

# PREAMBLE TO THE FEE GUIDE

## 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<sup>1</sup>” services from billing for interpretation of diagnostic or laboratory test results).

---

<sup>1</sup> 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.

- 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 and/or diagnostic and laboratory requisitions, unless the patient's medical condition indicates that the patient should be seen and assessed again by the medical practitioner in order to receive such advice.
- vii) Making and maintaining an adequate medical record of the encounter that appropriately supports the service being claimed. A service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit under the Plan.

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

**“General practitioner”**

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

**“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, Thanksgiving Day, Remembrance Day, Christmas Day, Boxing Day

The list of dates designated as statutory 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:

## PREAMBLE TO THE FEE GUIDE - Continued

- 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 British Columbia Medical Association;
- b) 3 members appointed on the joint recommendation of the minister and the British Columbia Medical Association to represent beneficiaries;
- c) 3 members appointed to represent the government.

See Preamble C. 2. for additional details

### **“MSP”**

Medical Services Plan

### **“No charge referral”**

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

### **“Palliative care”**

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

**“Practitioner”**

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

**“PREFIXES TO FEE CODES”**

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

- A** designates services not insured by the Medical Services Plan.
- 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 the surgical assistant’s fee is not payable.
- T** designates fee items approved on a temporary basis awaiting further information.
- V** designates general surgery 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 days post-operative days in hospital.
- Y** designates office or hospital visit on the same day is billable in addition 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 (eg. 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.

## PREAMBLE TO THE FEE GUIDE - Continued

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

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

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

### **“Specialist”**

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

### **“Third party”**

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

### **“Transferral”**

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

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

### **“Time categories”**

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

**“Uninsured service”**

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

## **C. ADMINISTRATIVE ITEMS**

### **Index to Administrative Items**

C. 1. Fees Payable by the Medical Service Plan (MSP)	1-8
C. 2. Setting and Modification of Fees	1-8
C. 3. Services Not Listed in the Schedule	1-10
C. 4. Miscellaneous Services	1-10
C. 5. Inclusive Services and Fees	1-12
C. 6. Medical Research	1-12
C. 7. MSP Billing Number	1-14
C. 8. Group Practice, Partnerships, and Locum Tenens	1-14
C. 9. Assignment of Payment	1-14
C. 10. Adequate Medical Records of a Benefit under MSP	1-14
C. 11. Reciprocal Claims	1-15
C. 12. Disputed Payments	1-16
C. 13. Extra Billing and Balance Billing	1-16
C. 14. Differential Billing for Non-Referred Patients	1-16
C. 15. Missed Appointments	1-17
C. 16. Payment for Specialist Consultations/Visits and specialty Restricted Items	1-17
C. 17. Motor Vehicle Accident (MVA) Billing Guidelines	1-17
C. 18. Guidelines for Payment for Services by Trainees, Residents and/or Fellows	1-18
C. 19. Services to Family and Household Members	1-19
C. 20. Delegated Procedures	1-19
C. 21. Diagnostic Facility Services	1-19
C. 22. Appliances, Prostheses, and Orthotics	1-20
C. 23. Accompanying Patients	1-20
C. 24. Salaried and Sessional Arrangements	1-20
C. 25. WorkSafeBC (WSBC)	1-21
C. 26. BC Transplant Society	1-21



## **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, the Medical Services Commission (MSC) and the British Columbia Medical Association (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 BC Medical Association (Doctors of BC) maintains and publishes the Doctors of BC Guide to Fees. 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 1<sup>st</sup> of the current fiscal year. For services not listed in the MSC Payment Schedule, please refer to the following sections C. 3. & C. 4.

### **Setting of Non-MSP-Insured Fees - General Considerations**

The Non-MSP-Insured Fees have been set by the Doctors of BC Tariff Committee in conjunction with Section representatives and in accordance with general policy established by the Board of Directors. Under the arrangement with the MSC, MSP fees have been approved by the MSC.

The recommended values for services when not paid for by the MSP, WorkSafeBC or ICBC are listed under “Non-MSP-Insured Fee”. The charges for these uninsured services, including A-lettered items, are not to be construed as maximum or minimum charges but only as a general guide for services of average complexity, by which the individual physician dealing with the patient can set a proper and responsible value on the individual services provided:

- a. You are in no way obligated, ethically or otherwise, to follow these Non-MSP-Insured Fees and you may charge either a higher or lower fee according to your own judgement.
- b. No special sanction of any kind is employed nor will be employed by the Association to enforce these Non-MSP-Insured Fees, and you are free to exercise your discretion and judgement with respect to any charge made for any service rendered that is not payable by the MSP, WorkSafeBC or ICBC or otherwise specified in the Preamble.
- c. If the patient’s financial circumstances are unusual, and other doctors have been called in attendance, it is the responsibility of the attending physician to acquaint his/her colleagues of such circumstances. Each doctor concerned in the care of the patient shall give or send to the patient or his/her agent a statement showing his/her own professional services.
- d. The fees listed under “MSP and WorkSafeBC Fee” have been accepted by the Medical Services Plan and WorkSafeBC through negotiated agreements as the basis for their Guide to Fees. WorkSafeBC supplies its own reporting and billing forms upon which one is asked to insert the MSP payment number to facilitate payments. MSP is currently processing claims on behalf of WorkSafeBC as an agent. It is mandatory for physicians to submit WorkSafeBC claims through MSP unless specifically exempted by WorkSafeBC.

### **Attorney General and Crown Counsel**

Information concerning Attorney General and Crown Counsel fees are contained in the Medical-Legal Matters section of this Guide to Fees.

### **Canadian Armed Forces Members (CAF)**

Medical services provided to eligible Canadian Armed Forces (CAF) members are to be billed using the same fee codes and rates established in provincial/territorial schedules for insured services in the province/territory where services are rendered. Where provincial/territorial rates for local residents do not exist, the CAF has its own billing rates for supplementary services. All billing for medical services provided to CAF members is to be directed to Medavie Blue Cross for processing. CAF members are not to be billed directly for services paid for by CAF.

All health care providers can file their claims for health services rendered directly to Medavie Blue Cross via the website: <https://www.medaviebc.ca/en/health-professionals/resources>.

### **C. 3. Services Not Listed in the Schedule**

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

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

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

### **C. 4. Miscellaneous Services**

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

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

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

- An estimate of an appropriate fee, with rationale for the level of that fee

- Sufficient documentation of the services (such as the operative report) to substantiate the claim.

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

### **Miscellaneous (...99) Fee Items**

00099	General Services
00199	General Practice
00299	Dermatology
00399	General Internal Medicine
00499	Neurology
00599	Pediatrics
00699	Psychiatry
00999	Diagnostic Procedures
01499	Critical Care
01799	Physical Medicine
01899	Emergency Medicine
01999	Anesthesia
02599	Otolaryngology
02999	Ophthalmology
03999	Neurosurgery
04999	Obstetrics & Gynecology
06999	Plastic Surgery
07999	General Surgery/Cardiac Surgery
08699	X-ray
08899	Miscellaneous Diagnostic Ultrasound
08999	Urology
09899	Nuclear Medicine
30999	Clinical Immunology and Allergy
31999	Rheumatology
32199	Respirology
33199	Cardiology
33299	Endocrinology and Metabolism
33399	Gastroenterology
33499	Geriatric Medicine
33599	Hematology and Oncology
33699	Infectious Diseases
33899	Nephrology
33999	Occupational Medicine
59999	Orthopaedics
77799	Vascular Surgery
79199	Thoracic Surgery

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

### **C. 5. Inclusive Services and Fees**

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

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.

## PREAMBLE TO THE FEE GUIDE - Continued

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 into 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 the 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 a 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 the 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 of 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 staff person who recorded the verbal requisition must be identified. The requisitions must be retained for 6 years.
- i. Results of all services rendered, and interpretation where appropriate. These data must be retained for 6 years.

## **C. 11. Reciprocal Claims**

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

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

- 1. Surgery for alteration of appearance (cosmetic surgery)
- 2. Gender-reassignment surgery
- 3. Surgery for reversal of sterilization
- 4. Routine periodic health examinations including routine eye examinations (including PAP tests for screening only)
- 5. In-vitro fertilization, artificial insemination
- 6. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
- 7. Services to persons covered by other agencies; Armed Forces, WorkSafe BC, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries)



8. Services requested by a “Third Party”
9. Team conference(s)
10. Genetic screening and other genetic investigation, including DNA probes
11. Procedures still in the experimental/developmental phase
12. Anesthetic services and surgical assistant services associated with all of the foregoing

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

### **C. 12. Disputed Payments**

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

### **C. 13. Extra Billing and Balance Billing**

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

“Balance billing” denotes the practice of medical practitioners who are opted in under MSP billing MSP for the MSP fee and the patient for the amount of the difference between the payment made by MSP for an insured service and the fee for that service listed in the Doctors of BC Guide to Fees, under the heading “Non-MSP-Insured Fee.” 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 general practitioner 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 General Practice Payment Schedule for the service rendered, and the

amount payable under the Payment Schedule to the specialist had the patient been referred.

### **C. 15. Missed Appointments**

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

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

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

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

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

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

8. Medical Practitioners are accountable for proper MVA identification and are subject to audit.

### **C. 18. Guidelines for Payment for Services by Trainees, Residents and/or 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.

## **C. 19. Services to Family and Household Members**

1. Services are not benefits of MSP if a medical practitioner provides them to the following members of the medical practitioner's family:
  - a) a spouse,
  - b) a son or daughter,
  - c) a step-son or step-daughter,
  - d) a parent or step-parent,
  - e) a parent of a spouse,
  - f) a grandparent,
  - g) a grandchild,
  - h) a brother or sister, or
  - i) a spouse of a person referred to in paragraph (b) to (h).
2. Services are not benefits of MSP if a medical practitioner provides them to a member of the same household as the medical practitioner.

## **C. 20. Delegated Procedures**

Procedures which are generally and traditionally accepted as those which may be carried out by a nurse, nurse practitioner or a medical assistant in the employ of a medical practitioner may, when so performed, only be billed to MSP by the medical practitioner when the performance of the procedure is under the "direct supervision" of the medical practitioner or a designated alternate medical practitioner with equivalent qualifications. Direct supervision requires that during the procedure, the medical practitioner be physically present in the office or clinic at which the service is rendered. While this does not preclude the medical practitioner from being otherwise occupied, s/he must be in personal attendance to ensure that procedures are being performed competently and s/he must at all times be available immediately to improve, modify or otherwise intervene in a procedure as required in the best interest of the patient. Billing for these procedures also implies that the medical practitioner is taking full responsibility for their medical necessity and for their quality. Any exceptions to this rule are subject to the written approval of MSP.

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

The foregoing limitations do not apply to approved procedures rendered in approved "diagnostic facilities", as defined under the Medicare Protection Act and Regulations, or to services rendered in approved laboratory facilities, as defined under the *Laboratory Services Act and Regulation*, 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 blood work services provided to that patient. Fee item 00012 cannot be billed or paid to a medical practitioner if any other blood work 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 Guide to Fees. The fees listed under “MSP and WSBC Fee” have been accepted by the WorkSafeBC through negotiated agreements as the basis for their Guide to Fees. 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**

Effective May 1, 2020 on a temporary basis, revised effective June 1, 2020

The BCP list of eligible fees has been temporarily amended to include telehealth fee items during COVID-19 pandemic to ensure BCP is paid given the majority of these services would have otherwise been provided to patients face-to-face at eligible physician offices.

Eligible BCP claims require a registered facility number and a community-based office service location code. While telehealth services do not need to be provided by the physician in their office, the appropriate facility number and service location code that should be entered on the claim is based on where the service would have been provided if it had been performed face-to-face.

Temporary list of eligible Telehealth fee items:

00470	00471	00477	01155	01470	01472	01770	01772	01777	03310
03312	03317	04070	04072	04077	08070	08072	08077	13041	13042
13236	13436	13536	13636	13736	13836	13237	13437	13537	13637

PREAMBLE TO THE FEE GUIDE - Continued

13737	13837	13238	13438	13538	13638	13738	13838	20207	20210
20214	22007	22010	22011	30070	30071	30072	30077	31107	31110
31112	32107	32110	32112	32114	32270	32271	32272	32277	32370
32372	32377	33107	33110	33112	33114	33260	33262	33267	33270
33272	33277	33360	33362	33367	33421	33422	33423	33424	33427
33470	33472	33473	33474	33477	33570	33572	33577	33630	33632
33637	33730	33732	33737	50507	50510	50511	50512	50514	50515
50516	50517	50518	50519	60607	60610	60613	60614	60622	60625
60626	60630	60631	60632	60633	60635	60636	60638	60639	66007
66010	66012	70070	70072	70077	70080	70087	77707	77710	77712
78007	78010	78012	79207	79210	79212	83070	94070	94072	94077

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

The current BCP eligible services are:

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

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

- i) City of Vancouver: 5% of eligible fees up to a maximum BCP payment of \$60 per day per physician.
- ii) Metro Vancouver (excluding the City of Vancouver) and Greater Victoria: 4% of eligible fees up to a maximum BCP payment of \$48 per day per physician.
- iii) Other communities (outside Greater Vancouver and Greater Victoria) not eligible for the Rural Retention Premiums: 3% of eligible fees up to a maximum BCP payment of \$36 per day per physician.

To receive the BCP:

- i) The physician is responsible for some or all of the lease, rental or ownership costs of that community-based office, and
- ii) The community-based facility in which the eligible services are provided must be in an eligible location and have a unique Facility Number registered with MSP, and

PREAMBLE TO THE FEE GUIDE - Continued

- iii) The physician must be registered with MSP as a physician practicing at that Facility, and
- iv) The correct Facility Number must be entered on each claim where the eligible service is rendered.

List of eligible BCP fee items:

00062	00064	00100	00101	00110	00120	00121	00122	00206	00207
00210	00214	00307	00310	00311	00312	00313	00314	00315	00407
00410	00411	00450	00457	00460	00485	00486	00487	00488	00491
00492	00507	00510	00511	00512	00513	00514	00515	00550	00551
00552	00553	00554	00590	00597	00607	00610	00611	00613	00614
00622	00623	00625	00626	00627	00630	00631	00632	00633	00635
00636	00638	00639	00663	00664	00665	00666	00667	00668	00669
00670	00671	00672	00673	00674	00675	00676	00677	00678	00679
00680	00681	01013	01015	01016	01107	01115	01116	01400	01402
01707	01710	01712	01713	01714	01715	02007	02010	02011	02012
02215	02507	02510	02511	02512	02513	02514	02515	02517	02519
03007	03010	03011	03315	04007	04010	04012	04717	06007	06010
06012	07007	07010	07012	07807	07810	07812	07815	08007	08010
08012	12100	12101	12110	12120	13013	13014	13015	13070	13075
13501	13502	13503	13763	13764	13765	13766	13767	13768	13769
13770	13771	13772	13773	13774	13775	13776	13777	13778	13779
13780	13781	14044	14045	14046	14047	14048	14090	14091	14094
14545	14560	15300	15301	15310	15320	16100	16101	16110	16120
17100	17101	17110	17120	18100	18101	18110	18120	22118	30007
30010	30011	30012	31007	31010	31012	31014	31050	31060	32007
32010	32012	32014	32207	32210	32212	32307	33007	33010	33012
33013	33014	33015	33207	33210	33212	33213	33214	33215	33307
33310	33312	33313	33314	33315	33401	33402	33403	33404	33407
33410	33412	33413	33414	33415	33440	33442	33447	33507	33510
33512	33513	33514	33515	33520	33522	33527	33607	33610	33612
33613	33614	33615	33620	33645	33707	33710	33712	33713	33714
33715	33907	33910	33912	51005	51007	51010	51012	51015	66015
71010	71015	71017	77007	77010	77012	77015	78763	78764	78765
78766	78767	78768	78769	78770	78771	78772	78773	78774	78775
78776	78777	78778	78779	78780	78781	79007	79010	79012	83000
94007	94010	94012							



## **D. TYPES OF SERVICES**

### **Index to Types of Services**

D. 1.	Telehealth Services	1-24
D. 2.	Consultation	
D. 2. 1.	General	1-25
D. 2. 2.	Restrictions	1-25
D. 2. 3.	Limited Consultation	1-26
D. 2. 4.	Special Consultation	1-26
D. 2. 5.	Continuing Care by Consultant	1-26
D. 2. 6.	Referral and Transferral	1-27
D. 3.	Visits and Examinations	
D. 3. 1.	Complete Examination	1-27
D. 3. 2.	Partial Examination	1-28
D. 3. 3.	Counselling	1-28
D. 3. 4.	Group Counselling	1-29
D. 4.	Hospital and Institutional Visits	
D. 4. 1.	Hospital Admission Examination	1-29
D. 4. 2.	Subsequent Hospital Visit	1-29
D. 4. 3.	Surgery by a Visiting Doctor	1-30
D. 4. 4.	Long-Stay Hospitalization	1-30
D. 4. 5.	Directive Care	1-30
D. 4. 6.	Concurrent Care	1-30
D. 4. 7.	Supportive Care	1-30
D. 4. 8.	Newborn Care in Hospital	1-31
D. 4. 9.	Long-Term-Care Institution Visits	1-31
D. 4. 10.	Palliative Care	1-31
D. 4. 11.	Sub-Acute care	1-31
D. 4. 12.	Emergency Department Examinations	1-32
D. 4. 13.	House Calls	1-32

## PREAMBLE TO THE FEE GUIDE - Continued

D. 5. Surgery	
D. 5. 1. General	1-32
D. 5. 2. Operation Only	1-33
D. 5. 3. Multiple Surgical Procedures	1-33
D. 5. 4. Surgical Assist	1-34
D. 5. 5. Cosmetic Surgery	1-35
D. 6. Fractures and Other Trauma	1-35
D. 7. Diagnostic and Selected Therapeutic Procedures	1-36
D. 8. Minor Diagnostic and Therapeutic Procedures	1-37
D. 9. Surgery for Alteration of Appearance	
D. 9. 1. General	1-37
D. 9. 2. Surface Pathology	1-38
D. 9. 2. 1. Trauma Scars	1-38
D. 9. 2. 2. Keloids and Hypertrophic Scars	1-39
D. 9. 2. 3. Tattoos	1-39
D. 9. 2. 4. Benign Skin Lesions	1-39
D. 9. 2. 5. Hair Loss	1-40
D. 9. 2. 6. Epilation of Hair	1-41
D. 9. 2. 7. Redundant Skin	1-41
D. 9. 3. Sub-Surface Pathology	
D. 9. 3. 1. Congenital deformities	1-41
D. 9. 3. 2. Post-Traumatic Deformities	1-42
D. 9. 3. 3. Deformities Resulting from local disease	1-42
D. 9. 3. 4. Breast Surgery	1-42
D. 9. 3. 5. Excision of excess fatty tissue	1-43
D. 9. 4. Gender Reassignment Surgery	1-44
D. 9. 5. Complications and Revisions	1-44
D. 10. Out-of-Office Premiums	1-44

## **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 services 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 general practitioner 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 General Practice 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 should claim the subsequent visit as a limited consultation, unless more than 6 months has passed since the telehealth consultation.

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 has 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 (chiropractor, for orthopaedic consultations; midwife, for obstetrical or neonatal related consultations; nurse practitioner; optometrist, for ophthalmology consultations; optometrist, for Neurology consultations for suspected optic neuritis or amaurosis fugax or Alon {anterior ischemic optic neuropathy} or stroke or diplopia; oral/dental surgeon (for diseases of mastication)), 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.

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 whom 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 General Practice Section of this MSC Payment Schedule. Exceptions to this limitation will only be made in cases of geographic need, as recommended by the College of Physicians and Surgeons of BC.

**D. 2. 3. Limited Consultation**

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

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

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

**D. 2. 4. Special Consultation**

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

**D. 2. 5. Continuing Care by Consultant**

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

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

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

months, until the responsibility for this aspect of the patient's care is returned to the Primary Care practitioner.

#### **D. 2. 6.      Referral and Transferral**

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

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

A transferral, as distinguished from a referral, involves the transfer of responsibility for the care of the patient temporarily or permanently. Thus, when one medical practitioner is going off call or leaving on holidays and is unable to continue to treat his/her cases, medical practitioners who are substituting for that medical practitioner should consider that the patients have been temporarily transferred (not referred) to their care.

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

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

#### **D. 3.            Visits and Examinations**

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

##### **D. 3. 1.        Complete Examination**

- i) A complete physical examination shall include a complete detailed history and physical examination of all parts and systems with special attention to local examination where clinically indicated, adequate record of findings and, if necessary, discussion with patient. The above should include complaints, history of present and past illness, family history, personal history, functional inquiry physical examination, differential diagnosis and provisional diagnosis.
- ii) Routine or periodic complete physical examination (check up) is not a benefit under MSP. This includes any associated diagnostic procedures or approved laboratory facility services unless significant pathology is found. The physician should advise the diagnostic or approved laboratory facility of the patient's

responsibility for payment.

**D. 3. 2. Partial Examination**

A visit for any condition(s) requiring partial examination or history includes both initial and subsequent examination for same or related condition(s). A partial examination includes a history of the presenting complaint(s), appropriate enquiry and examination of the affected part(s), region(s) and/or systems(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.

**D. 3. 4. Group Counselling**

The group counselling fee items found in the General Practice 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 items 00109 or 13109) may be claimed when a patient is admitted to an acute care hospital for medical care rendered by a general practitioner. 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 unit, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities, whether or not any of these facilities are situated on the campus of an acute care facility) claims may be made to a maximum of one visit every two weeks. It is not sufficient, however, for the medical practitioner simply to review the patient's chart. A face-to-face patient/medical practitioner encounter must be made. For acute concurrent illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation.

**D. 4. 10 Palliative Care**

The Palliative Care listings are applicable to the visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS, or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months. These listings only apply where aggressive treatment of the underlying disease process is no longer taking place and care is directed instead to maintaining the comfort of the patient until death occurs.

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

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

**D. 4. 11. Sub Acute Care**

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

**D. 4. 12.     Emergency Department Examinations**

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

**D. 4. 13.     House Calls**

- i) A house call is considered necessary and may be billed only when the patient cannot practically attend a physician's office due to a significant medical or physical disability or debility and the patient's complaint indicates a serious or potentially serious medical problem that requires a medical practitioner's attendance in order to determine appropriate management;
- ii) A house call may be initiated by the patient, the patient's advocate, or the physician when planned proactive care is determined to be medically necessary to manage the patient's condition;
- iii) If a house call is determined to be necessary and is rendered any day of the week between 0800 and 2300 hours, the house call should be billed as a home visit (use 00103);
- iv) If the house call is initiated and rendered between 2300 and 0800 hours, the visit may be billed as an out-of-office visit with the night call-out charge (01201).
- v) A house call provided for patient convenience should be billed as an out-of-office visit (12200, 13200, 15200, 16200, 17200 or 18200) without a service charge;
- vi) The above also applies to house calls rendered by medical practitioners taking call for other medical practitioners;
- vii) As practicality dictates, the necessity and detail and the time of the call should be documented in the patient's clinical record.

**D. 5            Surgery**

**D. 5. 1.       General**

The fees for surgery, unless otherwise specifically indicated, include the surgical procedure itself and in-hospital post-operative follow-up, including removal of sutures and care of the operative wound by the surgeon or associate. Unless otherwise specifically indicated, the normal post-operative period included in the surgical fee is 14 days and the surgery fees include all concomitant services necessary to perform the listed service (including preparation of the operative site, incision, exploration, review of the results of

diagnostic tests and approved laboratory facility services rendered during the surgery, closure, and pre and post-operative discussion with the patient and/or patient's family).

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

**D. 5. 2.      Operation Only**

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

**D. 5. 3.      Multiple Surgical Procedures**

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

## PREAMBLE TO THE FEE GUIDE - Continued

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 a 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).

## PREAMBLE TO THE FEE GUIDE - Continued

- 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 orthopaedic 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 (eg. 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 Procedure**

- 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**

- b. 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.
- c. 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.

- d. 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.

- e. Surgery to revise or remove features of physical appearance which are familial in nature is not a benefit of MSP.
- f. 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.
- g. Within the context of this policy, the word “trauma” includes trauma due to treatment such as surgery, radiation, etc.
- h. As the phrase “reasonable period of convalescence” is imprecise, independent consideration will be given to more complex cases or extenuating circumstances.
- i. 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.
- j. 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 angiomas 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 acuminata)
- plantar warts
- viral induced cutaneous tumours in the immune compromised patient
- inflamed dermal and epidermal cyst
- dysplastic naevi
- lentigo maligna
- congenital naevi
- actinic (solar) keratosis
- atypical pigmented naevi
- lesions which cause significant pathophysiologic dysfunction

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

**D. 9. 2. 5. Hair Loss**

**a. Scalp or Neck**

- (i) Post-traumatic:
  - Repair to the area of traumatic hair loss is a benefit of MSP only if carried out within a reasonable period of convalescence.
  - MSP authorization is required.
- (ii) Other Etiology:
  - Not a benefit of MSP
- (iii) Usual repair procedures may include skin shifts or flaps, skin grafts, or hair plugs.

**b. Other Anatomical Areas**

- Not a benefit of MSP

**D. 9. 2. 6. Epilation of Hair**

- Not a benefit of MSP

**D. 9. 2. 7. Redundant Skin**

- a. Excision of redundant skin for elimination of wrinkles, etc. is not a benefit of MSP.
- b. Blepharoplasty is not a benefit of MSP unless there is documented evidence of medical necessity such as a visual field defect caused by the redundant eyelid skin and which meets the Doctors of BC/MSD 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, VIIth 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 General Practitioners and Specialists.

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

## MEDICAL-LEGAL MATTERS

These fees cannot be correctly interpreted without reference to Preamble Section C, Clause 2, which includes information about how fees are set.

### **Non-MSP-Insured Services Generally**

Fees listed in this fee guide for medical services that are not paid by or through MSP are referred to as “Non-MSP-Insured fees”. Recommended Non-MSP-Insured fees are determined by the Doctors of BC Tariff Committee in conjunction with Section representatives and in accordance with general policy established by the Board of Directors. They are not negotiated with or set by the Government, WorkSafeBC or ICBC.

The recommended Non-MSP-Insured fees are not to be construed as maximum or minimum charges, but are intended as a general guide for services of average complexity by which the individual physician dealing with the patient can set a proper and responsible value on the individual services provided. You are in no way obligated, ethically or otherwise, to use these recommended Non-MSP-Insured fees and you may charge either a higher or lower fee according to your own judgement. The Association will not enforce these fees on your behalf (however, there is a dispute resolution mechanism further described below).

### **Non-MSP-Insured Fees – Medical Legal Services**

Physicians are often called upon to prepare reports, opinions and to testify in civil, criminal and administrative matters.

- Civil matters are generally compensated privately by whoever requests the physician's services. Examples of civil cases are those involving motor vehicle accidents, medical malpractice, family disputes, and disability or life insurance claims.
- Criminal prosecution and government administrative matters where evidence is given on behalf of the Crown are compensated by the Attorney General's office, while other government agencies may pay the physician directly.
- Criminal defence matters are compensated by the accused, his/her counsel or the Legal Services Society (LSS). LSS invariably pays the representative counsel for services provided to qualified person in civil, criminal and administrative matters, who then pays the physician.

Physicians should clarify important issues in writing prior to agreeing to do any medical-legal work, including but not limited to:

- who is responsible for payment;
- the rate;
- payment in the event of short term cancellation; and
- when payment will be due.

It is prudent to also arrange a fee at the same time for potential court appearance in relation to the report or opinion.



a) Reports

Reports and opinions fall into two basic divisions:

- i) Those given by an attending physician or consultant who has already seen the patient in the course of his/her ordinary professional duties.
- ii) Those given by a non-attending physician or consultant who has examined the patient at the request of a lay person and who would not have seen the patient but for this request (*Independent Medical Exam or IME*).

Physicians giving an *expert opinion report* are generally qualified as an expert as per the Supreme Court Rules. The Rules specify what must be included in the report, such as qualifications, instructions provided to them, nature of the opinion and reasons for the opinion.

Physicians giving an *expert factual report* or letter will focus only on their observations and actions taken.

In settling on fees, physicians should consider the time actually spent on such matters as:

- examination of the patient, where applicable;
- review of medical records;
- preparation, dictation and revision of report;
- discussions with counsel.

b) Giving testimony in court/hearings for civil, criminal and administrative matters

i) Civil matters

Civil matters are non-criminal cases, for example those involving motor vehicle accidents, medical malpractice, family disputes, and disability or life insurance claims.

Compensation for giving oral testimony should include your appearance, plus preparation time and expenses.

Although physicians bring special training and experience to bear at trial, that is not determinative as to whether they are giving testimony as a fact witness or an opinion witness.

Physicians providing expert fact evidence will testify to their observations and actions taken. An opinion beyond what the evidence reveals is not necessary.

If a physician is appearing as an expert fact witness, counsel will normally contract with the physician for costs associated with attendance to give oral testimony. Some counsel may opt to only pay a \$20 witness fee for court attendance, plus reasonable preparation time and expenses (travel, meals and overnight accommodation if required). The witness fee is accompanied by the service of a subpoena.

Successful parties to a lawsuit are generally entitled to recover from the losing side reasonable costs they incurred in retaining expert witnesses. This is never more than what has actually been paid. The fee may need to be defended before the Court Registrar who will disallow any portion of the expert's fee considered unreasonable in relation to work done or time spent and leave the retaining party to bear the cost of this portion.

ii) Criminal and Government Administrative Cases

Physicians may be asked to testify as an expert for the criminal prosecution in a criminal trial or for a government agency or board in an administrative hearing (for example a Provincial Disability Plan claim). In such cases, physicians can make a claim for both hearing attendance and preparation. Scale "B" below reflects the fees and billing guidelines recommended by the Doctors of BC for these services.

LSS pre-approves the retainer and specifics, such as the fees, number of hours being funded, etc. for physicians who are testifying on behalf of the defence for an accused in a criminal matter which is being funded by LSS. Physicians may wish to refer to Scale "B" as a reference. Physicians should obtain a copy of the LSS approval and have agreement on the specifics with the accused's counsel prior to accepting the case.

Physicians who are testifying on behalf of the defence for an accused in a criminal case which is not being funded by LSS, or for an individual in a government administrative hearing, may choose to charge either the rates at Scale "A" or "B" or whatever rates they can agree to with the accused or his/her counsel.

c) Disputes

The Medical Legal Dispute Resolution Program is a joint initiative of the Doctors of BC, the Law Society of British Columbia and the College of Physicians and Surgeons of British Columbia. The Program's mandate is to attempt resolution of disputes regarding medical legal matters between the legal and medical professions. The process is confidential to the parties to the dispute, and referrals to the facilitator may be made by the Doctors of BC, the LSBC, the CPSBC, or by individual members of the respective professions. Contact the [Doctors of BC Fee Guide Advisor](#) for more information.

**SCALE “A”**

**MEDICAL-LEGAL FEES**

**CIVIL MATTERS (NOT CRIMINAL PROSECUTION OR CRIMINAL DEFENCE)**

	<b>Non-MSP- Insured Fee (\$)</b>
A00070 For filling out an ordinary printed form reporting on a patient’s condition or submitting like information in letter-form. This item should not be used for time loss benefit or insurance forms normally covered under A00059, A00060 and A00069.....	177.00
A00071 A Medical-Legal letter is defined as a short factual written communication given to any lay person (e.g.: lawyer, insurance representative) in relation to a patient’s medical condition for some purpose primarily unconnected with treatment .....	374.00
A00072 A simple Medical-Legal factual report is one, which will recite symptoms, history and records and give diagnosis, treatment, results and present condition. This is a factual summary of all the information available on the case.....	1117.00
A00073 A Medical-Legal opinion report will usually include the information contained in the medical-legal factual report and will differ from it primarily in the area of opinion. This may be opinion as to the course of events when these cannot be known for sure. It can include opinion as to long-term consequences and possible complications in the further development of the condition. All the known facts will probably be mentioned, but in addition there will be the extensive exercise of the physician’s expert knowledge and judgement with respect to those facts with a detailed prognosis <b>Required to meet specific criteria to qualify for court admission as an expert report</b> .....	1869.00
A00095 Review of paper or EMR records by physician ( <i>for medical/legal purposes or transfer of patient records</i> ) - per 15 minutes or portion thereof.....	105.00
NOTES:	
i) The fee for this service can be adjusted at the physician’s discretion based on the time and extent of physician involvement and secretarial and other direct or indirect costs such as cost of supplies to produce an electronic copy.	
ii) This fee is for review of the paper or EMR file only.	
iii) Photocopying paper records may be charged in addition.	
iv) At the physician’s discretion, an additional \$1.45 per page for paper copies is billable for large and/or complex charts.	
A00096 Photocopying per page (paper copies) (first 10 pages) .....	1.85
– subsequent pages - per page .....	.30

*(see notes on next page)*

**Non-MSP-  
Insured  
Fee (\$)**

**NOTES:**

- i) A00096 is extra to A00093 and/or A00095.
- ii) The fee for this service does not include review and/or summary of the patient's chart.

**ORAL TESTIMONY**

The following fees may be billed for court attendance, participation in depositions, witness discoveries, in-person meetings and telephone consultations with lawyers.

A00074	Testimony per day.....	2985.00
A00075	Testimony per half-day or less .....	1869.00
A00091	Preparation to give testimony, per hour .....	444.00
	NOTE: This fee does not include charges for extra record keeping necessary to provide expert testimony. These charges are in addition.	
A00092	Failure of notification of hearing, scheduled consultation meeting, discovery, depositions, or trial adjournment or out-of-court settlement.....	2241.00
	NOTE: Fee item A00092 applies where the patient or legal counsel fails to give 5 working days' notice of cancellation of court or other legal appearance or meeting.	
A00009	Mileage:	
	– per mile .....	N/A
	– per kilometer .....	0.55

## CROWN COUNSEL

### SCALE “B”

### MEDICAL EXPERT WITNESS FEES

### CRIMINAL AND OTHER GOVERNMENT MATTERS

**Non-MSP-  
Insured  
Fee (\$)**

The following fees and billing guidelines are recommended when a physician provides expert testimony in a criminal or Government of British Columbia ministry, board or agency matter.

**Preparation and Court Time (Per Hour):**

A94525	– General Practitioner .....	253.00
A94526	– Specialist.....	296.00

**Travel Time (Per Hour):**

A94527	– General Practitioner .....	145.00
A94528	– Specialist.....	167.00

**NOTES:**

- i) “General Practitioner”, means a Physician who is not a specialist.
- ii) “Specialist” means a Physician who is a certificant or fellow of the Royal College of Physicians and Surgeons of Canada.

## BILLING GUIDELINES

### 1. Travel to Site

- a) Time starts when the physician leaves home, office or hospital to go to the hearing location or Crown counsel office.
- b) Time ends when the physician arrives at the hearing location or Crown Counsel office or otherwise begins direct work on the case.
- c) If work on the case does not start until the day after travel, then travel time ends upon arrival at the hotel or at 1800 hours, whichever is later.

### 2. Return Travel

- a) Return time starts at the end of the proceedings or when no other services (e.g.: discussions) are required from the physician.
- b) Time ends when the physician arrives at home, office, hospital, etc.

## MEDICAL-LEGAL MATTERS - Continued

- c) If the physician is unable to return home the same day, then travel time ends at 1800 hours on the day that work on the case is finished and restarts the next morning at 0900 hours or upon leaving the hotel, whichever is earlier.
- d) If the hearing schedule and travel arrangements are such that a physician is required to stay away from home over a weekend, then travel time up to 8 hours per day is billed for the weekend days, to the extent that the physician's time is not occupied with the case work over the weekend.

### 3. **Hearing Time**

- a) Hearing time includes all relevant professional activities, including preparation, interviews, discussions, testimony, listening to other testimony and associated waiting time.
- b) Hearing time starts when the physician arrives at the hearing location or Crown Counsel office or at 0900 hours if he/she had already traveled away from home on a prior day.
- c) Hearing time ends when the hearing ends or no other services are required, but continues to 1800 hours if further services are required next day and the physician has traveled out of town.
- d) Time for preparation work prior to arrival or during evenings or weekends is billed in addition to the above and for the actual time spent.
- e) If lunch is primarily social, then a one-hour lunch break is not billable, but time for a working lunch is billable.
- f) In the event that out of town travel is necessary, in respect of single day trips only, and where the combination of hearing/preparation and travel are less than 8 billing hours, the balance up to 8 hours shall be billed as hearing/preparation time.
- g) Where physicians are testifying in their home community, hearing time shall be compensated at a minimum of 4 hours for the morning session and 4 hours for the afternoon session. Any Court time spent in excess of 4 hours in either the morning or afternoon session shall be paid at the appropriate fee.

#### 4. **Cancellations**

For the purposes of this section:

*“Fees otherwise payable”* includes travel time and hearing time and is in addition to preparation time already incurred.

*“Working days”* does not include Saturday, Sunday or Statutory holidays

- a) A cancellation is defined as a situation where the physician is informed that a previously arranged hearing appearance is no longer required or is to be rescheduled for any reason including testimony not needed, the hearing scheduling changes and adjournments.
- b) Where the physician is given more than 10 working days’ notice of cancellation of a hearing appearance, no compensation is payable.

Where the cancellation notice is received 10 full working days or less prior to scheduled commencement of travel (as defined in 1.a), the physician will be paid 100% of fees otherwise payable if the physician had attended the hearing, for each day or half day scheduled.

***Fees otherwise payable*** includes travel time and court time and is in addition to preparation time already incurred. ***Working days*** does not include Saturday, Sunday or Statutory holidays.

#### 5. **Expenses**

Expenses related to expert witness billing shall be in accordance with the rates established for “Group 2” (public service) employees. Such expenses may be claimed where the physician is required to attend a hearing location more than 32 km from his/her residence or where unusual road conditions exist which, for example, requires travel by ferry.

# GENERAL SERVICES

These fees cannot be correctly interpreted without reference to the Preamble unless otherwise specified. No additional charge for the visit should be made unless an extra examination of a distinct problem is rendered.

**Letter prefix ‘A’** designates services not payable by MSP or WSBC.

**Letter prefix ‘B’** designates services that are included in visit fee. For an isolated service, see Preamble Clause D. 8.

**Letter prefix ‘Y’** designates office or hospital visit on same day extra to procedure fee.

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
T13071 Office Visit for COVID-19 with test .....			50.00
NOTES:			
i) Payable for patients with suspected or active COVID-19 symptoms only.			
ii) COVID-19 testing must be performed.			
iii) Not intended for providing general information on a viral infection, including COVID-19.			
iv) Not payable in addition to any other office visits to the same physician for same patient, same day.			
T13072 Office visit for COVID-19 without test .....			40.00
NOTES:			
i) Payable for patients with suspected or active COVID-19 symptoms only.			
ii) Not intended for providing general information on a viral infection including COVID-19.			
iii) Not payable in addition to any other office visits to the same physician for same patient, same day			
A00001 General insurance examination, industrial examinations (to include MOT, marine personnel, pilots, and air traffic controllers), preplacement and periodic examinations, and CPP examinations. ....	220.00		
A00002 Limited examinations for special policies .....	156.00		
A00003 Industrial preplacement and periodic examination not requiring complete examination .....	91.20		
A00055 Examinations (other than the eyes) to obtain a driver's licence - full exam .....	214.00		
A00056 – partial exam .....	95.90		
A00004 Group examination of apparently healthy persons, including school examinations - per hour .....	371.00		



GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
A00005 Part-time professional employment where fee for service is not applicable - half day session (3.5 hours), 5 or less sessions per week, per session.....	993.00		
A00006 6th or additional half day session the same week, per session.....	828.00		
NOTE: MSP reimbursement agreement for sessional fees may be found elsewhere in this Guide.			
A00007 Consultative or advisory committee work - per half day (3.5 hours) .....	1211.00		
A00008 – per day .....	2417.00		

**INJECTIONS**

B00010 Intramuscular medications .....	25.00		11.37
B00011 Intravenous medications .....	29.75		12.77

The following test is not payable to approved laboratory facilities or hospitals:

00012 Venepuncture and dispatch of specimen to an approved laboratory facility, when no other blood work performed .....	13.55		5.95
--	-------	--	------

NOTES:

iv) This is the only fee applicable for taking blood specimens and is to apply in those situations where a single blood work service is provided by a medical practitioner.

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

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

B00013 Intra-arterial medications .....	43.20		16.03
Y00014 Intra-articular medications by injection - hip (initial injection) .....	64.30		25.57
Y00015 – tendons, bursae and all other joints (initial injection).....	43.25		17.00
– subsequent injections - injection fee only (includes visit fee) .....	43.25		17.00
00016 Intrathecal medications by injection .....	127.00		33.69

**BLOOD TRANSFUSIONS**

00020 Administered outside hospital .....	159.00		62.24
---	--------	--	-------

GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
00021 Administered in hospital .....	145.00		37.10
00022 Serum transfusion .....	62.50		24.78
00023 With vein dissection - additional .....	199.00		52.57
NOTE: The above rates include cross-matching, taking and giving of blood and are applicable only when the Canadian Blood Services 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 Services, it is to be made clear that no charge is being made other than ordinary call rates which are applicable.			
00024 Vein dissection for intravenous therapy (not paid in the immediate pre- and post-operative phase of surgery)...	124.00		36.96
00019 Venesection for polycythemia or phlebotomy - procedural fee .....	84.90		31.55
00018 Autologous ascitic infusion .....	197.00		47.85
00017 Insertion of central venous pressure catheter .....	96.40		23.77

**DIALYSIS FEES**

**Acute Renal Failure:**

**a) Hemodialysis:**

33750 Blood dialysis - physician in charge .....	2048.00		531.27
33751 Repeat blood dialysis - physician in charge .....	779.00		199.65

NOTES:

- i) Maximum number of repeat dialysis on one patient is four (4). Thereafter, bill as chronic renal failure under fee item 33758.
- ii) When items 33750 or 33751 are charged, there should be no charge under the applicable consult or hospital visit fee item codes or 00081.

33752 Blood dialysis - fee for cutdown by surgeon to be charged in addition to item 33750 or 33751 .....	517.00		134.31
--	--------	--	--------

**b) Peritoneal Dialysis:**

00308 Subsequent hospital visits (Preamble Clause B.4.e.ii) ..	89.20		28.93
33756 Re-insertion of peritoneal catheter after 10 days from initial insertion .....	208.00		52.22

NOTE: Item 00081 not to be charged in addition to Item 33723. Where an initial peritoneal dialysis is performed and for various reasons, hemodialysis initiated within next forty-eight (48) hours, the subsequent service should be charged under fee item 33758 plus fee item 33756 for the insertion of catheter.

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</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.....	208.00	52.22
	NOTE: Other medical situations which may arise such as Septicemia, etc. to be covered by item 00081 and always to be accompanied by a letter of explanation when billing a payment agency.		

**b) Peritoneal Dialysis:**

33723	Performance of initial peritoneal dialysis, chronic or acute renal failure to include consultation and two (2) weeks care.....	1530.00	397.47
-------	--	---------	--------

33759	Performance of each peritoneal dialysis thereafter - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions and any other problem that may arise during dialysis .....	208.00	52.22
-------	--	--------	-------

**NOTES:**

- i) Other situations requiring medical care such as bacteremias, etc. to be covered by item 00081 in the present Guide and always to be accompanied by a letter of explanation.
- ii) If a period greater than three (3) months elapses since last dialysis, then charge as an initial dialysis 33723.

33761	Supervision of home dialysis - per week.....	255.00	63.13
	NOTE: Fee item 33761 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 charged in lieu of fee item 33761.		

**IMMUNIZATION, SKIN TESTS**

B00030	Diagnostic skin tests (Schick, Dick, TB and Frei).....	24.55	8.93
B00031	Vaccination against smallpox (with certificate).....	21.65	8.60
B00034	Subcutaneous injections, including desensitization treatments, immunization, oral polio vaccine, etc. (maximum per sitting - three (3)).....	25.00	11.37

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Immunizations for Patients 18 Years of Age or Younger</b>			
NOTES:			
i) For immunizations of patients age 19 or older, use fee item B00010, B00034.			
ii) Not payable for immunizations required for travel, employment and emigration.			
iii) Payable per injection.			
iv) Payable in full with an office visit to a maximum of 4 injections per patient per day.			
v) Not payable on the same day with B00010, B00034.			
10010 DTaP-IPV (Diphtheria, Tetanus, Pertussis, Polio).....	13.65		5.43
10011 DTaP-IPV-Hib (Diphtheria, Tetanus, Pertussis, Polio, Hib).....	13.65		5.43
NOTE: Not payable with P10010 or P10018 on the same day, same patient			
10012 Td (Tetanus, Diphtheria).....	13.65		5.43
10013 Td/IPV (Tetanus, Diphtheria, Polio).....	13.65		5.43
NOTE: Not payable with P10012 or P10019 on the same day, same patient			
10014 TdaP (Tetanus, Diphtheria, Pertussis).....	13.65		5.43
NOTE: Not payable with P10013 on the same day, same patient			
10015 Influenza (Flu).....	13.65		5.43
10016 Hepatitis A.....	13.65		5.43
10017 Hepatitis B.....	13.65		5.43
10018 Haemophilus influenza type b (Hib).....	13.65		5.43
NOTE: Not payable with P10011 on the same day, same patient			
10019 Polio (IPV).....	13.65		5.43
NOTE: Not payable with P10010, P10011 or P10013 on the same day, same patient			
10020 Meningococcal C Conjugate (MEN-C).....	13.65		5.43
10021 Meningococcal Quadrivalent Conjugate (Groups A, C, Y, W-135).....	13.65		5.43
10022 MMR (Measles, Mumps, Rubella).....	13.65		5.43
10030 MMR/V (Measles, Mumps, Rubella and Varicella).....	13.65		5.43
10023 Pneumococcal Conjugate (PCV13).....	13.65		5.43
10024 Pneumococcal Polysaccharide (PPV23).....	13.65		5.43
10025 Rabies.....	13.65		5.43
10026 Varicella (Chickenpox).....	13.65		5.43
10027 DTap-HB-IPV-Hib (Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib).....	13.65		5.43
NOTE: Not billable with fee items P10010, P10011, P10012, P10013, P10014, P10017, P10018			

GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10028 HPV (Human Papillomavirus) .....	13.65		5.43
10029 Rotavirus.....	13.65		5.43

**EYE BANK SERVICES**

00050 Enucleation of eye(s) for corneal transplants .....	472.00		138.67
NOTES: Payment of this fee item is limited to:			
i) Enucleations yielding tissue which is confirmed by the Eye Bank of BC as falling within its guidelines for enucleations; and			
ii) Enucleations where the donors were insured by MSP at the time of death.			
00051 Corneal tissue processing.....	1649.00		375.66
NOTES:			
i) Payment of this fee item is limited to:			
ii) Corneal tissue which is processed by the Eye Bank of British Columbia; and			
iii) Corneas, which are used for transplant into recipients who are insured under the Medical Services Plan.			

