

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	6.82	
15136	Fungus, direct microscopic examination, KOH preparation	8.57	
15100	Glucose - semiquantitative (dipstick analysed visually or by reflectance meter)	5.02	
15137	Hemoglobin cyanmethemoglobin method and/or haematocrit.	3.19	
15000	Hemoglobin - other methods	1.66	

***Note**: 15137 and 15000 - see the Laboratory Services Payment Schedule for additional hematology information.*

15110	Occult blood – feces	5.49	

***Note:** Applies only to guaiac methods.*

15120	Pregnancy test, immunologic - urine	14.09	
30015	Secretion smear for eosinophils	7.45	

		$	Anes. Level
15139	Sperm, Seminal examination for presence or absence	15.11	
15140	Stained smear	7.56	
15141	Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination	6.55	
15130	Urinalysis - Chemical or any part of (screening)	3.67	
15131	Urinalysis - Microscopic examination of centrifuged deposit	5.03	
15142	Urinalysis - Complete diagnostic, semi-quant and micro	5.78	
15143	White cell count only (see the Laboratory Services Payment Schedule for additional information)	6.63	
	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)	17.38	

Investigation

00117	Interpretation of electrocardiogram by non-internist	11.15	

No Charge Referral

03333	Use this code when submitting a claim for a "no charge referral."		

Family Practice Services Committee (FPSC) 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 Family Practice Services Committee (FPSC). Note that the FPSC Preamble governs the FPSC initiated listings in this section, however, the FPSC 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 FPSC Incentives if:

- They are working under an Alternate Payment/Funding model as defined below and their duties would otherwise include provision of this care; and
- They have been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

Additional detailed eligibility requirements are identified in each section.

Definitions in FPSC Initiated Listings:

(1) Physicians

Community Longitudinal Family Physician (CLFP)
For the purpose of FPSC 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 G14070.
- 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
FPSC 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, FPSC 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 FPSC 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, FPSC 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 FPSC incentives may require ACPs to be College-certified for the delegation of tasks, whereas other FPSC 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, FPSC 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, FPSC 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 FPSC incentives are already included in an Alternative Payment/Funding Model contract, FPSC incentives are not billable in addition. Private agreements between physicians to pool fee for service 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.

Longitudinal Family Physician (LFP) Payment Model:
The LFP Payment Model is a compensation option for family physicians who provide longitudinal, relationship-based, family medicine care to a known panel of patients, aligned with the attributes of a Patient Medical Home. It is grounded in a commitment to increase patient access to community-based, longitudinal family medicine care, and expand primary care capacity across British Columbia.
The LFP Payment Model is designed as a comprehensive payment model for longitudinal family physicians, incorporating several aspects of family medicine care. It includes clinic-based services that are provided via longitudinal family physician clinics, pregnancy & newborn clinics, and patients' home settings. It also includes facility-based care in long-term care facilities and palliative care facilities, as well as inpatient care and pregnancy & newborn care in hospital.

(4) Miscellaneous

Assisted Living:
For the purpose of its incentives when referring to assisted living, FPSC 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, FPSC 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, FPSC defines “face to face” to mean in in-person.

Living in Community
For the purpose of its incentives, FPSC considers patients living in group homes to be living in community.

Patient’s Medical Representative:
For the purpose of its incentives, FPSC 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 FPSC 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 FPSC fees must first meet the FPSC Preamble and fee criteria and may then be billed through the MSP claims system (with the exception of Quebec) as follows:

(a) FPSC fees payable for services provided to residents of other provinces (with the exception of Quebec) are:
- G14021, G14022, G14023 FP with Consultative Expertise Fees
- G14018 FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise
- G14019 FP Advice to a Nurse Practitioner/Registered Midwife Fee
- G14004, G14005, G14008, G14009 FP Obstetrical Premiums
- G14063 Palliative Care Planning
- H14088 FP Unassigned In-patient Care Fee

(b) FPSC 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:

- G14075 FP Frailty Complex Care Planning and Management Fee
- G14076 FP Patient Telephone Management Fee
- G14078 FP Email/Text/Telephone Medical Advice Relay Fee
- G14050, G14051, G14052, G14053 Chronic Disease Management Fees
- G14029 Allied Care Provided Practice Code
- G14033 Complex Care Planning & Management
- G14043 Mental Health Planning Fee
- G14044, G14045, G14046, G14047 and G14048 Mental Health Management Fees
- G14066 Prevention/Personal Health Risk Assessment
- H14041 CLFP New Patient Intake Fee

(c) FPSC 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:

- G14250, G14251, G14252, G14253 Chronic Disease Management Fees
- G14029 Allied Care Provider Practice Code
- G14276 Patient Telephone Management Encounter Code

1. Community Longitudinal Family Physician Portals (G14070, G14071)

Submitting code G14070 provides access to the following fee codes:

- G14075 FP Frailty Complex Care Planning and Management Fee
- G14076 FP Patient Telephone Management Fee
- G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- G14078 FP Email/Text/Telephone Medical Advice Relay Fee
- G14050, G14051, G14052, G14053 Chronic Disease Management Fees
- G14033 Complex Care Planning & Management Fee – 2 Diagnoses
- G14075 Complex Care Planning and Management Fee - Frailty
- G14043 Mental Health Planning fee (Behind portal as of April 2, 2020)
- G14044, G14045, G14046, G14047 and G14048 Mental Health Management Fees
- G14063 Palliative Care Planning
- G14066 Prevention/Personal Health Risk Assessment
- H14041 CLFP New Patient Intake Fee
- H14002 Maternity Care Risk Assessment
- G14004, G14005, G14008 and G14009 FP Obstetrical Premiums

Submitting G14070 signifies that:

- You are a community longitudinal family physician (as defined in the FPSC 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 FPSC 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

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G14070 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 G14070 allows access to fees listed in the notes below during the calendar year.

Submit fee item G14070 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:

- *G14076 FP Patient Telephone Management Fee*
- *G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
- *H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *G14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *G14050, G14051, G14052, G14053 Chronic Disease Management Fees*
- *G14033 Complex Care Planning & Management Fee – 2 Diagnoses*
- *G14075 Complex Care Planning and Management Fee - Frailty*
- *G14043 Mental Health Planning fee*
- *G14044, G14045, G14046, G14047 and G14048 Mental Health Management Fees*
- *G14063 Palliative Care Planning Fee*
- *G14066 Personal Health Risk Assessment (Prevention) Fee*
- *H14041 CLFP New Patient Intake Fee*
- *H14002 Maternity Risk Assessment Fee*
- *G14004, G14005, G14008 and G14009 FP Obstetrical Premiums*

iii) Not payable to a physician who has been paid for a Specialist

consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

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 (G14071) provides access to the following incentive fee codes:

- G14075 FP Frailty Complex Care Planning and Management Fee
- G14076 FP Patient Telephone Management Fee
- G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- G14078 FP Email/Text/Telephone Medical Advice Relay Fee
- G14050, G14051, G14052, G14053 Chronic Disease Management Incentive Fees (Behind portal as of April 1, 2020)
- G14033 Complex Care Planning & Management Fee – 2 Diagnoses (Behind portal as of April 1, 2020)
- G14043, G14044, G14045, G14046, G14047, G14048 Mental Health Planning & Management Fees (Behind portal as of April 1, 2020)
- G14063 Palliative Care Planning (Behind portal as of April 1, 2020)
- G14066 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 FPSC 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 G14070 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 H14067 (FP Brief Clinical Conference with Allied Care Provider and/or Physician), G14076 (FP Patient Telephone Management Fee) and G14078 (FP Patient Email/Text/Telephone Medical Advice Relay Fee), and H14067 (FP Brief Clinical Conference with Allied Care Provider and/or Physician).

Submitting G14071 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 G14070.

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G14071	Locum Community Longitudinal Family Physician Portal Code	0.00

The Locum Community Longitudinal Family Physician Portal Code may be submitted by the FP who provides locum coverage for Family Physicians who have submitted G14070. G14071 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 G14070 in the same calendar year. Once processed by MSP, the locum may access the fees listed in note ii) below.

Submit fee item G14071 Locum Community Longitudinal Family Physician Portal Code using the following “Patient” demographic information:

PHN:	9753035697
Patient Surname:	Portal

First name:	FPSC
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 G14070 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 G14070 in the same calendar year.

ii) Submission provides access to the following fee codes:

- *G14076 FP Patient Telephone Management Fee*
- *G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
- *H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *G14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *G14050, G14051, G14052, G14053 Chronic Disease Management Fees*
- *G14033, G14075 Complex Care Planning & Management Fees*
- *G14043, G14044, G14045, G14046, G14074, G14048 Mental Health Planning and Management Fees*
- *G14063 Palliative Care Planning Fee; and*
- *G14066 Personal Health Risk Assessment (Prevention)*

iii) Not payable to a physician who has been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

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 FPSC Preamble) in a community-based physician office or clinic will not be eligible to submit the Community Longitudinal Family Physician Portals (G14070, G14071).

They may submit the Long-Term Care Portal Code (G14072) to access the following fee codes:

- G14076 FP Patient Telephone Management Fee
- G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- G14078 FP Email/Text/Telephone Medical Advice Relay Fee
- G14050, G14051, G14052, G14053 Chronic Disease Management Fees

		$
G14072	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 a family physician who has a focused practice in a long-term care facility and is not working as a Community Longitudinal Family Physician (as defined in the FPSC 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 G14072 allows access to fees listed in the notes below during the calendar year.

Submit fee item G14072 Long-Term Care Portal Code using the following "Patient" demographic information:

PHN:	9753035697
Patient Surname:	Portal
First name:	FPSC
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:

- *G14076 FP Patient Telephone Management Fee*
- *G14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof*
- *H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *G14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *G14050, G14051, G14052, G14053 Chronic Disease Management Fees*

iii) Not payable to a physician who has been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

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 Fees (G14050, G14051, G14052, G14053, G14029)

Chronic Disease Management (CDM) fees compensate for the work of providing guideline-informed care to a patient with an eligible condition, including consideration of the patient's goals, values and comorbidities. Patients in long-term care facilities are eligible when active chronic disease management is clinically appropriate.

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. A claim note record note indicating the locum or colleague coverage must be submitted with the claim.

When a new family physician (FP) takes over patient care from another FP, CDM fees can be billed on the anniversary of the previous billing if both FPs provided guideline-informed care.

- If one or more of the required visits were done by the previous FP, the new FP should include a claim note record when submitting the CDM fee.
- The claim note record should indicate that they've assumed responsibility for the patient's care, and the previous FP's name.

Care provision must be documented in the patient's chart, including support provided to help build the patient's skills and confidence to manage their chronic condition.

CDM fees G14050, G14051, G14052, G14053, and G14029 are payable to MRP Family Physicians billing under Fee-For-Service who have submitted G14070, G14071, or G14072.

		$
G14050	Annual chronic disease management fee (diabetes mellitus)	137.89

Notes:

i) Payable only to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.

ii) Payable to Family Physicians who have successfully submitted G14072.

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 (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (see FPSC Preamble definition of "working within" and "College-certified ACP").

v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

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 items G14051 or G14053 for the same patient if eligible.

ix) Not payable once G14063 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.

		$
G14051	Annual chronic disease management fee (heart failure)	137.89

Notes:

i) Payable only to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.

ii) Payable to Family Physicians who have successfully submitted G14072.

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 (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (see FPSC Preamble definition of "working within" and "College-certified ACP").

v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

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 G14050 or G14053 for the same patient if eligible.

ix) Not payable once G14063 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.

G14052	Annual chronic disease management fee (hypertension)	55.17

Notes:

i) Payable only to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.

ii) Payable to Family Physicians who have successfully submitted G14072.

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 (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (see FPSC Preamble definition of "working within" and "College-certified ACP").
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.
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 G14050 or G14051 paid within the previous 12 months
ix) Not payable once G14063 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.

$

G14053 Annual chronic disease management fee (Chronic Obstructive Pulmonary Disease- COPD).....137.89

Notes:

i) Payable only to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.
ii) Payable to Family Physicians who have successfully submitted G14072.
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 (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (see FPSC Preamble definition of "working within" and "College-certified ACP").
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.
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 G14050, G14051 or G14052 for the same patient if eligible.
ix) Not payable once G14063 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.

G14029 Allied Care Provider Practice Code.....0.00

Notes:

i) Applicable for medical services (office, prenatal, home or long-term care) 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 FPSC Preamble definition of "working within" and "College-certified ACP").
ii) A College-certified allied care provider may provide one of the two visits required for billing chronic disease management fees.
iii) Visits may be provided in-person or by telehealth (G14029, G14076).
iv) Payable for care provided to a patient with a condition eligible for one of the chronic disease management fees.
v) Not payable in addition to a visit fee on the same day to the same physician for the same patient, except for H14067 or G14077.
vi) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

4. Chronic Disease Management fees for MRP Family Physicians billing under Alternate Payment/Funding Model Programs (G14250, G14251, G14252, G14253, G14276)

G14250, G14251, G14252, and G14253 are payable to FPs billing under sessional, salary, service or independent contractor contracts when the required two visits are billed as an encounter record. Post-adjudication monitoring will be performed within 2 years. If encounter records were not submitted for the required two visits, funds will be recovered.

		$
G14250	Annual chronic disease management fee (diabetes mellitus) for MRP FPs on alternate payment/funding models	125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.

ii) 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.

iii) This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (See FPSC Preamble definition of "working within" and "College-certified ACP").

iv) Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.

v) Not payable to physicians remunerated under the LFP Payment Model.

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 G14251 or G14253 for same patient if eligible.

ix) Not payable once G14063 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.

		$
G14251	Annual chronic disease management fee (heart failure) for MRP FPs on alternate payment/funding models	125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.

ii) 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.

iii) This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (See FPSC Preamble definition of "working within" and "College-certified ACP").

iv) Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.

v) Not payable to physicians remunerated under the LFP Payment Model.

vi) Claim must include the ICD-9 code for heart failure (428).

vii) Payable once per patient in a consecutive 12 month period.

viii) Payable in addition to fee items G14250 or G14253 for same patient if eligible.

ix) Not payable once G14063 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.

$

G14252 Annual chronic disease management fee (hypertension) for MRP FPs on alternate payment/funding models 50.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.

ii) 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.

iii) This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.

1. Only one of the qualifying visits may be a group medical visit.

2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (See FPSC Preamble definition of "working within" and "College-certified ACP").

iv) Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.

v) Not payable to physicians remunerated under the LFP Payment Model.

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 G14250 or G14251 paid within the previous 12 months.

ix) Not payable once G14063 has been billed and paid.

x) If a visit is provided on the same date the bonus is billed, both services will be paid at the full fee.

G14253 Annual chronic disease management fee (Chronic Obstructive Pulmonary Disease – COPD) for MRP FPs on alternate payment/funding models.....125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.

ii) 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.

iii) This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.

1. Only one of the qualifying visits may be a group medical visit.

2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (See FPSC definition of "working within" and "College-certified ACP").

iv) Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.

v) Not payable to physicians remunerated under the LFP Payment Model.

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 G14250, G14251 or G14252 for the same patient if eligible.

ix) Not payable once G14063 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.

G14276 Patient Telephone Management encounter code for MRP Family Physicians on alternate payment/funding models providing chronic disease management 0.00

Notes:

i) Billable only by MRP Family Physicians who are employed or under contract to a facility or working under an alternate payment/funding model to demonstrate one of the two required visits as per fees G14250, G14251, G14252, and/or G14253.

ii) Not payable to physicians remunerated under the LFP Payment Model.
iii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician. Alternatively, telephone management 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 FPSC Preamble for definition of allied care provider "employed by" a physician practice and "College-certified ACP").
iv) 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.
v) Not billable for prescription renewal alone.
vi) Not billable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
vii) Billable to a maximum of 1500 services per physician per calendar year.
viii) Not billable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of G14250, G14251, G14252, G14253.

5. Complex Care Planning and Management Fees (G14033, G14075)

There are two Complex Care Planning and Management Incentives: G14033 and G14075.

Both G14033 and G14075 are available only to MRP Family Physicians who have submitted G14070 or G14071. G14033 and G14075 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 G14033 and G14075. When patients meet eligibility requirements for both Complex Care Incentives, choose either G14033 or G14075 - 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.

		$
G14033	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 FPSC 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.	337.28

Patient Eligibility:
- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long-Term Care Facilities are not eligible.

G14033 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 G14070 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 G14071 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 G14033.

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) G14018**,** G14077**,** or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14033.*

viii) G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.

ix) Not payable once G14063 has been billed and paid.

x) G14043, G14063, G14076 and G14078 not payable on the same day for the same patient.

xi) Maximum daily total of 5 of any combination of G14033 and G14075 per physician.

xii) G14075 is not payable in the same calendar year for same patient as G14033.

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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

Diagnostic codes submitted with G14033 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 (G14033)

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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G14075 Complex Care Planning and Management Fee - Frailty 337.28

The Complex Care Planning and Management Fee- Frailty is payment for the creation of a care plan (as defined in the FPSC 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 G14075.

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 G14070 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 G14071 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 G14075.

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) G14018, G14077, or H14067 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for G14075.

ix) Maximum daily total 5 of any combination of G14033 and G14075 per physician.

x) G14075 not payable once G14063 has been billed.

xi) G14033 is not payable in the same calendar year for same patient as G14075.

xii) G14043, G14063, G14076, G14078 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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

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6. Prevention Fee (G14066)

G14066 Personal Health Risk Assessment (Prevention).....54.12
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.

G14066 is payable only to MRP Family Physicians who have submitted G14070 or G14071.

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 G14070 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 G14071 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 G14066 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 G14066.

vi) G14077 or H14067 payable on same day for same patient if all criteria met.

vii) G14033, G14043, G14063, H14002, G14076 and G14078 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 G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

xi) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

7. Mental Health Planning Fee (G14043)

This fee is payable upon the completion and documentation of a care plan (as defined in the FPSC 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.

G14043 is payable only to Family Physicians who have submitted G14070 or G14071. 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.

		$
G14043	FP Mental Health Planning Fee	110.30

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 G14070 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 G14071 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 G14043.

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) G14077 or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for G14043.

viii) G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14075, G14076 and G14078 not payable on the same day for the same patient.

ix) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for 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

CATEGORY	DIAGNOSIS	ICD-9
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
Trauma and stressor related disorders	Adjustment Disorders	309
	Post-Traumatic Stress Disorder	309

8. Mental Health Management Fees (G14044, G14045, G14046, G14047, G14048)

		$
G14044	FP Mental Health Management Fee age 2 - 49	76.88
G14045	FP Mental Health Management Fee age 50 - 59	82.49
G14046	FP Mental Health Management Fee age 60 - 69	86.20
G14047	FP Mental Health Management Fee age 70 - 79	97.13
G14048	FP Mental Health Management Fee age 80+	112.44

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 G14070 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 G14071 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) G14077 or H14067, payable on same day for same patient if all criteria met.

viii) G14043, G14076, G14078 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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

9. Palliative Care Planning Fee (G 14063)

This fee is payable upon the development and documentation of a care plan as described in the FPSC 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.

G14063 is payable only to Family Physicians who have submitted G14070 or G14071 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.

		$
G14063	FP Palliative Care Planning Fee	110.30

Notes:

i) Payable only to Family Physicians who have successfully submitted and met the requirements for G14070. 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 G14071 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 G14063.

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) G14077 or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14063.

viii) Not payable if G14033 or G14075 has been paid within 6 months.

x) Not payable on same day as G14043, G14076 or G14078.

xi) G14050, G14051, G14052, G14053, G14250, G14251, G14252, G14253, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid.

xii) The FPSC Mental Health Initiative Fees (G14043, G14044, G14045, G14046, G14047, G14048) are still payable once G14063 has been billed provided all requirements are met, but are not payable on same day.

xiii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

10. FP Email, Text & Telephone Fees: Medical Advice to Patients (G14076, G14078)

		$
G14076	FP Patient Telephone Management Fee	22.14

Notes:

i) Payable only to:
a. MRP Family Physicians who have successfully submitted and met the requirements for G14070 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 G14071 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 G14072 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 FPSC 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 G14077, H14067, G14018, G14050, G14051, G14052, G14053, 13005.

viii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

		$
G14078	FP Email/Text/Telephone Medical Advice Relay	9.43

G14078 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 G14070 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 G14071 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 G14072 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 FPSC 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 G14077 or H14067.

vii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

11. Conferencing and Advice Fees (G14077, H14067, G14018, G14019)

FP Conference with Allied Care Provider and/or Physician - per 15 minutes or greater portion thereof

G14077 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 G14077.

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 G14077 start/end time.

		$
G14077	FP Conference with Allied Care Provider and/or Physician - per 15 minutes or greater portion thereof	50.35

Notes:

i) Payable only to:
- *a. MRP Family Physicians who have successfully submitted and met the requirements for G14070 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 G14071 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 G14072 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) 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 H14067 is payable if all criteria are met.

vii) 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).

viii) 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.

ix) Start and end times must be included with the claim and documented in the patient chart.

x) 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.

xi) 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.

xii) Not payable for simple advice to a non-physician allied care provider about a patient in a facility.

xi) Not payable in addition to 14018 or 14067 on the same day to the same physician for the same patient.

xii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

xiii) Not payable for a patient admitted under a Hospital at Home program.

FP Brief Clinical Conference with Allied Care Provider and/or Physician

H14067 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 H14067.

H14067 should not be billed for conferencing activities that can be billed as 13005 or G14077. 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.
- G14077 for two-way conferencing about a patient with at least one allied care provider or physician per 15 minutes or greater portion thereof.

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FPSC fees cannot be correctly interpreted without reading the FPSC Preamble.

H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician 18.45

Notes:

i) Payable only to:
- *a. MRP Family Physicians who have successfully submitted and met the requirements for G14070 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 G14071 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 G14072 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 G14077 or G14018 on the same day for the same patient by the same physician.

x) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

FP Urgent Telephone Advice from a Physician with Consultative Expertise

G14018 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 FPSC Preamble), in order to develop and implement a plan to keep the patient stable in their current environment. The intent of G14018 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.

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G14018 FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise.....50.44

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 FPSC Preamble) regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.

ii) The 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.

iii) Include start time in time fields when submitting claim.

iv) Payable for only one service per patient per physician per day.

v) Payable for a maximum of 6 services per patient per physician per calendar year.

vi) Payable in addition to a visit on the same date.

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) Not payable in addition to 14067 or 14077 on the same day to the same physician for the same patient.

ix) Out-of-Office Hours Premiums are not payable in addition.

x) Not payable to a physician who has been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

xi) Not payable for a patient admitted under a Hospital at Home program.

xii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

FP – Advice to Nurse Practitioner/Registered Midwife Fee

The intent of G14019 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.

		$
G14019	FP Advice to a Nurse Practitioner/Registered Midwife Fee–Telephone or In Person	50.35

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) G14019 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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

12. Family Physicians with Consultative Expertise Fees (G14021, G14022, G14023

FP with Consultative Expertise Telephone Advice Fees (G14021, G14022, G14023) 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 FPSC Preamble defines Family Physicians with Consultative Expertise as:

FPSC 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 FPSC Preamble, the following criteria must be met:

- Must not have billed another FPSC 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.

		$
G14021	FP with Consultative Expertise Telephone/video Advice - Initiated by a Specialist, Family Physician, or Allied Care Provider, Response within 2 hours	69.64

Notes:

i) Payable to a FP with consultative expertise (as defined in the FPSC 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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for 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).

$

G14022 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 50.35

Notes:
i) Payable to a FP with Consultative Expertise (as defined in the FPSC 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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for 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.)

		$
G14023	FP with Consultative Expertise - Patient Telephone/video Management/Follow-Up	23.19

Notes:

i) This fee applies to two-way telephone/video communication between the FP with Consultative Expertise (as defined in the FPSC 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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

13. Family Physician Obstetrical Premiums (G14004, G14005, G14008, G14009) and Maternity Care Risk Assessment (H14002)

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. These fees are not payable to physicians who have been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

H14002, G14004, G14005, G14008, and G14009 are payable only to family physicians who have submitted G14070 or G14071 in the same calendar year, or who are registered in a Maternity Network.

		$
H14002	Maternity Care Risk Assessment	50.63

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 G14070 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 G14071 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 H14002.

v) *Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.*

vi) G14033, G14043, G14063, G14066, G14076 and G14078 not payable on the same day for the same patient.

$

G14004 Obstetric Delivery Incentive for Family Physicians– associated with vaginal delivery and postnatal care.....430.48

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 G14070, or on behalf of Locum Family Physicians who have successfully submitted code G14071 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 G14004, G14008, G14009 per patient delivered.

iv) Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.

v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

$

G14005 Obstetric Delivery Incentive for Family Physicians – associated with management of labour and transfer for delivery to an alternate facility 179.28

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 G14070, or on behalf of Locum Family Physicians who have successfully submitted code G14071 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 P14105 billed in conjunction.

iii) Payable in addition to G14004 or G14009 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 G14004, G14005, G14008, G14009 or a combination of these items.

v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

$

G14008 Obstetric Delivery Incentive for Family Physicians– associated with postnatal care after elective caesarean-section.....88.57

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 G14070, or on behalf of Locum Family Physicians who have successfully submitted code G14071 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 G14004, G14008, G14009 per patient delivered.
iv) Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

$

G14009 Obstetric Delivery Incentive for Family Physicians – associated with attendance at delivery and postnatal care associated with emergency caesarean section 358.58

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 G14070, or on behalf of Locum Family Physicians who have successfully submitted code G14071 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 G14004, G14008, G14009 per patient delivered.
iv) Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

14. FPSC Incentives for In-patient Care (H14088)

The FPSC 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. The initiative includes funding aimed at better supporting and compensating FPs who provide this important aspect of care.

This initiative will support family physicians who provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned Inpatients). The FP Unassigned Inpatient Care Fee (H14088) is for family physicians who are a 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 Inpatients):

To participate in the FPSC 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 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.

		$
H14088	FP Unassigned Inpatient Care Fee	151.88

Notes:

i) Payable only to Family Physicians who are actively participating in:
  a. an FP Assigned Inpatient Care Network and an FP Unassigned Inpatient Care Network and/or
  b. an FP Maternity Care Network.
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, 13010, 13011, 00127) or delivery fee.

iv) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

15. CLFP New Patient Intake Fee (H14041)

		$
H14041	CLFP New Patient Intake Fee	15.19

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 H14041, 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 G14070 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 renumerated under the LFP Payment Model or an Alternative Payment model that includes payment for 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	51.66
3	01173	51.66
4	01174	51.66
5	01175	55.09
6	01176	55.09
7	01177	55.09
8	01178	57.14
9	01179	57.14
10	01180	57.14
11	01181	57.14

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, 01093, 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 20%.

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 20%).

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). 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 58.03
Note: *Not paid with other listings.*

01108 Hospital visit (weekday) 51.88
Notes:
i) Not paid with other listings.
ii) Applies only on weekdays, excluding statutory holidays.
iii) Out-of-Office Hour Premiums are not applicable.

01109 Hospital visit (Saturday, Sunday, or statutory holiday) 90.63
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) 62.23
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. 150.00

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. 90.00

01118 In-patient Extended Consultation – 40 to 54 minutes 30.30
Notes:
i) Applies only to patients seen while in the emergency department or while admitted to hospital (Service Location Code E or I).
ii) Paid only in addition to an in-person consultation (01015).
iii) Not applicable for services performed in a "pre-admission" clinic.
iv) Start and end times of the service must be entered in both the billing claim and the patient's chart.
v) Service must be performed in one continuous session.

01119 In-patient Extended Consultation – exceeding 54 minutes 60.60
Notes:
i) Applies only to patients seen while in the emergency department or while admitted to hospital (Service Location Code E or I).
ii) Paid only in addition to an in-person consultation (01015).
iii) Not applicable for services performed in a "pre-admission" clinic.
iv) Start and end times of the service must be entered in both the billing claim and the patient's chart.
v) Service must be performed in one continuous session.

		$
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.	245.42
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.	122.71

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	150.00

Anesthetic Procedural Fee Modifiers

01059	Prone position	60.36
01065	Patients under 1 year of age ***Note:*** *Not to be billed in addition to 01168.*	93.12
01070	Controlled hypotension in neurosurgical anesthetic to lower mean blood pressure to 60 mm Hg or less, or the appropriate safe lower limit	85.62
01071	Thoracic epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up	55.51
01072	Lumbar epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up.	42.69
01093	Spinal cord monitoring (interpretation of SSEP during anesthetic)	41.68
01164	Patients 70 – 79 years of age	20.84
01165	Patients 80 years of age and over	42.50
01166	Sitting position where there is a danger of venous air embolism	70.86
01168	Neonates (less than 42 gestational weeks and/or 4000 grams or less)	186.24
01192	Awake intubation by any means in the patient with a suspected or proven difficult airway ***Note:*** *Applicable only when airway score is 3 or 4.*	62.51

		$
01169	BMI ≥ 35 - per 15 minutes or part thereof	12.50

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 20% 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	138.55
01124	Peripheral nerve block - single	65.62
01125	Peripheral nerve block - multiple	99.16
01035	Gasserian ganglion	260.17
	Epidural Blocks:	
01135	Lumbar	153.76
01036	Thoracic	233.19
01037	Cervical	269.07
01138	Caudal blocks	153.76
	Nerve Root or Facet Blocks:	
	Cervical:	
01140	- single	187.27
01141	- multiple	249.69
	Thoracic:	
01142	- single	171.52
01143	- multiple	228.66

		$
	Lumbar:	
01144	- single	155.75
01145	- multiple	207.69

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)	163.63
01034	Differential spinal	218.19
	Sympathetic Nerves:	
01040	Stellate ganglion	120.58
01042	Paravertebral (lumbar sympathetic)	198.25
01044	Coeliac plexus	275.94
	Permanent Cryosection and/or Neurolysis:	
01146	Major plexus or nerve root	360.84
01147	Single peripheral nerve	170.65
01148	Multiple peripheral nerves	228.66
01149	Epidural or subarachnoid neurolysis	406.02
01150	Gasserian ganglion neurolysis	406.02
	Injection Tendon Sheath, Ligaments, Trigger Points:	
01156	Single injection	62.13
01157	Multiple injections	77.92
01159	IV injection for diagnosis and/or therapeutic management of chronic pain syndromes - local anesthetic only	62.13
01160	IV injections for diagnosis and/or therapeutic management of chronic pain syndromes –ketamine only	124.27

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	85.63

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)	85.63

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.	184.07

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).	170.87
01095	Intra-arterial catheter placement - isolated procedure	35.24
00017	Insertion of central venous pressure catheter	26.63

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.	103.31
01026	Thoracic epidural catheter insertion, to include initial injection and/or infusion set up	233.19
01025	Lumbar or caudal epidural catheter insertion, to include initial injection and/or infusion set up	153.76
01050	Repeat injection via indwelling epidural catheter to a maximum of 4 per day - per injection	62.23

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

01073	Hospital visit for supervision of epidural infusion to a maximum of 2 per day - per visit	41.49

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

01074	Axillary catheter insertion, to include initial injection and/or infusion set up	74.19
01075	Repeat injections via indwelling axillary catheter to a maximum of 4 per day – per injection	62.23

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

01076	Hospital visit for supervision of axillary catheter infusion to a maximum of 2 per day - per visit	41.49

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

01007	Intrapleural catheter insertion, to include initial injection and/or infusion set up	85.43
01019	Repeat injections via indwelling intrapleural catheters to a maximum of 4 per day - per injection	62.23

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

01021	Hospital visit for supervision of intrapleural infusion to a maximum of 2 per day - per visit	41.49

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

		$
01012	Hospital visit for supervision of patient controlled analgesia during second and subsequent days, to a maximum of 2 visits per day - per visit	41.49

Notes:

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

01186	Major peripheral nerve block - single	46.88
01187	Major peripheral nerve block - multiple	70.85

Obstetric Analgesia Fees

01102	Insertion of epidural catheter. To include initial injection and/or set-up of infusion for analgesia during labour.	149.20

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)	9.79
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)	14.71
01049	Medical Supervision of Labour Epidural Analgesia: Night (Monday to Sunday, 2300-0800 hours), per 5 minutes (or major portion thereof)	19.59

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	51.58

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	53.98
01110	Anesthesia for dental procedures (all procedures unless otherwise listed) - per 15 minutes or part thereof	51.58
01111	Anesthesia for emergency relief of acute upper airway obstruction (above the carina) - per 15 minutes or part thereof	85.63

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	51.58

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	185.93

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	87.98	
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) ***Note:*** *Punch and shave biopsies are included in consultation or visit fees.*	62.07	
	Continuing care by consultant:		
00204	Directive care	36.00	
00207	Subsequent office visit	36.00	
00208	Subsequent hospital visit	36.00	
00209	Subsequent home visit	71.12	
00205	Emergency visit when specially called out of office (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	124.91	
	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	87.98	
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) ***Note:*** *Punch and shave biopsies are included in consultation or visit fees.*	62.07	
20207	Telehealth subsequent office visit	36.00	
20208	Telehealth subsequent hospital visit	36.00	
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	87.98	

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	49.04	

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	184.03	

Special Therapy

00217	Treatment of skin disorders and lesions other than: ultraviolet, x-ray, grenz ray: such as cryosurgery, electrosurgery, etc., - extra (operation only)	19.39	

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)	80.00	
00219	For each additional lesion – to a maximum of two additional lesions per day (operation only)	40.00	

** These items are subject to the general regulations covering surgical procedures.*

00222	Psoralen Ultra Violet A treatment: - whole body	20.79	
00223	- partial body.	20.79	

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	20.79	
00235	Pulsed laser surgery of the face and/or neck, treatment area less than 50 cm^2 (operation only)	70.65	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)	105.84	3
00237	Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia	57.35	

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	35.73	

Surgical Procedures and Repairs

Mohs' microscopically controlled excision:

00225	Initial cut, including debulking	354.55	
00226	One or more additional cuts, extra	307.11	
00227	Special overhead and technical component, extra	330.60	

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.*

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)	208.58	2
20222	Single	322.61	2

		$	Anes. Level
20223	Multiple	582.30	2
20224	- with free skin graft to secondary defect	662.29	2
20225	Eyebrow, eyelid, lip, ear, nose - single	303.23	3
	Note: *Repair of torn earlobe to be claimed under 06027.*		

Free Skin Grafts (including mucosa)

Full-thickness grafts:

20226	Eyelid, nose, lips, ear	317.52	2
20227	Finger, more than one phalanx	303.23	2
20228	Sole or palm	303.23	2

Tumours of the Skin:

13600	Biopsy of skin or mucosa (operation only)	59.26	2
13601	Biopsy of facial area (operation only)	59.26	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	30.34	
20232	Biopsy, not sutured, multiples same sitting, maximum of four (extra)	15.17	
	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	50.75	2
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	75.70	2
13621	- additional lesions removed at the same sitting (maximum per sitting, five) each (operation only)	37.87	
	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)	87.72	
06146	Lip shave - vermilionectomy	408.16	3

Diagnostic Procedures

Allergy, patch and photopatch tests:

S00762	Scratch test, per antigen	1.08	
	Note: *Minor tray fees may be paid in addition if a minimum of 16 antigens are used.*		
S00763	- children under 5 years of age, per antigen	2.37	
	Note: *Minor tray fees may be paid in addition if a minimum of 14 antigens are used.*		
S00764	Intracutaneous test, per test	2.20	
S00765	Annual maximum (to include scratch or intracutaneous tests) for each physician - per patient	35.18	
S00767	Patch testing (extra) (annual maximum, 80 tests) per test	2.00	

		$	Anes. Level
S00768	Photopatch test, per test	8.81	
S00769	- annual maximum	88.07	
15136	Fungus, direct microscopic examination KOH preparation	8.57	

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.	104.76	
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	51.54	
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 ***Note:*** *Where referred for emergency surgery and surgery is performed within 3 days from date consultation requested, charge an ordinary consultation.*	139.21	
	<u>Continuing care by consultant:</u>		
02007	Subsequent office visit	38.15	
02008	Subsequent hospital visit	51.43	
02009	Subsequent home visit	63.62	
02005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) ***Note:*** *Claim must state time service rendered.*	94.83	
	<u>Telehealth Service with Direct Interactive Video Link with the Patient:</u>		
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	104.30	
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	51.54	
22007	Telehealth subsequent office visit	37.98	
22008	Telehealth subsequent hospital visit	51.43	

		$	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 ***Note:*** *Fee items 02015, 02018 and 02019 are payable to certified ophthalmologists only.*	53.69	
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 ***Note****: Item 02014 includes 02007 and 02017.*	64.25	
02017*	Oculo-motor function tests	36.42	
02018*	Biomicroscopy	33.72	
02019*	Tonometry	33.72	
02020*	Ophthalmo-dynamometry	30.20	
02028	Examination for low visual aid at low-vision clinic	52.26	
02038*	Keratometry	16.50	
02040	Retinoscopy, keratometry, tonometry, indirect fundoscopy, fundus photography and prosthetic fitting under general anesthetic	140.43	3
02048	Exophthalmometry	14.20	
22016	Pachymetry – extra (when billed with other eye examinations) ***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.*	10.78	

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	11.83	2
22047	Anterior segment gonioscopy	15.84	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	112.90	
02026	- professional fee	28.39	
02027	- technical fee	84.51	
02030	Electro-retinogram	99.42	
02031	- professional fee	36.93	
02032	- technical fee	62.48	
02034	Dark adaptation, per eye	22.58	

		$	Anes. Level
02035	Colour vision assessment (to include a screening test and at least one quantitative test of hue discrimination)	43.32	
02036	- professional fee	28.40	
02037	- technical fee	14.93	
02039	Fundus photography (limitations - glaucomatous, disc changes, tumour progression and potentially progressive retinal disease)	14.15	
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)	34.39	

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) — 48.23

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) — 66.83

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	80.56	
02045	- professional fee	28.40	
02047	Dacryocystogram	66.04	

		$	Anes. Level
02049	Potentiometry	33.05	
22023	10 or 24 hour diurnal tension curve	37.24	

***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	68.80	
02068	- professional fee	13.22	
02069	- technical fee	55.57	

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)	57.02	
22068	- professional fee	13.22	
22069	- technical fee	45.41	

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	61.97	
22076	- professional fee	16.80	
22077	- technical fee	45.15	

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)	13.89	
S00771	Retinal examination under anesthesia - procedural fee (when done as an independent procedure)	21.19	3
22050	Specular Microscopy – total fee	82.46	
22051	Specular Microscopy – professional fee	21.53	
22052	Specular Microscopy – technical fee	60.95	

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):	67.92	

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):	106.17	

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	84.25	
02058	Contact Lens - aphakia - unilateral	280.88	
	Note: *Fee item 02058 includes follow-up visits for three months.*		
22059	Contact lens - keratoconus - unilateral	280.88	

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	21.89	
S02109	Injections – subconjunctival (operation only)	23.59	
	Note: *Not to be billed at the time of any intra-ocular surgery.*		
S02110	Placement of radioactive plaque	1,057.94	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	144.24	
S02075	Botulinum toxin injections for entropion	78.83	
S02076	Botulinum toxin injections for strabismus in patients age 12 or older	219.54	

Lacrimal Apparatus

S02111	En bloc micro-dissection lacrimal gland for tumour with excision by lateral approach with levator dissection	1,181.57	6
S02118	Two or three snip procedure (operation only)	50.60	3
S02120	Punctum dilation and syringing sac	26.97	3
S22121	Duct probing - under general anesthesia – unilateral or bilateral	186.23	3
	Note: *Not to be billed with S02123 on the same eye.*		
S02122	- under local anesthesia (operation only)	26.97	3
S02123	Insertion of Quickert tube	217.63	3
S02129	Insertion of Lester Jones tube	446.92	3
S02119	Dacryocystostomy - under local anesthesia (operation only)	37.26	3
S02112	Dacryocystectomy with unroofing of bony lacrimal canal and removal of lacrimal duct for tumour	1,117.35	4
S02126	Dacryocystorhinostomy	591.24	3
	Note*: Not to be billed with S02123 on the same eye.*		
S02127	Repair of canaliculi	521.40	3

		$	Anes. Level
	Orbit		
S02132	Retrobulbar injection (operation only) ***Note:*** *Not to be paid in addition to intra-ocular surgery.*	95.98	2
S02133	Enucleation or evisceration	559.08	4
S02134	Orbit - enucleation with insertion of complicated implant (e.g.: dermis fat graft and/or scleral wrapped porous implant).	819.37	4
S02135	Exenteration of orbit	1,064.25	4
S22136	Biopsy or excision of anterior orbital tumour	372.45	4
S22140	Orbital exploration (posterior route) - to biopsy posterior orbital tumour or to fenestrate optic nerve sheath ***Note****: Not payable with fee item S22138.*	1,191.81	6
S22138	Posterior orbitotomy for removal of posterior orbital tumour not involving the orbital apex or optic nerve ***Note:*** *Not payable with fee item S22140.*	1,489.79	6
S02144	Aspiration needle biopsy of orbit under scan control	143.15	3
S02101	Posterior orbitotomy with microscopic dissection for lesions of optic nerve or orbital apex	1,862.21	7
S02145	Orbital exenteration with en bloc resection of bony orbital walls - Ophthalmologist ***Note:*** *Fee from Neurosurgeon and Plastic Surgeon in addition.*	1,772.82	7
	Orbital decompression:		
S22141	- 1 wall	670.39	6
S22142	- 2 wall	1,035.33	6
S22143	- 3 wall ***Note****: Orbital decompression is not paid in addition to fee items S22140 or S22138.*	1,489.79	6
	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)	93.48	3
S02104	Major lid reconstruction (one or two stage) ***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.*	931.10	3
S02105	Two-stage reconstruction with micrographic tumour excision ***Note:*** *Includes resection of tumour with micrographic control, cross lid flaps, skin grafts and subsequent division of transposition flaps.*	1,551.86	3
S02106	Microscopic repair of trichiasis including muscular graft or mucosal membrane graft	614.89	3
S02107	Repair of eyelid margin defect, requiring layered closure.	372.45	3
S02146	Trichiasis - epilation, forceps (operation only)	23.59	3
S02147	- electric (operation only)	67.96	3
S02148	Cryotherapy of eyelids for trichiasis or tumour (operation only)	124.16	3
S02149	Meibomian gland evacuation (operation only)	23.59	
S02150	Chalazion excision (operation only)	83.27	3

		$	Anes. Level
S02152	Tarsorrhaphy (operation only)	123.42	3
S02153	Ectropion/Entropion - Ziegler or simple procedure - involves simple skin incision but does not require associated lid shortening or skin grafting (operation only)	59.48	3
S02154	Ectropion/Entropion - complicated, including neoplasms and plastic repair - requires both repair and associated lid shortening and/or skin grafting	353.56	3
S02155	Ptosis repair - frontalis sling using synthetic material	310.37	3
S02159	- frontalis sling using autologous material	577.66	3
S02160	- levator resection	567.62	3
S02158	Fasanella Servat	279.71	3
S02166	Lid elevation and scleral graft for lower lid retraction	496.58	3
S02100	Graded Muellerectomy with levator recession under local anesthesiology	496.58	3
S02156	Excision of tumour of lid margin or conjunctiva – benign (operation only)	93.48	3
S02157	Excision of benign tumour of lids (operation only)	40.45	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	394.96	3
S02162	- three or more muscles	558.67	3
S22165	- five or more muscles	806.95	4
S02163	- complicated re-operation	620.75	4
S22166	Adjustable suture fee - extra to strabismus surgery	186.23	
S22167	Prism adaptation therapy and/or amblyopia therapy correction of fusional disturbances and/or amblyopia	146.07	

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.	443.43	4
S22172	Complicated pterygium excision (re-operation) or cancer excision, with mucous membrane graft	638.55	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)	33.60	3
S02171	Pterygium or limbus tumour excision (operation only)	133.99	3
S02172	Gundersen-type flap	310.37	3
	Keratoplasty:		
S02173	- lamellar	897.78	3
S02175	- penetrating	898.70	4
S02168	- complicated re-operation	1,009.83	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)	23.37	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	427.05	
S22176	Technical fee	533.83	

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	327.18	4
S02169	- complicated	740.24	4

Glaucoma/Iris/Anterior Chamber

S22070	Molteno implant (includes phase 1 and phase 2)	1,131.65	5

Note: *Includes placement of scleral graft if indicated.*

S02176	Sclerotomy - posterior with or without insufflation of gas - isolated procedure	138.75	4
S02177	Glaucoma - peripheral iridectomy - isolated procedure	364.42	4
S02178	- filtering procedure, non-microscopic	631.46	4
S02180	- goniotomy	574.00	4
S02183	- goniotomy, repeat within 3 months	238.40	4
S02184	- cyclodialysis	353.56	4
S22185	- cycloablative procedures	327.18	4
S02187	- filtering procedure, microscopic	679.97	4
S22187	- complicated trabeculectomy	991.46	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	666.00	4
S02197	Surgical evacuation of a hyphema	547.50	4

Cataract/Lens

S02188	Cataract - linear extraction, congenital, traumatic or senile	294.65	
S22191	- capsulotomy (needling or discission) - isolated procedure	219.82	

		$	Anes. Level
	Pediatric cataract extraction		
22188	- 0 to 7 years	1,184.90	
22189	- 8 to 16 years	789.93	
S02190	Primary intraocular lens implantation to include repositioning of lens within the 42 day post-operative period - extra	77.55	
S02192	Secondary intraocular lens implantation to include repositioning of lens within the 42 day post-operative period	508.47	
S02196	Surgical repositioning of implant lens ***Note:*** *For non-surgical repositioning use visit fees.*	238.40	

Retinal Procedure

S02181	Foreign body intraocular - magnetic extraction - isolated procedure	654.64	4
S02182	- non-magnetic extraction - isolated procedure	791.80	4
S02090	Intravitreal injection of vitreous paracentesis ***Note****: Not to be billed with S02199 or S02194.*	137.47	4
S02091	Paracentesis, anterior chamber	137.27	4
S02092	Intravitreal biopsy (microbiology, cytology) or intraocular tumour needle biopsy	227.12	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.*	852.57	5
S02195	Diathermy or cryopexy for retinal tear or other retinal disorder ***Note:*** *Not to be billed in addition to S02199 or S02194.*	239.58	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.*	368.94	4
S02199	Posterior vitrectomy with 2 or 3 port infusion cutting device. Includes membrane peel and/or dissection	961.37	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)	70.97	5
S22200	Panretinal endolaser greater than 200 burns when done with a posterior vitrectomy	218.77	5
S22201	Scleral buckle done with posterior vitrectomy (operation only)	59.11	5
S22202	Intra-ocular lens removal and/or lensectomy when done with a posterior vitrectomy (operation only)	59.11	5
S22203	Removal of intra-ocular foreign body at the time of posterior vitrectomy	236.50	5
S22196	Pneumato retinopexy with air or gas - isolated procedure ***Note****: Includes cryopexy or laser.*	409.16	5
S22195	Removal of buckle material or sponge ***Note****: Not paid with any other fee item on the same eye.*	183.27	5

		$	Anes. Level
S22197	Additional gas (C3F8 or SF6) or air injection	105.22	5
	Note: *Payable within 42-day post-operative period following buckling procedure, vitrectomy, or pneumato retinopexy.*		
S22198	Repair of scleral laceration and cryopexy and/or gas injection with scleral buckle – isolated procedure	1,035.86	5

Laser Procedures

S02072	Laser interferometry	34.29	4
S22113	Laser iridotomy per eye (operation only)	124.16	4
S22114	Laser trabeculoplasty per eye	135.53	
	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*		
S22115	YAG laser capsulotomy per eye (operation only)	112.35	4
S22116	Retinal photocoagulation - left	135.53	4
S22117	Retinal photocoagulation - right	135.53	4
S02116	Panretinal photocoagulation - defined as greater than 700 burns maximum fee for one eye for any 6 month period	553.82	4

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.

S22118	Laser follow-up visit	35.05	

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.

S22125	Photodynamic therapy for age-related wet macular degeneration – professional fee	295.29	
	Note: *Payable to Retinal Physicians certified in PDT treatment only.*		
00094	YAG laser tray service fee	71.58	

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.

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 86.23

02511 Consultation with pure tone audiogram 103.15

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. 50.71

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 189.81

02513 Consultation for management of malignancy 117.54

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 153.91

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 146.05

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.