**HYPERBARIC CHAMBER**

NOTES:			
i) Use of hyperbaric Chamber is insured under MSP 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 half hour .....	278.00	7	81.83
00026 – each additional 15 minutes .....	144.00		42.02
00027 – physician outside chamber - 1st half hour .....	191.00	5	55.73
00028 – each additional 15 minutes .....	101.00		29.59
00046 Additional charge to pertinent medical, anesthetic or surgical fee, per hour .....	111.00		28.44

**BLOOD ALCOHOL SAMPLING**

A00036 Taking sample.....	99.60		
A00037 Additional charge for standby time, per half hour.....	169.00		
NOTE: Service charges and surcharges extra.			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**MISCELLANEOUS**

<p>P13013 Assessment for Induction of Opioid Agonist Treatment (OAT) for Opioid Use Disorder Initial assessment requires complete medical history, substance use history and appropriate targeted physical examination. If assessment and induction are done on the same day, withdrawal assessment using COWS or SOWS and administration of first dose of OAT included – per 15 minutes or greater portion thereof .....</p>	97.70	42.97
---	-------	-------

NOTES:

- i) Payable to a maximum of 4 units per patient/per day/per intended induction.
- ii) Payable only to the physician who intends to provide or share management of the patient’s OAT induction for opioid use disorder.
- iii) Start and end times must be entered in both the billing claim and the patient’s chart.
- iv) No other visit fees billable same day except 13014, 14018 and 14077. 13014, 14018 and 14077 payable in addition to 13013 only when not performed concurrently.
- v) Payable for assessment for change of OAT with induction to a different medication.
- vi) May not be repeated within 30 days by the same physician.
- vii) This service payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day).

<p>P13014 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 .....</p>	45.80	20.15
---	-------	-------

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.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
vi) May be billed when delegated to a nurse (LPN, RN, NP) employed within the eligible physician practice.			
vii) Start time must be entered in both the billing claim and patient's chart.			
P00039 Management of Maintenance Opioid Agonist Treatment (OAT) for Opioid Use Disorder.....	62.90		23.60
Management of ongoing maintenance Opioid Agonist Treatment for Opioid Use Disorder			
NOTES:			
i) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.			
ii) 00039 is not the only fee payable for any medically necessary service associated with opioid agonist treatment for opioid use disorder. This includes but is not limited to the following:			
a. At least one visit (in-person, telephone or video conference) per month with the patient after induction/stabilization on opioid agonist treatment is complete.			
b. At least one in-person visit with the patient every 90 days. Exceptions to this criterion will be considered on an individual basis.			
c. Supervised urine drug screening and interpretation of results.			
d. Simple advice/communication with other allied care providers involved in the patients OAT.			
iii) Claims for treatment of co-morbid medical conditions, including psychiatric diagnoses other than substance use disorder, are billable using the applicable visit or service fees. Counselling and visit fees related only to substance use disorder are not payable in addition with the exception of visits required to support Substance Use Risk Mitigation in the context of COVID-19 (claim note record must indicate "COVID-19 risk mitigation").			
iv) This fee is payable once per week per patient regardless of the number of services per week for management of OAT maintenance.			
v) This fee is not payable with out of office hours premiums.			
<i>(notes continued on next page)</i>			

GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
vi) Eligibility to submit claims for this fee item is limited to physicians who are actively supervising the patient's continuing use of opioid agonist medications for treatment of opioid use disorder.			
vii) This payment stops when the patient stops opioid agonist treatment.			
P15039 GP Point of Care (POC) testing for oral opioid agonist treatment .....	32.15		12.75
NOTES:			
i) Restricted to patients in opioid agonist treatment.			
ii) Maximum billable: <u>26 per annum, per patient.</u>			
iii) Confirmatory testing (reanalyzing a specimen which is positive on the initial POC test using a different analytic method) is expensive and seldom necessary once a patient is in treatment for opioid use disorder. Accordingly, confirmatory testing should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management.			
iv) This fee includes the adulteration test.			
v) Only POC urine testing kits that have met Health Canada Standards are to be used.			
15040 GP Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone. ....	32.15		12.81
NOTES:			
i) Not billable for patients in opioid agonist treatment.			
ii) Confirmatory testing (reanalyzing 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 .....	83.20		26.38
00041 Ultrasound treatments .....	24.55		8.68



GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
00042 Mileage, per mile one way (in the country beginning 5 miles (8 kilometers) from town centre, in the city from the boundary of the city).....	14.25		2.77
NOTE: Payment agencies honour accounts for unusual emergency services to a patient residing outside one's practice area and with a written report.			
00043 Anticoagulation therapy by telephone .....	26.85		6.98
A00047 Renewal of prescription by telephone, fax or secure electronic transmission (per telephone call, fax or transmission).....	32.70		
A94523 Completion of Drug Benefit Form for third party insurer .....	78.90		
A00048 Tray service .....	45.70		
A00049 Advice by telephone on the establishing of a tentative diagnosis and prescribing treatment per 15 minutes or portion thereof.....	91.20		
A00009 Mileage - per kilometre.....	0.55		
A00093 Transfer of patient records .....	37.40		
NOTES:			
i) This fee is recommended for a simple transfer of records. Photocopying may be charged in addition.			
ii) Other direct costs, such as courier services, may be charged in addition based on the actual cost.			
iii) A fee for review of records may be charged in addition if the physician reviews the records for the purpose of selecting current and necessary medical information to be transferred.			
iv) Original records must be retained by the transferring physician as required by law.			
v) When multiple records are being transferred, the total time spent should be taken into account.			
A00095 Review of paper or EMR records by physician (for medical-legal purposes or transfer of patient records) - per 15 minutes or portion thereof.....	105.00		
NOTES:			
i) The fee for this service can be adjusted at the physician's discretion based on the time and extent of physician involvement and secretarial and other direct or indirect costs such as cost of supplies to produce an electronic copy.			

*(notes continued on next page)*

GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
ii) This fee is for review of the paper or EMR file only.			
iii) Photocopying paper records may be charged in addition.			
iv) At the physician's discretion, an additional \$1.45 per page for paper copies is billable for large and/or complex charts.			
A00096 Photocopying per page (paper copies) (first 10 pages) .....	1.85		
– subsequent pages - per page.....	.30		
NOTES:			
i) A00096 is extra to A00093 and/or A00095.			
ii) The fee for this service does not include review and/or summary of the patient's chart.			

**PREVENTIVE MEDICINE**

A00052 Biofeedback rendered by a physician for other than neurological and/or muscular retraining - per half hour .	156.00		
A00053 Hypnosis for services not insured by MSP; e.g.: smoking withdrawal, weight loss or other lifestyle services - per half hour.....	156.00		
A00054 Preventive medicine counseling all forms; e.g.: health maintenance assessment and counseling to include physical examination, smoking withdrawal and other harmful habits, weight and/or diet control, exercise programs (planning and management), stress management techniques, social support systems, establishing normal sleep patterns and other forms of lifestyle counseling - per half hour.....	156.00		

**CERTIFICATES AND FORMS**

A00060 Written certificate, including time loss benefit form (extra to examination) and death certificates.....	45.70		
A00061 Medical advice by letter.....	156.00		
00062 Initial "in-care" or adoption examination of a well baby or child (with report) - fee for each doctor.....	160.00		77.34
00064 Subsequent "in-care" or adoption examination by same doctor within six (6) months.....	77.90		34.79
A00063 Initial screening examination for chronic or rehabilitation care.....	160.00		
00065 Investigation, with completion of B.C. Mental health Act Forms 3, 4 or 6 (fee per doctor) .....	160.00		103.50

GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
00066 Completion of B.C. Mental Health Act Forms 3, 4 or 6, on previously assessed or treated cases .....	77.90		46.52
00067 Investigation with cancellation of B.C. Mental health Act Forms 4 or 6, and subsequent voluntary treatment status .....	83.20		46.40
96400 Medical Practitioners Completion of Part B Only of MHR Monthly Nutritional Supplement Application Form .....	25.00		
NOTES:			
i) To include confirmation of a chronic, progressive deterioration of health due to a severe medical condition.			
ii) Submit claim for fee item 96400 to MSP. Do not bill privately.			
96501 Physician completion of Section 2, Physician Report of MHR Person with Disabilities (Application or Review Form) .....	130.00		
96502 Physician completion of Section 3, Assessor Report of MHR Person with Disabilities (Application or Review Form) .....	75.00		
NOTE: Submit claims for 96400, 96501, 96502 and 96505 to MSP. Do not bill privately.....			
96503 Medical Practitioners completion of MHR Medical Report – Persons with Persistent Multiple Barriers .....	50.00		
<b>Note:</b> Includes full completion of part C 1-5 medical assessment in the detail prescribed by the report format.			
96504 Medical Practitioners completion of MHR Medical Report – Employability Forms .....	25.00		
<b>Note:</b> Includes full completion of part C 1-4 medical assessment in the detail prescribed by report format			
96505 MHR medical report – child.....	25.00		
A00068 Physical fitness examination for school, summer camp, etc., including certificate .....	77.20		
A00058 Premarital examination .....	156.00		
A00069 Insurance company form to include review of records - short report .....	156.00		
A00059 – extensive report .....	204.00		
A00097 Examination and completion of Canadian Blood Services form for report on plasmapheresis donors.....	111.00		
A94529 Completion of the Occupational Fitness Assessment (OFA) form (extra to examination). .....	177.00		
A94533 Completion of Public Trustee’s form for Opinion of incapacity (extra to examination) .....	374.00		

## ROADSAFETYBC FORM FEES

The RoadSafetyBC requires that patients with certain medical conditions be examined periodically in order to facilitate renewal of their driver’s license. These services are not insured by MSP and physicians are entitled to set their own fee for these services and charge patients privately.

The RoadSafetyBC will pay a set fee for the completion of certain driver’s medical examination reports. Forms will specify if the RoadSafetyBC will reimburse or if the patient or their employer are to be billed the entire fee. Forms reimbursed by the RoadSafetyBC are paid through MSP Teleplan. While MSP Teleplan is acting as the processor for the RoadSafetyBC, it is the RoadSafetyBC who is paying for the service.

For those forms reimbursed by the RoadSafetyBC, physicians have three billing options:

- i) Bill RoadSafetyBC through MSP Teleplan the RoadSafetyBC Fee Amount.
- ii) Bill RoadSafetyBC through MSP Teleplan and balance bill the patient the difference between the RoadSafetyBC Fee Amount and the total fee as determined by the physician. The Non-MSP-Insured Fee Amount is only a guideline and physicians may charge either a higher or lower fee according to their own judgment.
- iii) Bill the entire amount to the patient privately.

Patients will not be reimbursed by RoadSafetyBC for any charges they incur.

<b>Non-MSP- Insured Fee (\$)</b>	<b>Road Safety BC Fee (\$)</b>
--	--

## ROADSAFETYBC FORM FEES

96220 RoadSafetyBC Driver's Medical Examination Report (DMER) for any driver with a known or possible medical condition.....	214.00	75.00
--	--------	-------

**NOTES:**

- i) Not billable in addition to fee item 96221.
- ii) This fee may only be claimed when specifically requested by the Superintendent of Motor Vehicles.
- iii) Patient birth date is required on the claims submission.
- iv) Patient driver’s license number is required on the claims submission. (Driver’s license number must be entered in the first 7 spaces of the note or comment field.)
- v) A consultation, complete physical, office or counseling visit may not be claimed in addition if the patient is seen for the same condition.
- vi) Repeat DMER is not payable to any practitioner within 3 months.

GENERAL SERVICES - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Road Safety BC Fee (\$)</b>
96221 RoadSafetyBC Diabetic Driver Report - standalone (no DMER): Diabetic Driver Report for commercial drivers with diabetes (known medical condition) .....	214.00	75.00
NOTES:		
i) Not billable in addition to fee item 96220.		
ii) This fee may only be claimed when specifically requested by the Superintendent of Motor Vehicles.		
iii) Patient birth date is required on the claims submission.		
iv) Patient driver's license number is required on the claims submission. (Driver's license number must be entered in the first 7 spaces of the note or comment field.		
v) A consultation, complete physical, office or counseling visit may not be claimed in addition if the patient is seen for the same condition.		
vi) Only applicable to claims submitted under diagnostic code 250 (diabetes mellitus).		
vii) Repeat Diabetic Driver Report-stand alone is not payable to any practitioner within 3 months.		
96222 RoadSafetyBC Diabetic Driver Report - sent out with DMER: Diabetic Driver Report for commercial drivers with diabetes (known medical condition).....	53.50	30.00
NOTES:		
i) Fee item 96220 must also be billed on the same date of service.		
ii) This fee may only be claimed when specifically requested by the Superintendent of Motor Vehicles.		
iii) Patient birth date is required on the claims submission.		
iv) Patient driver's license number is required on the claims submission. (Driver's license number must be entered in the first 7 spaces of the note or comment field.)		
v) A consultation, complete physical, office or counseling visit may not be claimed in addition if the patient is seen for the same condition.		
vi) Only applicable to claims submitted under diagnostic code 250 (diabetes mellitus).		
vii) Repeat Diabetic Driver report with DMER is not payable to any practitioner within 3 months.		
* The fees in the RoadSafetyBC column are paid through the Medical Services Plan on behalf of RoadSafetyBC.		

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>JAIL VISITS</b>			
A00085 Jail visit to examine one prisoner including certification - daytime .....	219.00		
A00086 Subsequent jail visit to examine prisoner again including certification .....	219.00		
A00087 Other prisoners examined at same jail visit including certification - each .....	156.00		
A00088 Jail visit to examine one prisoner including certification - night (1700 hours to 0830 hours), Saturday, Sunday or statutory holiday .....	284.00		
A00089 Examination of prisoners in doctor's office including certification - each .....	156.00		

**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 hemodynamic compromise,
  - g) Hypothermia, and
  - h) Other immediate life threatening situations.
3. 00081 includes the following procedure items where required: defibrillation, cardioversion, peripheral intravenous lines, arterial blood gases, neogastric 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.  
*(notes continued on next page)*

GENERAL SERVICES - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p>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):</p> <p>a) Endotracheal Intubation – as a separate entity, i.e. not part of a cardiac arrest or followed by an anesthetic,</p> <p>b) Cricothyroidotomy,</p> <p>c) Venous Cutdown,</p> <p>d) Arterial Catheter,</p> <p>e) Diagnostic Peritoneal Lavage,</p> <p>f) Chest Tube Insertion, and</p> <p>g) Pacemaker Insertion.</p>			
<p>6. 00081 is not intended for standby time such as waiting for laboratory results, or simple monitoring of the patient.</p>			
<p>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.</p>			
<p>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.</p>			
<p>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.</p>			
00081			
Emergency care – per ½ hour or major portion thereof	314.00		105.79
<p>NOTE: Start and end times must be entered in both the billing claims and the patient's chart.</p>			
00082			
Monitoring of critically ill patients (when modification of the care and active intervention is not necessary) – per ½ hour or major portion thereof .....	156.00		63.47
<p>NOTE: Start and end times must be entered in both the billing claims and the patient's chart.</p>			

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

## TRAUMA ASSESSMENT AND SUPPORT

### 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  $\leq 90$  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  $\leq 8$  with a mechanism suggestive of injury.
- v) Gunshot or other penetrating wounds to head, neck, chest, abdomen or proximal extremity (at or above knee or elbow).
- vi) Autolaunched Trauma Patient.
- vii) Pediatric Trauma Patient under 16 years of age.
- viii) Special consideration will be given for patients with significant co-morbidities, pregnant patients, and patients  $< 5$  years of age and  $> 65$  years of age.

### Trauma Team Consults:

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

*(notes continued on next page)*



Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

- vii)- Partial thickness (2°) burn ≥ 10% and full thickness (3°) burn
  - Electrical or lightning burn
  - Chemical burn or Inhalation injury
  - Burn injury in patients with significant co-morbidities
  - Burn injury with concomitant trauma
- viii) Obvious significant injury and – Falls > 20 feet.
- ix) Obvious significant injury and – Pedestrian hit (thrown or run over).
- x) Obvious significant injury and – Motorcycle crash with separation of the rider and bike.
- xi) Obvious significant injury and – Motor vehicle crash with either
  - Ejection
  - Rollover
  - Speed > 70 kph
  - A death at the scene
- xii) 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

*(notes continued on next page)*

GENERAL SERVICES - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
- 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 .....	1375.00		301.88
NOTES:			
i) Restricted to General Surgeons			
ii) Indicated for those patients experiencing any of the Trauma Team Activation Criteria.			
iii) Minimum of 2 hours of bedside care required on Day 1 (excluding stand by time).			

*(notes continued on next page)*

GENERAL SERVICES - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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.).....	475.00		104.00
NOTES:			
i) Restricted to General Surgeons			
ii) Not paid on same date of service as 10087 or 10089.			
iii) Not paid unless 10087 has been previously claimed (on same PHN).			
iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.			
v) Not paid with any consult, visit or emergency care fees, by the same practitioner on the same date of service.			
vi) Payable to only one physician for one patient, per facility, per day.			
10089 Trauma Team Leader Subsequent Hospital Visit (Days 3-15 inclusive) .....	361.00		78.72
NOTES:			
i) Restricted to General Surgeons			
ii) Not paid on same date of service as 10087 or 10088.			
iii) Not paid unless 10087 has been previously claimed (on same PHN).			
iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.			
v) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.			
vi) Payable to only one physician for one patient, per facility, per day.			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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 .....	314.00	105.80
--	--------	--------

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, counseling, etc. is rendered. Claims for more than three (3) hours under fee item 00083 will be given independent consideration by MSP.
- 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.

**ACCOMPANYING PATIENTS**

00084 Accompanying patient(s) to a distant hospital where medically required – per ½ hour or major portion thereof .....	343.00	222.37
--	--------	--------

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.

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>TRAY SERVICE FEES</b>			
00044 Mini Tray Fee.....	11.60		5.22
NOTE: 00044 is applicable to fee items 00190, 00217, S00744 and 14560 only.			
00080 Minor Tray Fee.....	23.45		10.46
The use of sterile tray suitable for cautery, cryotherapy, dilation or similar procedure.			
00090 Major Tray Fee.....	70.50		31.37
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.			
NOTES:			
i) Tray fees are only applicable where the costs are actually incurred by the physician.			
ii) Tray fees are only applicable in conjunction with the procedures included in the attached lists. Other procedures will be given independent consideration with the British Columbia Medical Association Tariff Committee.			
iii) Tray fees are not applicable when the service is performed at a funded facility (e.g.: hospital, D&T Centre, Psychiatric Institution, etc.).			
iv) Applicable to 04111 only when rendered in private (non-funded) facilities. Not applicable when rendered in hospital or other publicly-funded facilities.			

**PROCEDURES ELIGIBLE FOR TRAY FEE SERVICE**

**Procedures Eligible for Major Tray Fee Service:**

- S00331 Closed drainage of chest
- S00571 Pediatric Oesophagogastroduodenoscopy in a patient 16 years of age and under
- S00701 Direct laryngoscopy - procedural fee
- S00704 Cystoscopy dilation and Panendoscopy
- S00706 Oesophagoscopy with biopsy
- S00707 Oesophagogastroduodenoscopy - procedural fee
- SY00715 Sigmoidoscopy with biopsy
- SY00716 Sigmoidoscopy flexible
- SY00718 Sigmoidoscopy flexible with biopsy
- S00723 Sialogram (per duct) or galactograms (per blast) - procedural fee for injection

## GENERAL SERVICES - Continued

- 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 Epidural 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
- S02157 Eyelid Tumour - benign excision
- S02171 Pterygium or limbus Tumour
  - 02251 Myringoplasty
  - 02254 Myringotomy - unilateral
  - 02255 Exploratory tympanotomy
  - 02266 Myringoplasty - paper patch, ear drum
  - 02274 Myringoplasty bilateral - with insertion of aerating tube
  - 02307 Naso-antral window - single
  - 02308 Naso-antral window - double
  - 02317 Electrocoagulation of turbinates - one side
  - 02318 Electrocoagulation of turbinates - both sides
  - 02322 Removal of nasal polypi - unilateral
- S02323 Removal of nasal polypi - bilateral
  - 02324 Antral lavage - unilateral
  - 02325 Antral lavage - bilateral
  - 02341 Posterior nasal packing - to include balloon control of epistaxis
  - 02345 Drainage of abscess or hematoma of septum

## GENERAL SERVICES - Continued

- 02346 Posterior nasal packing with trans-oral gauze pack, under local, topical or GA
- 02412 Biopsy of larynx and/or cauterization (including laryngoscopy)
- 02413 Operative control of post-tonsillectomy or post-adenoidectomy hemorrhage requiring local or general anesthetic
- 02419 Direct or indirect laryngoscopy with foreign body removal
- 02447 Incision of peritonsillar abscess - under LA
- 02535 Maxillary sinus endoscopy
- 02538 Laryngostroboscopy
- 03211 Muscle biopsy
- 04032 Biopsy of vulva, excisional lesion > or = 2 cm
- 04300 Hymen incision
- 04301 Bartholin's cyst incision
- 04312 Resection of labia minora
- 04317 Biopsy vulva, lesion <2 cm
- 04404 Cyst vaginal inclusion removal
- 04405 Removal of other vaginal cyst
- 04406 Operation for removal of vaginal septum
- 04111 Therapeutic abortion (vaginal) by whatever means – less than 14 weeks gestation (operation only)
- S04500 Cervix dilation and curettage
- 04510 Biopsy of cervix, with dilation and curettage
- 04536 Cone biopsy cervix (includes D & C)
- 06016 Removal of Tumour or scar under GA or regional block
- 06017 Removal of Tumour
- 06019 Skin grafts - single or multiple flaps under 2 cm
- 06020 Skin grafts - single
- 06021 Skin grafts - single with free skin graft to secondary defect
- 06022 Skin grafts - multiple
- 06023 Skin grafts - multiple with free skin graft to secondary defect
- 06024 Skin grafts - eyebrow, eyelid, lip, ear, nose
- 06027 Repair of torn (split) earlobe (simple)
- 06040 Free skin grafts - finger, phalanx
- 06041 Free skin grafts - ear eyelid, lip, nose
- 06043 Free skin grafts - finger tip
- 06044 Free skin grafts - sole or palm
- 06046 Free skin grafts - less than 6.5 sq. cm or less
- 06051 Free skin grafts - finger tip
- 06052 Free skin grafts - head and neck - 6.5 sq. cm or less
- 06060 Free skin grafts - mouth
- 06069 Tumour or scar excision - face
- 06070 Skin graft following removal of Tumour
- 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
- 06125 Blepharoplasty - simple
- 06126 Blepharoplasty - complicated
- 06130 Accessory auricle
- 06156 Peripheral nerve - transplant or neuroma

## GENERAL SERVICES - Continued

- 06182 Ganglia of tendon sheath or joint
- 06184 Extensor - primary or secondary repair
- 06186 Tenoplasty
- 06187 Tenoplasty - 2 or more tendons
- 06188 Tenolysis
- 06193 Palmar fasciectomy more than one digit
- 06197 Tenosynovitis - finger
- 06210 Neurolysis external
- 06218 Amputation - transmetacarpal
- 06219 Amputation - finger
- S06258 Neurolysis and exploration of peripheral nerve
- 07025 Biopsy, temporal artery
- 07041 Aspiration - abdomen or chest
- 07045 Abscess anterior closed space
- 07053 Excision of nail bed, complete, with shortening of phalanx
- 07110 Multiple ligations and stripping tributaries: 3 to 6 incisions
- 07111 Multiple ligations and stripping tributaries: 6 or more incisions
- 07112 Ligation of 2 or more perforators
- 07464 Sigmoidoscopy; flexible - with removal of polyp(s) (operation only)
- 07470 Microdochectomy, nipple exploration
- 07516 Excision of salivary cyst
- 07685 Pilonidal sinus
- S08262 Meatotomy and plastic repair
- S08264 Urethra dilation
- S08301 Dorsal slit
- S08340 Epididymis abscess incision
- S08345 Vasectomy - bilateral
- 08513 Dacryocystogram
- 08595 Cystogram or retrogradeurethrogram (not including catheterization)
- SY10714 Proctosigmoidoscopy, rigid, diagnostic
- PSY10750 Transnasal esophagogastroduodenoscopy (TGD), procedural fee
- SP10761 Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral – procedural fee
- SP10762 Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee
- S11230 Shoulder Girdle, Clavicle, and Humerus, Excision-Diagnostic, Percutaneous: Needle biopsy under GA
- S11330 Elbow, Proximal Radius and Ulna, Excision-Diagnostic, Percutaneous: Needle biopsy under GA
- S11430 Hand and Wrist, Excision-Diagnostic, Percutaneous: Needle biopsy under GA
- S11530 Pelvis, Hip and Femur, Excision-Diagnostic, Percutaneous: Needle biopsy under GA
- S11630 Femur, Knee Joint, Tibia and Fibula, Excision-Diagnostic, Percutaneous: Needle biopsy under GA
- S11730 Tibial Metaphysis (Distal), Ankle and Foot, Excision-Diagnostic, Percutaneous: Needle biopsy under GA
- S11830 Vertebra, Facette and Spine, Excision-Diagnostic, Percutaneous: Needle biopsy – soft tissue/bone – thoracic spine, under GA



GENERAL SERVICES - Continued

- S11831 Shoulder Girdle, Clavicle, and Humerus, Excision-Diagnostic, Percutaneous:  
Needle biopsy – soft tissue/bone – lumbar spine, under GA
- 13600 Biopsy - mucosa or skin
- 13601 Biopsy - face
- 13611 Lacerations or foreign body, minor
- 13612 Lacerations, extensive
- 13620 Scar or Tumour excision
- 13622 Localized carcinoma of skin, proven histopathologically
- 13623 Excision of tumour of skin or subcutaneous tissue or small scar under local  
anesthetic - face (operation only)
- 13632 Removal of nail - with destruction of nail bed
- 13633 Wedge excision of one nail
- 13650 Hemorrhoid thrombotic, enucleation
- 14540 Insertion of IUD
- P20221 Single or multiple flaps under 2 cm in diameter used in repair of defect (except for  
special areas as in P20225) (operation only)
- P20222 Local tissue shifts - Single
- P20223 Local tissue shifts - Multiple
- P20224 Local tissue shifts - with free skin graft to secondary defect
- P20225 Local tissue shifts - Eyebrow, eyelid, lip, ear, nose - single
- P20226 Full-thickness grafts - Eyelid, nose, lips, ear
- P20227 Full-thickness grafts - Finger, more than one phalanx
- P20228 Full-thickness grafts - Sole or palm
- SP33322 Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI  
hemorrhage, bleeding esophageal varices or other pathologic conditions –  
operation only
- S33373 Colonoscopy with flexible colonoscope - biopsy
- S33374 Colonoscopy with flexible colonoscope – removal of 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)
- PS61250 Autologous Lipotransfer – Aspiration – Volume less than 20 ml
- PS61251 Autologous Lipotransfer – Aspiration – Volume between 21-60 ml
- PS61252 Autologous Lipotransfer – Aspiration – Volume greater than 60 ml
- SP61300 Wounds - Simple, or involving minor debridement of traumatic wounds - up to 5  
cm - other than face, simple closure (operation only)
- SP61301 Wounds - Simple, or involving minor debridement of traumatic wounds - up to 5  
cm - on face and/or requiring tying of bleeders and/or closure in layers (operation  
only)
- SP61302 Wounds - Simple, or involving minor debridement of traumatic wounds - 5.1 to 10  
cm - other than face, simple closure (operation only)
- SP61303 Wounds - Simple, or involving minor debridement of traumatic wounds - 5.1 to 10  
cm - on face and/or requiring tying of bleeders and/or closure in layers (operation  
only)

## GENERAL SERVICES - Continued

- SP61310 Trunk, Arms and Legs - Resulting in repair less than 5 cm (operation only)
- SP61311 Trunk, Arms and Legs - Resulting in a repair 5-10 cm (operation only)
- SP61313 Face, scalp, neck, genitalia, hands, feet, axilla - Resulting in repair less than 5 cm (operation only)
- SP61314 Face, scalp, neck, genitalia, hands, feet, axilla - Resulting in a repair 5-10 cm (operation only)
- SP61316 Eyelids, ears, lips, nose, mucous membrane, eyebrow - Resulting in repair less than 2 cm (operation only)
- SP61317 Eyelids, ears, lips, nose, mucous membrane, eyebrow - Resulting in a repair 2-4 cm (operation only)
- SP61318 Eyelids, ears, lips, nose, mucous membrane, eyebrow -Resulting in a repair greater than 4 cm (operation only)
  - P61324 Defect up to 2 cm - Nose, Lids, Lips or Scalp (operation only)
- SP61325 Defect 2.1 to 5 cm - Nose, Lids, Lips or Scalp (operation only)
- SP61326 Defect 2.1 to 5 cm -other areas (operation only)
- SP61327 Defect 5.1 to 10 cm - Nose, Lids, Lips or Scalp
- SP61328 Defect 5.1 to 10 cm - other areas
  - P61329 Defects more than 10 cm (such as a thoracic abdominal flap)
- P61330 Trunk - Defect up to 40 cm<sup>2</sup>
- P61331 Trunk - Defect 40 cm<sup>2</sup> to 100 cm<sup>2</sup>
- P61332 Trunk - Defect greater than 100 cm<sup>2</sup>
- SP61333 Arms, legs and scalp - Defect up to 6 cm<sup>2</sup>
  - P61334 Arms, legs and scalp - Defect 6 cm<sup>2</sup> to 19 cm<sup>2</sup>
  - P61335 Arms, legs and scalp - Defect greater than 19 cm<sup>2</sup>
- SP61336 Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck - Defect up to 6 cm<sup>2</sup>
- SP61337 Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck - Defect 6 cm<sup>2</sup> to 19 cm<sup>2</sup>
  - P61338 Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck - Defect greater than 19 cm<sup>2</sup>
- SP61339 Ears, eyelids, lips and nose - Defect up to 6 cm<sup>2</sup>
- SP61340 Ears, eyelids, lips and nose - Defect 6 cm<sup>2</sup> to 19 cm<sup>2</sup>
- SP61341 Ears, eyelids, lips and nose - Defect greater than 19 cm<sup>2</sup>
  - P61342 Revision of Graft - Revision, less than 2 cm
  - P61343 Revision of Graft -Revision, between 2 and 5 cm
  - P61344 Revision of Graft - Revision, greater than 5 cm
- P61350 Full-thickness graft - Trunk (2 to 19 cm<sup>2</sup>) (operation only)
- P61351 Full-thickness graft - Arms, legs, scalp (2 to 19 cm<sup>2</sup>)
- P61352 Full-thickness graft - Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm<sup>2</sup>)
- P61353 Full-thickness graft - Ears, eyelids, lips and nose (2 to 19 cm<sup>2</sup>)
- SP61354 Full-thickness graft - 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)
  - P61360 Eyebrow ptosis repair – simple skin excision – non-cosmetic - unilateral
  - P61361 Eyebrow ptosis repair – simple skin excision – non-cosmetic - bilateral
  - P61368 Extensor - primary or secondary repair - first tendon
- 70041 Fine needle aspiration of solid or cystic lesion
- V70116 Removal of tumor (including intraoral) or scar revision - 2 to 5 cm (operation only)

## GENERAL SERVICES - Continued

- V70117 Removal of tumor (including intraoral) - 5.1 cm to 10 cm
- V70119 Single flap under 2 cm in diameter used in repair of a defect (except for special areas as in V70124) (operation only)
- V70120 Single flap for lesion greater than 2 cm
- V70121 Single flap for lesion greater than 2 cm with free skin graft to secondary defect
- V70122 Multiple flap for lesion greater than 2 cm
- V70123 Multiple flap for lesion greater than 2 cm with free skin graft to secondary defect
- V70124 Eyebrow, eyelid, lip, nose - single
  - 70470 Breast biopsy incisional
  - 70471 Breast biopsy excisional
  - 70472 Stereotactic or ultrasound-guided core needle biopsy: 1 to 5 core samples
  - 70473 Stereotactic or ultrasound-guided core needle biopsy: 6 to 10 core samples
  - 70547 Oesophagogastroduodenoscopy, including collection of specimen(s) by brushing or washing – with band ligation of oesophageal varices (including endoscopy) (operation only)
- PS71281 Removal of indwelling enteral tubes with or without exploration of tube insertion site: - requiring local or regional anesthesia (operation only)
- PSV71682 Botox injection for anal fissure
  - 71684 Papillectomy or excision of anal tag or polyp - single
  - 71686 Papillectomy or excision anal tag or polyp - multiple
  - 71690 Hemorrhoid(s); office procedure - infrared photocoagulation to include proctoscopy
  - 72669 Excision rectal Tumour - 0 to 2.5
  - 72670 Excision rectal Tumour - 2.6 to 5 cm
  - 72672 Electrodesiccation or fulguration of malignant Tumour of rectum
  - 77045 Varicose veins, injection, each visit
    - NOTE: Treatment for cosmetic purposes is not a benefit under MSP.
  - 77046 Ultrasound directed (with image capture) foam sclerotherapy - initial
  - 77047 Ultrasound directed (with image capture) foam sclerotherapy - repeat
  - 77050 Compression sclerotherapy - initial
  - 77060 Compression sclerotherapy - repeat
  - 77065 High ligation, long saphenous
- P77142 Removal of totally implantable access device (e.g.: portacath), operation only
- 77390 Removal of hemodialysis shunt

### **Procedures Eligible for Minor Tray Fee Service:**

- 00019 Venesection for polycythemia or phlebotomy
- \*00218 Curettage and electrosurgery of skin carcinoma
- \*00219 Curettage of skin carcinoma, additional lesion
- 00424 Botulinum toxin injection
- S00743 Breast lesion, non-palpable localizing
- S00762 Scratch test, per antigen
  - Note: Minor tray fee 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 fee 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

## GENERAL SERVICES - Continued

- S00803 Loopogram
- S00811 Joint injection, aspiration or arthrogram, under radiological guidance
  - 01042 Nerve block paravertebral sympathetic
  - 01124 Peripheral nerve block - single
  - 01125 Peripheral nerve block - multiple
- S02076 Botulinum toxin injection for strabismus
- S02118 Snip procedure, two or three
- S02119 Dacryocystostomy
- S02120 Punctum dilation
- S02122 Lacrimal duct probing local anesthetic
- S02147 Trichiasis, electric
- S02148 Cryotherapy of eyelids
- S02167 Cauterization or cryotherapy of corneal ulcer
  - 02210 Paracentesis of the ear drum
  - 02221 Aural polyp removal or debridement, foreign body removal
  - 02303 Cauterization of septum, electric
  - 02364 Nasal fracture - simple reduction
- S02365 Nasal fracture - reduction and splinting
  - 02452 Sialolithotomy - simple, in duct
  - 04305 Venereal warts
  - 04503 Cervix, cryosurgery, cautery or excision
  - 04509 Cervical polypectomy
  - 04533 Electric cauterization, cervix
- 06028 Abscess, web space
- 06271 Alveolar fracture
- 07678 Abscess - perianal, I & D, superficial
- 08601 Radiographic study of sinus, fistula, etc., with contrast media, including injection and fluoroscopy, if necessary
- 13605 Abscess, superficial opening, including furuncle
- 13610 Laceration or foreign body, minor (not requiring anesthesia)
- 13630 Paronychia
- 13631 Nail removal
- P20231 Biopsy, not sutured
- P20232 Biopsy, not sutured, multiples same sitting, maximum of four (extra)
- P61291 Biopsy, not sutured
  - 70469 Breast biopsy - needle core
  - 70674 Destruction of anal lesion, anus fulguration and condylomata
- PS71280 Removal of indwelling enteral tubes with or without exploration of tube insertion site:
  - not requiring anesthesia (operation only)
  - 71689 Hemorrhoid(s); office procedure (e.g.: band ligation), to include proctoscopy

**Procedures Eligible for Mini Tray Fee Service:**

- 00190 Forms of treatment other than excision, x-ray or Grenz ray, such as removal of hemangiomas and warts with electrosurgery, cryotherapy, etc., per visit
- 00217 Treatment of skin disorders and lesions other than: ultraviolet, x-ray, Grenz ray, such as cryosurgery, etc. - extra
- S00744 Thyroid biopsy
- 14560 Routine pelvic examination including Papanicolaou smear

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Individual Tray Fee Items:</b>			
00094 YAG laser tray service fee .....	165.00		65.33

NOTES:

- i) Applicable to fee items 22113 and 22115 only.
- ii) Hospitals and physicians who use hospital based YAG lasers are not eligible to bill this fee.

## **OUT-OF-OFFICE HOURS PREMIUMS** **(Applicable to General Practitioners and Specialists)**

### **EXPLANATORY NOTES**

- a) The out-of-office hour 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 also are 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 and 94005) are not payable in addition to the out-of-office hours premium. Neither are emergency visits payable to the attending surgeon (or his/her substitute) within 10 post-operative days from a surgical procedure (except "operation only" procedures).
- g) The non-operative continuing care surcharge applies to delivery only (not standby time or first stage of labour). State in the note field the continuous time spent with the patient during second or third stage of labour only.
- h) These items are not applicable to full- or part-time emergency physicians, or physicians designated by a hospital emergency room as the on duty/on site physician. Those physicians are referred to the Emergency Medicine section of this Guide.

OUT-OF-OFFICE HOURS PREMIUMS - Continued

- 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 general practitioners, 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 the Medical Services Plan 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.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**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) .....	147.00	72.17
01201 Night (call placed and service rendered between 2300 hours and 0800 hours).....	206.00	101.35
01202 Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours). .....	147.00	72.17

NOTE: Claims must state time service rendered.

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

**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 .....	135.00	66.36
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof .....	185.00	90.73
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof.....	135.00	66.36

**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.

**b) OPERATIVE**

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

01210	Evening (1800 hours to 2300 hours) – 44.46% of surgical (or assistant) fee		
	– minimum charge .....	131.00	64.32
	– maximum charge .....	905.00	443.67



OUT-OF-OFFICE HOURS PREMIUMS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
01211 Night (2300 hours to 0800 hours) – 71.37% of surgical (or assistant) fee		
– minimum charge .....	185.00	90.32
– maximum charge .....	1271.00	623.05
01212 Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 44.46% of surgical (or assistant) fee		
– minimum charge .....	131.00	64.32
– maximum charge .....	905.00	443.67

NOTES:

- i) When emergency surgery commences within evening time period (1800–2300 hours) and continues into nighttime period (2300–0800 hours), 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 hours, even if the major portion of the surgical time is after 1800 hours, surgical surcharges are not applicable.
- iii) If emergency surgery commences prior to 0800 hours and continues after 0800 hours, surcharges are applicable to the entire surgical time.
- iv) State time surgery commenced.

**These items are not applicable to full or part time emergency practitioners, designated by a hospital**

- c) emergency room as the on duty/on site physician and billing under the Emergency Medicine Section of the Payment Schedule.**

**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.

*(continued on next page)*

OUT-OF-OFFICE HOURS PREMIUMS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p>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:</p> <ul style="list-style-type: none"> <li>i) as an emergency</li> <li>ii) to provide subsequent resuscitative care under fee code 01088.</li> <li>iii) to provide labour epidural insertion under fee code 01102.</li> </ul> <p>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.</p>		
01215 Evening (service rendered between 1800 hours and 2300 hours) - per half hour or major part thereof .....	135.00	66.36
01216 Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof .....	185.00	90.73
01217 Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof.....	135.00	66.36

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 surcharges in these cases is payable after 15 minutes of continuous care (i.e. 1815 hours).
- (notes continued on next page)*

OUT-OF-OFFICE HOURS PREMIUMS - Continued

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- 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.

## DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES

These fees cannot be correctly interpreted without reference to the Preamble.  
Letter prefix 'Y' indicates office or hospital visits on same day are additional to the procedure fee.

*NOTE: The word "extra" implies that the second procedure at the same sitting is charged at 100% of listed fee. The third and subsequent different procedure at the same sitting is charged at 50% of listed fee.*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION</b>			
S00700 Bronchoscopy or bronchofibroscopy - procedural fee .....	288.00	4	117.42
S00702 Bronchoscopy with biopsy - procedural fee .....	531.00	4	207.08
10700 Endobronchial cautery - extra .....	193.00	6	76.47
NOTES:			
i) To a maximum of 3 lesions.			
ii) Second and third lesion payable at 50%			
iii) Payable only with S00700 or S00702 and 10702, P10703, S00736			
iv) Not payable with P10739 or 02450			
10702 Endobronchial cryotherapy - extra.....	193.00	6	76.47
NOTES:			
To a maximum of 3 lesions			
Second and third lesion payable at 50%			
Payable only with S00700 or S00702 and 10700, P10703, S00736			
Not paid with P10739, 02450 and 02422			
P10703 Transbronchial Needle Aspiration (TBNA) .....	127.00	6	69.64
NOTES:			
i) To a maximum of 3 separate stations or lesions			
ii) Second and third station or lesion payable at 100%			
iii) Payable with S00700, S00702 or P10739 and 10700, 10702, S00736			
iv) Paid at 100% with other diagnostic procedures.			
S00719 Thoracoscopy .....	464.00	7	329.62
S00701 Direct laryngoscopy - procedural fee.....	141.00	5	37.70
NOTE: S00701 not payable with bronchoscopy, except when done under general anesthesia.			
S00717 Microlaryngoscopy - procedural fee .....	277.00	5	75.39
<i>(see note on next page)</i>			

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)	
NOTE: S00717 to be charged at 50% if performed with a surgical procedure (see also fee items 02423, 02428 and 02429).				
SY00907	Endoscopic flexible or rigid examination of the nose and nasopharynx - procedure only .....	122.00	3	33.07
SY00908	– procedure and biopsy .....	197.00	3	52.89
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy .....	145.00	3	39.06
NOTES:				
i) SY00909 is not payable with S00700, S00702, SY00907, SY00908 or 02540.				
ii) Billable only by certified Otolaryngologists.				
S00704	Cystoscopy to include dilation and panendoscopy - procedural fee .....	347.00	2	95.37
S00705	Cystoscopy with catheterization of ureters (with kidney function test and injection of solution for pyelogram) to include dilation and panendoscopy - procedural fee .....	370.00	2	101.51
<b>Upper Gastrointestinal System</b>				
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee.....	400.00	3	89.73
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing - procedural fee .	332.00	3	74.74
S10763	Initial esophageal, gastric or duodenal biopsy .....	128.00	3	29.06
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, Eosinophilic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma .....	196.00	3	43.58
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.				
PSY10750	Transnasal esophagogastroduodenoscopy (TGD), procedural fee .....	299.00		89.73
NOTE: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.				

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
P10708 Video capsule endoscopy using M2A capsule – professional fee NOTE: Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have ruled out other causes.	727.00		256.63
<b>Lower Gastrointestinal System</b>			
SY00715 Sigmoidoscopy with biopsy - procedural fee .....	145.00	2	37.98
SY10714 Proctosigmoidoscopy, rigid - diagnostic .....	141.00	2	35.40
SY00716 Sigmoidoscopy, flexible - diagnostic.....	263.00	2	76.09
SY00718 – with biopsy .....	335.00	2	77.34
S10730 Colonoscopy, flexible, via colostomy - single or multiple.....	978.00	4	240.14
S10731 Colonoscopy, flexible, proximal to splenic flexure - diagnostic, with or without collection of specimen(s) by brushing or washing .....	978.00	2	231.61
S10732 – with removal of foreign body .....	1108.00	2	272.07
S10733 – with control of bleeding, any method.....	1241.00	2	303.99
Notes:			
i) Proctosigmoidoscopy is the examination of the rectum and sigmoid colon.			
i) Sigmoidoscopy is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.			
ii) 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 .....	330.00	4	195.57
10900 Abdominal aortic aneurysm repair using endovascular stent graft – second operator .....	2380.00		509.83
Notes:			
i) Intraoperative renal artery angioplasty payable in addition at 50% of fee item S00982 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.			

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10901 Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery .....	1443.00	2	587.65
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 Peripherally inserted image-guided central venous catheter line (PICC) .....	273.00	2	111.94
NOTES:			
i) Interventional Radiology consultation not payable in addition, regardless of when rendered.			
ii) Not applicable if performed via other than peripheral access			
iii) Includes placement, venogram/angiogram, and all medically required image guidance.			
iv) May not be delegated.			
10903 Percutaneous hemodialysis graft thrombolysis .....	1443.00	2	587.65
NOTES:			
i) Includes declotting and treatment of underlying cause of access failure			
ii) Includes angioplasty and all necessary imaging and intervention			
iii) Consultation not payable in addition, regardless of when rendered.			
iv) An interventional radiology consultation is not payable unless the procedure is cancelled.			
P10904 Percutaneous transcatheter arterial chemo-embolization (TACE) .....	1443.00	3	587.65
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.			
P10905 Cerebral intra-arterial thrombolysis .....	3288.00	5	1307.68
<i>(see notes on next page)</i>			

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Notes:			
i) Payable only once, regardless of number of arterial territories treated			
ii) Includes all diagnostic and superselective angiograms performed during procedure and immediate post procedure CT scans			
iii) An interventional radiology consultation is not payable unless the procedure is cancelled.			
10906			
Image-guided percutaneous vertebroplasty – first level.....	959.00	4	363.79
10907			
– each additional level (to a maximum of 3).....	225.00	4	83.96
NOTES:			
i) Payable only when rendered on in-patient or day-care basis in acute care facility.			
ii) Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating.			
iii) Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure			
iv) Interventional Radiology consultation not payable unless the procedure is cancelled.			
10908			
Percutaneous image-guided tumour ablation – first lesion.....	1443.00	3	528.39
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 the same session – 100% for first lesion, 75% for second lesion and 25% for third lesion.			
iii) Includes all CT and ultrasound guidance necessary to complete the procedure.			
iv) Paid at 50% if repeated within 30 days.			
v) Interventional Radiology consultation is payable			
P10909			
Percutaneous intravascular/intracorporeal medical device/foreign body removal .....	959.00	3	391.78
<i>(see notes on next page)</i>			



DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
NOTES:			
i) All angiography, angioplasty and/or intravascular stenting included.			
ii) If a second or third foreign body/medical device is removed, payable at 50% each to a total maximum of three.			
iii) An interventional radiology consultation is not payable unless the procedure is cancelled.			
P10911 Selective salpingography/fallopian tube recanalization (FTR) .....	959.00	2	391.78

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 it is used to correct scarring of the fallopian tubes after reversal of tubal ligation.			
iv) Any imaging related to the procedure is inclusive.			
v) An interventional radiology consultation is not payable unless the procedure is cancelled.			
P10912 Transjugular liver/renal biopsy .....	959.00	2	391.78

- NOTES:
- i) Ultrasound guidance, venous puncture, central access catheter are included in the fee.
  - ii) Payable only for uncorrectable coagulopathy.
  - iii) The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day.
  - iv) If repeated within 6 months, payable at 50%.
  - v) An interventional radiology consultation is not payable unless the procedure is cancelled.