<u>Continuing care by consultant</u>:

02507 Subsequent office visit 39.74

02508 Subsequent hospital visit 37.68

02509 Subsequent home visit 94.22

02505 Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) 125.12

Note: *Claim must state time service rendered.*

		$	Anes. Level
02215	Pre-Operative Assessment	87.56	

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	86.23	
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.	50.71	
25007	Telehealth subsequent office visit	39.74	
25013	Telehealth consultation for management of malignancy	117.54	

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	31.04	

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)	17.39	
02521	Audiogram - speech (SRT,PB, MCL)	19.13	
02525	Impedance test	10.19	
02531	Impedance test, including contralateral reflex	19.84	
02532	PI-PB test	6.38	
02533	Play audiometry	24.64	
02534	Free field audiometry	24.64	
02536	Brain stem evoked response audiometry	48.28	
02541	Electrocochleography	52.58	
02539	Brain stem evoked response audiometry with electrocochleography	69.76	
	Note*: Only one additional specialist examination can be billed in addition to this item.*		
	Vestibular tests:		
02526	Cold calorics test	11.36	
02527	Bithermal test	24.64	
02528	E.N.G. (Electronystagmography)	53.42	
	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	24.64	
02542	Measurement of autoacoustic emissions	36.20	
	Miscellaneous tests:		
	Note*: See also SY00907, SY00908 under Diagnostic Procedures*		
02538	Laryngostroboscopy	86.72	
02535	Maxillary sinus endoscopy via canine fossa, with or without biospy	119.51	3

Ear

	Removal of foreign body or aerating tubes from ear - simple	per visit	
02221	Microscopic debridement, or aural polyp removal	27.72	2
	Note: *can be billed as an extra at 100% with fee item 02507*		
02223	- under general anesthesia (operation only)	78.12	2
	Note: *02221 and 02223 are not payable with 02254, 02274, 02228, and 02229.*		
02206	Removal of ear canal osteoma (operation only)	92.38	2
02209	Removal of obstructing exostosis of the ear canal	619.69	3

		$	Anes. Level
02210	Paracentesis of the ear drum (operation only)	54.70	2
02233	Transmastoid facial nerve decompression - vertical and horizontal segment	1,153.30	4
02234	- vertical segment	600.14	4
02224	Transcanal labyrinthotomy transmastoid for posterior semicircular canal occlusion.	223.84	4
02241	Labyrinthectomy - drill out of petrous bone.	587.06	4
02242	Microsurgical repair and reconstruction soft tissue atresia, external ear canal – complete ***Note:*** *Includes skin grafting or flap.*	814.07	3
02243	Repair atresia external ear canal, complete, bony	1,082.81	3
02244	Repair stenosis external ear canal, bony	626.20	3
02245	Microsurgical repair and reconstruction soft tissue stenosis - external ear canal ***Note:*** *Includes skin grafting or flap.*	678.39	3
02231	Microsurgical revision and reconstruction, soft tissue stenosis - external ear ***Note:*** *Includes skin grafting or flap.*	542.69	3
02247	Mastoidectomy - partial, canal wall up (Cortical)	626.20	3
02248	Radical mastoidectomy	795.79	4
02249	Stapes-reconstruction	701.97	3
02250	- mobilization of	409.46	3
02246	- reconstruction with laser	760.47	3
02251	Myringoplasty repair of drum – without exploration of middle ear	213.11	3
02239	Tympanotomy - with ossicular chain reconstruction	441.58	3
02252	Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of tympanotomy)	511.85	3
02264	- with ossicular chain reconstruction	775.08	3
02276	- lateral graft, homograft tympanic membrane ***Note****: Applicable to adhesive otitis media or total perforation.*	775.08	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.*	851.11	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.*	581.82	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.*	58.19	3

		$	Anes. Level
T25273	Mastoid cavity obliteration with autologous bone dust, bone chip, and/or abdominal adipose tissue (extra)	750.00	
	Notes: *i) Payable only with 02253, 02273, 02268, 02272 or 22268.* *ii) If bilateral mastoid cavity obliterations are performed on the same date of service, the second mastoid cavity obliteration (25273) is payable at 50%.* *iii) Must include obliteration with autologous bone pate, bone chips, and/or abdominal adipose tissue (palva flap rotation or cartilage placement only is not sufficient).* *iv) Includes autologous adipose tissue harvesting and grafting.*		
02253	Tympanomastoidectomy - Complete, canal wall down, including tympanoplasty	1,184.59	3
02265	- partial, canal wall down (atticotomy)	688.20	3
02263	Trans-tympanic polyneurectomy	339.19	3
	Myringotomy with insertion of aerating tube:		
02254	- unilateral (operation only)	93.22	2
02274	- bilateral (operation only)	142.08	2
	Myringotomy with insertion of aerating tube, under GA		
02228	- unilateral (operation only)	138.99	2
02229	- bilateral (operation only)	212.74	2
02255	Exploratory tympanotomy	241.36	2
02261	- with chemical control, tac procedure, cryosurgical control, ultrasound	397.90	3
02266	Myringoplasty - paper patch or synthetic (operation only)	45.66	2
02256	Endolymphatic shunt, any procedure	887.10	6
02259	Excision of glomus - by tympanotomy approach	691.43	3
02260	- where extensive dissection is required	1,275.70	6
02269	Implantable bone conductor	480.31	4
02267	Conchal cartilage graft	326.13	3
02268	Intra-cochlear implant (unilateral)	1,414.59	4
22268	Intra-cochlear implant (bilateral)	2,475.53	4
C02225	Middle Fossa Approach for Repair of Superior Canal Dehiscence ***Note:*** *To include approach and plugging or repair of canal.*	1,176.99	5
02270	Transmastoid - posterior semicircular canal occlusion or repair of superior canal dehiscence	1,554.65	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.	2236.66	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	1,476.20	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.*		

		$	Anes. Level
02273	Microsurgical tympanomastoidectomy - complete, canal wall up.	1,292.84	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)	65.21	3
	Cauterization of septum - chemical	per visit	
02303	Cauterization of septum – electric (operation only)	42.99	3
	Cryosurgical treatment of turbinates:		
02298	- unilateral	156.55	3
02299	- bilateral	195.68	3
	Turbinectomy:		
02304	- unilateral (operation only)	97.84	3
02305	- bilateral	143.48	3
02306	Submucous resection of septum	169.58	3
	Naso-antral window:		
02307	- single (operation only)	117.41	3
02308	- double	182.65	3
02309	Radical antrostomy	326.13	3
02310	- with closure of alveolar fistula	469.66	4
	Intranasal ethmoidotomy to include polypectomy, posterior:		
02360	- unilateral	365.27	3
02361	- bilateral	560.97	3
	Intranasal ethmoidotomy, anterior:		
02362	- unilateral	195.68	3
02363	- bilateral	326.13	3
02357	Endoscopic sinus surgery: Functional endoscopic sinus surgery in children under 14 years of age.	326.15	
	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	600.14	4
	Electrocoagulation of turbinates:		
02317	- one side (operation only)	52.19	3
02318	- both sides (operation only)	78.26	3
02319	Trephining frontal sinus	260.92	3
02321	Sinus sphenoidotomy/sphenoid sinusotomy (intranasal)	273.96	3
	Removal of nasal polypi:		
S02322	- unilateral (operation only)	104.37	3
S02323	- bilateral	169.58	3
	Lavage or debridement of sino-nasal tract or cavity:		
02324	- unilateral (operation only)	34.34	3
02325	- bilateral (operation only)	51.49	3
	Choanal atresia, definitive repair of:		
02326	- unilateral	495.75	3
02327	- bilateral	691.43	4
	Choanal atresia; perforation of:		
02328	- unilateral	169.58	3
02329	- bilateral	234.81	4
02336	Laser revision of choanal stenosis	135.68	4

		$	Anes. Level
	Submucous turbinectomy:		
02330	- unilateral	169.58	3
02331	- bilateral	260.92	3
	Lateral rhinotomy and excision tumour:		
02332	- benign	600.14	3
02333	Lateral rhinotomy and/or medial maxillectomy for excision of nasal tumour	639.25	3
	Notes: *i) To include open or endoscopic techniques* *ii) Not payable for polyps.*		
02334	Transantral ethmoidectomy	495.75	3
02335	Transantral ligation, internal maxillary artery	521.85	6
02337	Ligation of anterior and posterior ethmoid arteries	326.13	6
02338	Removal of angiofibroma-nasal pharynx	756.66	6
02342	Maxillectomy with exenteration of ethmoid	821.90	5
02339	Palatal fenestration	263.65	3
02343	Septal reconstruction	391.38	3
02341	Posterior nasal packing - to include balloon control of epistaxis (operation only)	121.73	3
02346	- with trans-oral gauze pack, under local, topical, or general anesthesiology (operation only)	194.81	3
02345	Drainage of abscess or haematoma of septum (operation only)	117.41	3
02347	External osteoplastic frontal flap operation	952.37	4
02364	Nasal fracture - simple reduction (operation only)	101.81	3
S02365	- reduction and splinting (operation only)	178.36	3
06123	- comminuted nasal fractures – transosseous wire plate fixation	314.00	3
02348	Operative closure of oral-nasal fistula	837.75	3
02349	Operative closure of nasal septal perforation	521.85	3
02359	Revision endoscopic intranasal spheno-ethmoidotomy (anterior, middle and posterior cells including sphenoid).	542.69	3
25100	Laser photocoagulation or electrosurgical plasmacoagulation (coblation) of hereditary hemorrhagic telangiectasia lesions of nasal cavities (HHT)	456.19	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	2,129.47	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	532.35	
	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.

		$	Anes. Level
25305	Endoscopic ligation – sphenopalatine artery	428.02	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.

25310	Endoscopic trans-nasal repair of CSF leak from anterior skull base	998.15	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	237.54	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.
v) Not payable with 25318.
vi) Not payable with 25316 or 25317 on same side.
vii) Payable at 50% if done within six months of 25318.
viii) Payable at 50% if done within six months of 25316 or 25317 on same side.

T25316	Comprehensive aeration of a complex frontal sinus-without drilling (unilateral)	366.00	3

Includes comprehensive removal of all septations within the frontal recess – resulting in a maximally expanded frontal sinus outflow tract bounded by the orbit, frontal beak, posterior table of the frontal sinus (including identification of the anterior ethmoid artery) and middle turbinate (or septum, if the middle turbinate is removed).

Notes:
i) Either a) or b) must apply:
  a. Frontal sinus with complex frontal recess cellularity as defined by the IFAC classification.
  b. For revision surgery, frontal sinus with complicated frontal recess anatomy (such as scarring following previous frontal sinus surgery).
ii) Requires direct visualization of the top of the frontal sinus with an angled endoscope.
iii) Frontal sinus disease must be present to bill this item.
iv) Not to be billed in uncomplicated anterior ethmoidotomy.
v) Payable at 100% with one of 02359, 02360, 02361, 02362 or 02363.
vi) Payable at 150% if done bilaterally.
vii) Not payable with 25318.
viii) Not payable with 25315 or 25317 on same side.
ix) Payable at 50% if repeated on same side within six months.
x) Payable at 50% if done within six months of 25318.
xi) Payable at 50% if done within six months of 25315 or 25317 on same side.

		$	Anes. Level
T25317	Comprehensive aeration of a complex frontal sinus-with drilling (unilateral)	470.18	3

Frontal recess must have chronic inflammation, scarring or narrow anatomy (usually because of a prominent bony frontal beak resulting in a poor AP diameter to the frontal recess) and where the bone/scar tissue in the frontal recess is firm enough to necessitate use of a drill. Includes comprehensive removal of all septations within the frontal recess – resulting in a maximally expanded frontal sinus outflow tract bounded by the orbit, fontal beak, posterior table of the frontal sinus (including identification of the anterior ethmoid artery) and middle turbinate (or septum, if the middle turbinate is removed).

Notes:

i) Requires direct visualization of the top of the frontal sinus with an angled endoscope.
ii) Frontal sinus disease must be present to bill this item.
iii) Not to be billed in uncomplicated anterior ethmoidotomy.
iv) Payable at 100% with one of 02359, 02360, 02361, 02362, or 02363.
v) Payable at 150% if done bilaterally.
vi) Not payable with 25318.
vii) Not payable with 25315 or 25316 on same side.
viii) Payable at 50% if repeated on same side within six months.
ix) Payable at 50% if done within six months of 25318.

T25318	Modified endoscopic Lothrop procedure (Draf III) Requires the drilling of the entire floor of both frontal sinuses, the frontal intersinus septum and an anterior/superior nasal septectomy (unilateral or bilateral)	800.00	8

Notes:

i) Restricted to Otolaryngologists.
ii) Requires direct visualization of frontal sinus recess/ostium.
iii) Frontal sinus disease must be present to bill this item.
iv) Not to be billed in uncomplicated anterior ethmoidotomy.
v) Payable at 100% with one of 02359, 02360, 02361, 02362, or 02363.
vi) Includes fee items 25315, 25316 or 25317.
vii) Payable at 50% if repeated within six months.
viii) Payable at 100% within six months of 25315, 25316 or 25317.

Rhinoplasty

02351	Nasal refracture requiring lateral osteotomies	401.44	3
02352	Reconstruction of nasal tip, ala, and columella	473.12	3
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma).	633.73	3
02354	Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture, and/or reconstruction of nasal tip, without skin grafting via closed approach	688.20	3
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and/or reconstruction of nasal tip without skin grafting via open (or external) approach.	927.33	3

Note: *To include a columellar incision with marginal incisions.*

Throat

	Incision of peritonsillar abscess:		
02447	- under local anesthetic (operation only)	106.87	4
02444	- under general anesthetic (operation only)	144.89	6
	Tonsillectomy:		
02403	- under local anesthesia	263.53	4

		$	Anes. Level
02445	- adult or child over the age of 14 years	282.24	4
02446	- child age 14 years and under (to include neonate)	300.13	4
02413	Operative control of post-tonsillectomy or post-adenoidectomy haemorrhage requiring local or general anesthetic	325.62	6
02399	Cryotherapy of tonsils and oral lesions (operation only)	117.41	3
02442	Adenoidectomy - adult or child over 14 years (operation only)	144.89	4
02443	- child 14 years and under (neonate included)	213.33	4
02448	Retropharyngeal abscess or hematoma - drainage under local anesthetic (operation only)	173.29	4
02406	Retropharyngeal abscess or hematoma - requiring lateral pharyngotomy	338.86	6
02408	Removal of tumour from larynx or trachea	195.68	5
02409	Uvulo-palato-pharyngoplasty for obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy	430.50	5

Notes:

The following two indications are requirements:

i) Patient is unable to use Continuous Positive Airway Pressure (CPAP). This maybe 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.)

02410	Thyrotomy (including cordectomy)	521.85	5
02431	Hemilaryngectomy	1,480.34	6
02432	Supraglottic laryngectomy	1,610.94	6
02433	Vocal cord implant - injection	326.13	5
02434	- external approach	652.31	5
02436	Arytenoid adduction	830.43	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	1,474.19	8
02449	Rigid oesophagoscopy for removal of foreign body	259.93	4
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	312.59	6
02422	- in a child under the age of 3 years	389.18	6
02418	Repair of fractured larynx – external approach	847.99	8
02420	Dilation of trachea (operation only)	156.10	5
02421	- repeat within one month (operation only)	155.88	5
02425	Arytenoidectomy	652.31	5
02437	Transphenoidal removal of pituitary tumour or hypophysectomy - two surgeons - otolaryngologist	1,261.67	8
02438	Trans-oral cricopharyngeal myotomy	430.50	5
02424	Tracheoesophageal puncture and insertion of voice prosthesis following laryngectomy	365.27	5
02440	Bilateral micro-transposition of submandibular salivary ducts when done with or without a microscope.	346.01	4

		$	Anes. Level
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) ***Note**: 02441 is not payable when tracheostomy is performed by the same surgeon at the same time. Bill under fee item 02407.*	305.28	11
02451	Excision of congenital cyst or fistula from neck	447.55	4
02452	Sialolithotomy - simple, in duct (operation only)	65.21	3
02453	- complicated, in gland	195.68	3
02454	Alveolectomy	195.68	3
02455	Excision of submandibular gland	390.71	4
02456	Salivary fistula - plastic to Stensen's duct	430.50	4
02457	Tongue tie - under general anesthetic (operation only)	93.22	3
02458	Local excision tongue - under general anesthetic	169.58	3
02459	Excision cystic hygroma	560.97	4

Salivary Glands and Ducts

07515	Drainage of abscess; parotid, submaxillary or sublingual (operation only)	207.17	3
07526	Dilation of salivary duct (operation only)	155.82	3
	Excision:		
S00844	Biopsy of salivary gland, fine needle or core needle	55.25	3
07516	Excision or marsupialization of sublingual salivary cyst (ranula) (operation only)	208.16	3
07522	Local excision of parotid tumour- without nerve dissection (operation only)	208.23	3

Laryngeal Endoscopy and Surgery

02412	Biopsy of larynx and/or cauterization (including laryngoscopy) (operation only)	173.28	5
02419	Direct or indirect laryngoscopy with foreign body removal	224.80	5
02423	Micro-laryngoscopy - with removal of non-pedunculated malignancy or extensive submucosal lesion	500.53	5
02428	Micro-laryngoscopy - with biopsy of larynx and/or cauterization	242.62	5
02429	Micro-laryngoscopy and removal of tumour from larynx or trachea	277.27	5
	Microsurgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:		
02430	- first procedure	501.50	6
02435	- subsequent procedure, each	501.50	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	2,732.90	8

		$	Anes. Level
02610	Middle cranial fossa approach without petrosectomy - for trauma, neoplasm resection, nerve section/decompression	1,620.19	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	1,973.42	8
02613	Middle cranial fossa approach – petrosectomy - procedure lasting longer than 8 hours.	2,466.65	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	2,255.92	8
02618	Repair of CSF leak following skull base approach with mastoid obliteration - to include exposure, dissection and closure with microscope.	1,574.84	8
02622	Infra-temporal fossa approach to skull base - Otolaryngology fee.	2,502.20	8
02623	Infra-temporal fossa approach to skull base - Otolaryngology fee for procedure lasting longer than 8 hours.	2,640.56	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	73.82	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.*		
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	120.07	3
	Note: *Not payable with 33341.*		
S00717	Micro-laryngoscopy - procedural fee	147.62	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	56.20	2
SY00907	Endoscopic flexible or rigid examination of the nose and nasopharynx - procedure only	33.81	3
SY00908	- procedure and biopsy	54.09	3
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy	45.30	3
	Notes: *i) 00909 is not payable with 00700, 00701, 00702, 00907, and 00908.* *ii) Payable only to certified Otolaryngologists.*		

		$	Anes. Level
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	1,969.95	6
02281	Conservative radical neck dissection	1,283.62	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	1,080.17	6
02471	Subtotal parotidectomy - with complete facial nerve dissection	861.07	4
02472	Total parotidectomy - with nerve dissection for malignancy or deep lobe tumour	991.49	4
02407	Tracheostomy	398.83	5
	Note: *Not applicable to cricothyrotomy puncture.*		
02411	Laryngectomy total	1,697.50	6
02431	Hemilaryngectomy	1,480.34	6
02432	Supraglottic laryngectomy	1,610.94	6
C02473	Laryngo-pharyngo-oesophagectomy - primary excision only	1,942.99	6
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon	652.31	5
C02474	Transoral maxillectomy with skin graft	1,080.14	5
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy	1,969.95	7
02477	Contralateral suprahyoid dissection	495.75	5
02600	Complete temporal bone resection, ENT fee	2,955.38	8
02601	Temporal bone resection for neoplasm, subtotal and lateral, to include mastoidectomy and excision of external auditory canal	1,845.20	8
02275	Glossectomy - subtotal with either division of mandible or transcervical resection	1,080.11	6
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)	3,688.11	8
	Note: *02280 includes rhinotomy, ethmoidectomy, cribriform plate, and orbital exenteration*		
02478	Glossectomy - partial for carcinoma	378.33	6
C02479	Transpalatal maxillectomy, ethmoidectomy, and sphenoidectomy	1,350.10	6
C02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy	1,350.10	7
Endocrine System			
V07771	Central neck dissection for confirmed and/or potential extrathyroidal metastatic thyroid cancer (with operative report)	1,124.89	5
	Note: *Payable for comprehensive removal of all resectable pathologic tissue between trachea and carotid from the innominate artery (inferiorly) to the hyoid bone superiorly with dissection of recurrent laryngeal nerve.*		

		$	Anes. Level
Mouth – Excision			
	Excision of lesion of tongue with closure anterior 2/3:		
V07789	- with local tongue flap	326.52	3
	Excision, lesion of floor of mouth:		
07790	- benign (operation only)	156.27	3
Head and Neck - Miscellaneous			
V07500	Resection of mandible	411.33	5
CV07725	Maxillectomy	1,037.32	5
V07749	Partial maxillectomy for malignancy - fenestration	829.82	5
V07796	Excision neurogenic neoplasm neck	1,140.95	5
	Diverticulectomy of hypopharynx or oesophagus, with or without myotomy:		
V70545	- cervical approach	548.90	6

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	186.14	
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	93.08	
33014	Prolonged visit for counselling (maximum, four per year)	66.47	
	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	95.67	
33015	- second hour, per 1/2 hour or major portion thereof	47.80	
	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	82.42	
33007	Subsequent office visit	82.51	
33008	Subsequent hospital visit	63.95	
33009	Subsequent home visit	88.71	
33005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	97.15	
	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	186.14	
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	93.08	
33114	Telehealth prolonged visit for counselling (maximum four per year)	66.47	
	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	82.42	
33107	Telehealth subsequent office visit	82.51	
33108	Telehealth subsequent hospital visit	63.95	

		$	Anes. Level
	Telehealth Single chamber permanent programmable pacemaker testing		
33126	- professional fee	47.29	
33153	- technical fee	23.64	
	Telehealth Dual chamber permanent programmable pacemaker testing		
33128	- professional fee	70.93	
33154	- technical fee	47.29	

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	63.82	

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	47.29	
33175	- technical fee	23.64	

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	70.93	
33177	- technical fee	47.29	

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	25.08	
33017	- home, each	34.88	
33018	Electrocardiogram - professional fee	9.01	
Y33025	Cardioversion (operation only)	105.70	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	52.32	
33053	- technical fee	23.64	
	Dual chamber permanent programmable pacemaker testing		
33028	- professional fee	70.93	
33054	- technical fee	47.29	
	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	180.05	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)	467.13	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)	82.49	4
33033	Generator placement and venous cutdown	269.28	4
33034	Graded exercise test (performance and interpretation)	79.42	
33035	- professional fee	47.11	
33036	- technical fee	32.29	
	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 ***Note**: Consultation and necessary hospital visits prior to initial transfusion extra.*	294.36	
	Scanning of 24 hour electrocardiogram:		
33047	- professional fee..	67.63	
33048	- technical fee	25.37	
	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	55.39	

Patient Activated Cardiac Event Recorders

33062	Event/unmonitored loop recorders (first strip) - professional fee	37.03	
33069	- each additional strip (per strip) ***Note:** Additional strips are limited to two extra strips per patient, per two-week period.*	18.51	
33092	Event/unmonitored loop recorder – technical fee ***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.*	44.49	

Intracardiac Electrophysiological Mapping

33066	- initial study	793.76	4
33068	Oesophageal or intra-atrial electro-physiological study	118.65	4

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).*	1,757.48	6
33085	Catheter ablation - AV node ***Note:** To include diagnostic study (33066).*	970.04	4
33086	Catheter ablation of SVT ***Note:** To include diagnostic study (33066).*	1,483.58	4
33087	Catheter ablation of VT ***Note:** To include diagnostic study (33066).*	1,757.48	4
33088	Repeat diagnostic EP study ***Note:** Not normally to be billed for re-check on the same day.*	342.35	4

		$	Anes. Level
	***Note**: Follow-up visits are billable in addition to fee items 33085, 33086, 33087 and 33088.*		
33089	Catheter ablation - assistants fee (per hour)	142.65	
	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.*		

Interventional Cardiology Procedures

S33073	Percutaneous transcatheter cardiac occluder device closure of ASD – for patients over 18 years of age – composite fee	729.89	7
	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.*		
S33074	Percutaneous transcatheter cardiac occluder device closure of PFO - for patients over 18 years of age - composite fee	573.49	7
	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.*		
S33075	Percutaneous balloon valvuloplasty for congenital or rheumatic mitral stenosis (composite fee)	938.43	9
	***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.*		
C33076	Percutaneous balloon valvuloplasty for aortic stenosis (composite fee)……	625.62	
	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%.*		

		$	Anes. Level
33077	Transcatheter edge to edge repair (TEER) – atrioventricular valve	1,789.60	9

Notes:

i) Restricted to Interventional Cardiologists and Cardiac Surgeons.
ii) All diagnostic imaging except echocardiography and CT scan, all necessary left and right heart catheterizations, arterial or venous cannulation, blood sampling, CVP, pressure or gradient measurement, infusion of pharmacological agents, temporary pacing and pacemaker, and percutaneous balloon valvuloplasty are included.
iii) 30 days pre and 48 hours post-operative in hospital visits included.
iv) Cardiac Surgeon (specialty 12) paid under 07917/07920 when assisting.
v) Cardiologist (specialty 26) paid under 00845/00846 when assisting.

33071	Percutaneous endovascular Aortic or Pulmonary Heart Valve Replacement	1,173.05	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 (specifically 12) paid under 07917/07920 when assisting for 33071.
iv) Cardiologist (specifically 26) paid under 00845/6 when assisting 33071.

33072	Percutaneous left atrial appendage closure	920.36	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	296.72
S00947	- professional fee	182.61
S00948	- technical fee	114.11

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	11.36	
	Puncture Procedure for obtaining body fluids (when performed for diagnostic purposes):		
S00751	Pericardial puncture - procedural fee	258.25	3
	Cardio-vascular Diagnostic Procedures – procedural fees:		
S00801	Intra-arterial cannulation - with multiple aspirations - procedural fee	22.60	
S00810	Right heart catheterization, by duly qualified specialist	169.19	4
S00812	Selective angiocardiogram, extra, by duly qualified specialist	56.77	4
S00813	Ergonovine provocative testing for coronary artery spasm	80.93	4
S00814	Dye dilution studies, extra, by duly qualified specialist	56.77	4
S00816	Hydrogen ion study	29.61	2
PS33131	Diagnostic cardiac catheterization	349.16	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	494.19	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	583.44	4
	Notes: *i) Restricted to Cardiologists and Pediatric Cardiologists.* *ii) Includes balloon inflation (angioplasty), stent insertion, and/or diagnostic cardiac catheterization.* *i) Not payable with 33131, 33132 and/or 33134.* *ii) Name of vessel must be provided in the note record.* *iii) When temporary pacemaker insertion is performed in addition, 33030 to be paid at 50%.*		

		$	Anes. Level
S33134	Percutaneous coronary intervention alone	384.02	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	193.28

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	56.77

Cardiology Assist Fees:

00845	For first hour or fraction thereof	175.08
00846	After one hour, for each 15 minutes or fraction thereof	43.78

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 169.20 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 148.61

33093 Level III Echocardiographer Complex Assessment of Previous Echocardiogram (clinical assessment and review, interpretation and written report of submitted echocardiograms) – per patient 258.10

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 130.33

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) 104.16

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 239.76

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 47.78

CLINICAL IMMUNOLOGY AND ALLERGY

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

$

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 207.10

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 215.23
Note: *This code is intended for internal medicine-trained allergists and immunologists when consulting on pediatric patients.*

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 97.15

Continuing care by consultant:

30006 Directive care 96.13
30007 Subsequent office visit 40.94
30008 Subsequent hospital visit 94.08
30005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums) 89.55
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 207.10

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 215.23

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 97.15

		$
30076	Telehealth directive care	96.13
30077	Telehealth subsequent office visit	40.94
30078	Telehealth subsequent hospital visit	94.08

Miscellaneous

30020 Allergy Provocation Testing (delegated) 50.00

Notes:

i) Restricted to Clinical Immunology and Allergy specialists.
ii) May be delegated to trained allied care providers.
iii) Per General Preamble C.20., the Medical Practitioner must be physically present in the office, clinic, or facility where the service is rendered.
iv) Not billable with a consultation or visit.
v) Not billable for aeroallergen subcutaneous immunotherapy (SCIT).

30021 Allergy Provocation Testing (non-delegated) 100.00

Notes:

i) Restricted to Clinical Immunology and Allergy specialists.
ii) Requires direct observation and ongoing evaluation by the physician.
iii) Payable in addition to 30006, 30007, 30008, 30010, 30011, 30012 on the same date of service.
iv) Not payable if a pediatric consultation (00510, 00511, 00550, 00551) or telehealth consultation (50510, 50515, 50516, 50511) has been billed by the same physician within the previous 12 months.
v) Limited to a maximum of 4 per physician per day.
vi) Limited to a maximum of 10 per patient per calendar year.
vii) Not billable for aeroallergen subcutaneous immunotherapy (SCIT).

Tests Performed in a Physician's Office

30015 Secretion smear for eosinophils 7.45

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 236.25

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 113.41

33214 Prolonged visit for counselling (maximum, four per year) 77.25

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 158.16

33215 - second hour, per 1/2 hour or major portion thereof 79.01

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 65.85

33207 Subsequent office visit 78.15

33208 Subsequent hospital visit 40.55

33209 Subsequent home visit 72.35

33205 Emergency visit when specially called 160.31
(not paid in addition to out-of-office-hours premiums)
Note: *Claim must state time service rendered.*

G33260 Initial virtual assessment, with patient or representative/family 132.76

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 33210, 33270, G33260 or 33280, for the same diagnosis.

iv) Not payable in addition to another service on the same day for the same patient by the same practitioner, with the exception of 33255, 33256 or 33257.

G33262 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 66.39

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 payable in addition to another service on the same day for the same

patient by the same practitioner, with the exception of 33255, 33256 or 33257.

		$	Anes. Level
33267	Subsequent virtual office visit, requiring a written individualized report to the Family Physician	43.24	

Notes:
i) Restricted to Endocrinology and Metabolism specialists.
ii) Maximum 12 per calendar year, per patient.
iii) Not payable in addition to another service on the same day for the same patient by the same practitioner, with the exception of 33255, 33256 or 33257.

G33250	Virtual communication with patient, or representative/family, for medically pertinent matters	11.24	

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.

Telehealth Service with Direct Interactive Video Link with the Patient:

33270	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	236.25	
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	113.41	
33276	Telehealth directive care	65.85	
33277	Telehealth subsequent office visit	78.15	
33278	Telehealth subsequent hospital visit	40.55	

Miscellaneous

G33240	Premium for patients 75 years and over, billed in addition to 33210, 33212, 33270, 33272, G33260 or G33262	59.25	

Notes:
i) Restricted to Endocrinology and Metabolism specialists.
ii) Maximum one premium, per patient, per day.

G33241	Premium for patients 75 years and over, billed in addition to 33207, 33209, 33277, 33267, G33250, GY33255, or GY33256	15.91	

Notes:
i) Restricted to Endocrinology and Metabolism specialists.
ii) Maximum one premium, per patient, per day.

GY33255	Diabetes injection medication start (insulin or glucagon-like-peptide receptor agonist)	45.00	

Notes:
i) Payable in addition to endocrinology consultations or visits (33210, 33212, 33280, 33206, 33207, 33208, 33209, G33260, G33262, 33267, 33270, 33272, 33276, 33277, or 33278).
ii) Restricted to Endocrinology and Metabolism specialists.
iii) Maximum of one per day, per patient. Repeats on a different date of service are payable if the patient starts on a new medication/injection device.
iv) Not payable on the same day as GY33256 or 33257.
v) Payable for insulin or glucagon-like-peptide receptor agonist.

		$	Anes. Level
GY33256	Insulin pump start	89.97	

Notes:

i) Payable in addition to endocrinology consultations or visits (33210, 33212, 33280, 33206, 33207, 33208, 33209, G33260, G33262, 33267, 33270, 33272, 33276, 33277 or 33278).

ii) Restricted to Endocrinology and Metabolism specialists.

iii) Maximum one per patient, per day. Repeats on a different date of service are payable if the patient starts on a new insulin pump device but not for a change in medication alone.

iv) Not payable on the same day as GY33255 or 33257.

P33257	Interpretation of insulin pump reports with Continuous Glucose Monitoring (CGM)	30.00	

Notes:

i) This fee is restricted to the Section of Endocrinology and Metabolism.

ii) Applicable for patients utilizing insulin pumps with CGM for management of type 1 or type 2 diabetes.

iii) Not payable in addition to 33255 or 33256.

iv) Payable for physician interpretation, in addition to endocrinology consultations or visits fees (33210, 33212, 33280, 33206, 33207, 33208, 33209, G33260, G33262, 33267, 33270, 33272, 33276, 32277 and 33278).

v) Payable twice per patient in a consecutive 12 month period.

P33280	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 endocrine condition requiring active endocrinologist 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	365.50	

Notes:

i) Restricted to Endocrinology and Metabolism specialists.

ii) This fee is payable to an endocrinologist who accepts the primary responsibility for the endocrine management of a patient transferring from pediatric to adult care, and includes review of all necessary data, including birth and developmental assessments.

iii) Limited to patients between 16 and 25 years of age.

iv) Not payable in addition to another consultation or visit on the same date of service.

v) Limited to one service per patient per lifetime.

Diagnostic - Miscellaneous

S00744	Thyroid biopsy - procedural fee	79.32	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	182.82	
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	101.07	
33314	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.*	56.07	
	Group counselling for groups of two or more patients:		
33313	- first full hour	107.43	
33315	- second hour, per 1/2 hour or major portion thereof	53.97	
	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	81.57	
33307	Subsequent office visit	95.32	
33308	Subsequent hospital visit	51.81	
33309	Subsequent home visit	50.34	
33305	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	114.18	
	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	182.82	
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	101.07	
33366	Telehealth directive care	81.57	
33367	Telehealth subsequent office visit	95.32	
33368	Telehealth subsequent hospital visit	51.81	

		$	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 ***Note:*** *Not payable with 33341.*	119.27	3
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee ***Note:*** *Not payable with 33341.*	120.07	3
S10763	Initial esophageal, gastric or duodenal biopsy ***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%.*	15.15	3
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 ***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.*	44.56	3
SY10750	Transnasal esophagogastroduodenoscopy (TGD), procedural fee ***Note****: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.*	119.27	
	Lower Gastrointestinal System:		
SY00715	Sigmoidoscopy (with biopsy) - procedural fee	38.83	2
SY00718	Sigmoidoscopy, flexible – with biopsy	79.09	2
10708	Video capsule endoscopy using M2A capsule - professional fee: ***Notes:*** *i) Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have ruled out other causes.*	262.44	
Upper Gastrointestinal System – Endoscopy (Surgical)			
S33321	Removal of foreign material causing obstruction, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	151.03	4
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only ***Notes:*** *i) Paid only once per endoscopy.* *ii) Paid only in addition to:* • S10761 or S10762; or • 33341, at 50%	151.18	3

		$	Anes. Level
S33323	Transendoscopic tube, stent or catheter – operation only	151.03	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	150.81	3
	Notes:		
	i) Paid only in addition to S10761 or S10762.		
	ii) Paid only once per endoscopy.		
S33325	Gastric polypectomy, operation only	61.36	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	176.22	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	100.51	3
	Notes:		
	i) Paid only in addition to S10761 or S10762.		
	ii) Paid only once per endoscopy.		
S33328	Esophageal dilation, blind bouginage, operation only	100.58	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	151.10	3
	Note: *Repeats within one month paid at 100%.*		
07528	Placement of gastroesophageal venous compression balloon (e.g.: Minnesota or Blakemore) operation only	206.68	5
	Notes:		
	i) Paid at 100% with 00081.		
	ii) Paid in addition to S10761 or S10762.		
	iii) Paid only once per endoscopy.		
V33330	Per Oral Endoscopic Myotomy (POEM) under general anesthesia	900.00	6
	Notes:		
	i) Payable with 07001.		
	ii) Not payable with 07003 or 10761.		
S33335	SBE or DBE (balloon assisted) enteroscopy	309.09	3
	Notes:		
	iii) Not paid with 10761, 33373, or 33374.		
	iv) Examination of the terminal ileum using a SBE/DBE is not billable under this fee item.		
	v) Billable only by specialist who are credentialed to bill fee item 10708.		
	The following fees are only paid in addition to S33335:		
S33336	- with biopsy (single or multiple) – extra	29.36	
S33337	- removal of polyp – extra	51.52	
S33338	- each additional polyp (maximum of 10) – extra	12.36	
S33339	- with fulguration or coagulation, by any means of one or more lesions – extra	41.21	

		$	Anes. Level

Endoscopic Retrograde Cholangiopancreatography (ERCP)

PV33341	Endoscopic Retrograde Cholangiopancreatography (ERCP), inclusive of sphincterotomy and biopsies or brushings	400.00	3
	***Notes**:* *i) Includes 10761 and 10762.* *ii) 33322 payable at 50%.*		
P33342	- with stone extraction (extra)	110.00	3
	***Note:** 00994 is not payable.*		
P33343	- with balloon dilation of ampullary/biliary/pancreatic stricture, biliary/pancreatic stenting or nasobiliary drainage tube (extra)	110.00	3
P33345	- with intraductal lithotripsy (extra)	110.00	3
	***Note:** 00994 is not payable.*		
T33348	- with cholangioscopy or pancreatoscopy, inclusive of guided biopsies (extra)	200.00	3
P33347	Replacement of a duodenal biliary stent (extra)	110.00	3

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)	157.47
	***Note:** Includes mucosal biopsy.*	
10740	Upper GI endoscopy utilizing radial ultrasound	262.44
10741	Upper GI endoscopy utilizing linear ultrasound	262.44
	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	52.49
	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	157.47
	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	209.97
	***Note**: Payable with 10740 or 10741 only.*	

Diagnostic – Miscellaneous

S00809	Retrograde pancreatography	221.44	3

		$	Anes. Level
Miscellaneous			
	Colonoscopy with flexible colonoscope:		
S33373	- biopsy	240.47	2
33374	- removal polyp	287.87	2
07375	Complex polypectomy (extra)	178.96	

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%.

33394	Assistant fee for PEG procedure	176.14	

Note: *33326, 33394 may be billed by any qualified physician.*

GENERAL INTERNAL MEDICINE

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

		$	Anes. Level

Referred Cases

32210 **Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report 250.60

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 137.76

PG32312 **Complex Consultation** - 2 medical conditions. 274.49

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 2 of the conditions listed in note iv) below.

iv) Payable for patients that have 2 of the following listed chronic diseases (if patient has more than 2 diagnoses from the list, use 00311). (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
00311	**Complex Consultation** - 3 medical conditions	298.37	

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)

Continuing care by consultant:

32206	Directive care	112.83	
32207	Subsequent office visit	99.33	
PG32317	Subsequent follow-up office visit, complex patient – 2 medical conditions	109.55	

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 for patients where the physician is actively managing 2 of the conditions listed in note iv) under fee item 32312. The condition must be noted at the time of each visit and documented in the patient's chart.

		$	Anes. Level
PG32307	Subsequent follow-up office visit, complex patient – 3 medical conditions	119.78	

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 for patients where the physician is actively managing 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	80.99	
PG32318	Subsequent hospital visit, complex patient – 2 medical conditions	85.94	

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 for patients where the physician is actively managing 2 of the conditions listed in note iv) under fee item 32312. The condition must be noted at the time of each visit and documented in the patient's chart.

iii) Payable only for an admitted patient.

PG32308	Subsequent hospital visit, complex patient – 3 medical conditions	94.86	

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 for patients where the physician is actively managing 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.

iii) Payable only for an admitted patient.

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

32370	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	250.60	
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	137.76	
P32373	Telehealth Complex Consultation - 2 medical conditions	274.49	

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 2 of the conditions listed in note iv) below.

iv) Payable for patients that have 2 of the following listed chronic diseases (if patient has more than 2 diagnoses from the list, use 00311). (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
32271	Telehealth Complex Consultation - 3 medical conditions	298.37	

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
32376	Telehealth directive care	112.83	
32377	Telehealth Subsequent office visit	99.33	
P32366	Telehealth subsequent follow-up office visit, complex patient – 2 medical conditions	109.55	

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 for patients where the physician is actively managing 2 of the conditions listed in note iv) under fee item 32312. The condition must be noted at the time of each visit and documented in the patient's chart.

PG32367	Telehealth subsequent follow-up office visit, complex patient – 3 medical conditions	119.78	

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 for patients where the physician is actively managing 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	80.99	

Examinations by Certified Internist

00322	Internists' part in cardioangiogram, per hour or fraction thereof	51.17	

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	294.36	

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)	5.11	
00344	- professional fee	2.56	
00345	- technical fee	2.56	
33032	Pacemaker standby and/or placement of the endocardial catheter (operation only)	82.49	4
33033	Generator placement and venous cutdown	269.28	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	347.74	
01421	2nd to 7th day (inclusive) per diem	174.38	
01431	8th to 30th day	133.01	
01441	31st day onward	138.53	

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	326.60	
01422	2nd to 7th day (inclusive) per diem	174.65	
01432	8th to 30th day	134.95	
01442	31st day onward	130.11	

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.

01413	1st day	519.02	
01423	2nd to 7th day (inclusive) per diem	262.42	

		$	Anes. Level
01433	8th to 30th day	145.33	
01443	31st day onwards	151.15	

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	26.63
00018	Autologous ascitic infusion	52.61

Blood Transfusions

00021	Administered in hospital	40.79

Dialysis Fees

Acute renal failure

Peritoneal dialysis:

33756 Reinsertion of peritoneal catheter after 10 days from initial insertion 53.40

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.

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 207.87

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).

		$	Anes. Level
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 ***Note**: This service is not payable more than once every 7 days.*	121.91	
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 ***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.*	74.17	

Diagnostic Procedures

Cardio-vascular Diagnostic Procedures – procedural fee

S00839	Direct intracoronary streptokinase thrombolysis ***Note:** When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).*	395.89	4

Pulmonary Investigative and Function Studies

S00930	Peak expiratory flow rate ***Note:** Fee item 00930 payable when performed in physicians' office (not restricted to an accredited facility).*	6.22	

Diagnostic Procedures:

S00928	Simple screening spirometry with FVC, FEV(i), and FEV(i)/FVC ratio using a portable apparatus without bronchodilators	13.79	
S00929	Simple screening spirometry as above but before and after bronchodilators	20.78	

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	22.86	
S00959	- technical fee	33.69	
	Precipitin tests-one or more antigens:		
S00970	- professional fee	12.44	
S00971	- technical fee	30.17	

		$	Anes. Level
Puncture Procedures for Obtaining Body Fluids			
(when performed for diagnostic purposes)			
S00753	Marrow aspiration - procedural fee	44.76	2
S00755	Artery puncture - procedural fee	7.15	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	103.74	2
Miscellaneous			
00319	Insertion of central catheter for total parenteral nutrition (operation only)	63.36	2

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.....214.73

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.....124.21

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 323.19

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 130.27

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.....323.19

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.....130.27

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.....295.89

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 158.32

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) 54.42

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 101.71

33415 - second hour, per 1/2 hour or major portion thereof.....50.80

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.....61.61

33446 Comprehensive or complex directive care 76.85

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 or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months.

iii) See 33401 note i) or 33403 note i) for billing criteria.

33407 Subsequent office visit.....76.76

33447 Comprehensive or complex subsequent office visit 92.20

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 or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months.

iii) See 33401 note i) or 33403 note i) for billing criteria.

33408 Subsequent hospital visit.....47.49

33448 Comprehensive or complex subsequent hospital visit 47.49

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 or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months.

iii) See 33401 note i) or 33403 note i) for billing criteria.

		$
33409	Subsequent home visit	207.02
33405	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	158.57

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	214.73
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	124.21
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	323.19

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	130.27

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	323.19

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.....130.27

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... .....295.89

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

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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 158.32

Notes:

i) Payable only for Geriatric Medicine specialists.

ii) See 33423 note ii) for billing criteria.

33476 Telehealth directive care 61.61

33426 Telehealth Comprehensive or complex directive care 76.85

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 or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months.

iii) See 33401 note i) or 33403 note i) for billing criteria.

33477 Telehealth subsequent office visit 76.76

33427 Telehealth Comprehensive or complex subsequent office visit 92.20

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 or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months.

iii) See 33401 note i) or 33403 note i) for billing criteria.

33478 Telehealth subsequent hospital visit 47.49

33428 Telehealth Comprehensive or complex subsequent hospital visit 47.48

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 or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months.

iii) See 33401 note i) or 33403 note i) for billing criteria.

Miscellaneous

G33445 Geriatric Care Conference (planning for patient) - per 15 minutes, or greater portion thereof..... 53.65

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.....47.01

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 six per patient, per sitting.
v) Annual maximum of eighteen per patient.
vi) The results of the conference, as well as the roles/relationships 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	199.86	
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	90.67	
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	307.09	

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.*

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	155.44	

Notes:

i) Restricted to Hematology and Oncology.

ii) Payable for complex patients (see notes for Complex Consultation – 33520).

33514	Prolonged visit for counselling (maximum, four per year)	80.67	

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
	Group counselling for groups of two or more patients:		
33513	- first full hour	116.33	
33515	- second hour, per 1/2 hour or major portion thereof	58.13	
	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	94.05	
33526	Directive care, Complex Patient	133.26	
	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	76.95	
33527	Subsequent Office Visit, Complex Patient	135.92	
	Notes: *i) Restricted to Hematology and Oncology. ii) Payable for complex patients (see notes for Complex Consultation 33520). vi) 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	69.66	
33509	Subsequent home visit	53.22	
33505	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums)	161.40	
	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	199.86	
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	90.67	
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	307.09	
	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.*

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 155.44

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.

33546 Telehealth Directive care, Complex Patient 133.26

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 76.95

33547 Telehealth Subsequent Office Visit, Complex Patient.....135.92

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 204.17

Diagnostic Procedures - Needle Biopsy Procedures

S00748 Bone biopsy under local/regional anesthetic 73.17

Puncture Procedure for obtaining body fluids (when performed for diagnostic purposes)

S00753 Marrow aspiration - procedural fee.....44.76 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.....207.87

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 121.91

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 74.17

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	236.39	
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	125.46	
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	342.87	
	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) ***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.*	57.22	
	Group counselling for groups of two or more patients:		
33613	- first full hour	117.23	
33615	- second hour, per 1/2 hour or major portion thereof	58.58	
	Note: *Start and end times must be entered in both the billing claims and the patient's chart.*		
	Continuing care by consultant:		
33606	Directive care	85.72	
33607	Subsequent office visit	79.35	
33608	Subsequent hospital visit	42.62	
33609	Subsequent home visit	53.60	
33605	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	118.79	

		$	Anes. Level
33645	Infectious Disease Care Management of HIV/AIDS - per half hour or major portion thereof	104.68	

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	236.39	

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	125.46	
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	342.87	

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	85.72	
33637	Telehealth subsequent office visit	79.35	
33638	Telehealth subsequent hospital visit	42.62	
33635	Telehealth Infectious Disease Care Management of HIV/AIDS – per half hour or major portion thereof	104.68	

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.

		$	Anes. Level

Miscellaneous

G33655	Home Parenteral Antibiotic Management Fee, for active antibiotic treatment only	19.20	

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)	59.26	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	61.83	2

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

S00753	Marrow aspiration - procedural fee	44.76	2
SY00757	Joint aspiration - procedural fee (not in addition to Y00014 or Y00015) - other joints	16.54	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	103.74	2
S00760	- (abdominal) - procedural fee	27.29	2

Needle biopsy Procedures

S00749	Parietal pleural, including thoracentesis - procedural fee	136.23	2

Allergy, patch and photopatch tests

S00764	Intracutaneous test, per test	2.20	

Orthopaedic Diagnostic Procedures

Elbow, Proximal Radius and Ulna

Incision - Diagnostic, Percutaneous:

S11302	Aspiration - bursa, tendon sheath.	23.76	2

		$	Anes. Level
	Hand and Wrist		
	Incision - Diagnostic, Percutaneous:		
S11402	Aspiration bursa, synovial sheath, etc.	23.76	2
	Pelvis, Hip and Femur		
	Incision - Diagnostic, Percutaneous:		
S11501	Aspiration hip joint	23.76	2
S11502	Aspiration bursa, tendon sheath.	11.90	2
	Femur, Knee Joint, Tibia and Fibula		
	Incision - Diagnostic, Percutaneous:		
S11602	Aspiration bursa, tendon sheath or other periarticular structures	23.76	2
	Tests Performed in a Physician's Office		
15136	Fungus, direct microscopic examination, KOH preparation	8.57	

INTERNAL MEDICINE

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

		$	Anes. Level
Internal Medicine:			
00310	**Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	192.59	
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	90.73	
00314	Prolonged visit for counselling (maximum, four per year)	61.77	
	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:		
00313	- first full hour	126.50	
00315	- second hour, per 1/2 hour or major portion thereof	63.22	
	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	80.51	
00307	Subsequent office visit	59.92	
00308	Subsequent hospital visit	52.82	
00309	Subsequent home visit	57.87	
00305	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	128.24	
	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	192.60	
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	90.73	
32276	Telehealth directive care	80.51	
32277	Telehealth subsequent office visit	58.80	
32278	Telehealth subsequent hospital visit	51.83	

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	198.18	
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	87.54	
33714	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.*	53.33	
	Group counselling for groups of two or more patients:		
33713	- first full hour	109.19	
33715	- second hour, per 1/2 hour or major portion thereof	54.57	
	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	61.53	
33707	Subsequent office visit	87.54	
33708	Subsequent hospital visit	49.41	
33709	Subsequent home visit	49.95	
33705	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	110.71	
	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 ***Note:*** *Restricted to FRCP Nephrology Physicians.*	198.18	
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	87.54	
33736	Telehealth directive care	61.53	
33737	Telehealth subsequent office visit	87.54	
33738	Telehealth subsequent hospital visit	49.41	

		$	Anes. Level

Dialysis Fees

(A) Acute renal failure

a) Hemodialysis:

33750 Blood dialysis - physician in charge 543.29

33751 Repeat blood dialysis - physician in charge 204.17

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 ..... 137.35

b) Peritoneal dialysis:

33756 Reinsertion of peritoneal catheter after 10 days from initial insertion 53.40

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 53.40

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 406.46

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..... 53.40

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 64.56

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	1,208.89	
77380	Insertion permanent peritoneal catheter; (procedure fee only)	194.99	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.*	135.25	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	182.51
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	91.81
	Continuing care by consultant:	
33907	Subsequent office visit	56.86

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 243.29

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 131.73

32014 Prolonged visit for counselling (maximum four per year) 101.81

***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 98.14

32007 Subsequent office visit 96.32

32008 Subsequent hospital visit 107.44

32005 Emergency visit when specially called 131.62
(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 75.17

Notes:

i) Restricted to Respiratory Medicine specialists who provide care in the following types of clinics or areas:
- *Adult Cystic Fibrosis: St. Paul's and Royal Jubilee Hospital*
- *Interstitial Lung Disease*
- *Severe Asthma*
- *Lung Transplant (includes pre and post lung transplant assessment)*
- *Pulmonary Hypertension: Vancouver General and Saint Paul's.*
- *Neuromuscular Disease not including solely obesity.*

ii) Physicians should have additional training/expertise in the specific area of care.

iii) Physicians must provide multidisciplinary care and/or be involved in active research in one of the above conditions.

iv) Care for the above conditions must be organized into a dedicated clinic for the above conditions to act as a resource for other respirologists.

v) Maximum of 7 hours per day, per physician.

vi) 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.

vii) Includes time spent in multidisciplinary case conferencing and teleconferencing with other health care providers and/or patients.

viii) A written consultation report is required for each patient seen in the clinic.

ix) Start and end times must be included on claims.

x) Paid to a maximum of one service per patient per visit.

		$	Anes. Level
	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	243.29	
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	131.73	
32114	Telehealth prolonged visit for counselling (maximum four per year)	101.81	
	***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.*		
32106	Telehealth directive care	98.14	
32107	Telehealth subsequent office visit	96.32	
32108	Telehealth subsequent hospital visit	107.44	

Diagnostic Therapeutic Procedures

S32031	Closed drainage of chest– operation only	144.53	4
10320	Insertion of permanent pleural drainage catheter	242.68	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	86.51	2
	***Note**: Not paid with S32031, 00749, 00759, 07924 and 08646.*		

Diagnostic procedures involving visualization by instrumentation

S00700	Bronchoscopy or bronchofibroscopy - procedural fee	138.87	4
S00702	Bronchoscopy with biopsy - procedural fee	218.67	6
	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.*		
10702	Endobronchial cryotherapy – extra	80.08	6
	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.*		
10703	Transbronchial needle aspiration (TBNA)	72.47	6
	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.*		

		$	Anes. Level
Diagnostic procedures utilizing radiological equipment			
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	69.68	4
10739	Endobronchial Ultrasound (EBUS)	399.81	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	42.72	
S00817	- technical fee	15.59	
	Polysomnogram:		
	Overnight home oximetry (continuous recording of oxygen and pulse)		
S00910	- professional fee	29.48	
S00911	- technical fee	16.64	
	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	174.28	
S11916	Polysomnography, standard – technical fee	402.47	
S11919	Multiple Sleep Latency Test (MSLT) - professional fee	87.04	
S11920	Multiple Sleep Latency Test (MSLT) - technical fee	201.24	
S11925	Four channel home polysomnography – professional fee	86.94	
S11926	Four channel home polysomnography – technical fee	87.21	
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	13.79	
S00929	Simple screening spirometry as above but before and after bronchodilators	20.78	
	Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume:		
S00931	- professional fee	17.28	
S00932	- technical fee	14.75	
	Spirometry - forced expiratory spirogram to include FVC, FEV(i) and FEV(i)/FVC ratio, MMEFR, etc.		
S00933	- without bronchodilators - professional fee	13.21	
S00934	- without bronchodilators - technical fee	12.48	
S00935	- before and after bronchodilators - professional fee	15.24	
S00936	- before and after bronchodilators- technical fee	14.86	

		$	Anes. Level
	Spirometry - flow volume loops:		
S00937	- without bronchodilators - professional fee	13.21	
S00938	- without bronchodilators - technical fee	18.93	
S00940	- before and after bronchodilators - professional fee	15.76	
S00941	- before and after bronchodilators - technical fee	28.00	
	Diffusion Studies with Carbon Monoxide:		
S00942	- at rest or exercise - professional fee	17.04	
S00943	- technical fee	13.38	

Detailed Pulmonary Function Studies:

S00945	- professional fee (includes 00931, 00935 and 00942)	44.29	
S00946	- technical fee (includes 00932, 00936 and 00943)	41.90	

***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	27.03	
S00951	- technical fee	33.89	
	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	98.64	
S00955	- technical fee	61.41	
	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	114.33	
S00957	- technical fee	73.13	

Miscellaneous Pulmonary Tests:

S11960	Oximetry at rest, with or without oxygen - professional fee	6.22	
S11961	- technical fee	5.30	
S11962	Oximetry at rest and exercise, with or without oxygen - professional fee	12.54	
S11963	- technical fee	16.59	
	Plethysmography and airway resistance:		
S00964	- professional fee	14.74	
S00965	- technical fee	28.00	
	Inhalation challenge - assessed by serial flow measurements, per day:		
S00968	- professional fee	42.20	
S00969	- technical fee	37.85	

***Note:** For fee items 00968 and 00969, serial spirometric measurement before and after inhalation of pharmacologic agents or agents encountered in working environment or antigen exposure for the diagnosis of Asthma. The*

		$	Anes. Level
	protocols/agents used as described for but not limited to the standardized agents of Methacholine, Histamine, Mannitol. For Occupational / Asthma antigen challenge to include peak expiratory flow rate recording hourly x 8 hours following exposure.		
	Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:		
SY11964	- professional fee	21.40	
SY11965	- technical fee	46.13	
	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	21.30	
S00973	- technical fee	11.54	
	Inspiratory and expiratory muscle strength:		
S00974	- professional fee	16.77	
S00975	- technical fee	13.23	

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 262.86

G31050 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 345.61

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) One of either 31050 or 31150 is payable per patient within six months of the last visit.

iv) Start and end times must be recorded on claim and in the patient's chart.

v) 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 154.32

31014 Prolonged visit for counselling (maximum, four per year) 50.17

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
P31027	Extended subsequent office visit – exceeding 30 minutes (at least 25 minutes spent with patient)	130.00	

Notes:

i) Applicable to patients with chronic and complex medical needs.
ii) Includes review of extensive documentation regarding the patient.
iii) Payment not contingent on whether or not 31050 or 31150 was billed within the preceding six months.
iv) For time spent with the patient, start and end times must be submitted with claim and recorded in the patient's chart.
v) 31015 and 31055 not payable in addition.

P31037	Complex multi-system/multi-organ subsequent office visit	120.00	

Notes:

i) Applicable for patients with complex inflammatory or autoimmune diseases involving active management by the rheumatologist of at least two or more systems or organs in order to minimize potential adverse effects while treating them simultaneously.
ii) Includes review of extensive documentation regarding the patient.
iii) Payment not contingent on whether or not 31050 or 31150 was billed within the preceding six months.
iv) 31037 and 31137 are limited to a maximum of two per patient within a 12-month period.
v) Not to be billed for additional unrelated joint pain, osteoarthritis, or chronic pain.

P31127	Telehealth extended subsequent office visit – exceeding 30 minutes (at least 25 minutes spent with patient)	130.00	

Notes:

i) Applicable to patients with chronic and complex medical needs.
ii) Includes review of extensive documentation regarding the patient.
iii) Payment not contingent on whether or not 31050 or 31150 was billed within the preceding six months.
iv) For time spent with the patient, start and end times must be submitted with claim and recorded in the patient's chart.
v) 31015 and 31055 not payable in addition.

P31137	Telehealth complex multi-system/multi-organ subsequent office visit	120.00	

Notes:

i) Applicable for patients with complex inflammatory or autoimmune diseases involving active management by the rheumatologist of at least two or more systems or organs in order to minimize potential adverse effects while treating them simultaneously.
ii) Includes review of extensive documentation regarding the patient.
iii) Payment not contingent on whether or not 31050 or 31150 was billed within the preceding six months.
iv) 31037 and 31137 are limited to a maximum of two per patient within a 12-month period.
v) Not to be billed for additional unrelated joint pain, osteoarthritis, or chronic pain.

<u>Continuing care by consultant:</u>

31006	Directive care	107.27	
31007	Subsequent office visit	101.00	
31008	Subsequent hospital visit	52.73	
31005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	99.41	

Note: *Claim must state time service rendered.*

		$	Anes. Level
31015	Rheumatology Management of Complex Joint(s) requiring Aspiration and/or Injection	30.50	

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.
v) Payable in addition to an in person visit, except for 31027.

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	262.86	
31150	Telehealth 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	345.61	

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 Entheospathy (720.1), Sacroiliitis, not Elsewhere Classified (720.2), Other Inflammatory Spodylopathies (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) One of either 31050 or 31150 is payable per patient within six months of the last visit.
iv) Not paid when there is no change in condition from previous assessment.
v) Start and end times must be recorded on claim and in the patient's chart.

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	154.32	
31106	Telehealth directive care	107.27	
31107	Telehealth subsequent office visit	101.00	
31108	Telehealth subsequent hospital visit	52.73	

		$	Anes. Level

Miscellaneous

G31055 Rheumatology Immunosuppressant Review 32.00

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.
vii) Payable in addition to a visit, except for 31027 or 31127.

G31060 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 232.79

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 inflammatory disease.
v) Maximum one per patient in 6 month period.
vi) Not payable in addition to a consultation or visit fee.
Service may be provided in person or using telephone or video technology.

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 204.82

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 144.85

G00450 Complex Care - Extended Consultation - per 15 minutes or major portion thereof 70.64

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.

P00452 Neurology in-hospital consultation - extra 75.00

Notes:

i) Not for patients seen within the last 6 months by the same physician for the same or related condition.
ii) Payable in addition to 00410, 00441, 00485 and 40441.
iii) Not payable for hospital outpatients, or for patients located in transient ischemic attack (TIA) or rapid access neurology clinics.
iv) Daily maximum of 5 claims per day per Neurologist.

G00460 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 416.61

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.

P00493 Pediatric neurology developmental assessment 40.00

Notes:

i) Restricted to Pediatric Neurologists.
ii) Must include completion of standardized developmental assessment scales including motor, fine motor, communication, cognitive and behavioural development.
iii) Payable once per patient in a 12-month period.
iv) Limited to 24 assessments per practitioner per month.
v) Payable only in addition to a consult or visit.

		$	Anes. Level
	Continuing care by consultant:		
00406	Directive care	151.45	
00407	Subsequent office visit	112.44	
00408	Subsequent hospital visit	146.43	
00409	Subsequent home visit	97.16	
00405	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	130.18	
00457	Complex Care – Extended Visit- per 15 minutes or major portion thereof ***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.*	68.65	
P00440	Neurologic review and written care plan ***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) If billed within 6 months of a 00410, 00470, 00440, 00441, 00485 or 40441 for the same diagnosis, the medical necessity must be provided in the note record.* *iv) Not payable in addition to a consultation or visit.* *v) Not payable with 00487, 00488, 00491, 00492, 00900, 00901, or 00902 by the same practitioner on the same date of service.* *vi) Limited to 20 virtual assessments per practitioner per month.*	122.66	
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.*	240.24	
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.*	116.59	

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.

		$	Anes. Level
00443	Face-to-face follow-up neurological clinical monitoring and treatment for persisting ACVS: with administration of tPA, per ½ hour or major portion thereof	116.59	

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.
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.

00444	Face-to-face follow-up ACVS relapse intervention, per ½ hour or major portion thereof	116.59	

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	233.17	

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.

		$	Anes. Level
00486	Face-to-face assessment for acute deterioration in status of an MS patient – each additional half hour or major portion thereof	123.78	

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	97.96	

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.

00488	Detailed cognitive assessment - extra	97.96	

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) Payable only in addition to a consult or visit.
vii) Not payable in addition to 00440.

00491	Detailed Parkinson's disease quantitative review for neurologists with a Movement Disorder (MD) fellowship – extra	97.97	

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	97.97	

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.

		$	Anes. Level
	Telehealth Service with Direct Interactive Video Link with the Patient:		
00470	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	204.82	
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	144.85	
00476	Telehealth directive care	151.45	
00477	Telehealth subsequent office visit	112.44	
00478	Telehealth subsequent hospital visit	146.43	

Telestroke Services

40441 Telestroke Consultation ……..... .....240.24
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…….....116.59

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 116.59

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	116.59	

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

P00416	Electroencephalogram – under 2-hour study – professional fee	110.00
P00413	Electroencephalogram - technical fee	80.41
	Note: *Payable only in addition to 00416, P00433, P00436, P00438, and P00439.*	
00417	Electrocorticography	246.29
00419	Electroclinical detailed interpretation of a set of seizures	434.71
00420	Short study of electroclinical interpretation of seizures - professional component	223.84
00421	Electrocorticography with functional mapping in awake craniotomy	530.75
P00433	Electroencephalogram with video monitoring, 2-12 hour study – professional	200.00
	Note: *00416 not payable in addition.*	
P00436	Ambulatory electroencephalogram, one day (minimum 20-hour study) – professional fee	275.00
P00438	Ambulatory electroencephalogram, two days (minimum 44-hour study) – professional fee	385.00
P00439	Ambulatory electroencephalogram, three days (minimum 68-hour study) – professional fee	495.00

		$	Anes. Level
Miscellaneous			
00424	Botulinum Toxin Injections ***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.*	127.53	2
00480	DMT (Disease Modifying Treatment) management for active inflammatory disease of the Central Nervous System (CNS) ***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 alone or if billed in addition to face-to-face services, telehealth 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.*	173.85	
P00481	DMT (Disease Modifying Treatment) management for active inflammatory disease of Peripheral Nervous System (PNS) ***Notes:*** *i) Payable every 6 months to prescribing Neurologists responsible for continuing care of patients with active PNS 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 alone or if billed in addition to face-to-face services, telehealth services, and physician-to physician phone calls.* *iv) Includes organization of all treatment plans, drug initiation algorithms, medication review 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) Payable to a maximum of 50 services per physician per calendar year.*	99.76	
G00462	Neurological interpretation and written report of submitted X-ray films (including CT scan, TCD, MRI) – per case ***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.*	56.33	

		$	Anes. Level

Doppler Ultrasound

G00468	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	127.57	

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.

G00469	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	31.88	

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

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)	130.77	
S00901	Schedule B - limited examination (four to seven items)	87.47	
S00902	Schedule C - short examination (one to three items)	43.59	
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests	61.58	
S00923	Technical fee for electrodiagnostic testing	20.85	
S00905	Daily measurements of nerve conduction thresholds in facial palsy	6.81	
S00906	- maximum per course	47.39	
S00915	Intra-carotid injection of sodium amytal, speech localization test	105.19	2
S00927	Decamethonium test - for attendance at, and follow-up observation if necessary	36.24	

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	185.26	
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	81.91	
	Continuing care by consultant:		
03007	Subsequent office visit	69.63	
03008	Subsequent hospital visit	32.27	
03009	Subsequent home visit	56.07	
03005	Emergency visit when specially called (not paid in addition to out-of-hours premiums) ***Note:*** *Claim must state time service rendered.*	115.49	
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.*	185.26	
	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	185.26	
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	81.91	
03317	Telehealth subsequent office visit	69.63	
03318	Telehealth subsequent hospital visit	32.27	
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.*	61.83	2

		$	Anes. Level
Miscellaneous			
03211	Muscle biopsy	88.80	2
S03216	Puncture of ventricular shunt for CSF aspiration (operation only)	37.02	2
S03217	Percutaneous ventricular puncture (operation only)	132.29	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.*	64.21	
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)	145.51	6
03111	Elevation of simple depressed skull fracture	746.49	5
03112	Elevation of compound depressed skull fracture	1,204.31	6
03113	Elevation of compound depressed skull fracture with repair of dura, debridement of cerebral laceration and sinuses	1,909.97	8
03115	Exploration of subdural space for chronic subdural haematoma - unilateral or bilateral	934.80	6
03116	Craniotomy for evacuation of intracranial haematoma (cerebral, subdural, extra-dural or abscess)	1,828.48	8
03118	Craniotomy for repair of CSF leak	1,648.65	8
03126	Re-opening or removal of bone flap	708.95	6
S03165	Insertion of intracranial pressure monitoring device - operation only	302.81	6
Cerebrovascular			
03141	Cerebral re-vascularization procedure with extracranial-intracranial anastomosis	2,272.47	9
03142	Application of Silverstone clamps (operation only)	574.37	5
03136	Craniotomy for intracranial aneurysm or angioma	3,096.71	9
03119	Craniotomy for microvascular decompression of cranial nerve	2,044.77	8
Neuro-oncology			
03129	Craniotomy for tumour	1,820.27	8
03114	Craniotomy and microsurgical removal of tumour of ventricle, brain stem, thalamus, hypothalamus, or basal ganglia	2,975.29	
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.*	4,591.91	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.*	4,013.39	9

		$	Anes. Level
03222	Craniotomy lasting more than 12 hours and requiring operating microscope	5,458.58	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	197.53	
	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	2,975.29	8
03128	Stereotactic biopsy for intracranial pathology via frame-based or frameless techniques	1,508.01	7
	Note: *Fee item 03189 is not payable in addition.*		
03320	Removal of skull tumour without craniectomy	428.25	6
03131	Transsphenoidal removal of pituitary tumour or hypophysectomy - one surgeon	2,272.76	8
03132	- two surgeons - neurosurgeon	2,065.68	8
02437	- otolaryngologist	1,261.67	8
03189	Stereotactic localization during neurosurgery in association with craniotomy and spinal fusion/stabilization procedures – extra	524.01	
	Note: *Applicable to procedures involving cranium or spine.*		

Skull Base

02262	Translabyrinthine approach for neurosurgical access exposure, closure with microscope	2,732.90	8
02610	Middle cranial fossa approach without petrosectomy - for trauma, neoplasm resection, nerve section/decompression	1,620.19	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	1,973.42	8
02613	Middle cranial fossa approach - petrosectomy - procedure lasting longer than 8 hours	2,466.65	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	2,255.92	8
02618	Repair of CSF leak following skull base approaches with mastoid obliteration - to include exposure, dissection and closure with microscope	1,574.84	8

		$	Anes. Level
02622	Infra-temporal fossa approach to skull base - Otolaryngology fee.	2,502.20	8
02623	Infra-temporal fossa approach to skull base - Otolaryngology fee for procedure lasting longer than 8 hours.	2,640.56	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)	1,676.55	7
	Note: *Not billable for exposure only.*		
03224	Neurosurgical component of microsurgical removal of cerebellar pontine angle tumour	1,927.72	8
	Note: *Not billable for exposure only.*		

Pediatric Neurosurgery

03183	Microsurgical repair of meningomyelocele	1,794.21	6
03175	Repair of meningocoele or encephalocoele	1,024.05	6
03095	Posterior decompression of Chiari malformation or foramen magnum - no dural repair	1,787.39	8
03096	- with dural repair	2,119.33	8
03097	- with fourth ventricular exploration	2,374.67	8
03121	Cranioplasty	971.62	7
03145	Cranioplasty using autologous bone graft	1,493.58	7
03122	Craniectomy for osteomyelitis or skull tumour	1,085.42	7
03123	- with cranioplasty	1,527.02	7
03124	Linear craniectomy or craniotomy for cranial stenosis - 1st suture	1,056.23	7
03127	- additional sutures to a maximum of 3 - each extra	259.24	7
	Lateral canthal advancement or similar procedure for coronal synostosis		
03137	- unilateral	1,222.75	8
03143	- bilateral	1,309.31	8
03125	Bilateral craniectomies for cranial expansion or delayed treatment of synostosis (patient must be older than 1 year)	1,956.60	8
03146	Morcellation of skull for craniosynostosis	1,785.02	8
03147	Cranial reconstruction for complex deformity in a child	2,536.48	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	292.31	
03053	Craniotomy for combined plastic surgical/neurosurgical Cranioplasty - neurosurgical component	701.10	8

		$	Anes. Level
03120	Neurosurgical fee for facial craniotomy reconstruction	1,377.82	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	2,285.82	8
03080	Neurosurgery portion	2,285.82	8
	Unilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61381	Plastic Surgery portion	2,120.57	8
03081	Neurosurgery portion	2,120.57	8
	Bilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61382	Plastic Surgery portion	2,836.39	8
03082	Neurosurgery portion	2,836.39	8

Endoscopy/Hydrocephalus

03181	Shunt for ventricular obstruction	1,034.19	6
03182	- revision	1,034.19	6
03184	Lumbar peritoneal shunt for hydrocephalus.	1,034.19	5
S03188	Ventriculostomy or insertion of external ventricular drain (operation only)	347.12	6
S03240	Implantation of totally implantable ventricular access device (e.g.: Ommaya reservoir) - (operation only)	478.40	6

Note: *03240 not to be used for external ventricular drain.*

03036	Ventricular shunt with ventriculoscopic guidance	1,099.19	6
S03037	Removal of ventricular shunt (operation only)…	294.67	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……	421.85	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	859.75	6
03031	Ventriculoscopy, third ventriculostomy	1,354.69	6
03032	Ventriculoscopy/endoscopy biopsy of intraventricular or intracranial lesion	1,952.87	6
03033	Ventriculoscopic retrieval of foreign body	1,675.93	6
03034	Ventriculoscopy and fenestration of cyst or septum pellucidum, or lysis of adhesions	1,508.83	
03035	Ventriculoscopic resection of intraventricular tumour	2,635.25	6

Epilepsy

03055	Craniotomy with microsurgical cortical resection for epilepsy - under general anesthetic	2,530.40	8
03056	- awake patient	3,322.75	8
03057	Craniotomy with cortical resection for epilepsy	2,198.12	8
03058	Hemispherectomy	2,490.75	8
03059	Craniotomy and microsurgical hemispherotomy for epilepsy	2,651.59	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	2,306.18	8
03221	Implantation of vagal nerve stimulator – to include electrodes and stimulator	639.86	4
03223	Replacement of stimulator component of vagal nerve stimulator	270.20	3
03225	Removal of vagal nerve stimulator and electrodes	476.59	4
03235	Intraoperative cortical localization SSEP or stimulation studies G.A. (extra to craniotomy)	284.02	
03236	Insertion of subdural strip electrodes - unilateral [epilepsy surgery, to include burrhole(s)]	1,123.89	8
03237	Removal of subdural strip electrodes - unilateral	481.67	6
03238	Cortical or deep brain localization with SEEP or stimulation in an awake patient (extra to craniotomy)	481.67	
03239	Craniotomy and insertion of subdural grid electrodes with or without additional strip electrodes – unilateral	1,498.38	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	807.04	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	95.07	2

Excision - Diagnostic, Percutaneous:

S11830	Needle Biopsy - soft tissue/bone, thoracic spine, under GA	219.58	2
S11831	Needle Biopsy - soft tissue/bone, lumbar spine, under GA	190.94	2

		$	Anes. Level
	Excision - Diagnostic, Open:		
11845	Biopsy, with GA	248.23	3
	Note: *Not payable with definitive spinal surgery.*		
	Fracture and/or Dislocation (Cervical Spine):		
	Cervical		
*58710	Application of Halo	190.94	4
03094	Anterior decompressing craniovertebral junction, using operating microscope	3,014.17	8
03155	Laminectomy for haematoma, tumour or vascular malformation	1,331.92	6
03368	Discogram (operation only)	95.07	2
03369	Abscess or hematoma, extraspinal, under GA (operation only)	190.94	4
03361	Percutaneous discectomy	276.87	3
03367	Removal of spinal instrumentation	1,035.38	5
03160	Laminectomy for congenital spinal malformation or tethered spinal cord	2,073.75	5
03168	Laminectomy for intradural spinal cord or extra-medullary tumour or vascular malformation by micro-surgical technique	2,458.37	7
S03167	Insertion of skull tongs (operation only)	129.15	4
03169	Fracture of spine without cord injury - open reduction and fusion	702.27	7
03170	- in conjunction with orthopaedic surgeon (operation only)	663.92	
03172	Fracture of spine with cord injury - open reduction and fusion	958.27	7
03173	- in conjunction with orthopaedic surgeon (operation only)	663.92	
03215	Insertion of spinal subarachnoid catheter (operation only)	47.67	2
03231	Repair of spinal CSF leak or pseudomeningocoele	919.30	5

Cervical

Decompression Procedures

	Laminectomy for cervical disc:		
03156	- one level	2,049.28	6
03157	- multiple levels	2,254.72	6
03180	Multiple level laminectomy for cervical cord compression, 3 or more levels	1,463.12	6
03163	Anterior cervical discectomy and fusion - one level	1,462.23	6
03164	- multiple levels	2,166.60	6
03362	Cervical - single level	639.68	6
03363	Cervical - two or more levels	825.85	6
	Vertebral body resection:		
03365	Cervical	1,670.80	6

Instrumented Procedures

	Stabilization - Anterior		
03347	Cervical - stabilization alone (with Neurosurgeon)	515.54	6
03348	Cervical - with plates and discectomy	1,812.93	6
03349	Cervical - with plates and vertebrectomy	2,066.41	6

		$	Anes. Level
	Stabilization - Posterior		
03340	Cervical - simple, single or multiple level (includes Gallie fusion)	553.74	6
03341	Cervical - segmental (includes C1-2 transarticular screws)	1,112.28	6
	Posterior osteotomy with instrumentation		
03354	Cervical	2,901.00	6
	Cervical		
03358	ORIF	1,031.13	7

Thoracic

Decompression Procedures

03166	Removal of thoracic disc	2,402.61	8
03185	Postero-lateral microsurgical thoracic discectomy	1,958.90	8
03174	Trans-thoracic or trans-abdominal removal of thoracic disc; team procedure - Neurosurgeon	1,267.84	8
03179	- Thoracic or General Surgeon	481.13	8

Thoracolumbar

Decompression Procedures

	Laminectomy for lumbar disc:		
03158	- one level	802.24	5
03159	- multiple levels	1,412.24	5
03161	Laminectomy for localized spinal stenosis (two levels or less)	906.31	5
03162	Laminectomy for generalized spinal stenosis (more than two levels)	1,274.70	5
	Posterior lumbar interspinous/interlaminar stabilization/instrumentation (extra)		
03371	- single level (extra)	206.06	
03372	- multiple level (extra)	412.12	

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	1,475.06	8
	Vertebral body resection:		
03366	Thoracolumbar	1,947.67	8

Instrumented Procedures

	Anterior release/osteotomy:		
03352	Thoracolumbar	1,475.06	8
03353	Thoracolumbar - with anterior instrumentation and correction	1,751.95	8
03351	Thoracolumbar - instrumentation with anterior release or vertebrectomy	2,504.84	8

***Note**: 03350 and 03351 are payable in full when done in conjunction with posterior instrumentation and fusion.*

		$	Anes. Level
	Posterior Instrumentation and Fusion		
03356	Adult	2,083.23	7
03357	Pediatric	1,728.95	7
	Thoracolumbar		
03359	ORIF with segmental fixation alone	1,336.64	7
03360	ORIF with segmental fixation and decompression	1,613.52	7
03342	Thoracolumbar - without instrumentation	501.24	5
03343	Thoracolumbar - simple instrumentation (Harrington or wires or screws, etc.)	792.44	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.*	973.84	8
03344	Thoracolumbar - segmental instrumentation and spinal fusion	1,432.75	7
03345	Thoracolumbar - segmental instrumentation and fusion with decompression - single level	2,104.70	7
03346	Thoracolumbar - segmental instrumentation and fusion with decompression - multiple levels	2,465.86	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.*	3,606.03	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.*	51.93	
	Posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF) (extra)		
03373	single level (extra)	412.12	
03374	multiple level (extra) ***Notes:*** *i) Paid only in addition to 03345, 03346, 03355, 03356 or 03357.* *ii) Restricted to Neurosurgery and Orthopaedic surgeons.*	618.18	

Functional Neurosurgery/Pain

03301	Laminotomy for insertion of spinal stimulator electrode for chronic pain (operation only)	575.08	5
03302	Percutaneous fluoroscopically controlled insertion of spinal stimulator electrode for chronic pain (operation only) ***Note:** Restricted to Neurosurgeons and certified specialists in Anesthesiology.*	422.69	2

		$	Anes. Level
03303	Implantation of pulse generator or receiver for chronic pain stimulation (operation only)	720.94	3
	***Note**: Restricted to Neurosurgeons and certified specialists in Anesthesiology.*		
03304	Implantation of spinal stimulator (complete system), to include implantation of pulse generator/receiver - using percutaneous electrode (operation only)	1,023.33	3
	***Note:** Restricted to Neurosurgeons and certified specialists in Anesthesiology.*		
03305	- using laminotomy electrode (operation only)	1,125.69	5
03306	Revision of spinal/cranial stimulator pulse generator	720.94	3
03307	Removal of spinal/brain stimulator system	460.52	3
	***Note:** Restricted to Neurosurgeons and certified specialists in Anesthesiology*		
03218	Replacement of spinal subarachnoid catheter access device with infusion pump for spinal subarachnoid infusion (operation only)	472.46	3
03219	Insertion of spinal subarachnoid device reservoir in paraspinal region (operation only)	400.39	3
	***Note:** 03219 to include insertion of spinal subarachnoid catheter.*		
03220	Insertion of spinal subarachnoid catheter access device-reservoir/pump in anterior chest wall or abdominal wall (operation only)	640.63	3
	***Note:** 03220 to include insertion of spinal subarachnoid catheter.*		
03152	Bischoff's or longitudinal myelotomy	957.28	5
03176	Percutaneous cordotomy	1,006.30	4
03177	Cordotomy	809.07	5
03178	Operative microsurgical rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic	953.53	5
	***Note:** Restricted to Neurosurgery and Orthopaedic Surgery.*		
03108	Operative facet rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic	460.19	4
	***Note:** Restricted to Neurosurgery and Orthopaedic Surgery.*		
03150	Laminectomy, 03153, 03155 for selective posterior rhizotomy	1,284.43	5
03153	Laminectomy with DREZ lesion for pain	1,440.56	6
03101	Supra or infra orbital nerve avulsion	231.04	3
03102	Decompression of Gasserian ganglion	1,222.85	8
03103	Pre-ganglionic rhizotomy 5th nerve	1,061.44	3
S03104	Percutaneous rhizotomy 5th nerve	1,250.75	3
03106	Posterior fossa exploration with rhizotomy 5th nerve	2,065.71	8
03232	Microsurgical anastomosis of intracranial portion of cranial nerve in conjunction with other craniotomy, with graft. (Extra to craniotomy)	749.81	
	***Note:** 03232 includes harvesting of graft.*		
03233	Microsurgical anastomosis of intracranial portion of cranial nerve in conjunction with other craniotomy, without graft. (Extra to craniotomy)	459.34	
03138	Unilateral stereotaxic intracranial procedures	1,222.75	7
03139	Implantation of stimulator	1,200.35	3
03140	Insertion of intracranial stimulating electrodes	2,809.35	7
03250	Microelectrode recording (MER) – electrophysiological (EP) mapping of the basal ganglia and thalamus, intra-operatively – extra	3,197.98	

		$	Anes. Level
	Single Channel Neural Stimulator Implant Testing		
03274	- professional fee	47.13	
03275	- technical fee	23.56	
	Dual Channel Neural Stimulator Implant Testing		
03276	- professional fee	70.67	
03277	- technical fee	47.13	

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

S03196	Exploration, mobilization and transposition	287.85	2
03198	Neurectomy of major nerve	227.46	2
03200	Secondary suture including transposition	588.25	3
03201	Secondary suture of major nerve	447.63	3
03204	Hypoglossal-facial anastomosis	697.20	4
03205	Nerve graft	441.58	3
03207	Microsurgical removal of neoplasm – major peripheral nerve	833.63	3
	Brachial Plexus Surgery		
03045	Brachial plexus exploration for neurolysis, primary repair or tumour removal	1,533.94	3
03046	Post traumatic delayed or repeat exploration in brachial plexus surgery, extra	562.45	3
03047	Intraoperative diagnostic monitoring in brachial plexus surgery, extra	218.25	
03048	Nerve graft done in addition to brachial plexus exploration, extra per graft ***Note:*** *Includes harvesting of graft.*	198.41	
03049	Neurotization in brachial plexus surgery, extra	462.95	
	Microneural Surgery		
	Neurolysis:		
06210	- external	347.38	2
06211	- intraneural	448.87	2
	Microfascicular neurorrhaphy, primary:		
06212	- digital or palmar	408.74	2
06213	- major nerve	628.85	2
	Interfascicular nerve graft (to include harvest of graft):		
06214	- digital or palmar	545.66	2
06215	- major nerve	1,636.20	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	171.95	
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	90.04	
	Continuing care by consultant:		
04007	Subsequent office visit (for gynecology visits only, all pregnant patients and routine prenatal patients billed under fee item 04191)	58.68	
04008	Subsequent hospital visit	60.74	
04009	Subsequent home visit	123.11	
04005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	159.30	
	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	171.95	
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	90.04	
04077	Telehealth subsequent office visit (for gynecology visits only)	58.68	
04078	Telehealth subsequent hospital visit	60.74	

Minor Procedures

P04681 Vaginal Speculum Examination Procedure (extra) 10.10

Notes:

i) Restricted to Obstetrics and Gynecology.

ii) Payable with a mini tray fee (00044).

iii) Payable only when:

a. fee items 00775, 00784, 00785, 04005, 04007, 04008, 04009, 04010, 04012, 04038, 04190, 04191, 04194, 04509, 04533, 04682, 04683, 04699, 04717, 14540, 14541, 14560, 15136, or 15141 are billed in conjunction; OR

b. when service performed in an office (Service Location Code Q) and fee items 00807, 00808, 04405, or 04500 are billed in conjunction.

T04682 Initial Pessary Fitting 101.00

Notes:

i) Restricted to Obstetrics and Gynecology specialists and Urologists.

ii) Not payable with a visit.

iii) Not payable if delegated to an allied care provider in a publicly-funded facility.

iv) Not payable with 04683.

		$	Anes. Level
T04683	Pessary Maintenance	75.75	

Notes:

i) Restricted to Obstetrics and Gynecology specialists and Urologists.
ii) Not payable with a consult or visit.
iii) Not payable if delegated to an allied care provider in a publicly-funded facility.
iv) Not payable with 04682.

Obstetrical Procedures

04038	Repeat intrapartum assessment by consultant at request of primary care physician	286.48	

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.

04039	Management of complicated labour by obstetrician	707.55	

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, 04414, 04419 or 14199.
v) Payable x 1 only, regardless of multiple gestation.
vi) Payable only for the following conditions:

Fetal conditions:

(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

Placental or amniotic fluid conditions:

(a) Placental abruption
(b) Severe oligohydramnios (AFI<6)
(c) Severe polyhydramnios (AFI>25)

Maternal Conditions:

(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.

		$	Anes. Level
G04718	Care of complex antepartum patient prior to transfer to higher level of care facility for delivery	358.10	

***Notes**:*
i) Restricted to Obstetrics and Gynecology specialists.
ii) Not paid with 04038, 04039, 04025, 04050, 04052, 04414, P14105.
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 P14105.
vi) Payable for pre-eclampsia, preterm labour, and for serious maternal condition(s) that requires stabilization prior to transfer.

T04721	Management of stillbirth fee >20 weeks gestation or ≥ 500g (extra)	169.93	4

Notes:
i) Includes all initial supportive care performed by the physician responsible for the delivery of the stillbirth, such as counselling of the patient, completing the necessary paperwork, liaising with social workers, arranging for serology and other bloodwork to identify the cause of the stillbirth, discussing the value of an autopsy with parents, arranging for pathology examination, and assisting with mortuary arrangements.
ii) Payable only in addition to fee items 04025, 04050, 04052, 04414, or 14104.
iii) Not payable with any in office or out of office individual counselling fee to same physician on same date of service.

04014	Complicated delivery - midcavity surgical delivery (operation only)	648.58	4
04017	Midcavity rotation from OP or OT to OA - surgical delivery (operation only)	798.29	4
04018	Breech vaginal birth (operation only)	798.05	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%.*

04000	Complicated vaginal delivery - includes shoulder dystocia, premature delivery less than 37 weeks or less than 2500 grams (operation only)	562.73	4

Notes:
i) Complicated delivery fees will be paid at 50% when 14104 or 04414 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)	317.78	3

***Note**: Not paid in addition to 04024.*

04023	Repair of extensive cervical and/or vaginal lacerations (operation only)	317.78	3

***Note:** Not paid in addition to 04022 and 04024.*

04024	Repair of 4th degree laceration (operation only)	397.17	3
04026	Manual removal of retained placenta (operation only)	275.09	3

04190	Prenatal visit - complete examination	148.71	
04191	Prenatal visit - subsequent examination	56.69	

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.

		$	Anes. Level
G04717	Prenatal office visit for complex obstetrical patient	68.52	

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	56.69	

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.	98.72	

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	221.20	

Note: *Administration of IV tocolytic agent and fetal heart monitoring included.*

04414	Delivery and postnatal care (1-14 days in hospital)	679.70	

Notes:

i) Restricted to Obstetrics and Gynecology specialists.
ii) Additional post-partum office visit(s) are payable under fee item 04194.

04050	Caesarean section - elective	542.27	5
04052	Caesarean section - emergency	653.43	6
04025	Caesarean section- high risk - fetus < 1500g	690.73	6
04106	Caesarean hysterectomy	1,666.92	8

04418	Postnatal care after caesarean section (1-14 days in-hospital)	139.85	

Notes:

i) Restricted to Obstetrics and Gynecology specialists.
ii) Postnatal office visits are payable under fee item 04194.
iii) Not payable in addition to 04419.

04419	Primary management of labour, attendance at delivery, and postnatal care associated with emergency caesarean section (1-14 days in hospital)	566.16	

Notes:

i) Restricted to Obstetrics and Gynecology specialists.
ii) Postnatal office visits are payable under fee item 04194.
iii) Not payable in addition to 04418.

04085	Trial of Forceps/Vacuum Delivery	224.78	4

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.

04092	Multiple live or stillbirths, each additional child - vaginal birth	211.87	
04093	Multiple live or stillbirths, each additional child - caesarean section…	87.11	

Note: *Fee item 04093 is paid in full in addition to fee items 04025, 04050, 04052 or 04106.*

		$	Anes. Level
04107	Supervision of labour and vaginal delivery in a case of previous caesarean section (operation only)	212.39	5
	Note: *04107 is a stand-by fee and is not payable in addition to delivery fees (14104, 04414, 04000, 04014, 04017, 04018, 04050, 04052, 04025) when done by the same physician.*		
04111	Therapeutic abortion (vaginal) including non-viable pregnancy – missed or incomplete abortion under 14 weeks gestation, by whatever means (operation only)	255.38	2
04110	Therapeutic abortion (surgical or medical) - 14 to 18 weeks including non-viable pregnancy or pregnancy with congenital malformations requiring termination. Ultrasound confirmed gestational age (operation only)	292.76	2
G04716	Obstetrical surcharge for therapeutic abortion (D&E) at 14 to 18 weeks (extra)	65.21	
	Note: *Paid only with 04110.*		
S04080	Insertion of Multiple Osmotic Dilators with Paracervical Block, prior to second trimester pregnancy termination	161.74	
	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.*		
04114	Therapeutic abortion by D&E, or medical means above 18 weeks gestation, including non-viable pregnancy or pregnancy with congenital abnormality requiring termination. Ultrasound confirmed gestational age (operation only)	413.92	3
G04715	Obstetrical surcharge therapeutic abortion (D&E) at 18 weeks and over (extra)	86.92	
	Notes: *i) Paid only with 04114.* *ii) Restricted to Obstetrics and Gynecology specialists.*		
04116	Curettage for post-partum haemorrhage (>20 weeks)	306.94	3
04118	Induction or stimulation of labour by oxytocin intravenous drip, where attendance by the physician is readily available - first hour	44.52	
04119	- subsequent hours	30.68	
	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

G04719	Gynecology surgical surcharge for patients 75 years and older	102.31	
	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, 04250, 04301, 04303, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 04330, 04331, 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, 04722, 04723, 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.*

		$	Anes. Level
04720	Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery or procedure performed for patients with a BMI of 35 or greater.		

Notes:
i) Payable only to Obstetricians and Gynecologists.
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 obstetricians or gynecologists 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 applicable preamble(s).
v) The surcharge does not apply to surgical fee modifiers 04715, 04716 or 04719, but may be paid in addition.
vi) Not payable if 04708 or 04714 is billed with the surgery or procedure.
vii) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the BMI surcharge.
viii) The surcharge is excluded from the calculation of total operative fee(s) for which surgical assist fees are based.
ix) Payable when the following Obstetrics and Gynecology fee items are performed for patients with a BMI of 35 or greater:
00770, 00775, 00776, 00787, 00794, 00807, 00808, 00815, 00819, 04000, 04001, 04003, 04011, 04014, 04017, 04018, 04022, 04023, 04024, 04025, 04026, 04029, 04032, 04033, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04049, 04050, 04052, 04080, 04085, 04106, 04110, 04111, 04114, 04116, 04141, 04142, 04201, 04202, 04203, 04204, 04206, 04208, 04212, 04216, 04217, 04218, 04219, 04220, 04221, 04222, 04223, 04224, 04225, 04227, 04228, 04229, 04232, 04233, 04250, 04300, 04301, 04303, 04304, 04305, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 04330, 04331, 04401, 04405, 04406, 04408, 04410, 04411, 04421, 04422, 04424, 04427, 04429, 04500, 04502, 04503, 04508, 04510, 04512, 04515, 04516, 04517, 04530, 04531, 04536, 04551, 04602, 04605, 04616, 04617, 04620, 04621, 04622, 04623, 04624, 04628, 04630, 04631, 04632, 04633, 04640, 04641, 04662, 04664, 04680, 04701, 04702, 04703, 04704, 04705, 04706, 04707, 04709, 04722, 04723, 04728, 04729.

G04708 Prolonged laparoscopic surgery, per 15 minutes or major portion thereof (extra) 102.31

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 procedure~~s~~ 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.*

		$	Anes. Level
G04714	Prolonged surgery – Open procedure per 15 minutes or major portion thereof (extra)	102.31	

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.*

Abdominal Operations

04228	Hysterectomy – total	1,110.85	5

Note: *Includes salpingectomy/oophorectomy (04003), ovarian cystectomy (04201) and abdominal enterocele repair.*

C04709	Laparoscopic total or supracervical hysterectomy, and/or laparoscopic assisted vaginal hysterectomy (LAVH) (includes oophorectomy and/or salpingectomy)	1,110.85	5

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 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.*

TC04722	Laparoscopic excision of rectovaginal endometriosis	1,110.85	6

Notes:
i) *Restricted to Obstetrics and Gynecology specialists for management of advanced endometriosis.*
ii) *For histologically confirmed rectovaginal endometriosis only.*
iii) *Inclusive of unilateral and/or bilateral ureterolysis, enterolysis, adhesiolysis, cystoscopy/cystectomy, ureteral stenting, para-rectal spaces, restoration of recto-vaginal anatomy.*
iv) *In cases where conversion to open surgery is necessary, pay as open procedure 04229 plus 04001 at 50%.*
v) *04708 will apply after 2 hours.*
vi) *Not payable with laparoscopic fees 04001, 04660, 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04723, 72658, 72659.*
vii) *Not payable with hysterectomy fees 04709, 04228, 04729, 04202.*
viii) *Not payable with 08159, 00704, 00815, 08155, 04003, 04201, 04216, 04208, 08201, 00724.*

TC04723	Laparoscopic excision of rectovaginal endometriosis with laparoscopic hysterectomy	1,512.84	6

Notes:

i) Restricted to Obstetrics and Gynecology specialists for management of advanced endometriosis.
ii) For histologically confirmed rectovaginal endometriosis only.
iii) Inclusive of unilateral and/or bilateral ureterolysis, enterolysis, adhesiolysis, cystoscopy/cystectomy, ureteral stenting, para-rectal spaces, restoration of recto-vaginal anatomy.
iv) In cases where conversion to open surgery is necessary, pay as open procedure 04229 plus 04001 at 50%.
v) 04708 will apply after 2 hours.
vi) Not payable with laparoscopic fees 04001, 04660, 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04722, 72658, 72659.
vii) Not payable with hysterectomy fees 04709, 04228, 04729, 04202.
viii) Not payable with 08159, 00704, 00815, 08155, 04003. 04201, 04216, 04208, 08201, 00724.

		$	Anes. Level
04229	Removal of complicated pelvic disease	1,110.85	6
04203	Myomectomy	741.12	5
04204	Abdominal hysterotomy - with or without sterilization	530.44	5
04206	Suspension of uterus	254.73	4
04208	Ectopic pregnancy removal by salpingotomy or salpingectomy (open procedure)	531.25	5
04003	Oophorectomy and/or salpingectomy (unilateral or bilateral), including for sterilization	380.49	5
04201	Ovarian cystectomy (to include ovary repair) not tubes	474.83	5
04216	Presacral neurectomy	443.40	5
04217	Post-operative haemorrhage - intra-abdominal management	526.63	6
04605	Abdominal sacrocolpopexy – open (includes oophorectomy when applicable)	1,040.20	5
C04707	Laparoscopic sacrocolpopexy, includes oophorectomy and/or salpingectomy	1,040.20	5

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.

Abdominal Operations for Cancer

04011	Debulking operation for cancer of ovary or fallopian tubes	1,330.08	6

Notes:
i) Not applicable to Stage 1 disease.
ii) Includes omentectomy and hysterectomy if done.

04029	Omentectomy	460.42	5

Notes:
i) Not to be billed in addition to 04011.
ii) Only payable for:
a. High-risk endometrial cancer (grade ≥ 2, and/or p-53 abnormal, and/or MMR-deficient {MSH2/6, MLH1, PMS2}, or stage 1 ovarian cancers, or
b. Elevated CA125 or ER negative or enlarged nodes on imaging.

iii) Exceptional circumstances will be given independent consideration upon receipt of an explanatory note record.

		$	Anes. Level
04628	Removal of extrapelvic soft tissue mass > 10 cm	665.05	5
04218	Radical abdominal hysterectomy for carcinoma, including partial vaginectomy	1,464.66	6
04212	Pelvic lymphadenectomy	631.99	6
04219	Para-aortic lymphadenectomy - total	767.36	6
04220	- partial	332.52	5
04630	Sentinel lymph node biopsy vulva (SLN-V) – unilateral	613.89	3
04631	Sentinel lymph node biopsy vulva (SLN-V) – bilateral	920.82	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	613.57	3
C04641	– bilateral	920.45	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.

04728	Laparoscopic assisted radical vaginal trachelectomy (LARVT) and sentinel node procedure	1,718.88	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.

C04729	Laparoscopic assisted radical hysterectomy (LARH) (includes oophorectomy and/or salpingectomy)	2,041.17	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……	474.07	4

Notes:
i) Restricted to Obstetrics and Gynecology specialists.
ii) Includes fee item 04001.

04142	Removal of intra-peritoneal catheter for chemotherapy……	205.48	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.*

		$	Anes. Level
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.*	255.79	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.*	434.83	2
04223	Resection of myoma - includes diagnostic hysteroscopy ***Notes:*** *i) Payable only when done under direct vision.* *ii) Not payable with a surgical assist except in exceptional circumstances (for example, needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). The medical necessity for the surgical assist must be provided in the note record.*	482.76	2
04224	Endometrial ablation - includes diagnostic hysteroscopy ***Note:*** *Not payable with a surgical assist except in exceptional circumstances (for example, needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). The medical necessity for the surgical assist must be provided in the note record.*	482.76	2
04225	Hysteroscopic division of uterine septum	434.83	2
04226	Hysteroscopic tubal occlusion (bilateral)	207.14	
T04250	Hysteroscopic removal of endometrial polyp(s), retained placental or other intrauterine tissue(s), and/or fragmented intrauterine device ***Notes:*** *i) Restricted to Obstetrics and Gynecology specialists.* *ii) Not payable with a surgical assist except in exceptional circumstances (for example, needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). The medical necessity for the surgical assist must be provided in the note record.*	325.00	2

Laparoscopic Operations

04001	Laparoscopy (operation only) ***Note:*** *Not paid with 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048.*	306.88	4
P04662	Laparoscopic removal of intraperitoneal foreign body (operation only)	422.37	4
P04664	Laparoscopic management of Ectopic pregnancy	603.15	4
	Laparoscopic salpingolysis		
P04034	- unilateral (operation only)	389.75	4
P04035	- bilateral (operation only)	505.77	4
P04036	Laparoscopic salpingostomy - unilateral (operation only)	503.44	4
P04037	Laparoscopic salpingostomy - bilateral	699.78	4
P04040	Laparoscopic cautery of endometriosis (operation only)	357.94	4
P04041	Laparoscopic oophorectomy and/or salpingectomy, including for sterilization – unilateral (operation only)	451.53	5
P04042	Laparoscopic oophorectomy and/or salpingectomy, including for sterilization – bilateral	623.26	5
P04043	Laparoscopic ovarian cystectomy – unilateral	554.61	5
P04044	Laparoscopic ovarian cystectomy – bilateral	795.12	5
P04045	Laparoscopic ventral suspension of uterus (operation only)	420.60	4

		$	Anes. Level
P04047	Laparoscopic excision of extensive peritoneal endometriosis including pelvic sidewall dissection and unilateral ureterolysis	682.07	6
P04048	Laparoscopic removal of complicated pelvic disease	832.76	6

Micro-Surgical Operations

04602	Salpingolysis and removal of adhesions – loupes or microscope (unilateral or bilateral)	474.83	5
	Micro salpingostomy:		
04616	- unilateral	654.02	5
04617	- bilateral	849.26	5
04626	Tubo-cornual anastomosis - unilateral (micro-surgical)	946.38	5
04627	Tubo-cornual anastomosis – bilateral (micro-surgical)	1,229.31	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

Note: Surgical assists are not billable in conjunction with fee items 04300, 04301, 04305, 04306, 04312, 04317 or 04330 except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.) In such cases, the medical necessity for the surgical assist must be provided in the note record.

04300	Incision of hymen - operation only	255.79	2
P04330	I&D of Bartholin's cyst with insertion of Word catheter (operation only)	275.00	2
	Note: *07027 to be charged if Bartholin's cyst/abscess is treated by Incision and Drainage (I&D) without insertion of a Word catheter.*		
04301	Marsupialization of a Bartholin's cyst – under general anesthesia or procedural sedation (operation only)	300.00	2
	Note: *When performed under local anesthesia, operative/procedural report must be submitted.*		
04331	Removal of Bartholin's Gland – under general anesthesia or procedural sedation (operation only)	400.00	2
04303	Excision of hydrocele or canal of Nuck	315.17	2
04304	Urethral caruncle - cautery or excision in hospital (operation only)	66.09	2
04305	Venereal warts, cautery or excision - operation only	53.64	
04306	Excision of venereal warts under general or local anesthesia in hospital (operation only)	255.79	2
	Note: *Must be performed in an Operating Room (location code G, I, Or P).*		
04307	Vulvectomy - simple	411.95	3
04309	Varicocele of labium (operation only)	210.04	2
04311	Operation for atresia of vulva or enlargement of vaginal introitus for stenosis (operation only)	255.79	2
04312	Resection of labia minora (operation only)	266.86	2
04317	Biopsy of vulva, excisional lesion < 2 cm	54.79	2
04032	Biopsy of vulva, excisional lesion >/= 2 cm	126.54	2
04316	Vulvovaginoplasty	269.69	2
	Note: *This item is payable for genetic females only.*		
04318	Radical vulvectomy	956.33	3
	Inguinal and femoral lymphadenectomy:		
04320	- unilateral	425.02	4
04322	- bilateral	743.73	4

		$	Anes. Level
04632	Vulvar wide local excision	460.42	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.*		
04633	Radical partial/hemi vulvectomy (RPV)	511.57	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	1,110.85	4
04232	Oophorectomy/ovarian cystectomy and/or salpingectomy (vaginal route), extra to vaginal hysterectomy – unilateral (operation only)	119.72	
04233	Oophorectomy/ovarian cystectomy and/or salpingectomy (vaginal route), extra to vaginal hysterectomy – bilateral	235.42	
04401	Repair of recto-vaginal fistula	700.31	3
04402	Colpotomy with drainage pelvic abscess (operation only)	255.79	2
04405	Removal of a vaginal cyst situated above the introitus (operation only)	255.79	2
04406	Operation for removal of vaginal septum (operation only)	255.79	2
04408	Vault prolapse following hysterectomy	569.12	4
04410	Post-operative haemorrhage, vaginal management (operation only) ***Note:*** *Must be performed in an Operating Room (location code G, I, or P)*	255.79	5
04033	Vaginectomy for VAIN (partial)	483.14	4
04411	Vaginectomy - Total	646.00	4

Plastic Operations for Genital Prolapse

04227	Cystocele and/or urethrocele repair	431.33	2
04421	Repair of rectocele	431.33	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.*	489.46	2
04424	Complete repair of prolapse (Manchester or Fothergill types)	626.54	3
04427	LeFort's operation	482.25	
04429	Repair of old 3rd degree perineal laceration	484.25	2
04432	Repeat vaginal plastic procedure, extra	161.47	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.*	445.70	4

		$	Anes. Level
G04702	Transection or removal of suburethral mesh sling	525.41	4
	Notes: *i) Restricted to Obstetrics and Gynecology specialists.* *ii) Fee items 00704, 00705 or 08232 not paid in addition.*		
G04703	Augmented anterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to Arcus Tendinous	441.19	2
	Notes: *i) Fee items 00704, 00705 or 04227 not paid in addition.* *ii) Restricted to Obstetrics and Gynecology specialists.*		
G04704	Augmented posterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to sacrospinous ligament	441.19	2
	Notes: *i) Fee items 04421 or 04422 not paid in addition.* *ii) Restricted to Obstetrics and Gynecology specialists.*		
G04705	Removal of trans-vaginal placed synthetic mesh where indicated, from anterior or posterior compartment, due to pain or complications	644.84	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.*		
G04706	Vaginal vault suspension – Apical support procedure	568.67	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

Note: Surgical assists are not billable in conjunction with fee items 04503, 04508, 04509, 04510, 04515, 04530, 04533, 04536, or 04545 except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). In such cases, the medical necessity for the surgical assist must be provided in the note record.