**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 on contrast material.

S00722 Arteriography, operative - procedural fee.....	308.00		75.51
S00721 Myelogram - procedural fee .....	111.00	2	44.04
S00723 Sialogram (per duct) or galactograms (per blast) - procedure fee for injection.....	105.00	2	46.96
S00724 Presacral air insufflation - procedural fee.....	105.00	2	39.04
S00727 Salpingogram - procedural fee.....	175.00	2	74.93

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00728 Orthodiagram - procedural fee .....	42.45	2	11.87
S00729 Fluoroscopy of chest by internist or pediatrician - procedural fee .....	49.15		11.11
S00730 Catheterization of bronchi for bronchogram - procedural fee .....	72.90	4	27.39
NOTE: When performed in conjunction with a bronchoscopy (S00700) both fees are to be paid in full.			
S00732 Voiding cystourethrogram - procedural fee .....	40.05	2	19.67
NOTE: When done in conjunction with 08599			
S00733 Venogram, intraosseous or intravenous - procedural fee .....	164.00	2	59.38
S00734 Lymphangiography or lymphography - surgical component (See item 08614) .....	363.00		130.52
S00736 Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee (extra) .....	288.00	4	66.73
P10739 Endobronchial Ultrasound (EBUS) .....	959.00	6	387.16
NOTES:			
i) Not payable with S00700, S00702, 02450, 10700 or 10702			
i) Fee item P10703 an S00736 payable in addition			
S00743 Localizing of non-palpable breast lesion .....	246.00	2	120.67
S00811 Joint injection, aspiration or arthrogram, under radiological guidance - procedural fee .....	110.00	2	53.13
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.			
S00826 Biopsy of pancreas - percutaneous .....	331.00	2	101.44
S00857 Percutaneous transhepatic cholangiogram - included in fee item S00980. ....	259.00	2	113.15
S00868 Percutaneous gastrostomy/gastrojejunostomy - procedural fee .....	1043.00	2	275.79
P10735 Rectal endoscopy utilizing ultrasound (radial/linear) . Note: Includes mucosal biopsy	429.00		153.99
P10740 Upper GI endoscopy utilizing radial ultrasound .....	750.00		256.63
P10741 Upper GI endoscopy utilizing linear ultrasound .....	750.00		256.63
<i>(see notes on next page)</i>			

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

NOTES:

- i) P10740 and P10741 are payable only when done in publicly funded acute care facilities.
- ii) P10741 payable at 50% when done subsequent to P10740 (same patient/same day)

P10742 Upper GI endoscopy utilizing radial/linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 per lesion. ....	148.00		51.33
---	--------	--	-------

NOTES:

- i) Payable with P10740 or P10741 only.
- ii) First biopsy paid at 100%. Second and third biopsies payable at 50%

P10743 Upper GI endoscopy utilizing radial/linear ultrasound – with injection of one or more of any of the following – metastases, nodes, masses or celiac plexus – extra .....	429.00		153.99
---	--------	--	--------

NOTE: Payable with P10740 or P10741 only.

P10744 Upper GI endoscopy utilizing radial/linear ultrasound – with drainage of pseudocyst (including stent insertion if performed) – extra .....	573.00		205.32
---	--------	--	--------

NOTE: Payable with P10740 or P10741 only.

**THERAPEUTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT**

S00738 Removal of biliary calculi by Burhenne technique.....	514.00	4	205.35
S00746 Reduction of intussusception using hydrostatic pressure, procedural fee .....	241.00	4	97.16
NOTE: Fee item 08576 is payable in addition, when performed.			
S00921 Varicocele and/or uterine artery embolization - unilateral .....	1056.00	3	463.39
S00925 Varicocele and/or uterine artery embolization - bilateral .....	1471.00	3	672.22

NOTES:

- i) Fee items S00921 and S00925 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 S00921 and S00925.

S00977 Antegrade pyelogram (not billable in conjunction with S00978 or S00979) .....	242.00	2	105.87
--	--------	---	--------

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00978 Percutaneous nephrostomy - procedural fee .....	631.00	2	300.12
S00979 Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation - procedural fee .....	834.00	2	400.08
S00980 Transhepatic biliary drainage procedure (includes fee item S00857) .....	883.00	3	423.99
S00981 Therapeutic radiological embolization .....	883.00	3	423.99
S00982 Percutaneous transluminal angioplasty .....	842.00	2	404.15
NOTES:			
i) Includes one step procedure involving inflation and deployment of a stent.			
ii) When stent is not deployed initially and follows angioplasty (two step), bill the stent as fee item 10919 at 50%.			
S00983 Percutaneous abdominal abscess drainage by catheter insertion .....	514.00	2	276.05
S00984 Exchange of previously inserted catheter or tract dilatation for percutaneous biliary or renal drainage..	289.00	2	126.46
S00989 Extra-corporeal shockwave lithotripsy .....	450.00	4	136.17
S00994 Extra-corporeal shockwave biliary lithotripsy - procedure only .....	431.00	4	166.54
NOTES:			
i) S00994 generally is applicable to common bile duct stones, only.			
ii) S00994 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 applies.			
00995 Embolization of brain and spinal cord AVM's .....	5094.00	3	2091.29
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 .....	3502.00	3	1307.68
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 .....	4321.00	3	1612.74
<i>(see notes on next page)</i>			

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

NOTES:

- i) 00995, S00997, and 00998 include the consultations associated with the procedure performed, preparation of the embolizing agent(s) and catheter(s), catheterization(s) and follow-up care of the patient by the radiologist.
- ii) 00995, S00997 and 00998 are billable only by physicians with appropriate training in interventional neuroradiology.
- iii) 00995, S00997 and 00998 are payable once per day, regardless of the number of embolizations or catheterizations performed, or balloons inserted.
- iv) 00995 and 00998 include:
  - a) Diagnostic angiograms done during the procedure.
  - b) Angiograms performed as a separate procedure before or after the embolization are billable.
  - c) Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted embolization procedure. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of \$1,700. Claims must be accompanied by written details of vessels injected.
  - d) Repeat procedures performed by the same physician and done within 30 days of the original procedure will be paid at 75% of the original fee.
- v) Includes 10913 if performed on same day as 00995, S00997 or 00998.

10913	Cerebral arterial balloon occlusion tolerance test ..... (see notes on next page)	1695.00	5	796.15
-------	--	---------	---	--------

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

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;
- 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 (10915) or embolization (00995, S00997, 00998) if performed on the same day.

10914 Percutaneous balloon angioplasty for cerebral vasospasm .....	2172.00	9	1023.28
---	---------	---	---------

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 S00982.
- 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% for the first angiogram and 50% 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 P10905.

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10915 Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique .....	4239.00	7	1990.40
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%; 3rd - 25% (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% for the first angiogram and 50% for subsequent angiograms, to a maximum of 75% of fee item 10915. Claims must be accompanied by written details of vessels injected.			
10918 Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance.....	996.00	6	468.33
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 .....	308.00		129.12
NOTES:			
i) Includes all diagnostic imaging associated with stent placement.			

*(notes continued on next page)*

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
ii) Payable once only when contiguous vessels are stented and/or where more than one stent is used per site.			
iii) When stent is not deployed initially and follows angioplasty procedure (00982) (two step), 10919 payable at 50%.			
iv) Placement of second stent in non-contiguous site payable at 50%.			
v) Procedures repeated within 30 days are payable at 50%. Not payable for Coronary stent placement.			
vi) Not payable for Coronary stent placement.			
vii) When done with 77177 (EVAR), payable to either the primary or the second operator			
10920 Intracorporeal stent placement - extra .....	308.00		129.12
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%.			

**NEEDLE BIOPSY PROCEDURES**

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

S00739 Percutaneous lung or mediastinal biopsy - procedural fee .....	220.00	2	106.79
S00740 Liver biopsy - procedural fee .....	175.00	2	105.37
S00741 Splenic biopsy - procedural fee .....	175.00	2	105.37
S00742 Renal biopsy - procedural fee .....	242.00	2	106.79
S00744 Thyroid biopsy - procedural fee .....	223.00	2	71.92
S00745 Peripheral or subcutaneous lymph node biopsy - procedural fee .....	174.00	2	48.94



DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00747 Prostate biopsy - procedural fee .....	119.00	2	32.47
S00748 Bone biopsy under local/regional anesthetic.....	143.00		63.72
S00749 Parietal pleural, including thoracentesis - procedural fee .....	200.00	2	130.41
S00844 Biopsy of salivary gland, fine needle or core needle ..	220.00	3	54.02

**PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS  
(When performed for diagnostic purposes)**

SY00750 Lumbar puncture in a patient 13 years of age and over .....	209.00	2	54.99
Note: Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.			
S00751 Pericardial puncture - procedural fee .....	200.00	3	165.44
S00752 Cisternal puncture - procedural fee .....	105.00	2	38.28
S00753 Marrow aspiration - procedural fee .....	145.00	2	43.77
S00755 Artery puncture - procedural fee .....	29.85	2	6.38
SY00757 Joint aspiration - procedural fee (not in addition to 00014 or 00015) - other joints .....	42.45	2	11.99
S00759 Paracentesis (thoracic) or transtracheal aspiration - procedural fee .....	96.40	2	84.00
S00760 Paracentesis (abdominal) - procedural fee .....	69.70	2	25.79
S00761 Cyst or bursa - procedural fee.....	124.00	2	14.60

**ALLERGY, PATCH AND PHOTOPATCH TESTS**

S00762 Scratch test - per antigen.....	7.00		1.06
Note: Minor tray fee may be paid in addition if a minimum of 16 antigens are used.			
S00763 – children under 5 years of age - per antigen .....	7.45		2.32
Note: Minor tray fee may be paid in addition if a minimum of 14 antigens are used.			
S00764 Intracutaneous test - per test .....	9.95		2.15
S00765 Annual maximum (to include scratch or intracutaneous tests) per patient for each physician ..	159.00		34.40
S00767 Patch testing (extra) - annual maximum is 80 tests - per test .....	6.45		1.96
S00768 Photopatch test - per test.....	37.75		5.66
S00769 Photopatch test - annual maximum.....	378.00		56.69

**EXAMINATION UNDER ANESTHESIA  
(When done as independent procedure)**

S00770 Pelvic examination under anesthesia when done as an independent procedure - procedural fee .....	322.00	2	150.00
S00771 Retinal examination under anesthesia - procedural fee .....	88.20	3	20.08

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>GYNECOLOGICAL</b>			
S00775 Hydrotubation .....	123.00		44.57
NOTE: When S00775 is done in conjunction with laparoscopy, fee included in laparoscopy fee.			
S00776 Fetal scalp sampling .....	123.00		44.57
S00782 Needle aspiration of pouch of Douglas - procedural fee .....	95.50	2	35.33
S00783 Huhner's Test - procedural fee .....	123.00		44.57
S00784 Cervix punch biopsy - procedural fee .....	48.00	2	19.23
S00785 Endometrial biopsy - procedural fee .....	123.00	2	44.57
NOTE: Includes Pap smear if required.			
S00786 Pelvic examination with needle aspiration of Pouch Douglas under anesthesia when not followed by a surgical procedure by the same surgeon .....	170.00	2	46.94
S00787 Transabdominal amniocentesis .....	266.00	2	87.80
S00790 Antepartum fetal heart monitoring (not to be charged for intrapartum fetal heart monitoring nor when done in conjunction with a consultation) - professional fee .....	52.70		17.61
S00794 Chorionic villus sampling .....	368.00	2	120.73
NOTE: Includes ultrasound guidance of the villus biopsy.			
S00807 Diagnostic hysteroscopy .....	354.00	2	123.29
NOTE: Not payable in addition to a D&C.			
S00808 Diagnostic hysteroscopy with biopsy(s), includes D&C .....	542.00	2	187.08
S00815 Laparoscopically directed biopsies and/or lysis of adhesions (extra) .....	175.00	4	62.32
S00819 Diagnostic vaginotomy, under general anesthetic ...	354.00	2	123.31
NOTES:			
i) Payable only for premenarchal patients unless medical necessity provided in the note record.			
ii) Not billable in addition to hysteroscopy.			
<b>UROLOGICAL</b>			
S00802 Urethrogram .....	144.00	2	39.53
S00792 Cystoureterogram - technical fee .....	35.60	2	12.48
S00793 – professional fee .....	18.90		6.24
S00799 Transurethral ureterorenoscopy to include C&P .....	575.00		158.13
S00800 Transurethral ureterorenoscopy with x-ray control to include C&P .....	1397.00	2	384.37
S00803 Loopogram .....	151.00		54.51

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00866 Dynamic cavernosometry and cavernosography ..... NOTE: Interpretation of x-ray is included in technical portion and is not billable in addition to procedure.	288.00	2	79.05
S00878 Cystometry, to include pelvic floor EMG .....	206.00		56.24
S00874 Urethral profilometry (water or gas) .....	72.50		19.77
S00875 Uroflowimetry (with sphincter EMG with or without pharmacologic manipulation) .....	116.00		31.64
S00876 Video uro-dynamics (full study) includes S00874, S00875 and S00878. ....	560.00		154.16

**MISCELLANEOUS**

S00780 Schirmer's test (included in fee item 02015) .....	57.80		13.15
SY00789 Peritoneal lavage .....	281.00	2	85.74
S00797 Esophageal motility test .....	561.00		176.15
S00788 – technical fee .....	300.00		74.35
S00798 – professional fee .....	259.00		101.79
S00818 Esophageal pH study for reflux (extra) - professional fee.....	177.00		40.82
S00817 – technical fee .....	54.40		12.44
S00809 Retrograde pancreatography .....	937.00	3	216.54
S00869 Manometry, anal - adult .....	259.00	2	101.37
P10320 Insertion of permanent pleural drainage catheter..... NOTES: i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter. ii) Not paid with 32031, 00749, 07924 and 08646	543.00	5	231.19
P10321 Removal of permanent pleural drainage catheter ..... NOTE: Not paid with 32031, 00749, 07924 and 08646.	287.00	2	68.71
Removal of indwelling Enteral tubes with or without exploration of tube insertion site:			
PS71280 - not requiring anesthesia (operation only)			
PS71281 requiring local or regional anesthesia (operation only)			
PS71282 requiring general anesthesia (operation only)			
PS71283 replacement of tube - extra			

(see notes on next page)

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

NOTES:

- i) Tray fee is not paid when the procedure is performed in hospital or publicly funded facilities (D&T centers, psychiatric facilities).
- ii) Not paid with Fee item 07517, 07518, 07519, 07562, 07781, 07782, 07783, and 70637.
- iii) Restricted to General Surgeons.

**CARDIO-VASCULAR PROCEDURES**

S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee .....	96.40		22.10
S00810	Right heart catheterization - by duly qualified specialist .....	724.00	4	165.44
S00812	Selective angiocardioqram (extra) - by duly qualified specialist .....	242.00	4	55.52
S00813	Ergonovine provocative testing for coronary artery spasm.....	351.00	4	79.14
S00814	Dye dilution studies (extra) - by duly qualified specialist .....	242.00	4	55.52
S00816	Hydrogen ion study .....	119.00	2	28.96
S00830	Trans-septal left heart catheterization - by duly qualified specialist.....	886.00	4	234.36
S00839	Direct intracoronary streptokinase thrombolysis.....	1447.00	4	360.09
	NOTE: When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).			
S00842	Percutaneous coronary intervention – for additional vessel(s), per vessel.....	819.00		189.01

NOTES:

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

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

Right Coronary:

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

*(notes continued on next page)*

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>• Second right posterolateral artery</li> <li>• Acute marginal artery</li> <li>• Inferior septal artery</li> </ul>			
Left Coronary:			
<ul style="list-style-type: none"> <li>• Left main coronary artery</li> <li>• Left anterior descending artery</li> <li>• First diagonal artery</li> <li>• Second diagonal artery</li> <li>• Ramus artery</li> <li>• Circumflex artery</li> <li>• First obtuse marginal artery</li> <li>• Second obtuse marginal artery</li> <li>• Third obtuse marginal artery</li> <li>• Left atrioventricular artery</li> <li>• First left posterolateral artery</li> <li>• Second left posterolateral artery</li> <li>• Left posterior descending artery</li> <li>• First septal artery</li> </ul>			
S00843 Selective arteriography or venography of any abdominal branch by catheter (extra) - first branch (each additional branch 50% extra) .....	253.00	2	100.64
S00847 Selective arteriography of any thoracic aortic branch, excluding coronaries (extra) - first branch (each additional branch 50% extra) .....	411.00	2	163.17
Pulse tracing, including interpretation:			
S00871 – intravascular including both arterial and venous	242.00		55.52
S00880 Portal pressures - hepatic vein wedge pressure - by duly qualified specialist .....	242.00		65.66
S00881 – percutaneous splenic portal pressure.....	200.00	2	52.55
S00898 Balloon septostomy.....	1272.00	7	336.90
S00890 Aortogram - abdominal - procedural fee .....	289.00	2	115.88
S00897 – thoracic - procedural fee (extra except when part of a retrograde left heart catheterization) .	420.00	2	166.58
S00892 Arteriogram - procedural fee - carotid percutaneous - unilateral .....	321.00	3	114.52
S00891 – bilateral.....	468.00	3	172.20
S00893 – femoral or axillary .....	233.00	2	88.68
S00894 – cerebral - by dissection.....	522.00	3	193.05
S00853 Superior venacavogram (by indirect means).....	78.10	2	24.18
S00854 Inferior venacavogram .....	289.00	2	115.88
S00855 Selective catheterization of branches of inferior vena cava or iliac system - first branch .....	225.00	2	90.00
S00856 – others .....	151.00	2	59.83

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00888 Ventriculogram, when no ventricular access device is present (i.e. ventricular reservoir, VP shunt or drain).....	727.00	3	256.41
S00889 Ventriculogram, through previously placed ventricular access device, drain or catheter .....	365.00	3	128.22
S00896 Pulmonary arteriography .....	393.00	3	140.67
S00885 Digital angiography - peripheral injection .....	113.00	2	46.83
NOTE: S00885 includes catheterization and contrast injection(s).			
S00857 Percutaneous transhepatic cholangiogram (included in fee item S00980).....	259.00	2	113.15
S00919 Impedance plethysmography - professional fee .....	24.20		6.89
S00920 – technical fee.....	119.00		34.55
10916 Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations - up to 4 hours procedural time .....	3107.00	5	1170.81
10917 – after 4 hours (extra to 10916) .....	637.00		292.72

NOTES:

- i) Includes injection of six or more intracranial or extracranial vessels in the head, neck and/or spine, or if procedure requires use of microcatheters, injection of four or more vessels.
- ii) Start and stop 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.

**CARDIOLOGY ASSISTANT FEES**

00845 First hour or fraction thereof .....	242.00		111.04
00846 After one hour, for each 15 minutes or fraction thereof .....	49.15		27.77
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

**ELECTRODIAGNOSIS**

**Items Under:**

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

**Bill According To:**

S00900	Schedule A - extensive examination (8 or more items) .....	465.00		121.85
S00901	Schedule B - limited examination (4 to 7 items) .....	324.00		81.49
S00902	Schedule C - short examination (1 to 3 items) .....	159.00		40.61
S00923	Technical fee for electrodiagnostic testing .....	78.70		20.39
S00905	Daily measurements of nerve conduction thresholds in facial palsy .....	24.30		6.35
S00906	– maximum per course .....	161.00		44.15
S00914	Insertion of sphenoidal electrodes temporal lobe epilepsy - EEG recording .....	161.00		43.61
S00915	Intra-carotid injection of sodium amytal - speech localization test .....	357.00	2	98.01
S00926	Seizure activation with intravenous activating agents associated with insertion of sphenoidal and/or orbital electrodes .....	532.00	2	147.86
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests .....	168.00		57.26
S00927	Decamethonium test - for attendance at and follow-up observation if necessary .....	152.00		34.34
S00944	Tilt table testing with continuous ECG monitoring and automatic BP recording - total fee .....	1268.00		290.15
S00947	– professional fee .....	688.00		178.57
S00948	– technical fee .....	522.00		111.59

**NOTES:**

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>POLYSOMNOGRAM/OVERNIGHT HOME OXIMETRY</b>			
Overnight home oximetry (continuous recording of oxygen and pulse) .....			
S00910 – professional fee .....	114.00		27.90
S00911 – technical fee.....	60.40		15.62
NOTE: Fee items S00910 and S00911 are limited to Category III pulmonary function diagnostic facilities and/or polysomnography diagnostic facilities with the established personnel qualifications for such facilities.			
S11915 Standard polysomnography - professional fee .....	448.00		167.40
S11916 Standard polysomnography - technical fee .....	1037.00		387.02
S11917 Two-night polysomnography - professional fee .....	672.00		251.10
S11918 Two-night polysomnography - technical fee .....	2071.00		774.04
NOTE: Fee items S11917 and S11918 are restricted to the UBC Sleep Laboratory at this time.			
S11919 Multiple sleep latency test (MSLT) - professional fee	223.00		83.70
S11920 Multiple sleep latency test (MSLT) - technical fee .....	518.00		193.51
PS11925 Four channel home polysomnography – Professional fee .....	210.00		83.61
PS11926 Four channel home polysomnography – Technical fee .....	210.00		83.86
<b>PULMONARY INVESTIGATIVE AND FUNCTION STUDIES</b>			
S00930 Peak expiratory flow rate.....	26.10		5.54
NOTE: Fee item S00930 payable when performed in physician’s office (not restricted to an accredited facility).			
<b>Diagnostic Procedures:</b>			
S00928 Simple screening spirometry with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus - without bronchodilators .....	55.30		12.77
S00929 – before and after bronchodilators .....	82.90		18.90
S00931 Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume - professional fee.....	63.40		14.18
S00932 – technical fee.....	63.40		14.18
S00933 Spirometry - forced expiratory spirogram to include FVC, FEV(i), FEV/FVC ratio MMEFR, etc. - without bronchodilators - professional fee .....	49.15		11.61
S00934 – technical fee.....	49.15		11.11
S00935 – before and after bronchodilators - professional fee.....	55.30		13.27



DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00936 – technical fee .....	63.40		14.18
S00937 Spirometry - flow volume loops - without bronchodilators - professional fee .....	49.15		11.61
S00938 – technical fee .....	82.90		18.20
S00940 – before and after bronchodilators - professional fee .....	63.40		14.68
S00941 – technical fee .....	119.00		26.92
S00942 Diffusion studies with carbon monoxide - at rest or exercise - professional fee .....	67.10		15.11
S00943 – technical fee .....	39.90		12.87
S00945 Detailed pulmonary function studies - professional fee (includes S00931, S00935 and S00942).....	185.00		42.06
S00946 – technical fee (includes S00932, S00936 and S00943).....	176.00		40.29

NOTE: Fee items S00931, S00932, S00933,  
S00934, S00935, S00936, S00942 and S00943  
will be paid at 100%.

**Exercise Studies:**

NOTE: No more than one exercise study item may  
be billed for a single patient on any one day without  
written explanation.

S00950 Progressive exercise test with at least three workloads, measuring ventilation and electro- cardiographic monitoring - professional fee .....	96.40		22.10
S00951 – technical fee .....	145.00		32.59
S00954 Exercise in a steady state at two or more workloads with measurements of ventilation, O <sub>2</sub> and CO <sub>2</sub> exchange, and electro-cardiographic monitoring - professional fee.....	355.00		91.95
S00955 – technical fee .....	228.00		59.06
S00956 Exercise in a steady state at two or more workloads with measurements of ventilation, O <sub>2</sub> and CO <sub>2</sub> exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space - professional fee.....	424.00		109.46
S00957 – technical fee .....	300.00		70.32
S00958 Testing for exercise-induced asthma by serial flow measurements - professional fee .....	96.40		22.35
S00959 – technical fee .....	145.00		32.95

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Miscellaneous Pulmonary Tests:</b>			
S00964 Plethysmography and airway resistance - professional fee .....	57.40		13.47
S00965 – technical fee.....	119.00		26.92
S00968 Inhalation challenge - assessed by serial flow measurements, per day - professional fee .....	159.00		36.41
S00969 – technical fee.....	159.00		36.41
S00970 Precipitin tests - one or more antigens - professional fee .....	49.15		11.11
S00971 – technical fee.....	119.00		26.92
S00972 CO <sub>2</sub> /O <sub>2</sub> responsiveness of respiratory centres by steady state test or rebreathing test - professional fee .....	82.90		18.20
S00973 – technical fee.....	49.15		11.11
S00974 Inspiratory and expiratory muscle strength - professional fee .....	47.75		12.25
S00975 – technical fee.....	47.75		12.72
S11960 Oximetry at rest, with or without Oxygen – professional fee .....	18.25		4.72
S11961 Oximetry at rest, with or without Oxygen – technical fee .....	19.65		5.10
S11962 Oximetry at rest and exercise, with or without Oxygen – professional fee.....	39.40		10.21
S11963 Oximetry at rest and exercise, with or without Oxygen – technical fee.....	61.70		15.94
Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:			
PSY11964 – professional fee .....	37.65		20.57
PSY11965 – technical fee.....	160.00		44.36

NOTES:

- i) Restricted to Respiriologists.
- 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.

**EVOKED RESPONSE PROCEDURES**

S00985 Brainstem auditory evoked response, supra threshold testing for integrity of brainstem function ...	212.00		48.66
---	--------	--	-------

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00986 Somatosensory evoked response - upper extremity..	145.00		37.08
S00987 – upper and lower extremity .....	285.00		64.10
S00988 Visual evoked response.....	321.00		71.89

**ORTHOPAEDIC DIAGNOSTIC PROCEDURES**

**SHOULDER GIRDLE, CLAVICLE AND HUMERUS**

**Incision: Diagnostic, Percutaneous:**

S11200 Arthroscopy shoulder joint.....	1157.00	2	298.77
--	---------	---	--------

**Incision: Diagnostic, Open:**

11215 Arthrotomy shoulder joint or bursa .....	720.00	2	186.72
--	--------	---	--------

**Excision: Diagnostic, Percutaneous:**

S11230 Needle biopsy, under general anesthetic.....	720.00	2	186.72
S11232 Arthroscopy - biopsy, shoulder.....	938.00	2	242.74

**Excision: Diagnostic, Open:**

11245 Biopsy - open.....	939.00	2	242.74
--------------------------	--------	---	--------

**ELBOW, PROXIMAL RADIUS AND ULNA**

**Incision: Diagnostic, Percutaneous:**

S11300 Arthroscopy elbow joint.....	1037.00	2	268.43
S11302 Aspiration - bursa, tendon sheath. ....	90.10	2	23.23

**Incision: Diagnostic, Open:**

11315 Arthrotomy elbow joint .....	720.00	2	186.72
------------------------------------	--------	---	--------

**Excision: Diagnostic, Percutaneous:**

S11330 Needle biopsy, under general anesthetic.....	720.00	2	186.72
S11332 Arthroscopy and biopsy .....	1146.00	2	296.44

**Excision: Diagnostic, Open:**

11345 Open biopsy.....	939.00	2	242.74
------------------------	--------	---	--------

NOTE: Not billable with other procedures on the same joint.

**HAND AND WRIST**

**Incision: Diagnostic, Percutaneous:**

S11400 Arthroscopy wrist joint.....	720.00	2	287.62
S11402 Aspiration - bursa, synovial sheath, etc. ....	90.10	2	23.23

**Incision: Diagnostic, Open:**

11415 Arthrotomy wrist joint (isolated procedure).....	720.00	2	186.72
--	--------	---	--------

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
11416 Arthrotomy - MP, PIP, DIP joints (isolated procedure).....	720.00	2	186.72
<b>Excision: Diagnostic, Percutaneous:</b>			
S11430 Needle biopsy, under general anesthetic .....	720.00	2	186.72
S11432 Arthroscopy and biopsy, wrist /hand joint(s).....	720.00	2	186.72
<b>Excision: Diagnostic, Open:</b>			
11445 Open biopsy, hand or wrist.....	939.00	2	242.74
<b>PELVIS, HIP AND FEMUR</b>			
<b>Incision: Diagnostic, Percutaneous:</b>			
S11500 Arthroscopy hip joint.....	2009.00	3	518.18
S11501 Aspiration hip joint.....	90.10	2	23.23
S11502 Aspiration - bursa, tendon sheath. ....	44.90	2	11.63
<b>Incision: Diagnostic, Open:</b>			
11515 Arthrotomy hip joint .....	1151.00	3	298.77
<b>Excision: Diagnostic, Percutaneous:</b>			
S11530 Needle biopsy, under general anesthetic .....	720.00	2	186.72
S11532 Arthroscopy and biopsy, hip .....	2009.00	3	518.18
<b>Excision: Diagnostic, Open:</b>			
11545 Arthrotomy and biopsy, hip.....	939.00	3	242.74
11546 Biopsy open, soft tissue or bone .....	939.00	2	242.74
<b>FEMUR, KNEE JOINT, TIBIA AND FIBULA</b>			
<b>Incision: Diagnostic, Percutaneous:</b>			
S11600 Arthroscopy knee joint.....	830.00	2	214.73
S11602 Aspiration - bursa, tendon sheath or other peri-articular structures.....	90.10	2	23.23
<b>Incision: Diagnostic, Open:</b>			
11615 Arthrotomy knee joint .....	938.00	3	242.74
<b>Excision: Diagnostic, Percutaneous:</b>			
S11630 Needle biopsy, under general anesthetic .....	720.00	2	186.72
S11632 Arthroscopy - biopsy.....	830.00	2	214.73
<b>Excision: Diagnostic, Open:</b>			
11645 Biopsy - open .....	939.00	2	242.74

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>TIBIAL METAPHYSIS (DISTAL), ANKLE AND FOOT</b>			
<b>Incision: Diagnostic, Percutaneous:</b>			
S11700 Arthroscopy - ankle joint/subtalar joint .....	720.00	2	186.72
S11702 Aspiration - bursa, tendon sheath .....	90.10	2	23.23
<b>Incision: Diagnostic, Open:</b>			
11715 Ankle joint .....	720.00	2	186.72
11716 Subtalar joint .....	720.00	2	186.72
11717 Midtarsal joint.....	720.00	2	186.72
11718 Tarso-metatarsal, metatarsal-phalangeal, interphalangeal joint.....	720.00	2	186.72
<b>Excision: Diagnostic:</b>			
S11730 Needle biopsy, under general anesthetic.....	720.00	2	186.72
11745 Open biopsy, under general anesthetic .....	939.00	2	242.74
<b>VERTEBRA, FACET AND SPINE</b>			
<b>Excision: Diagnostic, Percutaneous:</b>			
S11830 Needle biopsy, soft tissue/bone - thoracic spine, under general anesthetic .....	830.00	2	214.73
S11831 Needle biopsy, soft tissue/bone - lumbar spine, under general anesthetic .....	720.00	2	186.72
<b>Excision: Diagnostic, Open:</b>			
11845 Biopsy, under general anesthetic.....	938.00	3	242.74
NOTE: Not payable with definitive spinal surgery.			

## GENERAL PRACTICE

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

**NOTE: COSMETIC SURGERY** - Physicians should be familiar with 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.

### **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.

In the latter case, the relevant item from that list applies instead of the out-of-office item.

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

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

## CONSULTATIONS

GP Consultations apply when a medical practitioner (GP or Specialist), or a health care practitioner (midwife, for obstetrical or neonatal related consultations; nurse practitioner; oral/dental surgeon, for diseases of mastication), 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 general practitioner 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 GP 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 general practitioner or another general practitioner in the same group during the preceding six months.

12110 Consultation - in office (Age 0 - 1) .....	212.00	84.87
00110 Consultation - in office (Age 2 - 49) .....	192.00	77.15
15310 Consultation - in office (Age 50 – 59).....	212.00	84.87
16110 Consultation - in office (Age 60 - 69).....	222.00	88.73
17110 Consultation - in office (Age 70 - 79).....	241.00	100.29
18110 Consultation - in office (Age 80+).....	251.00	115.75
12210 Consultation - out of office (Age 0 – 1).....	299.00	101.85
13210 Consultation - out of office (Age 2 – 49).....	271.00	92.59
15210 Consultation - out of office (Age 50 – 59).....	299.00	101.85
16210 Consultation - out of office (Age 60 – 69).....	314.00	106.48
17210 Consultation - out of office (Age 70 – 79).....	340.00	120.35
18210 Consultation - out of office (Age 80+) .....	354.00	138.90
00116 Special in-hospital consultation.....	377.00	163.94

*(see notes on next page)*

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

## 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 general practitioner 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) Item 00116 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 general practitioner or another general practitioner in the same group during the preceding six months.

**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 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 the 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.



GENERAL PRACTICE - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
12101 Complete examination - in office (Age 0 - 1).....	195.00	76.83
00101 Complete examination - in office (Age 2 - 49).....	173.00	69.85
15301 Complete examination - in office (Age 50 – 59).....	195.00	76.83
16101 Complete examination - in office (Age 60 - 69).....	202.00	80.32
17101 Complete examination - in office (Age 70 - 79).....	220.00	90.80
18101 Complete examination - in office (Age 80+) .....	227.00	104.79
NOTE: Fee 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).....	232.00	92.20
13201 Complete examination - out of office (Age 2 - 49).....	209.00	83.82
15201 Complete examination - out of office (Age 50 – 59).....	232.00	92.20
16201 Complete examination - out of office (Age 60 - 69).....	242.00	96.39
17201 Complete examination - out of office (Age 70 - 79).....	263.00	108.95
18201 Complete examination - out of office (Age 80+).....	272.00	125.74

**VISITS**

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

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

12100 Visit - in office (Age 0 - 1).....	88.70	34.79
00100 Visit - in office (Age 2 - 49).....	80.50	31.62
15300 Visit - in office (Age 50 - 59).....	88.70	34.79
16100 Visit - in office (Age 60 - 69).....	92.40	36.36
17100 Visit - in office (Age 70 - 79).....	100.00	41.10
18100 Visit - in office (Age 80+).....	105.00	47.44

NOTE: Items 12100, 00100, 15300, 16100, 17100 and 18100 are subject to the daily volume payment rules described earlier in this section.

13070 In office assessment of an unrelated condition(s) in association with a WorkSafe BC service.....	41.45	16.44
--	-------	-------

*(see notes on next page)*

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

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 General Practitioners.

13075 In office assessment of an unrelated condition(s) in association with an ICBC service .....	41.45	16.44
---	-------	-------

NOTES:

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

12200 Visit - out of office (Age 0 - 1) .....	107.00	41.74
13200 Visit - out of office (Age 2 - 49) .....	96.50	37.95
15200 Visit - out of office (Age 50 - 59) .....	107.00	41.74
16200 Visit - out of office (Age 60 - 69) .....	111.00	43.73
17200 Visit - out of office (Age 70 - 79) .....	119.00	49.33
18200 Visit - out of office (Age 80+) .....	124.00	56.91

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

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

**GENERAL PRACTICE 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). The GP Group Medical Visits are not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns other than in the context of the individual medical condition. Fee per patient, per ½ hour or major portion thereof:

13763	Three patients .....	64.90	25.87
13764	Four patients .....	52.40	20.89
13765	Five patients.....	45.00	17.95
13766	Six patients .....	40.05	15.98
13767	Seven patients .....	36.50	14.57
13768	Eight patients .....	33.90	13.53
13769	Nine patients .....	31.80	12.67
13770	Ten patients .....	30.10	12.02
13771	Eleven patients.....	26.40	10.53
13772	Twelve patients .....	24.80	9.90
13773	Thirteen patients .....	22.95	9.17

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
13774 Fourteen patients .....	22.60	9.00
13775 Fifteen patients .....	21.65	8.63
13776 Sixteen patients .....	21.05	8.38
13777 Seventeen patients .....	20.10	8.04
13778 Eighteen patients .....	19.65	7.86
13779 Nineteen patients .....	19.05	7.58
13780 Twenty patients .....	18.60	7.39
13781 Greater than 20 patients (per patient)	17.85	7.12

**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).  
(see notes on next page)

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**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 in both the billing claims and patient's chart.
- iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

12120 Individual counselling - in office (Age 0 - 1).....	159.00	62.05
00120 Individual counselling - in office (Age 2 - 49).....	145.00	56.41
15320 Individual counselling - in office (Age 50 - 59).....	159.00	62.05
16120 Individual counselling - in office (Age 60 - 69).....	167.00	64.86
17120 Individual counselling - in office (Age 70 - 79).....	188.00	73.32
18120 Individual counselling - in office (Age 80+).....	217.00	84.60

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

12220 Individual counselling - out of office (Age 0 - 1) .....	232.00	74.44
13220 Individual counselling - out of office (Age 2 - 49) .....	209.00	67.67
15220 Individual counselling - out of office (Age 50 - 59).....	232.00	74.44
16220 Individual counselling - out of office (Age 60 - 69).....	242.00	77.83
17220 Individual counselling - out of office (Age 70 - 79).....	263.00	87.99
18220 Individual counselling - out of office (Age 80+).....	272.00	101.52

**COUNSELLING - GROUP (FOR GROUPS OF TWO OR MORE PATIENTS)**

00121 first full hour .....	328.00	160.00
00122 second hour, per 1/2 hour or major portion thereof.....	163.00	80.00

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

**MISCELLANEOUS VISITS**

T13706 FP Delegated Patient Telehealth Management Fee ....	N/A	20.00
--	-----	-------

Notes:

- i) For verbal, real-time telephone or video technology communication discussion between the patient or the patient's medical representative and a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed within a physician's practice. Not payable when the delegated representative is paid or funded by alternate means by a health authority or the Ministry of Health.

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
ii) 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.		
iii) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.		
iv) Only one service payable per patient per day.		
v) Not payable on the same calendar day as a visit or service fee by same physician for same patient.		
vi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.		
T3707 FP Email/Text/Telephone Medical Advice Relay or ReRx Fee .....	N/A	7.00
Notes:		
i) Email/Text/Telephone Relay Medical Advice requires two-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.		
ii) 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.		
iii) Payable for prescription renewals without patient interaction.		
iv) Not payable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.		
v) Only one service payable per patient per day.		
vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient.		
vii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.		
T13708 FP COVID-19 communication with specialist and/or allied care provider .....	N/A	40.00

*(see notes on next page)*

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

Notes:

- i) Payable to the Family Physician who participates in a 2 way telephone or video conference communication with a specialist and/or allied care provider about a patient regarding COVID-19.
- ii) T13708 FP COVID-19 communication with specialist and/or allied care provider cannot be delegated. No claim may be made where communication is with a proxy for either provider.
- iii) Payable in addition to any visit fee on the same day.
- 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 work flow within a physician's community practice.
- v) Not payable in addition to G14018 or G14077 on the same day for the same patient.
- vi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

13015 HIV/AIDS Primary Care Management - in or out of office - per 1/2 hour or major portion thereof.....	223.00	85.95
---	--------	-------

NOTES:

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

13501 MAiD Assessment Fee – Assessor Prescriber Includes all requirements of a MAiD assessment, including review of medical records, patient encounter and completion of the MAiD Assessment Record (Prescriber). The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof.....	97.70	42.97
--	-------	-------

*(see notes on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
NOTES:		
i) Maximum payable is 135 minutes (9 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.		
ii) Start and end time for the assessment must be entered in both the billing claim and patient's chart.		
iii) Additionally, start and end time for the patient encounter must be entered in the patient's chart.		
iv) Only one service for 13501 or 13502 may be performed by video conference.		
13502 MAiD Assessment Fee – Assessor	97.70	42.97
Includes all requirements of a MAiD assessment, including review of medical records, patient encounter and completion of the MAiD Assessment Record (Assessor). The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof.....		
NOTES:		
i) Maximum payable is 105 minutes (7 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.		
ii) Start and end time for the assessment must be entered in both the billing claim and the patient's chart.		
iii) Additionally, start and end time for the patient encounter must be entered in the patient's chart.		
iv) Not payable with 13501 by same physician.		
v) Only one service for 13501 or 13502 may be performed by video conference.		
13503 Physician witness to video conference MAiD Assessment – Patient Encounter	97.70	42.97
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 .....		

*(see notes on next page)*



**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

**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 .....	641.00	282.10
-------	--	--------	--------

**NOTES:**

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

13505	MAiD Medication Pick-up and Return .....	287.00	125.94
-------	--	--------	--------

**NOTES:**

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

**Telehealth Service with Direct Interactive Video Link with the Patient**

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

T13236	Telehealth GP Consultation (age 0-1) .....	N/A	84.87
T13436	Telehealth GP Consultation (age 2-49).....	N/A	77.15
T13536	Telehealth GP Consultation (age 50-59).....	N/A	84.87
T13636	Telehealth GP Consultation (age 60-69).....	N/A	88.73
T13736	Telehealth GP Consultation (age 70-79).....	N/A	100.29
T13836	Telehealth GP Consultation (age 80+).....	N/A	115.75

GENERAL PRACTICE - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
T13237 Telehealth GP Visit (age 0-1) .....	N/A	34.79
T13437 Telehealth GP Visit (age 2-49) .....	N/A	31.62
T13537 Telehealth GP Visit {age 50-59} .....	N/A	34.79
T13637 Telehealth GP Visit {age 60-69} .....	N/A	36.36
T13737 Telehealth GP Visit (age 70-79) .....	N/A	41.10
T13837 Telehealth GP Visit (age 80+) .....	N/A	47.44
T13238 Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 0-1) .....	N/A	62.05
T13438 Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 2-49) .....	N/A	56.41
T13538 Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 50-59) .....	N/A	62.05
T13638 Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit- 20 minutes) (age 60-69) .....	N/A	64.86
T13738 Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 70-79) .....	N/A	73.32
T13838 Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 80+) .....	N/A	84.60
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.		
Telehealth GP in-office Group Counselling For groups of two or more patients		
P13041 – First full hour .....	223.00	86.94
P13042 – Second hour, per ½ hour or major portion thereof ..	112.00	43.50
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
Telehealth GP out-of-office Group Counselling For groups of two or more patients.		
P13021 – First full hour .....	223.00	87.46
P13022 – Second hour, per ½ hour or major portion thereof..	112.00	43.76
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		
13020 Telehealth General Practitioner Assistant – Physical Assessment as requested by receiving specialist – for each 15 minutes or major portion thereof.....	77.90	31.46
NOTES:		
i) Applicable only if general practitioner 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.		

**HOME VISITS**

00103 Home visit (service rendered between 0800 and 2300 hours - <u>any day</u> ) .....	224.00	115.73
NOTE: Additional patients seen during same house call are to be billed under the applicable out-of-office visit fee items (12200, 13200, 15200, 16200, 17200 and 18200).		

**GP FACILITY VISITS**

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

00109 Acute care hospital admission examination .....	157.00	81.61
NOTES:		
i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a GP 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.		

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<ul style="list-style-type: none"> <li>iii) Fee item 00109 is not applicable if fee item 12101, 00101, 15301, 16101, 17101, 18101, 12201, 13201, 15021, 16201, 17201 or 18201 has been billed by the same physician within the week preceding the patient's admission.</li> <li>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.</li> <li>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.</li> <li>vi) Limit of one hospital admission (00109 or 13109) payable per patient per hospitalization.</li> </ul>		
00108 Hospital visit .....	68.30	31.93
NOTES:		
<ul style="list-style-type: none"> <li>i) Billable by GP's with active hospital privileges for daily attendance on the patients they have most responsibility for.</li> <li>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.</li> </ul>		

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p>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.</p>		
00128 Supportive care hospital visit .....	68.30	27.52
NOTES:		
<p>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.).</p> <p>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 in a note record.</p> <p>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.</p>		
00127 Palliative care patient facility visit .....	157.00	53.87
<i>(see notes on next page)</i>		

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

## NOTES:

- i) This item is applicable to the visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.
- ii) This item may be billed for necessary visits rendered for a period not to exceed 180 days prior to death and is applicable to patients in an acute care hospital, nursing home or palliative care patient facility, whether or not the patient is in a palliative care unit. Under extenuating circumstances, for visits that exceed 180 days, a note record must be submitted.
- iii) Palliative care patient visit fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.
- iv) The chemotherapy listings (33581, 33582, 33583, 00578, 00579, and 00580) may not be billed when palliative care patient facility visit fees are being billed.
- v) Essential non-emergent additional palliative care patient facility visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00127. The claim must include the time of each visit and a statement of need included in a note record.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

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

**Community Based GP Hospital Visits**

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

**Physician Eligibility:**

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

**Community Based GP with Active Hospital Privileges**

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

13109	Community based GP: Acute care hospital admission examination .....	236.00	102.52
-------	---	--------	--------

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

NOTES:

- i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a community based GP 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 a 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 GP, first facility visit of the day bonus, extra (active hospital privileges) (for routine, supportive or palliative care) .....

94.90

49.53

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.



	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
13008 Community based GP: hospital visit (active hospital privileges) .....	157.00	53.87
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 including 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.		
13028 Community based GP: supportive care hospital visit (active hospital privileges) .....	85.30	35.79
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.		

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p>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.</p>		
<p><b>Community Based GP With Courtesy or Associate Hospital Privileges</b></p>		
13339		
Community based GP, first facility visit of the day bonus, extra (courtesy/associate privileges) .....	68.30	30.00
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 GP: hospital visit (courtesy/associate privileges) .....	68.30	30.00
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.		