S04500	Cervix dilation and curettage (pelvic examination not billable in addition when done as an isolated procedure) (operation only)	255.79	2
04502	Repair of cervix (operation only)	255.79	2
04503	Cryosurgery of cervix (operation only)	153.48	2
04509	Cervical polypectomy (operation only)	32.13	2
04508	Biopsy of cervix under general anesthesiology	255.79	2
04510	Biopsy of cervix, with dilation and curettage (operation only)	255.79	2
04512	Vaginal myomectomy (operation only)	255.79	4
04516	Cervical incompetence - emergency repair	460.42	2
04517	Cervical incompetence - elective repair	306.94	2
04515	Removal of buried cervical ligature under anesthesiology (operation only)	255.79	2
04530	Cauterization of cervix - under general anesthesia (operation only)	255.79	2
S04531	- with dilation and curettage (operation only)	255.79	2
04533	Electric cauterization of cervix in office (operation only)	51.17	

		$	Anes. Level
04536	Cone biopsy of cervix with endocervical curettage (dilation and curettage included in the fee)	279.88	2
14540	Insertion of intrauterine contraceptive device (operation only)	55.77	2

***Notes**:*

i) Includes cervical cancer screening, if clinically indicated.

ii) Not payable in addition to 14541.

04545	Artificial insemination - operation only	34.68	
04551	Cervical stump removal	409.26	3
S00770	Pelvic examination under anesthesia when done as an independent procedure – procedural fee	255.79	2

Laser Vaporization

Note: Surgical assists are not billable in conjunction with fee items listed under Laser Vaporization except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). In such cases, the medical necessity for the surgical assist must be provided in the note record.

04620	Cervical neoplasia (operation only)	255.79	2
04621	Vaginal neoplasia with or without general anesthetic (operation only)	255.79	2
04622	Vulvar condylomata (operation only)	255.79	2
04623	Extensive vulvar or vaginal condylomata under general anesthetic	306.94	2
04624	Vulvar intraepithelial diffuse, multifocal and/or perianal Lesions	431.46	2

Surgical Assistance

Total operative fee(s) for procedures(s):

00195	- less than $317.00 inclusive	147.95
00196	- $317.01 to 529.00 inclusive	209.92
00197	- $529.01 to $869.00 inclusive	309.31
P13197	- greater than $869.00	450.00
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	34.10

Notes:

i) Surgical assist fees are based on the total operative fee(s) for the associated surgical procedure(s). Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s).

ii) When a physician provides surgical assistance for two surgeries at different operative sites under one anesthetic, they may charge a separate surgical assistance fee for each surgery. This applies whether the two surgeries were performed by the same surgeon or by different surgeons. This does not apply to bilateral procedures, procedures within the same body cavity, or procedures on the same limb.

iii) Visit fees are not payable to the same physician on the same day as surgical assistance fees, unless each service is performed at a distinct/separate time. When this occurs, start and end times must be noted on each billing claim.

iv) When a surgical assistant is required for minor surgery, a detailed explanation of the need for the surgical assistant is required in the claim note record.

04795	Certified Gynecologic Surgeon Assist (extra) Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	18.12

Notes:

i) Restricted to Gynecologists.

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, 00198 and 13197 only.
v) Start and end times must be entered in both the billing claims and the patient's chart.

		$	Anes. Level
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	282.60	
	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	32.96	
	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	8.57
04699	Fern Test	16.03
15137	Hemoglobin cyanmethemoglobin: method and/or haematocrit	3.19
	Note: *See the Laboratory Services Payment Schedule for additional hematology information.*	
15000	Hemoglobin - other methods	1.66
	Note*: 15137 and 15000 - see the Laboratory Services Payment Schedule for additional hematology information.*	

Diagnostic Ultrasound

15139	Sperm, Seminal examination for presence or absence	15.11
15141	Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination	6.55
15142	Urinalysis, complete diagnostic, semi-quant and microscopic	5.78
15120	Pregnancy test, immunologic - urine	14.09
	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)	116.03
	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.*	
86051	Obstetrical B scan (14 weeks gestation or over) (for multiples – each additional fetus)	86.34
08655	Obstetrical B scan (under 14 weeks gestation)	87.05
08652	B scan I.U.D. localization	58.03

		$	Anes. Level
08653	Pelvic B-scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal doppler	115.50	

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	116.14	
04680	Ultrasonic guidance for amniocentesis	204.63	

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 116.15

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..... 61.05

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. 167.43

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 53.53

51008 Orthopaedic hospital visit 31.39

51005 Pre-Operative Assessment..... 116.15

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..... 56.14

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	116.15	
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	61.05	
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.*	169.53	
51107	Telehealth Orthopaedic office visit	53.53	

Surgical Fee Modifiers

P51003 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery performed when the patient has a Body Mass Index (BMI) of 35 of greater.

Notes:

i) Payable only to Orthopaedic 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 Orthopaedic 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) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the BMI surcharge.

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

vii) Payable when the following Orthopaedic fee items are performed for patients with a BMI of 35 or greater: 51051, 51052, 51053, 51054, 51055, 51056, 51057, 52365, 52370, 52415, 52505, 52506, 52515, 52516, 52519, 52526, 52545, 52601, 52602, 52603, 52604, 52605, 52606, 52607, 52705, 52710, 52715, 52725, 52735, 52736, 52745, 52982, 53250, 53255, 53365, 53370, 53505, 53510, 53515, 53521, 53601, 53602, 53603, 53604, 53605, 53642, 53643, 53644, 53705, 53715, 53725, 53726, 53735, 53745, 53755, 53765, 53775, 54310, 54315, 54387, 54505, 54510, 54515, 54601, 54602, 54603, 54632, 54705, 54715, 54725, 54810, 55370, 55371, 55385, 55515, 55603, 55605, 55632, 55633, 55634, 55635, 55661, 55662, 55663, 55671, 55672, 55673, 55674, 55675, 55705, 55706, 55707, 55715, 55735, 55736, 55745, 55746, 55751, 55755, 55761, 55771, 55783, 55785, 55983, 55984, 55985, 56285, 56360, 56365, 56370, 56385, 56510, 56515, 56520, 56525, 56530, 56540, 56541, 56542, 56601, 56602, 56603, 56604, 56661, 56662, 56663, 56664, 56665, 56704, 56705, 56715, 56716, 56735, 56745, 56746, 56754, 56755, 56980, 57280, 57290, 57385, 57505, 57510, 57515, 57516, 57535, 57550, 57601, 57602, 57603, 57631, 57632, 57661, 57662, 57705, 57715, 57716, 57735, 57745, 57810, 57811, 57812 and 57813.

		$	Anes. Level

Surgical Assistant

51194	First Surgical Assist of the Day - Orthopaedics	78.45	

Notes:

i) Restricted to Orthopaedic Surgeons.

ii) Maximum of one per day per physician, payable in addition to 00195,00196, 00197 and 13197.

Total operative fee(s) for procedures(s):

00195	- less than $317.00 inclusive	147.95	
00196	- $317.01 to 529.00 inclusive	209.92	
00197	- $529.01 to $869.00 inclusive	309.31	
P13197	- greater than $869.00	450.00	
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	34.10	

Notes:

i) Surgical assist fees are based on the total operative fee(s) for the associated surgical procedure(s). Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s).

ii) When a physician provides surgical assistance for two surgeries at different operative sites under one anesthetic, they may charge a separate surgical assistance fee for each surgery. This applies whether the two surgeries were performed by the same surgeon or by different surgeons. This does not apply to bilateral procedures, procedures within the same body cavity, or procedures on the same limb.

iii) Visit fees are not payable to the same physician on the same day as surgical assistance fees, unless each service is performed at a distinct/separate time. When this occurs, start and end times must be noted on each billing claim.

iv) When a surgical assistant is required for minor surgery, a detailed explanation of the need for the surgical assistant is required in the claim note record.

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	282.60	

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	32.96	

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)	23.76	2
*51017	Long Arm (axilla to hand)	23.76	2
*51018	Shoulder spica	88.92	2
*51019	Below knee	23.76	2
*51020	Long leg cylinder	23.76	2

		$	Anes. Level
*51021	Long leg	23.76	2
*51022	Hip spica - child	299.01	2
*51023	Hip spica - adult	88.92	2
*51024	Body (shoulder to hips)	88.92	2
S51025	Cast brace	47.54	2

Miscellaneous - Ortho

51030	Orthopaedic interpretation and written report of submitted x-ray films - including CT scan and MRI. ***Note:*** *Not payable in addition to consultation rendered within 2 months on the same patient on referral by the same physician.*	42.46	
*51035	Application of skeletal traction (operation only)	95.49	2
*51036	Compartment pressure monitoring - extra	95.07	2
*51037	Harvesting of iliac crest autograft - extra	149.51	2
*51038	Harvesting of skin graft - extra (for orthopaedic procedures only)	105.00	2
	Ilizarov Instrumentation (Any Bone/Joint) To Include Corticotomy:		
51065	Simple construction - lengthening/angular correction with or without lengthening/ Nonunion stabilization/fracture stabilization	1,134.71	3
51066	Complex construction - multiplanar corrections/multiple level lengthening/elevator technique	1,541.97	4
*51067	Extension/revision of frame	219.58	3

Shoulder Girdle, Clavicle and Humerus

	Incision - Diagnostic, Percutaneous:		
S11200	Arthroscopy shoulder joint	305.53	2
SY00757	Aspiration - other joints	16.54	2
	Incision - Diagnostic, Open:		
11215	Arthrotomy shoulder joint or bursa	190.94	2
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.76	
51040	Aspiration, joint (operation only)	23.76	
*52210	Bursa, I and D, under GA	316.89	2
*52215	Abscess, I and D, under GA	316.89	2
52220	Hematoma, drainage under GA, when sole procedure ***Note:*** *Payable at 50% in post-op period.*	248.23	2
*52225	Shoulder joint arthrotomy, I and D	316.89	2
	Incision - Therapeutic, Release:		
52250	Soft tissue release (muscle, tendon)	389.05	2
52255	Major release (shoulder contracture)	593.00	2
	Excision - Diagnostic, Percutaneous:		
S11230	Needle biopsy under GA	190.94	2
S11232	Arthroscopy - biopsy, shoulder	248.23	2
	Excision - Diagnostic, Open:		
11245	Biopsy, open	248.23	2

		$	Anes. Level
	Excision - Therapeutic, Endoscopic:		
52305	Removal loose body	294.13	2
52306	Drilling osteochondral defect, with or without loose body.	294.13	2
52307	Pinning osteochondral fragment	358.05	2
52310	Debridement, synovectomy - total or subtotal ***Note:*** *Includes debridement of articular surface and/or synovium and/or debridement of partial tears of the rotator cuff.*	453.46	2
52315	Shoulder, abrasion	358.05	2
52320	Excision labrum tear	248.23	2
52325	Stabilization procedure	582.39	2
52330	Endoscopic acromioplasty	453.46	2
52335	Arthroscopic clavicle excision-medial/lateral (extra) ***Notes:*** *i) Paid only with 52330.* *ii) Not paid with 52505, 52506, 52515, 52516, 52525, 52526, 52535, 52540, 52541, 52545, 52602.*	108.98	
	Excision - Therapeutic, Open:		
52355	Bursa, excision, subacromial.	219.58	2
52356	Acromionectomy, acromioplasty, with or without resection of coraco-acromial ligament	358.05	2
52357	Clavicle, excision lateral/medial	302.00	2
52360	Arthrotomy, shoulder: synovectomy, capsulectomy.	438.34	2
52365	Benign soft tissue tumour (sub-fascial)	449.83	2
52370	Bone tumour, benign	449.83	2
*52380	Osteomyelitis, acute, decompression	305.35	2
*52385	Osteomyelitis, debridement with or without reconstruction. ***Note:*** *52380 and 52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.*	408.07	3
	Introduction and/or Removal, Therapeutic:		
52405*	Injection joint	11.90	
52410*	Injection bursa, tendon sheath, other peri articular structures.	11.90	
52415	Removal of internal fixation device(s), when performed in the operating room	316.89	2
52420*	Removal of internal fixation device(s), (operation only)	71.61	2
	Repair, Revision, Reconstruction (Soft Tissue):		
	When fee items 52505, 52506, 52310, 52517, 52518, 52519, 52520, 52521, 52525, 52526, 52535, 52540, 52541, 52545 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)	524.07	3
52506	Rotator cuff reconstruction, complex (rotation flap or muscle transfer) (to include acromioplasty)	796.68	4
52515	Acromioclavicular joint stabilization, acute (within six weeks post injury).	508.05	2

		$	Anes. Level
52516	Acromioclavicular joint stabilization, chronic (beyond six weeks post injury)	617.56	2
52517	Open or arthroscopic SLAP/Biceps tenodesis repair (reattachment of the biceps anchor utilizing an anchoring device) (isolated procedure) ***Notes:*** *i) Not paid with 52506, 52518, 52519, 52520 and 52521.* *ii) Includes 52505, 52550, 52555, 52526, 52535 and 52541.*	686.73	3
52518	Open or arthroscopic SLAP/Biceps tenodesis repair and anterior or posterior glenohumeral stabilization and/or Bankart repair (isolated procedure) ***Notes:*** *i) Not paid with 52519, 52520 and 52521.* *ii) Includes 52505, 52506, 52550, 52555, 52526, 52535, 52541 and 52517.*	977.64	3
52519	Open or arthroscopic SLAP/Biceps tenodesis or Bankart repair, and rotator cuff reconstruction, complex ***Notes:*** *i) Not paid with 52520 and 52521.* *ii) Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517 and 52518.*	1,099.13	3
52520	Open or arthroscopic SLAP/Biceps tenodesis repair, and Bankart repair including tendon transfer, and Rotator cuff repair ***Notes:*** *i) Not paid with 52521.* *ii) Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517, 52518 and 52519.*	1,436.19	3
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 ***Note:*** *Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517, 52518, 52519 and 52520.*	1,656.40	3
52525	Shoulder instability: inferior capsular shift	603.22	3
52526	Shoulder instability: Bankart	702.10	3
52535	Shoulder instability: other anterior repairs	470.21	3
52540	Shoulder instability, posterior: glenoid osteotomy	776.68	3
52541	Shoulder instability, posterior: soft tissue	695.24	3
52545	Shoulder instability, revision stabilization (post previous stabilization)	831.60	3
52550	Tendon repair, proximal biceps, pectoralis major	453.46	3
52555	Tendon transfer, transplant	727.32	3
	Repair, Revision, Reconstruction (Bone, Joint):		
	<u>Osteotomy, Malunion/Nonunion with or without Internal Fixation:</u>		
52601	Proximal humerus	856.32	3
52602	Clavicle	604.52	2
	<u>Glenohumeral Joint Arthroplasty:</u>		
52603	Hemi-arthroplasty shoulder	664.34	4
52604	Total shoulder prosthesis	1,078.34	5
52605	Removal prosthesis shoulder ***Note:*** *Includes repair of rotator cuff and/or soft tissues.*	472.60	3
52606	Revision total shoulder arthroplasty to hemi-arthroplasty	956.61	5
52607	Revision total shoulder arthroplasty	1,510.98	5

		$	Anes. Level
	Bone Grafting (ie. onlay grafting):		
52651	Proximal humerus	248.23	2
52652	Clavicle	152.76	2
	Fracture and/or Dislocation:		
	Clavicle, Acromion, Coracoid:		
52705	ORIF	542.04	2
52708*	Open injury, primary wound care (operation only)	152.79	2
52709*	Open injury, secondary wound management	214.45	2
52710	Sterno-clavicular joint stabilization	680.27	2
	Notes: *i) Restricted to Orthopaedic Surgeons.* *ii) Not paid with 52357, 52602, 52652, 52705, 52708 or 52709.*		
	Scapula:		
52715	ORIF	1,015.74	3
52718*	Open injury, primary wound care (operation only)	152.79	2
52719*	Open injury, secondary wound management	214.45	2
	Glenohumeral Dislocation - Acute:		
52721*	Closed reduction without GA (operation only)	95.49	2
52722	Closed reduction with GA	255.56	2
52725	Open reduction	468.59	2
	Proximal Humerus:		
52731*	Closed reduction with GA	190.94	2
52732*	Closed reduction with GA, traction/pin	251.60	2
52735	ORIF - two part	687.49	2
52736	ORIF - three or more parts	806.68	2
	***Note**: 52735 and 52736 include repair of rotator cuff if required.*		
52737	Hemiprosthesis and wiring for fracture	828.24	3
52738*	Open injury, primary wound care (operation only)	152.79	2
52739*	Open injury, secondary wound management	214.45	2
	Humerus - Shaft:		
52741	Closed reduction with GA	248.23	2
52742	Closed reduction external fixation	409.05	2
52745	ORIF/intramedullary nailing	722.12	2
52748*	Open injury, primary wound care (operation only)	152.79	2
52749*	Open injury, secondary wound management	224.55	2
	Manipulation: Shoulder Joint:		
S52800*	Manipulation under GA	95.49	2
	Arthrodesis:		
52810	Shoulder joint	973.84	4
52811	Scapula-thoracic joint	763.81	4
	Amputation:		
52980	Shoulder disarticulation	792.44	4
52981	Forequarter	945.21	5
52982	Humeral shaft	654.71	3
52998*	Open injury, primary wound care (operation only)	152.79	3

		$	Anes. Level
52999*	Open injury, secondary wound management	214.45	3

Elbow, Proximal Radius and Ulna

Incision - Diagnostic, Percutaneous:

S11300	Arthroscopy elbow joint	274.51	2
S11302	Aspiration - bursa, tendon sheath.	23.76	2
SY00757	Aspiration - other joints	16.54	2

Incision - Diagnostic, Open:

11315	Arthrotomy elbow joint	190.94	2

Incision - Therapeutic, Drainage:

51039	Aspiration, bursa (operation only)	23.76	
51040	Aspiration, joint (operation only)	23.76	
*53210	Bursa, I and D (Olecranon, etc.), under GA	316.89	2
*53215	Abscess, I and D, under GA	316.89	2
53220	Hematoma, drainage, under GA, when sole procedure ***Note**: Payable at 50% in post-op period.*	248.23	2
*53225	Elbow joint arthrotomy, I and D	316.89	2

Incision - Therapeutic, Release:

53250	Decompression, neurolysis, nerve	368.81	2
53255	Decompression, neurolysis, submuscular Transposition of nerve	473.09	2
*53260	Fasciotomy, compartment syndrome	353.75	2
*53269	Fasciotomy, secondary wound management	318.02	2

Excision - Diagnostic Percutaneous:

S11330	Needle biopsy under GA	190.94	2
S11332	Arthroscopy and biopsy	303.15	2

Excision - Diagnostic, Open:

11345	Open - biopsy ***Note**: Not payable with other procedures on the same joint.*	248.23	2

Excision - Therapeutic, Endoscopic:

53305	Removal loose body	341.40	2
53310	Debridement, synovectomy - total	685.03	2

Excision - Therapeutic, Open:

53355	Bursa/ganglion, excision	252.17	2
53360	Arthrotomy, elbow; open synovectomy with or without radial head resection	415.31	2
53365	Benign soft tissue tumour, subfascial	302.11	2
53370	Bone tumour, benign	302.11	2
53380*	Osteomyelitis - acute, decompression	305.35	2
53385*	Osteomyelitis - debridement, with or without reconstruction.	408.07	2
53386	Radial head resection with or without replacement	418.34	2

Introduction and/or Removal, Therapeutic:

53405*	Injection joint	11.90	
53410*	Injection bursa, tendon sheath, other peri articular structures.	11.90	

		$	Anes. Level
53415	Removal of internal fixation device(s), when performed in the operating room	316.89	2
53420*	Removal of internal fixation device(s), (operation only)	71.61	2
	Repair, Revision, Reconstruction (Soft Tissue):		
53505	Elbow instability, chronic	766.82	2
53510	Recurrent dislocating radial head	632.49	2
53515	Triceps tendon, acute	428.46	2
53516	Triceps tendon, fascial reconstruction	501.95	2
53520	Biceps tendon, longhead, tenodesis	302.11	2
53521	Biceps tendon, distal insertion	639.37	2
53530	Tendon transfer, major ***Note**: Includes latissimus/pectoralis to biceps transfer.*	765.90	2
53531	Tendon transfer, minor (steindler or triceps).	454.40	2
53540	Epicondylitis, fascial stripping	281.94	2
	Repair, Revision, Reconstruction (Bone, Joint):		
	Osteotomy, Malunion/Nonunion; with or without internal fixation:		
53601	Humeral shaft	815.74	2
53602	Distal humerus	841.79	2
53603	Radius shaft	642.41	2
53604	Ulna shaft	564.30	2
53605	Radius and ulna shafts	775.98	2
53606	Epiphysiodesis	276.87	2
53607	Physeal bar excision ***Note:** Includes harvest with or without insertion of fat graft, cement or other material.*	458.28	2
	Arthroplasty:		
53641	Interposition/distraction arthroplasty ***Note:** Includes harvest and insertion of local fascial graft, application of distraction device and neurolysis, if applicable.*	981.60	3
53642	Total elbow arthroplasty	1,135.36	3
53643	Revision total elbow arthroplasty ***Note:** 53642 and 53643 include ligament balancing, neurolysis and nerve transposition.*	1,528.74	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.*	1,000.82	4
	Bone Grafting (ie. onlay grafting):		
53651	Humerus	248.23	2
53652	Radius and/or ulna	248.23	2
53653	Olecranon	152.76	2
	Fracture and/or Dislocation:		
	Humeral Epicondyle:		
53701	Closed reduction, with GA, cast	248.23	2

		$	Anes. Level
53702	Closed reduction percutaneous fixation	276.87	2
53705	ORIF	393.42	2
53708*	Open injury, primary wound care (operation only)	152.79	2
53709*	Open injury, secondary wound management	214.45	2
	Distal Humerus: Supracondylar:		
53711*	Closed reduction, with GA, cast/traction	190.94	2
53712	Closed reduction external fixation/percutaneous fixation	493.74	2
53715	ORIF	637.90	2
53718*	Open injury, primary wound care (operation only)	152.79	2
53719*	Open injury, secondary wound management	214.45	2
	Distal Humerus: Intra-articular:		
53721*	Closed reduction, with GA, cast/traction/ and/or percutaneous fixation	190.94	2
53722	Closed reduction external fixation	409.05	2
53725	ORIF - unicondylar/osteochondral	637.50	2
53726	ORIF - bicondylar with or without olecranon osteotomy. ***Note:*** *Includes ulnar nerve transposition, if required.*	1,004.87	2
53727*	Open Injury, primary wound care (operation only)	152.79	2
53728*	Open injury, secondary wound management	214.45	2
	Olecranon:		
53735	ORIF	548.87	2
53738*	Open injury, primary wound care (operation only)	152.79	2
53739*	Open injury, secondary wound management	214.45	2
	Radial Head/Neck:		
53741	Closed reduction, with GA, cast	248.23	2
53742	Closed reduction percutaneous fixation	374.36	2
53745	ORIF	608.57	2
53748*	Open injury, primary wound care (operation only)	152.79	2
53749*	Open injury, secondary wound management	214.45	2
	Elbow Joint Dislocation:		
53751	Closed reduction, without GA	183.69	2
53752	Closed reduction, with GA	248.23	2
53755	Open reduction	357.27	2
	Radius and Ulna Shaft:		
53761*	Closed reduction, without GA, cast (operation only)	102.18	2
53762	Closed reduction, with GA, cast	316.87	2
53765	ORIF	667.39	2
53768*	Open injury, primary wound care	152.79	2
53769*	Open injury, secondary wound management	214.45	2
	Radius or Ulna Shaft/Monteggia:		
53771	Closed reduction, with GA, cast	276.87	2
53772	Closed reduction external fixation	276.87	2

		$	Anes. Level
53775	ORIF	533.09	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)	152.79	2
53779*	Open injury, secondary wound management	214.45	2
	Manipulation: Elbow Joint:		
S53800*	Manipulation under GA	95.49	2
	Arthrodesis:		
53810	Elbow joint	766.58	3
	Amputation:		
53980	Elbow	611.13	3
53981	Forearm	611.13	3
53998*	Open injury, primary wound care (operation only)	152.79	3
53999*	Open injury, secondary wound management	214.45	3

Hand and Wrist

	Incision - Diagnostic, Percutaneous:		
S11400	Arthroscopy wrist joint	294.13	2
S11402	Aspiration bursa, synovial sheath, etc.	23.76	2
SY00757	Aspiration - other joints	16.54	2
	Incision - Diagnostic, Open:		
11415	Arthrotomy wrist joint - isolated procedure	190.94	2
11416	Arthrotomy MP, PIP, DIP Joints – isolated procedure	190.94	2
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.76	
51040	Aspiration, joint (operation only)	23.76	
	Excision - Diagnostic, Percutaneous:		
S11430	Needle biopsy under GA	190.94	2
S11432	Arthroscopy and biopsy, wrist /hand joint(s)	190.94	2
	Excision - Diagnostic, Open:		
11445	Open biopsy, hand or wrist	265.66	2
	Excision - Therapeutic, Endoscopic:		
54305	Removal loose body	248.23	2
54310	Debridement synovectomy, total	383.70	2
54315	Excision triangular fibro cartilage complex (TFCC)	448.35	2
	Excision - Therapeutic, Open:		
54350	Foreign body from wound under GA	301.90	2
54351	Meniscus, radiocarpal	352.56	2
V07055	Ganglia - of the wrist	255.66	2

		$	Anes. Level
	Bone Tumour, Benign:		
54372	Carpals, distal radius	376.76	2
54380*	Osteomyelitis, acute, decompression	352.29	2
54385*	Osteomyelitis, debridement with or without reconstruction.	423.16	2
54386	Excision of radial or ulnar styloid ***Note:*** *Not payable with other wrist procedures.*	252.17	2
54387	Proximal row carpectomy ***Note****: Not payable with wrist arthrodesis.*	624.47	2
	Introduction and/or Removal, Therapeutic:		
54405*	Injection joint	25.54	
54410*	Injection bursa, tendon sheath, other peri articular structures.	25.54	
54415	Removal of internal fixation device(s), when performed in the operating room	316.89	2
54420*	Removal of internal fixation device(s), (operation only)	47.73	2
	Repair, Revision, Reconstruction (Soft Tissue):		
	Ligament:		
54505	Carpal instability: acute	654.48	2
54510	Carpal instability: chronic	728.00	2
54515	Distal radio-ulnar instability: chronic	582.83	2
	Repair, Revision, Reconstruction (Bone, Joint):		
	Osteotomy, Malunion or Nonunion:		
54601	Distal radius	761.94	2
54602	Distal ulna ***Note:*** *Darrach resection or limited resection/hemiresection arthroplasties are not payable under this item.*	413.41	2
54603	Carpal bone (scaphoid)	590.45	2
54604	Epiphysiodesis, epiphysioplasty, radius and/or ulna, or hand	488.65	2
	Arthroplasty Joint		
54631	Ulna, distal excision with or without silastic	271.90	2
54632	Total wrist joint replacement, includes tenosynovectomy & distal ulnar reconstruction	796.81	2
54633	Silastic wrist arthroplasty, includes tenosynovectomy & distal ulnar reconstruction	586.05	2
54634	Removal prosthesis	302.11	2
54635	Revision total wrist arthroplasty	1,046.07	3
	Bone Grafting (ie. onlay grafting)		
54651	Distal radius and/or ulna	272.63	2
54652	Metacarpal or phalanx (operation only)	124.11	2
	Fracture and/or Dislocation:		
	Radius with or without Ulna - Distal, Fracture		
54701	Closed reduction without GA	270.86	2
54702	Closed reduction with GA	327.12	2
54703	Closed reduction, external or percutaneous fixation	453.11	2
54705	ORIF	598.70	2
54708*	Open injury, primary wound care (operation only)	86.50	2

		$	Anes. Level
54709*	Open injury, secondary wound management (operation only)	127.43	2
	Carpal Bone Fracture (Scaphoid)		
54715	Open reduction, internal fixation	522.88	2
	Carpus: Dislocations: with or without Fracture		
54721	Closed reduction without GA	285.63	2
54722	Closed reduction, percutaneous fixation	393.66	2
54725	Open reduction, internal and/or external fixation	663.64	2
54728*	Open injury, primary wound care (operation only)	86.50	2
54729*	Open injury, secondary wound management (operation only)	127.43	2
	Manipulation: Hand/Wrist Joint:		
S54800	Manipulation under GA	95.49	2
	Arthrodesis/Tenodesis:		
54810	Wrist arthrodesis, limited or total	736.98	2
	Amputation:		
06218	Transmetacarpal	306.79	2
06219	Finger, any joint or phalanx (operation only)	306.79	2

Pelvis, Hip and Femur

	Incision - Diagnostic, Percutaneous:		
S11500	Arthroscopy hip joint	529.91	3
S11501	Aspiration hip joint	23.76	2
S11502	Aspiration bursa, tendon sheath.	11.90	2
	Incision - Diagnostic, Open:		
11515	Arthrotomy hip joint	305.53	3
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.76	
51040	Aspiration, joint (operation only)	23.76	
55210*	Bursa, I and D (trochanteric, etc.), under GA	316.89	2
55215*	Abcess, I and D, under GA	316.89	2
55220	Hematoma, drainage under GA, when sole procedure	305.53	2
	Note: *Payable at 50% in post-op period.*		
55225*	Hip Joint - arthrotomy, I and D	443.38	3
	Incision - Therapeutic, Release:		
55255	Soft tissue release: percutaneous	276.87	2
55270	Minor release hip, one tendon	305.53	2
55275	Major release hip, two or more	453.17	3
	Excision - Diagnostic, Percutaneous:		
S11530	Needle biopsy under GA	190.94	2
S11532	Arthroscopy and biopsy, hip	529.91	3

		$	Anes. Level
	Excision - Diagnostic, Open:		
11545	Arthrotomy and biopsy, hip	248.23	3
11546	Biopsy open, soft tissue or bone	248.23	2
	Excision - Therapeutic, Endoscopic:		
55305	Removal loose body	386.67	3
55310	Debridement or synovectomy, total	654.69	3
	Excision - Therapeutic, Open:		
55355	Bursa, excision, trochanteric, etc.	219.58	2
55360	Arthrotomy, hip: open synovectomy, total	582.39	3
55365	Benign soft tissue tumour subfascial	504.65	3
55370	Bone tumour, benign	504.65	3
S55371	Heterotopic bone resection ***Note:*** *Paid only for heterotopic bone resection which meets the criteria for Brooker Classification III or IV.*	572.55	3
55380*	Osteomyelitis, acute, decompression	305.35	3
55385*	Osteomyelitis, debridement with or without reconstruction	503.49	3
	Introduction and/or Removal, Therapeutic:		
55405*	Injection joint	15.30	
55410*	Injection bursa, tendon sheath, other peri articular structures.	15.30	
55415	Removal of internal fixation device(s), when performed in the operating room	316.89	3
55420*	Removal of internal fixation device(s), (operation only)	71.61	3
	Repair, Revision, Reconstruction (Soft Tissue):		
55505	Hip instability: soft tissue repair	668.33	3
55510	Tendon-muscle transfer, hip	812.91	3
55515	Tendon avulsion repair	610.12	3
	Repair, Revision, Reconstruction (Bone, Joint):		
	<u>Osteotomy:</u>		
55601	Pelvis, adult	936.20	6
55602	Pelvis, pediatric	936.20	6
55603	Proximal femur, adult	911.34	4
55604	Proximal femur, pediatric	926.32	4
55605	Femoral shaft, adult	926.32	4
55606	Femoral shaft, pediatric	926.32	4
55607	Multiple for Osteogenesis Imperfecta	1,036.97	6
	<u>Malunion or Nonunion:</u>		
C55631	Pelvis (including Sacroiliac joint arthrodesis) ***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.*	1,511.03	4
55632	Acetabulum	2,008.56	4
55633	Proximal femur (ie. subtrochanteric)	1,017.85	4
55634	Shaft, femur (includes closed femoral lengthening and open femoral shortening)	911.39	4
55635	Femoral lengthening, open	957.32	4

		$	Anes. Level
55636	Femoral shortening, closed	957.32	4
	Bone Grafting (ie. onlay grafting):		
55651	Femur: Intertrochanteric, shaft	276.87	4
55652	Epiphysiodesis, greater trochanter	453.10	4
	Arthroplasty:		
55661	Hip resection arthroplasty	567.73	5
55662	Hemi-arthroplasty hip	695.34	5
55663	Total hip prosthesis	849.66	5
	Revision Total Hip Arthroplasty:		
55671	Components, removal only (isolated procedure)	847.62	5
55672	Exchange of modular component	703.70	5
55673	Revision femur or acetabulum	1,095.31	6
55674	Revision femur and acetabulum, includes PROSTALAC	1,461.04	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	1,702.27	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.		
	Hip Arthroscopy:		
55520	Hip arthroscopy with labral debridement +/- microfracture/chondroplasty +/- iliopsoas release	782.43	3
55521	Hip arthroscopy with labral repair and/or abductor repair, and/or hamstring repair, +/- capsule closure	1,095.40	3
55522	Hip arthroscopy with femoral and/or acetabular osteoplasty +/- capsule closure	1,095.40	3
55523	Hip arthroscopy with labral repair and femoral and/or acetabular osteoplasty	1,356.21	4
C55524	Hip arthroscopy with labral reconstruction and/or ligamentum teres reconstruction	1,512.69	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:		
	<u>Pelvis: Operative Rx. Unstable:</u>		
55701*	Closed reduction - skeletal traction (operation only)	95.49	3
55702	Closed reduction - external fixation	506.03	4
55705	External fixation and ORIF	1,244.67	5
55706	ORIF - anterior or posterior	1,196.68	5
55707	ORIF - anterior and posterior	1,396.46	5

		$	Anes. Level
	Hip: Dislocation, Traumatic (Includes Total Hip Arthroplasty):		
55711*	Reduction hip without anesthetic (operation only)	95.49	2
55712*	Reduction hip, with GA	352.21	2
55715	Open reduction	603.57	4
	Hip: Dislocation, Congenital: Conservative Management:		
55721	Closed reduction under GA, with or without tenotomy	448.32	2
	Hip: Dislocation, Congenital: Operative Management:		
55725	Open reduction	846.54	2
55726	Open reduction and femoral or pelvic osteotomy	1,181.08	4
55727	Open reduction and femoral and pelvic osteotomy	1,540.73	4
	Hip:Fracture Dislocation, (includes lip and/or head fractures):		
55731*	Reduction hip without anesthetic (operation only)	95.49	2
55732*	Reduction hip, with GA	252.32	2
55735	Open reduction	590.45	4
55736	ORIF	1,070.00	5
55738*	Open injury, primary wound care (operation only)	152.79	2
55739*	Open injury, secondary wound management	214.45	2
	Hip: Acetabulum Fracture (one or two column fractures):		
55741*	Closed reduction	190.94	2
55745	ORIF - one approach	1,455.82	5
55746	ORIF - two approach/extensile approach	2,055.30	6
	Hip:Fracture Femoral Neck or Subcapital:		
55751	Closed reduction, internal fixation	588.89	5
55755	ORIF (with supporting documentation)	949.21	5
55758*	Open injury, primary wound care (operation only)	152.79	
55759*	Open injury, secondary wound management	214.45	2
55760	SCFE insitu fixation	592.67	5
	Hip:Fracture Intertrochanteric with or without Subtrochanteric Extension:		
55761	Reduction internal fixation	754.98	5
55768*	Open injury, primary wound care	152.79	
55769*	Open injury, secondary wound management	214.45	2
	Hip:Fracture Subtrochanteric:		
55771	Internal fixation	971.96	5
55778*	Open injury, primary wound care	152.79	2
55779*	Open injury, secondary wound management	214.45	2
	Femur: Shaft:		
55780*	Closed reduction, without GA, cast/traction (operation only)	124.11	2
55781*	Closed reduction, with GA, cast/traction (operation only)	219.58	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	409.05	4
55783	Closed reduction, IM nail	856.52	5
55785	ORIF	856.52	5
55788*	Open injury, primary wound care (operation only)	152.79	2
55789*	Open injury, secondary wound management	214.45	2
	Manipulation: Hip Joint:		
S55800*	Manipulation under GA	95.49	2

		$	Anes. Level
	Arthrodesis:		
55810	Hip joint	1,312.55	6
	Amputation:		
55980	Hemicorpectomy	2,535.69	6
55981	Hemipelvectomy	1,441.31	6
55982	Hip Disarticulation	1,225.08	6
55983	Above knee	684.95	4
55984	Knee disarticulation	684.95	4
55985	Revision, amputation, below knee, after 14 days ***Note:*** *Restricted to Orthopaedic Surgeons.*	705.49	3
55998*	Open injury, primary wound care	152.79	4
55999*	Open injury, secondary wound management	214.45	4

Femur, Knee Joint, Tibia and Fibula

	Incision - Diagnostic, Percutaneous:		
S11600	Arthroscopy knee joint	219.58	2
SY00757	Aspiration - other joints	16.54	2
S11602	Aspiration bursa, tendon sheath or other periarticular structures	23.76	2
	Incision - Diagnostic, Open:		
11615	Arthrotomy knee joint	248.23	3
	Incision - Therapeutic, Drainage:		
51039	Aspiration, bursa (operation only)	23.76	
51040	Aspiration, joint (operation only)	23.76	
56210*	Bursa, I and D (Prepatellar, etc.), under GA	316.89	2
56215*	Abcess, I and D, under GA	316.89	2
56220	Hematoma, drainage under GA, when sole procedure ***Note****: Payable at 50% in post-op period.*	316.89	2
56225*	Knee Joint - arthrotomy, I and D	316.89	3
	Incision - Therapeutic, Release:		
56250	Decompression, neurolysis, nerve	219.58	2
56260*	Fasciotomy, compartment syndrome	419.25	3
56269*	Fasciotomy, secondary closure wound, with or without Graft	214.45	2
	<u>Soft Tissue Release:</u>		
56270	Minor release knee - tendons only, uni- or bilateral	392.68	2
56275	Major release knee - includes posterior capsulotomy, uni- or bilateral	498.85	3
56280	Knee liberation/major release (post ligament reconstruction)	807.88	3
56285	Quadriceps plasty	693.24	3
56290	Open lateral / medial retinacular release	261.92	2
	Excision - Diagnostic, Percutaneous:		
S11630	Needle biopsy under GA	190.94	2
S11632	Arthroscopy - biopsy	219.58	2
	Excision - Diagnostic, Open:		
11645	Biopsy, open	248.23	2

		$	Anes. Level
	Excision - Therapeutic, Endoscopic:		
56315	Resection 'plica' (isolated procedure)	354.79	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	169.31	2
	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.*		
56323	Abrasion/debridement, extra - each additional 15 minutes, or major portion thereof	78.76	
	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.*		
56325	Meniscal repair	507.90	2
	Notes: *i) Includes 56320, debridement of attachment site.* *ii) Not paid for trimming of the meniscus.*		
56330	Abrasion / debridement (isolated procedure)	354.94	2
56335	Lateral or medial release, endoscopic (isolated procedure)	352.63	2
	Excision – Therapeutic, Knee Arthroscopic: Synovial biopsy is included in 56305, 56306, 56356, 56315, 56320, 56325, 56330 and 56322.		
56305	Removal symptomatic loose body	352.54	2
	Note: *Not paid for removal of iatrogenic loose body(ies).*		
56306	Pinning/drilling osteochondral fragment(s) for osteoarthritic cartilage deficiency	483.40	2
	Note: *Includes removal of loose body(ies).*		
56310	Synovectomy knee, for diseased synovium, anterior, posterior or complete total	521.47	2
56320	Meniscectomy knee, partial or total for symptomatic meniscal tear	354.61	2
56321	Drilling of defect or microfracture and/or abrasion arthroplasty	354.61	2
	Excision - Therapeutic, Open:		
56353	Ganglion or cyst	304.60	2
56354	Popliteal cyst	305.53	2
56355	Bursa, prepatellar	377.75	2
	<u>Arthrotomy Knee:</u>		
56356	Removal loose body	405.69	3
56357	Pinning/drilling osteochondral fragments	360.42	3

		$	Anes. Level
56360	Synovectomy knee, total	514.84	3
56361	Meniscectomy knee	271.90	3
56362	Meniscal repair	403.11	3
56365	Benign soft tissue tumour subfascial	402.81	3
56370	Bone tumour, benign	402.81	3
56380*	Osteomyelitis, acute, decompression	352.29	3
56385*	Osteomyelitis, debridement, with or without reconstruction	406.71	3
56390	Patellectomy	521.52	3
	Introduction with or without Removal, Therapeutic:		
56405*	Injection joint	24.53	
56410*	Injection bursa, tendon sheath, other peri articular structures.	24.53	
56415	Removal of internal fixation device(s), when performed in the operating room	316.89	2
56420*	Removal of internal fixation device(s), (operation only)	71.61	2
	Repair, Revision, Reconstruction (Soft Tissue):		
	Knee ligament, Instability (with or without arthroscopy)		
56505	One ligament repair/reconstruction, acute or chronic	736.91	3
56510	Posterior cruciate repair/reconstruction, acute or chronic	891.30	3
56515	Two ligament repair/reconstruction, acute or chronic	1,015.94	3
56520	Three ligament repair/reconstruction, acute or Chronic (includes PCL)	1,241.17	3
56525	Revision knee ligament reconstruction (post previous ligament reconstruction)	886.55	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)	152.79	2
56529*	Open injury, secondary wound care	214.45	2
	Recurrent Subluxation/Dislocation Patella:		
56530	Extensor realignment procedures, soft tissue/bone.	557.76	3
56531	Lateral release, open or endoscopic	376.86	2
56540	Quadriceps tendon rupture, acute (within six weeks post injury)	570.38	2
56541	Quadriceps tendon rupture, chronic (beyond six weeks post injury)	633.65	2
56542	Patellar tendon repair	570.38	2
	Notes: *i) Restricted to Orthopaedic Surgeons.* *ii) Not paid with 56540, 56541 or 56545.*		
56545	Tendon transfer, transplant	383.31	2
	Repair Reconstruction Bone/Joint:		
	Osteotomy and/or Internal Fixation: Arthritis, Malunion or Nonunion		
56601	Distal femur	948.24	3
56602	Proximal tibia	821.57	3
56603	Tibia, shaft, includes fibula	821.57	3
56604	Fibula	302.11	3
	Bone Grafting (ie. onlay grafting)		
56651	Femur	276.87	3
56652	Tibia, with or without fibular osteotomy	276.87	3
56653	Epiphysiodesis	407.77	3
56654	Physeal bar excision	562.45	3

		$	Anes. Level
	Arthroplasty: Knee Joint		
56661	Knee replacement unicompartmental	846.63	4
56662	Total knee replacement	849.66	4
56663	Total knee, removal prosthesis knee, includes PROSTALAC	519.88	4
56664	Revision total knee	1,234.01	4
56665	Revision patellar component	544.03	3
C56666	Meniscal Allograft Transplant	1,359.73	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)	124.11	2
56702*	Closed reduction, with GA, cast/traction	219.58	2
56703	Closed reduction, external fixation / percutaneous fixation	409.05	2
56704	Closed reduction, IM nail	856.44	5
56705	ORIF	856.44	4
56708*	Open injury, primary wound care (operation only)	152.79	2
56709*	Open injury, secondary wound management	214.45	2
	Metaphysis Femur: Condyle or Intracondylar		
56711*	Closed reduction, without GA, cast/traction (operation only)	95.49	2
56712*	Closed reduction with GA, cast/traction	190.94	2
56713	Closed reduction, external fixation /percutaneous fixation	409.05	2
56715	ORIF - unicondylar	856.44	4
56716	ORIF - bicondylar	1,289.64	4
56718*	Open injury, primary wound care (operation only)	152.79	2
56719*	Open injury, secondary wound management	214.45	2
	Patellar Dislocation		
56725	Open reduction and repair	248.23	2
56728*	Open injury, primary wound care (operation only)	152.79	2
56729*	Open injury, secondary wound management	214.45	2
	Patellar Fractures		
56734	Patellectomy	408.12	2
56735	ORIF	558.81	2
56738*	Open injury, primary wound care (operation only)	152.79	2
56739*	Open injury, secondary wound management	214.45	2
	Tibial Plateau Fractures		
56741*	Closed reduction, with GA, cast/traction	190.94	2
56742	Closed reduction, external fixation with or without minimal internal fixation	409.05	2
56745	ORIF - unicondylar	793.82	3
56746	ORIF - bicondylar	1,037.76	3
56748*	Open injury, primary wound care (operation only)	152.79	2
56749*	Open injury, secondary wound management	214.45	2
	Tibial Shaft Fractures		
56751*	Closed reduction, without GA, cast/traction (operation only)	95.49	2

		$	Anes. Level
56752*	Closed reduction, with GA, cast/traction	219.58	2
56753	Closed reduction, external fixation with or without minimal internal fixation	409.05	2
56754	Closed reduction, IM nail	771.87	3
56755	ORIF	771.87	3
56758*	Open injury, primary wound care (operation only)	152.79	2
56759*	Open injury, secondary wound management	214.45	2
	Fibular Shaft Fractures		
56769*	Open injury, primary/secondary wound care	190.94	2
	Manipulation: Knee Joint:		
S56800*	Manipulation, with GA	112.42	2
	Arthrodesis:		
56810	Knee joint	848.68	3
	Amputation:		
56980	Below knee	674.81	3
56998*	Open injury, primary wound care (operation only)	152.79	3
56999*	Open injury, secondary wound management	214.45	3

Tibial Metaphysis (Distal), Ankle and Foot

	Incision - Diagnostic, Percutaneous:		
S11700	Arthroscopy - ankle joint / subtalar joint	190.94	2
S11702	Aspiration bursa, tendon sheath.	23.76	2
SY00757	Aspiration - other joints	16.54	2
	Incision - Diagnostic, Open:		
11715	Ankle joint,	190.94	2
11716	Subtalar joint	190.94	2
11717	Midtarsal joint	190.94	2
11718	Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint.	190.94	2
	Incision - Therapeutic, Drainage:		
51039	Aspiration – bursa (operation only)	23.76	
51040	Aspiration – joint (operation only)	23.76	
57210*	Bursa, I and D (Tendo-achilles, etc.), under GA	316.89	2
57215*	Abcess, I and D, under GA	316.89	2
57220	Hematoma, drainage under GA, when sole procedure ***Note:*** *Payable at 50% in post-op period.*	305.53	2
57225*	Ankle/foot Joint, I and D, under GA	316.89	2
	Incision - Therapeutic, Release:		
57250	Decompression, neurolysis, nerve (isolated procedure)	305.53	2
57260*	Fasciotomy, compartment syndrome	272.17	2
57269*	Fasciotomy, secondary closure wound	201.89	2
	Soft Tissue Release: Musculo-tendonous		
57270	Plantar fascia: open release or partial excision, uni- or bilateral	276.87	2
57275	Plantar fasciectomy - total	434.21	2
57280	Achilles tendon lengthening, percutaneous, uni- or bilateral	288.96	2
57285	Posterior hindfoot release	487.99	2
57286	Posteromedial release (club foot /vertical talus)	806.67	2

		$	Anes. Level
57290	Tendon lengthening, open	309.77	2
57295	Tenosynovectomy	309.77	2
	Excision – Diagnostic:		
S11730	Needle biopsy under GA	190.94	2
11745	Open biopsy under GA	248.23	2
	Excision - Therapeutic, Endoscopic:		
57305	Removal loose body	311.84	2
57306	Pinning/drilling osteochondral fragments	448.47	2
57310	Synovectomy ankle, total	508.90	2
57330	Abrasion or debridement	331.68	2
	Excision - Therapeutic, Open:		
57354	Ganglion: tendon sheath, or joint	261.94	2
57355	Bursa, excision, achilles.	228.70	2
57356	Neuroma (ie. sensory, digital, etc.)	236.79	2
57360	Total synovectomy / debridement.	373.12	2
57365	Benign soft tissue tumour	246.78	2
57370	Bone tumour, benign	398.35	2
57371	Tarsal coalition ***Note**: Includes harvesting of interposition material, if required.*	418.29	2
57372	Sesamoidectomy	271.16	2
57373	Excision - accessory navicular	319.35	2
57374	Talectomy	576.05	2
57375	Excision - nail bed, under GA, single or multiple	226.70	2
57380*	Osteomyelitis, acute, decompression	323.02	2
57385*	Osteomyelitis, debridement with or without reconstruction.	407.46	2
	Introduction and/or Removal, Therapeutic:		
57405*	Injection joint	11.90	
57410*	Injection bursa, tendon sheath, other peri articular structures.	11.90	
57415	Removal of internal fixation device(s), when performed in the operating room	306.79	2
57420*	Removal of internal fixation device(s), (operation only)	47.73	2
	Repair, Revision, Reconstruction (Soft Tissue):		
	<u>Ankle Instability: Capsule or Ligament Repair</u>		
57505	Acute ligament repair - medial and/or lateral	287.03	2
57510	Reconstruction for ankle instability	553.90	2
	<u>Tendon Muscle Repair</u>		
57515	Tendo achilles repair - acute (within six weeks post injury)	442.37	2
57516	Tendo achilles repair - chronic (beyond six weeks post injury)	622.46	2
57520	Flexor tendon repair, ankle or foot, single or multiple	392.45	2
57525	Extensor tendon(s), without GA (operation only)	133.23	2
57526	Extensor tendon, single, under GA	313.76	2
57527	Extensor tendon, multiple, under GA	403.42	2
57535	Repair/reconstruction of tendon sheath	453.25	2
	<u>Tendon Muscle Transfer, Transplant, Tenoplasty</u>		
57550	Tendon transfer	502.99	2
57555	Jones' procedure	357.44	2

		$	Anes. Level
	Repair, Revision, Reconstruction (Bone, Joint):		
	Osteotomy/Malunion		
57601	Distal tibial	746.89	2
57602	Malleolus: lateral and/or medial	567.76	2
57603	Calcaneal osteotomy (not to include Hagelund's)	592.61	2
57604	Midtarsal osteotomy	642.32	2
57605	Metatarsals: base, shaft, neck	408.36	2
57606	Phalanges, open osteotomy	252.46	2
	Osteotomy/Nonunion		
57631	Distal tibial	664.45	2
57632	Malleolus: lateral and/or medial	499.02	2
57633	Tarsals	417.81	2
57634	Metatarsals: base, shaft, neck	264.28	2
57635	Phalanges	219.58	2
57636	Epiphysiodesis	314.38	2
57637	Physeal bar excision	483.09	2
	Bone Grafting (ie. onlay grafting)		
57651	Distal tibia	248.23	2
57652	Malleolus - medial and/or lateral-tarsals, metatarsals, phalanges	152.76	2
	Arthroplasty: Ankle Joint		
57661	Total ankle prothesis	1,102.55	3
57662	Revision total ankle	1,421.20	3
57663*	Removal of total ankle arthroplasty	190.94	3
	Metatarsal Phalangeal Joint: Arthroplasty		
57671	Excision arthroplasty great toe (Keller's cheilectomy)	302.74	2
57672	Resection/soft tissue reconstruction	326.88	2
57673	Distal metatarsal osteotomy	326.88	2
57674	Proximal metatarsal osteotomy with distal realignment.	460.88	2
57675	Implant arthroplasty	326.88	2
57676	Interphalangeal joint arthroplasty, single or multiple	276.87	2
57677	Minor forefoot reconstruction (lesser toes).	418.26	2
57678	Major forefoot reconstruction - (includes excision arthroplasty, stabilization with or without implant, includes great toe)	654.30	2
	Fracture and/or Dislocation:		
	Ankle Fracture: Intra-articular Tibial Metaphysial (PILON)		
57701*	Closed reduction, with GA, cast/traction	190.94	2
57702	Closed reduction, external fixation with or without percutaneous fixation, with or without minimal internal fixation, with or without ORIF distal fibula	501.24	2
57705	ORIF (include fibular fracture)	985.74	2
57708*	Open injury, primary wound care (operation only)	152.79	2
57709*	Open injury, secondary wound management	214.45	2
	Ankle (Malleolar) Fracture		
57711*	Closed reduction without GA, application of cast (operation only)	102.18	2
57712*	Closed reduction, with GA, application of cast	276.87	2
57713	Closed reduction, external fixation/percutaneous fixation	356.91	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.*	443.34	2