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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 in patient's hospital or office chart.		
vi) If a hospitalist or GP member of an Unassigned In-Patient Care Network is providing GP care to the patient, the community based GP with courtesy or associate hospital privileges may bill 13228.		
vii) Note vi) also applies to Community based GPs 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) .....	145.00	51.77
00105 Night (between 2300 hours and 0800 hours).....	191.00	71.95
00123 Saturday, Sunday or Statutory Holiday .....	145.00	51.77

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

**LONG TERM CARE FACILITY VISITS**

00114 One or multiple patients, per patient .....	86.00	36.31
---	-------	-------

13334 Community based GP, long term care facility visit - first visit of the day bonus, extra .....	86.00	34.23
---	-------	-------

NOTES:

- i) Paid only if 00114 paid the same day.
- ii) Limit of one payable for the same physician, same day, regardless of the number of long term care facilities attended.

00115 Nursing home visit – one patient, when specially called and patient seen between hours of 0800 hrs and 2300 hrs - <u>any day</u> The visit must take place within 24 hours of receiving the request from the Nursing home .....	224.00	115.73
---	--------	--------

NOTE: See Preamble clause D. 4. 9.) for long-stay patients.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**EMERGENCY VISITS**

00112 Emergency visit (call placed between hours of 0800 and 1800 hrs - <u>weekdays</u> ).....	259.00	115.73
--	--------	--------

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 of the criteria are met.*

Example 3: Physician is visiting patients at the hospital during the daytime. S/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.*

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

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 .....	271.00	117.10
-------	---	--------	--------

**TELEPHONE ADVICE**

00043	Anticoagulation therapy by telephone	26.85	6.98
-------	--------------------------------------	-------	------

13000	Telephone advice to a Community Health Representative in First Nation’s Communities .....	40.25	18.22
-------	---	-------	-------

NOTES:

- i) Applicable only to medically required calls to physician for medical advice initiated by and provided to a Community Health Representative.
- ii) Not billable if a Community Health Nurse is available in the Community.

13005	Advice about a patient in Community Care .....	40.25	18.22
-------	--	-------	-------

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 health care worker specifically assigned to the care of the patient.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- ii) Community Care comprises Residential, Intermediate and Extended care and includes patients receiving Home Nursing care, Home support or Palliative care at home.
- iii) Allied health care workers are defined as: home care coordinators, nurses, (registered, licensed practical, public health, and psychiatric), psychologists, mental health workers, physiotherapists, occupational therapists, respiratory therapists, social workers, ambulance paramedics, and pharmacists (including completion of faxed medication review with orders, up to twice per calendar year, but not for simple prescription renewal).
- 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 and whose duties would otherwise include provision of this care. Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care. Similarly, the fee does not cover advice provided by doctors who are on-site, on-duty in an emergency department, who are being paid at the time on a sessional basis, or who are working at the time as hospitalists.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**PREGNANCY AND CONFINEMENT**

14199 Management of prolonged second stage of labour, per 30 minutes or major portion thereof .....	221.00	84.94
---	--------	-------

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 fee item 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.

14090 Prenatal visit - complete examination .....	187.00	84.43
---	--------	-------

14091 Prenatal visit - subsequent examination .....	83.70	31.62
---	-------	-------

NOTES:

- i) Uncomplicated pre-natal 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 written explanation.
- ii) Where a patient transfers her total on-going uncomplicated pre-natal care to another physician, the second physician also may charge a complete examination (item 14090) 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, etcetera, should not be considered as a patient transfer.
- iii) Other than during pre-natal or post-natal 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.

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
iv) Other than procedures, services for the care of unrelated conditions, during a pre-natal or post-natal visit are included in the pre-natal (14091) or post-natal visit fee (14094), 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.		
14094 Post-natal office visit .....	83.70	31.62
NOTE:		
i) 14094 may be billed in the six weeks following delivery (vaginal or Caesarean Section).		
ii) Not payable to physician performing Caesarean Section.		
14104 Delivery and post-natal care (1-14 days in-hospital) ....	1401.00	584.78
NOTES:		
i) Care of new-born in hospital (see fee item 00119).		
ii) Repair of cervix is not included in fee item 14104. Charge 50% of listed fee when done on same day as delivery.		
iii) When medically necessary additional post-partum office visit(s) are payable under fee item P14094.		
14105 Management of labour and transfer to higher level of care facility for delivery.....	584.00	243.53
NOTES:		
i) This fee includes all usual hospital care associated with the confinement and provided by the referring physician.		
ii) May be claimed by the referring physician when the referring physician intended to conduct the delivery providing the following conditions are met:		
a) The referring physician attended the patient during <u>active</u> labour and provided assessment of the progress of labour, both initial and on-going.		
b) Active labour is defined as “regular painful contractions, occurring at least once in five minutes, lasting at least 40 seconds, accompanied by either spontaneous rupture of the membranes, or full cervical effacement and dilatation of at least two centimeters.”		

*(notes continued on next page)*



	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<ul style="list-style-type: none"> <li>c) There is a documented complication warranting the referral such as fetal distress or dysfunctional labour (failure to progress).</li> <li>d) Where the referring physician must transfer the patient to another facility.</li> <li>iii) Not payable with assessment or visit fee or 14104, 14109 and generally 14199 (provide details if claiming for 14199 in addition).</li> <li>iv) OOOHP Continuing Care Surcharges do not apply to maternity services in the first stage of labour only.</li> <li>v) When medically necessary additional post-partum office visit(s) are payable under P14094.</li> </ul>		
14108 Post-natal care after elective cesarean section (1-14 days in-hospital).....	288.00	120.31
NOTE: When medically necessary additional post-partum office visit(s) are payable under fee item P14094.		
14109 Primary management of labour and attendance at delivery and post-natal care associated with emergency cesarean section (1-14 days in-hospital) .....	1167.00	487.10
NOTES:		
<ul style="list-style-type: none"> <li>i) Surgical assistant is extra to fee item 14108 and 14109.</li> <li>ii) When medically necessary additional post-partum office visit(s) are payable under fee item P14094.</li> </ul>		
15120 Pregnancy test, immunologic - urine.....	28.70	11.65
<b>INFANT CARE</b>		
00118 Attendance at cesarean section (if specifically requested by surgeon for care of baby only) .....	236.00	90.81
NOTE: Not payable if a pediatrician is present at the caesarean section to care for the baby)		
00119 Routine care of new-born in hospital .....	168.00	92.82

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>GYNECOLOGY</b>			
14540 Insertion intrauterine contraceptive device (operation only) .....	99.80	2	43.15
NOTE: Includes pap smear if required.			
14541 Removal of intrauterine device (IUD) – operation only. NOTE: Not payable with a pap smear (14560) or IUD insertion (14540).	79.30		31.62
14545 Medical abortion..... NOTE: Includes all associated services rendered on the same day as the abortion including the consultation whenever rendered, required components of Rh factor associated services including counselling rendered on the day of the procedure, and any medically necessary clinical imaging.	351.00		164.96
14560 Routine pelvic examination including Papanicolaou smear (no charge when done as a pre and post-natal service) .....	83.70		31.62
NOTE: Services billed under this code must include both a pelvic examination and a Pap smear.			

**SURGICAL ASSISTANCE**

NOTES:

- i) In those rare situations where an assistant is required for minor surgery, a detailed explanation of need must accompany the account to the payment agency.
- ii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anesthetic, s/he may charge a separate assistant fee for each operation, except for bilateral procedures, procedures within the same body cavity or procedures on the same limb.
- iii) Visit fees are not payable with surgical assistance listings on the same day, unless each service is performed at a distinct/separate time. In these instances, each claim must state time service was rendered.

<b>Total Operative Fee(s) for Procedure(s):</b>			
00195 – less than \$317.00 inclusive.....	339.00		134.22
00196 – \$317.01 - \$529.00 inclusive .....	477.00		189.24
00197 – over \$529.00.....	624.00		260.35

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
00198 Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof .....	71.30		28.52
13194 First Surgical Assist of the Day .....	207.00		88.16
NOTES:			
i) Restricted to General Practitioners			
ii) Maximum of one per day per physician, payable in addition to 00195, 00196, 00197 or 00193.			

**OPEN HEART SURGERY**

00193 Non-CVT certified surgical assistance at open-heart surgery, per quarter hour or major portion thereof .....	88.70		29.84
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.			

**ANESTHESIOLOGY**

13052 Anesthetic evaluation, non-certified Anaesthesiologist NOTE: See Anesthetic Preamble regarding Pre-Anesthetic Evaluation Fees.	94.40		55.76
---	-------	--	-------

**MINOR PROCEDURES**

00190 Forms of treatment other than excision, x-ray, or Grenz ray; such as removal of hemangiomas and warts with electrosurgery, cryotherapy, etc. (per visit) - operation only .....	83.70		31.62
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. <u>"Surgery for Alteration of Appearance"</u> .			
Y10710 In-office Anoscopy .....	20.25		7.94
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 General Practitioners			

GENERAL PRACTICE - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
13660 Metatarsal bone – closed reduction - operation only....	122.00	2	52.78
13600 Biopsy of skin or mucosa - operation only.....	119.00	2	51.92
13601 Biopsy of facial area - operation only .....	119.00	2	51.92
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) .....	104.00	2	44.48
13610 Minor laceration or foreign body – not requiring anesthesia (operation only).....	82.60		35.62
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) .....	156.00	2	66.35
13612 Extensive lacerations over 5 cm (maximum charge 35 cm) – (operation only) - per cm.....	30.55	2	13.32
NOTE: Not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			
13620 Excision of tumour of skin or subcutaneous tissue or small scar, under local anesthetic – up to 5 cm - operation only .....	156.00	2	66.35
13621 – additional lesions removed at the same sitting (maximum per sitting – five) – each - operation only	76.50		33.18
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 Alteration of Appearance”.			
ii) Fee items 13620 and 13621 are not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			
13622 Localized carcinoma of skin, proven histopathologically	168.00	2	73.30
13623 Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic – face (operation only) .....	207.00		89.49
NOTE: Not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			

GENERAL PRACTICE - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
13624 Removal of extensive scars – 5 cm or more – per cm over 5 cm (in addition to 13623 or 13620) .....	19.75		8.57
NOTES:			
i) Payment for scar revision based on length of sca, not length of incision.			
ii) A note record is required for scars >30 cm.			
iii) Not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			
13630 Paronychia (operation only) .....	82.40	2	35.53
13631 Removal of nail – simple (operation only) .....	82.40	2	35.53
13632 – with destruction of nail bed - operation only .....	165.00	2	71.89
13633 Wedge excision of one nail - operation only .....	147.00	2	63.44
13650 Enuclation or excision of external thrombotic hemorrhoid - operation only .....	121.00	2	52.12
Y13655 GP Vasectomy bonus (associated with bilateral vasectomy) .....	55.00		21.44
NOTES:			
i) Restricted to General Practitioners.			
ii) Maximum of 25 bonuses per calendar year per physician.			
iii) Payable only when fee item S08345 billed in conjunction.			
iv) Maximum of one bonus per vasectomy per patient.			
	<b>Non-MSP- Insured Fee (\$)</b>		<b>MSP &amp; WSBC Fee (\$)</b>

**INVESTIGATION**

00117 Interpretation of electrocardiogram by non-internist.....	29.30	10.38
---	-------	-------

**NO CHARGE REFERRAL**

03333 Use this code when submitting a claim for a “no charge referral”
--

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

**TESTS PERFORMED IN A PHYSICIAN'S OFFICE**

The following tests when performed in physician's offices are accepted for payment by the Medical Services Plan of British Columbia. These tests are not payable to laboratories, vested interest laboratories and/or hospitals:

00012 Venepuncture and dispatch of specimen to an approved laboratory facility, when no other blood work performed.....	13.55	5.95
NOTES:		
i) This is the only fee applicable for taking blood specimens and is to apply in those situations where a single blood work service is provided by a medical practitioner.		
ii) Where a blood specimen is taken by a physician's office and dispatched to another unassociated physician's office or to an approved laboratory facility, the original physician's office may charge 00012 only when it does not perform another laboratory procedure using blood collected at the same time. (see Preamble Clause C. 21.)		
iii) When billed with another service such as an office visit, 00012 may be billed at 100%.		
15132 Candida culture .....	18.20	6.67
15133 Examination for eosinophils in secretions, excretions and other body fluids.....	27.70	7.14
15134 Examination for pinworm ova.....	19.00	5.85
15136 Fungus, direct microscopic examination, KOH preparation.....	27.05	8.39
15100 Glucose – semiquantitative (dipstick analysed visually or by reflectance meter) .....	9.95	3.70
15137 Hemoglobin - cyanmethemoglobin method and/or hematocrit .....	8.25	3.12
15000 Hemoglobin – other methods.....	4.40	1.62
NOTE: 15137 and 15000 – see the Laboratory Services Payment Schedule for additional hematology information.		
15110 Occult blood – feces.....	13.15	5.34
Note: Applies only to guaiac methods.		
15120 Pregnancy test, immunologic, urine .....	28.70	11.65
30015 Secretion smear for eosinophils .....	28.65	7.29
15138 Sedimentation rate .....	8.10	2.51
15139 Sperm, Seminal examination for presence or absence	47.25	14.78

GENERAL PRACTICE - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
15140 Stained smear.....	23.75	7.40
15141 Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination .....	21.95	5.65
15130 Urinalysis – Chemical or any part of (screening) .....	5.75	2.18
15131 Urinalysis – microscopic examination of centrifuged deposit .....	11.60	4.12
15142 Urinalysis – Complete diagnostic, semi-quant and micro.	17.05	5.62
15143 White cell count only (see the Laboratory Services Payment Schedule for additional hematology information).....	17.75	6.48
<b>The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:</b>		
93120 ECG tracing, without interpretation (technical fee).....	40.75	16.90

SEE NEXT PAGE FOR GPSC INITIATED LISTINGS.  
(GENERAL\_PRACTICE\_GPSC)

## GENERAL PRACTICE - GPSC

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

### **Preamble – General Practice Services Committee (GPSC) Initiated Listings**

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. These fees were previously administered by the General Practice Services Committee (GPSC). Note that the GPSC Preamble governs the GPSC initiated listings in this section, however, the GPSC Preamble does not apply to the rest of the MSP fee listings.

Unless otherwise identified in the individual fee description, physicians are eligible to bill the following incentive payments if they are:

1. A Family Physician who has a valid BC MSP practitioner number;
2. Currently in family practice in BC as a full service family physician;
3. The most responsible practitioner for the majority of the patient's longitudinal primary medical care.

Unless otherwise identified in the individual fee description, physicians are NOT eligible to bill GPSC incentives if:

1. They are working under an Alternate Payment/Funding model as defined below and their duties would otherwise include provision of this care; and
2. They have billed any specialty consultation fee in the previous 12 months.

Additional detailed eligibility requirements are identified in each section.

### **Definitions in GPSC Initiated Listings:**

#### **(1) Physicians**

##### Full Service Family Physician

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g.: Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

##### Family Physician with Consultative Expertise

GPSC defines a Family Physician with Consultative Expertise as: "A family physician who has consultative expertise and provides consultative services or support to colleagues through a health authority supported or approved program. Examples of health authority supported programs include (but are not limited to) mental health, addictions, palliative, chronic pain, and emergency medicine.



### Locum Tenens

For the purpose of its incentives, GPSC defines a locum tenens as a physician with appropriate accreditation who substitutes on a temporary basis for another physician who is away from practice.

### Most Responsible Physician/Provider (MRP)

For the purpose of its incentives, the GPSC defines “Most Responsible Physician/Provider” (MRP) as a physician who takes responsibility for directing and coordinating the ongoing care and management of a patient. This includes coordinating clinical services delegated to other providers, ensuring cross coverage when MRP is unavailable, and coordinating referrals to specialty care when needed.

## **(2) Allied Care Providers**

### Allied Care Provider

For the purposes of its incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Physicians, Nurses, Nurse Practitioners; Mental Health Workers; Midwives Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dietitians; Physiotherapists; Occupational Therapists; and Pharmacists, etc.

**Note: Not all allied care providers are College-certified.**

### College-certified Allied Care Provider

Allied Care Providers who are College-certified are governed by a provincial regulatory college or body. Specific GPSC incentives may require ACPs to be College-certified for the delegation of tasks, whereas other GPSC incentives may not require ACPs to be College-certified to undertake delegated tasks. Fee notes will clearly indicate whether the ACP must be College-certified to be delegated tasks.

### Allied Care Provider “Employed by” a Physician Practice

For the purposes of its incentives, GPSC defines Allied Care Providers (ACPs) “employed by” a physician practice as ACPs who are employed by a physician practice and paid out of practice earnings to work directly within the practice team, with no cost recovery either directly or indirectly from a third party (e.g.: Health Authority, Division of Family Practice, Ministry of Health, etc.), unless otherwise specified.

### Allied Care Provider “Working Within” a Physician Practice Team

For the purposes of its incentives, GPSC defines Allied Care Providers (ACPs) “working within” a physician practice team as ACPs who work as part of an FP practice’s team to support the ongoing care of its patients. The costs of an ACP “working within” the practice team may be paid either by the physician practice or a third party (directly or indirectly). ACPs employed by a Health Authority, are considered to be “working within” the practice team if they are assigned to work with an FP practice to support the longitudinal care of its patients. By contrast, ACPs not assigned to work with an FP practice and who provide episodic services to patients on a referral basis such as through Specialized Health Authority Programs or in stand-alone chronic disease clinics are not considered to be “working within” the physician practice team.

### **(3) Payment Models**

#### Alternative Payment/Funding Model:

For the purposes of these fees Alternative Payment/Funding Model means an Alternative Payment Arrangement or Alternative Funding contract between an entity (e.g.: Ministry of Health, Health Authority or other organization) and an individual physician or physician clinic. An Alternative Payment Arrangement or Alternative Funding contract may or may not be governed by the Physician Master Agreement. If services supported and paid through GPSC incentives are already included in an Alternative Payment/Funding Model contract, GPSC incentives are not billable in addition. Private agreements between physicians to pool FFS billings and pay out physicians in a mutually acceptable way (e.g.: per day, per shift, per hour, etc.) are not considered as an Alternative Payment/Funding Model..

### **(4) Miscellaneous**

#### Assisted Living:

For the purpose of its incentives when referring to assisted living, GPSC utilizes the ministry definitions as found at: <https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living>

#### Care plan

For the purpose of its incentives, when referring to a care plan, GPSC requires documentation of the following core elements in the patient's chart, as follows:

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face to face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

#### Face to Face:

For the purpose of its incentives, GPSC defines "face to face" to mean in-person.

Living in Community:

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

Patient's Medical Representative:

For the purpose of its incentives, GPSC defines Patient's Medical Representative as outlined in the "Health Care (Consent) and Care Facility (Admission) Act".

Representative means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative.

Temporary Substitute decision makers (Alternate Representative) in listed order, of the following who is available and qualifies under subsection 16(2):

- (a)the adult's spouse;
- (b)the adult's child;
- (c)the adult's parent;
- (d)the adult's brother or sister;
- (d.1)the adult's grandparent;
- (d.2)the adult's grandchild;
- (e)anyone else related by birth or adoption to the adult;
- (f)a close friend of the adult;
- (g)a person immediately related to the adult by marriage.

Patient self-management:

Patient self-management can be defined as the decisions and behaviours that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. There are a variety of publicly available tools that FPs can provide to patients, to help build the patients' skills and confidence to manage their chronic conditions.

Patient Panel:

For the purpose of its incentives, the GPSC defines a "patient panel" as the group of patients for which a family physician has assumed the role of MRP, and has confirmed their ongoing patient-physician relationship.

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

## 1. GPSC PORTALS (PG14070, PG14071)

Effective April 1, 2020, PG14070 will continue to provide access to the following fee codes:

- PG14075 FP Frailty Complex Care Planning and Management Fee
- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
- PG14029 FP Allied Care Provider Practice Code

In addition to the fee below:

- PG14050, PG14051, PG14052, PG14053 Chronic Disease management Fees (Behind portal as of April 1, 2020)
- PG14033 Complex Care Planning & Management (Behind portal as of April 1, 2020)
- PG14043 Mental Health Planning fee (Behind portal as of April 1, 2020)
- PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management fees (Behind portal as of April 1, 2020)
- PG14063 Palliative Care Planning (Behind portal as of April 1, 2020)
- PG14066 Prevention/Personal Health Risk Assessment (Behind portal as of April 1, 2020)

Submitting PG14070 signifies that:

- You are providing full-service family practice services to your patient's 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'.

### **Family Physician-Patient 'Compact'**

The standardized wording of the Family Physician-Patient 'Compact' was developed in consultation with physicians and members of the Patient Voices Network. The GPSC believes this compact appropriately

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

describes the relationship between a FP and their patients. The compact states:

As your family doctor I, along with my practice team, agree to:

- Provide you with the best care that I can
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:

- Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s)
- Name me as your family doctor if you have to visit an emergency facility or another provider
- Communicate with me honestly and openly so we can best address your health care needs

PG14070 GPSC Portal Code.....	0.00	0.00
-------------------------------	------	------

The GPSC Portal should be submitted once at the beginning of each calendar year by MRP FSFPs who maintain a comprehensive longitudinal practice OR at any time during the year when the MRP FSFP begins their comprehensive longitudinal practice. Successful submission of PG14070 allows access to fees listed in the notes below during the calendar year.

Submit fee item PG14070 GPSC Portal Code using the following "Patient" demographic information:

<b>PHN:</b>	<b>9753035697</b>
<b>Patient Surname:</b>	<b>Portal</b>
<b>First name:</b>	<b>GPSC</b>
<b>Date of Birth:</b>	<b>January 1, 2013</b>
<b>ICD9 code:</b>	<b>780</b>

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**NOTES:**

- i) Submit once per calendar year per physician.
- ii) Submission provides access to the following fee codes:
  - PG14075 FP Frailty Complex Care Planning and Management Fee
  - PG14076 FP Patient Telephone Management Fee
  - PG14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
  - PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
  - PG14029 FP Allied Care Provider Practice Code (\$0.00 Fee)
  - PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees
  - PG14033, PG14075 Complex Care Planning & Management Fees
  - PG14043 Mental Health Planning fee
  - PG14044, PG14045, PG14046, PG14047 and PG14078 Mental Health Management fees
  - PG14063 Palliative Care Planning Fee; and
  - PG14066 Personal Health Risk Assessment (Prevention) Fee.
- iii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months

**GPSC Locum Portal**

Effective April 1, 2020, GPSC Locum Portal Code provides access to the following incentive fee codes:

- PG14075 FP Frailty Complex Care Planning and Management Fee
- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
- PG14029 FP Allied Care Provider Practice Code

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- PG14050, PG14051, PG14052, PG14053  
Chronic Disease management Fees (Behind portal as of April 1, 2020)
- PG14033 Complex Care Planning & Management (Behind portal as of April 1, 2020)
- PG14043 Mental Health Planning fee (Behind portal as of April 1, 2020)
- PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management fees (Behind portal as of April 1, 2020)
- PG14063 Palliative Care Planning (Behind portal as of April 1, 2020)
- PG14066 Prevention/Personal Health Risk Assessment (Behind portal as of April 1, 2020)

These fees are accessible by a locum tenens when working on a temporary basis for a MRP FP who is away from practice. As per the GPSC Preamble, a locum tenens is defined as a physician with appropriate credentials who substitutes on a temporary basis for another physician who is away from practice.

The host MRP FP must have submitted PG14070 in the same calendar year. The locum tenens and host FP should discuss and mutually agree which of the services accessed through the GPSC Portal may be provided and billed by the locum. However, locums have their own annual allotment of PG14076 (FP Patient Telephone Management Fee) and PG14078 (FP Patient Email/Text/Telephone Medical Advice Relay Fee).

Submitting PG14071 signifies that:

- You are providing full service family practice services to patients of host physician, and will continue to do so for the duration of any locum coverage for a family physician who has submitted PG14070

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
PG14071 GPSC Portal Code .....	0.00	0.00
<p>The GPSC Portal should be submitted once at the beginning of each calendar year by MRP FSFPs who maintain a comprehensive longitudinal practice OR at any time during the year when the MRP FSFP begins their comprehensive longitudinal practice. Successful submission of PG14070 allows access to fees listed in the notes below during the calendar year.</p>		

Submit fee item PG14071 Locum Portal Code using the following “Patient” demographic information:

**PHN:** 9753035697  
**Patient Surname:** Portal  
**First name:** GPSC  
**Date of Birth:** January 1, 2013  
**ICD9 code:** 780

Submission of this code signifies that:

- You are providing continuous comprehensive coordinated family practice services to the patients of the host physician who has submitted PG14070 and will continue to do so for the duration of locum coverage.

**NOTES:**

- i) Submit once per calendar year per physician.
- ii) Submission provides access to the following fee codes:
  - PG14075 FP Frailty Complex Care Planning and Management Fee
  - PG14076 FP Patient Telephone Management Fee
  - PG14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
  - PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
  - PG14029 FP Allied Care Provider Practice Code (\$0.00 Fee)
  - PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees
  - PG14033, PG14075 Complex Care Planning & Management Fees

*(notes continued on next page)*



Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

- PG14043 Mental Health Planning fee
- PG14044, PG14045, PG14046, PG14047 and PG14078 Mental Health Management fees
- PG14063 Palliative Care Planning Fee; and
- PG14066 Personal Health Risk Assessment (Prevention) Fee.

iii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months

## **2. CHRONIC DISEASE MANAGEMENT INCENTIVES – FEE FOR SERVICE (PG14050, PG14051, PG14052, PG14053, PG14029)**

The GPSC Chronic Disease Management Incentives compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full twelve-month period. Guideline-informed care includes consideration of the patient’s goals, values and comorbidities.

To confirm an ongoing doctor-patient relationship, there must be at least 2 visits billed over the previous 12 months. Visits provided by a locum or colleague covering for the MRP FP may be counted toward these 2 visits however, an electronic note indicating the locum or colleague coverage must be submitted with the claim. Patients in long-term care facilities are eligible when active chronic disease management is clinically appropriate.

When a new FP assumes the practice of another FP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fees are billable on the anniversary date of the previous billing, provided the new FP has continued to provide guideline-informed care for these patients. To demonstrate continuity, if some of the required visits have been provided by the previous FP, an electronic note should be submitted at the time of the CDM submission by the new FP, indicating they have taken over the practice of the previous FP and there has been continuity of care over 12 months. Documentation in the patient chart of the provision of patient self-management supports as part of the patients’ chronic disease management is expected

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p>Effective April 1, 2020, PG14050, PG14051, PG14052, PG1403 are payable only to MRP FPs who have submitted PG14070 or PG14071.</p>		
<p>PG14050 Incentive for MRP Family Physicians - annual chronic care incentive (diabetes mellitus).....</p>	275.00	125.00
<p>NOTES:</p> <ul style="list-style-type: none"> <li>i) Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.</li> <li>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.</li> <li>iii) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be:               <ul style="list-style-type: none"> <li>1. a telephone visit (PG14076); or</li> <li>2. a group medical visit (13763-13781); or</li> <li>3. an in-person visit with a College certified allied care provider working within the family physician’s practice team (PG14029). (See Preamble definition of “working within” and “College-certified ACP”).</li> </ul> </li> <li>iv) Not payable if the required two visits were provided while working under an alternate payment/funding model as described in the GPSC Preamble.</li> <li>v) Claim must include the ICD-9 code for diabetes (250).</li> <li>vi) Payable once per patient in a consecutive 12 month period.</li> <li>vii) Payable in addition to fee items PG14051 or PG14053 for same patient if eligible.</li> <li>viii) Not payable once PG14063 has been billed and paid.</li> <li>ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.</li> </ul>		

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
PG14051 Incentive for MRP Family Physicians - annual chronic care incentive (heart failure) .....	275.00	125.00
NOTES:		
i) Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.		
ii) 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 has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be:		
1. a telephone visit (PG14076); or		
2. a group medical visit (13763-13781); or		
3. an in-person visit with a College -certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP")		
iv) Not payable if the required two visits were provided while working under an alternate payment/funding model as described in the GPSC Preamble.		
v) Claim must include the ICD-9 code for heart failure (428).		
vi) Payable once per patient in a consecutive 12 month period.		
vii) Payable in addition to items PG14050 or PG14053 for the same patient if eligible.		
viii) Not payable once PG14063 has been billed and paid.		
ix) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.		

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
PG14052 Incentive for MRP Family Physicians - annual chronic care incentive (hypertension) .....	110.00	50.00
NOTES:		
i) Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.		
ii) 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 has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be:		
1. a telephone visit (PG14076); or		
2. a group medical visit (13763-13781); or		
3. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").		
iv) Not payable if the required two visits were provided while working under an alternate payment/funding model as described in the GPSC Preamble.		
v) Claim must include the ICD-9 code for hypertension (401).		
vi) Payable once per patient in a consecutive 12 month period.		
vii) Not payable if PG14050, or PG14051 paid within the previous 12 months.		
viii) Not payable once PG14063 has been billed and paid.		
ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.		

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
G14053 Incentive for MRP Family Physicians - annual chronic care incentive (Chronic Obstructive Pulmonary Disease – COPD) .....	275.00	125.00
NOTES:		
i) Payable only to the family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.		
ii) 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 has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be: <ol style="list-style-type: none"> <li>1. a telephone visit (PG14076); or</li> <li>2. a group medical visit (13763-13781); or</li> <li>3. an in-person visit with a College-certified allied care provider working within the family physician’s practice team (PG14029). (See Preamble definition of “working within” and “College-certified ACP”).</li> </ol>		
iv) Not payable if the required two visits were provided while working under an alternate payment/funding model as described in the GPSC Preamble.		
v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).		
vi) Payable once per patient in a consecutive 12 month period.		
vii) Payable in addition to fee items PG14050, PG14051 or PG14052 for the same patient if eligible.		
viii) Not payable once PG14063 has been billed and paid.		
ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.		

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**Allied Care Provider Code (PG14029)**

To support team based care, College-certified Allied Care Providers (ACPs) may provide one of the two visits required for billing GPSC chronic disease management incentives. Visits provided by the College-certified ACP can be in person (PG14029) or by telephone (PG14078)

PG14029 Allied Care Provider Practice Code.....	0.00	0.00
---	------	------

NOTES:

- i) Only billable by the family physician who has submitted code PG14070 in the same calendar year and who is most responsible for the majority of the patient’s longitudinal primary medical care. May also be billed by Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071.
- ii) Applicable only for in-person medical services (office, home or LTC) provided by a College-certified allied care provider working within the family physician’s practice team where the family physician has accepted responsibility for the provision of the care. (See Preamble definition of “working within” and “College-certified ACP”).
- iii) Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14077.
- iv) Billable on patients receiving guideline informed care who will be eligible for one of the chronic disease management incentives (CDM’s).

**3. CHRONIC DISEASE MANAGEMENT INCENTIVES – MRP FAMILY PHYSICIANS UNDER ALTERNATE PAYMENT/FUNDING MODEL PROGRAMS (PG14250, PG14251, PG14252, PG14253, PG14276)**

Use the following CDM incentive fee codes if the required two visits were billed as an encounter record while working under sessional, salary, service or independent contractor contracts. Post review will be performed within 2 years and recoveries made if encounter records were not submitted for the required visits.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

A new telephone management encounter code (PG14276) is billable for physicians on alternate payment/funding models.

PG14250 Incentive for MRP Family Physicians (who bill encounter record visits) – annual chronic care incentive (diabetes mellitus).....	293.00	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 has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be:
  - 1. a GPSC telephone visit (PG14276); or
  - 2. a group medical visit (13763-13781); or
  - 3. an in-person visit with a College-certified allied health provider working within the family physician's practice team (PG14029). (See 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 GPSC Preamble.
- v) Claim must include the ICD-9 code for diabetes (250).
- vi) Payable once per patient in a consecutive 12 month period.
- vii) Payable in addition to fee items PG14251, PG14253 for same patient if eligible.
- viii) Not payable once PG14063 has been billed and paid.
- ix) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

GENERAL PRACTICE - GPSC - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
PG14251 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (heart failure).....	293.00	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 has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be:		
1. a telephone visit (PG14276); or		
2. a group medical visit (13763-13781); or		
3. an in-person visit with a College-certified allied care provider working within the family physician’s practice team (G14029). (See Preamble definition of “working within” and “College-certified ACP”).		
iv) Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble.		
v) Claim must include the ICD-9 code for heart failure (428).		
vi) Payable once per patient in a consecutive 12 month period.		
vii) Payable in addition to fee items PG14250 or PG14253 for same patient if eligible.		
viii) Not payable once PG14063 is billed and paid.		
ix) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.		
G14252 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (hypertension) .....	293.00	50.00

*(see notes on next page)*



<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

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 has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be:
  - 1. a GPSC telephone visit (PG14276); or
  - 2. a group medical visit (13763-13781); or
  - 3. an in-person visit with a College-certified allied health provider working within the family physician’s practice team (PG14029). (See Preamble definition of “working within” and “College-certified ACP”).
- iv) Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble.
- v) Claim must include the ICD-9 code for hypertension (401).
- vi) Payable once per patient in a consecutive 12 month period.
- vii) Not payable if fee items PG14250 or PG14251 paid within the previous 12 months.
- viii) Not payable once PG14063 has been billed and paid.
- ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

G14253 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease – COPD).....	293.00	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.
- (notes continued on next page)*

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>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.</li> <li>iii) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively one of the two visits must be a physician visit, while the second visit may be:               <ul style="list-style-type: none"> <li>1. a GPSC telephone visit (PG14276) or</li> <li>2. a group medical visit (13763-13781); or</li> <li>3. an in-person visit with a College-certified allied care provider working within the family physician’s practice team (PG14029). (See Preamble definition of “working within” and “College-certified ACP”).</li> </ul> </li> <li>iv) Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble.</li> <li>v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).</li> <li>vi) Payable once per patient in a consecutive 12 month period.</li> <li>vii) Payable in addition to fee items PG14250, PG14251 or PG14252 for the same patient if eligible.</li> <li>viii) Not payable once PG14063 has been billed and paid.</li> <li>ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.</li> </ul>		
<p>PG14276 Patient Telephone Management encounter code for MRP Family Physicians on alternate payment/funding models providing chronic disease management</p>	0.00	0.00

*(see notes on next page)*

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

**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 PG14250, PG14251, PG14252 and/or PG14253.
- ii) 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 a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed by the eligible physician practice (see GPSC Preamble for definition of allied care provider "employed by" a physician practice and "College-certified ACP").
- iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.
- iv) Not billable for prescription renewal alone.
- v) Not billable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
- vi) Billable to a maximum of 1500 services per physician per calendar year.
- vii) Not billable on the same calendar day as a visit or service by same physician for same patient, with the exception of PG14250, PG14251, PG14252, PG14253.

#### **4. COMPLEX CARE PLANNING AND MANAGEMENT FEES (PG14033, PG14075)**

There are two Complex Care Planning and Management Incentives: PG14033 and PG14075.

Effective April 1, 2020, both PG14033 and PG14075 are available only to MRP Family Physicians who have submitted PG14070 or PG14071. PG14033 and PG14075 are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing calendar year.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

Only one Complex Care Planning and Management Incentive may be billed for an individual patient in any given calendar year, even if the patient meets eligibility requirements for both PG14033 and PG14075. When patients meet eligibility requirements for both Complex Care Incentives, choose either PG14033 or PG14075 – whichever best reflects the cause of their medical complexity.

To be eligible for either of the Complex Care Planning and Management Fees, the effects of the patient’s condition(s) should be significant enough to warrant the development of a management plan. In other words, eligibility is not based solely on the individual diagnoses. Consideration should be given to the overall clinical impact of the diagnoses on the patient.

PG14033	Complex Care Planning and Management Fee - 2 Diagnoses .....	693.00	315.00
---------	---	--------	--------

The Complex Care Planning and Management Fee is payment for the creation of a care plan 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.

**Patient Eligibility:**

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

**PG14033 Complex Care Planning & Management Fee – 2 Diagnoses**

The Complex Care Planning and Management Fee - 2 Diagnoses was developed to compensate FPs for the management of complex patients living in their home or assisted living, who have documented confirmed diagnoses of 2 eligible conditions from at least 2 of the 8 categories listed below.

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

**Eligible Complex Care Condition Categories**

- 1) Diabetes mellitus (type 1 and 2)
- 2) Chronic Kidney Disease
- 3) Heart Failure
- 4) Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis, etc.)
- 5) Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g.: TIA, Migraine)
- 6) Ischemic heart disease, excluding the acute phase of myocardial infarct
- 7) Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.)
- 8) Chronic Liver Disease with evidence of hepatic dysfunction.

If a patient has more than 2 of the eligible conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

**NOTES:**

- i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host MRP FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.
- ii) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions as listed in Table 1.
- iii) Payable once per calendar year per patient on the date of the complex care planning visit.
- iv) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14033.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- v) Minimum required total planning time 30 minutes. The majority of the planning time must be spent face to face between physician and patient (or patient’s medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of “working within” and “College-certified ACP”).
- vi) Chart documentation must include:
  - 1. The care plan;
  - 2. total planning time (minimum 30 minutes); and
  - 3. physician face to face planning time (minimum 16 minutes).
- vii) PG14018 or PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14033.
- viii) PG14050, PG14051, PG14052, PG14053 payable on same day for same patient, if all other criteria met.
- ix) Not payable once PG14063 has been billed and paid.
- x) PG14043, PG14063, PG14076 and PG14078 not payable on the same day for the same patient.
- xi) Maximum daily total of 5 of any combination of PG14033 and PG14075 per physician.
- xii) PG14075 is not payable in the same calendar year for same patient as PG14033.
- xiii) Eligible patients must be living at home or in assisted living. patients in Acute or Long Term Care facilities are not eligible.
- xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

Diagnostic codes submitted with PG14033 billing must be from Table 1. If the patient has multiple comorbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

<b>Table 1: Complex Care Diagnostic Codes</b>		
<b>Diagnostic Code</b>	<b>Condition One</b>	<b>Condition Two</b>
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
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
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
H250	Heart Failure	Diabetes
H430	Heart Failure	Cerebrovascular Disease
H585	Heart Failure	Chronic Kidney Disease
H573	Heart Failure	Chronic Liver Disease
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease
D573	Diabetes	Chronic Liver Disease
C585	Cerebrovascular Disease	Chronic Kidney Disease
C573	Cerebrovascular Disease	Chronic Liver Disease
K573	Chronic Kidney Disease	Chronic Liver Disease

**PG14075 Complex Care Planning and Management Fee - Frailty**      693.00      315.00  
 The Complex Care Planning and Management Fee - Frailty is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for eligible patients of any age with documented frailty from any cause. Frailty is defined as requiring assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL). The effect of the frailty on the patient must be significant enough to warrant the development of a management plan.

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

Patients of any age who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for PG14075.

<b>Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community:</b>	<b>Non-Instrumental Activities of Daily Living (NIADL) = Activities that are related to personal care:</b>
Meal preparation	Mobility in bed
Ordinary housework	Transfers
Managing finances	Locomotion inside and outside the home
Managing medications	Dressing upper and lower body
Phone use	Eating
Shopping	Toilet use
Transportation	Personal hygiene
	Bathing

**Patient eligibility:**

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and long term Care Facilities are not eligible.

**NOTES:**

- i) Payable to the family physician who is most responsible for the majority of the patient’s longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host MRP FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.
- ii) Payable only for patients who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living, the effects of which are significant enough to warrant the development of a management plan.
- iii) Claim must include the diagnostic code V15.
- iv) Payable once per calendar year per patient on the date of the complex care planning visit.
- v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14075.

*(notes continued on next page)*



<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- 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 with the patient and/or their medical representative (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. face to face planning time (minimum 16 minutes)
- viii) PG14018 or PG14077 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for PG14075.
- ix) Maximum daily total 5 of any combination of PG14033 and PG14075 per physician.
- x) PG14075 not payable once PG14063 has been billed and paid.
- xi) PG14033 is not payable in the same calendar year for same patient as PG14075.
- xii) PG14043, PG14063, PG14076, PG14078 not payable on the same day for the same patient.
- xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.
- xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>5. PREVENTION FEE (PG14066)</b>		
PG14066 Personal Health Risk Assessment (Prevention).....	110.00	50.00

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). 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.

Effective April 1, 2020, PG14066 is payable only to MRP Family Physicians who have submitted PG4070 or PG14071.

**Patient Eligibility:**

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

The Ministry of Health website contains:  
 The current Lifetime Prevention Schedule  
<https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/health-priorities/lifeth-prevention>  
 and the BC Prevention Guidelines  
<https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/preventative-health>

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**NOTES:**

- i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host MRP FP have agreed that the locum may provide a planning visit the locum must have successfully submitted and met the requirements for PG14701 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.
- iii) Diagnostic code submitted with PG14066 must be one of the following: Tobacco Use/Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783).
- iv) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.
- v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under PG14066.
- vi) PG14077 payable on same day for same patient if all criteria met.
- vii) PG14033, PG14043, PG14063, PG14076 and PG14078 not payable on the same day for the same patient.
- viii) Payable to a maximum of 100 patients per calendar year, per physician.
- ix) Payable once per calendar year per patient.
- x) Not payable once PG14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.
- xi) Not payable to physicians working an Alternative Payment/Funding model whose duties would otherwise include provision of this care.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**7. MENTAL HEALTH PLANNING AND MANAGEMENT FEE (PG14043)**

This fee is payable upon the completion and documentation of a care plan (as defined in the GPSC Preamble) in the patient’s chart for patients with a confirmed eligible mental health diagnosis when the effect on the patient is significant enough to warrant the development of a care plan. This is not intended for patients with short-lived mental health symptoms (e.g.: normal grief, life transitions).

The mental Health Planning Fee requires a face to face visit with the patient and/or the patient’s medical representative and the physician.

Effective April 1, 2020, PG14043 is payable only to Family Physicians who have submitted PG14070 or PG14071. The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient’s longitudinal comprehensive primary medical care for the ensuing year.

Successful billing of the mental health Planning fee PG14043 allows access to four counselling equivalent mental health management fees in that same calendar year which may be billed once the four MSP counselling fees (any combination of 00120 age differential or telehealth counselling codes) have been utilized.

**Patient eligibility:**

- Eligible patients must be living at home or in assisted living.
- Patients in acute or long term care facilities are not eligible.

PG14043 FP Mental Health Planning Fee .....	220.00	100.00
---	--------	--------

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**NOTES:**

- i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host MRP FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.
- ii) Payable only for patients with documentation of a confirmed eligible mental health diagnosis of sufficient severity to warrant the development of a management plan. Not intended for patients with self-limited or short lived mental health symptoms.
- iii) Payable once per calendar year per patient. Not intended as a routine annual fee.
- iv) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14043.
- v) Minimum required total planning time 30 minutes. The majority of the planning time must be face to face between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to College-certified allied care providers (e.g.: Nurse, Nurse Practitioner) employed 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. face to face planning time (minimum 16 minutes)

*(notes continued on next page)*

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

- vii) PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for PG14043.
- viii) PG14044, PG14045, PG14046, PG14047, PG14048, PG14033, PG14063, PG14075, PG14076 and PG14078 not payable on the same day for the same patient.
- ix) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**Table 1**

Effective April 1, 2020, the following list of eligible diagnoses and ICD-9 codes is to be used when billing the Mental Health Planning and Management Fees, PG14043, PG14044 – PG14048:

<b>CATEGORY</b>	<b>DIAGNOSIS</b>	<b>ICD-9</b>
<b>Anxiety Disorders</b>	Anxiety Disorders	300, 308, 50B
<b>Bipolar and Related Disorders</b>	Bipolar	296
	Cyclothymia	301.13
<b>Depressive Disorders</b>	Depressive disorders	311
<b>Dissociative Disorder</b>	Dissociative Disorders	300
<b>Eating Disorders</b>	Eating Disorders	307, 307.1
<b>Gender Dysphoria</b>	Gender Dysphoria	302
<b>Impulse Control Disorders</b>	Impulse Control Disorders	312
<b>Neurocognitive Disorders</b>	Delirium	293
	Dementia	290, 331, 331.0, 331.2
<b>Neurodevelopmental disorders</b>	Attention Deficit Disorder	314
	Autism Spectrum Disorder	299.0
	Pervasive Developmental Disorder	299.0
<b>Obsessive-Compulsive &amp; Related Disorders</b>	Obsessive-Compulsive Disorder	300
	Body Dysmorphic Disorder	300.7
<b>Schizophrenia and other Psychotic Disorders</b>	Schizophrenia and other Psychotic disorders	293, 295, 297, 298
<b>Sexual Dysfunction</b>	Sexual Dysfunction	302
<b>Sleep Disorders</b>	Sleep wake disorders: Insomnia / hypersomnolence / narcolepsy	307.4, 347
	Parasomnias	307.4
	Breathing-Related Sleep Disorders	780.5
<b>Somatic Symptom &amp; Related Disorders</b>	Factitious disorder	300, 312
	Pain Disorder with Affective Symptoms	338
	Somatic Symptom Disorder	300.8
	Conversion Disorder	300.1
<b>Substance use Disorders</b>	Substance Use Disorder: Alcohol	303
	Substance Use Disorder: Drugs	304
<b>Trauma and stressor related disorders</b>	Adjustment Disorders	309
	Post-Traumatic Stress Disorder	309

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

## 7. MENTAL HEALTH MANAGEMENT FEES (PG14044, PG14045, PG14046, PG14047, PG14048)

PG14044 FP Mental Health Management Fee age 2–49 .....	131.00	56.41
PG14045 FP Mental Health Management Fee age 50–59 .....	147.00	62.05
PG14046 FP Mental Health Management Fee age 60–69 .....	153.00	64.86
PG14047 FP Mental Health Management Fee age 70–79 .....	171.00	73.32
PG14048 FP Mental Health Management Fee age 80+ .....	200.00	84.60

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee PG14043 has been successfully billed. The four MSP counselling fees (any combination of age-appropriate 00120 or telehealth counselling) must first have been paid in the same calendar year.

### NOTES:

- i) Payable only to the physician who has previously billed and been paid the Mental Health Planning fee (PG14043) in the same calendar year, unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note.
- ii) Payable a maximum of 4 times per calendar year per patient.
- iii) Not payable unless the four age-appropriate 00120 or telehealth counselling fees have already been paid in the same calendar year in any combination.
- iv) Minimum time required is 20 minutes.
- v) Start and end times must be included with the claim and documented in the patient chart.
- vi) Counselling may be provided face to face or by videoconferencing.
- vii) PG14077, payable on same day for same patient if all criteria met.
- viii) PG14043, PG14076, PG14078 not payable on same day for same patient.
- ix) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.
- x) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**8. PALLIATIVE CARE PLANNING FEE (PG14063)**

This fee is payable upon the development and documentation of a care plan as described in the GPSC Preamble for patients who in the FP’s clinical judgment 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.