		$	Anes. Level
57716	ORIF - two or more	518.11	2
57718*	Open injury, primary wound care (operation only)	152.79	2
57719*	Open injury, secondary wound management	214.45	2
	Hindfoot/Midfoot/Lisfranc Dislocation with or without Fracture		
57721*	Closed reduction without GA, cast (operation only)	95.49	2
57722*	Closed reduction, with GA, cast	190.94	2
57723	Closed reduction, fixation	362.84	2
57725	Open reduction with or without internal fixation	617.52	2
57728*	Open injury, primary wound care (operation only)	152.79	2
57729*	Open injury, secondary wound management	214.45	2
	Os Calcis Fracture		
57732*	Closed reduction, with GA, cast	190.94	2
57733	Closed reduction, fixation	305.53	2
57735	ORIF	746.91	2
57738*	Open injury, primary wound care (operation only)	152.79	2
57739*	Open injury, secondary wound management	214.45	2
57749*	Open injury, secondary wound management	214.45	2
	Talus Fracture		
57741*	Closed reduction, without GA, cast (operation only)	95.49	2
57742*	Closed reduction, with GA, cast	190.94	2
57743	Closed reduction, fixation	353.31	2
57745	ORIF	662.37	2
57748*	Open injury, primary wound care (operation only)	152.79	2
	Tarsal Fracture		
57751*	Closed reduction, without GA, cast (operation only)	95.49	2
57752*	Closed reduction, with GA, cast	190.94	2
57753	Closed reduction, fixation	305.53	2
57755	ORIF	443.26	2
57758*	Open injury, primary wound care (operation only)	152.79	2
57759*	Open injury, secondary wound management	214.45	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	276.87	2
57765	ORIF - one	373.64	2
57766	ORIF - two or more	429.15	2
57768*	Open injury, primary wound care (operation only)	152.79	2
57769*	Open injury, secondary wound management	214.45	2
	Metatarso-Phalangeal Dislocation		
57771*	Closed reduction, without GA, cast, single or multiple (operation only)	95.49	2
57772*	Closed reduction, with GA, cast, single or multiple	190.94	2
57773	Closed reduction, fixation, single or multiple	219.58	2
57775	ORIF	373.64	2
57778*	Open injury, primary wound care (operation only)	152.79	2
57779*	Open injury, secondary wound management	214.45	2

		$	Anes. Level
	Phalangeal Fracture		
57781	Closed reduction, fixation, single or multiple	302.74	2
57785	ORIF	305.53	2
57788*	Open injury, primary wound care (operation only)	81.45	2
57789*	Open injury, secondary wound management (operation only)	112.28	2
	Interphalangeal Dislocations with or without Fracture		
57791*	Closed reduction, without GA, cast, single or multiple (operation only)	47.73	2
57792*	Closed reduction, with GA, cast, single or multiple	190.94	2
57793	Closed reduction, fixation, single or multiple	276.87	2
57795	Open reduction with or without fixation	305.53	2
57798*	Open injury, primary wound care (operation only)	81.45	2
57799*	Open injury, secondary wound management (operation only)	112.28	2
	Manipulation: Ankle/Foot:		
S57800*	Manipulation, with GA	95.49	2
	Arthrodesis:		
57810	Tibiocalcaneal	664.71	2
57811	Pantalar	896.24	2
57812	Ankle joint	801.68	3
57813	Subtalar joint/triple	856.52	2
57814	Midtarsal joint	652.29	2
57815	Tarso-Metatarsal joints	714.02	
57816	Metatarsophalangeal	443.14	2
57817	Interphangeal, single or multiple	308.75	2
	Amputation:		
57980	SYME	544.18	2
57981	Midtarsal	521.41	2
57982	Transmetatarsal	521.41	2
57983	Single metatarsal/ray resection	382.34	2
57984	Toe	190.94	2
57998*	Open injury, primary wound care (operation only)	81.45	2
57999*	Open injury, secondary wound management (operation only)	112.28	2

Vertebra, Facette and Spine

	Incision - Diagnostic, Percutaneous:		
SY00757	Aspiration - other joints	16.54	2
	Incision - Therapeutic, Percutaneous:		
58205*	Injection/aspiration facet joint	95.07	2
	Incision - Therapeutic, Drainage:		
51039	Aspiration – bursa (operation only)	23.76	
	Excision - Diagnostic, Percutaneous		
S11830	Needle biopsy - soft tissue/bone - thoracic spine, under GA	219.58	2
S11831	Needle biopsy - soft tissue/bone - lumbar spine, under GA	190.94	2
	Excision - Diagnostic, Open:		
11845	Biopsy, with GA ***Note**: Not payable with definitive spinal surgery.*	248.23	3

		$	Anes. Level
	Excision - Therapeutic, Open:		
	Decompression - Posterior		
	Laminectomy:		
03155	- for hematoma, tumour or vascular malformation	1,331.92	6
03161	- for localized spinal stenosis (two levels or less)	906.31	5
03162	- for generalized spinal stenosis (more than two levels)	1,274.70	5
03160	- for congenital spinal malformation or tethered spinal cord	2,073.75	5
03180	Multiple level laminectomy for cervical cord compression, three or more levels	1,463.12	6
	Introduction and/or Removal, Therapeutic:		
S03167	Insertion of skull tongs (operation only)	129.15	4
	Fracture and/or Dislocation (Cervical Spine):		
	Cervical		
S03167	Insertion of skull tongs (operation only)	129.15	4
58710*	Application of Halo	190.94	4

Musculoskeletal Oncology

51051	Resection of subfascial malignant soft tissue tumour, simple	644.13	5
51052	Resection of subfascial malignant soft tissue tumour, complex (involvement of neuro/vascular structures)	1,367.13	6
51053*	Resection of malignant bone tumour limb, limb sparing.	1,157.93	6
51054	Reconstruction of skeletal defect following excision	1,178.25	6
51055	Resection of malignant girdle tumour, scapula	1,107.52	6
51056*	Resection of malignant girdle tumour, pelvis and/or sacrum.	1,676.97	6
51057	Reconstruction of shoulder/pelvis or sacrum	1,360.32	6
51058	Resection of malignant tumour, rotation plasty	2,249.46	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	40.64	

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	75.71	2
13630	Paronychia - operation only	40.50	2
13631	Removal of nail - simple operation only	40.50	2
13632	- with destruction of nail bed (operation only)	81.96	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	72.32	2

Peripheral Nerve

S03196	Exploration, mobilization and transposition	287.85	2
03198	Neurectomy of major nerve	227.46	2

		$	Anes. Level
S06258	Exploration of peripheral nerve and neurolysis ***Note:*** *Multiple neurolyses are paid in accordance with Preamble Clause D. 5. 3. to a maximum of four Neurolyses per sitting.*	262.46	2

Spine

03152	Bischoff's or longitudinal myelotomy	957.28	5
03153	Laminectomy with DREZ lesion for pain	1,440.56	6
03155	Laminectomy for haematoma, tumour or vascular malformation	1,331.92	6
	Laminectomy for cervical disc:		
03156	- one level	2,049.28	6
03157	- multiple levels	2,254.72	6
	Laminectomy for lumbar disc:		
03158	- one level	802.24	5
03159	- multiple levels	1,412.24	5
03160	Laminectomy for congenital spinal malformation or tethered spinal cord	2,073.75	5
03161	Laminectomy for localized spinal stenosis (two levels or less)	906.31	5
03162	Laminectomy for generalized spinal stenosis (more than two levels)	1,274.70	5
03168	Laminectomy for intradural spinal cord or extra-medullary tumour or vascular malformation by micro-surgical technique	2,458.37	7
03180	Multiple level laminectomy for cervical cord compression, 3 or more levels	1,463.12	6
03163	Anterior cervical discectomy and fusion - one level	1,462.23	6
03164	- multiple levels	2,166.60	6
03166	Removal of thoracic disc	2,402.61	8
03185	Postero-lateral microsurgical thoracic discectomy	1,958.90	8
S03167	Insertion of skull tongs (operation only)	129.15	4
03169	Fracture of spine without cord injury - open reduction and fusion	702.27	7
03231	Repair of spinal CSF leak or pseudomeningocoele	919.30	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)	317.02	2
06050	Regions of major joints and hands - early	449.96	2

Hand and Wrist, Excision; Therapeutic, Open:

V07055	Ganglia - of the wrist	255.66	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)	562.45	5
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	301.31	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	132.78	

		$	Anes. Level
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	306.30	4
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	133.93	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	316.74	4
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	147.32	
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.*	80.35	
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.*	128.56	4

PEDIATRICS

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

		$	Anes. Level

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 271.26

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 392.49

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..... 470.54

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..... 523.23

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 175.65

***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..... 115.63

		$	Anes. Level
00585	Diabetic Ketoacidosis (DKA) – 1st day management – in hospital	522.12	

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	150.85	

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	230.08	
00515	- second hour, per 1/2 hour or major portion thereof	115.02	

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	135.72	
00507	Subsequent office visit	102.86	
00552	Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient)	119.10	

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)	181.33	

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)	265.63	

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	52.03	
	***Note**: Payable in cases of prematurity or fetal anomaly.*		
00508	Subsequent hospital visit	136.00	
00509	Subsequent home visit	196.03	
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).*	153.06	
	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	271.26	
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.*	392.49	
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.*	470.54	
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.*	523.23	

		$	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	115.63	
50514	Telehealth prolonged visit for counselling	101.02	
	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.*		
50506	Telehealth directive care	135.72	
50507	Telehealth subsequent office visit	102.86	
50517	Telehealth Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient)	119.10	
	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.*		
50518	Telehealth Extended subsequent office visit – exceeding 23 minutes (at least 20 min. spent with patient)	181.33	
	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.*		
50519	Telehealth Extended subsequent office visit – exceeding 38 minutes (at least 30 min. spent with patient)	265.63	
	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.*		
50508	Telehealth subsequent hospital visit	136.00	

Miscellaneous

50571	Pediatric evening surcharge (service rendered between 1800 hours and 2300 hours)	38.26	
50572	Pediatric Saturday, Sunday, and Statutory Holiday surcharge (service rendered between 0800 hours and 2300 hours)	38.26	
50573	Pediatric night surcharge (service rendered between 2300 hours and 0800 hours)	117.99	
	Notes: *i) Restricted to Pediatrics and Pediatric Cardiology.* *ii) Payable only in addition to fee items 00510, 00550, 00551, 00585, 01511, 01512, and 01513*		

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.....89.64

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.

P00546 Pediatric to Adult Transition Care and Communication.
For patients 15-19 years of age transitioning from community Pediatric care to adult services.....381.78

Notes:
i) Limited to one service per patient per year per physician.
ii) Limited to two services per patient per lifetime per physician.
iii) Limited to pediatricians in community practice.
iv) Limited to patients with chronic and complex medical needs.
v) Not payable unless the patient has been seen by the physician in the preceding 12 months.

vi) A visit is payable for the same patient on the same day provided the services are not concurrent and start and end times are provided for both.
vii) A written transition summary, for example the BC Pediatric Society Medical Transfer Summary form, must be recorded in the patient's chart.
viii) Transition documentation must be communicated to accepting adult service(s).

		$	Anes. Level
00547	Adolescent (12-19 years of age) care surcharge	33.00	

Notes:
i) Restricted to Pediatricians.
ii) Payable only in addition to 00510, 00550, 00551, 50510, 50515 or 50516 on the same date of service.
iii) Limited to one claim per patient per physician per day.

Special Procedures

00525	Insertion of intra-arterial infusion line in infants - extra to consultation	107.03	
00523	Exchange transfusion - procedural fee	512.88	

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.

00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	64.01	
	Electrocardiogram and interpretation:		
00527	- office (each)	39.08	
00528	- home (each)	54.32	
	Electrocardiogram:		
00529	- professional fee	13.68	
	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)	17.38	
	Graded exercise test:		
00530	- technical fee	48.23	
00535	- professional fee	70.36	
00531	- total fee	118.61	

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	64.01	
00533	- interpretation	15.01	
00534	- technical fee	48.99	
00539	Rectal suction biopsy in children	118.93	
00540	24 hour intraoesophageal pH study in children (to include probe and monitoring)	274.59	
SY00541	Pediatric urethral catheterization in child under 5 years – isolated procedure	22.26	

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.

		$	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 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 272.05
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.
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 210.19
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 123.63
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

		$	Anes. Level
	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.*	61.83	2
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.*	92.73	2
S00755	Artery puncture - procedural fee	7.15	2
S00571	Pediatric esophagogastroduodenoscopy in a patient 16 years of age and under ***Note:*** *Restricted to pediatricians and pediatric general surgeons.*	222.55	3
S00572	Pediatric colonoscopy with flexible colonoscope – patients 16 years of age and under ***Notes:*** *i) Includes biopsies, removal of polyps, collection of specimens by brushing or washing, control of bleeding, removal of foreign body, if required.* *ii) Restricted to pediatricians and pediatric general surgeons.*	408.03	2
S50520	Pediatric right heart catheterization – patients 0 – 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	401.27	4
S50521	Pediatric right heart catheterization – patients 7 – 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	300.95	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.*	115.29	
S50527	Pediatric retrograde left heart catheterization, extra – patients 0 – 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	320.95	4
S50528	Pediatric retrograde left heart catheterization, extra – patients 7 – 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	240.68	4
S50530	Pediatric trans-septal left heart catheterization – patients 0 – 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	432.50	4
S50531	Pediatric trans-septal left heart catheterization – patients 7 – 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	324.37	4
S50539	Pediatric percutaneous transluminal coronary angioplasty – patients 0- 6 years of age ***Note:*** *Restricted to BC Children's Hospital.*	913.53	4
S50540	Pediatric percutaneous transluminal coronary angioplasty – patients 7- 16 years of age ***Note:*** *Restricted to BC Children's Hospital.*	685.14	4

		$	Anes. Level
S50541	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 0 – 6 years of age	481.58	4
	Note: *Restricted to BC Children's Hospital.*		
S50542	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 7– 16 years of age	361.19	4
	Note: *Restricted to BC Children's Hospital.*		
S50545	Pediatric therapeutic radiological embolization – patients 0 – 6 years of age	837.65	3
	Note: *Restricted to BC Children's Hospital.*		
S50546	Pediatric therapeutic radiological embolization – patients 7 – 16 years of age	628.26	3
	Note: *Restricted to BC Children's Hospital.*		
50550	Percutaneous cardiac stenting in pediatric patients (0 – 18 years of age) - composite fee (operation only)	1,174.66	7
	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.* *v) Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.*		
50551	Additional stents – extra	247.30	
	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)	1,174.66	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.*		
T50556	Fetal Echocardiogram (Per 15 minutes or greater portion thereof)	60.60	
	Notes: *i) Restricted to Pediatric Cardiologists.* *ii) When antenatal consultation (00590) or antenatal follow-up visit (00597) is charged in addition, for billing purposes the antenatal consultation fee shall constitute the first ½ hour or the antenatal follow-up visit will constitute the first 15 minutes of the time spent with the patient.* *iii) Start and end times of the pediatric cardiologist must be entered in both the billing claims and the patient's chart.*		

iv) Not payable with any services performed concurrently.
v) Limited to maximum of 6 units per patient per sitting.

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	716.38	
01521	Day 2 - 10	288.18	
01531	Day 11 onward	193.65	
	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	550.09	
01522	Day 2 - 10	202.59	
01532	Day 11 onward	146.48	
	LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.		
01513	Day 1	474.76	
01523	Day 2 - 10	149.74	
01533	Day 11 onward	133.50	

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.

		$

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	303.31
00611	Extended Adult Psychiatry Consultation > 68 minutes	410.62

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	303.31
00613	Geriatric consultation (patients 75 years or older)	454.98
00622	**Emotionally disturbed child:** Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian, or other relatives and written report	530.80
00623	**Multiple disturbed family (three or more members)**: Simultaneous diagnostic interviews or examination, including mental status of the members, their interactions, and written report	530.80

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)	154.58
00614	Geriatric (see 00613)	227.48
00626	Emotionally disturbed child (see 00622)	265.40
00627	Multiple disturbed family (see 00623)	265.40

Continuing care by consultant:

Psychiatric Treatment

00607	Office visit to include services such as chemotherapy management and/or minimal psychotherapy	65.14
00608	Hospital visit	65.14
00609	Home visit	87.26
00605	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	170.45

Note: *Claim must state time service rendered.*

Individual (office or hospital out-patient):

00630	- per 1/2 hour	132.44
00631	- per 3/4 hour	198.67
00632	- per 1 hour	264.89

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	132.44
00651	- per 3/4 hour	198.67
00652	- per 1 hour	264.89

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	132.44
00635	- per 3/4 hour	198.67
00636	- per 1 hour	264.89
00638	- per 1 ¼ hour	331.04
00639	- per 1 ½ hour	397.32

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	64.52
00664	Four patients	50.48
00665	Five patients	42.05
00666	Six patients	36.44
00667	Seven patients	32.43
00668	Eight patients	29.40
00669	Nine patients	27.07
00670	Ten patients	25.19
00671	Eleven patients	23.67
00672	Twelve patients	22.39
00673	Thirteen patients	21.32
00674	Fourteen patients	20.39
00675	Fifteen patients	19.59
00676	Sixteen patients	18.88
00677	Seventeen patients	18.26
00678	Eighteen patients	17.71
00679	Nineteen patients	17.22
00680	Twenty patients	16.78
00681	Greater than 20 patients (per patient)	16.38

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.	303.31
60613	Telehealth Geriatric consultation (patients 75 years or older)	454.98
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	530.80
	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	154.58
60614	Telehealth - Geriatric consultation	227.48
60626	Telehealth - Emotionally disturbed child	265.40
	Telehealth Psychiatric Treatment:	
60607	Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy	65.14
60608	Telehealth hospital in-patient visit	65.14
	Individual Telehealth Psychiatric Treatment:	
60630	- per 1/2 hour	132.44
60631	- per 3/4 hour	198.67
60632	- per 1 hour	264.89

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	132.44
60635	- per 3/4 hour	198.67
60636	- per 1 hour	264.89
60638	- per 1 ¼ hour	331.04
60639	- per 1 ½ hour	397.32

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	66.22

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.	66.22

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	66.22

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	107.05
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.	66.22

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 235.72

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 134.58

01714 Prolonged visit for counselling (up to four annually. See Preamble, D. 3. 3.) 87.01
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 155.06
01715 Second hour, per 1/2 hour (or major portion thereof) 77.49
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 118.47
01707 Office visit 118.56
01708 Hospital visit 76.92
01709 Home visit 161.32
01705 Emergency visit when specially called 116.05
(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 235.72

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 134.58

01776 Telehealth directive care 118.47
01777 Telehealth office visit 118.56
01778 Telehealth hospital visit 76.92

Miscellaneous:

01728 Biofeedback for neurological and/or muscular retraining 22.93
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	36.64
01731	- professional fee	53.48
01732	- total fee	90.12

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	97.49

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 Queryrat*
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	111.03	
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	54.56	
	<u>Continuing care by consultant</u>:		
06007	Subsequent office visit	31.22	
06008	Subsequent hospital visit	38.86	
06009	Subsequent home visit	129.50	
06005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	127.56	
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.*	111.03	
	<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	111.03	
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	54.56	
66007	Telehealth subsequent office visit	31.22	
66008	Telehealth subsequent hospital visit	38.86	

Surgical Fee Modifiers

P06003 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery performed when:

- The patient has a Body Mass Index (BMI) of 35 or greater for major surgery.

Notes:

i) Payable only to Plastic 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 plastic 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) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the BMI surcharge.

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

vii) Payable when the following Plastic Surgery fee items are performed for patients with a BMI of 35 or greater: 06031, 06032, 06085, 06086, 06127, 06128, 06150, 06151, 06156, 06159, 06164, 06165, 06166, 06167, 06168, 06169, 06170, 06177, 06178, 06179, 06215, 06220, 61050, 61053,61054, 61152, 61156, 61157, 61158, 61166 and 61167.

		$	Anes. Level

Skin and Subcutaneous Tissues

Biopsy

61291	Biopsy, not sutured	91.11	
61292	Biopsy, not sutured, multiples same sitting, maximum of four (extra)	25.58	

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).

07025	Temporal artery biopsy (operation only)	203.96	2
07028	Biopsy of sural nerve – operation only	181.28	2
	Excision - Diagnostic, Open:		
11445	Open biopsy, hand or wrist	265.66	2
	Incisional or excisional biopsy, includes suture closure		
13600	Biopsy of skin or mucosa (operation only)	59.26	2
13601	Biopsy of facial area (operation only)	59.26	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)	77.73	2
	Hand and Wrist		
	Incision - Diagnostic, Percutaneous:		
S11402	Aspiration bursa, synovial sheath, etc	23.76	2

Abscess – incision and drainage

	Abscess:		
07059	- deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	83.30	2
07027	- under general anesthesia or procedural sedation (operation only)	255.34	2
07061	- deep, post operative wound infection under general anesthesia (operation only)	230.09	2
07045	Anterior closed space abscess - operation only	103.74	2
13605	Opening superficial abscess, including furuncle operation only	50.75	2

		$	Anes. Level
	Pilonidal Cyst or Sinus		
70084	- incision and drainage abscess (operation only)	103.66	2
07685	- excision or marsupialization - operation only	306.79	2
	Hand and Wrist Abscess		
06028	Web space abscess - (operation only)	306.47	2
06029	- under general anesthetic (operation only)	352.43	2
06042	Mid palmar, thenar, and dorsal: subaponeurotic space abscess – (operation only)	306.47	2
06197	Acute tenosynovitis - finger - (operation only)	367.70	2
06198	- ulnar or radial bursa – (operation only)	367.70	2
13630	Paronychia - operation only	40.50	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)	562.45	5
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	301.31	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	132.78	
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	306.30	4
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	133.93	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	316.74	4
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	147.32	
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	80.35	
	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)	128.56	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.*		

		$	Anes. Level

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	Extraction of foreign body from a wound requiring general anesthesia or procedural sedation - operation only	306.47	2

Notes:

i) Also, payable when performed under local anesthetic if the extraction requires at least 30 min and is complicated due to:
- *a) The need for increased surgical exposure, or*
- *b) A delicate or deeper dissection, or*
- *c) Difficulty localizing the foreign body*

ii) If performed under local anesthetic, a note record must be provided with the length of the procedure and explaining why the extraction was complex in nature.

13610	Minor laceration or foreign body - not requiring anesthesia - operation only	40.64	

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	75.71	2

Ablation

Abrasive Surgery

06112	Abrasive surgery - less than quarter face (operation only)	129.56	3
S06113	- between quarter and half-face	251.75	3
S06114	- full face	535.64	3

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)	35.87	

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)	80.00	
00219	For each additional lesion – to a maximum of two additional lesions per day (operation only)	40.00	

* *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)	70.65	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)	105.84	3

		$	Anes. Level
00237	Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia	57.35	

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	332.49	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	141.11	2

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)	255.66	2
07075	- inguinal (operation only)	255.66	2
07076	- perianal (operation only)	255.66	2
07082	- perineal (operation only)	255.66	2

Nail Surgery

13631	Removal of nail - simple operation only	40.50	2
13632	- with destruction of nail bed (operation only)	81.96	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	72.32	2

Ganglia

06182	Ganglia of tendon sheath or joint	186.40	2

Torn Ear Lobe

06027	Repair of torn (split) earlobe (simple) (operation only)	120.99	3

Notes:
i) Single flap only, under 2 cm.
ii) Paid only for complete tear of lobe through margin.

		$	Anes. Level

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)	140.65	2
S61301	- up to 5 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)	208.38	2
S61302	- 5.1 to 10 cm - other than face, simple closure (operation only)	250.06	2
S61303	- 5.1 to 10 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)	260.48	2
S61304	- 10.1 to 15 cm - other than face, simple closure (operation only)	291.75	2
S61305	- 10.1 to 15 cm - on face and/or requiring tying of bleeders and/or closure in layers (operation only)	364.67	2
S61306	- 15.1 cm or more - other than face, simple closure (operation only)	312.57	2
S61307	- 15.1 cm or more – on face and/or closure in layers (operation only)	416.77	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	208.38	2

Notes:
i) Restricted to Plastic Surgery, Orthopaedics.and Otolaryngology.
ii) Paid in addition to 61300-61307 and 61310-61322.

Wounds - avulsed and complicated (in special areas)

V70150	Complicated lacerations of tongue, floor of mouth	276.62	3
06238	Repair of complicated fingertip injury under digital block or anesthetic (regional/general) **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*.	280.78	2
06075	Lips and eyelids	347.09	3
06076	Nose and ear	436.01	3
06077	Complicated lacerations of the scalp, cheek and neck	340.66	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.*

		$	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)	125.04	
S61311	Resulting in a repair 5 - 10 cm (operation only)	161.49	
S61312	Resulting in a repair greater than 10 cm (operation only)	239.65	

Face, scalp, neck, genitalia, hands, feet, axilla

S61313	Resulting in repair less than 5 cm (operation only)	172.95	
S61314	Resulting in repair 5 -10 cm (operation only)	229.22	
S61315	Resulting in repair greater than 10 cm (operation only)	281.33	

Eyelids, ears, lips, nose, mucous membrane, eyebrow

S61316	Resulting in repair less than 2 cm (operation only)	189.18	
S61317	Resulting in repair 2 - 4 cm (operation only)	224.98	
S61318	Resulting in repair greater than 4 cm (operation only)	296.95	
61319	For excision of lesion (in hospital), to achieve tumour-free margin with frozen section, (extra)	132.82	

Notes:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Paid once per sitting.
iii) Paid with 61310-61318, 61320-61322 and 61325-61341.

		$	Anes. Level

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)	62.51	2
61321	Area 51-100 cm^2 (minimum 51 cm^2) – extra (operation only)	143.17	2
61322	Area over 100 cm^2 (minimum 101 cm^2) – extra (operation only)	204.53	2

Notes:

i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Not paid with direct linear closure fees (61310-61318).
iii) For areas ≥10 cm^2.
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)	189.64	2
61325	- 2.1 to 5 cm (operation only)	239.65	2
61327	- 5.1 to 10 cm (operation only)	363.31	2

Other Areas:

61326	- 2.1 to 5 cm (operation only)	186.51	2
61328	- 5.1 to 10 cm (operation only)	238.75	2
61329	- defects more than 10 cm (such as a thoracic abdominal flap)	402.76	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 cm^2	312.82	2

		$	Anes. Level
61331	Defect 40 cm^2 to 100 cm^2	332.17	2
61332	Defect greater than 100 cm^2	433.25	2
	Arms, legs and scalp		
61333	Defect up to 6 cm^2	312.68	2
61334	Defect 6 cm^2 to 19 cm^2	353.83	2
61335	Defect greater than 19 cm^2	469.23	2
	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck		
61336	Defect up to 6 cm^2	312.68	2
61337	Defect 6 cm^2 to 19 cm^2	354.62	2
61338	Defect greater than 19 cm^2	479.62	2
	Ears, eyelids, lips and nose		
61339	Defect up to 6 cm^2	354.88	2
61340	Defect 6 cm^2 to19 cm^2	468.28	2
61341	Defect greater than 19 cm^2	520.79	2
	Revision of Graft		
61342	Revision, less than 2 cm	207.61	2
61343	Revision, between 2 and 5 cm	249.13	2
61344	Revision, greater than 5 cm	290.65	2
	Specialized Flaps		
06026	Arterial island flap	361.91	2
06177	Neurovascular pedicle flap	761.28	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	604.85	2
06031	– second stage - over 10 cm^2	482.16	2
06032	Lower extremity (plaster cast included) - initial stage - over 10 cm^2	726.33	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	361.91	4
06034	Minor Second stage - per operation - under 10 cm^2	240.71	3
06035	Delaying a flap (operation only) - under 10 cm^2	167.18	3
	Specific areas: **Eyebrow**		
06148	Hair bearing scalp vascular island flap to eyebrow	494.93	3
	Hand		
06171	Syndactyly, local flaps - first cleft	306.47	2
06172	- with skin grafts - first cleft	511.31	2

		$	Anes. Level
	Free Skin Grafts (including mucosa)		
	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)	233.55	2
61351	Arms, legs, scalp (2 to 19 cm^2)	347.38	2
61352	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm^2)	363.31	2
61353	Ears, eyelids, lips and nose (2 to 19 cm^2)	404.85	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)	317.02	2
	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)	306.79	2
06047	- 65 sq.cm. (operation only)	441.77	2
06048	- 650 sq.cm.	662.66	2
06049	For each 6.5 sq.cm. over 650 sq.cm. (operation only)	8.18	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)	317.02	2
06050	Regions of major joints and hands - early	449.96	2
06058	- late - with scar excision graft	535.64	2
06052	Head and neck - 65 sq.cm. or less	449.96	3
06053	- in excess of 65 sq.cm.	662.66	3
06054	- in excess of 195 sq.cm.	1,057.36	3
	Major Flap Procedures		
06151	Decubitus ulcers - excision and treatment of bone, rotation flaps, and skin grafts to secondary defect	886.31	4
61152	Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment	930.59	4
	Note: *To include umbilicoplasty where medically indicated*		

		$	Anes. Level
C61156	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving small muscles	454.85	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.

C61157	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving medium muscles	645.19	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	976.61	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)	665.26	3
06110	- dynamic slings with local functional muscle transfer (unilateral)	803.47	3
06120	Complete repair for facial paralysis, plication of paralyzed muscles, meloplasty, and resection of overactive muscles – bilateral	857.04	3

		$	Anes. Level
06129	Combined complete repair as above and rhytidectomy – unilateral	997.06	3

Cell-assisted Lipotransfer for soft defects (Aspiration and Injections)

	Cell-assisted Lipotransfer – Aspiration		
S61250	- Volume less than 20 ml	97.09	3
S61251	- Volume between 21-60 ml	122.59	3
61252	- Volume greater than 60 ml	163.50	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.

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	157.25	3
S61261	- Volume greater than 20 ml	224.73	3
	Non-functional area:		
S61270	- less than 20 ml	127.64	3
S61271	- 21 to 60 ml	173.66	3
61272	- greater than 60 ml	214.56	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	664.71	3
06086	Tissue expansion - minor areas	359.94	2

		$	Anes. Level

Blepharoplasty

06125	Blepharoplasty, simple, non-cosmetic (unilateral)	306.47	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)	414.81	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.

06126	Blepharoplasty, complicated, non-cosmetic (unilateral)	434.61	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)	602.61	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.

<u>Eyebrow ptosis</u>

61360	Eyebrow ptosis repair - simple skin excision- non-cosmetic – unilateral	267.82	
61361	Eyebrow ptosis repair - simple skin excision – non-cosmetic – bilateral	401.71	

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	409.05	2

		$	Anes. Level
61364	- second to sixth tendon repair (extra)	204.53	2
61365	- seventh to eleventh tendon repair (extra)	102.26	2
61366	– twelfth and over tendon repair (extra)	51.14	2
	Extensor - primary or secondary repair		
61368	- first tendon	304.45	2
61369	- second to sixth tendon repair (extra)	143.17	2
61370	- seventh to eleventh tendon repair (extra)	71.59	2
61371	– twelfth and over tendon repair (extra)	35.79	2
	Tenoplasty - tenodesis, tenovaginitis, shortening or lengthening, stenosing tenosynovitis:		
06186	- one tendon, any location	276.24	2
06187	- two or more tendons	393.88	2
06188	Tenolysis	401.01	2
06189	- each additional, to a maximum of three (extra) (operation only)	148.73	2
06185	Tendon graft	721.59	2
06203	Tendon transfer in hand and wrist	511.54	2
06204	- each additional, to a maximum of three (extra)	184.15	2
06175	Pollicization	1,176.62	4
06176	Digital transplant	974.27	5
S61230	Needle Aponeurectomy - Dupuytren's Disease	194.11	
	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	276.87	2
06193	Extensive palmar - fasciectomy involving one or more digits	511.31	2
06194	- with skin grafting	613.58	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	472.63	3

Cavity grafting

06055	Eye socket	451.00	3
06056	- with mucosa	690.97	3
06057	Nose	402.81	3
06060	Mouth	535.64	3
06061	Lining pedicle flaps	307.47	3
06062	Bone cavity over 7.5 cm in diameter in large bone, e.g.: femur	451.00	4
06065	Bone cavity up to 7.5 cm in diameter in large bone	318.17	3
06064	Bone cavity in small bone, e.g.: hand or foot	260.69	2
06066	Operation for congenital absence of vagina (McIndoe) plastic surgery and care	595.63	4

		$	Anes. Level

Burns (with or without general anesthesia - per operation)

General care, severe only:

06083	- first hour	260.69	
06084	- subsequent hour (per hour)	208.54	
	- 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)	58.92	4
06079	- surgical debridement-for each 5% of body surface (operation only)	125.12	5
06080	- subsequent debridement-for each 5% of body surface (operation only)	31.06	5
06081	Surgical excision of burnt tissue prior to immediate skin grafting-for first 5 percent of body surface, extra (operation only)	384.59	5
06082	- for each subsequent 5 percent of body surface, extra (operation only)	208.54	5

Osteomyelitis

06087	Incision subperiosteal abscess (operation only)	260.69	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	456.05	6
06241	Wiring with Gunning splints or dentures	468.23	6
	Open reduction:		
06242	- unilateral	766.97	6
06243	- bilateral	920.36	6

		$	Anes. Level
	Open reduction and intermaxillary wiring:		
06244	- unilateral	818.10	6
06245	- bilateral	1,022.63	6
06246	Removal of sutures, intra-oral splints, etc., under general anesthetic - (operation only)	308.29	4
	Fracture-maxilla (central mid-third):		
06250	Le Fort I - horizontal fractures	1,073.76	6
06251	Le Fort II - pyramidal fractures	1,176.02	6
06252	Le Fort III - cranio facial dysjunction	1,329.41	6
06253	Open reduction and internal or external craniomaxillary wire suspension with or without intermaxillary fixation	1,227.15	6
	Fracture - Zygomatic (lateral mid-third):		
	Zygomatico-maxillary, including orbital floor		
06260	Temporal elevation (operation only)	357.92	3
06261	Open reduction and interosseous wiring (to include antral packing where necessary)	690.27	4
06262	Reduction via transantral approach and antral packing (operation only)	468.29	4
	Zygomatic arch:		
06265	Temporal elevation (operation only)	383.49	3
06266	Open reduction and interosseous wiring	456.35	4
	Orbital floor fractures (blow-out fractures):		
06270	Open reduction (to include antral packing where necessary)	818.10	4
	Fracture-alveolus:		
06271	Alveolar fracture - with one tooth extraction (operation only)	131.10	3
06272	- each additional tooth (operation only)	81.52	3
06273	Arch bar fixation of teeth	418.89	3
	Temporo-mandibular joint:		
06280	Meniscectomy	456.35	3
06281	Condylectomy	522.20	3
06282	Arthroplasty	818.10	3
	Mandibular resection:		
06291	Tumours - enucleation, partial, or complete resection	620.26	4
06292	- with bone graft	880.26	4
06293	Bone graft to jaw or face - autologous	588.01	4
06294	- non-autologous	536.88	4

Maxillo-facial

	Osteotomies:		
C06300	Le Fort I - horizontal	1,155.68	6
C06301	Le Fort II - pyramidal	1,431.11	6
C06302	Le Fort III - intracranial	2,973.49	8
C06303	Le Fort III - extracranial	2,532.81	7
	Bilateral orbital advancement – intracranial approach for correction of hypertelorism when done as a team procedure with a Neurosurgeon and Plastic Surgeon		

		$	Anes. Level
61380	Plastic Surgery portion	2,285.82	8
03080	Neurosurgery portion	2,285.82	8
	Unilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
P61381	Plastic Surgery portion	2,120.57	8
03081	Neurosurgery portion	2,120.57	8
	Bilateral orbital advancement – intracranial approach – when done as a team procedure with a Neurosurgeon and Plastic Surgeon		
61382	Plastic Surgery portion	2,836.39	8
03082	Neurosurgery portion	2,836.39	8
C06310	Unilateral orbital advancement, intracranial approach	2,863.31	8
C06311	Intracranial orbital advancement and correction of hypertelorism	3,193.82	8
C06312	Intracranial correction of hypertelorism	3,854.85	8
C06313	Unilateral orbital expansion by osteotomy for macrophthalmia	3,083.65	8
06314	Canthopexy	593.12	3
C06304	Malar maxillary	1,320.94	6
	Mandibular - for prognathism, micrognathism, malocclusion, etc.:		
C06305	- unilateral with intermaxillary fixation	825.17	6
C06306	- bilateral with intermaxillary fixation	990.43	6
C06307	Premaxillary set back	825.17	6
C06308	Mandibular osteotomy with rigid internal fixation - unilateral	841.69	6
C06309	- bilateral	1,210.76	6

Nose and Sinuses

	Cryosurgical treatments of turbinates:		
02298	- unilateral	156.55	3
02299	- bilateral	195.68	3
02306	Submucous resection of septum	169.58	3
	Rhinoplasty:		
06109	Removal of hump	281.03	3
06118	Bone graft to nose-autologous	614.75	3
06119	- non-autologous	504.58	3
06115	Forehead rhinoplasty- two operations	938.44	3
	***Note**: Partial forehead rhinoplasties charge under item 61339, 61340, or 61341.*		
02351	Nasal refracture requiring lateral osteotomies	401.44	3
02352	Reconstruction of nasal tip, ala, and columella	473.12	3
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma).	633.73	3
02354	Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture, and/or reconstruction of nasal tip, without skin grafting via closed approach	688.20	3
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and/or reconstruction of nasal tip without skin grafting via open (or external) approach.	927.33	3
	***Note:** To include a columellar incision with marginal incisions.*		
06116	Composite graft	357.68	3
06117	Rhinophyma	342.63	3

		$	Anes. Level
	Fractures:		
06123	Comminuted nasal fractures – transosseous wire plate fixation	314.00	3
06124	Naso-orbital fractures-open reduction and interosseous wiring or transosseous wire plate fixation	545.34	3
02364	Nasal fracture - simple reduction (operation only)	101.81	3
S02365	- reduction and splinting (operation only)	178.36	3

Ears

06131	Outstanding ears - unilateral otoplasty	352.80	3
61031	Outstanding ears - bilateral otoplasty	562.45	3
06132	Microtia or loss of ear - partial - per stage	434.30	3
06133	- total - major stage	959.59	3
06134	- total - minor stage	314.00	3
06130	Accessory auricle (operation only)	286.34	3
06135	Preauricular sinus - simple	301.76	3
06180	- complicated	311.21	3

Mouth

06181	Lip adhesion procedure for cleft palate	402.12	3
06146	Lip shave - vermilionectomy	408.16	3
06136	Plastic repair, e.g.: Abbe operation - two stages	766.97	4
06137	Full lip thickness transfer by rotation flap	664.71	4
06139	Unilateral cleft lip	740.58	4
06138	Bilateral cleft lip - complete	1,227.15	4
06144	- incomplete	767.89	4
06140	Wedge resection of lip – vermilion (operation only)	205.11	3
06141	- to sulcus	256.39	3
06142	Pharyngoplasty or pharyngeal flap	715.21	6
06143	Push-back of palate - with pharyngeal flap or similar procedure	919.74	6
06145	Cleft palate	715.21	6
06147	Bone graft to palatal cleft	626.86	4

Orbit

06153	Bone graft to orbit-autologous	626.86	4
06154	- non-autologous implant	472.63	4

Breast

Note: See Preamble regarding cosmetic surgery.

06150	Reduction mammoplasty for hypermastia - unilateral ***Note:*** *For ptosis, cosmetic only.*	664.71	4
61050	Reduction mammoplasty for hypermastia – bilateral ***Note****: For ptosis, cosmetic only.*	955.20	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.*	206.89	

		$	Anes. Level
P61046	Biologic tissue for breast reconstruction - extra	310.32	
	Notes: *i) Payable only in addition to fee items 06164 or 06165 or 06085.* *ii) Payable only for cases that require major functional repair.* *iii) Not payable for secondary revision cases requiring pocket modifications for cosmetic corrections.* *iv) Paid at 100% for unilateral and 150% for bilateral reconstruction.* *v) Payable only to Plastic Surgeons.*		
06085	Tissue expansion - major areas - breast, scalp and tibial areas, regions of major joints	664.71	3
61047	Filling of tissue expander	55.51	
	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.*		
T61048	Drainage of post-operative hematoma of the breast under general anesthesia or procedural sedation, when sole procedure	298.77	3
C61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	976.61	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)	1,124.89	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	1,227.15	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	3,476.93	5

Cell-assisted Lipotransfer for soft defects (Aspiration and Injections)

		$	Anes. Level
	Cell-assisted Lipotransfer – Aspiration		
S61250	- Volume less than 20 ml	97.09	3
S61251	- Volume between 21-60 ml	122.59	3
61252	- Volume greater than 60 ml	163.50	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.

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	127.64	3
S61271	- 21 to 60 ml	173.66	3
61272	- greater than 60 ml	214.56	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	409.05	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)	1,124.89	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.

		$	Anes. Level
	Prosthetic breast replacement in unilateral agenesis or following mastectomy:		
06164	- unilateral	613.58	3
06165	- bilateral	818.10	3
61166	Mastopexy, balancing unilateral (isolated procedure)	664.71	3
61167	Mastopexy, balancing – when performed at same time as contralateral breast surgery	460.19	3
06178	Excision of breast implant and associated pathologic capsule	419.28	2
06179	Excision of breast implant only (operation only)	251.26	2
06157	Nipple-areolar reconstruction ***Note:*** *This procedure is to result in a pigmented areolar complex using pigmented epithelium.*	378.38	2
61057	Nipple areolar reconstruction and tattooing ***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.*	468.20	2

Leg

06127	Lymphoedema of limbs, excision and grafting - entire leg	715.88	3
06128	- entire lower extremity	1,070.26	3
06167	Treatment of lymphoedema, using the Thompson procedure - upper extremity forearm	361.91	4
06168	- arm (Total of $577.96 whether one or two stages.)	240.71	4
06169	- lower extremity leg	604.86	4
06170	- thigh (Total of $1,160.18 whether one or two stages.)	604.86	4

Microsurgery

06259	Microsurgical removal of neoplasm – digital or palmar	343.64	2
	Microneural Surgery:		
	Neurolysis:		
06210	- external	347.38	2
06211	- intraneural	448.87	2
	Microfascicular neurorrhaphy, primary:		
06212	- digital or palmar	408.74	2
06213	- major nerve	628.85	2
	Interfascicular nerve graft (to include harvest of graft):		
06214	- digital or palmar	545.66	2
06215	- major nerve	1,636.20	4
03207	Microsurgical removal of neoplasm - major peripheral nerve	833.63	3
	Microvascular Surgery:		
06216	Artery or vein - primary repair (to include operative report) ***Note:*** *If a major artery in trunk, anesthetic IC Level 9.*	690.76	6
C06220	Free flap, including closure of defect at donor site	3,476.93	5

		$	Anes. Level
	Microreimplantation:		
C06217	Digit or extremity (to include operative report)	3,476.93	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	71.46	

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 00198, and 13197 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.

Amputations

06218	Transmetacarpal	306.79	2
06219	Finger, any joint or phalanx (operation only)	306.79	2

Bone Grafting

06221	Inlay bone grafting of metacarpal or phalanx	362.95	2

Fractures

06222	Finger phalanx, requiring reduction (operation only)	129.56	2
06223	Metacarpal requiring reduction (operation only)	129.56	2
61222	CRIF of phalangeal (middle or proximal) or metacarpal fracture	306.78	2
61223	ORIF of phalangeal (middle or proximal) or metacarpal fracture	409.05	2

Note: *Multiple fractures paid in accordance with Preamble D. 6.*

61224	Open (compound) hand fracture – Primary wound management (operation only)	46.02	2

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.

61225	Open (compound) hand fractures – Secondary Wound Management (operation only)	92.04	2

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.

		$	Anes. Level
	Distal phalanges open reduction and wiring:		
06224	- first	426.62	2
06225	- each additional (extra) (operation only)	292.48	2

Joints - Interphalangeal or Metacarpophalangeal

06228	Arthroplasty of metacarpophalangeal or interphalangeal (hand) joint	352.55	2
06229	Arthrodesis of metacarpophalangeal or interphalangeal (hand) joint	352.55	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.*	1,014.66	3
06232	Finger joint prosthesis - first joint	265.52	2
06233	- subsequent joints same sitting – each (operation only)	150.92	2
06234	Synovectomy - of flexor or extensor tendons in wrist and hand for rheumatoid disease	359.15	2
06235	Intrinsic release	281.22	2
	Dislocations:		
06236	Metacarpophalangeal or interphalangeal joint: - closed reduction (operation only)	128.19	2
06237	- open reduction (operation only)	260.69	2

Nerves

	Peripheral nerve:		
06255	Minor, digital, primary suture or secondary	260.69	2
06256	Repair of palmar nerve	260.69	2
06257	Major, primary suture	412.43	3
S06258	Exploration of peripheral nerve and neurolysis ***Note:*** *Multiple neurolyses are paid in accordance with Preamble, clause D. 5. 3. to a maximum of four neurolyses per sitting.*	262.46	2
S03196	Exploration, mobilization and transposition	287.85	2
03198	Neurectomy of major nerve	227.46	2
03200	Secondary suture including transposition	588.25	3
03201	Secondary suture of major nerve	447.63	3
03205	Nerve graft	441.58	3
06156	Transplant of neuroma	260.69	2

Tattooing Surgery (for haemangiomata, vitiligo, lentigines, etc.)

	Facial area:		
S06200	Less than one-quarter of face (operation only)	117.28	3
S06201	One-quarter to one half of face	240.71	3
S06202	Full face	361.91	4
	Nonfacial area:		
06205	Less than 6.5 sq.cm. (operation only)	61.11	2
S06206	Less than 65 sq.cm. (operation only)	120.99	2
S06207	Less than 650 sq.cm. ***Note:*** *Fee items 06205-06207 are not payable for nipple areolar tattooing.*	240.71	2

		$	Anes. Level
Salivary Gland and Ducts – Excision			
07522	Local excision of parotid tumour - without nerve dissection (operation only)	208.23	3
Arteries			
	Trauma:		
	Repair of injury of major vessel in extremity:		
77330	- suture	596.96	6
77335	- graft	767.87	6
Elbow, Proximal Radius and Ulna			
	Incision - Therapeutic, Release:		
53250	Decompression, neurolysis, nerve	368.81	2
53255	Decompression, neurolysis, submuscular transposition of nerve	473.09	2
	Repair, Revision, Reconstruction (Soft Tissue):		
53520	Biceps tendon, longhead, tenodesis	302.11	2
Shoulder Girdle, Clavicle and Humerus			
	Repair Revision, Reconstruction (Soft Tissue):		
52555	Tendon transfer transplant	727.32	

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	121.20	
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	60.61	
	Continuing care by consultant:		
07007	Subsequent office visit	36.38	
07008	Subsequent hospital visit	31.70	
07009	Subsequent home visit	51.14	
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)	121.20	
	Note: *Claim must state time service rendered.*		
07006	Directive care in emergent surgical conditions - per visit	31.70	
	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)	31.70	
	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	121.20	

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	202.02	
71017	Special office visit for new diagnosis or recurrent malignancy	85.91	

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 18 months prior.

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

70070	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and written report	120.19	
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	60.61	
70077	Telehealth subsequent office visit	33.50	
70078	Telehealth subsequent hospital visit	31.70	
70076	Telehealth directive care in emergent surgical conditions - per visit	31.70	

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	202.02	
70087	Telehealth Special office visit for new diagnosis or recurrent malignancy	85.91	

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.*	119.97	
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.*	71.88	

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 308.71

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.)	106.35	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10089.
iii) Not paid unless 10087 or 01871 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)	80.50	

Notes:

i) Restricted to General Surgeons
ii) Not paid on same date of service as 10087 or 10088.
iii) Not paid unless 10087 or 01871 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+)	92.04	

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, 07483, 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, 33330, 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.

07003 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery performed

- The patient has a Body Mass Index (BMI) greater than or equal to 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 or equal to 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, 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 or equal to 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

		$	Anes. Level
	Total operative fee(s) for procedures(s):		
00195	- less than $317.00 inclusive	147.95	
00196	- $317.01 to 529.00 inclusive	209.92	
00197	- $529.01 to $869.00 inclusive	309.31	
P13197	- greater than $869.00	450.00	
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	34.10	

Notes:

i) *Surgical assist fees are based on the total operative fee(s) for the associated surgical procedure(s). Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s).*

ii) *When a physician provides surgical assistance for two surgeries at different operative sites under one anesthetic, they may charge a separate surgical assistance fee for each surgery. This applies whether the two surgeries were performed by the same surgeon or by different surgeons. This does not apply to 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. When this occurs, start and end times must be noted on each billing claim.*

iv) *When a surgical assistant is required for minor surgery, a detailed explanation of the need for the surgical assistant is required in the claim note record.*

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	282.60	

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

		$	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	32.96	

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.