Effective April 1, 2020, PG14063 is payable only to Family Physicians who have submitted PG14070 or PG14071 in the same calendar year.

This fee is payable only to the family physician who commits to providing the majority of the patient’s longitudinal comprehensive primary medical care for the patient.

**Patient Eligibility:**

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

PG14063	FP Palliative Care Planning Fee .....	220.00	100.00
---------	---------------------------------------	--------	--------

**NOTES:**

- i) Payable only to Family Physicians who have successfully submitted and met the requirements for PG14070. Alternatively, if a locum and host MRP FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.

*(notes continued on next page)*



Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

- ii) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.
- iii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).
- iv) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new FP who is assuming the ongoing palliative care for the patient.
- v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under PG14063.
- vi) Minimum required total planning time 30 minutes. The majority of the planning time must be spent face to face between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").
- vii) Chart documentation must include:
  1. the care plan;
  2. total planning time (minimum 30 minutes);  
and
  3. face to face planning time (minimum 16 minutes).
- viii) PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14063.
- ix) Not payable if PG14033 or PG14075 has been paid within 6 months.
- x) Not payable on same day as PG14043, PG14076 or PG14078.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- xi) PG14050, PG14051, PG14052, PG14053, PG14250, PG14251, PG14252, PG14253, PG14033, PG14066, PG14075 not payable once Palliative Care Planning fee is billed and paid.
- xii) The GPSC Mental Health Initiative Fees (PG14043, PG14044, PG14045, PG14046, PG14047, PG14048), are still payable once PG14063 has been billed provided all requirements are met, but are not payable on same day.
- xiii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**9. FP EMAIL, TEXT & TELEPHONE FEES: MEDICAL ADVICE TO PATIENTS (PG14076, PG14078)**

PG14076 FP Patient Telephone Management Fee .....	33.00	20.00
---	-------	-------

NOTES:

- i) Payable only to:
  - a) MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or
  - b) Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or
  - c) Family Physicians Registered in a Maternity Network, Long Term Care 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 a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed by the eligible physician practice. (see GPSC Preamble for definition of allied care provider “employed by” a physician practice and “College-certified ACP”).
- iii) Chart entry must record the name of the person who communicated with the patient or patient’s medical representative, as well as capture the elements of care discussed.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- iv) Not payable for prescription renewals alone.
- v) Not payable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
- vi) Payable to a maximum of 1500 services per physician per calendar year.
- vii) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of PG14077, PG14018, PG14050, PG14051, PG14052, PG14053, 13005.
- viii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

PG14078	FP Email/Text/Telephone Medical Advice Relay Fee ..	16.35	7.00
---------	---	-------	------

PG14078 is payable for 2-way communication of medical advice from the MRP Family Physician to eligible patients, or the patient’s medical representative, via email/text or telephone relay. This fee is not payable for prescription renewals, anticoagulation therapy by telephone (00043) or notification of appointments or referrals.

**NOTES:**

- i) Payable only to:
  - a. MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or
  - b. Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or
  - c. Family Physicians Registered in a Maternity Network, Long Term Care Network, or FP Unassigned In-patient network on a prior date.

*(notes continued on the next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- ii) Email/Text/Telephone Relay Medical Advice requires 2-way relay/communication of medical advice from the physician to eligible patients, or the patient’s medical representative, via email/text or telephone. Alternatively, the task of relaying the physician’s advice may be delegated to any allied care provider or MOA working within the physician practice. (See GPSC Preamble for definition of allied care provider “working within” a physician practice team).
- iii) Chart entry must record the name of the person who communicated with the patient or patient’s medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.
- iv) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
- v) Payable to a maximum of 200 services per physician per calendar year.
- vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of PG14077.

## **10. CONFERENCING AND ADVICE FEES (PG14077, PG14018, PG14019)**

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

PG14077 pays for two-way case conferencing about a patient with at least one allied care provider or physician. The fee is billable regardless of where the patient is located or how the conference occurs (in-person, by phone). Time spent talking to the patient or family member does not count towards conferencing time under PG14077.

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

As start and end times must be submitted, consider:

- a) If conferencing takes place as a series of separate phone calls, use the start time of the first call and calculate the “end time” based on total time spent conferencing.
- b) If billing a same day out-of-office hour’s visit fee code (which also requires start/end times), the time submitted must either be before or after the PG14077 start/end time.

PG14077 FP Conference with Allied care Provider and/or Physician – per 15 minutes or greater portion thereof .	88.00	40.00
--	-------	-------

NOTES:

- i) Payable only to:
  - a) MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or
  - b) Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or
  - c) Family Physicians registered in a Maternity Network, Long Term Care 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.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- vi) Not payable for situations where the purpose of the call is to:
  - a) book an appointment
  - b) arrange for an expedited consultation or procedure
  - c) arrange for laboratory or diagnostic investigations
  - d) convey the results of diagnostic investigations
  - e) arrange a hospital bed for the patient
- vii) If multiple patients are discussed, the billings must be for consecutive, non-overlapping time periods.
- viii) 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).
- ix) Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.
- x) Start and end times must be included with the claim and documented in the patient chart.
- xi) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility or communications which occur as part of regular work flow within a physician's community practice.
- xii) Not payable for simple advice to a non-physician allied care provider about a patient in a facility.
- xiii) Not payable in addition to PG14018.
- xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**Non-MSP-  
Insured  
Fee (\$)**                      **MSP &  
WSBC  
Fee (\$)**

**FP Urgent Telephone Advice from a Physician with Consultative Expertise**

PG14018 is billable when the severity of the patient's condition justifies urgent advice (within 2 hours of request) from a Specialist or Physician with Consultative Expertise (as defined in the GPSC Preamble), in order to develop and implement a plan to keep the patient stable in their current environment. The intent of PG14018 is to improve the management of patients with acute needs, and reduce unnecessary ER or hospital admissions/transfers. This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

PG14018 FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise.....	88.00	40.00
---	-------	-------

PG14018 is payment for telephone advice that is needed on an urgent basis (within 2 hours of request) from a Specialist or Family Physician with Consultative Expertise (as defined in the Preamble). Includes the creation, documentation, and implementation of a plan for the care of patients with acute needs (i.e. requiring attention within the next 24 hours) and communication of that plan to the patient or patient's representative.

**NOTES:**

- i) Payable to the FP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or family physician with consultative expertise (as defined in the GPSC Preamble) regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.
- ii) Conversation must take place within two hours of the FP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, email).

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- 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.
- iv) 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.
- v) Not payable to the same patient on the same date of service as fee item PG14077.
- vi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.
- vii) Include start time in time fields when submitting claim.
- viii) 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. not required within the next 2 hours)
- ix) Limited to one claim per patient per physician per day.
- x) Out-of-Office Hours Premiums may not be claimed in addition.
- xi) Maximum of 6 (six) services per patient, per practitioner per calendar year.
- xii) Payable in addition to a visit on the same day.



<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

**FP Advice to Nurse Practitioner/Registered Midwife Fee**

The intent of PG14019 is to support collaboration between nurse practitioners, registered midwives and community family physicians. This fee is billable when providing advice by telephone or in person to a Nurse Practitioner who is an independent practitioner providing care to patients under his/her MRP care. This fee is not billable for providing advice to a NP when the patient is attached to a FP. This fee is also billable when providing advice by telephone or in person to a Registered Midwife who is an independent practitioner providing maternity care to patients under their MRP care.

PG14019 FP Advice to a Nurse Practitioner/Midwife Fee - Telephone or In person.....	99.20	40.00
---	-------	-------

**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).

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- v) A chart entry, including advice given and to whom, is required.
- vi) NP/Midwife Practitioner number required in referring practitioner field when submitting fee through Teleplan.
- vii) Not payable for situations where the purpose of the call is to:
  - a. Book an appointment
  - b. Arrange for transfer of care that occurs within 24 hours
  - c. Arrange for an expedited consultation or procedure within 24 hours
  - d. Arrange for laboratory or diagnostic investigations
  - e. Convey the results of diagnostic investigations
  - f. Arrange a hospital bed for the patient.
- viii) Limited to 1 (one) claim per patient per day with a maximum of 6 (six) claims per patient per calendar year.
- ix) Limit of 5 (five) PG14019 units may be billed by a FP on any calendar day.
- x) Not payable in addition to another service on the same day for the same patient by same FP.
- xi) Out-of-Office Hours Premiums may not be claimed in addition.
- xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**11. Family Physicians with Consultative Expertise Fees (PG14021, PG14022, PG14023)**

FP with Consultative Expertise Telephone Advice Fees (PG14021, PG14022, PG14023) support tele/videoconferencing between FP's with Consultative Expertise and other Family Physicians, Specialists or Allied Care Providers for the purpose of improving patient care.

The GPSC Preamble defines Family Physicians with Consultative Expertise as:

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

GPSC defines a Physician with Consultative Expertise as “A family physician who has consultative expertise and provides consultative services or support to colleagues through a health authority supported or approved program”. Examples of health authority supported programs include (but are not limited to) mental health, addictions, palliative, chronic pain and emergency medicine.

Eligibility for FP with Consultative Expertise Telephone Advice Fees:

In addition to meeting the definition of FP with Consultative Expertise listed above and in the GPSC Preamble, the following criteria must be met:

- Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- Service may be provided when physician is located in office or hospital.
- Telephone advice must be related to the field in which the FP provides consultative services or support.

Requirements for submission of FP with Consultative Expertise Fee

Effective April 1, 2020, PG14021, PG14022, PG14023 fees will only be billable by physicians who have applied and been confirmed as “FPs with Consultative Expertise” as per the GPSC Preamble. For applications to bill FP with consultative expertise fees, email [gpsc.billing@doctorsofbc.ca](mailto:gpsc.billing@doctorsofbc.ca)

PG14021	FP with Consultative Expertise Telephone/Video Advice - Initiated by a Specialist, Family Physician, or Allied Care Provider, Response within 2 hours .....	132.00	60.00
---------	---	--------	-------

NOTES:

- i) Payable to a FP with consultative expertise (as defined in the GPSC Preamble) for two-way telephone/video communication regarding assessment and management of a patient but without the consulting physician seeing the patient.
- ii) Conversation must take place within two hours of the initiating provider’s request. Not payable for written communication (i.e. fax, letter, e-mail).

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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: <ul style="list-style-type: none"> <li>a) book an appointment</li> <li>b) arrange for transfer of care that occurs within 24 hours</li> <li>c) arrange for an expedited consultation or procedure within 24 hours</li> <li>d) arrange for laboratory or diagnostic investigations</li> <li>e) convey the results of diagnostic investigations</li> <li>f) arrange a hospital bed for the patient</li> </ul>		
v) Not payable to provider initiating call.		
vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).		
vii) Limited to one claim per patient per physician per day.		
viii) A chart entry, including advice given and to whom, is required.		
ix) Start times must be included with the claim and documented in the patient chart.		
x) Not payable in addition to another service on the same day for the same patient by same physician.		
xi) Out-of-Office Hours Premiums may not be claimed in addition.		
xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.		
xiii) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note record specifying the type of provider).		

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

PG14022 FP with Consultative Expertise Telephone/Video Advice  
- Initiated by a Specialist, Family Physician or Allied  
Care Provider, Response within one Week – per 15  
minutes or portion thereof.....

88.00

40.00

**NOTES:**

- i) Payable to a FP with Consultative Expertise (as defined in the GPSC Preamble) for two-way telephone/video communication regarding assessment and management of a patient but without the consulting physician seeing the patient.
- ii) Conversation must take place within 7 days of initiating provider’s request. Initiation may be by phone or referral letter.
- iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient’s condition and management after reviewing laboratory and other data where indicated.
- iv) Not payable for situations where the purpose of the call is to:
  - a) book an appointment
  - b) arrange for transfer of care that occurs within 24 hours
  - c) arrange for an expedited consultation or procedure within 24 hours
  - d) arrange for laboratory or diagnostic investigations
  - e) convey the results of diagnostic investigations
  - f) arrange a hospital bed for the patient
- v) Not payable to provider initiating call.
- vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).
- vii) Limited to two services per patient per physician per week.
- viii) A chart entry, including advice given and to whom, is required.
- ix) Start and end times must be included with the claim and documented in the patient chart.
- x) Not payable in addition to another service on the same day for the same patient by same physician.

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
xi) Out-of-Office Hours Premiums may not be claimed in addition.		
xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.		
xiii) Include the practitioner number of the provider requesting advice in the “referred by” field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note record specifying the type of provider).		
 G14023 FP with Consultative Expertise - Patient Telephone/Video Management/Follow-Up .....	44.00	20.00
NOTES:		
i) This fee applies to two-way telephone/video communication between the FP with consultative expertise (as defined in the GPSC Preamble) and patient, or a patient’s representative. Not payable for written communication (i.e. fax, letter, e-mail).		
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.		

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

viii) Out-of-Office Hours Premiums may not be claimed in addition.

ix) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**12. FAMILY PHYSICIAN OBSTETRICAL PREMIUMS (PG14004, PG14005, PG14008, PG14009)**

The following fees are payable to BC's eligible family physicians. The purpose of the payment is to encourage family physicians to continue to provide obstetrical care, giving women the benefit of choice and longitudinal care. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

Effective April 1, 2020, PG14004, PG14005, PG14008 and PG14009 are payable only to Family Physicians who have submitted PG14070 or PG14071 in the same calendar year, or who are registered in a Maternity Network

G14004 Obstetric Delivery Incentive for Family Physicians - associated with vaginal delivery and postnatal care ....	700.00	375.40
--	--------	--------

NOTES:

- i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care and who has successfully:
  - a) Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
  - b) Registered in a Maternity Network on a prior date.
- ii) Payable only when fee item 14104 billed in conjunction.
- iii) Maximum of one incentive under fee item PG14004, PG14008, PG14009 per patient delivered.
- iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
G14005 Obstetric Delivery Incentive for Family Physicians - associated with management of labour and transfer to a higher level of care facility .....	293.00	156.34
NOTES:		
i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care and who has successfully:		
a) Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or		
b) Registered in a Maternity Network on a prior date.		
ii) Payable only when fee item 14105 billed in conjunction.		
iii) Payable in addition to PG14004 or PG14009 when billed and paid to a different GP attending delivery in the receiving hospital.		
iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.		
G14008 Obstetric Delivery Incentive Family Physicians - associated with postnatal care after an elective caesarean section .....	145.00	77.23
NOTES:		
i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care and who has successfully:		
a) Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or		
b) Registered in a Maternity Network on a prior date.		
ii) Payable only when fee item 14108 billed in conjunction.		
iii) Maximum of one incentive under fee item PG14004, PG14008, PG14009 per patient delivered.		
iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.		



	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
G14009 Obstetric Delivery Incentive for Family Physicians – associated with attendance at delivery and postnatal care associated with emergency caesarean section....	584.00	312.70
NOTES:		
i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient’s primary medical care and who has successfully:		
a) Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or		
b) Registered in a Maternity Network on a prior date.		
ii) Payable only when fee item 14109 billed in conjunction.		
iii) Maximum of one incentive under fee item PG14004, PG14008, PG14009 per patient delivered.		
iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.		

### **13. MATERNITY NETWORK INITIATIVE (H14010)**

Eligible family physicians can receive a quarterly payment each quarter ending March 31, June 30, September 30 & December 31, to cover the costs of group/network activities for their shared care of obstetric patients (both assigned and unassigned obstetric patients).

To support conferencing with other health care providers with other health care providers and communication with patients, registration in a Maternity Network allows access to FP Conferencing Incentive PG14077 and FP Patient telephone/advice Incentives PG14076 and PG14078. As part of the GPSC In-patient Initiative, members of Maternity Networks are eligible to bill the Unassigned In-patient Care fee H14088 for unassigned pregnant patients for whom they are the Most Responsible Physician (MRP). Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned.

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

**Note: Claims received for processing before the date of service or with a date of service other than the last day in a quarter will be refused.**

Effective April 1, 2020, registration in a Maternity Network provides access to the Obstetrical Delivery Incentives for Family Physicians (PG14004, PG14005, PG14008 and PG14009)

H14010 Maternity Care Network Initiative Payment – per quarter	2100.00
--	---------

**Eligibility:**

To be eligible to be a member of the network, you must, for the 3-month period up to the payment date:

- Be a family physician in active practice in BC;
- Have hospital privileges to provide obstetrical care;
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care). Refer to the Maternity Network Registration Form found on the GPSC website at <http://www.gpsc.bc.ca/>;
- Cooperate with other members of the network so that one member is always available for deliveries;
- Make patients aware of the members of the network and the support specialists available for complicated cases;
- Accept a reasonable number of referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy; the referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care);

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- Share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic prenatal record;
- Each doctor must schedule at least four deliveries in each 6-month period of time (April to September, October to March); and
- The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day).

**Billing Information for Maternity Care Network Initiative Payment:**

PHN:	9824870522
Patient Last name:	Maternity
Patient First name/initial:	G
Date of Birth:	November 2, 1989
Diagnostic code:	V26
For Date of service use:	Last day in a calendar quarter
Billing Schedule:	Last day of the month, per calendar quarter

**14. GPSC INCENTIVES FOR IN-PATIENT CARE (H14086, H14088)**

The GPSC In-patient Initiative was developed to recognize and better support the continuous relationship with a family physician (FP) that can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. An important aspect of such continuous care is the coordination of care through the in-patient journey as well as in transitions between hospital and community FP offices. There are two separate levels of incentives aimed at better supporting and compensating FPs who provide this important aspect of care. This initiative will support family physicians who:

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- Provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned In-patients); and may also
- As part of a network, provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned In-patients).

To participate in the GPSC In-patient Initiative, it is expected that these FPs agree to the following expectations:

- A. They are members of the active or equivalent medical staff category and have hospital privileges in the identified acute care hospital.
- B. That their on-call colleagues (Network) are also members of the active or equivalent medical staff category and have hospital privileges.
- C. That they will:
  - Coordinate and manage the care of hospitalized patients (assigned and/or unassigned), admitted under them as the MRP.
  - Provide supportive care when their hospitalized patient is admitted under a specialist as MRP.
  - See all acute patients under their MRP care on a daily basis and document a progress note in the medical record.
  - 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.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- 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.

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

**FP Assigned Inpatient Care Network (H14086)**

The FP Assigned Inpatient Care Network Initiative was designed to support community Family Physicians who continue to accept Most Responsible Physician (MRP) status to provide care to their own patients who have been admitted to hospital. The Assigned In-patient Network payment is for FPs who provide in-patient care services for their own and colleagues' patients (assigned). Maternity patients are not included under the Assigned In-patient Network if the FP is also participating in a GPSC Maternity Care Network because those patients are counted as part of that incentive.

H14086	FP Assigned Inpatient Care Network Initiative .....	4620.00	2100.00
--------	---	---------	---------

**Eligibility**

To be eligible to be a member of a FP Assigned Inpatient Care Network, you must meet the following criteria:

- Be a Family Physician in active practice in BC.
- Have active hospital privileges.
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing inpatient care – see below).
- Submit a completed Assigned Inpatient Care Network Registration Form.
- Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.
- Each doctor must provide MRP care to at least 24 admitted patients over the course of a year; networks may average out this number across the number of members.

This network incentive is payable in addition to visit fees, but is inclusive of time spent in associated Quality Improvement activities necessary to maintain privileges such as M and M rounds as well as time spent on network administration, etc.

**Non-MSP-  
Insured  
Fee (\$)**

**MSP &  
WSBC  
Fee (\$)**

Exemptions for communities where it may be difficult to achieve the minimum volume of MRP inpatient cases will be considered by the GPSC Inpatient Care Working Group.

The FP Assigned In-Patient Care Network Incentive is payable for participation in the network activities for the majority of the following calendar quarter (50% plus 1 day). Once your registration in the network has been confirmed, submit fee item H14086 GP Assigned in-patient care network fee using the following billing specifics:

Billing Schedule: First day of the month, per calendar quarter (January 1, April 1, July 1, October 1) and is paid for the subsequent quarter. ICD9 Code: 780

Your location will determine which PHN# to use:

**Interior Health Authority:**

PHN#	9752590587
Patient Surname:	Assigned
First Name:	IHA
Date of birth:	January 1, 2013

**Fraser Health Authority:**

PHN#	9752590548
Patient Surname:	Assigned
First Name:	FHA
Date of birth:	January 1, 2013

**Vancouver Coastal Health Authority:**

PHN#	9752590523
Patient Surname:	Assigned
First Name:	CVHA (note first name starts with 'C')
Date of birth:	January 1, 2013

**Vancouver Island Health Authority:**

PHN#	9752590516
Patient Surname:	Assigned
First Name:	VIHA
Date of birth:	January 1, 2013

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

**Northern Health Authority:**

PHN#	9752590509
Patient Surname:	Assigned
First Name:	NHA
Date of birth:	January 1, 2013

**FP Unassigned Inpatient Care Fee (H14088)**

The term “Unassigned Inpatient” is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted.

The FP Unassigned Inpatient Care Fee is designed to provide an incentive for Family Physicians to accept Most Responsible Physician (MRP) status for an unassigned patient’s hospital stay. It is intended to compensate the Family Physician for the extra time and intensity required to evaluate an unfamiliar patient’s clinical status and care needs when the patient is admitted and is only billable once per hospital admission.

This fee is restricted to Family Physicians actively participating in the FP Unassigned Inpatient Care Network or the FP Maternity Network. This fee is billable through the MSP Teleplan system and is payable in addition to the hospital visit (00109, 13109, 13008, 00127) or delivery fee.

H14088 FP Unassigned Inpatient Care Fee ..... 330.00      150.00

**NOTES:**

- i) Payable only to Family Physicians who have submitted a completed FP Unassigned Inpatient Care Network Registration Form and/or a FP Maternity Network Registration Form.
- ii) Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.
- iii) Payable once per unassigned patient per in-hospital admission in addition to hospital visit (00109, 13109, 13008, 00127) or delivery fee.
- iv) Not payable to physicians who are employed by or who are under contract to a facility or working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.



# ALLERGY AND IMMUNOLOGY

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

	Non-MSP - Insured Fee (\$)	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>		
NOTES:		
i) 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.		
ii) 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.).		
iii) Allergy skin test fees are payable in addition to consultations.		
30010 <b>Allergy and Immunology Consultation:</b> 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 .....	570.00	184.96
30011 <b>Pediatric Allergy and Immunology Consultation:</b> 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 .....	687.00	187.36
30012 <b>Repeat or Limited Allergy and Immunology Consultation:</b> To apply where a consultation is repeated for the same condition within six (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 .....	287.00	61.96
<b><u>Continuing Care by Consultant:</u></b>		
30006 Directive care.....	105.00	35.96
30007 Subsequent office visit.....	111.00	37.97
30008 Subsequent hospital visit.....	80.90	22.14
30005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums) .....	327.00	87.57
NOTE: Claim must state time service rendered.		

	<b>Non-MSP - Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>		
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.....	570.00	184.96
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.....	687.00	187.36
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.....	287.00	61.96
30076 Telehealth directive care .....	105.00	35.96
30077 Telehealth subsequent office visit .....	111.00	37.97
30078 Telehealth subsequent hospital visit.....	80.90	22.14
 <b>ALLERGY SKIN TESTING</b>		
S00762 Scratch test, per antigen..... Note: Minor tray fee may be paid in addition if a minimum of 16 antigens are used.	7.00	1.06
S00763 Scratch test, children under 5 years of age, per antigen .. Note: Minor tray fee may be paid in addition if a minimum of 14 antigens are used.	7.45	2.32
S00764 Intracutaneous test (per test).....	9.95	2.15
S00765 Annual maximum (to include scratch or intracutaneous tests) for each physician - per patient.....	159.00	34.40
S00767 Patch testing (extra) - annual maximum is 80 tests (per test) .....	6.45	1.96
 <b>PULMONARY INVESTIGATIVE AND FUNCTION STUDIES</b>		
<b>Exercise Studies:</b>		
NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation.		
S00958 Testing for exercise-induced asthma by serial flow measurements - professional fee .....	96.40	22.35
S00959 – technical fee.....	145.00	32.95

	<b>Non-MSP - Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>TESTS PERFORMED IN A PHYSICIAN'S OFFICE</b>		
30015 Secretion smear for eosinophils.....	28.65	7.29

# ANESTHESIOLOGY

## PREAMBLE

The tariff is for all types of anesthetic service. This includes general and regional anesthesia, resuscitation, 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	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<b>Per 15 min or part thereof</b>			
2	01172	126.00	34.89
3	01173	134.00	34.89
4	01174	143.00	36.64
5	01175	148.00	38.41
6	01176	155.00	40.15
7	01177	160.00	41.90
8	01178	165.00	43.67
9	01179	171.00	45.46
10	01180	179.00	47.20
11	01181	189.00	48.98

THE TOTAL ANESTHETIC FEE is determined by selecting the appropriate item or items:

1. Pre-anesthetic evaluation fee.
2. Consultation and continuing care fees.
3. Anesthetic intensity/complexity levels.
4. Anesthetic 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 anesthesia is required. The assessment when performed immediately prior to anesthesia 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, then **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 physical is 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 listings. 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 "anesthesia procedural fee modifier" and "acute pain management" sections of the fee guide.
- 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 **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 **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 has the highest procedural rate (e.g.: emergency craniotomy with compound fractured 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 anesthesia care for all surgical, therapeutic and/or diagnostic procedures. These fees are payable to all anesthesiologists. They do not apply to diagnostic and therapeutic anesthesia fees.
- b) **01059, 01065, 01070, 01071, 01072, 01077, 01082, 01084, 01093, 01164, 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) **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 in 3.d) i) by 15%.

## ANESTHESIOLOGY - Continued

- d) **01080** can only be used once per case, even if it qualifies more than once (e.g.: ASA 5E cardiac surgical case with an I.A.B.P. lasting 12 hours will be paid at 15%).
- e) 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 anesthesiologists.

- 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 OR 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** and **01095** are eligible for out-of-office hours premium 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 hours premium charges and continuing care surcharges.
- e) DTAF's 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 OR, 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 anesthesia procedural modifiers (**01071, 01072, 01082, 01084**). Catheters placed subsequently in the **P.A.R.** and/or ICU will be paid according to the acute pain management listings (**01025, 01026, 01074, 01007**). Catheter supervision visits (**01076, 01021, 01073**) in the **P.A.R.** should be billed as routine **P.A.R.** care as per 3. d) i).

- c) All acute pain management fee items are eligible for out-of-office hours premium 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 payment agency 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. Payment of visits in excess of this will require written explanation to the payment agency.
  - 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 anesthesia.
    - 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 anesthesia 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 for PCA post-operatively is included in the anesthesia 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 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. MONITORED ANESTHETIC CARE

An anesthesiologist's continuous 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 anesthesia 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) When 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 ANESTHESIA 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 anesthesia in addition to the procedure performed. In emergency situations it may be necessary for the surgeon to act as an anesthesiologist; a charge for such service should be accompanied with a written explanation of the circumstances by the surgeon concerned when billing payment agencies.

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 charge.
- b) The foregoing also applies to anesthetic procedural fees 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 the second anesthesiologist would pose an unacceptable risk of adverse outcome to the second patient SO THAT, in the judgement of the attending physicians, 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 respiratory arrest in a **P.A.R.** requires intubation. The patient undergoing a procedure in the OR 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" caesarean section for life threatening fetal distress and supervising two anesthetics

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 anesthesia 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. Examples where unusual detention may be required include (but not limited to) are:
- i) Patients with: prolonged neuromuscular paralysis, hemodynamic 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. Dental Anesthesia Policy

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 anesthesia. The exceptions will apply to dental services regardless of the location in which they are performed.

Dental-related anesthesia services are only a benefit when the dental procedure is an insured service under MSP unless one of the following exceptions exists:

- i) 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
- ii) The patient has a severe mental or physical disability that precludes the performance of the dental procedure(s) under local anesthesia; or
- iii) There is a demonstrated medical contra-indication (e.g.: allergy) to local anesthesia precluding the performance of the dental procedure(s) under local anesthesia; or
- iv) There is difficulty with access to the airway precluding the performance of the dental procedure(s); or
- v) 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 anesthesia; or
- vi) The emergent nature of the dental condition requires immediate attention under general anesthesia.

*(See notes on following page)*

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 anesthesia 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 anesthesia 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 anesthesia claims, the dental or oral and maxillofacial surgeon requesting the anesthesia will be responsible for reimbursement. Recoveries will be applied to the Available Amount for physician services.

## ANESTHESIA FEE ITEMS

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>VISIT / EVALUATION</b>			
01107 Office visit .....	208.00		56.75
NOTE: Not paid with other listings.			
01108 Hospital visit (weekday) .....	172.00		50.74
NOTE:			
i) Not paid with other listings.			
ii) Applies only on weekdays, excluding statutory holidays.			
iii) Out-of-Office Hour Premiums are not applicable.			
P01109 Hospital visit (Saturday, Sunday, or statutory holiday)...	206.00		88.62
NOTES:			
i) Not paid with other listings.			
ii) Applies only on Saturday, Sunday or statutory holidays.			
iii) Out-of-Office Hour Premiums are not applicable.			
01151 <b>Pre-anesthetic Evaluation:</b> Applies to standard pre-anesthetic evaluation .....	112.00		60.85
NOTE: Applicable to certified anesthesiologist only.			
<b>REFERRED CASES</b>			
01015 <b>Consultation:</b> By a certified specialist in anesthesiology 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 .....	374.00		132.71
01115 <b>Repeat or Limited Consultation:</b> By a certified specialist in anesthesiology to apply where a consultation is repeated for the same condition/problem within six (6) months by the same consultant, or where, in the judgement 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.....	241.00		76.14

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
01016 <b>Consultation:</b> By a certified specialist in anesthesiology <b>for diagnostic opinion and/or therapeutic management of complicated chronic pain, and/or related problems.</b> 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 .....	753.00		201.75
01116 <b>Repeat or Limited Consultation:</b> By a certified specialist in anesthesiology to apply for a diagnostic opinion and/or therapeutic pain management where a consultation is repeated for the same condition/problem within six (6) months by the same consultant, or where in the judgement of the consultant, the consultative service does not warrant 01016. ....	372.00		100.86
NOTES:			
i) 01016 and 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 for 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 <u>re-referred</u> for further blocks within 6 months, then a follow-up consultation (01116) plus the nerve block is payable.			
<b><u>Telehealth Service with Direct Interactive Video Link with the Patient:</u></b>			
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 .....	354.00		132.71

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>ANESTHETIC PROCEDURAL FEE MODIFIERS</b>			
01168 Neonates (less than 42 gestational weeks and/or 4000 grams or less) .....	299.00		122.20
01169 BMI ≥ 35 – per 15 minutes or part thereof .....	34.30		10.00
NOTES:			
i) Restricted to certified specialists in Anesthesiology.			
ii) Payable only when fee items 01172, 01173, 01174, 01175, 01176, 01177, 01178, 01179, 01180, 01181, 01005, 01106, 01110, or 01111 are also payable.			
iii) Applicable to all patients ≥ 19 years of age with a BMI ≥ 35 and to all patients < 19 years of age with a BMI ≥ 97 <sup>th</sup> 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.			
01164 Patients 70 - 79 years of age .....	74.80		20.38
01165 Patients 80 years of age and over .....	155.00		41.56
01065 Patients under one year of age .....	151.00		61.10
NOTE: Not to be billed in addition to 01168.			
01059 Prone position .....	112.00		35.50
01166 Sitting position where there is a danger of venous air embolism .....	223.00		61.13
01070 Controlled hypotension in neurosurgical anesthesia to lower mean blood pressure to 60 mm Hg or less, or the appropriate safe lower limit .....	223.00		61.13
01093 Spinal cord monitoring (interpretation of SSEP during anesthetic) .....	151.00		40.76
01077 Pulmonary artery catheterization .....	206.00		55.60
01071 Thoracic epidural catheter insertion during anesthesia, to include initial injection and/or infusion set-up .....	200.00		54.28
01072 Lumbar epidural catheter insertion during anesthesia, to include initial injection and/or infusion set-up .....	155.00		41.75
01082 Axillary catheter insertion during anesthesia, to include initial injection and/or infusion set-up .....	89.00		24.26
01084 Intrapleural catheter insertion during anesthesia, to include initial injection and/or infusion set-up .....	104.00		27.93
01192 Awake intubation by any means in the patient with a suspected or proven difficult airway .....	223.00		61.13
NOTE: Applicable only when airway score is 3 or 4.			
01096 Retrobulbar/peribulbar block administered by an anesthesiologist in conjunction with an anesthetic .....	124.00		34.04

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- 01080 In the following cases an additional 15% of the procedural fee will be paid:
- a) All patients (except cardiac surgery patients) who have an incapacitating, systemic disease which is a constant threat to life, or who are not expected to survive for 24 hours, i.e. ASA 4 or 5.
  - b) Cardiac surgery patients who have emergency surgery, i.e. ASA 4E or 5E.
  - c) Cardiac or transplant surgery patients who require an I.A.B.P. 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.**

**RESUSCITATION BY AN ANESTHESIOLOGIST**

NOTE: 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 .....	214.00	83.73
---	--------	-------

NOTES:

- i) Includes endotracheal intubation, cricothyroidotomy, chest tube drainage, monitoring and pacemaker insertion.
- ii) Consultations not paid in addition.

01090 Neonatal resuscitation by an anesthesiologist - per 15 minutes or part thereof .....	214.00	83.73
--	--------	-------

NOTES:

- v) Applicable where the Apgar score is 5 or less, as noted on the delivery record.
- vi) Includes endotracheal intubation and/or umbilical vessel catheterization.
- vii) Consultation not paid in addition.

01091 Intubation requested by attending physician with no responsibility for subsequent care. ....	487.00	170.28
--	--------	--------

NOTES:

- i) Applicable to removal and reinsertion of ET tube.
- ii) Consultations will not be paid in addition.

ANESTHESIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
01094 Pulmonary artery catheter placement (not associated with an anesthetic).....	615.00		167.09
01095 Intra-arterial catheter placement (isolated procedure) ...	126.00		34.46
00017 Insertion of central venous pressure catheter .....	96.40		23.77

**DIAGNOSTIC AND THERAPEUTIC ANESTHESIA FEES**

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.....	499.00		135.49
01124 Peripheral nerve block - single.....	241.00		64.17
01125 Peripheral nerve block - multiple.....	362.00		96.97
01035 Gasserian ganglion.....	933.00		254.41

**Epidural Blocks:**

01135 Lumbar.....	555.00		150.36
01036 Thoracic.....	861.00		228.03
01037 Cervical.....	994.00		263.12
01138 Caudal block.....	555.00		150.36

**Nerve Root or Facet Blocks:**

01140 Cervical – single .....	672.00		183.13
01141 Cervical – multiple .....	896.00		244.17
01142 Thoracic – single.....	614.00		167.72
01143 Thoracic – multiple.....	825.00		223.60
01144 Lumbar – single .....	558.00		152.31
01145 Lumbar – multiple .....	746.00		203.09

NOTE: Fee items 01140, 01141, 01142, 01143, 01144  
 and 01145 must be performed under medical imaging  
 guidance (ultrasound, fluoroscopy or CT) with image  
 capture.

**Subarachnoid (Spinal) Blocks:**

01032 Subdural - spinal.....	587.00		160.01
01034 Differential - spinal .....	783.00		213.36

**Sympathetic Nerves:**

01040 Stellate ganglion .....	431.00		117.92
01042 P.A.R avertebral (lumbar sympathetic).....	716.00		193.87
01044 Celiac plexus .....	990.00		269.84



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Permanent Cryosection and/or Neurolysis:</b>			
01146 Major plexus or nerve root.....	1293.00		352.86
01147 Single peripheral nerves.....	614.00		166.87
01148 Multiple peripheral nerves.....	825.00		223.60
01149 Epidural or subarachnoid neurolysis.....	1455.00		397.04
01150 Gasserian ganglion neurolysis.....	1455.00		397.04
<b>Injection Tendon Sheath, Ligaments, Trigger Points:</b>			
01156 Single injections.....	223.00		60.75
01157 Multiple Injections.....	279.00		76.20
01159 IV injections for diagnosis and/or therapeutic management of chronic pain syndromes - local anesthetic only.....	223.00		60.75
01160 IV injections for diagnosis and/or therapeutic management of chronic pain syndromes – ketamine only.....	396.00		121.52

## ACUTE PAIN MANAGEMENT

**See anesthesia preamble for application and limitations.**

01013 Consultation by a certified specialist in anesthesiology 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 .....	241.00		101.03
01026 Thoracic epidural catheter insertion, to include initial injection and/or infusion set-up.....	616.00		228.03
01025 Lumbar or caudal epidural catheter insertion (to include initial injection and/or infusion set-up) .....	464.00		150.36
01050 Repeat injection via indwelling epidural catheter to a maximum of 4 per day - per injection..... NOTE: Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.	160.00		60.85
01073 Hospital visit for supervision of epidural infusion to a maximum of 2 per day - per visit..... NOTE: Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.	95.60		40.57
01074 Axillary catheter insertion, to include initial injection and/or infusion set-up.....	268.00		72.55

ANESTHESIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
01075 Repeat injections via indwelling axillary catheter to a maximum of 4 per day - per injection ..... NOTE: Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.	160.00		60.85
01076 Hospital visit for supervision of axillary catheter infusion to a maximum of 2 per day - per visit..... NOTE: Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.	95.60		40.57
01007 Intrapleural catheter insertion, to include initial injection and/or infusion set-up .....	306.00		83.54
01019 Repeat injections via indwelling intrapleural catheters to a maximum of 4 per day - per injection ..... NOTE: Where more than 4 injections per day are necessary, an explanatory note in the claim note record is required.	160.00		60.85
01021 Hospital visit for supervision of intrapleural infusion to a maximum of 2 per day - per visit..... NOTE: Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.	95.60		40.57
01011 Patient controlled analgesia (PCA) - first day only (to include set up) .....	80.10		21.79
01012 Hospital visit for supervision of patient controlled analgesia during second and subsequent days, to a maximum of two visits per day - per visit ..... NOTES: i) Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required. ii) 01012 is not claimable on the same day as 01011.	80.10		40.57
01186 Major peripheral nerve block - single .....	171.00		45.85
01187 Major peripheral nerve block - multiple .....	259.00		69.28

**OBSTETRIC ANALGESIA FEES**

01102 Insertion of epidural catheter. To include initial injection and/or set up of infusion for analgesia during labour .....	482.00		127.43
<b>Supervision of Labour Epidural Analgesia</b>			
01047 Medical supervision of labour epidural analgesia: Daytime (Monday to Friday, 0800-1800 hours), per 5 minutes (or major portion thereof)	28.15		9.57

ANESTHESIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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) .....	42.20		14.38
01049 Medical supervision of labour epidural analgesia: night (Monday to Sunday, 2300-0800 hours), per 5 minutes (or major portion thereof).....	56.10		19.16

Notes:

- i) Fees are payable to the same physician concurrently with services provided to other patients, including concurrent payment of fee items 01047, 01048, 01049 for more than one patient.
- ii) The fee items 01047, 01048, 01049 are payable to a maximum of 48 units per patient, per maternity.
- iii) Payment begins immediately after the labour epidural catheter is inserted.
- iv) Payment continues until the earliest of the following:
  - 4 hours duration of medical supervision (48 time units).
  - Time of Birth.
  - Time when payment begins for anesthetic care on the same patient related to C-section, complicated delivery, or surgical delivery.
- v) Fees include payment for labour epidural analgesia top-up and supervision visit services.
- vi) Reinsertion of a labour epidural catheter is payable under fee item 01102, and does not form part of the medical supervision period.
- vii) Our-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**

01110 Anesthesia for dental procedures - all procedures unless otherwise listed - per 15 minutes or part thereof .....	134.00		36.64
--	--------	--	-------

ANESTHESIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
01005 Anesthesia for magnetic resonance imaging (MRI) or CT scanning - per 15 minutes or part thereof ..... NOTE: Intended to apply only to very heavy sedation, general anesthesia and/or ventilatory assistance associated with MRI.	143.00		36.64
01105 Anesthesia for cataract surgery – per 1 minute increment ..... Note: This item applies to fee codes S02188, S02190, S02192, S02196 and S22191.	8.35		2.00
01106 Anesthesia for electroconvulsive therapy (ECT) - per 15 minutes or part thereof.....	126.00		41.90
01111 Anesthesia for emergency relief of acute upper airway obstruction (above the carina) - per 15 minutes or part thereof..... NOTES: i) Applicable to conditions such as acute epiglottitis but not applicable to conditions 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 01110, 01106 and 01111.	189.00		48.98
01112 Anesthetic attendance - per 15 minutes or part thereof. .... 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.	119.00		36.64
01158 Epidural blood patch .....	464.00		181.82

**TRANSPLANT SURGERY**

**Anesthetic Levels for Transplant Surgery:**

Pulmonary transplant - single or double.....	11
Repeat intrathoracic surgery in the pulmonary transplant recipient during initial hospitalization.....	10
Cardiac transplant.....	9
Cardio-pulmonary transplant.....	10
Repeat intrathoracic surgery in the cardiac or cardio-pulmonary transplant recipient during initial hospitalization .....	10
Hepatic transplant.....	11
Repeat hepatic transplant .....	11
Renal transplant.....	6

ANESTHESIOLOGY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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	
Anesthesia level for retrieval of organ(s) for transplant ..		7	

# CARDIAC SURGERY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
07810 <b>Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, and a written report .....	309.00		193.65
07812 <b>Repeat or Limited Consultation:</b> 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 judgement of the consultant the consultative service does not warrant a full consultative fee .....	159.00		65.10
07815 Pre-Operative Assessment .....	402.00		193.65

**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.

**Continuing Care by Consultant:**

07807 Subsequent office visit .....	66.90		28.85
07808 Subsequent hospital visit.....	57.30		24.63
07809 Subsequent home visit .....	117.00		49.62
07805 Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	235.00		99.03

NOTE: Claim must state time service rendered.

**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. ....	309.00		193.65
--	--------	--	--------

CARDIAC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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.....	159.00		65.10
78007 Telehealth subsequent office visit.....	66.90		28.85
78008 Telehealth subsequent hospital visit.....	57.30		24.63

**ARTERIAL SYSTEM**

07818 Resection of ascending aortic aneurysm .....	3903.00	10	1690.88
07819 Resection of descending aortic aneurysm .....	3903.00	10	1690.88
07820 Coarctation of aorta .....	2155.00	9	941.63
07822 Ruptured thoracic aneurysm.....	4163.00	11	1825.97
07825 Resecting left ventricular aneurysms in conjunction with another procedure .....	628.00	10	273.08
07826 Resection of aortic arch aneurysm.....	5462.00	10	2395.05
07827 Repair of aortic dissection (thoracic).....	3855.00	10	1690.88
07828 Repair of aortic injury (thoracic).....	3855.00	10	1690.88
07829 Repair of traumatic injury of major intrathoracic vessels.	2155.00	10	941.63

**HEART AND MEDIASTINUM**

**Heart:**

07830 Banding of pulmonary artery.....	1880.00	9	822.92
07831 Pericardiotomy with poudrage.....	1880.00	9	822.92
07832 Pericardectomy .....	1880.00	9	822.92
07833 Left atrial appendage ligation .....	1373.00	9	597.73
07834 Patent ductus arteriosus .....	1880.00	9	822.92
07835 Tetralogy of Fallot - Blalock or Pott's.....	1880.00	9	822.92
07836 Blalock-Hanlon procedure.....	1880.00	9	822.92
07837 Mitral commissurotomy (closed) .....	1880.00	9	822.92
07838 Pulmonary valvulotomy (closed) .....	1880.00	9	822.92
07839 Aortic valvulotomy.....	1880.00	9	822.92
S07843 Endocardial pacemaker (ventricular) .....	984.00	4	414.25
S07953 Double lead endocardial pacemaker.....	1263.00	4	541.77
S78030 AICD and single ventricular lead.....	1192.00	8	578.55
NOTE: Thoracotomy (79045) is paid in addition at 50% when required for incision in chest for RV lead.			
S78031 - each additional lead, to a maximum of 3 extra leads ....	499.00		210.39
S07952 Electronic monitoring of pacing and pacemaker function .....	227.00		96.22

CARDIAC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S07844 Implantation or replacement of pulse generator for cardiac pacing .....	588.00	4	250.28
07845 Repair, replacement, adjustment of electrode .....	588.00	4	253.15
NOTE: For implantation of temporary pacemaker, see 33030.			
07846 Surgical treatment of cardiac arrest by cardiac massage (operation only) .....	957.00	11	418.95
NOTE: To be supported by a written letter. Clause D. 5. 3. of the General Preamble will apply.			
78045 Thoracotomy post cardiac surgery for hemorrhage .....	1891.00	8	751.07
NOTE: Must be performed by a Cardiac Surgeon in the Operating Room, under general anesthetic.			
07851 Phrenic nerve stimulator .....	1092.00	8	473.55
07852 Gore-Tex modified aorto-pulmonary shunt .....	2155.00	9	941.63
78041 Laser Lead Extraction after 30 days, first lead .....	2910.00	9	1409.88
NOTES:			
i) Not payable with 07845, 33030 and S33057.			
ii) Includes any and all diagnostic imaging related to the surgery.			
iii) Claims for surgical assistance for laser lead extraction are payable under 00197.			
78042 Laser Lead Extraction after 30 days, additional leads, to a maximum of two – extra .....	1962.00	9	529.26
78043 Debridement of chest wall during laser lead extraction – extra (payable only with P78041) .....	189.00	9	52.92
78044 Wide debridement of chest wall during laser lead extraction – extra (payable only with P78041) .....	418.00	9	105.87

**OPEN HEART SURGERY**

07824 Resecting aneurysm of the ventricle as an isolated procedure .....	3624.00	10	1587.14
<b>Mitral Valve:</b>			
07853 Commissurotomy .....	3241.00	9	1422.02
07854 Plication .....	3241.00	9	1422.02
07855 Replacement .....	3624.00	9	1587.14
07856 Simple repair .....	3624.00	9	1587.14
NOTES: Restricted to Cardiac Surgery.			
78056 Mitral Valve Complex repair – including remodeling Annuloplasty and repair of anterior or posterior leaflet, with or without transposition and/or implantation of chordae/neo-chordae .....	4990.00	9	1983.95
NOTE: Restricted to Cardiac Surgery.			



CARDIAC SURGERY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
78051 Minimal Access Mitral or Aortic valve replacement or Mid-Cavity CABG (extra) .....	940.00		373.70
NOTES:			
i) Paid at 100% and only paid with 07853, 07854, 07855, 07856, 07857, 07858, 07859, 07860 and 07908.			
ii) Restricted to Cardiac Surgery.			
<b>Aortic Valve:</b>			
07857 Commissurotomy .....	3241.00	9	1422.02
07858 Plication .....	3241.00	9	1422.02
07859 Replacement.....	3624.00	9	1587.14
07860 Aortic root reconstruction with mechanical valved conduit, Homograft, or Xenograft room.....	5468.00	10	2700.32
<b>Tricuspid Valve:</b>			
07861 Commissurotomy .....	3241.00	9	1422.02
07862 Replacement.....	3624.00	9	1587.14
07863 Annuloplasty .....	3241.00	9	1422.02
<b>Multiple Valve Replacement:</b>			
07864 Two valves .....	5462.00	10	2395.05
07865 Three valves .....	6310.00	10	2768.96
07866 Valved external conduit.....	5026.00	10	2203.98
<b>Atrial Septum Defect:</b>			
07867 Secundum - suture.....	3241.00	9	1422.02
07868 – patch.....	3241.00	9	1422.02
07869 Primum .....	3624.00	9	1587.14
07870 Multiple .....	3241.00	9	1422.02
07871 – plus pulmonary stenosis .....	3241.00	10	1422.02
07872 – plus partial anomalous pulmonary drainage .....	3624.00	10	1587.14
<b>Ventricular Septal Defect:</b>			
07874 Simple.....	3489.00	9	1527.12
07875 Multiple .....	3489.00	9	1527.12
07876 – plus patent ductus .....	3489.00	9	1527.12
07877 – plus pulmonary hypertension.....	3489.00	10	1527.12
07878 – plus corrected transposition.....	3489.00	10	1527.12
07879 – plus aortic regurgitation .....	3489.00	10	1527.12
<b>Subaortic Stenosis:</b>			
07881 Fibrous ring.....	3241.00	9	1422.02
07882 Muscular hypertrophy .....	3624.00	9	1587.14

CARDIAC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Pulmonary Valve:</b>			
07884 Valvulotomy.....	3241.00	9	1422.02
07885 Infundibulectomy .....	3624.00	9	1587.14
07886 Patch .....	3624.00	9	1587.14
07887 Pulmonary arterioplasty with bypass .....	3626.00	9	1587.14
07889 Tetralogy of Fallot .....	3624.00	10	1587.14
07890 – plus outflow patch .....	4163.00	10	1825.97
07893 – with previous anastomosis shunt .....	4163.00	10	1825.97
07898 Transposition.....	4504.00	10	1974.73
07899 Anomalous pulmonary drainage - total.....	4504.00	10	1974.73
07900 Aorticopulmonary window .....	3624.00	10	1587.14
07901 Ruptured sinus of valsalva .....	3624.00	10	1587.14
07902 Atrioventricular communis .....	5462.00	10	2395.05
07905 Intracardiac tumours.....	3624.00	9	1587.14
07906 Pulmonary embolectomy with bypass .....	3241.00	11	1422.02
07908 Coronary artery by-pass graft (end-to-side or side-to-side) - one artery .....	3241.00	9	1440.05
07909 – each additional artery.....	629.00		273.64
NOTE: When 7 or more arteries are by-passed, a written explanation must be submitted along with the account.			
07990 Harvest of arterial conduit for the purpose of coronary revascularization – per conduit (extra)	486.00		178.45
NOTES:			
i) Paid with fee items 07908 and 07909 only.			
ii) Paid to a maximum of two per patient.			
iii) Restricted to Cardiac Surgery.			
07910 Complete Cox-Maze procedure to include all right and left atrial lesion sets and pulmonary vein isolation .....	4239.00	9	1819.71
Note: Not paid with 33084.			
07962 Left atrial lesion sets only, with or without pulmonary vein isolation .....	5073.00	9	1357.73
Note: Not paid with 33084.			
07963 Pulmonary vein isolation only.....	2226.00	9	611.78
Note: Not paid with 33084.			
07911 Ventricular arrhythmia surgery - must include mapping and ablation, and includes aneurysmectomy if necessary.....	5145.00	9	2209.66
07912 Endocardial mapping.....	896.00		382.12
07913 Pericardectomy with bypass.....	3241.00	9	1422.02
07914 Recurrent surgery after 21 days (add to 07824, 07855, 07859, 07860, 07862, 07864, 07865, 07908 and congenital heart operations), extra .....	687.00		560.12

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Specially Qualified Assistant Fees:</b>			
07915 1st Assistant for operations of \$1,033 or less .....	630.00		275.83
07916 2nd and 3rd Assistant for operations of \$1,033 or less ...	383.00		161.32
07917 1st Assistant for operations over \$1,033 .....	909.00		395.75
07918 2nd and 3rd Assistant for operations over \$1,033.....	573.00		247.53
07920 Time, after 4 hours of continuous surgical assistance for one patient, each 15 minute period or fraction thereof.....	49.80		21.66
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			

## RESPIRATORY SYSTEM

### Pleura and Lung:

S07924 Decompression of traumatic pneumothorax - (operation only).....	88.10	4	38.20
S07925 Artificial pneumothorax - operation only .....	63.00	4	26.60

### Ribs and Chest Wall:

07949 Laser therapy for intra-tracheal or intra-bronchial tumour - to include endoscopy .....	1057.00	7	454.93
--	---------	---	--------

## 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 (78701, 78072 and 78073).
- iv) Restricted to Cardiac Surgery.

78061 Uni-ventricular temporary device (i.e. Abiomed Impella 5.0) – transcutaneous .....	1284.00	10	509.83
78062 Removal of Abiomed Impella 5.0 (includes artery repair) .....	898.00	10	356.88
78063 Uni-ventricular – temporary device (i.e. Levitronix) – thoracotomy (includes blood vessel repair).....	4361.00	10	1733.38
78064 Removal of Levitronix device .....	1797.00	10	713.74
78065 Uni-ventricular – fully implantable (i.e. Heartmate II or Heartware) includes blood vessel repair .....	7438.00	10	2956.95
78066 Removal of fully implantable device includes blood vessel repair.....	3848.00	10	1529.46
07960 Intra-aortic balloon insertion, removal and care .....	1539.00	8	672.80

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

### 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.....	1540.00	10	611.78
78072	Veno-Arterial (V-A) ECMO insertion – central.....	2052.00	10	815.71
78073	Veno-Veno (V-V) ECMO insertion – peripheral.....	1027.00	10	407.86

### ESOPHAGEAL 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.....	1048.00		256.63
-------	---	---------	--	--------

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

70020	Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof.....	119.00		32.23
-------	---	--------	--	-------

**NOTES:**

- i) After 3 hours of continuous 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.

**Esophagus - Incision:**

V70500	Esophagotomy - cervical approach with removal of foreign body .....	2186.00	5	536.76
V70501	– thoracic approach with removal of foreign body.....	2594.00	8	637.58
V70502	Cricopharyngeal myotomy - cervical approach .....	1909.00	4	469.34

**Esophagus - Excision:**

Excision of lesion, esophagus, with primary repair:

VC70530	– cervical approach.....	2186.00	6	536.76
VC70531	– thoracic or abdominal approach, open.....	3164.00	8	777.59

CARDIAC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
VC70532 – thoracic or abdominal approach, laparoscopic or thoracoscopic .....	3164.00	8	777.59
<b>Total or Near Total Esophagectomy; without Thoracotomy (Transhiatal):</b>			
• <b>with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty:</b>			
V70533 – primary surgeon.....	5822.00	8	2030.14
70503 – secondary surgeon .....	1927.00		650.00
• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b>			
V70534 – primary surgeon.....	6808.00	8	2030.14
70504 – secondary surgeon .....	1927.00		650.00
<b>Total or Near Total Esophagectomy:</b>			
• <b>with thoracotomy, with or without pyloroplasty (3 hole):</b>			
V70535 – primary surgeon.....	6650.00	8	2283.91
70505 – secondary surgeon .....	1927.00		650.00
• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b>			
V70536 – primary surgeon.....	7586.00	8	2283.91
70506 – secondary surgeon .....	1927.00		650.00
V70538 Partial esophagectomy, distal 2/3 - with thoracotomy and separate abdominal incision and thoracic esophagogastronomy.....	6650.00	8	1634.89
NOTE: Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.			
• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b>			
V70539 – primary surgeon.....	7586.00	8	1864.78
70509 – secondary surgeon .....	1927.00		650.00
VC70540 Partial esophagectomy, thoraco-abdominal or abdominal approach-with esophagogastronomy.....	5822.00	8	1430.50
NOTES:			
i) Includes vagotomy.			
ii) Includes proximal gastrectomy, pyloroplasty and splenectomy, if required.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b></li> </ul>			
VC70541 – primary surgeon .....	6808.00	8	1673.20
70511 – secondary surgeon .....	1927.00		650.00
VC70542 Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy (includes gastrostomy) .....	4368.00	6	1073.50
<p><b>Diverticulectomy of hypopharynx or esophagus, with or without myotomy:</b></p>			
V70545 – cervical approach .....	2186.00	6	536.76
V70544 – thoracic approach .....	2660.00	8	653.95
<p><b>Upper Gastrointestinal System – Endoscopy (Surgical)</b></p>			
S33321 Removal of foreign material causing obstruction, operation only .....	454.00	4	101.91
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33322 Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only ...	521.00	3	116.68
NOTES:			
i) Paid only once per endoscopy.			
ii) Paid only in addition to S10761 or S10762..			
S33323 Transendoscopic tube, stent or catheter – operation only .....	454.00	3	101.86
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 .....	191.00	3	42.60
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33325 Gastric polypectomy, operation only .....	721.00	5	161.47
NOTES:			
i) Paid only in addition to S10761 or S10762..			
ii) Paid only once per endoscopy.			
S33326 Percutaneous endoscopically placed feeding tube – operation only .....	329.00	3	73.78
<i>(see notes on next page)</i>			

CARDIAC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)	
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 .....	63.40	3	14.25
NOTES:				
i) Paid only in addition to S10761 or S10762..				
ii) Paid only once per endoscopy.				
S33328	Esophageal dilation, blind bouginage, operation only .....	258.00	3	57.25
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 .....	486.00	3	109.02
NOTE: Repeats within one month paid at 100%.				
<b>Esophagus Repair:</b>				
V71530	Cervical esophagostomy .....	2162.00	5	531.36
V71531	Cervical approach - repair TE fistula .....	3277.00	6	2000.00
NOTE: 71530 and 71531 include gastrostomy.				
Esophagoplasty (plastic repair or reconstruction) thoracic approach:				
VC71532	- without repair of tracheo-esophageal fistula .....	3660.00	8	2000.00
VC71533	- with repair of tracheo-esophageal fistula .....	4238.00	8	2250.00
V71534	Division of tracheo-esophageal fistula without esophageal anastomosis (thoracic approach) .....	3277.00	8	804.44
NOTE: C71533 and 71534 include gastrostomy.				
Esophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:				
V71535	- laparoscopic .....	4198.00	6	920.65
V71536	- open .....	3000.00	6	736.52
V71537	Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach .....	3224.00	8	791.86
V71538	- with gastroplasty - Collis .....	3224.00	8	1218.09
<b>Plastic Operation for Cardiospasm; Heller:</b>				
VC71539	- thoracic approach - open .....	2740.00	8	672.58
V71540	- laparoscopic or thorascopic (endoscopy to be billed separately).....	3833.00	6	840.72
VC71541	- with fundoplication - open .....	3829.00	6	940.05
VC71542	- with fundoplication - laparoscopic.....	5357.00	6	1175.07

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Gastrointestinal Reconstruction for Previous Esophagectomy; for Obstructing Esophageal Lesion or Fistula or for Previous Esophageal Exclusion:</b>			
VC71543 – with stomach, with or without pyloroplasty .....	5822.00	6	1430.50
VC71544 – with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es) .....	6808.00	6	1673.20
<b>Suture of Esophageal Wound or Injury:</b>			
V71548 – cervical approach.....	1764.00	6	1268.85
VC71549 – transthoracic or transabdominal approach.....	3161.00	8	1522.60
<b>Closure of Esophagostomy or Fistula:</b>			
VC71550 – cervical approach.....	2193.00	6	1268.85
VC71551 – transthoracic or transabdominal approach.....	3328.00	8	1522.60
02449 Rigid esophagoscopy for removal of foreign body .....	692.00	4	191.35
<b>DIAPHRAGM - REPAIR</b>			
V70601 Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplication .....	3087.00	6	1212.64
NOTE: For anti-reflux procedures, funduplications, etc., please see Esophageal section. Diaphragmatic or other hernia to include fundoplication, vagotomy and drainage procedure where indicated:			
V70602 – open.....	3087.00	6	1212.64
V70603 – laparoscopic.....	3087.00	6	1212.64
VC70604 Congenital diaphragmatic hernia.....	3107.00	9	1522.60
Repair diaphragmatic hernia or laceration; thoracic or abdominal approach:			
VC70605 – acute (traumatic).....	3277.00	8	1215.00
VC70606 – chronic .....	3000.00	8	1215.00
V70607 Imbrication of diaphragm for eventration, transthoracic or transabdominal .....	2740.00	8	800.00

**TRAUMA**

NOTE: Trauma fee items are to be charged in cases of blunt and/or penetrating abdominal injury. They do not apply to incidental intra-operative injury to abdominal structures.

V07431 Repair diaphragmatic injury.....	3277.00	8	804.44
---	---------	---	--------



<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**MISCELLANEOUS**

70023	Excisional biopsy of lymph glands for malignancy - neck - operation only.....	541.00	3	203.62
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation).....	1638.00	5	505.35
V07630	Gastrostomy - open .....	1369.00	5	456.79
V07648	Revision of ileostomy or colostomy - simple - incision of scar, etc. ....	1023.00	4	450.00
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body .....	931.00	6	255.15
02422	- in a child under the age of 3 years.....	1385.00	6	380.57
02420	Dilation of trachea - operation only .....	299.00	5	152.64
02421	- repeat within one month - operation only.....	537.00	5	152.43
	Microsurgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:			
02430	- first procedure.....	1616.00	6	445.46
02435	- subsequent procedure, each .....	1601.00	6	445.46
	NOTES:			
	i) Maximum of 5 subsequent procedures in six (6) month period, otherwise support with written letter.			
	ii) Microsurgery treatment with CO <sub>2</sub> laser other than removal of tumour(s) of larynx or trachea, bill under 07999 with operative report.			
02407	Tracheostomy puncture .....	1067.00	5	390.00
	NOTE: Not applicable to cricothyrotomy.			
C02473	Laryngo-pharyngo-esophagectomy - primary excision only .....	5749.00	6	1900.00

**DIAGNOSTIC PROCEDURES**

**THORACIC PROCEDURES:**

**Procedures Involving Visualization by Instrumentation:**

S00700	Bronchoscopy or bronchofibroscope - procedural fee.....	288.00	5	117.42
S00702	Bronchoscopy with biopsy - procedural fee .....	531.00	5	207.08
S00719	Thoracoscopy .....	464.00	7	329.62
S00701	Direct laryngoscopy - procedural fee .....	141.00	5	37.70
	NOTE: S00701 not payable with bronchoscopy, except when done under general anesthesia.			
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee.....	400.00	3	89.73
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee.....	332.00	3	74.74

CARDIAC SURGERY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
S10763 Initial esophageal, gastric or duodenal biopsy.....	128.00	3	29.06
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.....	196.00	3	43.58
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 .....	330.00	4	195.57
<b>Procedures Utilizing Radiological Equipment:</b>			
S00736 Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee (extra) .....	288.00	4	66.73
S00868 Percutaneous gastrostomy / gastrojejunostomy - procedural fee .....	1043.00	2	275.79
<b>Needle Biopsy Procedures:</b>			
S00745 Peripheral or subcutaneous lymph node biopsy - procedural fee .....	174.00	2	48.94
S00749 Parietal pleural, including thoracentesis - procedural fee .....	200.00	2	130.41
<b>Puncture Procedures for Obtaining Body Fluids (When performed for diagnostic purposes):</b>			
S00751 Pericardial puncture - procedural fee .....	200.00	3	165.44
S00755 Artery puncture - procedural fee.....	29.85	2	6.38
S00759 Paracentesis (thoracic) or transtracheal aspiration - procedural fee .....	96.40	2	84.00
<b>Miscellaneous:</b>			
S00797 Esophageal motility test .....	561.00		176.15
S00798 – professional fee .....	259.00		101.79
S00788 – technical fee.....	300.00		74.35
S00818 Esophageal pH study for reflux (extra) - professional fee .....	177.00		40.82
S00817 – technical fee.....	54.40		12.44

# CARDIOLOGY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
33010 <b>Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, and a written report .....	570.00		171.46
33012 <b>Repeat or Limited Consultation:</b> 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 judgement of the consultant the consultative service does not warrant a full consultative fee .....	287.00		85.73
33014 Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only).....	287.00		60.66
NOTES:			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
33013 Group counseling for groups of two or more patients - first full hour.....	581.00		93.55
33015 – second hour, per 1/2 hour or major portion thereof....	296.00		46.75
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
<b><u>Continuing Care by Consultant:</u></b>			
33006 Directive care .....	105.00		64.27
33007 Subsequent office visit .....	111.00		62.88
33008 Subsequent hospital visit.....	80.90		54.52
33009 Subsequent home visit .....	162.00		42.80
33005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	327.00		94.84
NOTE: Claim must state service rendered.			
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
33110 Telehealth consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report. ....	570.00		171.46
33112 Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant that consultative services do not warrant a full consultative fee. ....	287.00		85.73

CARDIOLOGY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
33114 Telehealth prolonged visit for counseling (maximum four per year). .....	287.00		60.66
NOTES:			
i) See Preamble 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. ....	105.00		64.27
33107 Telehealth subsequent office visit. ....	111.00		62.88
33108 Telehealth subsequent hospital visit. ....	80.90		54.52
Telehealth Single Chamber permanent programmable pacemaker testing			
33126 – professional fee .....	206.00		46.24
33153 – technical fee .....	90.40		23.12
Telehealth Dual chamber permanent programmable pacemaker testing			
33128 – professional fee .....	314.00		69.36
33154 – technical fee .....	181.00		46.24
NOTES:			
i) 33126, 33153, 33128, 33154 include telehealth office visit or an office visit and necessary ECG.			
ii) May be billed by any qualified physician who performs this service from a location in BC.			
iii) Paid only on outpatients.			

**REMOTE MONITORING CARDIAC DEVICES**

Remote Monitoring of Single chamber implantable cardiac devices

33174 – professional fee .....	206.00		46.24
33175 – technical fee .....	90.40		23.12

NOTES:

- i) For the virtual or telephone assessment of single chamber implantable cardiac devices with virtual or telephone connection with patient.
- ii) Includes a telehealth, virtual or telephone assessment, necessary ECG and/or heart rhythm assessment including device interrogation.
- iii) May be billed by any qualified physician who performs this service from a location in BC.
- iv) Paid only on outpatients.

Remote Monitoring of Dual chamber implantable cardiac devices

33176 – professional fee .....	314.00		69.36
33177 – technical fee .....	181.00		46.24

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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.

**EXAMINATIONS BY CERTIFIED CARDIOLOGIST**

33016	Electrocardiogram and interpretation - office, each .....	98.50			24.52
33017	- home, each .....	155.00			34.10
33018	Electrocardiogram - professional fee .....	40.05			8.58
	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) .....	40.75			16.90
Y33025	Cardioversion - operation only .....	366.00	2		88.90
	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.				
33026	Single chamber, permanent programmable pacemaker testing - professional fee .....	209.00			46.24
33053	- technical fee .....	92.30			23.12
33028	Dual chamber permanent programmable pacemaker testing - professional fee .....	320.00			69.36
33054	- technical fee .....	187.00			46.24
	NOTE: 33026, 33053, 33028 and 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 - certified cardiologist, internal medicine specialist or other qualified physicians .....	726.00	4		176.07
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) .....	1302.00	4		456.79

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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.....	368.00	4	80.66
33033	Generator placement and venous cut-down .....	1191.00	4	263.32
33034	Graded exercise test (performance and interpretation)...	337.00		77.66
33035	– professional fee .....	201.00		46.06
33036	– technical fee .....	138.00		31.58

NOTES:

- i) This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer or pharmaceutical agents with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and post-exercise records must be obtained.
- ii) When a 12 lead cardiogram is done on the same day as the graded exercise test, it is included in fee 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 payment agency, 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 or 33036) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50%.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
33037 Replacement transfusion - hepatic failure to include two weeks care after transfusion .....	1287.00		287.85
NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra.....			
<b>Scanning of 24-hour Electrocardiogram:</b>			
33047 – professional fee .....	302.00		66.13
33048 – technical fee.....	111.00		24.81
33049 Technical fee for scanning:			
<b>Level I:</b> 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 .....			
	242.00		54.16
33063 <b>Level II:</b> Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data .....	187.00		40.61
33065 <b>Level IV:</b>			
a) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adapter that feeds the information to the standard ECG machine.			
b) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly summary of heart rate, minimum and maximum R-R intervals, premature beats, and ventricular complexes of abnormal width .....	61.20		13.57
<b>Patient Activated Cardiac Event Recorders:</b>			
33062 Event/unmonitored loop recorder (first strip) - professional fee .....	135.00		36.21
33069 – each additional strip (per strip).....	70.10		18.10
NOTE: Additional strips are limited to two extra strips per patient, per two-week period.			
33092 Event/unmonitored loop recorder - technical fee.....	161.00		43.51

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**NOTES:**

The following notes apply to fee items 33062, 33069 and 33092:

- i) These items are intended to cover a two-week period.
- ii) Consultation not paid in addition.
- iii) Provide note record when more than one recording billed per patient, per year.
- iv) Holter monitor not payable in addition.
- v) An explanatory note is required for second test, same patient.

**Intracardiac Electrophysiological Mapping:**

33066	– initial study.....	3441.00	4	776.20
33068	Oesophageal or intra-atrial electrophysiological study....	537.00	4	116.03

**Electrophysiological Mapping and Ablation:**

33084	Catheter ablation for atrial fibrillation.....	5981.00	6	1718.60
	NOTE: Includes percutaneous right heart catheterization, transeptal left heart catheterization, all diagnostic imaging, ECG's (electrophysiological mapping/ablation fee items 33066, 33085, 33086 and 33087).			
33085	Catheter ablation-AV node.....	3703.00	4	948.58
	NOTE: To include diagnostic study (33066).			
33086	Catheter ablation of SVT.....	5665.00	4	1450.76
	NOTE: To include diagnostic study (33066).			
33087	Catheter ablation of VT .....	6101.00	4	1718.60
	NOTE: To include diagnostic study (33066).			
33088	Repeat diagnostic EP study .....	1309.00	4	334.78
	NOTE: Not normally to be billed for recheck on the same day.			
33089	Catheter ablation - assistant's fee (per hour) .....	542.00		139.50

**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.



<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**PULMONARY INVESTIGATIVE AND FUNCTION STUDIES**

**Diagnostic Procedures:**

Overnight home oximetry (continuous recording of oxygen and pulse):

S00910 – professional fee .....	114.00	27.90
S00911 – technical fee.....	60.40	15.62
S00944 Tilt table testing with continuous ECG monitoring and automatic BP recording - total fee .....	1268.00	290.15
S00947 – professional fee .....	688.00	178.57
S00948 – technical fee.....	522.00	111.59

**NOTES:**

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

**MISCELLANEOUS**

P33020 Supervision of patient in a Cardiac Rehabilitation Program .....	111.00	62.41
---	--------	-------

**NOTES:**

- i) Payable only for patients enrolled at a Health Authority approved Cardiac Rehabilitation Program.
- ii) Payable only to cardiologists with fellowship training in cardiac rehabilitation working at Health Authority approved Cardiac Rehabilitation programs.
- iii) Payable once per week and includes all services and multiple encounters, necessary for management and supervision of patient while patient is actively enrolled in a comprehensive cardiac rehabilitation program.
- iv) Visits by primary cardiologist may be billed for reasons unrelated to cardiac rehabilitation.

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Diagnostic Ultrasound:</b>				
S33057	Trans-esophageal echocardiography - procedural fee....	201.00	3	165.45
	NOTES:			
	i) This procedural 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.			
	iii) Real-time ultrasound fees may only be claimed for studies performed when a physician is on site in the laboratory for the purpose of diagnostic ultrasound supervision.			
32090	Intra-operative transesophageal echocardiographic imaging - first hour or portion thereof .....	720.00		
32091	Intra-operative transesophageal echocardiographic imaging – subsequent 30 minutes or portion thereof .....	287.00		

**DIAGNOSTIC PROCEDURES**

PS33131	Diagnostic cardiac catheterization .....	909.00	4	483.26
	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.			
PS33132	Diagnostic cardiac catheterization with advanced arterial assessment.....	1317.00	4	483.26
	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.			
	<i>(notes continued on next page)</i>			

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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).			
<b>Procedures Utilizing Radiological Equipment</b> 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 on contrast material.			
33091			
Echocardiography - combined with two-dimensional real time and M-mode .....	573.00		144.20
NOTE: The professional/technical split is as follows: Professional fee - \$66.91, Technical fee - \$77.29			
33093			
Level III Echocardiographer Complex Assessment of Previous Echocardiogram (clinical assessment and review, interpretation and written report of submitted echocardiograms) - per patient .....	472.00		252.39
NOTES:			
i) Payable following a written request from a cardiologist or cardiac surgeon for a clinical assessment, review and interpretation of submitted echocardiograms done on an out-patient basis only, performed in another institution by a different Echocardiographer.			
ii) A written report and management recommendation must be provided to the referring physician.			
iii) Not payable when echocardiograms above are used for comparison purposes with echocardiograms made in the Level III Echocardiographer's facility.			
iv) Not payable with a consult, visit or 33091 done on the same day.			
v) Payable once per year per patient, unless substantiated in note record.			
<i>(notes continued on next page)</i>			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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.....	169.00		127.45
NOTES:			
i) Paid only in addition to fee items 33091, 08638 or 08662.			
ii) Submit claim on the first patient the vial is used for. No claims should be made on subsequent patients for the same vial.			
S00729 Fluoroscopy of chest by internist or pediatrician – procedural fee.....	49.15		11.11
<b>Puncture Procedures for Obtaining Body Fluids</b> (When performed for diagnostic purposes)			
S00751 Pericardial puncture - procedural fee.....	200.00	3	165.44
<b>Cardio-Vascular Procedures</b>			
S00801 Intra-arterial cannulation (with multiple aspirations) - procedural fee.....	96.40		22.10
S00810 Right heart catheterization - by duly qualified specialist..	724.00	4	165.44
S00812 Selective angiocardiogram (extra) - by duly qualified specialist.....	242.00	4	55.52
S00813 Ergonovine provocative testing for coronary artery spasm.....	351.00	4	79.14
S00814 Dye dilution studies (extra) - by duly qualified specialist.	242.00	4	55.52
S00816 Hydrogen ion study.....	119.00	2	28.96
Pulse tracing, including interpretation:			
S00871 – intravascular, including both arterial and venous .	242.00		55.52
<b>Cardiology Assistant Fees</b>			
00845 First hour or fraction thereof.....	242.00		111.04
00846 After one hour, for each 15 minutes or fraction thereof...	49.15		27.77
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**INTERVENTIONAL CARDIOLOGY PROCEDURES**

33071 Percutaneous endovascular aortic or pulmonary heart valve replacement .....	4216.00	9	1147.10
---	---------	---	---------

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 visits in hospital are included.

P33072 Percutaneous left atrial appendage closure .....	2747.00	7	900.00
---	---------	---	--------

NOTES:

- i) Includes all necessary catheterizations, angiography (00801, 00810, 00812, 00871, 00888, 00889, 33030), angiocardiology, 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.

S33073 Percutaneous transcatheter cardiac occluder device closure of ASD for patients over 18 years of age - (composite fee) .....	2625.00	7	713.74
--	---------	---	--------

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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 .....	2062.00	7	560.80
--	---------	---	--------

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) .....	3374.00	9	917.67
---	---------	---	--------

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) .....	2250.00	9	611.78
---	---------	---	--------

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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) at 50%.

**Percutaneous coronary interventions:**

PS33133	Percutaneous coronary intervention with diagnostic cardiac catheterization .....	1535.00	4	563.36
---------	--	---------	---	--------

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.

PS33134	Percutaneous coronary intervention alone .....	1023.00	4	375.53
---------	--	---------	---	--------

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.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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.

S00842	Percutaneous coronary intervention – for additional vessel(s), per vessel .....	819.00	189.01
--------	---	--------	--------

**NOTES:**

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

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

Right Coronary:

- Right coronary artery
- Right posterior descending artery
- Right posterior atrioventricular artery
- First right posterolateral artery
- Second right posterolateral artery
- Acute marginal artery
- Inferior septal artery

Left Coronary:

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



Non-MSP- Insured Total Fee (\$)	MSP and WSBC		
	A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)

**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.

**Heart:**

08638	Echocardiography - real-time .....	269.00	59.48	42.38	101.86
08662	Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis.....	654.00	132.87	101.59	234.46

NOTE: Where the exercise stress test (00530, 00531, 00535, 01730, 01731, 01732, 33034, 33035 and 33036) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent.

**Doppler Studies - Heart:**

08679	Doppler echocardiography .....	121.00	28.46	18.27	46.73
-------	--------------------------------	--------	-------	-------	-------

## CHEST SURGERY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
79010 <b>Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, and a written report.....	300.00		144.80
79012 <b>Repeat or Limited Consultation:</b> 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 judgement of the consultant the consultative service does not warrant a full consultative fee.....	156.00		65.18
<b><u>Continuing Care by Consultant:</u></b>			
79007 Subsequent office visit .....	65.50		28.91
79008 Subsequent hospital visit .....	55.60		24.65
79009 Subsequent home visit.....	114.00		49.68
79005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	228.00		99.12
NOTE: Claim must state time service rendered.			
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
79210 <b>Telehealth Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, and a written report.....	300.00		144.80
79212 <b>Telehealth repeat or limited consultation:</b> To apply where a consultation is repeated for the 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 .....	156.00		65.18
79207 Telehealth subsequent office visit.....	65.50		28.91
79208 Telehealth subsequent hospital visit.....	55.60		24.65
<b>LUNG SURGERY</b>			
<b>Lobe:</b>			
79015 Lobectomy.....	1968.00	8	1359.03
79020 Bronchoplasty (extra to lobectomy).....	565.00	9	246.41
<b>Entire Lung:</b>			
79025 Pneumonectomy .....	2141.00	9	1476.68

CHEST SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Other Lung Operations:</b>			
79030 Segmental resection of lung (operative report required) .....	1968.00	8	1359.03
79035 Thoracotomy, including wedge resection .....	1108.00	8	762.50
79036 – each additional wedge resection of lung when done thorascopically, to a maximum of two extra .....	219.00		77.99
79040 Drainage of lung abscess (operation only).....	1142.00	8	509.62
<b>Thoracotomy (Miscellaneous):</b>			
S07924 Decompression of traumatic pneumothorax (operation only) .....	88.10	4	38.20
79045 Exploratory thoracotomy with or without biopsy or removal of foreign body .....	1108.00	8	771.18
79050 Decortication of lung .....	1723.00	8	1188.93
79055 Pleurectomy .....	1108.00	8	762.50
79060 Intrathoracic tumour - without lung involvement.....	1471.00	8	1023.99

**AIRWAY SURGERY**

**Trachea:**

79065 Tracheal resection .....	2141.00	10	960.53
79070 – with laryngeal release (extra).....	1062.00	10	474.12
79075 – with hilar release (extra) .....	1062.00	10	474.12
02420 Dilation of trachea - operation only .....	299.00	5	152.64
02421 – repeat within one month - operation only.....	537.00	5	152.43
02407 Tracheostomy .....	1067.00	5	390.00

NOTE: Not applicable to cricothyrotomy puncture.

**Bronchus:**

79080 Closure of bronchopleural fistula.....	2141.00	10	949.72
79085 Repair of ruptured bronchus .....	2141.00	9	960.53
07949 Laser therapy for intra-tracheal or intra-bronchial tumour - to include endoscopy .....	1057.00	7	454.93
02450 Bronchoscopy or microlaryngoscopy with removal of foreign body .....	931.00	6	255.15
02422 – in a child under the age of 3 years.....	1385.00	6	380.57

**Micro-surgery with Use of CO<sub>2</sub> Laser for Removal of Tumour(s) of Larynx or Trachea:**

02430 – first procedure.....	1616.00	6	445.46
02435 – subsequent procedure, each.....	1601.00	6	445.46

(see notes on next page)

CHEST SURGERY - Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

NOTES:

- i) Maximum of 5 subsequent procedures in six (6) month period, otherwise support with written letter.
- ii) Microsurgery treatment with CO<sub>2</sub> laser other than removal of tumour(s) of larynx or trachea, bill under 02599 with operative report.

**MEDIASTINAL SURGERY**

79095 Mediastinal cyst or tumour .....	1540.00	8	1060.72
79100 Thymectomy.....	1142.00	8	792.40

**CHEST WALL SURGERY**

79105 Rib resection for empyema .....	1108.00	6	495.99
79110 Closure of pleurostomy following long term management of empyema with rib section .....	1108.00	6	495.99
79115 Pectus excavatum and carinatum .....	1723.00	8	773.31
79120 Thoracoplasty.....	1723.00	6	773.31
79125 Cervical rib resection.....	805.00	5	359.33
79130 Trans-axillary resection of first rib .....	1259.00	5	865.45
79135 Chest wall tumour with rib resection.....	1471.00	6	1012.46

**DIAPHRAGM SURGERY**

V70601 Repair paraoesophageal hiatus hernia, transabdominal, with or without fundoplication.....	3087.00	6	1212.64
--	---------	---	---------

NOTE: For anti-reflux procedures, funduplications, etc., please see Oesophageal section (in General Surgery).

**Diaphragmatic or Other Hernia to Include Fundoplication, Vagotomy and Drainage Procedure where Indicated:**

V70602 – open.....	3087.00	6	1212.64
V70603 – laparoscopic.....	3087.00	6	1212.64
VC70604 Congenital diaphragmatic hernia.....	3107.00	9	1522.60

**Repair Diaphragmatic Hernia or Laceration; Thoracic or Abdominal Approach:**

VC70605 – acute (traumatic).....	3277.00	8	1215.00
VC70606 – chronic .....	3000.00	8	1215.00
V70607 Imbrication of diaphragm for eventration, transthoracic or transabdominal .....	2740.00	8	800.00
V07431 Repair diaphragmatic injury.....	3277.00	8	804.44

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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.....	1048.00		256.63
---	---------	--	--------

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

70020 Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof.....	119.00		32.23
---	--------	--	-------

NOTES:

- i) After 3 hours of continuous 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.

**ESOPHAGEAL SURGERY**

**Esophagus - Incision:**

V70500 Esophagotomy - cervical approach with removal of foreign body .....	2186.00	5	536.76
V70501 – thoracic approach with removal of foreign body .....	2594.00	8	637.58
V70502 Cricopharyngeal myotomy - cervical approach .....	1909.00	4	469.34

**Esophagus - Excision:**

Excision of lesion, oesophagus, with primary repair:

VC70530 – cervical approach .....	2186.00	6	536.76
VC70531 – thoracic or abdominal approach - open .....	3164.00	8	777.59
VC70532 – thoracic or abdominal approach - laparoscopic or thoracoscopic .....	3164.00	8	777.59

**Total or Near Total Esophagectomy, without Thoracotomy (Transhiatal):**

- with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty:

V70533 – primary surgeon.....	5822.00	8	2030.14
70503 – secondary surgeon .....	1927.00		650.00

CHEST SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b></li> </ul>			
V70534 – primary surgeon .....	6808.00	8	2030.14
70504 – secondary surgeon .....	1927.00		650.00
<p><b>Total or Near Total Esophagectomy;</b></p> <ul style="list-style-type: none"> <li>• <b>with thoracotomy, with or without pyloroplasty (3-hole):</b></li> </ul>			
V70535 – primary surgeon .....	6650.00	8	2283.91
70505 – secondary surgeon .....	1927.00		650.00
<ul style="list-style-type: none"> <li>• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b></li> </ul>			
V70536 – primary surgeon .....	7586.00	8	2283.91
70506 – secondary surgeon .....	1927.00		650.00
V70538 Partial esophagectomy, distal 2/3 - with thoracotomy and separate abdominal incision and thoracic esophagogastromy .....	6650.00	8	1634.89
NOTE: Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.			
<ul style="list-style-type: none"> <li>• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b></li> </ul>			
V70539 – primary surgeon .....	7586.00	8	1864.78
70509 – secondary surgeon .....	1927.00		650.00
VC70540 Partial esophagectomy, thoraco-abdominal or abdominal approach - with esophagogastromy .....	5822.00	8	1430.50
NOTES:			
i) Includes vagotomy.			
ii) Includes proximal gastrectomy, pyloroplasty and splenectomy, if required.			
<ul style="list-style-type: none"> <li>• <b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b></li> </ul>			
VC70541 – primary surgeon .....	6808.00	8	1673.20
70511 – secondary surgeon .....	1927.00		650.00
VC70542 Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy (includes gastromy) .....	4368.00	6	1073.50
<p><b>Diverticulectomy of Hypopharynx or Esophagus, with or without Myotomy:</b></p>			
V70545 – cervical approach .....	2186.00	6	536.76
V70544 – thoracic approach .....	2660.00	8	653.95

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Upper Gastrointestinal System – Endoscopy (Surgical)</b>			
S33321 Removal of foreign material causing obstruction, operation only .....	454.00	4	101.91
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33322 Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only .....	521.00	3	116.68
NOTES:			
i) Paid only once per endoscopy.			
ii) Paid only in addition to S10761 or S10762.			
S33323 Transendoscopic tube, stent or catheter – operation only .....	454.00	3	101.86
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 .....	191.00	3	42.60
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33325 Gastric polypectomy, operation only .....	721.00	5	161.47
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33326 Percutaneous endoscopically placed feeding tube – operation only .....	329.00	3	73.78
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 .....	63.40	3	14.25
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33328 Esophageal dilation, blind bouginage, operation only ....	258.00	3	57.25
NOTE: Repeats within one month paid at 100%.			

CHEST SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S33329 Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only.....	486.00	3	109.02
NOTE: Repeats within one month paid at 100%.			
<b>Esophagus Repair:</b>			
V71530 Cervical oesophagostomy .....	2162.00	5	531.36
V71531 Cervical approach - repair TE fistula .....	3277.00	6	2000.00
NOTE: 71530 and 71531 include gastrostomy.			
<b>Esophagoplasty (Plastic Repair or Reconstruction); Thoracic Approach:</b>			
VC71532 – without repair of tracheo-esophageal fistula .....	3660.00	8	2000.00
VC71533 – with repair of tracheo-esophageal fistula .....	4238.00	8	2250.00
V71534 Division of tracheo-esophageal fistula without oesophageal anastomosis (thoracic approach).....	3277.00	8	804.44
NOTE: C71533 and 71534 include gastrostomy.			
<b>Esophagogastric Fundoplasty (e.g.: Nissen, Belsey IV, Hill Procedures); Antireflux:</b>			
V71535 – laparoscopic.....	4198.00	6	920.65
V71536 – open.....	3000.00	6	736.52
V71537 Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure) - abdominal and/or thoracic approach .....	3224.00	8	791.86
V71538 – with gastroplasty - Collis .....	3224.00	8	1218.09
<b>Plastic Operation for Cardiospasm; Heller:</b>			
VC71539 – thoracic approach - open .....	2740.00	8	672.58
VC71540 – laparoscopic or thorascopic (endoscopy to be billed separately).....	3833.00	6	840.72
VC71541 – with fundoplication - open .....	3829.00	6	940.05
VC71542 – with fundoplication - laparoscopic .....	5357.00	6	1175.07
<b>Gastrointestinal Reconstruction for Previous Esophagectomy; for Obstructing Esophageal Lesion or Fistula or for Previous Esophageal Exclusion:</b>			
VC71543 – with stomach, with or without pyloroplasty .....	5822.00	6	1430.50
VC71544 – with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es) .....	6808.00	6	1673.20
<b>Suture of Esophageal Wound or Injury:</b>			
V71548 – cervical approach.....	1764.00	6	1268.85



CHEST SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
VC71549 – transthoracic or transabdominal approach.....	3161.00	8	1522.60
<b>Closure of Esophagostomy or Fistula:</b>			
VC71550 – cervical approach .....	2193.00	6	1268.85
VC71551 – transthoracic or transabdominal approach.....	3328.00	8	1522.60
02449 Rigid esophagoscopy for removal of foreign body .....	692.00	4	191.35
C02473 Laryngo-pharyngo-esophagectomy - primary excision only .....	5749.00	6	1900.00

**MISCELLANEOUS SURGERY**

70023 Excisional biopsy of lymph glands for suspected malignancy - neck - operation only .....	541.00	3	203.62
V70624 Pyloromyotomy, cutting of pyloric muscle (Fredet- Ramstedt type operation).....	1638.00	5	505.35
V07630 Gastrostomy - open .....	1369.00	5	456.79
S32031 Closed drainage of chest (operation only) .....	428.00	4	136.94
79140 Anterior scalenotomy .....	443.00	3	200.02

**DIAGNOSTIC PROCEDURES**

**THORACIC PROCEDURES:**

**Procedures Involving Visualization by  
Instrumentation:**

S00700 Bronchoscopy or bronchofibroscopy - procedural fee .....	288.00	4	117.42
S00702 Bronchoscopy with biopsy - procedural fee.....	531.00	4	207.08
S00719 Thoracoscopy .....	464.00	7	329.62
S00701 Direct laryngoscopy - procedural fee .....	141.00	5	37.70
NOTE: S00701 not payable with bronchoscopy, except when done under general anesthesia.			
S00710 Mediastinoscopy or anterior mediastinotomy (combined 50% extra) - procedural fee.....	330.00	4	195.57

**Procedures Utilizing Radiological Equipment:**

NOTE: 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 material.

S00736 Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee (extra) .....	288.00	4	66.73
S00868 Percutaneous gastrostomy / gastrojejunostomy - procedural fee .....	1043.00	2	275.79

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>NEEDLE BIOPSY PROCEDURES</b>			
NOTE: 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 - procedural fee .....	174.00	2 48.94
S00749	Parietal pleural, including thoracentesis - procedural fee .....	200.00	2 130.41
<b>Puncture Procedures for Obtaining Body Fluids (When performed for diagnostic purposes):</b>			
S00751	Pericardial puncture - procedural fee .....	200.00	3 165.44
S00755	Artery puncture - procedural fee .....	29.85	2 6.38
S00759	Paracentesis (thoracic) or transtracheal aspiration - procedural fee .....	96.40	2 84.00
<b>Miscellaneous:</b>			
S00797	Esophageal, motility test .....	561.00	176.15
S00798	– professional fee .....	259.00	101.79
S00788	– technical fee .....	300.00	74.35
S00818	Esophageal pH study for reflux (extra) - professional fee .....	177.00	40.82
S00817	– technical fee .....	54.40	12.44

# 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 Guide 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 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 Guide 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, hemodynamic 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.

## CRITICAL CARE - Continued

- 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.

Post-operative 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 Guide to Fees".

### **"C. 18. Guidelines for Payment for Services by Trainees, Residents and/or 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.

CRITICAL CARE - Continued

- 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.

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 premiums and emergency visit fees are not payable in addition to this schedule, as historically, these fees are included in the critical care fees.

Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
---------------------------------	---------------------------

**REFERRED CASES**

01400 <b>Consultation:</b> To consist of examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report (not for ICU patients).....	628.00	297.06
--	--------	--------

**Note:** Restricted to Critical Care Physicians

01402 <b>Repeat or Limited Consultation:</b> 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).....	317.00	152.26
---	--------	--------

**Note:** Restricted to Critical Care physicians

**Continuing Care by Consultant:**

01408 Subsequent hospital visit (not for ICU patients).....	347.00	154.40
---	--------	--------

**Note:** Restricted to Critical Care Physicians

01469 Direction of care/end of life assessment .....	628.00	247.51
--	--------	--------

**Notes:**

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>		
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).....	628.00	297.06
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)...	317.00	152.26
Note: Restricted to Critical Care Physicians.		

**MISCELLANEOUS**

P01450 Adult and Pediatric Critical Care 1 <sup>st</sup> day modifier – extra .	133.00	42.87
NOTES:		
i) Restricted to Critical Care physicians.		
ii) Payable only in addition to 01411, 01412 or 01413 by the same practitioner.		
P01455 Adult and Pediatric Critical care modifier (2 <sup>nd</sup> day onward) – extra .....	16.30	7.26
NOTES:		
i) Restricted to Critical Care physicians.		
ii) Payable only in addition to 01421, 01422, 01423, 01431, 01432, 01433, 01441, 01442 or 01443 by the same practitioner.		

**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.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
01411 1st day.....	848.00	340.05
01421 2nd to 7th day (inclusive) per diem .....	420.00	172.55
01431 8th day to 30th day .....	215.00	117.00
01441 31st day onward.....	177.00	135.47

2. **VENTILATORY SUPPORT** - Includes provision of ventilatory care, initial consultation and assessment of the patient, family counselling, cutdown, 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<sub>2</sub>, 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 post-operative care by the surgeon.

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
01412 1st day .....	737.00	294.96
01422 2nd to 7th day (inclusive) per diem .....	370.00	152.26
01432 8th day to 30th day .....	246.00	120.00
01442 31st day onward.....	227.00	110.89

3. **COMPREHENSIVE CARE** - These fees apply to intensive care physicians who provide complete care, both critical care and ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment, 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, cutdowns, 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.



	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
01413 1st day .....	1386.00	507.54
01423 2nd to 7th day (inclusive) per diem .....	632.00	256.61
01433 8th day to 30th day.....	318.00	142.11
01443 31st day onward.....	273.00	147.80

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

### **NEONATAL INTENSIVE CARE**

These listings may be used for patients receiving neonatal intensive care and are intended for use by the Neonatologist or Pediatrician (or Team) in charge of the patient. These listings may be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment such as ventilatory support, hemodynamic support including vasoactive medications or prolonged resuscitation. They are to be billed only on sick or pre-term 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-operative 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 Guide to Fees” applies.

#### **“C. 18. Guidelines for Payment for Services by Trainees, Residents and/or 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.

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 counseling, 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 premiums 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 re-admitted, 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.

CRITICAL CARE - Continued

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.