70021	Certified General Surgeon Assist (extra) Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	40.58	

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, 00198 and 13197 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	664.71	

with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

70504	- secondary surgeon	664.71	

Total or near total oesophagectomy;

with thoracotomy; with or without pyloroplasty (3 hole):

70505	- secondary surgeon	664.71	

with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

70506	- secondary surgeon	664.71	

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	664.71	

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	664.71	

		$	Anes. Level
07702	Fee for second surgeon participating in total correction of cloacal anamolies	519.02	
	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	346.80	
	Note: *When 07571 and 07593 are claimed, assistant's fees are not applicable to either surgeon for assisting the other.*		
	Second Operator:		
77025	Synchronous combined bypass graft - extremities	609.98	
77030	- trunk	609.98	
	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	50.75	2
07041	Aspiration: abdomen or chest (operation only)	77.73	2
	Abscess:		
07059	- deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	83.30	2
07027	- under general anesthesia or procedural sedation (operation only)	255.34	2
07061	- deep, post operative wound infection under general anesthesia (operation only)	230.09	2
07045	Anterior closed space abscess - operation only	103.74	2
06028	Web space abscess - operation only	306.47	2
06029	- under general anesthetic (operation only)	352.43	2
	Pilonidal Cyst or Sinus:		
70084	- incision and drainage abscess (operation only)	103.66	2
07685	- excision or marsupialization - operation only	306.79	2
	Wounds - simple:		
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	40.64	
	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	75.71	2
06063	Extraction of foreign body from a wound requiring general anesthesia or procedural sedation - operation only	306.47	2
	Notes:		
	i) Also, payable when performed under local anesthetic if the extraction requires at least 30 min and is complicated due to:		
	a) The need for increased surgical exposure, or		
	b) A delicate or deeper dissection, or		
	c) Difficulty localizing the foreign body		
	ii) If performed under local anesthetic, a note record must be provided with the length of the procedure and explaining why the extraction was complex in nature.		
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	75.70	2

		$	Anes. Level
13621	- additional lesions removed at the same sitting (maximum per sitting, five) - each (operation only)	37.87	

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)	59.26	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)	87.72	2

Removal of Tumours or Scars

V70116	Removal of tumour (including intraoral) or scar revision – 2 to 5 cm (operation only)	141.42	2
	Note: *For tumours or scars under 2 cm, bill under fee item 13620.*		
V70117	Removal of tumour (including intraoral) or scar revision – 5.1 cm to 10 cm	267.82	2
V70118	Removal of tumour (including intraoral) or scar revision – greater than 10 cm	462.80	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	306.79	2
V70126	Radical resection of malignant skin or soft tissue tumour measuring 10 cm or greater	462.80	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	183.88	

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.

		$	Anes. Level
V70119	Single flap under 2 cm in diameter used in repair of a defect (except for special areas as in V70124) (operation only)	161.96	2
V70120	Single flap for lesion greater than 2 cm	332.09	2
V70121	Single flap for lesion greater than 2 cm with free skin graft to secondary defect	417.81	2
V70122	Multiple flap for lesion greater than 2 cm	584.91	2
V70123	Multiple flap for lesion greater than 2 cm with free skin graft to secondary defect	665.26	2
V70124	Eyebrow, eyelid, lip, ear, nose – single	301.82	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)	255.66	2
07075	- inguinal (operation only)	255.66	2
07076	- perianal (operation only)	255.66	2
07082	- perineal (operation only)	255.66	2
06166	Excision of axillary sweat glands for hyperhidrosis - unilateral	332.49	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)	311.04	3
V07074	- resection	263.82	3
	Notes: *i) Payable only when performed in an Operating Room (Service Location Code G, I, or P)* *ii) Not payable for percutaneous procedures.* *iii) For operative section of transverse carpal ligament – bill under 06258*		
	Excisional biopsy of lymph glands for suspected malignancy:		
70023	- neck (operation only)	245.43	3
V70024	- axilla	245.43	2
70025	- groin (operation only)	245.43	2
13630	Paronychia - operation only	40.50	2
13631	Removal of nail - simple operation only	40.50	2
13632	- with destruction of nail bed (operation only)	81.96	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	72.32	2
V07053	Excision of nail bed, complete, with shortening of phalanx	141.11	2
07025	Temporal artery biopsy (operation only)	203.96	2
07028	Biopsy of sural nerve – operation only	181.28	2
V07055	Ganglia - of the wrist	255.66	2

Wounds

13612	Extensive laceration greater than 5 cm (maximum charge 35 cm) - operation only - per cm	15.19	
	Note: *Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
	Wounds - avulsed and complicated:		
06075	Lips and eyelids	347.09	3
06076	Nose and ear	436.01	3

		$	Anes. Level
06077	Complicated lacerations of the scalp, cheek and neck	340.66	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	276.62	3

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)	562.45	5
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	301.31	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	132.78	
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	306.30	4
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	133.93	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	316.74	4
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	147.32	
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	80.35	

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.

		$	Anes. Level
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)	128.56	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)	63.36	2
	Broviac type catheter:		
07139	- insertion of	166.23	2
V07140	- insertion of - less than 3 months of age or less than 3 kg	275.11	4
07141	- removal of (operation only)	129.65	2
	Totally implantable venous access port with subcutaneous reservoir (portacath type device):		
07142	- insertion of	261.77	2
V07143	- revision (removal and reinsertion)	357.92	2
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	64.01	
07145	Intra osseous – access (operation only)	103.59	2
V07134	Peritoneal venous shunt for ascites	399.20	6
V07146	Insertion of inferior vena cava filter; percutaneous placement or cutdown (e.g.: Kimray Greenfield filter)	376.16	2
V07147	Insertion of a peritoneal catheter under general anesthetic or procedural sedation	312.81	4

Notes:

i) Includes fee items 77380, 07600 and 04001 (laparoscopy).

S00801	Intra-arterial cannulation - with multiple aspirations - procedural fee	22.60	

Head and Neck

Lips:

06140	Wedge resection of lip – vermilion (operation only)	205.11	3
06141	- to sulcus	256.39	3

Mouth - Excision

	Excision of lesion of tongue with closure anterior 2/3:		
V07789	- with local tongue flap	326.52	3
	Excision, lesion of floor of mouth:		

		$	Anes. Level
07790	- benign (operation only)	156.27	3
02457	Tongue tie - under general anesthetic (operation only)	93.22	3
02458	Local excision tongue - under general anesthetic	169.58	3
02275	Glossectomy - subtotal with either division of mandible or transcervical resection	1,080.11	6
02279	Resection base of tongue and/or tonsil and soft palate	1,969.95	6
02478	Glossectomy - partial for carcinoma	378.33	6
C02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy	1,350.10	

Pharynx and Tonsils

S00701	Direct laryngoscopy - procedural fee	73.82	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)	106.87	4
02444	- under general anesthetic (operation only)	144.89	6
	Tonsillectomy:		
02403	- under local anesthesia	263.53	4
02445	- adult or child over the age of 14 years	282.24	4
02446	- child age 14 years and under (to include neonate)	300.13	4
02413	Operative control of post-tonsillectomy or post-adenoidectomy haemorrhage requiring local or general anesthetic	325.62	6
02399	Cryotherapy of tonsils and oral lesions (operation only)	117.41	3
02442	Adenoidectomy - adult or child over 14 years (operation only)	144.89	4

Salivary Glands and Ducts

07515	Drainage of abscess; parotid, submaxillary or sublingual (operation only)	207.17	3
07526	Dilation of salivary duct (operation only)	155.82	3
02452	Sialolithotomy - simple, in duct (operation only)	65.21	3
02453	- complicated, in gland	195.68	3
02456	Salivary fistula - plastic to Stensen's duct	430.50	4
	Excision:		
S00844	Biopsy of salivary gland, fine needle or core needle	55.25	3
07516	Excision or marsupialization of sublingual salivary cyst (ranula) (operation only)	208.16	3
07522	Local excision of parotid tumour- without nerve dissection (operation only)	208.23	3
02455	Excision of submandibular gland	390.71	4
02471	Subtotal parotidectomy - with complete facial nerve dissection	861.07	4
02472	Total parotidectomy - with nerve dissection for malignancy or deep lobe tumour	991.49	4

		$	Anes. Level
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.*	1,283.62	6
02470	Radical neck dissection	1,080.17	6
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy	1,969.95	7
02477	Contralateral suprahyoid dissection	495.75	5
Head and Neck - Miscellaneous			
02459	Excision cystic hygroma	560.97	4
V07500	Resection of mandible	411.33	5
V07749	Partial maxillectomy for malignancy - fenestration	829.82	5
CV07725	Maxillectomy	1,037.32	5
V07796	Excision neurogenic neoplasm neck	1,140.95	5
	Diverticulectomy of hypopharynx or oesophagus, with or without myotomy:		
V70545	- cervical approach	548.90	6
02407	Tracheostomy ***Note****: Not applicable to cricothyrotomy puncture.*	398.83	5
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon	652.31	5
Breast			
	Incision		
70041	Fine needle aspiration of solid or cystic lesion – operation only	50.81	2
70042	- each additional cyst or lesion (maximum of 3) – operation only	12.73	2
70043	Mastotomy with exploration or drainage of abscess or hematoma; deep - operation only	153.40	2
V70044	- under general anesthetic or procedural sedation	255.66	2
	Excision		
	Biopsy of breast:		
70469	- needle core – operation only	102.26	2
70470	- incisional - operation only	204.53	2
70471	- excisional - operation only	255.66	2
	Stereotactic or ultrasound-guided core needle biopsy:		
70472	- 1 to 5 core samples – operation only	95.81	2
70473	- 6 to 10 core samples (operation only)	135.28	2
V07470	Nipple exploration, with excision of lactiferous duct(s) or papilloma of lactiferous duct (microdochectomy)	306.79	2
V07497	Biopsy or segmental resection of non-palpable breast lesion following radiological fine wire or seed localization	306.79	2
70477	- each additional lesion identified by a radiologic marker	112.92	2

		$	Anes. Level

Mastectomy:

For malignant breast disease or invasive melanoma the following procedures when performed by the same surgeon will be paid at 100% for the greater procedure, lesser procedures will be paid at 100% for the second, 75% for the third, and 50% for the remaining.

NOTE: This does not apply to procedures that are inclusive of others (e.g., oncolplastic breast-conserving procedures – see notes under 07481, 07482, 07483).

Mastectomy: 07472, 07473, 07498, 07481, 07482, 07483

Axillary dissection: 07474, 07475

Sentinel lymph node biopsy: 07479

Tumours or scars: 70116, 70125, 70126

V70478	- for gynaecomastia	409.05	3
V07471	- simple for benign disease (female only)	409.05	3
V07498	- skin sparing, when performed for reconstruction – unilateral (female only)	715.84	3
V07473	- partial, for malignancy	383.49	3
V07472	- total, for malignancy	511.31	3
V70479	- radical	795.18	3
	Note: *Includes pectoral muscles and complete axillary node dissection.*		
V07475	Partial axillary dissection	242.72	3
V07474	Complete axillary dissection (level II)	562.45	3
79135	Chest wall tumour with rib resection	1,078.49	6
V07479	Sentinel lymph node biopsy (SLN)	484.86	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.

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	460.19	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.

iii) Not payable when additional ipsilateral breast reconstructive procedures(s) are performed on the same day by a second surgeon, or when part of a pre-planned staged breast reconstruction.

iv) Not payable in addition to the Mastectomy fee items 07472, 07473, 07498, 07482, and 07483 as well as fee items 06150, 06164, 61045, 61050, 61157, and 61158.

		$	Anes. Level
CV07482	Oncoplastic breast conserving surgery – Level 2	562.45	4

Notes:

i) Restricted to General Surgeons with appropriate training and/or mentoring.

ii) Includes mobilization of breast parenchyma, creation of skin flaps, rotational flap closure, and nipple areolar complex repositioning.

iii) Not payable when additional ipsilateral breast reconstructive procedure(s) are performed on the same day by a second surgeon, or when part of a pre-planned staged breast reconstruction.

iv) Not payable in addition to the Mastectomy fee items 07472, 07473, 07498, 07481, and 07483 as well as fee items 06150, 06164, 61045, 61050, 61157, and 61158.

TCV07483	Oncoplastic breast conserving surgery – Level 3	725.00	4

Notes:

i) Restricted to General Surgeons with appropriate postgraduate or post-fellowship training.

ii) Includes glandular pedicles coupled with large mobilizations, transpositions, and rotations of residual breast tissue.

iii) Only payable when resected breast volume exceeds 25% of ipsilateral breast parenchyma, and the operative report documents the use of reduction mammoplasty techniques sufficient to achieve cosmesis.

iv) Not payable when additional ipsilateral breast reconstructive procedure(s) are performed on the same day by a second surgeon, or when part of a pre-planned staged breast reconstruction.

v) Not payable in addition to the Mastectomy fee items 07472, 07473, 07498, 07481, and 07482, as well as fee items 06150, 06164, 61045, 61050, 61157, and 61158.

Oesophagus

Incision

V70500	Oesophagotomy - cervical approach with removal of foreign body	548.90	5
V70501	- thoracic approach with removal of foreign body	652.01	8
V70502	Cricopharyngeal myotomy - cervical approach	479.96	4

Excision

	Excision of lesion, oesophagus, with primary repair:		
CV70530	- cervical approach	548.90	6
CV70531	- thoracic or abdominal approach; open	795.18	8
CV70532	- thoracic or abdominal approach; laparoscopic or thorascopic	795.18	8
	Total or near total oesophagectomy; without thoracotomy (Transhiatal):		
	With pharyngogastrostomy or cervical oesophagogastrostomy, with or without pyloroplasty:		
V70533	- primary surgeon	2,076.08	8
70503	- secondary surgeon	664.71	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70534	- primary surgeon	2,076.08	8
70504	- secondary surgeon	664.71	
	Total or near total oesophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):		
V70535	- primary surgeon	2,335.58	8

		$	Anes. Level
70505	- secondary surgeon	664.71	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70536	- primary surgeon	2,335.58	8
70506	- secondary surgeon	664.71	
V70538	Partial oesophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic oesophagogastrostomy (Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required)	1,671.88	8
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70539	- primary surgeon	1,906.97	8
70509	- secondary surgeon	664.71	
CV70540	Partial oesophagectomy, thoraco-abdominal or abdominal approach; with esophagogastrostomy ***Notes:*** *i) Includes vagotomy.* *ii) Includes proximal gastrectomy, pyloroplasty, and splenectomy if required.*	1,462.86	8
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70541	- primary surgeon	1,711.06	8
70511	- secondary surgeon	664.71	
CV70542	Total or partial oesophagectomy, without reconstruction (any approach), with cervical oesophagostomy (includes gastrostomy)	1,097.79	6
	Diverticulectomy of hypopharynx or oesophagus, with or without myotomy:		
V70545	- cervical approach	548.90	6
V70544	- thoracic approach	668.74	8

Oesophagus – Endoscopy

S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee ***Note:*** *Not payable with 33341.*	119.27	3
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee ***Note:*** *Not payable with 33341.*	120.07	3
S10763	Initial esophageal, gastric or duodenal biopsy ***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%.*	15.15	3
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 ***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.*	44.56	3

		$	Anes. Level
	Upper Gastrointestinal System – Endoscopy (Surgical)		
S33321	Removal of foreign material causing obstruction, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	151.03	4
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only ***Notes:*** *i) Paid only once per endoscopy.* *ii) Paid only in addition to:* *a) S10761 or S10762; or* *b) 33341, at 50%.*	151.18	3
S33323	Transendoscopic tube, stent or catheter – operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	151.03	3
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.*	150.81	3
S33325	Gastric polypectomy, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	61.36	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.*	176.22	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.*	100.51	3
S33328	Esophageal dilation, blind bouginage, operation only ***Note:*** *Repeats within one month paid at 100%.*	100.58	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%.*	151.10	3
07528	Placement of gastroesophageal venous compression balloon (e.g.: Minnesota or Blakemore) operation only ***Notes:*** *i) Paid at 100% with 00081.* *ii) Paid in addition to S10761 or S10762.* *iii) Paid only once per endoscopy.*	206.68	5
	Oesophagus – Repair:		
V71530	Cervical oesophagostomy	543.38	5

		$	Anes. Level
V71531	Repair tracheo-oesophageal fistula – cervical approach	2,045.25	6
	Note: *71530 and 71531 include gastrostomy.*		
	Oesophagoplasty, (plastic repair or reconstruction) thoracic approach:		
CV71532	- without repair of tracheo-oesophageal fistula	2,045.25	8
CV71533	- with repair of tracheo-oesophageal fistula	2,300.91	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach)	868.66	8
	Note: *C71533 and 71534 include gastrostomy.*		
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	1,022.63	6
V71536	- open	843.66	6
CV71537	Oesophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	920.36	8
V71538	- with gastroplasty - Collis	1,245.65	8
	Plastic operation for cardiospasm; Heller:		
CV71539	- thoracic approach - open	766.97	8
CV71540	- laparoscopic or thorascopic (endoscopy to be billed separately)	945.93	6
CV71541	- with fundoplication - open	1,073.76	6
CV71542	- with fundoplication - laparoscopic	1,227.15	6
V33330	Per Oral Endoscopic Myotomy (POEM) under general anesthesia	900.00	6
	Notes: *i) Payable with 07001.* *ii) Not payable with 07003 or 10761.*		
	Gastrointestinal reconstruction for previous oesophagectomy; for obstructing oesophageal lesion or fistula, or for previous oesophageal exclusion:		
CV71543	- with stomach; with or without pyloroplasty	1,462.86	6
CV71544	- with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	1,711.06	6
CV07536	Direct ligation of oesophageal varices	753.19	7
CV71546	Transection of oesophagus with repair, for oesophageal varices	920.36	6
CV71547	Ligation or stapling at gastro-oesophageal junction for pre-existing oesophageal perforation	1,227.15	6
	Suture of oesophageal wound or injury:		
V71548	- cervical approach	1,297.56	6
CV71549	- transthoracic or transabdominal approach	1,557.05	8
	Closure of oesophagostomy or fistula:		
CV71550	- cervical approach	1,297.56	6
CV71551	- transthoracic or transabdominal approach	1,557.05	8

Diaphragm - Repair

V70601	Repair of para-oesophageal hiatus hernia, transabdominal, with or without fundoplication	1,328.31	6

		$	Anes. Level
	Repair of diaphragmatic hernia of any type, with or without fundoplication, vagotomy, or drainage procedure:		
CV70603	- laparoscopic	1,378.81	6
CV70604	- congenital diaphragmatic hernia	1,557.05	9
CV70605	- open	1,328.34	8
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	818.10	8

Note: *For anti-reflux procedures, such as fundoplications, etc., please see Oesophageal section.*

Stomach

	Incision		
V70620	Gastrotomy or enterotomy - with exploration or foreign body removal only	516.79	5
V70621	- with suture repair of bleeding ulcer (including duodenal)	689.65	6
CV70622	Gastrotomy - with suture repair of pre-existing oesophagogastric laceration (e.g.: Mallory-Weiss)	718.36	6
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	516.79	5
	Excision		
	Limited or wedge excision:		
V70625	- ulcer or benign tumour of stomach - open	585.15	6
CV72725	- ulcer or benign tumour of stomach - laparoscopic	731.45	6
V70626	- malignant tumour of stomach - open	816.25	6
CV72726	- malignant tumour of stomach - laparoscopic	835.94	6
	Gastrectomy, total:		
CV70627	- with oesophagoenterostomy - open	1,738.46	6
CV72727	- with oesophagoenterostomy - laparoscopic	2,045.25	6
CV70628	- with Roux-en-Y reconstruction - open	1,738.46	6
CV72728	- with Roux-en-Y reconstruction - laparoscopic	2,045.25	6
CV70629	- with formation of intestinal pouch, any type - open	1,738.46	6
CV72729	- with formation of intestinal pouch, any type - laparoscopic	2,045.25	6
	Gastrectomy, partial, distal:		
V70630	- with gastroduodenostomy (Billroth I) - open	1,124.89	6
CV72730	- with gastroduodenostomy (Billroth I) - laparoscopic	1,253.92	6
V70631	- with gastrojejunostomy (Billroth II) - open	1,124.89	6
CV72731	- with gastrojejunostomy (Billroth II) - laparoscopic	1,253.92	6
V70632	- with Roux-en-Y reconstruction - open	1,227.15	6
CV72732	- with Roux-en-Y reconstruction - laparoscopic	1,306.13	6
V70633	- with formation of intestinal pouch - open	1,329.41	6
CV72733	- with formation of intestinal pouch - laparoscopic	1,410.66	6
70634	Vagotomy (extra)	65.31	
V70635	Proximal gastrectomy; thoracic or abdominal approach including oesophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy with or without splenectomy - open	1,229.88	6

		$	Anes. Level
CV72735	Proximal gastrectomy; thoracic or abdominal approach including oesophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy with or without splenectomy – laparoscopic	1,537.33	6
CV70639	Radical gastrectomy including D2 Extended Lymphadenectomy – open or laparoscopic – first 60 minutes	677.76	6
CV70640	Radical gastrectomy including D2 Extended Lymphadenectomy – open or laparoscopic – each additional 15 minutes or greater portion thereof	78.20	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)	1,227.15	7
V07628	Gastrojejunostomy or pyloroplasty – with vagotomy - with or without gastrostomy	651.05	5
CV07578	Highly selective vagotomy	651.05	5

Stomach – Introduction

V07630	Gastrostomy - open	467.13	5
33394	Assistant fee for PEG procedure	176.14	

Note: *33326, 33394 may be billed by any qualified physician.*

70637	Change of gastrostomy tube (operation only)	51.08	2

Stomach - Other Procedures

V07626	Pyloroplasty	411.33	5
V07627	Gastrojejunostomy - open	570.93	5
CV72737	Gastrojejunostomy - laparoscopic	816.01	5
V07632	Patch or suture of perforated duodenal or gastric ulcer, wound or injury - open	766.97	6
V70641	- laparoscopic	766.97	6
V70642	Gastric restrictive procedure, without gastricbypass, for morbid obesity (includes vertical banded and other gastroplasties)	1,038.04	7
CV72739	Laparoscopic vertical sleeve gastrectomy	1,130.07	7
V70643	Gastric restrictive procedure - with bypass, for morbid obesity; gastroenterostomy - open	1,636.20	7
CV72743	Gastric restrictive procedure - with bypass, for morbid obesity; gastroenterostomy - laparoscopic	1,447.78	7
V70644	- with small bowel reconstruction to limit absorption - ileojejunal bypass	950.83	7
V70645	Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity - open	1,653.84	7

		$	Anes. Level
CV72775	Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity – laparoscopic	1,738.46	7
CV07623	Revision gastrectomy after previous gastrectomy - with or without vagotomy - open	1,244.92	7
CV72723	Revision gastrectomy after previous gastrectomy - with or without vagotomy - laparoscopic	1,556.11	7
V70646	Closure of gastrostomy, surgical	411.33	4
CV07633	Closure of gastro-jejuno-colic fistula	1,165.85	5
CV70649	Closure of gastrocolic fistula	804.58	5

Intestines

V70650	Lysis of intra-abdominal adhesions – first 30 minutes (extra)	163.62	7
70651	- each additional 15 minutes or greater portion thereof (extra)	81.81	

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)	163.62	7
70661	- each additional 15 minutes or greater portion thereof (extra)	81.81	

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	562.45	5

***Note**: Not payable with fee items 70650, 70651, 70660, 70661.*

CV72650	Intestinal obstruction, resection of bands, enterolysis – laparoscopic	641.82	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	518.47	4
V07634	Full thickness repair of iatrogenic intestinal perforation (single) open	498.40	5
V07635	Full thickness repair of iatrogenic intestinal perforation (multiple) open	654.34	5
CV71634	Full thickness repair of iatrogenic intestinal perforation (single) laparoscopic…	623.02	5
CV71635	Full thickness repair of iatrogenic intestinal perforation (multiple) laparoscopic.	817.93	5
V07654	Intestinal obstruction - plication or insertion of intraluminal tube	582.94	5
V07651	Reduction of volvulus, intussusception, internal hernia, by laparotomy	538.14	5
V71650	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) - open	517.05	5

		$	Anes. Level
V71651	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic	599.28	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%.

Excision

V07636	Resection of small intestine with anastomosis - open	696.58	5
CV72736	Resection of small intestine with anastomosis - laparoscopic	763.09	5
CV72620	- with enterostomy; without anastomosis (does not include separate enterostomies or resections) - open	832.19	5
CV72720	- with enterostomy; without anastomosis (does not include separate enterostomies or resections) - laparoscopic	1,040.24	5
CV71725	Resection of duodenum	1,503.19	8

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).

V07643	Enteroenterostomy	620.16	5
V07570	Colo-colostomy or entero-colostomy - open	820.99	6

Note: *07570 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.*

CV72770	Colo-colostomy or entero-colostomy – laparoscopic	1,026.23	6

Note: *CV72770 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.*

72621	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy- extra (not applicable to right or left hemicolectomy) (operation only) - open	97.96	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)	122.45	6

Notes:
i) Restricted to General surgeons.
ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100%.

V72622	Limited resection of colon - open	970.35	6
CV72623	- laparoscopic	1,010.12	6
V72624	Hemicolectomy; right - open	1,022.63	6
CV72625	- laparoscopic	1,085.88	6
V72626	Hemicolectomy; left - open	1,110.12	6
CV72631	- laparoscopic	1,124.85	6
V72632	Sigmoid resection - open	1,111.14	6
CV72633	- laparoscopic	1,262.64	6

		$	Anes. Level
V72634	- with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) - open	1,010.12	6
CV72734	- with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) - laparoscopic	1,103.28	6
CV72635	Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) with or without protective stoma - open	1,566.19	6
CV72755	Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) with or without protective stoma - laparoscopic	1,686.92	6
V72636	Proctectomy; abdominal and transanal approach; coloanal anastomosis (with or without protective colostomy) - synchronous abdominal portion	2,034.21	7
CV07662	Abdomino-perineal resection - single surgeon - open	1,868.73	7
CV72762	Abdomino-perineal resection - single surgeon - laparoscopic	1,941.98	7
V07663	- synchronous abdominal portion - open	1,431.68	7
CV72763	- synchronous abdominal portion - laparoscopic	1,532.77	7
V07664	Proctectomy, in combination with any abdominal resection – synchronous – perineal portion	517.01	7
CV07569	Colectomy and hemiproctectomy - open	1,124.89	6
CV72769	Colectomy and hemiproctectomy - laparoscopic	1,391.30	6
CV07640	Colectomy - total, abdominal, (without proctectomy) - open ***Note:*** *Includes ileostomy or ileoproctostomy*	1,327.55	6
CV72760	Colectomy - total, abdominal, (without proctectomy) - laparoscopic ***Note:*** *Includes ileostomy or ileoproctostomy.*	1,440.93	6
V07567	Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy - open	1,789.60	6
CV72767	Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy - laparoscopic	1,979.83	6
V07566	Rectal mucosectomy and ileoanal anastomosis	856.38	6
CV07641	Total proctocolectomy - with perineal excision of rectum and ileostomy - single surgeon - open	2,249.78	7
CV72741	Total proctocolectomy - with perineal excision of rectum and ileostomy - single surgeon - laparoscopic	2,449.98	7
V07589	- synchronous - abdominal portion - open	1,346.90	7
CV72789	- synchronous - abdominal portion - laparoscopic	1,737.79	7
V07565	Take-down of pelvic pouch, to include ileostomy - open	1,245.65	5
CV72765	Take-down of pelvic pouch, to include ileostomy - laparoscopic	1,555.30	5
V72640	Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy - open	970.67	6
CV72740	Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy – laparoscopic	1,010.12	6
72641	Caecostomy, tube for decompression (extra) - open	413.34	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%*	460.19	5

		$	Anes. Level
	Transanal Minimally Invasive total Mesorectal Excision (TaTME)		
CV72602	TaTME second surgeon – synchronous perineal portion ***Notes:*** *for second surgeon when performed with synchronous abdominal fees 72604, 72606, 72608, or 72610.*	1,636.20	7
CV72603	Rectosigmoid resection in combination with a TaTME – single surgeon – open	2,403.17	7
CV72604	Rectosigmoid resection in combination with a TaTME – synchronous abdominal portion – open	1,022.63	7
CV72605	Rectosigmoid resection in combination with a TaTME – single surgeon laparoscopic	2,594.40	7
CV72606	Rectosigmoid resection in combination with a TaTME – synchronous abdominal portion – laparoscopic	1,278.29	7
CV72607	Proctocolectomy in combination with a TaTME – single surgeon – open	2,709.96	7
CV72608	Proctocolectomy in combination with a TaTME – synchronous abdominal portion – open	1,431.68	7
CV72609	Proctocolectomy in combination with a TaTME – single surgeon - laparoscopic	2,978.40	7
CV72610	Proctocolectomy in combination with a TaTME – synchronous abdominal portion – laparoscopic	1,789.60	7
	Revision of colostomy, ileostomy:		
V07648	- simple incision or scar, etc.	562.45	4
V07649	- radical; reconstruction with bowel resection	766.97	5
V72644	- with repair of paracolostomy hernia requiring laparotomy	715.29	5
V72645	Continent ileostomy (Koch procedure) - open	1,026.94	6
CV72745	Continent ileostomy (Koch procedure) - laparoscopic	1,283.67	6
V07645	Colostomy or ileostomy – loop - open	516.82	5
CV72715	Colostomy or ileostomy – loop - laparoscopic	561.96	5
V07588	- end - open	517.07	5
CV72788	- end - laparoscopic	602.94	5
72646	- multiple biopsies (e.g.: for Hirschsprung disease) – extra (operation only)	137.53	5
	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction:		
V72647	- single	620.26	5
V72648	- multiple (two or more)	930.13	5
	Closure of loop enterostomy, large or small intestine:		
V07646	- without resection	562.45	4
V07647	- with resection and anastomosis	715.84	5
V72651	Reconstruction Hartmann procedure with or without protective colostomy - open	1,111.13	5
CV72652	- laparoscopic	1,245.25	5
	Closure of fistula; enterovesical, colovesical or colovaginal:		
V72653	- without intestinal and/or bladder resection - open	930.47	5
72654	- with bowel resection (extra to 72653) - open	413.49	5

		$	Anes. Level
	Closure of fistula; enterovesical, colovesical or colovaginal:		
CV72683	- without intestinal and/or bladder resection - laparoscopic	1003.95	5
72684	- with bowel resection (extra to 72683) - laparoscopic	430.79	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	1,227.15	6
V07658	Exteriorization of large bowel lesion (carcinoma, perforation, etc.)	616.15	5

Meckel's Diverticulum and the Mesentery

Excision

V07655	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	516.66	4

Suture and Repairs

V07447	Repair of mesenteric injury	869.24	6

Appendix

Incision

V72660	Incision and drainage of appendiceal abscess, transabdominal ***Note:*** *Not payable in addition to appendectomy listings.*	444.02	4

Excision

V72656	Appendectomy - open	511.06	4
V72658	- laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee)	511.31	4
V72657	Appendectomy; perforated with abscess or generalized peritonitis - open	536.63	5
V72659	- laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee)	536.88	5

Rectum

Incision

V07660	Transrectal drainage of pelvic abscess	310.01	2

Excision

07665	Biopsy of anorectal wall, anal approach (e.g.: congenital megacolon) – operation only	154.40	2
CV07662	Abdomino-perineal resection - single surgeon - open	1,868.73	7
CV72762	Abdomino-perineal resection - single surgeon - laparoscopic	1,941.98	7
V07663	- synchronous abdominal portion - open	1,431.68	7
CV72763	- synchronous abdominal portion - laparoscopic	1,532.77	7
V07664	Proctectomy, in combination with any abdominal resection - synchronous – perineal portion	517.01	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	1,344.65	7
CV72664	- with subtotal or total colectomy, with multiple biopsies	2,343.78	7
V72665	Proctectomy, partial, without anastomosis, perineal approach	570.93	5

		$	Anes. Level
V72666	Altemeier transperineal excision of rectal procidentia with anastomosis	766.97	3
	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.*		
72667	Division of stricture of rectum (includes endoscopy) - operation only	306.19	2
V07580	Excision of rectal tumour by posterior parasacral, transacral or transcoccygeal approach (Kraske)	818.10	5
	Excision of rectal tumour, transanal approach to include operative sigmoidoscopy:		
72669	- 0 to 2.5 cm – operation only	306.20	2
72670	- 2.6 to 5 cm - operation only	357.35	2
72671	- greater than 5 cm -operation only	465.39	2
72672	Electrodesiccation or fulguration of malignant tumour of rectum, transanal - includes endoscopy – operation only	258.40	2
CV72673	Transanal Endoscopic Microsurgical Resection of rectal tumour	938.43	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.*		
	Repair		
V07672	Complete rectal prolapse - transabdominal rectopexy – open	714.50	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	893.14	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.		

		$	Anes. Level
SY10714	Proctosigmoidoscopy, rigid; diagnostic	36.20	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	38.83	2
S07460	- with decompression of volvulus – operation only	234.01	2
SY00716	Sigmoidoscopy, flexible; diagnostic	77.81	2
SY00718	- with biopsy	79.09	2
S07461	- with removal of foreign body (operation only)	185.09	2
S07462	- with control of bleeding, any method – operation only	185.09	2
S07463	- with decompression of volvulus, any method (operation only)	234.01	2
S07464	- with removal of polyp(s) (operation only)	256.70	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	173.59	2
S10730	Colonoscopy, flexible, transabdominal via colostomy - single or multiple	234.43	4
S10731	Colonoscopy, flexible, proximal to splenic flexure; diagnostic with or without collection of specimen(s) by brushing or washing	234.35	2
S10732	- with removal of foreign body	278.22	2
S10733	- with control of bleeding, any method	310.87	2
07375	Complex polypectomy (extra)	178.96	

Notes:

i) Restricted to General Surgeons and Gastroenterologists.

ii) Only for resection of a polyp with one or more of the following:
-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, 34111.

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	461.71	2
V70666	Sphincteroplasty; anal for incontinence or prolapse; posterior anal repair - adult	461.71	2
V07690	Anoplasty for imperforate anus	714.61	4
70668	Graft (Thiersch operation) for rectal incontinence or prolapse (operation only)	208.54	2
V70670	Sphincteroplasty; anal, for incontinence; Gracilis muscle implant	718.41	3
V70671	Levator muscle imbrication - Park posterior; anal repair	461.71	2
V70672	Implantation of artificial sphincter	1,032.16	4

Note: *70670 to 70672 are not payable together.*

V07452	Repair extra-peritoneal rectum with or without colostomy	1,227.15	7

		$	Anes. Level
70674	Destruction of anal lesion, any method including fulguration anal condylomata - simple - less than 10% perianal skin involvement (operation only)	152.45	2
70680	- complicated - greater than 10% of perianal skin involvement (with operative report) (operation only)	306.19	2
S70683	EUA with or without sigmoidoscopy; with or without biopsy (operation only)	178.68	2
CV72673	Transanal Endoscopic Microsurgical Resection of rectal tumour	938.43	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 or procedural sedation (operation only)	156.13	2
04401	Repair of recto-vaginal fistula	700.31	3

Incision

70675	Removal of anal seton, other marker (operation only)	29.32	2
V70676	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	398.77	2
07691	Anus imperforate - simple incision (operation only)	309.92	2
07679	Incision and drainage of ischiorectal, intramural, intramuscular or submucosal abscess, under general anesthesia or procedural sedation – operation only	306.79	2
07678	Incision and drainage, perianal abscess – superficial (operation only)	153.40	2

Excision

07687	Anal fissure, excision under local anesthetic (operation only)	117.60	2
V71681	Sphincterotomy with or without fissurectomy	309.93	2
SV71682	Botox injection for anal fissure	280.93	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)	102.26	2
71686	- multiple – extra (operation only)	143.17	2
71689	Hemorrhoid(s); (e.g.: band ligation) to include proctoscopy (operation only)	82.41	2
71690	Hemorrhoid(s); – infrared photocoagulation to include proctoscopy (operation only)	82.41	2

		$	Anes. Level
71691	Hemorrhoid(s) add on fee	17.20	
	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	306.79	2
	Fistula-in-ano (fistulectomy or fistulotomy):		
07675	- subcutaneous or submucous – operation only	306.79	2
V07676	- submuscular	345.36	2
V07677	- multiple or horseshoe, with or without placement of seton	461.71	2
V07666	Fistula-in-ano; second stage; division of sphincter after placement of seton	306.16	2
V71700	Closure of congenital or acquired anal fistula with rectal advancement flap	659.75	2

Liver

Incision

V07402	Hepatotomy for drainage of abscess or cyst; laparoscopic or open - single	511.31	6
V07403	- multiple, including marsupialization	668.74	6
CV71380	Open or Laparoscopic operative liver tumour non-resectional ablation by any means	1,021.36	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	1,124.89	7
CV72794	Laparoscopic non-anatomic sub-segmental excision of liver mass	1,226.41	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

		$	Anes. Level
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 ***Note:*** *Cholecystectomy is not paid in addition.*	1,329.41	8
CV72795	Laparoscopic hepatectomy, segmental resection-one or more, same side ***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.*	1,328.93	8
CV07406	- two or more segments, bilateral lobes ***Notes:*** *i) Surgeon must operate on right and left lobes* *ii) Cholecystectomy is not paid in addition.*	1,738.46	8
CV72796	Laparoscopic segmental resection of liver: two or more segments, bilateral lobes ***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.*	2,247.25	8
CV07407	- total left lobectomy - open ***Note:*** *Cholecystectomy is not paid in addition.*	2,147.51	8
CV72797	Laparoscopic total left lobectomy ***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.*	2,758.56	8
CV07408	- total right lobectomy - open ***Note:*** *Cholecystectomy is not paid in addition.*	2,147.51	8
CV72798	Laparoscopic total right lobectomy ***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.*	2,758.56	8
CV07409	- extended left lobectomy (includes caudate lobe and at least one portion of right lobe)	2,352.04	8
CV07410	- caudate lobectomy (isolated procedure)	2,249.78	8
CV07411	- extended right lobectomy; 5 or more segments (includes caudate) ***Note:*** *Cholecystectomy is not paid in addition.*	2,454.30	8

		$	Anes. Level
	Liver - Repair (Trauma)		
V07412	Hepatorrhaphy; suture of liver wound or injury - simple	622.82	8
V07413	- with packing	920.36	8
CV07440	Resectional debridement of liver	1,585.07	8
CV07441	Hepatic artery ligation, to include resectional debridement where indicated	1,038.04	8
CV07442	Hepatic lobectomy for trauma to include resectional debridement where indicated	2,812.22	9
	Biliary Tract		
	Incision		
	Choledochotomy or choledochostomy and exploration, drainage or removal of calculus:		
V70694	- open	869.24	5
V70695	- laparoscopic	920.36	5
V70696	- with transduodenal sphincteroplasty	971.50	5
V07769	Duodenotomy and sphincteroplasty	1,036.97	5
	Cholecystostomy:		
V07698	- open	526.65	5
V70698	- laparoscopic	526.65	5
71698	- percutaneous (operation only)	168.58	2
	Biliary Tract – Endoscopy		
07780	Biliary endoscopy; intraoperative, choledochoscopy (extra)	207.35	
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	207.17	2
07782	- with removal of stone (operation only)	233.22	2
07783	- with dilation of duct stricture with or without stent (operation only)	233.22	2
PV33341	Endoscopic Retrograde Cholangiopancreatography (ERCP), inclusive of sphincterotomy and biopsies or brushings	400.00	3
	***Notes**:* *i) Includes 10761 and 10762.* *ii) 33322 payable at 50%.*		
P33342	- with stone extraction (extra)	110.00	3
	***Note:** 00994 is not payable.*		
P33343	- with balloon dilation of ampullary/biliary/pancreatic stricture, biliary/pancreatic stenting or nasobiliary drainage tube (extra)	110.00	3
P33345	- with intraductal lithotripsy (extra)	110.00	3
	***Note:** 00994 is not payable.*		
T33348	- with cholangioscopy or pancreatoscopy, inclusive of guided biopsies (extra)	200.00	3
P33347	Replacement of a duodenal biliary stent (extra)	110.00	3
	Biliary Tract – Excision		
	Cholecystectomy:		
V07707	- laparoscopic	562.45	5

		$	Anes. Level
V07699	- open	674.93	5
V70700	- open cholecystectomy immediately preceded by attempted laparoscopic cholecystectomy	723.86	5
V70701	- with exploration of CBD (laparoscopic)	1,240.10	5
V70702	- with exploration of CBD (open)	1,240.10	5
V70703	- with choledochoduodenostomy (includes CBD exploration)	1,343.54	5
V70704	- with choledochojejunostomy (includes CBD exploration)	1,343.64	5
V70705	- with transduodenal sphincterotomy or sphincteroplasty (includes CBD exploration)	1,343.54	5
07764	Cholangiography - operative, extra	102.02	
CV70710	Exploration for congenital atresia of bile ducts without repair ***Note**: Includes liver biopsy and/or cholangiography if required.*	2,443.22	5
CV70711	Portoenterostomy (Kasai procedure)	1,620.75	6
	Excision of bile duct tumour or stricture:		
CV70712	- lower (below bifurcation), any repair	2,245.99	6
CV70713	- upper (at or above bifurcation) – one anastomosis	2,451.78	6
CV70714	- upper (at or above bifurcation) – multiple anastomoses	2,758.56	6
	Excision of choledochal cyst (to include cholecystectomy):		
CV70715	- below bifurcation	1,446.54	5
CV70716	- above bifurcation requiring one ductoplasty	1,504.66	5
CV70717	- above bifurcation - multiple anastomoses	1,630.07	5
CV70718	Portal lymphadenectomy ***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.*	782.03	4

Biliary Tract – Repair

	Cholecystoenterostomy:		
V07706	- direct (loop)	1,123.82	6
V70720	- with gastroenterostomy	1,328.38	5
V70721	- Roux-en-Y	1,226.10	5
V70722	- Roux-en-Y with gastroenterostomy	1,430.65	5
CV07703	Choledochoduodenostomy	1,327.10	6
V07705	Choledochojejunostomy (anastomosis of extra-hepatic biliary ducts and GI tract)	1,429.38	6
V70725	- with gastrojejunostomy	1,839.46	6
V70726	- Roux-en-Y	1,839.46	6
V70727	- Roux-en-Y with gastrojejunostomy	1,839.46	6
CV70728	Anastomosis of intra-hepatic ducts and GI tract; (Longmyer); Roux-en-Y	1,941.33	6
07561	Placement of choledochal stent (operation only)	176.36	5
CV70730	U-tube hepatico enterostomy	1,941.33	5
CV70731	Primary repair of extra-hepatic biliary duct for injury (including intraoperative), any method	1,532.94	5
V07776	Repair of cholecystenteric fistula	1,022.63	5

		$	Anes. Level
Endocrine System			
	Thyroid – Incision		
70740	Incision and drainage of thyroglossal cyst; infected (operation only)	208.54	3
S00744	Thyroid biopsy - procedural fee	79.32	2
	Thyroid – Excision		
V07740	Thyroid biopsy - open	362.86	4
	Total thyroid lobectomy:		
V70742	- unilateral, with or without isthmusectomy	601.14	4
V70743	- unilateral, with contralateral subtotal lobectomy including isthmus	744.51	4
	Thyroidectomy:		
V07743	- total or complete	1,111.13	4
V07741	- subtotal unilateral (local excision of thyroid lesion)	460.19	4
V70745	- subtotal bilateral	722.81	4
V70747	- removal of all remaining thyroid tissue following previous removal of portion of thyroid (completion thyroidectomy)	710.57	4
C70748	Sternal split for substernal thyroid; (extra)	167.18	
V07771	Central neck dissection for confirmed and/or potential extrathyroidal metastatic thyroid cancer (with operative report)	1,124.89	5
	Note: *Payable for comprehensive removal of all resectable pathologic tissue between trachea and carotid from the innominate artery (inferiorly) to the hyoid bone superiorly with dissection of recurrent laryngeal nerve.*		
	Endocrine System – Parathyroid		
	Parathyroidectomy or exploration of parathyroids:		
V07745	- removal of single adenoma	1,010.11	4
V07744	- subtotal parathyroidectomy	1,212.13	4
V71746	- re-exploration	1,430.41	4
CV71747	- with mediastinal exploration and sternal split	1,328.36	6
	Note*: Re-exploration is not payable in addition to C71747.*		
71748	Parathyroid autotransplantation - extra to thyroidectomy and parathyroidectomy procedures (operation only)	104.26	
	Endocrine System – Adrenal		
CV71703	Adrenalectomy for Pheochromocytoma - open	1,042.24	8
	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.*		
CV72703	Adrenalectomy for Pheochromocytoma - laparoscopic	1,531.08	8
	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.*		

		$	Anes. Level
	Adrenalectomy; any approach:		
CV71704	- unilateral - open	1,020.16	8
CV72704	- unilateral - laparoscopic	1,224.70	8
CV71705	- bilateral - open	1,636.20	8
CV72705	- bilateral - laparoscopic	2,042.73	8

Endocrine System - Carotid Body

	Excision of carotid body tumour:		
CV71706	- without excision of carotid artery	1,325.81	6
CV71707	- with excision of carotid artery	1,378.87	8

Endocrine System - Pancreas – Incision

V71708	Placement of drains, peripancreatic for acute pancreatitis	1,224.63	2
V71709	Resectional debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis; to include gastrostomy, jejunostomy and cholecystostomy - any approach (operation only)	1,329.41	8

Endocrine System - Pancreas – Excision

71710	Open biopsy of pancreas, any method (fine needle, core, wedge) intraoperative – extra (operation only)	102.26	6
S00826	Biopsy of pancreas - percutaneous	103.74	2
CV71712	Limited excision of pancreatic lesion (e.g.: cyst or adenoma)	1,325.63	6
	Pancreatectomy, distal subtotal:		
CV71713	- with splenectomy and without pancreaticojejunostomy -open	1,329.41	7
CV72713	- with splenectomy and without pancreaticojejunostomy – laparoscopic	1,555.26	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	1,636.20	7
CV72714	- with splenic preservation - laparoscopic	1,834.13	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	1,533.94	7
CV71716	- with splenic preservation and pancreaticojejunostomy	1,738.46	7
CV71717	Pancreatectomy, distal, near total with preservation of duodenum	2,454.30	7
CV71718	Excision ampulla of vater	1,124.89	6
CV71719	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochojejunostomy and gastroenterostomy (with or without pancreatojejunostomy) (Whipple procedure)	3,476.93	8
CV71720	- pyloric sparing (Whipple procedure)	3,476.93	8
CV71721	Regional pancreatectomy to include above Whipple procedures with portal vein reconstruction, with portosystemic shunt and with coeliac lymphadenectomy	3,681.45	9

		$	Anes. Level
CV71722	Total pancreatectomy with Whipple procedure	3,067.88	8
CV07714	Pancreaticojejunostomy; side-to-side anastomosis (Peustow type procedure)	1,431.68	6
	***Note**: Includes removal of calculi.*		

Endocrine System - Pancreas - Repair

External drainage, pseudocyst of pancreas:

V07756	- open	1,022.63	5
V07758	- laparoscopic	1,022.63	5
CV07711	Internal drainage or anastomosis of: pancreatic pseudocyst to gastrointestinal tract – cyst gastrostomy; open (endoscopy payable separately)	986.13	5
CV72711	Internal drainage or anastomosis of pancreatic pseudocyst of GI tract – laparoscopic	1,139.69	5
	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.*		
CV07732	- transduodenal	1,038.04	5
CV07733	- Roux-en-Y	1,038.04	5

Hernia – Repair

V71600	Repair inguinal or femoral hernia; under 6 months of age; with or without hydrocoelectomy	427.46	2
V71601	- bilateral	745.49	2
V71602	- incarcerated or strangulated	534.84	3
V71603	Repair inguinal or femoral hernia; age 6 months to 12 years; with or without hydrocoelectomy	398.83	2
V71604	- bilateral	639.14	2
V71605	- incarcerated or strangulated	456.10	3
	Repair inguinal or femoral hernia; greater than age 12:		
V71606	- reducible open	393.71	2
V71607	- reducible laparoscopic	423.37	4
V71608	- incarcerated or strangulated	439.73	3
	Repair recurrent inguinal or femoral hernia; any age:		
V71609	- reducible open	479.61	2
V71610	- reducible laparoscopic	532.79	4
V71611	- incarcerated or strangulated	542.00	3
	Bilateral primary inguinal or femoral hernias greater than age 12, not incarcerated or recurrent:		
V71612	- open	639.14	2
V71613	- laparoscopic	702.55	4
	Repair initial incisional hernia: ***Note**: Lysis of adhesions not payable in addition*.		
V71614	- reducible	610.15	2

		$	Anes. Level
V71615	- incarcerated or strangulated	610.15	3
V71616	- using prosthetic mesh	610.15	3
V71623	Laparoscopic initial ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis.	713.22	5
	Repair recurrent incisional hernia:		
V71617	- reducible	622.63	2
V71618	- incarcerated or strangulated	622.94	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*.	778.44	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.*	920.36	7
	Repair umbilical hernia:		
V71619	- reducible	363.03	2
V71620	- incarcerated or strangulated	363.03	3
V71621	Repair of hernia with resection of bowel; all performed through same incision	869.24	5
V71622	Repair of hernia with resection of bowel requiring a separate incision	945.93	5
07596	Hernia; incisional; repair following laparotomy (with operative report) – extra (operation only)	127.83	2
V07610	Epigastric	363.03	4
CV70604	Congenital diaphragmatic hernia	1,557.05	9

Pediatric Procedures

	Broviac type catheter:		
07139	- insertion of	166.23	2
V07140	- insertion of - less than 3 months of age or less than 3 kg	275.11	4
07141	- removal of (operation only)	129.65	2
V07571	Pena posterior sagittal anal proctoplasty; primary surgeon	1,176.17	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.*	346.80	
V07700	Total correction cloacal anomalies; primary surgeon	2,199.19	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.*	519.02	
V07690	Anoplasty for imperforate anus	714.61	4
V07466	Anal stricture; plastic repair; child	460.68	2

		$	Anes. Level
	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	1,344.65	7
CV07697	Excision sacrococcygeal teratoma	1,557.05	6
	Intestinal strictoplasy (enterotomy and enterorrhaphy) with or without dilation for intestinal obstruction:		
V72647	- single	620.26	5
V72648	- multiple (two or more)	930.13	5
	Omphalocoele or gastroschesis:		
V07615	- permanent repair	626.94	7
V07614	- temporary repair	411.33	7
CV70604	Congenital diaphragmatic hernia	1,557.05	9
V07651	Reduction of volvulus, intussusception; internal hernia by laparotomy	538.14	5
CV72751	Reduction of volvulus, intussusception; internal hernia – laparoscopic	672.68	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%.*		
V70624	Pyloromyotomy, cutting of pyloric muscle (Fradet-Ramstedt type operation)	516.79	5
V07552	Aortopexy for tracheomalacia	1,038.04	9
V07653	Atresia of the small bowel	1,557.05	6
V07655	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	516.66	4
CV07692	Repair major ano-rectal anomalies – with concurrent uro-genital malformations via sacral approach	1,557.05	7
V71531	Repair tracheo-oesophageal fistula - cervical approach to include gastrostomy ***Note:*** *71530 and 71531 include gastrostomy.*	2,045.25	6
V07630	Gastrostomy - open	467.13	5
33394	Assistant fee for PEG procedure ***Note:*** *33326, 33394 may be billed by any qualified physician.*	176.14	
CV71532	Oesophagoplasty (plastic repair or reconstruction); thoracic approach - without repair of tracheo-oesophageal fistula	2,045.25	8
CV71533	- with repair of tracheo-oesophageal fistula	2,300.91	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach) ***Note:*** *C71533 and 71534 include gastrostomy.*	868.66	8
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	1,022.63	6
V71536	- open	843.66	6
V71650	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure)- open	517.05	5

		$	Anes. Level
V71651	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic	599.28	
	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%.*		