**NEONATAL INTENSIVE CARE**

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>LEVEL A</b> - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all procedures.		
01511 Day 1 .....	2392.00	633.46
01521 Day 2 - 10.....	957.00	253.36
01531 Day 11 onward .....	638.00	168.95
<b>LEVEL B</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 .....	1755.00	464.58
01522 Day 2 - 10.....	638.00	168.95
01532 Day 11 onward .....	475.00	125.53
<b>LEVEL C</b> - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.		
01513 Day 1 .....	1516.00	401.20
01523 Day 2 - 10.....	469.00	123.99
01533 Day 11 onward .....	370.00	99.47

# DERMATOLOGY

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

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
00210 <b>Consultation:</b> To include history, and dermatological examination, with review of any previous x-ray and laboratory findings and written report .....	283.00		75.91
00214 <b>Repeat or Limited Consultation:</b> To apply where a consultation is repeated for the same condition within six (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 (laboratory test and biopsy, when necessary, extra).....	213.00		50.56
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. ....	416.74		75.91
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.			
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. ....	223.16		40.65
NOTES:			
i) Restricted to Dermatologists.			
ii) Referral is required.			
iii) Payable within 6 months of a consultation, visit or initial Teledermatology assessment by the same practitioner.			
iv) Not paid with another service on the same day by the same practitioner.			

DERMATOLOGY - Continued

**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

**Continuing Care by Consultant:**

00204	Directive care .....	259.00		30.75
00207	Subsequent office visit .....	138.00		30.75
00208	Subsequent hospital visit .....	259.00		30.75
00209	Subsequent home visit.....	414.00		63.28
00205	Emergency visit when specially called out of office (not paid in addition to out-of-office hours premiums) .....	536.00		105.28

NOTE: Claim must state time service rendered.

**Telehealth Service with Direct Interactive Video Link with the Patient**

20210	<b>Telehealth Consultation:</b> To include history and dermatological examination, with review of any previous x-ray and laboratory findings and written report .....	283.00		75.91
20214	<b>Telehealth repeat or limited consultation:</b> 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 judgement of the consultant, the consultative service does not warrant a full consultative fee (laboratory test and biopsy, when necessary, extra).....	213.00		50.56
20207	Telehealth subsequent office visit .....	138.00		30.75
20208	Telehealth subsequent hospital visit .....	259.00		30.75

**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.....	517.00		179.96
-------	---	--------	--	--------

**SPECIAL THERAPY**

00217	Treatment of skin disorders and lesions other than ultraviolet, x-ray, Grenz ray (such as cryosurgery, electrosurgery, etc.) extra - operation only.....	195.00		14.81
-------	--	--------	--	-------

NOTES:

- i) Payable to specialists certified in Dermatology only.
- ii) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the plan. Refer to Preamble, D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance".

*00218	Curettage and electrosurgery of skin carcinoma proven histopathologically - operation only .....	251.00		61.38
*00219	– for each additional lesion – to a maximum of two additional lesions per day - operation only .....	188.00		30.69
00222	Psoralen ultra violet A treatment - whole body.....	110.00		20.33

DERMATOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
00223 – partial body .....	110.00		20.33
NOTE: Both 00222 and 00223 include an office visit and have a maximum of 40 treatments per year.			
00224 Ultra violet B treatment, whole or partial body - includes office visit .....	82.90		20.33
00235 Pulsed laser surgery of the face and/or neck, treatment area less than 50 cm <sup>2</sup> - operation only .....	467.00	3	67.92
00236 Pulsed laser surgery of the face and/or neck, treatment area greater than or equal to 50 cm <sup>2</sup> <u>or</u> treatment of the eyelids with eye shield insertion - operation only .....	1011.00	3	101.87
00237 Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia.....	195.00		56.08
NOTES:			
i) Only the following conditions qualify for payment under 00235, 00236 and 00237:			
a) Port wine stains involving the face and/or neck;			
b) Complicated superficial hemangiomas			
– lesions interfering with function (vision, breathing or feeding);			
– lesions which are ulcerated, bleeding or prone to infections where standard wound care has failed;			
c) Facial naevus of Ota; and			
d) Disfiguring facial pigmentary anomalies (e.g.: segmental or systematized).			
ii) Only the following types of lasers qualify for payment under 00235, 00236 and 00237:			
a) Pulsed dye laser;			
b) Q-Switched Ruby laser; and			
c) Q-Switched YAG laser.			
iii) Restricted to Dermatology and Plastic Surgery.			
00019 Venesection for polycythemia or phlebotomy - procedural fee .....	84.90		31.55

**SURGICAL PROCEDURES AND REPAIRS**

**Mohs' Technique**

00225 Initial cut, including debulking.....	1104.00		346.71
00226 One or more additional cuts (extra).....	774.00		300.32
00227 Special overhead and technical component (extra) .....	774.00		323.29

*(see notes on next page)*

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

NOTES:

- i) 00225, 00226 and 00227 are billable only for complicated epithelial cancer and only by physicians specially qualified in this technique.
- ii) 00226 and 00227 are billable only once whether or not excision of the lesion extends to 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.

DERMATOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Local Tissue Shifts:</b>			
Advancements, rotations, transpositions "Z" plasty, etc.			
20221			
Single or multiple flaps under 2 cm in diameter used in repair of defect (except for special areas as in 20225) (operation only) .....	1061.00	2	203.96
20222			
Single .....	1061.00	2	315.48
20223			
Multiple .....	1857.00	2	569.41
20224			
– with free skin graft to secondary defect.....	1727.00	2	647.63
20225			
Eyebrow, eyelid, lip, ear, nose - single	1230.00	3	296.52
NOTE: Repair of torn earlobe to be claimed under 06027.			
<b>FREE SKIN GRAFTS (INCLUDING MUCOSA)</b>			
Full-thickness grafts:			
20226			
Eyelid, nose, lips, ear .....	1061.00	2	310.50
20227			
Finger, more than one phalanx .....	1061.00	2	296.52
20228			
Sole or palm .....	1061.00	2	296.52
<b>TUMOURS OF THE SKIN</b>			
13600			
Biopsy of skin or mucosa - operation only .....	119.00	2	51.92
13601			
Biopsy of facial area - operation only .....	119.00	2	51.92
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 .....	168.00		19.48
20232			
Biopsy, not sutured, multiples same sitting, maximum of four (extra).....	125.00		9.74
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) .....	104.00	2	44.48
13620			
Excision of tumour of skin or subcutaneous tissue or small scar, under local anesthetic - up to 5cm - operation only .....	156.00	2	66.35
13621			
– additional lesions removed at the same sitting (maximum 5 per sitting) - operation only .....	76.50		33.18
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 Alteration of Appearance".			
13622			
Localized carcinoma of the skin, proven histopathologically - operation only .....	168.00	2	73.30
06146			
Lip shave - vermilionectomy .....	1588.00	3	399.13



DERMATOLOGY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>DIAGNOSTIC PROCEDURES</b>			
<b>Allergy, Patch and Photo Patch Tests:</b>			
S00762 Scratch test, per antigen .....	7.00		1.06
Note: Minor tray fee may be paid in addition if a minimum of 16 antigens are used.			
S00763 – children under 5 years of age, per antigen .....	7.45		2.32
Note: Minor tray fee may be paid in addition if a minimum of 14 antigens are used.			
S00764 Intracutaneous test, per test .....	9.95		2.15
S00765 Annual maximum (to include scratch or intracutaneous tests) for each physician per patient .....	159.00		34.40
S00767 Patch testing (extra) - annual maximum is 80 tests, per test .....	6.45		1.96
S00768 Photopatch test, per test .....	37.75		5.66
S00769 Photopatch test - annual maximum.....	378.00		56.69

# 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 General Practice. Physicians working in diagnostic treatment centers or free-standing emergency clinics should also refer to the listings in the Section of General Practice. Call-in fees (e.g.: 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 1:

- 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 Royal College Certified emergency physicians. Other full-time emergency physicians may bill a general practice out-of-office consultation (fee item 12210, 13210, 15210, 16210, 17210 or 18210) where indicated.
- b) An emergency medicine consultation (whether billed as 01810, 12210, 13210, 15210, 16210, 17210 or 18210) 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 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 to 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 the 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.

EMERGENCY MEDICINE - Continued

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%.

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

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

**REFERRED CASES**

01810 <b>Consultation:</b> 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.....	372.00	130.28
<b>Level I:</b>		
01811 Level I, Day .....	81.30	35.37
01821 Level I, Evening .....	102.00	42.28
01831 Level I, Night.....	157.00	64.67
01841 Level I, Saturday, Sunday or Statutory Holiday .....	129.00	45.43
<b>Level II:</b>		
01812 Level II, Day.....	131.00	76.00
01822 Level II, Evening .....	163.00	88.53
01832 Level II, Night.....	250.00	122.22
01842 Level II, Saturday, Sunday or Statutory Holiday .....	270.00	95.23
<b>Level III:</b>		
01813 Level III, Day.....	185.00	96.14
01823 Level III, Evening .....	229.00	110.25
01833 Level III, Night.....	371.00	163.63
01843 Level III, Saturday, Sunday or Statutory Holiday .....	336.00	118.54

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

**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 the patient (or guardian) about temporary immobilization for comfort and arranging orthopaedic follow up as required. Cannot be billed in addition to a visit or Emergency Medicine Level I, II, or III fee items. Must be performed in the Emergency Department (location code E).

01850 Clavicle.....	318.00	2	105.60
01851 Fibula - shaft or malleolus not requiring reduction.....	275.00		91.34

**Dislocations:**

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

01860 Temporo-mandibular joint, dislocation - closed reduction.	207.00	3	68.95
01861 Patella - closed reduction .....	199.00	2	66.05
01862 Toe - closed reduction .....	149.00	2	49.54

**Resuscitation:**

P01870 Emergency Medicine Resuscitation fee: Treatment of acute life-threatening emergency that requires constant bedside resuscitative care– per 5 minutes or part thereof	62.20		27.70
---	-------	--	-------

**NOTES:**

- i) Applicable only to emergency physician 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 emergencies.
- iii) Start and end times must be entered in both the billing claims and the patient's chart.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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 whole time shall be claimed on only one patient on whom the majority of time was spent. 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 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.			
P01871 Trauma Team Leader Resuscitation fee: Treatment of acute life-threatening emergency that requires constant bedside resuscitative care – per 5 minutes or part thereof	62.20		27.70
NOTES:			
i) Applicable only to Trauma Team Leaders on contract with a Health Authority to provide on call Trauma Team Leader Services and where the contract does not include provision of this service. Not applicable for General Surgery Trauma Team Leaders.			
ii) Includes endotracheal intubation, cricothyrotomy, vascular access (including intraosseous), invasive monitoring, chest tube drainage, and pacemaker insertion and/or other procedures which are central to the resuscitation for acute life-threatening 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 whole time shall be claimed on only one patient on whom the majority of time was spent. No more than 12 units may be claimed within a 60 minute period.			
<i>(notes continued on next page)</i>			



<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- 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 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.

# ENDOCRINOLOGY AND METABOLISM

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
33210 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report .....	638.00		214.21
33212 <b>Repeat or Limited Consultation:</b> Where a consultation for the 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 .....	322.00		102.84
33214 Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) .....	322.00		70.05
NOTES:			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
33213 Group counseling for groups of two or more patients - first full hour .....	652.00		143.40
33215 – second hour, per 1/2 hour or major portion thereof .....	331.00		71.65
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
<b><u>Continuing Care by Consultant:</u></b>			
33206 Directive care .....	117.00		59.69
33207 Subsequent office visit .....	123.00		62.34
33208 Subsequent hospital visit .....	90.70		36.76
33209 Subsequent home visit .....	181.00		65.60
33205 Emergency visit when specially called (not paid in addition to out-of-office hour premiums) .....	368.00		145.35
NOTE: Claim must state time service rendered.			
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
33270 Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.....	638.00		214.21

ENDOCRINOLOGY AND METABOLISM - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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.....	322.00		102.84
33276	Telehealth directive care .....	117.00		59.69
33277	Telehealth subsequent office visit .....	123.00		62.34
33278	Telehealth subsequent hospital visit.....	90.70		36.76
PG33260	Initial virtual assessment, with patient or representative/ family .....	300.00		120.95
	NOTES:			
	i) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received.			
	ii) Restricted to Endocrinology and Metabolism specialists.			
	iii) Not paid within 6 months of a 33210 (consultation), 33270 (Telehealth consult), or G33260 (virtual assessment), for the same diagnosis.			
	iv) Not payable in addition to another service on the same day for the same patient by the same practitioner.			
PG33262	Repeat virtual assessment for same illness within six months of the last visit by the consultant, or where in the judgment of the consultant the services do not warrant an initial assessment fee ..	151.00		60.48
	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 and care plan to the referring physician within 14 days of referral being received.			
	<i>(notes continued on next page)</i>			

ENDOCRINOLOGY AND METABOLISM - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
	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.			
33267	Subsequent virtual office visit, requiring a written individualized report to the GP.....	94.90		38.92
	NOTES:			
	i) Restricted to Endocrinology and Metabolism specialists.			
	ii) Maximum 12 per calendar year, per patient.			
PG33250	Virtual communication with patient, or representative/family, for medically pertinent matters.....	25.40		10.25
	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.			
<b>MISCELLANEOUS</b>				
PGY33255	Insulin start.....	102.00		40.99
	NOTES:			
	i) Paid with endocrinology consultations or visits (33210, G33260, 33206, 33207, 33208, 33209, G33262, 33267).			
	ii) Restricted to Endocrinology and Metabolism specialists.			
	iii) Maximum one per day, per patient.			
	iv) Not paid same day as GY33256.			
	v) Also payable for the other injected non-insulin diabetes medications: liraglutide and exenatide.			
PGY33256	Insulin pump start.....	204.00		81.97
	NOTES:			
	i) Paid with face to face endocrinology consultations or visits (33210, 33206, 33207, 33208, 33209, G33260, G33262 or 33267).			

*(notes continued on next page)*

ENDOCRINOLOGY AND METABOLISM - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>ii) Restricted to Endocrinology and Metabolism specialists.</li> <li>iii) Maximum one per patient, per day</li> <li>iv) Not paid same day as GY33255.</li> </ul>			
PG33240 Premium for patients 75 years and over, billed in addition to 33210, G33212, G33270, G33272, G33260, or G33262.....	134.00		53.97
NOTES: <ul style="list-style-type: none"> <li>i) Restricted to Endocrinology and Metabolism specialists.</li> <li>ii) Maximum one premium, per patient, per day.</li> </ul>			
PG33241 Premium for patients 75 years and over, billed in addition to 33207, 33209, 33277, 33267, G33250, GY33255, or GY33256.....	35.95		14.47
NOTES: <ul style="list-style-type: none"> <li>i) Restricted to Endocrinology and Metabolism specialists.</li> <li>ii) Maximum one premium, per patient, per day.</li> </ul>			
<b>DIAGNOSTIC - MISCELLANEOUS</b>			
S00744 Thyroid biopsy - procedural fee.....	223.00	2	71.92

# GASTROENTEROLOGY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
33310 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report .....	570.00		177.31
33312 <b>Repeat or Limited Consultation:</b> Where a consultation for the same illness is repeated within six (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 .....	287.00		101.14
33314 Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) .....	287.00		54.82
<b>NOTES:</b>			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
33313 Group counseling for groups of two or more patients - first full hour .....	581.00		105.06
33315 – second hour, per 1/2 hour or major portion thereof ....	296.00		52.78
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
<b><u>Continuing Care by Consultant:</u></b>			
33306 Directive care.....	105.00		59.43
33307 Subsequent office visit.....	111.00		67.10
33308 Subsequent hospital visit.....	80.90		40.95
33309 Subsequent home visit .....	162.00		49.22
33305 Emergency visit when specially called (not paid in addition to out-of-office hour premiums) .....	327.00		111.65
NOTE: Claim must state time service rendered.			
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
33360 Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report. .	570.00		177.31
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. ....	287.00		101.14

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
33366	Telehealth directive care .....	105.00		59.43
33367	Telehealth subsequent office visit .....	111.00		67.10
33368	Telehealth subsequent hospital visit.....	80.90		40.95

**DIAGNOSTIC PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION**

**Upper Gastrointestinal System**

S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee .....	400.00	3	89.73
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee .....	332.00	3	74.74
S10763	Initial esophageal, gastric or duodenal biopsy.....	128.00	3	29.06

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.....	196.00	3	43.58
--------	---	--------	---	-------

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 .....	299.00		89.73
---------	---	--------	--	-------

NOTE: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.

**Lower Gastrointestinal System**

SY00715	Sigmoidoscopy with biopsy - procedural fee .....	145.00	2	37.98
SY00718	Sigmoidoscopy, flexible – with biopsy .....	335.00	2	77.34
10708	Video capsule endoscopy using M2A capsule – professional fee .....	727.00		256.63

NOTE: Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have ruled out other causes.

GASTROENTEROLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S33335 SBE or DBE (balloon assisted) enteroscopy .....	1210.00	3	302.25
NOTES:			
i) Not paid with 10761, 33373 or 33374.			
ii) Examination of the terminal ileum using a SBE/DBE is not billable under this fee item.			
iii) Billable only by specialist who are credentialed to bill fee item 10708.			
<b>The following fees are only paid in addition to S33335:</b>			
S33336 – with biopsy (single or multiple) – extra .....	115.00		28.71
S33337 – removal of polyp – extra .....	202.00		50.38
S33338 – each additional polyp (maximum of 10) – extra ....	48.40		12.09
S33339 – with fulguration or coagulation, by any means of one or more lesions – extra .....	162.00		40.30
<b>Upper Gastrointestinal System - Endoscopy (Surgical)</b>			
S33321 Removal of foreign material causing obstruction, operation only .....	454.00	4	101.91
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33322 Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only	521.00	3	116.68
NOTES:			
i) Paid only once per endoscopy.			
ii) Paid only in addition to S10761 or S10762.			
S33323 Transendoscopic tube, stent or catheter – operation only	454.00	3	101.86
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 .....	191.00	3	42.60
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33325 Gastric Polypectomy, operation only .....	721.00	5	161.47
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S33326 Percutaneous endoscopically placed feeding tube – operation only.....	329.00	3	73.78
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.....	63.40	3	14.25
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33328 Esophageal dilation, blind bouginage, operation only	258.00	3	57.25
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.....	486.00	3	109.02
NOTE: Repeats within one month paid at 100%.			

**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 for contrast material.

10735 Rectal endoscopy utilizing ultrasound (radial/linear) Note: Includes mucosal biopsy.....	429.00		153.99
10740 Upper GI endoscopy utilizing radial ultrasound .....	750.00		256.63
10741 Upper GI endoscopy utilizing linear ultrasound .....	750.00		256.63
NOTES:			
i) P10740 and P10741 are payable only when done in publicly funded acute care facilities.			
ii) P10741 payable at 50% when done subsequent to P10740 (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.....	148.00		51.33
NOTES:			
i) Payable with P10740 or P10741 only.			
ii) First biopsy paid at 100%. Second and third biopsies payable at 50%.			

GASTROENTEROLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10743 Upper GI endoscopy utilizing radial/linear ultrasound – with injection of one or more of any of the following – metastases, nodes, masses, or celiac plexus – extra. Note: Payable with P10740 or P10741 only.	429.00		153.99
10744 Upper GI endoscopy utilizing radial/linear ultrasound – with drainage of pseudocyst (including stent insertion if performed) – extra .....	573.00		205.32
Note: Payable with P10740 or P10741 only.			
<b>DIAGNOSTIC - MISCELLANEOUS</b>			
S00809 Retrograde pancreatography .....	937.00	3	216.54
<b>MISCELLANEOUS</b>			
S33373 Colonoscopy with flexible colonoscope - biopsy .....	935.00		235.15
33374 – removal of polyp .....	1393.00		283.50
33394 Assistant fee for PEG procedure .....	433.00		112.47
NOTE: 33326, 33394 may be billed by any qualified physician.			

# GENERAL SURGERY

General Surgeons billing General Surgery fee items identified with a “V” prefix are exempt from the postoperative general preamble rule (Preamble D. 5. 1) and can bill fee items 71008 for post operative visits (in hospital) during post-op days 1 - 14.

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES (CONSULTATIONS OR VISITS)</b>			
07010 <b>Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report.....	517.00		114.06
07012 <b>Repeat or Limited Consultation:</b> 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 .....	228.00		59.96
<b><u>Continuing Care by Consultant:</u></b>			
07007 Subsequent office visit .....	98.90		26.23
07008 Subsequent hospital visit .....	84.50		25.00
07009 Subsequent home visit.....	199.00		49.48
07005 Emergency visit when specially called (not paid in addition to out-of-office hour premiums nor within 10 post-operative days from a surgical procedure).....	391.00		102.49
NOTE: Claim must state time service rendered.			
07006 Directive care in emergent surgical conditions, per visit	115.00		29.34
NOTE:			
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) .....	88.90		25.63

*(see notes on next page)*

GENERAL SURGERY – Continued

**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

NOTES:

- i) Restricted to General Surgeons whose most recent specialty is General Surgery.
- ii) Restricted to General Surgery 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 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.

71015 Pre-Operative Assessment.....	420.00		114.06
-------------------------------------	--------	--	--------

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 ..	558.00		141.56
--	--------	--	--------

71017 Special office visit for new diagnosis or recurrent malignancy .....	213.00		60.64
--	--------	--	-------

NOTES:

- i) Payable only to the General Surgeon who is the most responsible physician in treatment of the malignancy.
- i) Applicable to new malignancy or recurrence of malignancy in remission.
- ii) For histologically confirmed malignancy only.
- iii) Not to be billed for non-melanoma skin carcinoma.
- iv) Only payable when seen by the same practitioner, in consultation, within 365 days prior.

## GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
70070 Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and written report.....	517.00		114.06
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.....	228.00		59.96
70077 Telehealth subsequent office visit.....	98.90		26.23
70078 Telehealth subsequent hospital visit.....	84.50		25.00
70076 Telehealth directive care in emergent surgical conditions – per visit.....	115.00		29.34
NOTES:			
i) Limited to 2 services per calendar week, when medically required, by the patient's condition.			
ii) Use only where 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.....	523.00		141.56
70087 Telehealth Special office visit for new diagnosis or recurrent malignancy.....	198.00		60.64
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.

*(notes continued on next page)*

## GENERAL SURGERY – Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

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 Hemodynamic compromise;
  - g) Hypothermia; and
  - h) Other immediate life threatening situations.
3. 00081 includes the following procedural items where required: defibrillation, cardioversion, peripheral intravenous lines, arterial blood gases, neogastric 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; and
  - g) Pacemaker Insertion.
6. 00081 is not intended for standby time such as waiting for laboratory results, or simple monitoring of the patient.

*(notes continued on next page)*

## GENERAL SURGERY – Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
7.	When a consultation fee is charged in addition to 00081, for billing purposes the consultation fee shall constitute the first half hour of the time spent with the patient.			
8.	When surgery is performed by the same doctor after prolonged emergency care, the surgical fee may be charged in addition to the appropriate emergency care fee.			
9.	When a second or third physician becomes involved in the emergency care of an acutely ill patient requiring continuous bedside care, item 00081 is applicable just as it is to the attending physician who is first on the scene.			
00081	Emergency care, per half hour or major portion thereof.	314.00		105.79
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof.....	156.00		63.47

## TRAUMA ASSESSMENT AND SUPPORT

### 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  $\leq$  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  $\leq$  8 with a mechanism suggestive of injury.
- v) Gunshot or other penetrating wounds to head, neck, chest, abdomen or proximal extremity (at or above knee or elbow).
- vi) Autolaunched Trauma Patient.
- vii) Pediatric Trauma Patient under 16 years of age.
- viii) Special consideration will be given for patients with significant co-morbidities, pregnant patients, and patients < 5 years of age and > 65 years of age.

## GENERAL SURGERY – Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

### **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 (i.e. humerus, femur)
- vi) Burns
- vii) - Partial thickness (2°) burn ≥ 10% and full thickness (3°) burn
  - Electrical or lightning burn
  - Chemical burn or Inhalation injury
  - Burn injury in patients with significant co-morbidities
  - Burn injury with concomitant trauma
- viii) Obvious significant injury and – Falls > 20 feet.
- ix) Obvious significant injury and – Pedestrian hit (thrown or run over).
- x) Obvious significant injury and – Motorcycle crash with separation of the rider and bike.
- xi) Obvious significant injury and – Motor vehicle crash with either
  - Ejection
  - Rollover
  - Speed > 70 kph
  - A death at the scene
- xii) 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

*(notes continued on next page)*



GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>• care of traumatic wounds or burns (including suturing) not requiring a general anesthetic</li> <li>• obtaining appropriate surgical consultations and transfer to higher level facilities when needed</li> <li>• coordinating with the transplant organ retrieval team, family counselling (related to organ donation) and obtaining consent for organ procurement</li> </ul> <ul style="list-style-type: none"> <li>- usual resuscitative procedures such as endotracheal intubation, tracheal toilet and artificial ventilation</li> <li>- extraordinary resuscitative procedures such as resuscitative thoracotomy or emergency surgical airway</li> <li>- all necessary measures for respiratory support</li> <li>- insertion of intravenous lines, peripheral and central</li> <li>- bronchoscopy</li> <li>- chest tubes</li> <li>- lumbar puncture</li> <li>- cut-downs</li> <li>- arterial and/or venous catheters and insertion of SWAN-GANZ catheter</li> <li>- pressure infusion sets and pharmacological agents</li> <li>- insertion of CVP lines</li> <li>- defibrillation</li> <li>- cardio-version and usual resuscitative measures</li> <li>- insertion of urinary catheters and nasal gastric tubes</li> <li>- securing and interpretation of laboratory tests</li> <li>- oximetry</li> <li>- transcutaneous blood gases</li> <li>- intra-cranial pressure (ICP) monitoring, interpretation and assessment when indicated</li> <li>- suturing of wounds not requiring a general anesthetic</li> <li>- ensuring adequate DVT prophylaxis</li> <li>- reduction of fractures and dislocations (including casting) not requiring a general anesthetic</li> <li>- clearance of C-spines or appropriate referral</li> </ul>			
10087 Trauma Team Leader – Initial Assessment, Secondary Survey and Support .....	1375.00		301.88

*(see notes on next page)*

GENERAL SURGERY – Continued

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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.) .....	475.00	104.00
---	--------	--------

NOTES:

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

10089 Trauma Team Leader Subsequent Hospital Visit (Days 3-15 inclusive) .....	361.00	78.72
--	--------	-------

NOTES:

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

GENERAL SURGERY – Continued

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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+).....	288.00	85.00
-------	-----------------------------------	--------	-------

NOTES:

- i) Payable only to General Surgeons.
- ii) Fee Item P07001 will be paid only once when multiple procedures are performed under the same anesthetic.
- iii) Payable when the following General Surgery 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, 07431, 07432, 07433, 07434, 07435, 07436, 07437, 07438, 07440, 07441, 07442, 07443, 07444, 07445, 07446, 07447, 07448, 07449, 07452, 07455, 07460, 07470, 07471, 07472, 07473, 07474, 07475, 07479, 07481, 07482, 07497, 07498, 07516, 07522, 07528, 07536, 07560, 07561, 07562, 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,

*(notes continued on next page)*

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
33321, 33322, 33323, 33324, 33325, 33326, 33329,			
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, 70641, 70642, 70643, 70644, 70645,			
70646, 70648, 70649, 70650, 70660, 70661, 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, 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,			
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, 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			
and 72798.			

P07003 Body Mass Index Surgical Surcharge payable at 25%  
of listed fee for surgery performed.....

*(see notes on next page)*

## GENERAL SURGERY – Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

- The patient has a Body Mass Index (BMI) greater than 35 for major surgery on the peritoneal cavity, pelvis, retroperitoneum or 40 for major surgery on the neck.
- The surgery is rendered under general anesthesia using either an open technique for the neck, or an open or laparoscopic technique for the peritoneal cavity, pelvis or retroperitoneum.
- The principal surgical technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation nor catheterization.

### NOTES:

- i) Payable only to General Surgeons.
- ii) Patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.
- iii) Maximum of one surcharge per operation unless two general surgeons perform two synchronous surgeries that are both eligible for the surcharge.
- iv) When multiple procedures are performed during the same operation, the surcharge applies to all eligible procedures based on the prorated value according to the surgical preamble for multiple procedures.
- v) The surcharge does not apply to surgical fee modifier 07001 (Surgical Surcharge Age 75+) but may be paid in addition.
- vi) Payable when the following General Surgery fee items are performed for patients with a BMI greater than 35: 07134, 07360, 07363, 07366, 07368, 07402, 07403, 07404, 07405, 07406, 07407, 07408, 07409, 07410, 07411, 07412, 07413, 07431, 07432, 07433, 07434, 07435, 07436, 07437, 07438, 07440, 07441, 07442, 07443, 07444, 07445, 07446, 07447, 07448, 07449, 07450, 07451, 07452, 07455, 07474,

*(notes continued on next page)*

GENERAL SURGERY – Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

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, 70620,  
 70621, 70622, 70624, 70625, 70626, 70627,  
 70628, 70629, 70630, 70631, 70632, 70633,  
 70635, 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, 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,

*(notes continued on next page)*

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
72715, 72720, 72721, 72723, 72725, 72726, 72727, 72728, 72729, 72730, 72731, 72732, 72733, 72734, 72735, 72736, 72737, 72740, 72741, 72745, 72751, 72755, 72760, 72762, 72763, 72765, 72767, 72769, 72770, 72775, 72788, 72789, 72794, 72795, 72796, 72797, and 72798			
vii) Payable when the following General Surgery Fee items are performed for patients with a BMI greater than 40: 07361, 07740, 07741, 07743, 07744, 07745, 07771, 07796, 70023, 70500, 70502, 70530, 70545, 70740, 70742, 70743, 70745, 70747, 71530, 71548, 71550, 71706, 71707, 71746, and 71748			

**SURGICAL ASSISTANT OR SECOND OPERATOR**

**Total Operative Fee(s) for Procedures:**

00195 Less than \$317.00 inclusive.....	339.00		134.22
00196 \$317.01 - \$529.00 inclusive.....	477.00		189.24
00197 Over \$529.00.....	624.00		260.35
00198 Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof.....	71.30		28.52

NOTES:

- i) In those rare situations where an assistant is required for minor surgery a detailed explanation of need must accompany the account to the Plan.
- ii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anesthetic, he may charge a separate assistant fee for each operation, except for bilateral procedures, procedures within the same body cavity or procedures on the same limb.

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.....	1048.00		256.63
---	---------	--	--------

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

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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 .....	119.00		32.23
NOTES:			
i) After 3 hours of continuous 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.....	62.80		15.36
NOTES:			
i) Restricted to General Surgery.			
ii) Paid only in addition to fee item 70020			
iii) Maximum payable is 8 units per surgery.			
iv) Any additional assistants, if required, are paid under fee items 00197 and 00198 only.			
v) Start and end times must be entered in both the billing claims and the patient's chart.			

**SECOND SURGEON**

**Total or near total esophagectomy, without thoracotomy (Transhiatal):**

• with pharyngogastrostomy or cervical esophagogastronomy, with or without pyloroplasty			
70503 – secondary surgeon.....	1927.00		650.00
• with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)			
70504 – secondary surgeon.....	1927.00		650.00

**Total or near total esophagectomy,**

• with thoracotomy, with or without pyloroplasty (3 - hole)			
70505 – secondary surgeon.....	1927.00		650.00
• with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)			
70506 – secondary surgeon.....	1927.00		650.00



GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Partial esophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic esophagogastrostomy:</b>			
(includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required)			
<ul style="list-style-type: none"> <li>• with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)</li> </ul>			
70509 – secondary surgeon .....	1927.00		650.00
<b>Partial esophagectomy, thoracoabdominal or abdominal approach, with esophagogastrostomy:</b>			
<ul style="list-style-type: none"> <li>• (includes vagotomy, proximal gastrectomy, pyloroplasty and splenectomy, if required)</li> <li>• with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)</li> </ul>			
70511 – secondary surgeon .....	1927.00		650.00
07702 Fee for second surgeon participating in total correction of cloacal anomalies .....	1798.00		507.54
NOTE: When 07700 and 07702 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.			
07593 Fee for second surgeon participating in Pena posterior sagittal anoproctoplasty .....	1385.00		339.13
NOTE: When 07571 and 07593 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.			
<b>Second operator:</b>			
77025 Synchronous combined bypass graft - extremities.....	848.00		300.19
77030 – trunk .....	848.00		300.19
NOTE: Items 77025 and 77030 provide operative report by second operator when requested from payment agency.			

**SUPERFICIAL/MISCELLANEOUS**

13605 Opening superficial abscess, including furuncle - (operation only) .....	104.00	2	44.48
07041 Aspiration: abdomen or chest (operation only) .....	192.00	2	76.01
<b>Abscess:</b>			
07059 – deep (complex, subfascial, and/or multi-locular) with local or regional anesthesia - operation only .....	232.00	2	81.46
07027 – under general anesthesia - operation only .....	520.00	2	203.59

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
07061 – deep post-operative wound infection, under GA - operation only.....	331.00	2	203.37
07045 Anterior closed space abscess (operation only) .....	160.00	2	101.44
06028 Web space abscess (operation only).....	284.00	2	71.53
06029 – under general anesthetic - operation only .....	1013.00	2	290.00
<b>Pilonidal cyst or sinus:</b>			
70084 – incision and drainage, abscess - operation only.....	232.00	2	101.36
07685 – excision or marsupialization (operation only) .....	1124.00	2	277.43
<b>Wounds - Simple:</b>			
13610 Minor laceration or foreign body - not requiring anesthesia (operation only) .....	82.60	2	35.62
13611 Minor laceration or foreign body - requiring anesthesia (operation only).....	156.00	2	66.35
06063 Removal of foreign body - requiring general anesthesia (operation only) .....	608.00	2	250.72
13620 Excision of tumour of skin or subcutaneous tissue or small scar, under local anesthetic - up to 5 cm - operation only .....	156.00		66.35
13621 – additional lesions removed at the same sitting (maximum per sitting - five), each - operation only...	76.50		33.18
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 Alteration of Appearance".			
ii) Fee items 13620 and 13621 are not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			
13601 Biopsy of facial area, sutured - operation only.....	119.00		51.92
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 histopathologically .....	168.00		73.30
V70116 Removal of tumour (including intraoral) or scar revision – 2 to 5 cm (operation only).....	522.00	2	127.72
NOTE: For tumours or scars under 2 cm, bill under fee item 13620.			
V70117 Removal of tumour (including intraoral) - 5.1 cm to 10 cm.....	1069.00	2	261.90
V70118 Removal of tumour (including intraoral) – greater than 10 cm.....	1848.00	2	452.56
NOTE: 70116, 70117 and 70118 are not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V70125 Radical resection of malignant skin or soft tissue tumour measuring 5-10 cm .....	1069.00	2	261.90
V70126 Radical resection of malignant skin or soft tissue tumour measuring 10 cm or greater .....	1848.00	2	452.56
70127 Closure or radical resection requiring a free split thickness skin graft greater than 65 cm <sup>2</sup> (extra).....	414.00		101.15
NOTES:			
i) Restricted to General Surgeons.			
ii) Must be performed in an Operating Room (location code E, G, I or P).			
iii) 70127 only paid in addition to 70125 or 70126.			
<b>Local tissue shifts: Advancements, rotations, transpositions, “Z” plasty, etc.</b>			
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 than 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, Orthopaedics Otolaryngology or Dermatology.			
V70119 Single flap under 2 cm in diameter used in repair of a defect (except for special areas as in V70124) (operation only) .....	646.00	2	158.38
V70120 Single flap for lesion greater than 2 cm.....	1325.00	2	324.74
V70121 Single flap for lesion greater than 2 cm with free skin graft to secondary defect .....	1667.00	2	408.56
V70122 Multiple flap for lesion greater than 2 cm .....	2335.00	2	571.97
V70123 Multiple flap for lesion greater than 2 cm with free skin graft to secondary defect .....	2655.00	2	650.54

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V70124 Eyebrow, eyelid, lip, ear, nose – single.....	1205.00	3	295.14
NOTE: Repair of torn earlobe to be claimed under 06027.			
<b>Foreign Body:</b>			
Excision of skin and subcutaneous tissue of hidradenitis suppurativa:			
07072 – axillary - operation only .....	497.00	2	250.00
07075 – inguinal - operation only .....	497.00	2	250.00
07076 – perianal - operation only.....	497.00	2	250.00
07082 – perineal - operation only.....	497.00	2	250.00
06166 Excision of axillary sweat glands for hyperhidrosis - unilateral.....	1293.00	4	325.14
NOTES:			
i) Direct closure included when open procedure used.			
ii) Aggressive removal of apocrine sweat glands by any means.			
<b>Tenotomy:</b>			
07073 – congenital torticollis - operation only .....	544.00	3	304.16
V07074 – resection.....	1052.00	3	257.99
(Section of transverse carpal ligament - bill under S06258)			
<b>Excisional biopsy of lymph glands for suspected malignancy:</b>			
70023 – neck - operation only.....	541.00	3	203.62
V70024 – axilla.....	965.00	2	237.34
70025 – groin - operation only.....	331.00	2	203.37
13630 Paronychia (operation only).....	82.40		35.53
13631 Removal of nail - simple (operation only).....	82.40		35.53
13632 – with destruction of nail bed - operation only .....	165.00		71.89
13633 Wedge excision of one nail - operation only .....	147.00		63.44
V07053 Excision of nail bed, complete, with shortening of phalanx.....	563.00	2	137.99
07025 Temporal artery biopsy - operation only .....	322.00	2	140.69
07028 Biopsy of sural nerve - operation only.....	299.00	2	177.27
V07055 Ganglia, of the wrist.....	561.00	2	202.23

**WOUNDS**

13612 Extensive lacerations over 5 cm (maximum charge 35 cm) - (operation only), per cm.....	30.55		13.32
NOTE: Not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Wounds - avulsed and complicated:</b>			
06075 Lips and eyelids .....	1349.00	3	339.41
06076 Nose and ear .....	1696.00	3	426.36
06077 Complicated lacerations of the scalp, cheek and neck ..	1324.00	3	333.13
NOTES: The following conditions are necessary for 06075, 06076 or 06077 to apply:			
i) A layered closure* is required and at least one of:			
iii) Injuries involving necrotic tissue requiring debridement such that simple suture closure is precluded; or			
iv) injuries involving tissue loss such that simple suture is precluded; or			
v) Wounds requiring tissue shifts for closure aside from minor undermining or advancement flaps; or			
vi) Skived, ragged or stellate wounds where excision of tissue margins is necessary to obtain 90 degree closure; or			
vii) Contaminated wounds that require excision of foreign material, or			
viii) Lacerations requiring layered closure <u>and</u> key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or			
ix) Lacerations into the subcutaneous tissue requiring alignment <u>and</u> repair of cartilage <u>and</u> layered closure.			
x) 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 .....	1100.00	3	270.50

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>DEBRIDEMENT OF SOFT TISSUES FOR NECROTIZING INFECTION OR SEVERE TRAUMA</b>			
V70155 Debridement of skin and subcutaneous tissue restricted to genitalia and perineum for necrotizing infection (Fournier’s Gangrene) (stand alone procedure) .....	1754.00	5	411.80
V70158 Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area .....	990.00	3	235.72
70159 Debridement of skin and subcutaneous tissue; for each additional 5% of body surface area or major portion thereof – extra.....	497.00		117.87
V70162 Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area.....	1110.00	4	261.93
70163 Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each additional 5% of body surface area or major portion thereof – extra.....	559.00	3	130.96
V70165 Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area .....	1228.00	4	288.10
70166 Debridement of skin, fascia, muscle and bone; for each additional 5% of body surface area or major portion thereof – extra.....	431.00		144.06
70168 Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area - operation only .....	331.00		78.57
Notes:			
i) Payable when rendered at the bedside but only when performed by a medical practitioner.			
ii) Requires wound assessment and dressing change and may include VAC application.			
iii) Applicable with or without anesthesia.			
70169 Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area - operation only .....	386.00	4	125.72

*(see notes on next page)*

## GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)	
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.				
<b>VASCULAR ACCESS</b>				
00319	Insertion of central catheter for total parenteral nutrition - operation only .....	224.00	2	56.54
<b>Broviac type catheter:</b>				
07139	– insertion of .....	561.00	2	162.55
V07140	– insertion of - less than 3 months of age or less than 3 kg.....	1096.00	4	269.03
07141	– removal of - operation only .....	157.00	2	126.79
Totally implantable venous access port with subcutaneous reservoir (port-a-cath type device):				
07142	– insertion of .....	1027.00	2	255.98
V07143	– revision (removal and reinsertion) .....	1200.00	2	350.00
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation .....	216.00		56.94
07145	Intra osseous - access - operation only .....	164.00	2	101.29
V07134	Peritoneal venous shunt for ascites .....	1592.00	6	390.37
V07146	Insertion of inferior vena cava filter, percutaneous placement or cutdown (e.g.: Kimray Greenfield filter) ....	1492.00	2	367.84
V07147	Insertion of a peritoneal catheter under general anesthetic .....	1268.00	4	305.89
NOTE: Includes fee items 77380, 07600 and 04001 (laparoscopy).				
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee .....	96.40		22.10

## HEAD AND NECK

### Lips:

06140	Wedge resection of lip - vermilion - operation only .....	446.00	3	200.57
06141	– to sulcus .....	936.00	3	250.72

## MOUTH

### Excision:

07790	Excision, lesion of floor of mouth - benign - operation only .....	497.00	3	152.81
02457	Tongue tie, under general anesthesia - operation only..	299.00	3	82.94

## GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02458 Tongue - local excision, under general anesthesia.....	601.00	3	165.83
V07789 Excision of lesion of tongue with closure anterior 2/3 with local tongue flap .....	1295.00	3	319.30
02275 Glossectomy subtotal with either division of mandible or transcervical resection.....	3835.00	6	1056.22
02279 Resection base of tongue and/or tonsil and soft palate .	6992.00	6	1926.37
02478 Glossectomy - partial for carcinoma .....	1343.00	6	369.96
C02480 Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy .....	4787.00	7	1320.23

## PHARYNX AND TONSILS

S00701 Direct laryngoscopy - procedural fee .....	141.00	5	37.70
NOTE: S00701 is not billable with bronchoscopy, except when done under general anesthesia.			
Incision of peritonsillar abscess:			
02447 – under local anesthesia - operation only .....	188.00	4	95.00
02444 – under general anesthesia - operation only .....	466.00	6	128.81
02403 Tonsillectomy - under local anesthesia.....	937.00	4	257.70
02445 Tonsillectomy - adult or child over the age of 14 years..	692.00	4	250.73
02446 – child age 14 years and under (to include neonate) ..	652.00	4	224.46
02413 Operative control of post-tonsillectomy or post- adenoidectomy hemorrhage requiring local or general anesthetic .....	601.00	6	263.45
02399 Cryotherapy of tonsils and oral lesions - operation only	418.00	3	114.81
02442 Adenoidectomy - adult or child over 14 years - operation only .....	466.00	4	128.81
02443 – child 14 years and under (neonate included) .....	574.00	4	158.22
NOTE: Office visits extra to 02442 and 02443, apart from usual one pre-operative and one post-operative visit.			
02449 Rigid esophagoscopy for removal of foreign body.....	692.00	4	191.35
02450 Bronchoscopy or microlaryngoscopy with removal of foreign body.....	931.00	6	255.15
02422 – in a child under the age of 3 years .....	1385.00	6	380.57

## SALIVARY GLANDS AND DUCTS

02452 Sialolithotomy, simple - in duct - operation only.....	229.00	3	63.76
02453 Sialolithotomy, complicated - in gland.....	692.00	3	191.35
07526 Dilation of salivary duct - operation only .....	601.00	3	152.38
02456 Salivary fistula, plastic to Stenson's duct.....	1527.00	4	420.98
07515 Drainage of abscess - parotid, submaxillary or sublingual (see abscess - deep) - operation only .....	331.00	3	202.59



## GENERAL SURGERY – Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Excision:</b>				
S00844	Biopsy of salivary gland - fine needle or core needle.....	220.00	3	54.02
07516	Excision or marsupialization of sublingual salivary cyst (ranula) - operation only .....	497.00	3	203.56
02455	Submandibular gland, excision .....	1157.00	4	318.91
07522	Local excision of parotid tumour, without nerve dissection - operation only .....	544.00	3	203.62
02471	Parotidectomy, subtotal with complete facial nerve dissection .....	3059.00	4	842.01
02472	Total parotidectomy with nerve dissection for malignancy or deep lobe tumour.....	3518.00	4	969.55

### NECK DISSECTION

02281	Conservative radical neck dissection .....	4556.00	6	1255.22
	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 .....	3835.00	6	1056.28
02477	Contralateral suprahyoid dissection .....	1757.00	5	484.78
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy .....	6992.00	7	1926.37

### HEAD AND NECK

<b>Miscellaneous:</b>				
02459	Cystic hygroma, excision .....	1993.00	4	548.56
V07500	Resection of mandible .....	1638.00	5	402.23
V07749	Partial maxillectomy for malignancy - fenestration .....	2216.00	5	811.46
CV07725	Maxillectomy .....	3323.00	5	1014.37
CV07726	- with exteneration of orbit and skin graft.....	4281.00	5	1051.77
V07796	Excision, neurogenic neoplasm - neck.....	2216.00	5	1115.70
V70545	Diverticulectomy of hypopharynx or esophagus, with or without myotomy - cervical approach.....	2186.00	6	536.76
02407	Tracheostomy .....	1067.00	5	390.00
	NOTE: Not applicable to cricothyrotomy puncture.			
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon.....	2316.00	5	637.88

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>BREAST</b>			
<b>Incision:</b>			
70041 Fine needle aspiration of solid or cystic lesion - operation only .....	177.00	2	46.33
70042 – each additional cyst or lesion (maximum of 3) - operation only .....	44.95	2	11.60
70043 Mastotomy with exploration or drainage of abscess - deep (operation only).....	331.00	2	81.45
V70044 – under general anesthesia.....	652.00	2	203.73
<b>Excision:</b>			
Biopsy of breast:			
70469 – needle core - operation only .....	232.00	2	57.48
70470 – incisional - operation only .....	469.00	2	152.26
70471 – excisional - operation only .....	500.00	2	203.56
<b>Stereotactic or ultrasound-guided core needle biopsy:</b>			
70472 – 1 to 5 core samples - operation only .....	331.00	2	87.38
70473 – 6 or more core samples - operation only .....	469.00	2	123.36
V07470 Nipple exploration, with excision of lactiferous duct(s) or papilloma of lactiferous duct (microdochectomy).....	687.00	2	277.88
V07497 Biopsy or segmental resection of non-palpable breast lesion following radiological fine wire localization .....	900.00	2	232.60
70477 – each additional lesion identified by a radiologic marker .....	449.00	2	110.42
<b>Mastectomy:</b>			
V70478 – for gynecomastia .....	912.00	3	305.89
V07471 – simple for benign disease (female only) .....	1388.00	3	340.96
V07498 – skin sparing, when performed for reconstruction - unilateral (female only) .....	2307.00	3	650.00
V07473 – partial for malignancy .....	965.00	3	329.57
V07472 – total for malignancy .....	1927.00	3	474.13
V70479 – radical.....	3164.00	4	777.59
NOTE: Includes pectoral muscles and complete axillary node dissection.			
V07475 Partial axillary dissection .....	965.00	3	237.35
V07474 Complete axillary dissection (level 2) .....	1927.00	3	507.42
79135 Chest wall tumour with rib resection .....	1471.00	6	1012.46
V07479 Sentinel lymph node biopsy (SLN) .....	1790.00	3	474.13

(see notes on next page)

GENERAL SURGERY – Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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 for 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				
<b>Oncoplastic breast surgery:</b>				
Lumpectomy for malignancy with immediate reconstruction of the defect using mammoplasty techniques. Excision of the tumour with planned margins to achieve locoregional control.				
PV07481	Oncoplastic breast conserving surgery – Level 1.....	1786.00	4	450.00
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.				
PCV07482	Oncoplastic breast conserving surgery – Level 2.....	2182.00	4	550.00
NOTES:				
i) Restricted to General Surgeons with appropriate post-graduate or post-fellowship training.				
ii) Includes mobilization of breast parenchyma, creation of skin flaps, rotational flap closure, and nipple areolar complex repositioning.				