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	255.66	4
	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.*		
S32031	Closed drainage of chest – operation only	144.53	4
07430	Diagnostic peritoneal lavage (catheter) – operation only	105.16	3
V07432	Laparotomy in the trauma patient	511.31	5
V07431	Full thickness repair diaphragmatic injury (traumatic) with or without mesh	1,073.76	8
	Hepatorrhaphy; suture of liver wound or injury:		
V07412	- simple	622.82	8
V07413	- with packing	920.36	8
CV07440	Resectional debridement of liver	1,585.07	8
CV07441	Hepatic artery ligation, to include resectional debridement where indicated	1,038.04	8
CV07442	Hepatic lobectomy for trauma to include resectional debridement where indicated	2,812.22	9
V07434	Splenic repair, any method	971.50	7
V07433	Laparotomy to include removal of injured spleen	1,073.76	7
V07435	Repair of lacerations to stomach	1,022.63	7
V07436	Exploration and mobilization of duodenum and pancreas	920.36	7
V07437	Repair of laceration of duodenum	1,124.89	7
V07438	Resection and debridement of duodenal injury to include duodenal diverticulisation where indicated	1,840.73	7
V07445	Repair of lacerations to small bowel	869.24	7
V07446	Resection of injured small bowel	920.36	7
V07450	Exteriorization of colonic injury	818.10	7
V07448	Repair of colonic injury with or without colostomy	1,227.15	7
V07449	Resection of colonic injury	1,227.15	7
V07452	Repair of extra-peritoneal rectum, with or without colostomy	1,227.15	7
V07447	Repair of mesenteric injury	869.24	6
V07443	Resection of distal pancreas for trauma	1,585.07	8
V07444	Pancreatico-duodenectomy (Whipple Procedure) for trauma	3,374.66	9
77350	Supra renal aortic crossclamp - extra to abdominal vascular or major trauma cases (operation only)	423.58	
	Note: *Operative report required.*		

		$	Anes. Level

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	13.77	
	Note*: Treatment for cosmetic purposes is not a benefit under MSP.*		
77046	Ultrasound directed (with image capture) foam sclerotherapy – initial	175.84	
77047	Ultrasound directed (with image capture) foam sclerotherapy – repeat	175.84	

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	82.65	2
77060	- repeat	38.72	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	228.08	2
V07108	Stripping long saphenous	269.85	2
V07109	Stripping short saphenous	233.46	2

Multiple ligations and stripping tributaries:

07110	- 3 to 5 incisions (operation only)	285.22	2
V07111	- 6 or more incisions	311.16	2
V07112	Ligation of 2 or more perforators	285.22	2
77070	Complete fasciotomy with or without multiple ligations	326.47	2
	Note*: For decompression fasciotomy, see 77360.*		
77075	Re-exploration of groin and/or popliteal fossa	306.98	2
V07116	Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy)	535.25	3
77077	Excision of ulcer and grafting - add full fee to venous procedures (operation only)	123.00	3
77079	Venous crossover graft for iliac obstruction	623.66	7

Acute Venous

77082	Ligation of femoral vein	152.21	2
77084	Ligation or fenestration of inferior vena cava (requires laparotomy)	506.47	5

		$	Anes. Level
77086	Thrombectomy for acute ilio-femoral thrombophlebitis	634.64	5

Portosystemic Shunting

C77090	Spleno-renal shunt	966.43	8
C77092	Porto-caval shunt	966.43	8
C77094	Mesocaval graft - synthetic	966.43	8
C77096	- autogenous	1,028.98	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	569.33	5
C77120	Embolectomy - trunk or extremities (subclassified by location and incision)	882.70	5
C77125	- one side	456.20	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

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	1,205.45	8
C77135	- innominate	796.76	5
C77140	- subclavian	1,067.65	5
C77145	Ligation of carotid artery	261.16	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) 126.92 9
Note: *Peripheral aneurysm - charge associated bypass graft procedure.*

C77110	Re-exploration of groin for bleeding or hematoma (operation only)	128.31	4
77112	Redissection of groin (after 21 days), extra	135.47	4

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

		$	Anes. Level
	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)	912.42	9
C77155	- aorta and/or iliac (bilateral)	1,943.81	9
C77160	- aorto-femoral and/or ilio-femoral (unilateral)	885.99	9
C77165	- aorto-femoral and/or ilio-femoral (bilateral)	1,943.81	9
	Aneurysm:		
	Note: *Peripheral aneurysm - charge associated bypass graft procedure.*		
77170	Arteriovenous aneurysm	506.47	9
C77175	Abdominal aneurysm - with grafting	2,042.33	9
C77185	Ruptured aneurysm - with grafting	1,941.21	10
	Mesenteric:		
C77190	Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy	1,417.41	7
C77195	Superior mesenteric bypass graft (autogenous vein)	1,417.41	7
	Renal:		
C77200	Renal bypass graft (synthetic) and/or thromboendarterectomy	1,417.41	7
C77205	Renal bypass graft (autogenous vein)	1,417.41	7
	Axillo-Femoral:		
	Axillo-femoral bypass graft and/or thromboendarterectomy		
C77210	- unilateral	1,001.38	7
C77215	- bilateral	1,298.11	7
	Femoral Crossover:		
C77230	Femoro-femoral crossover bypass graft (synthetic) and/or thromboendarterectomy	951.74	5
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	951.74	5
	Infrainguinal:		
C77240	Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	877.77	5
C77245	- popliteal (endarterectomy)	694.96	5
C77250	- popliteal (synthetic)	634.57	5
C77255	- anterior, posterior tibial, or peroneal	759.09	5
	Bypass graft (autogenous vein):		
C77260	- femoral	878.67	5
C77265	- popliteal	1,601.42	5
C77270	- anterior, posterior tibial or peroneal	1,645.88	5
77275	- in situ vein graft (extra)	363.83	7
77280	- non-ipsilateral long saphenous graft (extra)	361.42	7
77285	- short saphenous graft (extra)	361.42	7
77290	- superficial femoral vein graft (extra)	361.42	7
77295	- arm vein graft (extra)	361.42	7
77300	- A-V fistula with bypass graft in limb salvage (extra)	189.76	7

		$	Anes. Level
	Profunda thromboendarterectomy:		
77310	Profunda thromoendarterectomy without patch repair	565.53	5
77315	Profunda thromboendarterectomy with patch repair (synthetic or autologous)	767.87	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	596.96	6
C77335	- graft	767.87	6
	Repair of injury of major vessel in trunk:		
C77340	- suture	896.03	9
C77345	- graft	1,195.15	9
77350	Supra renal aortic crossclamp - extra to abdominal vascular or major trauma cases (operation only) ***Note:*** *Operative report required.*	423.58	
	Fasciotomy:		
77360	Decompression fasciotomy - subcutaneous ***Note:*** *77360 includes secondary closure*	342.14	3
	Miscellaneous:		
77370	Release of popliteal entrapment syndrome ***Note:*** *Not to be paid if full femoral popliteal bypass is performed.*	342.14	3
00722	Arteriography, operative - procedural fee	127.71	
	Second Operator:		
77025	Synchronous combined bypass graft - extremities	609.98	
77030	- trunk ***Note:*** *Items 77025 and 77030, provide operative report by second operator when requested by MSP.*	609.98	

Renal Access

77380	Insertion permanent catheter - procedure fee only	194.99	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.*	135.25	3
77395	Creation of internal arterio-venous fistula	424.32	4
77396	Revision of AV fistula ***Notes:*** *i) Restricted to Vascular and General Surgeons.* *ii) Not paid with renal access fees (77380, 77385, 77395, 77402, 77405).* *iii) Not paid with the following vein graft fees (77275, 77280, 77285, 295, 77295, 77300).* *iv) 77043 not paid with this fee.*	517.02	

		$	Anes. Level
77400	Synthetic AV graft for hemodialysis ***Note:*** *Not paid with 77295, 77395, 77396 and 77402.*	723.49	4
77402	Creation of brachiobasilic arteriovenous fistula with vein transposition ***Note:*** *Not paid with 77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77330, 77395 and 77400.*	723.76	5
77403	Arm revascularization with distal revascularization and interval ligation (DRIL) ***Note:*** *Not paid with 77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77300, 77395 and 77396.*	723.75	5
77405	Thrombectomy of arterio-venous fistula	356.90	3

Sympathectomy

77420	Lumbar sympathectomy - unilateral	379.55	4
77422	Cervical sympathectomy - unilateral	513.22	5
77424	Preganglionic sympathectomy, upper dorsal region - unilateral	468.75	7
77426	Lumbo-dorsal sympathectomy and splanchnicneurectomy - unilateral	468.75	7
	Lumbar sympathectomy - with abdominal procedure:		
77428	- unilateral (extra)	126.93	3
77430	- bilateral (extra)	253.87	

Lymphatic System

V07360	Splenectomy	826.87	6
CV07368	Laparoscopic splenectomy ***Notes:*** *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%.*	869.24	6
V07361	TB glands - radical removal	357.92	4
V07363	Radical femoral, inguinal and/or iliac dissection	715.84	5
CV07365	Isolated limb perfusion to include groin dissection and laparotomy	960.22	5
CV07366	Laparotomy and staging of lymphoma to include splenectomy	930.44	6

Lymphoedema - Leg

06127	Lymphoedema of limbs, excision and grafting - entire leg	715.88	3
06128	- entire lower extremity	1,070.26	3

Abdominal Surgery – Miscellaneous

V07603	Resuture abdominal wound evisceration	415.22	5
07451	Thoracic extension of abdominal incision, extra	511.31	8
V07600	Exploratory laparotomy to include biopsy	460.19	5
V07597	Post-operative haemorrhage - intra-abdominal management	483.84	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.*	485.75	5

		$	Anes. Level
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)	408.75	5
	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.*		
04001	Laparoscopy (operation only)	306.88	4
	Note: *Not paid with 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048.*		
V07414	Exploratory laparoscopy with incisional, excisional or core liver biopsy and/or peritoneal washings	516.04	6
	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).*		
07415	Liver biopsy in conjunction with other open or laparoscopic abdominal procedure - extra	130.66	
	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.*		
	Removal of indwelling Enteral tubes with or without exploration of tube insertion site:		
S71280	- not requiring anesthesia (operation only)	50.88	
S71281	- requiring local or regional anesthesia (operation only)	101.80	
S71282	- requiring general anesthesia (operation only)	208.54	2
S71283	- replacement of tube – extra	50.88	
	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	677.76	8
C71291	Resection of retroperitoneal or intra-abdominal soft tissue tumour measuring 10 cm or greater – each additional 15 minutes or greater portion thereof	78.20	
	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.*		

		$	Anes. Level
CV71292	Peritonectomy, with or without intraperitoneal chemotherapy – each hour (up to 8 hours)	677.76	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)	77.32	7
	Notes:		
	i) Payment restricted to General Surgeons.		
	ii) This is an all-inclusive fee, for the day of surgery, under the same anesthetic.		
	iii) Start and end times are required in the claim and the patient's chart.		

Diagnostic Procedures or Endoscopy

07710	Pancreatogram - with or without sphincterotomy, done in conjunction with any of the biliary or pancreatic surgical procedures –extra	68.71	
S00869	Manometry; anal - adult	103.67	2
S00797	Oesophageal motility test	180.13	
S00788	- technical fee	76.03	
S00798	- professional fee	104.09	
S00818	Oesophageal pH study for reflux, extra - professional fee	42.72	
S00817	- technical fee	15.59	
S00826	Biopsy of pancreas - percutaneous	103.74	2
S00809	Retrograde pancreatography	221.44	3
T00879	EMG pudendal nerve testing for fecal incontinence	151.50	
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	119.27	3
	Note: *Not payable with 33341.*		
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	120.07	3
	Note: *Not payable with 33341.*		
S10763	Initial esophageal, gastric or duodenal biopsy	15.15	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	44.56	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	208.31	4
SY00716	Sigmoidoscopy, flexible; diagnostic	77.81	2

		$	Anes. Level
SY00718	- with biopsy	79.09	2
	Colonoscopy with flexible colonoscope:		
33373	- biopsy	240.47	2
33374	- removal polyp	287.87	2
S00780	Schirmer's Test (included in fee Item 02015)	13.89	

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.

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

		$	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	181.59	
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	91.57	
	Continuing care by consultant:		
77007	Subsequent office visit	43.84	
77008	Subsequent hospital visit	31.60	
77009	Subsequent home visit	45.64	
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.*	91.08	
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.*	31.60	
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.*	139.73	
	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	181.59	
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	91.57	
77707	Telehealth subsequent office visit	43.84	
77708	Telehealth subsequent hospital visit	31.60	

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.*	119.97	
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.*	71.88	

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)	79.08
01201	Night (call placed and service rendered between 2300 hours and 0800 hours)	111.05
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours)	79.08

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	72.69
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	99.40

		$	Anes. Level
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	72.69	

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.

P01210	Evening(1800 hours to 2300 hours) – 44.86% of surgical (or assistant) fee		
	- minimum charge	66.32	
	- maximum charge for surgeries under two hours	457.46	
	- maximum charge for surgeries of two hours or longer	1,246.00	
P01211	Night (2300 hours to 0800 hours) – 72.02% of surgical (or assistant) fee		
	- minimum charge	93.12	
	- maximum charge for surgeries under two hours	734.42	
	- maximum charge for surgeries of two hours or longer	2,000.00	
P01212	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 44.86% of surgical (or assistant) fee		
	- minimum charge	66.32	
	- maximum charge for surgeries under two hours	457.46	
	- maximum charge for surgeries of two hours or longer	1,246.00	

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 hrs, surgical surcharges are payable provided the major portion of surgical time is after 1800 hrs.

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

iv) Claim must state start and end time of surgery.

Surgical Assistant Or Second Operator

Total operative fee(s) for procedures:

00195	- less than $317.00 inclusive	147.95
00196	- $317.01 to 529.00 inclusive	209.92
00197	- $529.01 to $869.00 inclusive	309.31
P13197	- greater than $869.00	450.00
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	34.10

Notes:

i) Surgical assist fees are based on the total operative fee(s) for the associated surgical procedure(s). Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s).

ii) When a physician provides surgical assistance for two surgeries at different operative sites under one anesthetic, they may charge a separate surgical assistance fee for each surgery. This applies whether the two surgeries were performed by the same surgeon or by different surgeons. This does not apply to 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. When this occurs, start and end times must be noted on each billing claim.

iv) When a surgical assistant is required for minor surgery, a detailed explanation of the need for the surgical assistant is required in the claim note record.

		$	Anes. Level
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	282.60	
	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	32.96	
	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	609.98	
77030	- trunk	609.98	
	Note: *Item 77025 and 77030 provide operative report by second operator when requested by MSP.*		

Abscess And Infection

13605	Opening superficial abscess, including furuncle – operation only	50.75	2
07041	Aspiration: abdomen or chest (operation only)	77.73	2
	Abscess:		
07059	- deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	83.30	2
07027	- under general anesthesia or procedural sedation (operation only)	255.34	2
07061	- deep, post operative wound infection under general anesthesia (operation only)	230.09	2
07045	Anterior closed space abscess - operation only	103.74	2
06028	Web space abscess - operation only	306.47	2
06029	- under general anesthetic (operation only)	352.43	2
07685	Pilonidal cyst or sinus - excision or marsupialization (operation only)	306.79	2
	Osteomyelitis:		
*52380	Osteomyelitis, acute, decompression	305.35	2
*52385	Osteomyelitis, debridement with or without reconstruction	408.07	3
	Note: *52380 and 52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.*		

		$	Anes. Level
	Wounds – Simple:		
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	40.64	
	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	75.71	2
06063	Extraction of foreign body from a wound requiring general anesthesia or procedural sedation - operation only	306.47	2
	Notes: *i) Also, payable when performed under local anesthetic if the extraction requires at least 30 min and is complicated due to: a) The need for increased surgical exposure, or b) A delicate or deeper dissection, or c) Difficulty localizing the foreign body ii) If performed under local anesthetic, a note record must be provided with the length of the procedure and explaining why the extraction was complex in nature.*		
13612	Extensive lacerations greater than 5 cm. (maximum charge 35 cm) - operation only - per cm	15.19	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)	562.45	5
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	301.31	3
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	132.78	3
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	306.30	
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	133.93	
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	316.74	3
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	147.32	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	80.35	
	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)	128.56	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.

		$	Anes. Level
	Wounds - Avulsed and Complicated:		
06075	Lips and eyelids	347.09	3
06076	Nose and ear	436.01	3
06077	Complicated lacerations of the scalp, cheek and neck	340.66	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	276.62	3
	Excisional biopsy of lymph glands for suspected malignancy:		
70023	- neck (operation only)	245.43	3
V70024	- axilla	245.43	2
70025	- groin (operation only)	245.43	2
	Foreign Body:		
	Excision of skin and subcutaneous tissue of hidradenitis suppurative:		
07072	- axillary (operation only)	255.66	2
07075	- inguinal (operation only)	255.66	2
07076	- perianal (operation only)	255.66	2
07082	- perineal (operation only)	255.66	2
06166	Excision of axillary sweat glands for hyperhidrosis - unilateral	332.49	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)	311.04	3
V07074	- resection	263.82	3

Notes:

i) Payable only when performed in an Operating Room (Service Location Code G, I, or P).

ii) Not payable for percutaneous procedures.

iii) For operative section of transverse carpal ligament – bill under 06258.

		$	Anes. Level
13630	Paronychia (operation only)	40.50	2
13631	Removal of nail - simple (operation only)	40.50	2
13632	- with destruction of nail bed (operation only)	81.96	2
13633	Wedge excision or Vandenbos procedure of one nail (operation only)	72.32	2
V07053	Excision of nail bed, complete, with shortening of phalanx	141.11	2
	Biopsy of nerve or artery:		
07025	Temporal artery biopsy (operation only)	203.96	2
07028	Biopsy of sural nerve (operation only)	181.28	2

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)	306.79	2
06047	- 65 sq.cm. (operation only)	441.77	2
06048	- 650 sq.cm.	662.66	2
06049	For each 6.5 sq.cm. over 650 sq.cm. (operation only)	8.18	3

Note: *Refrigerated graft - 50% of appropriate fee.*

Vascular Access

Broviac type catheter:

07139	- insertion of	166.23	2
V07140	- insertion of - less than 3 months of age or less than 3 kg.	275.11	4
07141	- removal of (operation only)	129.65	2
	Totally implantable venous access port with subcutaneous reservoir (portacath type device):		
07142	- insertion of	261.77	2
77142	Removal of totally implantable access device (e.g.: portacath), operation only	130.85	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)	357.92	2
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	64.01	
07145	Intra osseous - access (operation only)	103.59	2
V07134	Peritoneal venous shunt for ascites	399.20	6
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee	22.60	
00319	Insertion of central catheter for total parenteral nutrition (operation only)	63.36	2

		$	Anes. Level
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	13.77	
	Note: *Treatment for cosmetic purposes is not a benefit under MSP.*		
77046	Ultrasound directed (with image capture) foam sclerotherapy – initial	175.84	
77047	Ultrasound directed (with image capture) foam sclerotherapy – repeat	175.84	
	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	82.65	2
77060	- repeat	38.72	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	228.08	2
V07108	Stripping long saphenous	269.85	2
V07109	Stripping short saphenous	233.46	2
	Multiple ligations and stripping tributaries:		
07110	- 3 to 5 incisions (operation only)	285.22	2
V07111	- 6 or more incisions	311.16	2
V07112	Ligation of 2 or more perforators	285.22	2
77070	Complete fasciotomy with or without multiple ligations	326.47	2
	Note: *For decompression fasciotomy, see 77360.*		
77075	Re-exploration of groin and/or popliteal fossa	306.98	2
V07116	Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy)	535.25	3
77077	Excision of ulcer and grafting - add full fee to venous procedures (operation only)	123.00	3
77079	Venous crossover graft for iliac obstruction	623.66	7
	Acute Venous:		
77082	Ligation of femoral vein	152.21	2
77084	Ligation or fenestration of inferior vena cava (requires laparotomy)	506.47	5

		$	Anes. Level
77086	Thrombectomy for acute ilio-femoral thrombophlebitis	634.64	5
V07146	Insertion of inferior vena cava filter; percutaneous placement or cutdown (e.g.: Kimray Greenfield filter)	376.16	2
	Portosystemic Shunting:		
C77090	Spleno-renal shunt	966.43	8
C77092	Porto-caval shunt	966.43	8
	Mesocaval graft:		
C77094	- synthetic	966.43	8
C77096	- autogenous	1,028.98	8

Arterial System

Notes: Repeat Vascular Surgery

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

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

Removal of synthetic graft:

77100 - without replacement (payable at 100% of the current fee listed for the initial insertion).

77102 - with replacement at the same site (payable at 50% of the current fee listed for the initial insertion), extra to the replacement graft.

77104 - with replacement at a different site (payable at 75% of the current fee listed for the initial insertion), extra to the replacement graft.

Notes:

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

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

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)	128.31	4
77112	Re-dissection of groin (after 21 days) - extra	135.47	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. 795.22

Notes:

i) Payable once per side only.

ii) Not payable with fee items 77100, 77102, 77104, or 77112

		$	Anes. Level

Arterial Procedures

Therapeutic procedures utilizing radiological equipment:

10900 Abdominal aortic aneurysm repair using endovascular stent graft – second operator 521.36

Notes:

i) Intraoperative renal artery angioplasty payable in addition at 50% of fee item 00982 when done.

ii) Intravascular stent placement – extra (10919) paid in addition under 10919 at 100%.

iii) This fee will not be paid to the primary operator.

Angioplasty

S77113 Intraoperative open or percutaneous tibial artery angioplasty 713.20 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 602.74 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 569.33 5

C77120 Embolectomy - trunk or extremities (subclassified by location and incision) 882.70 5

C77125 - one side 456.20 5

Neck or Thoracic:

C77130 Bypass graft (synthetic) and/or thrombo-endarterectomy - carotid arteries .. 1,205.45 8

77135 - innominate 796.76 5

C77140 - subclavian 1,067.65 5

C77145 Ligation of carotid artery 261.16 5

		$	Anes. Level
	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)	912.42	9
C77155	- aorta and/or iliac (bilateral)	1,943.81	9
C77160	- aorto-femoral and/or ilio-femoral (unilateral)	885.99	9
C77165	- aorto-femoral and/or ilio-femoral (bilateral)	1,943.81	9
	Aneurysm:		
	Note: *Peripheral aneurysm - charge associated bypass graft procedure.*		
77170	Arteriovenous aneurysm	506.47	9
C77175	Abdominal aneurysm, with grafting	2,042.33	9
77177	Abdominal aortic aneurysm repair using endovascular stent graft – vascular surgery component	1,428.76	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. iv) When done with 77177, if second operator present, 77114 and 10919 payable to either the primary or second operator. v) When Coil-plug embolization occlusion of the internal iliac artery is required, S00981 is payable in addition to 77177 at 50% for the first and 25% for the second, to a maximum of 2. vi) S00981 is not payable when iliac branch graft (T77178 or T77179) is done with 77177.*		
	Iliac Branch Graft (IBG): Endovascular abdominal aneurysm repair involving the left or right common iliac and internal iliac arteries		
T77178	Unilateral – extra	707.00	
T77179	Bilateral – extra	1,060.50	
	Notes: *i) Restricted to Vascular Surgeons. ii) Payable only with 77177. iii) Includes all necessary procedures such as construction of iliac conduit, iliac or femoral endarterectomy/artery repair as well as open revascularization of femoral artery, coil embolization of internal iliac arteries, in situ fenestration, and drain placements.*		
T77176	Surgical repair of unilateral or bilateral iliac artery aneurysms during open repair of infra-renal abdominal aortic aneurysm – extra	429.69	
	Notes: *i) Extra fee to be billed in addition to 77175 when one or both common and/or internal iliac aneurysms are repaired by grafting. ii) Maximum of one per surgery.*		
C77180	Resection of abdominal aneurysm with associated femoral dissection - one or both sides (extra fee to be added to procedure) (operation only)	126.92	9
	Note: *Peripheral aneurysm - charge associated bypass graft procedure.*		
C77185	Ruptured aneurysm, with grafting	1,941.21	10

		$	Anes. Level
	Complex endovascular aneurysm repair:		
77485	Ruptured endovascular abdominal aneurysm repair (REVAR)	2,043.03	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.		
77487	Emergency endovascular thoracic aorta repair (EEVTAR)	2,334.10	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.		
77490	Fenestrated endovascular graft for repair of juxta renal abdominal aortic aneurysm (FEVAR)	1,785.95	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.		
77495	Thoracic endovascular aneurysm repair (TEVAR)	2,043.03	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.

		$	Anes. Level
77497	Complex thoraco-abdominal endovascular aneurysm repair (CTAEVAR)	2,143.15	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.

77500	Second Operator – complex endovascular aneurysm repair	651.71	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.

Mesenteric:

C77190	Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy	1,417.41	7
C77195	Superior mesenteric bypass graft (autogenous vein)	1,417.41	7

Renal:

C77200	Renal bypass graft (synthetic) and/or thromboendarterectomy	1,417.41	7
C77205	Renal bypass graft (autogenous vein)	1,417.41	7

Axillo - Femoral:

	Axillo-femoral bypass graft and/or thromboendarterectomy		
C77210	- unilateral	1,001.38	7
C77215	- bilateral	1,298.11	7

Femoral Crossover:

C77230	Femoro-femoral crossover bypass graft (synthetic) and/ or thromboendarterectomy	951.74	5
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	951.74	5

Infrainguinal:

C77240	Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	877.77	5
C77245	- popliteal (endarterectomy)	694.96	5
C77250	- popliteal (synthetic)	634.57	5

		$	Anes. Level
C77255	- anterior, posterior tibial or peroneal	759.09	5
	Bypass graft (autogenous vein):		
C77260	- femoral	878.67	5
C77265	- popliteal	1,601.42	5
C77270	- anterior, posterior tibial or peroneal	1,645.88	5
77275	- in situ vein graft, (extra)	363.83	7
77280	- non-ipsilateral long saphenous graft; (extra)	361.42	7
77285	- short saphenous graft; (extra)	361.42	7
77290	- superficial femoral vein graft; (extra)	361.42	7
77295	- arm vein graft; (extra)	361.42	7
77300	- A-V fistula with bypass graft in limb salvage; (extra)	189.76	7
	Profunda thromboendarterectomy:		
77310	Profunda thromoendarterectomy without patch repair	565.53	5
77315	Profunda thromboendarterectomy with patch repair (synthetic or autologous)	767.87	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	596.96	6
C77335	- graft	767.87	6
	Repair of injury of major vessel in trunk:		
C77340	- suture	896.03	9
C77345	- graft	1,195.15	9
77350	Supra-renal aortic cross-clamp - extra to abdominal vascular or major trauma cases (operation only) ***Note:*** *Operative report required.*	423.58	
V07447	Repair of mesenteric injury ***Note:*** *Trauma fee item 07447 is to be charged in cases of blunt and/or penetrating abdominal injury. It does not apply to incidental intraoperative injury to abdominal structures.*	869.24	6
	Operative repair – arteriorraphy – for iatrogenic injury during percutaneous endovascular aortic valve implantation :		
77352	Repair of major vessel in extremity - suture	576.33	6
77353	Repair of major vessel in extremity - graft	741.33	6
77354	Repair of major vessel in trunk - suture	865.09	9
77355	Repair of major vessel in trunk - graft	1,153.83	9
	Fasciotomy:		
77360	Decompression fasciotomy - subcutaneous ***Note:*** *77360 includes secondary closure.*	342.14	3
	Tibial Metaphysis (Distal) Ankle and Foot:		
	Incision - Therapeutic, Release:		
57250	Decompression, neurolysis, nerve (isolated procedure)	305.53	2
57260*	Fasciotomy, compartment syndrome	272.17	2
57269*	Fasciotomy, secondary wound closure	201.89	2

		$	Anes. Level
	Miscellaneous:		
77370	Release of popliteal entrapment syndrome	342.14	3
	Note: *Not to be billed if full femoral popliteal bypass is performed.*		
S00722	Arteriography, operative - procedural fee	127.71	

Renal Access

77380	Insertion permanent peritoneal catheter; (procedure fee only)	194.99	3
77385	Removal by dissection of chronic peritoneal catheter; (operation only)	135.25	3
	Note: *For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.*		
77395	Creation of internal arterio-venous fistula	424.32	4
77396	Revision of AV fistula	517.02	
	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	723.49	4
	Notes: *i) Not paid with 77295, 77395, 77396 and 77402.*		
77402	Creation of brachiobasilic arteriovenous fistula with vein transposition	723.76	5
	Note: *Not paid with 77260 to 77300 and 77395 and 77400.*		
77403	Arm revascularization with distal revascularization and interval ligation (DRIL)	723.75	5
	Note: *Not paid with 77260 to 77300 and 77395.*		
77405	Thrombectomy of arterio-venous fistula	356.90	3
	Sympathectomy:		
77420	Lumbar sympathectomy - unilateral	379.55	4
77422	Cervical sympathectomy - unilateral	513.22	5
77424	Preganglionic sympathectomy; upper dorsal region - unilateral	468.75	7
77426	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	468.75	7
	Lumbar sympathectomy with abdominal procedure:		
77428	- unilateral (extra)	126.93	
77430	- bilateral (extra)	253.87	
	Lymphatic System:		
V07361	TB glands - radical removal	357.92	4
V07363	Radical femoral, inguinal and/or iliac dissection	715.84	5
V07360	Splenectomy	826.87	6
CV07366	Laparotomy and staging of lymphoma to include splenectomy	930.44	6
CV07365	Isolated limb perfusion to include groin dissection and laparotomy	960.22	5

		$	Anes. Level
	Lymphoedema: Leg		
	Lymphoedema of limbs - excision and grafting:		
06127	- entire leg	715.88	3
06128	- entire lower extremity	1,070.26	3

Abdominal Surgery

	Miscellaneous:		
V07603	Resuture abdominal wound evisceration	415.22	5
07451	Thoracic extension of abdominal incision (extra)	511.31	8
V07600	Exploratory laparotomy to include biopsy	460.19	5

Transplantation

	Implantation of kidney graft:		
77440	Vascular surgeon	855.39	7

Amputation

	Hand and wrist:		
06218	Transmetacarpal	306.79	2
06219	Finger, any joint or phalanx (operation only)	306.79	2
	Pelvis, Hip & Femur:		
55983	Above knee	684.95	4
55980	Hemicorpectomy	2,535.69	6
55981	Hemipelvectomy	1,441.31	6
55982	Hip disarticulation	1,225.08	6
55984	Knee disarticulation	684.95	4
55998*	Open injury, primary wound care	152.79	4
55999*	Open injury, secondary wound management	214.45	4
	Femur, Knee Joint, Tibia & Fibula:		
56980	Below knee	674.81	3
56998*	Open injury, primary wound care (operation only)	152.79	3
56999*	Open injury, secondary wound management	214.45	3
	Tibial Metaphysis (Distal), Ankle & Foot:		
57981	Midtarsal	521.41	2
57982	Transmetatarsal	521.41	2
57983	Single metatarsal/Ray resection	382.34	2
57980	SYME	544.18	2
57984	Toe	190.94	2
57998*	Open injury, primary wound care (operation only)	81.45	2
57999*	Open injury, secondary wound management (operation only)	112.28	2

Chest Wall Surgery

79125	Cervical rib resection	382.77	5
79130	Trans-axillary resection of first rib	921.87	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	199.28	
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	66.99	
	Continuing care by consultant:		
07807	Subsequent office visit	29.69	
07808	Subsequent hospital visit	25.35	
07809	Subsequent home visit	51.06	
07805	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	101.91	
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.*	199.28	
	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	199.28	
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	66.99	
78007	Telehealth subsequent office visit	29.69	
78008	Telehealth subsequent hospital visit	25.35	
Arterial System			
07820	Coarctation of aorta	969.02	9
07818	Resection of ascending aortic anuerysm	1,740.08	10
07819	Resection of descending aortic aneurysm	3,254.76	10
07826	Resection or repair of total aortic arch, semiarch, or hemiarch ***Note:*** *Restricted to Cardiac Surgery.*	1,730.62	10
07829	Repair of traumatic injury of major intrathoracic vessels	969.02	10

		$	Anes. Level
Heart			
	Heart:		
07830	Banding of pulmonary artery	846.86	9
07831	Pericardiotomy - with poudrage	846.86	9
07832	Pericardectomy	846.86	9
07833	Left atrial appendage ligation ***Note:*** *Not paid in addition to fee items 07910 and 07962.*	682.31	9
07834	Patent ductus arteriosus	846.86	9
07835	Blalock or Pott's procedure for Tetralogy of Fallot	846.86	9
07836	Blalock-Hanlon procedure	846.86	9
07837	Mitral commissurotomy (closed)	846.86	9
07838	Pulmonary valvulotomy (closed)	846.86	9
07839	Aortic valvulotomy	846.86	9
S07843	Implantation of endocardial pacemaker (ventricular)	426.30	4
S07953	Double lead endocardial pacemaker	557.53	4
S78030	AICD and single ventricular lead ***Note:*** *Thoracotomy (79045) is paid in addition at 50% when required for incision in chest for RV lead.*	595.38	8
S78031	- each additional lead, to a maximum of 3 extra leads	216.51	
S78032	Subcutaneous Implantable Cardiac Defibrillator Implantation ***Notes:*** *i) Fee for implantation, testing and programming of S-ICD.* *ii) Restricted to Cardiac Surgery and Cardiology.* *iii) Includes 33025*	876.51	8
S07952	Electronic monitoring of pacing and pacemaker function	99.01	
S07844	Implantation or replacement of pulse generator for cardiac pacing	257.56	4
07845	Repair, replacement, adjustment of electrode ***Note:*** *For implantation of temporary pacemaker, see 33030.*	260.51	4
07851	Phrenic nerve stimulator	487.32	8
07846	Surgical treatment of cardiac arrest by cardiac massage (operation only) ***Note:*** *To be supported by explanation, and Clauses D. 5. 3. of the Preamble will apply.*	431.14	11
07852	Gore-tex modified aorto-pulmonary shunt	969.02	9
78041	Laser Lead Extraction after 30 days, first lead ***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 13197.*	1,450.90	9
78042	Laser Lead Extraction after 30 days, additional leads, to a maximum of two – extra	544.66	9
78043	Debridement of chest wall during laser lead extraction- extra (payable only with 78041)	54.46	9
78044	Wide debridement of chest wall during laser lead extraction - extra (payable only with 78041)	108.94	9
78045	Thoracotomy post cardiac surgery for hemorrhage ***Note:*** *Must be performed by a Cardiac Surgeon in the Operating Room, under general anesthetic.*	772.92	8
Open Heart Surgery			
07824	Resecting aneurysm of the ventricle as an isolated procedure	1,633.32	10
07825	Resecting left ventricular aneurysms in conjunction with another procedure	281.02	10

		$	Anes. Level
78051	Minimal Access Mitral or Aortic valve replacement or Mid-cavity CABG (extra)	514.71	
	Notes: *i) Paid at 100% and only paid with 07853, 07854, 07855, 07856, 07857, 07858, 07859, 07860 and 07908.* *ii) Restricted to Cardiac Surgery.*		
78052	Explant Transcatheter Heart Valve Repair Device – extra	801.51	10
	Notes: *i) Restricted to Cardiac Surgery.* *ii) Paid only in addition to 07855, 07859, 07860, 07862, 07864, 07865, 07866, 78060.* *iii) Paid up to a maximum of 2 per patient per day.*		
	Mitral valve:		
07853	Commissurotomy	1,463.40	9
07854	Plication	1,463.40	9
07855	Replacement	2,036.63	9
07856	Simple repair	1,633.32	9
	Note: *Restricted to Cardiac Surgery.*		
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	2,041.68	9
	Note: *Restricted to Cardiac Surgery.*		
	Aortic valve:		
07857	Commissurotomy	1,463.40	9
07858	Plication	1,463.40	9
07859	Replacement	1,633.32	9
07860	Aortic root reconstruction with mechanical valved conduit, Homograft, or Xenograft root	3,258.77	10
78059	Valve-Sparing Root Replacement (David Procedure)	4,797.46	10
	Notes: *i) Restricted to Cardiac Surgery.* *ii) Not payable with 07860, 78060.*		
78060	Pulmonary Autograft (Ross Procedure)	5,046.21	10
	Notes: *i) Restricted to Cardiac Surgery.* *ii) Includes 07860, 78059.*		
	Tricuspid valve:		
07861	Commissurotomy	1,463.40	9
07862	Replacement	1,633.32	9
07863	Annuloplasty	1,463.40	9
	Multiple valve replacement:		
07864	Two valves	2,844.77	10
07865	Three valves	3,253.71	10
07866	Valved external conduit	2,268.11	10
	Atrial septum defect:		
07867	Secundum - suture	1,463.40	9
07868	- patch	1,463.40	9

		$	Anes. Level
07869	Primum	1,633.32	9
07870	Multiple	1,463.40	9
07871	- plus pulmonary stenosis	1,463.40	10
07872	- plus partial anomalous pulmonary drainage	1,633.32	10
	Ventricular septal defect:		
07874	Simple	1,571.55	9
07875	Multiple	1,571.55	9
78057	Apical Myectomy, Transapical Approach ***Notes:*** *i) Restricted to Cardiac Surgery.* *ii) Start and end times must be entered in both the billing claim and the patient's chart.*	2,003.76	9
78058	Extended Septal Myectomy ***Notes:*** *i) Restricted to Cardiac Surgery.* *ii) Start and end times must be entered in both the billing claim and the patient's chart.*	2,137.35	9
07876	- plus patent ductus	1,571.55	9
07877	- plus pulmonary hypertension	1,571.55	10
07878	- plus corrected transposition	1,571.55	10
07879	- plus aortic regurgitation	1,571.55	10
	Subaortic stenosis:		
07881	Fibrous ring	1,463.40	9
07882	Muscular hypertrophy	1,633.32	9
	Pulmonary valve:		
07884	Valvulotomy	1,463.40	9
07885	Infundibulectomy	1,633.32	9
07886	Patch	1,633.32	9
07889	Tetralogy of Fallot	1,633.32	10
07890	- plus outflow patch	1,879.09	10
07893	- with previous anastomosis shunt	1,879.09	10
07898	Transposition	2,032.18	10
07887	Pulmonary arterioplasty with bypass	1,633.32	9
07899	Anomalous pulmonary drainage - total	2,032.18	10
07900	Aorticopulmonary window	1,633.32	10
07901	Repair aortic root, sinus of Valsalva, or aortic annulus, including with patch repair; root enlargement (Nicks or Manougian); or aortic annuloplasty ***Notes:*** *i) Restricted to Cardiac Surgery.* *ii) Not payable with 07860 or with 78059.*	1,633.32	10
07902	Atrioventricular communis	2,464.73	10
07905	Intracardiac tumours	1,633.32	9
07906	Pulmonary embolectomy with bypass	1,463.40	11
07908	Coronary artery bypass graft (end-to-side or side-to-side) - one artery	1,481.95	9
07909	- each additional artery ***Note:*** *When 7 or more arteries are bypassed, a written explanation must be submitted along with the account.*	281.60	

		$	Anes. Level
07990	Harvest of arterial conduit for the purpose of coronary revascularization – per conduit (extra)	282.87	
	Notes: *i) Paid with fee items 07908 and 07909 only.* *ii) Paid to a maximum of two per patient.* *iii) Restricted to Cardiac Surgery.*		
07991	Repair of acute thoracic aortic dissection or intramural hematoma (extra)	845.44	
	Notes: *i) Restricted to Cardiac Surgery.* *ii) Paid at 100% with fees listed under the headings "Open Heart Surgery: and "Arterial System".*		
07992	Hypothermic circulatory arrest (extra)	704.17	
	Notes: *i) Restricted to Cardiac Surgery.* *ii) Paid at 100% with fees listed under the headings "Open Heart Surgery: and "Arterial System".* *iii) Includes cannulation of one of the following vessels for purposes of cerebral perfusion: axillary, subclavian, carotid, and/or innominate arteries and/or superior vena cava for purposes of cerebral perfusion.* *iv) If a second site of cannulation for cerebral perfusion is required, fee item 07992 will be paid at 25%.*		
07910	Complete Cox-Maze procedure to include all right and left atrial lesion sets and pulmonary vein isolation	1,872.65	9
	Note: *Not paid with 33084.*		
07962	Left atrial lesion sets only, with or without pulmonary vein isolation	1,397.23	9
	Note: *Not paid with 33084.*		
07963	Pulmonary vein isolation only	629.58	9
	Note: *Not paid with 33084.*		
07911	Ventricular arrhythmia surgery (must include mapping and ablation and includes aneurysmectomy if necessary)	2,273.95	9
07912	Endocardial mapping	393.24	
07913	Pericardiectomy with bypass	1,463.40	9
07914	Recurrent surgery after 21 days (add to 07824, 07855, 07859, 07860, 07862, 07864, 07865, 07908 and congenital heart operations) - extra	1,537.62	
	Specially Qualified Assistant fees:		
07915	First assistant for operations of $1,033.00, or less	283.85	
07916	Second and third assistant for operations of $1,033.00, or less	166.01	
07917	First assistant for operations over $1,033.00	407.27	
07918	Second and third assistant for operation over $1,033.00	254.73	
07920	Time, after four hours of continuous surgical assistance for one patient, each 15 minute period or fraction thereof.	22.29	
	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	39.32	4

		$	Anes. Level
S07925	Artificial pneumothorax (operation only)	27.37	4
	Ribs and Chest Wall:		
07949	Laser therapy for intra-tracheal or intra-bronchial tumour to include endoscopy	468.17	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).
v) Restricted to Cardiac Surgery.

78061	Uni-ventricular temporary device (i.e. Abiomed Impella 5.0) – transcutaneous	524.66	10
78062	Removal of Abiomed Impella 5.0 (includes artery repair)	367.26	10
78063	Uni-ventricular – temporary device (i.e. Levitronix) – thoracotomy (includes blood vessel repair)	1,783.81	10
78064	Removal of Levitronix device	734.51	10
78065	Uni-ventricular – fully implantable (i.e. Heartmate II or Heartware) includes blood vessel repair	3,042.98	10
78066	Removal of fully implantable device includes blood vessel repair	1,573.96	10
07960	Intra-aortic balloon insertion, removal and care	692.37	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	629.58	10
78072	Veno - Arterial (V-A) ECMO insertion – central	839.45	10
78073	Veno - Veno (V-V) ECMO insertion – peripheral	419.73	10

Oesophageal Surgery

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.*	282.60	

		$	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	32.96	

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	548.90	5
V70501	- thoracic approach with removal of foreign body	652.01	8
V70502	Cricopharyngeal myotomy - cervical approach	479.96	4

Oesophagus - Excision

Excision of lesion, oesophagus, with primary repair:

CV70530	- cervical approach	548.90	6
CV70531	- thoracic or abdominal approach; open	795.18	8
CV70532	- thoracic or abdominal approach; laparoscopic or thorascopic	795.18	8

Total or near total oesophagectomy; without thoracotomy (Transhiatal):

With pharyngogastrostomy or cervical oesophagogastrostomy, with or without pyloroplasty:

V70533	- primary surgeon	2,076.08	8
70503	- secondary surgeon	664.71	

With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

V70534	- primary surgeon	2,076.08	8
70504	- secondary surgeon	664.71	

Total or near total oesophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):

V70535	- primary surgeon	2,335.58	8
70505	- secondary surgeon	664.71	

With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

V70536	- primary surgeon	2,335.58	8
70506	- secondary surgeon	664.71	

V70538	Partial oesophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic oesophagogastrostomy. (Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.)	1,671.88	8

With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

V70539	- primary surgeon	1,906.97	8
70509	- secondary surgeon	664.71	

CV70540	Partial oesophagectomy, thoraco-abdominal or abdominal approach; with esophagogastrostomy	1,462.86	8

Notes:

i) Includes vagotomy.

ii) Includes proximal gastrectomy, pyloroplasty, and splenectomy if required.

		$	Anes. Level
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70541	- primary surgeon	1,711.06	8
70511	- secondary surgeon	664.71	
CV70542	Total or partial oesophagectomy, without reconstruction (any approach), with cervical oesophagostomy (includes gastrostomy)	1,097.79	6
	Diverticulectomy of Hypopharynx or Oesophagus:		
V70545	- with or without myotomy - cervical approach	548.90	6
V70544	- with or without myotomy - thoracic approach	668.74	8
	Upper Gastrointestinal System – Endoscopy (Surgical)		
S33321	Removal of foreign material causing obstruction, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	151.03	4
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only ***Notes:*** *i) Paid only once per endoscopy.* *ii) Paid only in addition to:* *a) S10761 or S10762; or* *b) 33341, at 50%.*	151.18	3
S33323	Transendoscopic tube, stent or catheter – operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	151.03	3
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.*	150.81	3
S33325	Gastric polypectomy, operation only ***Notes:*** *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*	61.36	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.*	176.22	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.*	100.51	3
S33328	Esophageal dilation, blind bouginage, operation only ***Note:*** *Repeats within one month paid at 100%.*	100.58	3

		$	Anes. Level
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only	151.10	3
	Note: *Repeats within one month paid at 100%.*		

Oesophagus – Repair

V71530	Cervical oesophagostomy	543.38	5
V71531	Cervical approach - repair tracheo-oesophageal fistula	2,045.25	6
	Note: *71530 and 71531 include gastrostomy.*		
	Oesophagoplasty, (plastic repair or reconstruction) thoracic approach:		
CV71532	- without repair of tracheo-oesophageal fistula	2,045.25	8
CV71533	- with repair of tracheo-oesophageal fistula	2,300.91	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach)	868.66	8
	Note: *C71533 and 71534 include gastrostomy.*		
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	1,022.63	6
V71536	- open	843.66	6
CV71537	Oesophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	920.36	8
V71538	- with gastroplasty - Collis	1,245.65	8
	Plastic operation for cardiospasm; Heller:		
V71539	- thoracic approach - open	766.97	8
V71540	- laparoscopic or thorascopic (endoscopy to be billed separately)	945.93	6
CV71541	- with fundoplication - open	1,073.76	6
CV71542	- with fundoplication - laparoscopic	1,227.15	6
	Gastrointestinal reconstruction for previous oesophagectomy; for obstructing oesophageal lesion or fistula, or for previous oesophageal exclusion:		
CV71543	- with stomach; with or without pyloroplasty	1,462.86	6
CV71544	- with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	1,711.06	6
	Suture of oesophageal wound or injury:		
V71548	- cervical approach	1,297.56	6
CV71549	- transthoracic or transabdominal approach	1,557.05	8
	Closure of oesophagostomy or fistula:		
CV71550	- cervical approach	1,297.56	6
CV71551	- transthoracic or transabdominal approach	1,557.05	8
02449	Rigid oesophagoscopy for removal of foreign body	259.93	4

Diaphragm - Repair

V70601	Repair para-oesophageal hiatus hernia, transabdominal, with or without fundoplication	1,328.31	6

		$	Anes. Level
	Repair of diaphragmatic hernia of any type, with or without fundoplication, vagotomy, or drainage procedure:		
CV70603	- laparoscopic	1,378.81	6
CV70604	-congenital diaphragmatic hernia	1,557.05	9
CV70605	- open	1,328.34	8
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	818.10	8

Note: *For anti-reflux procedures, such as fundoplications, etc., please see Oesophageal section.*

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	Full thickness repair diaphragmatic injury (traumatic) with or without mesh	1,073.76	8

Miscellaneous

70023	Excisional biopsy of lymph glands for suspected malignancy – neck (operation only)	245.43	3
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	516.79	5
V07630	Gastrostomy - open	467.13	5
V07648	Revision of colostomy, ileostomy – simple incision or scar, etc.	562.45	4
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	312.59	6
02422	- in a child under the age of 3 years	389.18	6
02420	Dilation of trachea (operation only)	156.10	5
02421	- repeat within one month (operation only)	155.88	5
	Microsurgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:		
02430	- first procedure	501.50	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 07999 with operative report.

02407	Tracheostomy	398.83	5

Note: *Not applicable to cricothyrotomy puncture.*

C02473	Laryngo-pharyngo-oesophagectomy - primary excision only	1,942.99	6

Thoracic Procedures

S00700	Bronchoscopy or bronchofibroscopy - procedural fee	138.87	4
00702	Bronchoscopy with biopsy - procedural fee	218.67	4
S00719	Thoracoscopy	351.12	7
S00701	Direct laryngoscopy - procedural fee	73.82	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
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	119.27	3
	Note: *Not payable with 33341.*		
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	120.07	3
	Note: *Not payable with 33341.*		
S10763	Initial esophageal, gastric or duodenal biopsy	15.15	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	44.56	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	208.31	4
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	69.68	4
S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	291.74	2
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	56.20	2
S00749	Parietal pleural, including thoracentesis - procedural fee	136.23	2
S00751	Pericardial puncture - procedural fee	258.25	3
S00755	Artery puncture - procedural fee	7.15	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	103.74	2
S00797	Oesophageal motility test	180.13	
S00788	- technical fee	76.03	
S00798	- professional fee	104.09	
S00818	Oesophageal pH study for reflux, extra - professional fee	42.72	
S00817	- technical fee	15.59	

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	154.25	
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	69.42	
	Continuing care by consultant:		
79007	Subsequent office visit	30.78	
79008	Subsequent hospital visit	26.26	
79009	Subsequent home visit	52.91	
79005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) ***Note:*** *Claim must state time service rendered.*	105.60	
	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	154.25	
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	69.42	
79207	Telehealth subsequent office visit	30.78	
79208	Telehealth subsequent hospital visit	26.26	
Lung Surgery			
	Lobe:		
79015	Lobectomy	1,447.66	8
79020	Bronchoplasty (extra to lobectomy)	262.48	9
	Entire Lung:		
79025	Pneumonectomy	1,572.97	9
	Other Lung Operations:		
79030	Segmental resection of lung (operative report required)	1,447.66	8
79035	Thoracotomy, including wedge resection	812.23	8
79036	- each additional wedge resection of lung when done thorascopically, to a maximum of two extra	83.08	
79040	Drainage of lung abscess - operation only	542.85	8

		$	Anes. Level
	Thoracotomy (Miscellaneous):		
S07924	Decompression of traumatic pneumothorax – operation only	39.32	4
79045	Exploratory thoracotomy with or without biopsy or removal of foreign body	821.47	8
79050	Decortication of lung	1,266.46	8
79055	Pleurectomy	812.23	8
79060	Intrathoracic tumour – without lung involvement	1,090.78	8

Airway Surgery

	Trachea:		
79065	Tracheal resection	1,023.17	10
79070	- with laryngeal release, extra	505.04	10
79075	- with hilar release, extra	505.04	10
02420	Dilation of trachea (operation only)	156.10	5
02421	- repeat within one month (operation only)	155.88	5
02407	Tracheostomy ***Note:*** *Not applicable to cricothyrotomy puncture*	398.83	5
	Bronchus:		
79080	Closure of bronchopleural fistula	1,011.65	10
79085	Repair of ruptured bronchus	1,023.17	9
07949	Laser therapy for intra-tracheal or intra-bronchial tumour - to include endoscopy	468.17	7
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	312.59	6
02422	- in a child under the age of 3 years	389.18	6
	Micro-surgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:		
02430	- first procedure	501.50	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*	501.50	6

Mediastinal Surgery

79095	Mediastinal cyst or tumour	1,129.89	8
79100	Thymectomy	844.08	8

Chest Wall Surgery

79105	Rib resection for empyema	528.33	6
79110	Closure of pleurostomy following long term management of empyema with rib section	528.33	6
79115	Pectus excavatum and carinatum	823.73	8
79120	Thoracoplasty	823.73	6
79125	Cervical rib resection	382.77	5
79130	Trans-axillary resection of first rib	921.87	5
79135	Chest wall tumour with rib resection	1,078.49	6

		$	Anes. Level
Diaphragm Surgery			
V70601	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).*	1,328.31	6
	Repair of diaphragmatic hernia of any type, with or without fundoplication, vagotomy, or drainage procedure:		
CV70603	- laparoscopic	1,378.81	6
CV70604	-congenital diaphragmatic hernia	1,557.05	9
CV70605	- open	1,328.34	8
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	818.10	8
	Note: *For anti-reflux procedures, such as fundoplications, etc., please see Oesophageal section.*		
V07431	Full thickness repair diaphragmatic injury (traumatic) with or without mesh	1,073.76	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.*	282.60	
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.*	32.96	
Oesophageal Surgery			
	Oesaphagus – Incision		
V70500	Oesophagotomy - cervical approach with removal of foreign body	548.90	5
V70501	- thoracic approach with removal of foreign body	652.01	8
V70502	Cricopharyngeal myotomy - cervical approach	479.96	4
	Oesophagus – Excision		
	Excision of lesion, oesophagus, with primary repair:		
CV70530	- cervical approach	548.90	6
CV70531	- thoracic or abdominal approach; open	795.18	8
CV70532	- thoracic or abdominal approach; laparoscopic or thorascopic	795.18	8

		$	Anes. Level
	Total or near total oesophagectomy; without thoracotomy (Transhiatal):		
	With pharyngogastrostomy or cervical oesophagogastrostomy, with or without pyloroplasty:		
V70533	- primary surgeon	2,076.08	8
70503	- secondary surgeon	664.71	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70534	- primary surgeon	2,076.08	8
70504	- secondary surgeon	664.71	
	Total or near total oesophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):		
V70535	- primary surgeon	2,335.58	8
70505	- secondary surgeon	664.71	
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70536	- primary surgeon	2,335.58	8
70506	- secondary surgeon	664.71	
V70538	Partial oesophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic oesophagogastrostomy. [Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.]	1,671.88	8
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):		
V70539	- primary surgeon	1,906.97	8
70509	- secondary surgeon	664.71	
CV70540	Partial oesophagectomy, thoraco-abdominal or abdominal approach; with esophagogastrostomy.	1,462.86	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	1,711.06	8
70511	- secondary surgeon	664.71	
CV70542	Total or partial oesophagectomy, without reconstruction (any approach), with cervical oesophagostomy (includes gastrostomy)	1,097.79	6
	Diverticulectomy of hypopharynx or oesophagus, with or without myotomy:		
V70545	- cervical approach	548.90	6
V70544	- thoracic approach	668.74	8
	Upper Gastrointestinal System – Endoscopy (Surgical)		
S33321	Removal of foreign material causing obstruction, operation only	151.03	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	151.18	3
	Notes: *i) Paid only once per endoscopy.* *ii) Paid only in addition to:* *a) S10761 or S10762; or* *b) 33341, at 50%.*		
S33323	Transendoscopic tube, stent or catheter – operation only	151.03	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	150.81	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33325	Gastric polypectomy, operation only	61.36	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	176.22	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	100.51	3
	Notes: *i) Paid only in addition to S10761 or S10762.* *ii) Paid only once per endoscopy.*		
S33328	Esophageal dilation, blind bouginage, operation only	100.58	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	151.10	3
	Note: *Repeats within one month paid at 100%.*		

Oesophagus - Repair

V71530	Cervical oesophagostomy	543.38	5
V71531	Repair tracheo-oesophageal fistula – cervical approach	2,045.25	6
	Note: *71530 and 71531 include gastrostomy.*		
	Oesophagoplasty, (plastic repair or reconstruction) thoracic approach:		
CV71532	- without repair of tracheo-oesophageal fistula	2,045.25	8
CV71533	- with repair of tracheo-oesophageal fistula	2,300.91	8
V71534	Division of tracheo-oesophageal fistula without oesophageal anastomosis (thoracic approach)	868.66	8
	Note: *C71533 and 71534 include gastrostomy.*		

		$	Anes. Level
	Oesophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:		
CV71535	- laparoscopic	1,022.63	6
V71536	- open	843.66	6
CV71537	Oesophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	920.36	8
V71538	- with gastroplasty - Collis	1,245.65	8
	Plastic operation for cardiospasm; Heller:		
CV71539	- thoracic approach - open	766.97	8
CV71540	- laparoscopic or thorascopic (endoscopy to be billed separately)	945.93	6
CV71541	- with fundoplication - open	1,073.76	6
CV71542	- with fundoplication - laparoscopic	1,227.15	6
	Gastrointestinal reconstruction for previous oesophagectomy; for obstructing oesophageal lesion or fistula, or for previous oesophageal exclusion:		
CV71543	- with stomach; with or without pyloroplasty	1,462.86	6
CV71544	- with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	1,711.06	6
	Suture of oesophageal wound or injury:		
V71548	- cervical approach	1,297.56	6
CV71549	- transthoracic or transabdominal approach	1,557.05	8
	Closure of oesophagostomy or fistula:		
CV71550	- cervical approach	1,297.56	6
CV71551	- transthoracic or transabdominal approach	1,557.05	8
02449	Rigid oesophagoscopy for removal of foreign body	259.93	4
C02473	Laryngo-pharyngo-oesophagectomy – primary excision only	1,942.99	6

Miscellaneous Surgery

70023	Excisional biopsy of lymph glands for suspected malignancy: - neck (operation only)	245.43	3
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	516.79	5
V07630	Gastrostomy – open	467.13	5
S32031	Closed drainage of chest – operations only	144.53	4
79140	Anterior scalenotomy	213.06	3

Diagnostic Procedures

	Thoracic procedures:		
	Procedures involving visualization by instrumentation:		
S00700	Bronchoscopy or bronchofibroscopy - procedural fee	138.87	4
S00702	Bronchoscopy with biopsy - procedural fee	218.67	4
S00719	Thoracoscopy	351.12	7
S00701	Direct laryngoscopy - procedural fee	73.82	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	119.27	3
	Note: *Not payable with 33341.*		
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	120.07	3
	Note: *Not payable with 33341.*		
S10763	Initial esophageal, gastric or duodenal biopsy	15.15	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	44.56	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	208.31	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	69.68	4
S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	291.74	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	56.20	2
S00749	Parietal pleural, including thoracentesis - procedural fee	136.23	2
	Puncture procedures for obtaining body fluids (when performed for diagnostic purposes):		
S00751	Pericardial puncture - procedural fee	258.25	3
S00755	Artery puncture - procedural fee	7.15	2
S00759	Paracentesis - (thoracic) or transtracheal aspiration - procedural fee	103.74	2

		$	Anes. Level
	Miscellaneous:		
S00797	Oesophageal motility test	180.13	
S00788	- technical fee	76.03	
S00798	- professional fee	104.09	
S00818	Oesophageal pH study for reflux, extra - professional fee	42.72	
S00817	- technical fee	15.59	

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	99.99	
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	55.67	
	<u>Continuing care by consultant:</u>		
08007	Subsequent office visit	45.44	
08008	Subsequent hospital visit	43.83	
08009	Subsequent home visit	61.35	
08005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:** Claim must state time service rendered.*	125.68	
	<u>Telehealth Service with Direct Interactive Video Link with the Patient:</u>		
08070	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	99.99	
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	55.67	
08077	Telehealth subsequent office visit	45.44	
08078	Telehealth subsequent hospital visit	43.83	

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 and 13197.*	78.20	
P81195	Certified urologic surgeon assist (extra) Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof ***Notes:*** *i) Restricted to Urology.* *ii) Paid only in addition to fee item 70020.* *iii) Maximum payable is 8 units per surgery.*	17.94	

iv) Any additional assistants, if required, are paid under fee items 00195, 00196, 00197, 00198 and 13197 only.
v) Start and end times must be entered in both the billing claims and the patient's chart.

		$	Anes. Level
Kidney and Perinephrium			
08100	Drainage of perinephric abscess	495.29	5
08117	Nephrolithotomy and/or pyelolithotomy	796.03	5
08118	Nephrolithotomy or pyelolithotomy with X-ray control with or without nephroscopy	864.61	5
S08123	Extra-corporeal shock wave lithotripsy (ESWL), operation only	227.58	4
08104	Partial nephrectomy	1,381.48	5
08105	Nephrectomy	1,277.21	5
08106	- ectopic kidney	1,277.36	5
08108	- thoraco-abdominal	1,355.41	8
08109	- radical, with gland dissection	1,303.26	6
C81104	Laparoscopic partial nephrectomy for suspected renal malignancy, with or without ipsilateral adrenalectomy, includes excision of perinephric fat ***Notes:*** *i) Restricted to Urologists.*	1,994.18	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).*	1,564.07	7
08110	Nephro-ureterectomy to include bladder cuff	1,538.01	6
C81110	Laparoscopic nephroureterectomy (including excision of bladder cuff) ***Note:*** *Not paid with 08105, 08106, 08109, 08110, C81104, C81105.*	1,922.48	6
08112	Open renal biopsy (as an independent procedure)	323.37	5
08113	Symphysiotomy and nephropexy or nephrectomy in horseshoe kidney	1,277.36	5
08114	Pyeloplasty, including management of aberrant vessels and nephropexy	1,024.11	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.*	1,382.63	7
08116	Ruptured or lacerated kidney - repair or removal	1,292.85	6
C08120	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.*	6,524.30	6

		$	Anes. Level
TC81115	Complex Radical Nephrectomy for Renal Tumours stage IIB or higher with or without ipsilateral adrenalectomy, includes excision of perinephric fat & thrombectomy if required	2,150.00	8
	Notes: *i) Restricted to Urologists.* *ii) Not paid with 08105, 08106, 08108, 08109, 08110, 81104 and 81105.*		

Endo-Urology

S08146	Ureteroscopy and basket manipulation of ureteral calculus with or without lithopaxy (operation only)	562.38	3
S08155	Insertion of internal ureteral stent to include C & P and ureteroscopy, (operation only)	153.20	3
	***Note**: Additional stents to be paid at 50%*		
08168	Nephroscopy and stone removal - to include lithopaxy - operation only	632.93	4
	***Note:** 00800 not payable in addition to 08168.*		
S08185	Endoscopic Treatment of upper Tract Transitional Cell Carcinoma	920.36	6
	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 or 08118.* *iv) Bilateral procedures which involve both kidneys/ureters are payable at 150%.* *v) Antegrade percutaneous access (00978, 00979) payable at 100% in addition.*		

Ureter

08144	Ureterocele Incision	357.46	2
	***Note**: Restricted to Urologists.*		
S08145	Subureteric endoscopic injection for vesicoureteral reflux (VUR)	314.88	2
	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.*		
08147	Ureterotomy, ureteral lithotomy, upper and lower	418.88	5
08151	Ureterotomy or removal of stump	772.97	5
	Uretero-vesical reanastomosis:		
08152	- unilateral	886.07	5
08148	- bilateral	1,034.22	5
	Ureteral tailoring:		
08153	- unilateral, extra to 08152 or 08148	237.84	5
08154	- bilateral, extra to 08148	336.10	5
08156	Uretero ureterostomy	911.05	5
08157	Uretero-cutaneous-anastomosis - unilateral	842.32	5
08158	Ureteral sigmoid anastomosis - bilateral	646.35	5
08159	Ureterolysis	614.20	5
08160	Reconstruction lower segment ureter by bladder flap	938.43	5
08161	Transurethral manipulation of ureteral calculus - with recovery of calculus	222.32	3
08163	Uretero-vesical anastomosis in the presence of ureterocele or ureteral duplication	801.46	5

		$	Anes. Level
TC81151	Distal Ureterectomy and Ureteric Reimplant	1,733.39	6

Notes:
i) Restricted to Urologists.
ii) Fee items 08160 paid at 50% when billed with TC81151, if a tubularized Baori bladder flap is utilized to obtain ureteric anastomosis.
iii) 04212 paid at 25% when billed with TC81151.
iv) Not paid with 08151, 08152, 08153, 08154, 08155 and 08159.

Urinary Diversion and Cystectomy

08170	Preparation of intestinal segment and reanastomosis	527.43	5
08174	Preparation of intestinal segment, reanastomosis, and ureteral transplantation (same surgeon)	932.57	6
08184	Cystectomy, isolated procedure, with or without urethrectomy.	1,266.08	6
08173	Radical cystectomy - with pelvic lymphadenectomy (isolated procedure)	1,981.91	7
08177	Cystectomy and ileal loop diversion (includes preparation of intestinal segment and ureteral transplantation - same surgeon)	2,198.65	6
08178	Radical cystectomy and ileal loop urinary diversion (to include preparation of intestinal segment and ureteral transplantation - same surgeon)	2,916.73	7
08181	Bladder augmentation with bowel segment.	1,240.95	5
08182	Continent urinary diversion	1,239.36	6

Note: *When a second urologist with expertise in continent diversion performs the continent urinary diversion, both surgeons shall be paid in full.*

08183	Radical Cystectomy and continent urinary diversion (includes preparation of intestinal segment and ureteral transplantation -same surgeon)	3,221.27	7

Bladder

S08200	Bladder fulguration with cystoscopy	237.46	2
08201	Cystostomy, isolated procedure	225.22	2
S08202	Cystostomy by Trochar, isolated procedure (operation only)	207.28	2
08203	Cystolithotomy	323.04	2
08204	Cystectomy - partial for tumour or diverticulum	727.43	5
S08205	Intravesical botulinum toxin injection(s)	291.45	2

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.

08207	Ruptured bladder repair	772.92	5
08255	Closure of fistula - suprapubic, vesico-vaginal, vesico-rectal, or vesico-sigmoid	729.89	5
C08355	Tensor fascia lata or abdominal rectus fascia harvest	1,072.76	2

To include operation for urinary incontinence or urinary tract reconstruction and 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) Not payable with fee item 08283.
iii) Includes cystoscopy.

		$	Anes. Level
T08356	Manual Bladder Irrigation and Clot Evacuation (operation only)	275.00	3
	Notes: *i) Restricted to Urologists.* *ii) To be utilized when 3-way irrigation catheters have failed to clear clot or otherwise contraindicated.* *iii) Maximum of 2 per patient per day.*		
	Endoscopy:		
S08250	Transurethral resection of bladder or urethral tumour and adjacent muscle and electrocoagulation, as necessary	355.54	3
S08251	Transurethral resection bladder neck, female	308.12	3
S08257	Transurethral removal of foreign body (excluding ureteric stents)	258.47	3
	Note: *Removal of ureteric stents is paid under 00704.*		
08253	Y-V vesical neck plasty	786.30	4
S08254	Litholapaxy and removal of fragments	354.02	2
S08256	Transurethral resection of external urinary sphincter	312.48	3

Urethra

S08232	Periurethral collagen injections	242.67	2
	Notes: *i) Includes cystoscopy.* *ii) Applicable to females only.* *iii) Additional training at recognized centre required.*		
S08260	Urethrotomy, external or internal	255.22	2
S08261	Urethrostomy	308.52	2
S08262	Meatotomy and plastic repair (operation only)	235.67	2
08263	Urethrectomy, total	361.96	3
S08264	Stricture of urethra - office dilation (operation only)	20.22	
S08265	- dilation in hospital, isolated procedure, with or without anesthesiology (operation only)	50.50	2
08266	- first-stage plastic repair (excluding urethrostomy)	1,094.84	3
08259	- first-stage plastic repair requiring pedicle graft	1,042.71	3
81159	Buccal mucosa graft harvest, extra	234.61	
	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)	1,042.71	3
08268	Urethral diverticulectomy, male or female	664.80	2
S08269	TUR posterior urethral valves	362.05	2
08283	Retropubic or transvaginal tape (TVT) or transobturator tape (TOT) operation for urinary incontinence	339.54	
C81153	Male suburethral sling, including cystoscopy	729.89	4
	Notes: *i) Daily maximum is one per patient.* *ii) Repeats within 30 days are paid at 50%. A note record is required.*		

		$	Anes. Level
81154	Transection or removal of sub-urethral mesh sling ***Notes:*** *i) Restricted to Urology specialists.* *ii) Fee items 00704, 00705 or 08232 not paid in addition.*	573.15	4
08272	Urethral fistula (penile excision)	461.15	2
08274	Hypospadias, excluding urethrostomy - first stage, chordee	561.56	2
08275	- second stage (penile)	562.80	2
08276	- penoscrotal	1,034.34	2
08277	- epispadias plastic repair	672.19	2
08278	Suprapubic cystostomy and primary repair of urethra	415.41	3
S08282	Excision prolapse of urethra or caruncle - includes cystoscopy (operation only)	248.57	2
S08271	Catheterization, complex – male patient (operation only) ***Notes:*** *i) Restricted to Urologists and General Surgeons.* *ii) Procedure must involve the use of Filiforms and Followers, or introducers (skylet or catheter guide).* *iii) Not paid in addition to the critical care fees, or diagnostic urological procedures (e.g.: voiding cystourethrogram).*	208.54	

Penis

08296	Insertion of semi rigid or self-contained inflatable prosthesis	625.62	3
08363	Revision of penile prosthesis (includes removal, correction of any mechanical failure, and replacement)	882.15	3
08364	Repair of penile fracture or traumatic laceration of cavernous tissue ***Notes:*** *i) Restricted to Urologists.* *ii) Diagnostic cystoscopy prior to surgery is payable at 100%.*	814.63	2
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”). ***Note:*** *08297 must be preceded by colour flow Doppler or duplex sonogram.*	413.73	2
08300	Priapism - saphena-cavernous shunt	582.03	2
08366	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.*	508.24	
S08301	Dorsal slit, isolated procedure (operation only)	167.09	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.*	302.02	2
08305	Simple amputation of penis	472.49	2
08299	Radical amputation of penis	620.57	2
08306	Clitoral recession	258.54	2

		$	Anes. Level
	Excision of inguinal and femoral glands with or without iliac glands:		
08308	- unilateral	938.43	4
08309	- bilateral	1,355.52	4
08307	Excision of Peyronies' plaque, with replacement graft (tissue or synthetic)	814.63	2
08365	Penile plication for correction of penile curvature for Peyronie's disease	814.63	2

Notes:

ii) Restricted to Urologists.

iii) Circumcision if required is payable in addition at 50%.

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	511.00	5
08314	- radical perineal retropubic prostate seminal vesiculectomy	1,412.08	7

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.*

TC81312	Open simple retropubic prostatectomy – operation only	1000.00	7

Notes:

i) Restricted to Urologists.

ii) Not billable with 08311 or 81311.

iii) Visits billable in addition for post operative care under 08008.

T81322	Cryosurgical ablation of recurrent prostate cancer, unilateral or bilateral	1,000.00	7

Notes:

i) Restricted to Urologists.

ii) Reserved for salvage cases following the local recurrence of prostate cancer. Not applicable for primary treatment of prostate cancer.

iii) Includes all necessary biopsy mapping and ultrasound required to complete the procedure.

iv) 00704, 00705, 08684 not paid in addition.

08318	- radical, to include lymphadenectomy	1,442.14	7
C81305	Laparoscopic radical prostatectomy	2,127.12	7

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.

C81310	Laparoscopic radical prostatectomy, with pelvic lymph node dissection (PLND)	2,450.37	7

Note:

i) Restricted to Urologists.

		$	Anes. Level
S81311	Holmium laser enucleation of prostate (HoLEP)	970.14	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).* *iv) Fee item 08254 will be paid at 50% when done with HoLEP.*		
T81313	Green Light Laser Photo Vaporization of the Prostate	625.00	5
	Notes: *i) Restricted to Urologists.* *ii) Not paid with 08311 or cystoscopy (00704 or 00705).*		
08317	Anti-incontinence procedure (artificial urinary sphincter)	788.73	4
S08319	Balloon dilation of prostate (Includes cystoscopy)	232.40	2

Testis

S08329	Simple orchidectomy (operation only)	306.06	2
08330	Orchidectomy via inguinal approach	349.31	2
	Note: *Includes excision of spermatic cord to level of internal inguinal ring*		
T08331	Bilateral orchidectomy in the context of gender-affirming surgery via transcrotal, bilateral inguinal/subinguinal approach	597.47	2
	Notes: *i) For MSP approved gender-affirming surgery under Preamble D. 9. 4. Gender Affirming Surgery.* *ii) Scrotal surgeries (i.e., scrotal skin removal, implants, structures adjacent to the spermatic cord, hydroceles) are payable in addition only if note record is submitted to explain medical rationale.* *iii) Not billable in addition to 08329, 08330, 08345, 08346, 08323, 08324.*		

Diagnostic Procedures

08322	Orchidopexy - one or two stages	398.31	2
S08323	Exploration of scrotal contents - unilateral (operation only)	273.50	2
08324	Exploration of undescended testicle, without orchidopexy	307.00	2
08328	Recurrent undescended testis	520.76	2
S08325	Reduction of torsion of testis and spermatic cord repair - bilateral	475.23	2
08326	Ruptured testicle - repair	511.40	2
S08327	Biopsy of testis	154.92	2
08349	Retroperitoneal lymphadenectomy for carcinoma of testis	2,085.41	4
08354	- post chemotherapy	2,372.17	4

Epididymis

S08340	Abscess, incision, complete care (operation only)	199.78	2
S08341	Spermatocoele or hydrocele excision	351.89	2
08342	Epididymectomy - unilateral	285.39	2
S08343	Epididymovasostomy or re-anastomosis of vas - unilateral	795.64	2
	Note: *This item is an insured benefit under the Plan only when a previous vasectomy has not been performed.*		

		$	Anes. Level
S08344	Vas cannulation, unilateral or bilateral	129.27	2
S08345	Vasectomy - bilateral (operation only)	103.81	2
08346	Varicocoele - resection	400.93	2
08370	Sub-inguinal Microsurgical Varicocelectomy ***Note:*** *Restricted to Urologists.*	1,066.60	7
08347	Avulsion of penile skin and scrotum - repair	414.27	2
08350	Urethro-vesical neck plasty for congenital incontinence	1,056.13	4
08353	Plastic repair of extrophy and plastic repair of bladder with skin	1,360.04	5
S00866	Dynamic cavernosometry and avernosography ***Note:*** *Interpretation of x-ray is included in technical portion and is not billable in addition to procedure.*	80.84	2

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. ***Note:*** *The Doppler Vascular listings are applicable to hospital-based, accredited and approved ultrasound vascular studies laboratories only*.	48.50	

Miscellaneous

TY08206	Intravesical treatment instillation ***Notes:*** *i) Restricted to Urologists.* *ii) For instillation of intravesical medication treatment (non-chemotherapy).* *iii) Does not apply to instillation of xylocaine jelly for routine cystoscopy or catheterization.* *iv) Not billable in addition to 00704, 00705, or 08205.* *v) This fee is payable once per 7 days per patient.*	32.36	2
TY08339	Intracavernosal penile injection for test dosing ***Notes:*** *i) Restricted to Urologists.* *ii) Maximum one per day, per patient.* *iii) Not payable in addition to penile Duplex ultrasound or peripheral nerve block.* *iv) Injections are only for evaluation/testing of erectile dysfunction response by intracavernosal injection or assessment of Peyronie's disease to determine severity for potential surgical treatment.*	67.50	

PALLIATIVE MEDICINE

Complete understanding of the following paragraphs is essential to appropriate billing of the palliative medicine fees. Not payable to physicians for services when working under salary, service contract, or sessional arrangement.

Preamble

These listings are applicable for referred services to a palliative medicine physician.

Palliative medicine fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

The palliative medicine fees are comprehensive time-based fees.

- Applicable only for palliative care patients and diagnostic code V66.7 must be submitted on the claim.
- Start and end times are for direct face-to-face time with the patient and include all services provided within those times.
- Travel time is not billable in addition.
- Documentation which occurs outside of the direct face-to-face times is not billable in addition and is compensated through the rate set for the palliative medicine fees.

When a referral from a physician is not available, referrals from a registered nurse for specialist palliative care can be accepted by indicating the practitioner number of the requesting nurse in the “referred by” field when submitting claims. For registered nurses not registered with MSP, use practitioner number 99987. The name of the referring registered nurse should be documented in the note field of the claim and in the patient’s clinical record.

PALLIATIVE MEDICINE

These listings cannot be correctly interpreted without reference to the Preamble

Referred Cases

		$
P43000	Consultation: To consist of examination, review of history, laboratory and imaging findings, and written report – per 15 minutes, or greater portion thereof	75.75

Notes:

i) Paid to a maximum of 4-6 units.

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

	Consultation in patient's home: To consist of examination, review of history, laboratory and imaging findings, and written report	
P43100	-first 15 minutes or greater portion thereof	175.75
P43101	-each additional 15 minutes or greater portion thereof (extra)	75.75

Notes:

i) Paid to a maximum of 6 units (43100 and 43101 combined).

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement. See Palliative Medicine preamble.

iv) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Continuing care by consultant

	Subsequent office visit	
P43001	– per 15 minutes, or greater portion thereof	50.50

Notes:

i) Paid to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum.

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

	Subsequent hospital or facility visit	
P43002	– per 15 minutes, or greater portion thereof	50.50

Notes:

i) Paid to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum.

ii) Start and end times must be included with the claim and documented in the patient chart.

iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

		$
Subsequent visit in patient's home		
P43200	-first 15 minutes or greater portion thereof	150.50
P43201	-each additional 15 minutes or greater portion thereof (extra)	50.50

Notes:

i) Paid to a maximum of 4 units (43200 and 43201 combined). Submit an explanatory note record for additional units claimed beyond the maximum.
ii) Start and end times must be included with the claim and documented in the patient chart.
iii) Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement. See Palliative Medicine preamble.
iv) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Complex End-of-Life Visits

	Complex end-of-life visit in hospital or facility (extra)	
P43006	-per 15 minutes, or greater portion thereof	75.75

Notes:

i) Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient's family, notifying other healthcare providers or services.
ii) Payable only in addition to 43002.
iii) Paid once per patient to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum.
iv) Start and end times must be included with the claim and documented in the patient chart.
v) Not payable in addition to out-of-office-hours premiums.
vi) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

	Complex end-of-life visit in patient's home (extra)	
P43007	-per 15 minutes, or greater portion thereof`	75.75

Notes:

i) Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient's family, notifying other healthcare providers or services.
ii) Payable only in addition to 43200 and 43201.
iii) Paid once per patient to a maximum of 4 units. Submit an explanatory note record for additional units claimed beyond the maximum.
iv) Start and end times must be included with the claim and documented in the patient chart.
v) Not payable in addition to out-of-office-hours premiums.
vi) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

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Telehealth Service:

P43010 Telehealth Consultation: To consist of examination, review of history, laboratory and imaging findings, and written report – per 15 minutes, or greater portion thereof 75.75

Notes:

i) Paid to a maximum of 4-6 units.
ii) Start and end times must be included with the claim and documented in the patient chart.
iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

P43011 Telehealth subsequent office or home visit – per 15 minutes, or greater portion thereof 50.50

Notes:

i) Paid to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum.
ii) Start and end times must be included with the claim and documented in the patient chart.
iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Miscellaneous

P43003 Palliative hospital or facility admission examination - per 15 minutes, or greater portion thereof 80.00

Notes:

i) Paid to a maximum of 4-6 units. Submit an explanatory note record for additional units claimed beyond the maximum.
ii) Start and end times must be included with the claim and documented in the patient chart. Start and end times must not be concurrent with another service.
iii) Not payable with a consultation or visit (43000, 430001, 43002, 43010, 43011, 43100, 43101, 43200, or 43201).
iv) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

P43004 Palliative Family Conference (planning for patient) – per 15 minutes or greater portion thereof 75.75

Notes:

i) Restricted to Palliative Medicine.
ii) Paid to a maximum of 4 units per patient, per sitting. Submit an explanatory note record for additional units claimed beyond the maximum.
iii) Annual maximum of 12 units per patient.
iv) Start and end times must be included with the claim and documented in the patient chart. Start and end times must not be concurrent with another service.
v) One or more family members/representatives must be present.
vi) Service may be provided face-to-face, telephone, or video technology.
vii) 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 Allied Care Provider involved in the care of the patient.
viii) Visit paid in addition, if medically required and does not take place concurrently with the conference.
ix) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

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P43005 Palliative Interdisciplinary Conference with Allied Care Provider and/or Physician
– per 15 minutes or greater portion thereof.....75.75

Notes:

i) Restricted to Palliative Medicine.
ii) Paid to a maximum of 2 units per sitting. Submit an explanatory note record for additional units claimed beyond the maximum.
iii) Start and end times must be included with the claim and documented in the patient chart. Start and end times must not be concurrent with another service.
iv) Service may be provided face-to-face, telephone, or video technology.
v) Payable for two-way collaborative conferencing with another physician and/or an allied care provider.
vi) 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, roles(s) in care, and information on clinical discussion and decisions made.
vii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

P43008 First palliative hospital or facility visit of the day bonus (extra) 100.00

Notes:

i) Paid only if 43002 paid the same day.
ii) Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended.
iii) Not payable same day for same physician as 13338 or 13339.

P43009 First palliative home visit of the day bonus (extra) 200.00

Notes:

i) Paid only if 43200 paid the same day.
ii) Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended.
iii) Not payable same day for same physician as 13338 or 13339.

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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	56.04
08501	Skull - special studies - additional	37.06
08503	Paranasal sinuses	37.06
08504	Facial bones - orbit	37.06
08505	Nasal bones	37.06
08506	Mastoids	56.04
08507	Mandible	37.06
08508	Temporo-mandibular joints	37.06
08509	Salivary gland region.	37.06
08510	Sialogram	57.83
08511	Eye - for foreign body	37.06
08512	- for localization of foreign body - additional	55.49
08513	Dacryocystogram	36.66
08514	Nasopharynx and/or neck, soft tissue - single lateral view	24.05
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).*	55.50
08518	Pre-MRI view(s) of orbits to rule out metallic foreign body	25.48
Upper Extremity		
08520	Shoulder girdle	37.06
08521	Humerus	37.06
08522	Elbow	37.06
08523	Forearm	37.06
08524	Wrist	37.06
08525	Hand (any part)	37.06
08526	Special requested views in upper extremity	18.69
Lower Extremity		
08530	Hip	37.06
08531	Femur	37.06
08532	Knee	37.06
08533	Tibia and fibula	37.06
08534	Ankle	37.06
08535	Foot (any part)	37.06
08536	Leg length films - whatever method	43.64
08537	Special requested additional views for lower extremity	18.69
Spine and Pelvis		
08540	Cervical spine	44.36
08541	Thoracic spine	37.06
08542	Lumbar spine	56.04
08543	Sacrum and coccyx	37.06
08549	Spine - requested additional views (flexion, bending views,etc.) ***Note:*** *This item shall not be used to cover normal oblique projections.*	34.90

		$
08544	Pelvis	37.06
08545	Sacro-iliac joints	37.06
08546	Scoliosis film - single AP or lateral - 14 x 36 film taken at 6 feet (1.85 metres)	48.50
08547	Pelvis and additional requested views (i.e. sacro-iliac joints, hip, etc.)	44.36
08548	Myelogram and/or posterior fossa positive contrast (excluding procedural fee)	109.77

Chest

08550	Thoracic viscera	36.77
08551	Thoracic inlet	36.77
08552	- additional requested views	18.69
08553	Fluoroscopy, when requested	18.82
08554	Ribs - one side	37.06
08555	Ribs - both sides	56.04
08556	Sternum or sterno-clavicular joints	37.06
08557	Sternum and sterno-clavicular joints	56.04

Abdomen

08570	Abdomen	37.06
08571	Abdomen, multiple views	56.04

Gastrointestinal Tracts

08572	Oesophagus only	63.20
08573	Oesophagus, stomach, and duodenum	90.27
08574	Small bowel	90.27
08576	Colon or double contrast air studies	101.75
08577	Hypotonic duodenography	90.27
08578	Pancreatography (excluding procedural fee)	55.24
08579	Glucagon assisted contrast study - in addition to routine fee	39.71

Gall Bladder

08581	Intravenous cholangiogram	80.13
08582	Operative cholangiogram (transhepatic also)	60.25
08583	Direct post-operative cholangiogram or pyelogram	64.97
08584	Removal of biliary calculi, by Burhenne technique or equivalent, including necessary cholangiogram and fluoroscopy (excluding procedural fee)	67.85

Genito-Urinary System

08590	K.U.B.	37.06
08591	Pyelogram - intravenous	83.48
08593	Pyelogram - retrograde or antegrade	55.49
08594	Intravenous pyelogram with voiding cystourethrogram	109.77
08595	Cystogram or retrograde urethrogram (not including catheterization)	55.49
08596	Hystero-salpingogram (excluding injection)	90.27
08597	Pelvimetry	76.58
08599	Voiding cystourethrogram	91.71

Miscellaneous

		$
08575	Video fluoroscopy - 50 percent to be added to fee items 08572 and 08573	45.15

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	69.76
08602	Body section radiography - applies to all tomographic procedures (including polytomography when done in one plane) per plane series, including orthopantogram	52.86
08603	Bone age - whatever method	38.84
08604	Bone survey - first anatomical area	37.06
08605	- each subsequent anatomical area	18.69
08606	Arthrogram, shoulder (excluding injection of contrast)	40.05
08607	Arthrogram, hip (excluding injection of contrast)	36.84
08608	Arthrogram, knee (excluding injection of contrast)	79.04
08609	Arthrogram, ankle (excluding injection of contrast)	36.84
08631	Arthrogram - wrist (excluding injection of contrast)	36.84
08637	Arthrogram - elbow (excluding injection of contrast)	36.84
08610	Mammography - unilateral	109.74
08611	- bilateral	153.82

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	142.90
08616	- bilateral	245.21
08617	Peripheral angiography (arteriography and venography) - unilateral.	73.97
08618	- bilateral	110.28
08620	Aortography (aortography plus peripheral angiography)	190.00

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	145.20
08627	- using multiple sequential views - selective	142.90
*08628	Interpretation of submitted films - per examination	54.12

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	42.86

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	335.71

Radiology Assistant Fee:

*08632	- first hour or fraction thereof	118.48
*08633	- each 15 minutes or fraction thereof after one hour	29.65

Note: *08632 and 08633 may be applicable:*

i) When a radiology assistant is required in conjunction with 00738, 00979, 00980, 00981, 00982, S00995, 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	72.66
08689	Bone density - second area	49.70
08696	Bone density - whole body	130.83

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.*

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Computerized Tomography

Professional Fees:

*08690 Head scan - without contrast 48.22
*08691 - with contrast 67.24
*08692 - double scan or 2 planes 86.83
*08693 Body scan - one region without contrast 96.21
*08694 - one region with contrast 106.35
*08695 - double scan or two regions 145.38
P83095 - additional body region 5.00

Notes:

i) Payable in addition to 08695 up to a maximum of seven claims, for each additional body region beyond those body regions counted in the associated 08695 claim.

ii) Eligible body regions include:
- *(a) neck*
- *(b) chest*
- *(c) abdomen*
- *(d) pelvis*
- *(e) cervical spine*
- *(f) thoracic spine*
- *(g) lumbar spine*
- *(h) upper extremity (maximum of 1)*
- *(i) lower extremity (maximum of 1).*

83090 Cardiac CT/CT Coronary Angiography, Professional fee 178.61

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)	65.27

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.
viii) 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 108.94

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 108.94

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	621.60	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.

10902	Complex peripherally inserted image-guided central venous catheter line (PICC)	136.07	2

Notes:

v) Restricted to Radiologists.

vi) Not applicable if performed via other than peripheral access as required for complex PICC placements.

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

viii) May not be delegated.

10323	Simple peripherally inserted image-guided central venous catheter line (PICC)	84.36	

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	621.60	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)	621.60	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	1,383.23	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	384.81	4
10907	- each additional level (to a maximum of 3)	88.82	4

Notes:

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

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

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

		$	Anes. Level
10908	Percutaneous image-guided tumour ablation – first lesion	558.91	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	414.41	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)	414.41	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.

10912	Transjugular liver/renal biopsy	414.41	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	842.15	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: S00995, 00997, 00998) if performed on the same day.

10914	Percutaneous balloon angioplasty for cerebral vasospasm	1,082.41	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.*

		$	Anes. Level
10915	Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique	2,105.39	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.*

10916	Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations – up to 4 hours procedural time	1,238.45	5
10917	– after 4 hours (extra to 10916)	309.63	

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	495.40	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	136.59	

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	136.59	

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)	1,173.73	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	662.11	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.

		$	Anes. Level
T10923	Adrenal Vein Sampling	650.00	

Notes:

i) Ultrasound guided vessel puncture, vessel catheterization, angiography, and interpretation are included in the fee.

ii) Payable once per day, per patient, regardless of the number of catheterizations performed.

Breast

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

Incision

70041	Fine needle aspiration of solid or cystic lesion – operation only	50.81	2
70042	- each additional cyst or lesion (maximum of 3) – operation only	12.73	2

Stereotactic or ultrasound-guided core needle biopsy:

70472	- 1 to 5 core samples – operation only	95.81	2
70473	- 6 to 10 core samples - (operation only)	135.28	2

Post biopsy marker

83045	Post biopsy radiological marker (clip) placement	158.14	

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.

Digital Breast Tomosynthesis
Includes detailed diagnostic workup of an abnormality
requiring follow-up (from previous breast imaging studies).

T83046	-Unilateral	50.50	
T83047	-Bilateral	74.30	

Notes:

i) Restricted to Radiologists.

ii) 83046 payable only in addition to 08610 or 08611 on the same date of service.

iii) 83047 payable only in addition to 08611 on the same date of service.

iv) Limited to one claim of either 83046 or 83047 per patient per day.

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) 106.17
Notes:
i) No additional charge for second eye when both eyes examined concurrently.
ii) 08641 includes 22399 when done at the same sitting.

08642 B scan soft tissues of neck. 72.15
Note: *To include thyroid, parathyroid, parotid and submandibular glands.*

08659 B scan of brain 110.44

Heart

08638 Echocardiography (real time) 104.16
08644 Ultrasonic guidance for pericardiocentesis 116.03

Thorax

08645 B scan 90.95
08646 Ultrasonic guidance for thoracentesis 105.46
86047 Breast sonogram, unilateral 74.45
86048 Breast sonogram, additional side 37.55
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.*

Abdomen

08648 Abdominal B scan, complete 115.52
08649 Renal B scan 90.95
Note: *08649 not chargeable when done in conjunction with 08648 and/or 08653.*

08650 Ultrasonic guidance for biopsy or cyst puncture 133.53
08684 Prostate scan using rectal probe 115.50

Obstetrics and Gynecology

08655 Obstetrical B scan (under 14 weeks gestation) 87.05
08651 Obstetrical B scan (14 weeks gestation or over)(for singles) 116.03
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.*
86051 Obstetrical B scan (14 weeks gestation or over) (for multiples – each additional fetus) 86.34

		$
86055	Obstetrical B Scan less than 14 weeks with Nuchal Translucency measurement (for singles)	133.83

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)	100.37
08652	B scan I.U.D. localization	58.03
08653	Pelvic B scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal doppler	115.50

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	116.14

Extremities

08658	Extremity B-scan	62.55

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	128.58

Peripheral Arterial:

08664	Resting arterial assessment: To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index	61.55

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	109.12
08666	- without monitoring physician present	73.82
08668	Vasospastic assessment: To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis	73.82

		$
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	44.96
	Note: *08669 not chargeable when done in conjunction with 08668.*	
	Peripheral Venous:	
08670	Diagnostic facility assessment for deep venous system	47.05
	Heart:	
08662	Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis	239.76
	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	47.78
	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	128.41
08677	Periorbital assessments; either oculoplethysmography (O.P.G.) or photoplethysmography (P.P.G.), and/or Doppler directional determination with extracranial artery compression manoeuvres	47.05
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	64.45

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.

Consultations and Visits

		$
94010	**Consultation:** To consist of examination, review of history and laboratory findings with a written report	170.17
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	94.56
	Continuing care by consultant:	
94006	Directive care	35.96
94007	Subsequent office visit	36.76
94008	Subsequent hospital visit	36.64
94009	Subsequent home visit	73.05
94005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) ***Note:*** *Claim must state time service rendered.*	145.93
	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	170.17
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	94.56
94076	Telehealth directive care	35.96
94077	Telehealth subsequent office visit	36.76
94078	Telehealth subsequent hospital visit	36.64
	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)	17.18

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.

Scanning and Localization Procedures

		$
09829	Adrenal imaging (isolated procedure)	456.02
09832	Blood pool joint scan	169.89
	Note: *Not payable with joint scans.*	
09833	Bone marrow scan	174.93
09834	Bone scan	240.42
	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)	367.91
09867	Brain scan, static	210.46
09805	Carbon-14 glycinecholate breath analysis	119.94
95000	Cardiac first pass	93.15
	Note: *Not paid with 95005.*	
09864	Cardiac scan, static	190.80
95005	Cardiac shunt	105.40
	Note: *Not paid with 95000.*	
09886	Cisternography	349.33
09813	CNS Shunt	179.63
09898	Coronary perfusion with radio particles, per radionuclide	202.39
09897	Coronary administration of radio particles, transcatheter	29.40
09802	Oesophageal motility - utilizing an orally administered radioisotope	210.74
09838	Gallium scan	289.31
09839	- each repeat, with no additional radionuclide	104.91
	Note: *09877 not payable same day.*	
09879	Gastric emptying (liquid)	292.59
09808	Gastric emptying (solid)	271.53
	Note: *If both liquid and solid phases are performed on the same day, charge 09877 for the second test.*	
09859	Gastrointestinal blood loss study	122.33
09895	Gastro-oesophageal reflux	255.09
	Note: *Not payable with 09808 or 09879*	
09858	Gastrointestinal protein loss study	156.35
09848	G.F.R. (In-Vitro)	130.23
09804	G.I. bleeding - red cell label	343.84
	Note: *09859/95045 are not payable with 09804.*	

		$
95015	Iodine 131 whole body scan	247.49
95020	Joint scan	247.49
	Note: *Not payable with blood pool joint scan.*	
09814	Lacrimal duct scan	151.28
09878	Liver clearance of H.I.D.A. (biliary scan)	276.47
	Note: *Included in 95025 when performed same day.*	
95025	Liver clearance of H.I.D.A. with pharmaceutical	406.70
09850	Liver scan, static	168.34
	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	232.39
09896	Lumbar administration of radionuclide	33.86
95030	Lung quantification	262.67
	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	232.16
	Note: *09866 not paid in addition*	
09816	Lymphoscintigraphy - isolated procedure	311.44
09853	Meckel's localization (ectopic gastric mucosa)	348.84
09807	M.I.B.G. imaging (I131-metaiodobenzyl- guanidine)	989.34
09870	Ocular tumour localization	189.92
09869	Pancreas scan, static	303.58
09806	Parathyroid imaging	423.02
09865	Perfusion study (dynamic scan), regional or organ - when done alone	122.77
09866	Perfusion study (dynamic scan), regional or organ - in addition to major scan	46.66
09835	Plasma volume (with plasma label), total blood volume, and red-cell mass by calculation	36.97
09849	Platelet survival	312.47
	Radioiron:	
09840	- clearance	156.57
09841	- turnover	152.46
09842	- red cell utilization	156.35
09843	- combined study at one time of above three	304.05
09863	Radionuclide cardiac ventriculography	269.21
95040	- with stress	396.39
	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	202.10
09817	Receptor imaging - isolated procedure	271.55
95045	RBC (Red Blood Cell) liver scan	296.83
	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	243.73
09837	Red cell mass (with RBC label) and plasma volume (with plasma label) combined study	163.03
09844	Red cell survival	238.71
95055	Renal imaging with pharmaceuticals (isolated procedure)	348.37
95060	Renal imaging without pharmaceuticals (isolated procedure)	315.56
	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	720.04
95062	Rest myocardial perfusion	281.33
95063	Stress myocardial perfusion	290.66
	Note*: 95062 and 95063, (as well as stress test) are billable same day, if performed.*	
09818	Salivary gland study	185.79
09819	SeCHAT	267.32
09873	Spleen scan, static	156.35
	Note: *When performed in conjunction with liver scan, static (09850), bill as 09851 only (liver and spleen scan, static).*	
09824	Testicular imaging - isolated procedure	177.27
09854	Thallium myocardial scan	425.86
95053	Thallium body imaging	484.11
	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	46.50
09821	- double determination	70.33
09823	Thyroid scan (Iodine – 123)	191.60
09825	Thyroid scan (pertechnetate)	76.63
09876	Transfer of radionuclide (CSF to blood)	77.24
09826	Tumour imaging with metabolic or biological imaging agent	1,440.09
	Note*: Includes imaging of the entire torso with tomographic and planar images as indicated*.	
09855	Ventilation lung scan	240.10
	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.	

		$
	Vitamin B12 absorption study (e.g.: Schilling test):	
09856	- without intrinsic factor	136.87
09857	- with intrinsic factor	164.40
09852	- with blood radioactive determination	75.30
09860	- with two radionuclides	94.22
09828	Voiding cystography	190.99
95065	White Blood Cell labelled with radioisotope	797.78

Therapeutic Procedures

09890	Joint injection with isotope - therapeutic	776.35
09880	Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (Iodine therapy)	400.89
09881	Treatment for polycythaemia vera with P32 - charge per course of treatment	236.58
09882	Treatment for thyroid cancer - charge per course of treatment	521.02
09883	Treatment for prostate cancer - charge per course of treatment	477.85
09884	Treatment for metastatic carcinoma of bone - charge per course of treatment	307.04

CONSULTANT SPECIALIST OF BC FEE LISTINGS

1. Preamble

The following Consultant Specialist of BC (CSBC) Fees items are billable only by Specialists certified by the Royal College of Physicians and Surgeons of Canada.

The objectives of CSBC 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. CSBC fees are not payable for situations where the sole purpose of the communication is to:
    a) book an appointment
    b) arrange for routine admission or transfer of care that occurs within 24 hours, except for coordination for patients under the Patient Transfer Network (PTN)
    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, and 78711, refer to section D.1. Telehealth Services of the General Preamble.

4. G10002, G10004, G10005, 78710 and 78711: All registered and regulated health care providers can serve as referral sources. When advice is requested by an Allied Care Provider who does not have an MSP practitioner number, or conferencing is initiated with one, use the generic practitioner number 99987: Allied Care Provider not registered with MSP.

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 or text message record should be included in the patient record.
    - Develop clear, written policies around use of email and/or text messaging.
    - 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, and phone numbers for text messaging, need to be double-checked.

6. CSBC fees are payable for face-to-face, telephone, video conference, email and text messaging communication. Review the individual fee notes which identify their respective eligible communication modality.

7. CSBC 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. Out-of-Office Hours Premiums may not be claimed in addition.

10. G10001, G10002, G10004, G10005, 78710, and 78711 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. CSBC Fees

Note: These fees cannot be correctly interpreted without reference to the Preamble for CSBC Fees above, and the Eligibilities preceding each set of fee items below.

Specialist Advice Fees G10001, G10002, G10005, 78710 and 78711

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) 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.

v) G10001, G10002, G10005, 78710, 78711 may not be delegated to resident physicians.

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G10001	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	75.00

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.

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G10002 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 57.00

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.

G10005 Specialist Email Advice for Patient Management–Initiated by a Specialist, Family Physician or Allied Care Provider. Response within 7 days of request 11.07

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.

78710 Specialist Text Message Advice – Initiated by a Specialist, Family Physician, or Allied Care Provider. Response within 7 days of request 20.00

Notes:

i) Payable for two-way text message communication in response to request for patient management advice from another physician or allied care provider.

ii) Not payable for advice rendered to allied care providers located in the same facility or clinic at the time the service is rendered.

iii) Document date of request, date of the response, as well as advice given and to whom.

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) Limited to one service per patient per physician per day.

vi) Limited to two services per patient per physician per week.

vii) Limited to 100 services per physician per calendar year.

P78711 Specialist Initiation of Conference with a Physician and/or Allied Care Provider 60.00

Notes:

i) Payable to the initiating specialist for two-way collaborative conferencing, care coordination or advice, either by telephone, video conferencing or in-person, between the specialist and one or more physicians and/or Allied Care Providers.

ii) Conferencing initiation cannot be delegated. No claim may be made unless conference initiation is performed by the provider themselves. No claim may

be made where communication is with a proxy for the receiving provider (with the sole exception of resident physicians).

iii) *Details of care conference must be documented in the patient's chart, including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.*

iv) *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 workflow within a physician's community practice.*

v) *Include the practitioner number of the receiving physician or Allied Care Provider in the "referred to" field when submitting claim. (For Allied Care Providers not registered with MSP, use practitioner number 99987).*

vi) *Document start and end times in the medical record, and in time fields when submitting claim.*

vii) *Payable in addition to a visit fee on the same day.*

viii) *Not payable in addition to 10004, 00545, or 33445 for the same patient on the same day by the same physician.*

ix) *Payable to a maximum of 3 services per patient per physician per day. Repeat conferences with the same physician(s) and/or allied care providers for the same patient on the same date of service are included in the initial conference.*

x) *Payable to a maximum of 6 services per patient per week.*

Specialist Patient Follow-up Fees G10003, G10006

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.

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Specialist Patient Follow-up Fees G10003, G10006

G10003 Specialist Patient Management / Follow-up – per 15 minutes or portion thereof.....26.35

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.

G10006 Specialist Email Patient Management / Follow-up 25.10

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 G10004

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 G10004

G10004 Multidisciplinary Conferencing for Complex Patients – per 15 minutes; maximum one hour.....60.00

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 G78763 – G78781 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).

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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

G78763	Three patients	51.68
G78764	Four patients	41.26
G78765	Five patients	35.87
G78766	Six patients	31.92
G78767	Seven patients	29.13
G78768	Eight patients	27.00
G78769	Nine patients	25.37
G78770	Ten patients	24.00
G78771	Eleven patients	21.04
G78772	Twelve patients	19.77
G78773	Thirteen patients	18.31
G78774	Fourteen patients	17.98
G78775	Fifteen patients	17.26
G78776	Sixteen patients	16.73
G78777	Seventeen patients	16.03
G78778	Eighteen patients	15.78
G78779	Nineteen patients	15.13
G78780	Twenty patients	14.76
G78781	Greater than 20 patients (per patient)	14.26

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:*
   - *f. Number of people in entire group*
   - *g. Number of patients billed by billing physician*
   - *h. Of the patients billed by the billing physician, how many were to each insurer*
   - *i. Name of any other billing physicians*

Specialist Discharge Care Plan for Complex Patients G78717

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.

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G78717	Specialist Discharge Care Plan for Complex Patients – extra	82.19

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.

Advanced Care Planning G78720

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.

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Specialist Advance Care Planning

G78720 Specialist Advance Care Planning Discussion – extra.....43.82

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%.