**ESOPHAGUS**

**Incision:**

Esophagotomy:

V70500	– cervical approach with removal of foreign body.....	2186.00	5	536.76
V70501	– thoracic approach with removal of foreign body .....	2594.00	8	637.58
V70502	Cricopharyngeal myotomy - cervical approach .....	1909.00	4	469.34

**Excision:**

Excision of lesion, esophagus with primary repair:

CV70530	– cervical approach .....	2186.00	6	536.76
CV70531	– thoracic or abdominal approach - open .....	3164.00	8	777.59
CV70532	– thoracic or abdominal approach - laparoscopic or thoracoscopic .....	3164.00	8	777.59

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Total or near total esophagectomy, without thoracotomy (transhiatal):</b>			
<ul style="list-style-type: none"> <li>with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty:</li> </ul>			
V70533 – primary surgeon .....	5822.00	8	2030.14
70503 – secondary surgeon.....	1927.00		650.00
With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70534 – primary surgeon .....	6808.00	8	2030.14
70504 – secondary surgeon.....	1927.00		650.00
<b>Total or near total esophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):</b>			
V70535 – primary surgeon .....	6650.00	8	2283.91
70505 – secondary surgeon.....	1927.00		650.00
With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70536 – primary surgeon .....	7586.00	8	2283.91
70506 – secondary surgeon.....	1927.00		650.00
V70538 Partial esophagectomy, distal 2/3 - with thoracotomy and separate abdominal incision and thoracic esophagogastrostomy .....	6650.00	8	1634.89
NOTE: Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.			
<ul style="list-style-type: none"> <li><b>with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):</b></li> </ul>			
V70539 – primary surgeon .....	7586.00	8	1864.78
70509 – secondary surgeon.....	1927.00		650.00
CV70540 Partial esophagectomy, thoracoabdominal or abdominal approach, with esophagogastrostomy.....	5822.00	8	1430.50
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 .....	6808.00	8	1673.20
70511 – secondary surgeon.....	1927.00		650.00
CV70542 Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy (includes gastrostomy).....	4368.00	6	1073.50

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Diverticulectomy of hypopharynx or esophagus, with or without myotomy:			
V70545 – cervical approach .....	2186.00	6	536.76
V70544 – thoracic approach .....	2660.00	8	653.95

**Endoscopy:**

S10761 Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee .....	400.00	3	89.73
S10762 Rigid esophagoscopy, including collection of specimens by brushing or washing - procedural fee .....	332.00	3	74.74
S10763 Initial esophageal, gastric or duodenal biopsy .....	128.00	3	29.06

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 .....	196.00	3	43.58
---	--------	---	-------

NOTES:

- i) Paid only once per endoscopy.
- ii) Paid only in addition to S10763 at 100%.
- iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.

**Upper Gastrointestinal System – Endoscopy (Surgical)**

S33322 Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions - operation only .....	521.00	3	116.68
S33323 Transendoscopic tube, stent or catheter – operation only .....	454.00	3	101.86

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 .....	191.00	3	42.60
---	--------	---	-------

NOTES:

- i) Paid only in addition to S10761 or S10762.
- ii) Paid only once per endoscopy.

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S33325 Gastric Polypectomy, operation only .....	721.00	5	161.47
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33326 Percutaneous endoscopically placed feeding tube – operation only .....	329.00	3	73.78
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 .....	63.40	3	14.25
NOTES:			
i) Paid only in addition to S10761 or S10762.			
ii) Paid only once per endoscopy.			
S33328 Esophageal dilation, blind bouginage, operation only ....	258.00	3	57.25
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 .....	486.00	3	109.02
NOTE: Repeats within one month paid at 100%.			
<b>Esophagus - Repair:</b>			
V71530 Cervical esophagostomy .....	2162.00	5	531.36
V71531 Repair tracheo-esophageal fistula - cervical approach..	3277.00	6	2000.00
NOTE: 71530 and 71531 include gastrostomy.			
<b>Esophagoplasty (Plastic Repair or Reconstruction) Thoracic Approach</b>			
CV71532 – without repair of tracheoesophageal fistula .....	3660.00	8	2000.00
CV71533 – with repair of tracheoesophageal fistula .....	4238.00	8	2250.00
V71534 Division of tracheoesophageal fistula without esophageal anastomosis (thoracic approach) .....	3277.00	8	804.44
NOTE: C71533 and 71534 include gastrostomy.			
<b>Esophagogastric Fundoplasty (e.g.: Nissen, Belsey IV, Hill Procedures), Antireflux:</b>			
CV71535 – laparoscopic .....	4198.00	6	920.65
V71536 – open .....	3000.00	6	736.52
CV71537 Esophagogastric fundoplasty, with fundic patch (Thal- Nissen procedure), abdominal and/or thoracic approach.....	3224.00	8	791.86
V71538 – with gastroplasty - Collis.....	3224.00	8	1218.09

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Plastic Operation for Cardiospasm, Heller:</b>			
CV71539 – thoracic approach - open .....	2740.00	8	672.58
CV71540 – laparoscopic or thoroscopic (endoscopy to be billed separately).....	3833.00	6	840.72
CV71541 – with fundoplication - open .....	3829.00	6	940.05
CV71542 – with fundoplication - laparoscopic.....	5357.00	6	1175.07

**Gastrointestinal Reconstruction for Previous  
Esophagectomy, for Obstructing Esophageal  
Lesion or Fistula or for Previous Esophageal  
Exclusion:**

CV71543 – with stomach, with or without pyloroplasty.....	5822.00	6	1430.50
CV71544 – with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es) .....	6808.00	6	1673.20
CV07536 Ligation, direct, esophageal varices.....	3000.00	7	736.52
CV71546 Transection of esophagus with repair, for esophageal varices .....	3378.00	6	830.20
CV71547 Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation.....	2740.00	6	1200.00

**Suture of Esophageal Wound or Injury:**

V71548 – cervical approach .....	1764.00	6	1268.85
CV71549 – transthoracic or transabdominal approach .....	3161.00	8	1522.60

**Closure of Esophagostomy or Fistula:**

CV71550 – cervical approach .....	2193.00	6	1268.85
CV71551 – transthoracic or transabdominal approach .....	3328.00	8	1522.60
07528 Placement of gastroesophageal venous compression balloon (e.g.: Minnesota or Blakemore) operation only..	271.00	5	202.10

**NOTES:**

- i) Paid at 100% with 00081.
- ii) Paid in addition to S10761 or S10762.
- iii) Paid only once per endoscopy.

**DIAPHRAGM – REPAIR**

V70601 Repair para-esophageal hiatus hernia, transabdominal, with or without fundoplication .....	3087.00	6	1212.64
<b>For anti-reflux procedures, funduplications, etc., please see Esophageal section.</b> Diaphragmatic or other hernia to include fundoplication, vagotomy and drainage procedure where indicated			
V70602 – open .....	3087.00	6	1212.64

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV70603 – laparoscopic .....	3087.00	6	1212.64
CV70604 Congenital diaphragmatic hernia .....	3107.00	9	1522.60
<b>Repair Diaphragmatic Hernia or Laceration; Thoracic or Abdominal Approach:</b>			
CV70605 – acute traumatic.....	3277.00	8	1215.00
CV70606 – chronic.....	3000.00	8	1215.00
V70607 Imbrication of diaphragm for eventration, transthoracic or transabdominal.....	2740.00	8	800.00

**STOMACH**

**Incision:**

Gastrotomy:

V70620 – with exploration or foreign body removal.....	1638.00	5	505.35
V70621 – with suture repair of bleeding ulcer (including duodenal) .....	2747.00	6	674.39
CV70622 – with suture repair of pre-existing esophagogastric laceration (e.g.: Mallory-Weiss).....	2862.00	6	702.47
V70624 Pyloromyotomy, cutting of pyloric muscle (Fredet- Ramstedt type operation) .....	1638.00	5	505.35

**Excision:**

Limited or wedge excision:

V70625 – ulcer or benign tumour of stomach - open.....	2330.00	6	572.21
CV72725 – ulcer or benign tumour of stomach – laparoscopic ..	3260.00	6	715.27
V70626 – malignant tumour of stomach - open.....	2660.00	6	653.95
CV72726 – malignant tumour of stomach – laparoscopic .....	3728.00	6	817.44

**Gastrectomy, total**

CV70627 – - with esophagoenterostomy - open .....	4639.00	6	1700.00
CV72727 – with esophagoenterostomy – laparoscopic .....	6496.00	6	2000.00
CV70628 – with Roux-en-Y reconstruction - open .....	4823.00	6	1700.00
CV72728 – with Roux-en-Y reconstruction – laparoscopic .....	6753.00	6	2000.00
CV70629 – with formation of intestinal pouch, any type - open ..	4973.00	6	1700.00
CV72729 – with formation of intestinal pouch, any type – laparoscopic .....	6965.00	6	2000.00

**Gastrectomy, partial, distal:**

V70630 – with gastroduodenostomy (Billroth I) - open .....	3994.00	6	1100.00
CV72730 – with gastroduodenostomy (Billroth I) – laparoscopic	5588.00	6	1226.17
V70631 – with gastrojejunostomy (Billroth II) - open .....	3994.00	6	1100.00
CV72731 – with gastrojejunostomy (Billroth II) – laparoscopic ...	5588.00	6	1226.17
V70632 – with Roux-en-Y reconstruction - open .....	4156.00	6	1200.00
CV72732 – with Roux-en-Y reconstruction – laparoscopic .....	5822.00	6	1277.23
V70633 – with formation of intestinal pouch - open .....	4493.00	6	1300.00
CV72733 – with formation of intestinal pouch – laparoscopic .....	6289.00	6	1379.45
70634 Vagotomy (extra).....	263.00		63.86



GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V70635 Proximal gastrectomy, thoracic or abdominal approach including esophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy, with or without splenectomy - open .....	4891.00	6	1202.67
CV72735 Proximal gastrectomy, thoracic or abdominal approach including esophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy, with or without splenectomy –laparoscopic .....	6853.00	6	1503.32
CV07624 Emergency gastrectomy for continued hemorrhage (with operative report).....	4088.00	7	1200.00
V07628 Gastrojejunostomy or pyloroplasty with vagotomy, with or without gastrostomy .....	2591.00	5	636.64
CV07578 Highly selective vagotomy .....	2591.00	5	636.64
<b>Stomach - Introduction:</b>			
V07630 Gastrostomy - open .....	1369.00	5	456.79
33394 Assistant fee for PEG procedure.....	433.00		112.47
NOTE: S33326, 33394 may be billed by any qualified physician.			
70637 Change of gastrostomy tube - operation only .....	124.00	2	45.46
<b>Stomach - Other Procedures:</b>			
V07626 Pyloroplasty .....	1638.00	5	402.23
V07627 Gastrojejunostomy - open .....	1764.00	5	558.30
CV72737 Gastrojejunostomy – laparoscopic .....	2476.00	5	634.10
Patch or suture of perforated duodenal or gastric ulcer, wound or injury:			
V07632 – open .....	1861.00	6	750.00
V70641 – laparoscopic .....	1861.00	6	750.00
V70642 Gastric restrictive procedure, without gastric bypass, for morbid obesity (includes vertical banded and other gastroplasties).....	3871.00	7	1015.07
CV72739 Laparoscopic Vertical Sleeve Gastrectomy .....	5035.00	7	1105.07
V70643 Gastric restrictive procedure, with bypass, for morbid obesity, gastroenterostomy - open.....	4156.00	7	1600.00
CV72743 Gastric restrictive procedure, with bypass, for morbid obesity, gastroenterostomy – laparoscopic.....	4818.00	7	1415.75
V70644 – with small bowel reconstruction to limit absorption - ileojejunal bypass .....	4569.00	7	929.80
V70645 Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity - open .....	3433.00	7	1617.25

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV72775 Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity – laparoscopic ....	4803.00	7	1700.00
CV07623 Revision gastrectomy after previous gastrectomy, with or without vagotomy - open .....	4088.00	7	1217.37
CV72723 Revision gastrectomy after previous gastrectomy, with or without vagotomy – laparoscopic .....	5723.00	7	1521.68
V70646 Closure of gastrostomy, surgical .....	1638.00	4	402.23
CV07633 Closure of gastrojejunal fistula .....	4639.00	5	1140.06
CV70649 Closure of gastrocolic fistula - operation only .....	3198.00	5	786.78

**INTESTINES**

V70650 Lysis of intra-abdominal adhesions - first 30 minutes (extra) .....	668.00	7	152.95
70651 – each additional 15 minutes or greater portion thereof (extra).....	227.00		76.47

NOTES:

- i) Restricted to General Surgeons only.
- ii) Payable for open procedures only.
- iii) Not payable with fee item 07650.
- iv) Not payable to same general surgeon doing the surgical assist.
- v) Start and stop times for Lysis must be provided in patient chart and claim time field.

V70660 Lysis of intra-abdominal adhesions, laparoscopic – first 30 minutes (extra).....	668.00	7	152.95
70661 - each additional 15 minutes or greater portion thereof (extra).....	227.00		76.47

NOTES:

- i) Restricted to General Surgeons only.
- ii) Not payable with fee item V07650, V70650, or S04001.
- iii) Not payable to same general surgeon doing the surgical assist.
- iv) Start and stop times for laparoscopic lysis must be provided in patient chart and claim time field.
- v) If conversion to open procedure is necessary, bill open procedure plus 50% of laparoscopy fee, S04001.

**Incision:**

V07650 Intestinal obstruction; resection of bands, enterolysis - open.....	2048.00	5	550.00
--	---------	---	--------

NOTE: Not payable with fee items 70650, 70651, 70660, 70661.

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV72650 Intestinal obstruction; resection of bands, enterolysis – laparoscopic.....	2697.00	5	627.62
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 .....	1096.00	4	507.00
V07634 Enterotomy or colotomy (single); for exploration, biopsy, or foreign body removal.....	2220.00	5	487.38
V07635 Multiple colotomy, with operative sigmoidoscopy.....	2920.00	5	639.86
V07654 Intestinal obstruction - plication or insertion of intraluminal tube.....	2318.00	5	570.04
V07651 Reduction of volvulus, intussusception, internal hernia, by laparotomy .....	2404.00	5	526.23
V71650 Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) - open .....	1909.00	5	505.61
V71651 Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic .....	2590.00	5	586.02
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%.			
<b>Intestines - Excision:</b>			
Resection of small intestine:			
V07636 – with anastomosis - open.....	2454.00	5	632.10
CV72736 – with anastomosis – laparoscopic.....	3438.00	5	754.18
CV72620 – with enterostomy; without anastomosis (does not include separate enterostomies or resections) - open .....	3308.00	5	813.78
CV72720 – with enterostomy; without anastomosis (does not include separate enterostomies or resections) – laparoscopic .....	4636.00	5	1017.22
V07643 Enteroenterostomy.....	2220.00	5	606.44
V07570 Colo-colostomy or entero-colostomy - open .....	3664.00	6	802.82
NOTE: 07570 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.			

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV72770 Colo-colostomy or entero-colostomy – laparoscopic ..... NOTE: CV72770 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.	4574.00	6	1003.53
72621 Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (extra) (not applicable to right or left hemicolectomy) - operation only - open.....	389.00	6	95.79
C72721 Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy – laparoscopic - extra (not applicable to right or left hemicolectomy) – (operation only)..... NOTES: i) Restricted to General Surgeons. ii) If conversion to open procedure is required, bill under the appropriate open procedures at 100%.	516.00	6	119.74
Limited resection of colon:			
V72622 – open .....	3598.00	6	859.52
CV72623 – laparoscopic .....	1212.00	6	984.85
Hemicolectomy; right (see also 72640):			
V72624 – open .....	3779.00	6	884.86
CV72625 – laparoscopic .....	4712.00	6	1033.43
Hemicolectomy; left:			
V72626 – open .....	4000.00	6	960.62
CV72631 – laparoscopic .....	5000.00	6	1096.80
Sigmoid resection:			
V72632 – open .....	4164.00	6	1011.14
CV72633 – laparoscopic .....	5205.00	6	1141.81
V72634 – with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) - open .....	3949.00	6	960.56
CV72734 – with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) – laparoscopic .....	4919.00	6	1078.87
CV72635 Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) - with or without protective stoma - open .....	4814.00	6	1515.90
CV72755 Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) - with or without protective stoma – laparoscopic .....	6006.00	6	1617.81
Proctectomy, abdominal and transanal approach; coloanal anastomosis (with or without protective colostomy):			

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V72636 – synchronous - abdominal portion.....	5141.00	7	1125.66
CV07662 Abdomino-perineal resection (single surgeon) - open....	6157.00	7	1718.82
CV72762 Abdomino-perineal resection (single surgeon) – laparoscopic.....	7683.00	7	1820.21
V07663 – synchronous - abdominal portion - open .....	5141.00	7	1314.61
CV72763 – synchronous - abdominal portion – laparoscopic.....	6414.00	7	1407.07
V07664 Proctectomy, in combination with any abdominal resection - synchronous - perineal portion .....	1727.00	7	505.57
CV07569 Colectomy and hemiproctectomy - open.....	4971.00	6	1088.40
CV72769 Colectomy and hemiproctectomy – laparoscopic.....	6202.00	6	1360.51
CV07640 Colectomy - total, abdominal (without proctectomy) - open.....	5145.00	6	1314.24
NOTE: Includes ileostomy or ileoproctostomy.			
CV72760 Colectomy - total, abdominal (without proctectomy) – laparoscopic.....	6422.00	6	1409.05
NOTE: Includes ileostomy or ileoproctostomy.			
V07567 Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy - open .....	7070.00	6	1750.00
CV72767 Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy – laparoscopic.....	8826.00	6	1936.03
V07566 Rectal mucosectomy and ileoanal anastomosis.....	3411.00	6	837.43
CV07641 Total proctocolectomy with perineal excision of rectum and ileostomy (single surgeon) - open .....	7515.00	7	1645.83
CV72741 Total proctocolectomy with perineal excision of rectum and ileostomy (single surgeon) – laparoscopic .....	9378.00	7	2057.30
V07589 – synchronous - abdominal portion - open .....	6012.00	7	1317.10
CV72789 – synchronous - abdominal portion – laparoscopic.....	7504.00	7	1646.40
V07565 Takedown of pelvic pouch, to include ileostomy - open .	3779.00	5	1218.09
CV72765 Takedown of pelvic pouch, to include ileostomy – laparoscopic.....	4712.00	5	1520.89
V72640 Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy - open.....	3602.00	6	884.71
CV72740 Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy – laparoscopic.....	4493.00	6	985.67
72641 Caecostomy, tube for decompression (extra) - open .....	1384.00	5	404.20
72601 Caecostomy, tube for decompression – laparoscopic (extra) .....	1622.00	5	377.50

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%.

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Revision of ileostomy or colostomy:</b>			
V07648 – simple incision of scar, etc. ....	1023.00	4	450.00
V07649 – radical; reconstruction with bowel resection .....	1918.00	5	505.42
V72644 – with repair of paracolostomy hernia requiring laparotomy .....	2580.00	5	657.12
V72645 Continent ileostomy (Koch procedure) - open .....	4088.00	6	1004.22
CV72745 Continent ileostomy (Koch procedure) – laparoscopic ..	5723.00	6	1255.27
V07645 Colostomy or ileostomy – loop - open.....	1870.00	5	505.38
CV72715 Colostomy or ileostomy – loop – laparoscopic.....	2333.00	5	511.75
V07588 – end - open .....	2153.00	5	505.63
CV72788 – end – laparoscopic .....	2689.00	5	589.60
72646 – multiple biopsies (e.g.: for Hirschsprung disease) - extra - operation only.....	544.00	5	134.49
<b>Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction:</b>			
V72647 – single .....	2078.00	5	606.54
V72648 – multiple (two or more).....	2862.00	5	909.55
Closure of loop enterostomy, large or small intestine:			
V07646 – without resection .....	1727.00	4	509.22
V07647 – with resection and anastomosis .....	2580.00	5	631.93
Reconstruction Hartman procedure with or without protective colostomy:			
V72651 – open .....	3779.00	5	1010.79
CV72652 – laparoscopic .....	4712.00	5	1033.43
<b>Closure of fistula; enterovesical, colovesical or colovaginal:</b>			
V72653 – without intestinal and/or bladder resection - open ....	3602.00	5	909.89
72654 – with bowel resection (extra to 72653) - open.....	1545.00	5	404.35
NOTE: For bladder resection, see Urology Guide.			
CV72683 – without intestinal and/or bladder resection – laparoscopic .....	3943.00	5	981.74
72684 – with bowel resection (extra to 72683) – laparoscopic .....	1693.00	5	421.25
NOTE: Fee items 72653, 72654, 72683, 72684 includes fee items 08207, 08255 or 04401 if performed by the same surgeon.			
V07455 Emergency resection obstructed colon, with lavage and anastomosis .....	4583.00	6	1011.50
V07658 Exteriorization of large bowel lesion (carcinoma, perforation, etc.) .....	2752.00	5	602.52

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)	
<b>MECKEL'S DIVERTICULUM AND THE MESENTERY</b>				
<b>Excision:</b>				
V07655	Excision of Meckel's diverticulum (diverticulectomy ) or omphalomesenteric duct.....	1496.00	4	505.22
<b>Suture and Repairs:</b>				
V07447	Repair of mesenteric injury .....	2330.00	6	572.71

**APPENDIX**

<b>Incision:</b>				
V72660	Incision and drainage of appendiceal abscess, transabdominal .....	1764.00	4	434.19
NOTE: Not payable in addition to appendectomy listings.				
<b>Appendix - Excision:</b>				
V72656	Appendectomy - open.....	1251.00	4	480.30
V72658	– laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee).....	1251.00	4	480.30
V72657	Appendectomy - perforated with abscess or generalized peritonitis - open.....	1835.00	5	505.30
V72659	– laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee).....	1835.00	5	505.30

**RECTUM**

<b>Incision:</b>				
V07660	Transrectal drainage of pelvic abscess.....	1023.00	2	303.15
<b>Excision:</b>				
07665	Biopsy of anorectal wall, anal approach (e.g.: congenital megacolon) - operation only .....	686.00	2	150.98
CV07662	Abdomino-perineal resection (single surgeon).....	6157.00	7	1718.82
PCV72762	Abdomino-perineal resection (single surgeon) – laparoscopic.....	7683.00	7	1820.21
V07663	– synchronous - abdominal portion - open .....	5141.00	7	1314.61
PCV72763	– synchronous - abdominal portion – laparoscopic.....	6414.00	7	1407.07
V07664	Proctectomy, in combination with any abdominal resection - synchronous - perineal portion .....	1727.00	7	505.57

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull through procedure and anastomosis (e.g.: Swenson, Duhamel, or Soave type operation):</b>			
V72662 – synchronous - abdominal .....	5897.00	7	1314.90
CV72664 – with subtotal or total colectomy, with multiple biopsies .....	7515.00	7	1645.83
V72665 Proctectomy, partial, without anastomosis, perineal approach.....	2286.00	5	558.30
V72666 Altemeier transperineal excision of rectal procidentia with anastomosis .....	3092.00	3	677.27
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).....	819.00	2	252.59
V07580 Excision of rectal tumour by posterior parasacral, transacral or transcoccygeal approach (Kraske) .....	2948.00	5	800.00
<b>Excision of rectal tumour, transanal approach to include operative sigmoidoscopy:</b>			
72669 – 0 to 2.5 cm - operation only .....	709.00	2	253.59
72670 – 2.6 to 5 cm (operation only).....	951.00	2	304.52
72671 – greater than 5 cm (operation only) .....	1959.00	2	455.09
72672 Electrodesiccation or fulguration of malignant tumour of rectum, transanal (includes endoscopy) - operation only .....	709.00	2	252.68
CV72673 Transanal Endoscopic Microsurgical Resection of rectal tumour.....	4080.00	6	917.67
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 70683, 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.			

*(notes continued on next page)*



GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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.			
<b>Repair:</b>			
V07672 Complete rectal prolapse - transabdominal rectopexy - open.....	3131.00	5	698.70
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 recopexy – laparoscopic.....	3516.00	5	873.38
NOTE: Paid as a stand-alone procedure with the exception when performed in conjunction with sigmoid resection (72632, 72633) payment will be at 25%.			
<b>Rectum - Endoscopy:</b>			
NOTES:			
i) <b>Proctosigmoidoscopy</b> is the examination of the rectum and sigmoid colon.			
ii) <b>Sigmoidoscopy</b> is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.			
iii) <b>Colonoscopy</b> is the examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum.			
SY10714 Proctosigmoidoscopy, rigid; diagnostic .....	141.00	2	35.40
SY00715 Sigmoidoscopy (with biopsy) - procedural fee .....	145.00	2	37.98
S07460 – with decompression of volvulus - operation only .....	996.00	2	228.83
SY00716 Sigmoidoscopy; flexible - diagnostic .....	263.00	2	76.09
SY00718 – with biopsy .....	335.00	2	77.34
S07461 – with removal of foreign body - operation only .....	491.00	2	107.53
S07462 – with control of bleeding, any method - operation only.....	655.00	2	177.51
S07463 – with decompression of volvulus, any method - operation only.....	550.00	2	228.83
S07464 – with removal of polyp(s) (operation only).....	1148.00	2	251.02
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).....	776.00	2	169.75

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S10730 Colonoscopy, flexible, via colostomy - single or multiple .....	978.00	4	240.14
S10731 Colonoscopy, flexible, proximal to splenic flexure; diagnostic with or without collection of specimen(s) by brushing or washing .....	978.00	2	231.61
S10732 – with removal of foreign body .....	1108.00	2	272.07
S10733 – with control of bleeding, any method .....	1241.00	2	303.99

**ANUS**

**Repair:**

V70665 Anoplasty; plastic procedure for stricture - adult .....	1638.00	2	451.50
V70666 Sphincteroplasty; for incontinence or prolapse (posterior anal repair) – adult .....	1638.00	2	451.50
V07690 Anoplasty for imperforate anus .....	2752.00	4	602.52
70668 Graft (Thiersch operation) for rectal incontinence or prolapse - operation only.....	541.00	2	203.93
V70670 Sphincteroplasty; anal, for incontinence - Gracillis muscle implant .....	2546.00	3	702.52
V70671 Levator muscle imbrication; Park posterior - anal repair.....	1638.00	2	451.50
V70672 Implantation of artificial sphincter.....	3660.00	4	1009.32
NOTE: 70670, 70671 & 70672 are not payable together.			
V07452 Repair extra-peritoneal rectum, with or without colostomy.....	4398.00	7	962.78
Destruction of anal lesion, any method including fulguration anal condylomata:			
70674 – simple; less than 10% perianal skin involvement - operation only .....	272.00	2	75.41
70680 – complicated; greater than 10% of perianal skin involvement (with operative report) - operation only .....	544.00	2	252.69
S70683 EUA with or without sigmoidoscopy, with or without biopsy - operation only .....	520.00	2	152.95
CV72673 Transanal Endoscopic Microsurgical Resection of rectal tumour .....	4080.00	6	917.67

**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 70683, 72669, 72670 and 72671.

*(notes continued on next page)*

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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 anesthesia - operation only.....	475.00	2	152.67
04401 Fistula, recto-vaginal repair .....	1584.00	3	536.63
<b>Incision:</b>			
70675 Removal of anal seton, other marker - operation only.	105.00	2	28.67
V70676 Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton .....	1414.00	2	389.95
07691 Anus imperforate, simple incision - operation only .....	203.00	2	303.06
07679 Incision and drainage of ischiorectal, intramural, intramuscular or submucosal abscess - under anesthesia - operation only .....	614.00	2	203.01
07678 Incision and drainage, perianal abscess - superficial - operation only.....	420.00	2	91.43
<b>Excision:</b>			
07687 Anal fissure, excision under local anesthetic - operation only.....	420.00	2	115.00
V71681 Sphincterotomy with or without fissurectomy .....	570.00	2	303.07
SV71682 Botox injection for anal fissure. ....	487.00	2	252.34
<b>NOTES:</b>			
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.			
<b>Papillectomy or excision of anal tag or polyp:</b>			
71684 – single (extra) - operation only.....	246.00	2	67.87
71686 – multiple (extra) - operation only.....	449.00	2	123.30
71689 Hemorrhoid(s); (e.g.: band ligation) - to include proctoscopy - operation only .....	369.00	2	80.58
71690 Hemorrhoid(s); - infrared photocoagulation to include proctoscopy - operation only .....	369.00	2	80.58

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
P71691 Hemorrhoid(s) add on fee .....	121.00		16.82
NOTES:			
i) Restricted to General Surgeons.			
ii) Paid only when service performed in an office (location code A or T), not payable in a public facility.			
iii) Paid only with fee item 71689 or 71690.			
V07683 Hemorrhoidectomy, with or without sigmoidoscopy ....	1224.00	2	268.05
07675 Fistula-in-ano (fistulectomy or fistulotomy) - subcutaneous or submucous - operation only .....	686.00	2	250.00
V07676 – submuscular .....	1542.00	2	337.72
V07677 – multiple or horseshoe, with or without placement of seton .....	2062.00	2	451.50
V07666 Fistula-in-ano; second stage; division of sphincter after placement of seton .....	719.00	2	250.00
V71700 Closure of congenital or acquired anal fistula with rectal advancement flap .....	2948.00	2	645.16

**LIVER**

**Incision:**

Hepatotomy for drainage of abscess or cyst;  
laparoscopic or open:

V07402 – single .....	1764.00	6	434.19
V07403 – multiple, including marsupialization .....	2660.00	6	653.95
CV71380 Open or Laparoscopic operative liver tumour non- resectional ablation by any means. ....	2902.00	7	713.74

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 P10908.

**Liver - Excision:**

CV07404 Non-anatomic, subsegmental excision of liver mass .....	2186.00	7	1000.00
CV72794 Laparoscopic non-anatomic sub-segmental excision of liver mass .....	2983.00	7	1141.96

*(see notes on next page)*

GENERAL SURGERY – Continued

Non-MSP-  
Insured  
Fee (\$)

Anes.  
Lev.

MSP &  
WSBC  
Fee (\$)

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) Cholecystectomy is not paid in addition.

**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 ICD9 code is 153, 154, 158 or 171.

The following lists of procedures are eligible for payment as team fees:

Liver resections: 07405, 72795, 07406, 72796, 07407, 72797, 07408, 72798, 07409, 07410, 07411.

Colorectal resections: 72622, 72623, 72624, 72625, 72626, 72631, 72632, 72633, 72634, 72734, 72635, 72755, 72636, 07664, 07662, 72762, 07663, 72763, 07569, 72769, 07640, 72760, 07641, 72646, 72740, 07662, 07580.

Sarcoma resections: 71290, 71291.

CV07405 – one or more, same side - open.....	4110.00	8	1200.00
CV72795 Laparoscopic hepatectomy, segmental resection – one or more, same side .....	5614.00	8	1261.93

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.

CV07406 – two or more segments, bilateral lobes - open.....	4823.00	8	1600.00
---	---------	---	---------

NOTES:

- i) Surgeon must operate on right and left lobes.
- ii) Cholecystectomy is not paid in addition.

CV72796 – two or more segments, bilateral lobes - laparoscopic .....	6590.00	8	1800.00
--	---------	---	---------

*(see notes on next page)*

GENERAL SURGERY – Continued

**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

NOTES:

- i) Restricted to General Surgery.
- ii) If conversion to open is necessary, bill under open procedure (07406) at 100% plus 50% of the laparoscopy fee (04001).
- iii) Surgeon must operate on right and left lobes.
- iv) Cholecystectomy is not paid in addition.

CV07407 – total left lobectomy - open .....	5323.00	8	2000.00
CV72797 – total left lobectomy - laparoscopic .....	7271.00	8	2500.00

NOTES:

- i) Restricted to General Surgery.
- ii) If laparoscopic procedure is converted to open, bill under open procedure (07407) at 100% and 04001 at 50%.
- iii) Cholecystectomy is not paid in addition.

CV07408 – total right lobectomy - open .....	5323.00	8	2000.00
CV72798 – total right lobectomy- laparoscopic .....	7271.00	8	2500.00

NOTES:

- i) Restricted to General Surgery.
- ii) If laparoscopic procedure is converted to open, bill under open procedure (07408) at 100% and 04001 at 50%.
- iii) Cholecystectomy is not paid in addition.

CV07409 – extended left lobectomy (includes caudate lobe and at least one portion of right lobe) .....	5822.00	8	2200.00
CV07410 – caudate lobectomy (isolated procedure) .....	5986.00	8	2100.00
CV07411 – extended right lobectomy; 5 or more segments (includes caudate) .....	6671.00	8	2300.00

NOTE: Cholecystectomy is not paid in addition.

**Liver - Repair (Trauma):**

Hepatorrhaphy; suture of liver wound or injury:

V07412 – simple .....	2239.00	8	609.04
V07413 – with packing .....	2631.00	8	644.63
CV07440 Resectional debridement of liver .....	4110.00	8	1268.85
CV07441 Hepatic artery ligation to include resectional debridement where indicated .....	3863.00	8	1015.07
CV07442 Hepatic lobectomy for trauma to include resectional debridement where indicated .....	5246.00	9	2500.00

**BILIARY TRACT**

**Incision:**

**Choledochotomy or choledochostomy and exploration, drainage or removal of calculus:**

V70694 – open .....	2158.00	5	850.00
---------------------	---------	---	--------

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V70695 – laparoscopic.....	2158.00	5	900.00
V70696 – with transduodenal sphincteroplasty .....	3765.00	5	950.00
V07769 Duodenotomy and sphincteroplasty .....	2688.00	5	1014.02
<b>Cholecystostomy:</b>			
V07698 - open .....	1721.00	5	505.43
V70698 – laparoscopic.....	1721.00	5	455.06
71698 – percutaneous (operation only) .....	672.00	2	164.85
<b>Biliary Tract - Endoscopy:</b>			
07780 Biliary endoscopy; intraoperative, choledochoscopy (extra).....	538.00		202.77
07781 Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen by brushing and/or washing to include biopsy - operation only .....	331.00	2	202.59
07782 – with removal of stone - operation only .....	538.00	2	228.06
07783 – with dilation of duct stricture with or without stent - operation only .....	538.00	2	228.06
Endoscopic Retrograde Cholangiopancreatography (ERCP); to include biopsies or brushings:			
V07517 – with papillotomy or sphincterotomy .....	1815.00	3	447.05
V07518 – with stone extraction .....	2158.00	3	530.07
V07519 – with biliary stenting.....	1764.00	3	434.25
V07554 – with balloon dilatation of biliary stricture.....	1764.00	3	434.25
V07556 – with stone extraction requiring lithotripsy .....	2259.00		555.62
07560 Insertion of naso-biliary drainage tube (operation only) .....	421.00	3	103.49
07562 Replacement of duodenal biliary stent - operation only.....	701.00	3	172.45
<b>Biliary Tract - Excision:</b>			
Cholecystectomy:			
V07707 – laparoscopic.....	2158.00	5	536.09
V07699 – open.....	2158.00	5	606.62
V70700 – open cholecystectomy immediately preceded by attempted laparoscopic cholecystectomy .....	2645.00	5	707.84
V70701 – with exploration of CBD (laparoscopic).....	3236.00	5	1212.66
V70702 – with exploration of CBD (open) .....	3236.00	5	1212.66
V70703 – with choledochoduodenostomy (includes CBD exploration) .....	4156.00	5	1313.82
V70704 – with choledochojejunostomy (includes CBD exploration) .....	4261.00	5	1313.92
V70705 – with transduodenal sphincterotomy or sphincteroplasty (includes CBD exploration).....	4156.00	5	1313.82

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV70710 Exploration for congenital atresia of bile ducts without repair. ....	1797.00	5	1522.60
NOTE: Includes liver biopsy and/or cholangiography, if required.			
CV70711 Portoenterostomy (Kasai procedure) .....	6450.00	6	1584.89
<b>Excision of bile duct tumour or stricture:</b>			
CV70712 – lower (below bifurcation), any repair .....	4302.00	6	1900.00
CV70713 – upper (at or above bifurcation) - one anastomosis	6450.00	6	2200.00
CV70714 – upper (at or above bifurcation) - multiple anastomoses .....	6967.00	6	2500.00
<b>Excision of choledochal cyst (to include cholecystectomy):</b>			
CV70715 – below bifurcation.....	4054.00	5	1414.54
CV70716 – above bifurcation requiring one ductoplasty .....	5986.00	5	1471.37
CV70717 – above bifurcation - multiple anastomoses.....	6484.00	5	1594.00
CV70718 Portal lymphadenectomy.....	3379.00	4	764.73
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.			
<b>Biliary Tract - Repair:</b>			
<b>Cholecystoenterostomy:</b>			
V07706 – direct (loop).....	2661.00	6	1015.07
V70720 – with gastroenterostomy.....	3543.00	5	1218.09
V70721 – Roux-en-Y .....	3161.00	5	1116.58
V70722 – Roux-en-Y with gastroenterostomy.....	4061.00	5	1319.59
CV07703 Choledochoduodenostomy .....	3378.00	6	1116.58
V07705 Choledochojejunostomy (anastomosis of extra- hepatic biliary ducts and GI tract).....	3744.00	6	1218.09
V70725 – with gastrojejunostomy .....	4415.00	6	1700.00
V70726 – Roux-en-Y .....	4054.00	6	1700.00
V70727 – Roux-en-Y with gastrojejunostomy .....	4936.00	6	1700.00
CV70728 Anastomosis of intra-hepatic ducts and GI tract (Longmyer); Roux-en-Y.....	4986.00	6	1769.19
07561 Placement of choledochal stent (operation only) .....	701.00	5	172.45
CV70730 U-tube hepatico enterostomy .....	2685.00	5	1769.19



GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV70731 Primary repair of extra-hepatic biliary duct for injury (including intraoperative), any method .....	4156.00	5	1421.10
V07776 Repair of cholecystenteric fistula.....	3122.00	5	1000.00

**ENDOCRINE SYSTEM**

**Thyroid - Incision:**

70740 Incision and drainage of thyroglossal cyst, infected - operation only .....	520.00	3	203.93
S00744 Thyroid biopsy - procedural fee .....	223.00	2	71.92

**Thyroid - Excision:**

V07740 Biopsy of thyroid - open .....	782.00	4	354.83
---------------------------------------	--------	---	--------

**Total thyroid lobectomy:**

V70742 – unilateral with or without isthmusectomy .....	2393.00	4	587.84
V70743 – unilateral with contralateral subtotal lobectomy including isthmus.....	2966.00	4	728.04

**Thyroidectomy:**

V07743 – total or complete.....	3373.00	4	1014.42
V07741 – subtotal unilateral (local excision of thyroid lesion)..	1369.00	4	407.53
V70745 – subtotal bilateral .....	2875.00	4	706.81
V70747 – removal of all remaining thyroid tissue following previous removal of portion of thyroid (completion thyroidectomy).....	2827.00	4	694.84
C70748 Sternal split for substernal thyroid (extra) .....	668.00		163.48
V07771 Picking operation; metastatic neck nodes for thyroid carcinoma (with operative report) .....	1660.00	5	1100.00

**Endocrine System - Parathyroid:**

**Parathyroidectomy or exploration of parathyroids:**

V07745 – removal of single adenoma .....	2738.00	4	900.00
V07744 – subtotal parathyroidectomy .....	2993.00	4	1014.37
V71746 – re-exploration .....	3624.00	4	1217.10
CV71747 – with mediastinal exploration and sternal split .....	3898.00	6	1217.17

NOTE: Re-exploration is not payable in addition to C71747.

71748 Parathyroid autotransplantation, extra to thyroidectomy and parathyroidectomy procedures - operation only .....	331.00		101.96
---	--------	--	--------

GENERAL SURGERY – Continued

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Endocrine System - Adrenal:</b>				
VC71703	Adrenalectomy for Pheochromocytoma - open .....	4007.00	8	1019.18
	NOTES:			
	i) Only to be billed if procedure takes longer than three hours. If surgery takes less than three hours, bill item C71704.			
	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	6016.00	8	1273.97
	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.			
	<b>Adrenalectomy; any approach:</b>			
CV71704	– Unilateral - open.....	3277.00	8	804.44
CV72704	– Unilateral – laparoscopic.....	4583.00	8	1005.57
CV71705	– Bilateral - open.....	4493.00	8	1600.00
CV72705	– Bilateral - laparoscopic.....	6289.00	8	1800.00
<b>Endocrine System - Carotid Body</b>				
<b>Excision of carotid body tumour:</b>				
CV71706	– without excision of carotid artery.....	3323.00	6	1014.37
CV71707	– with excision of carotid artery.....	4075.00	8	1217.37
<b>Endocrine System – Pancreas - Incision</b>				
V71708	Placement of drains, peripancreatic for acute pancreatitis .....	1764.00	2	1000.00
V71709	Resectional debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis; to include gastrostomy, jejunostomy and cholecystostomy any approach .....	2860.00	8	1300.00
PCV71725	Resection of duodenum .....	5904.00	8	1469.94

*(see notes on next page)*

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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 mesenteric vessels.			
iii) For limited resection of the duodenum requiring only Kocherisation bill fee item 07636.			
iv) Includes lymph node biopsies (00745).			
<b>Endocrine System - Pancreas - Excision</b>			
71710	Open biopsy of pancreas, any method (fine needle, core, wedge) intraoperative (extra) - operation only .....	331.00	6 100.00
S00826	Biopsy of pancreas - percutaneous .....	331.00	2 101.44
CV71712	Limited excision of pancreatic lesion (e.g.: cyst or adenoma) .....	2860.00	6 1000.00
<b>Pancreatectomy, distal subtotal:</b>			
CV71713	– with splenectomy and without pancreaticojejunostomy - open .....	3328.00	7 1300.00
CV72713	– with splenectomy and without pancreaticojejunostomy – laparoscopic.....	4456.00	7 1520.85
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 .....	4156.00	7 1600.00
CV72714	– with splenic preservation – laparoscopic .....	5570.00	7 1277.23
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 with splenectomy .....	4156.00	7 1500.00
CV71716	– with splenic preservation and pancreaticojejunostomy .....	4366.00	7 1700.00
CV71717	Pancreatectomy, distal, near total with preservation of duodenum.....	4467.00	7 2400.00

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV71718 Excision ampulla of vater.....	4322.00	6	1062.67
CV71719 Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochojejunostomy and gastroenterostomy, with or without pancreaticojejunostomy (Whipple procedure).....	5721.00	8	3045.21
CV71720 – pyloric sparing (Whipple procedure) .....	5721.00	8	3045.21
CV71721 Regional pancreatectomy to include above Whipple procedures with portal vein reconstruction, with portosystemic shunt and with celiac lymphadenectomy .....	6498.00	9	3449.82
CV71722 Total pancreatectomy with Whipple procedure.....	5976.00	8	2500.00
CV07714 Pancreaticojejunostomy; side-to-side anastomosis (Peustow type procedure) .....	3822.00	6	1400.00

**Endocrine System - Pancreas - Repair:  
External drainage, pseudocyst of pancreas:**

V07756 – open.....	1764.00	5	1000.00
V07758 – laparoscopic.....	1764.00	5	1000.00
CV07711 Internal drainage or anastomosis of pancreatic pseudocyst to gastrointestinal tract - cyst-gastrostomy open (endoscopy payable separately).....	2454.00	5	964.32
CV72711 Internal drainage or anastomosis of pancreatic pseudocyst of GI tract-laparoscopic .....	4622.00	5	1114.48

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 .....	3000.00	5	1015.07
CV07733 – Roux-en-Y.....	3122.00	5	1015.07

**HERNIA - REPAIR**

V71600 Repair inguinal or femoral hernia; under 6 months age, with or without hydrocelectomy.....	1557.00	2	406.03
V71601 – bilateral.....	2078.00	2	707.68
V71602 – incarcerated or strangulated.....	1763.00	3	507.54
V71603 Repair inguinal or femoral hernia; age 6 months to 12 years, with or without hydrocelectomy .....	1295.00	2	379.23
V71604 – bilateral.....	1815.00	2	606.64
V71605 – incarcerated or strangulated.....	1557.00	3	433.34

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Repair inguinal or femoral hernia; greater than age 12:</b>			
V71606 – reducible - open.....	1727.00	2	364.12
V71607 – reducible - laparoscopic.....	1727.00	4	404.42
V71608 – incarcerated or strangulated.....	1769.00	3	411.85
<b>Repair recurrent inguinal or femoral hernia; any age:</b>			
V71609 – reducible - open.....	1912.00	2	455.15
V71610 – reducible - laparoscopic.....	1912.00	4	505.52
V71611 – incarcerated or strangulated.....	2212.00	3	514.78
<b>Bilateral primary inguinal or femoral hernias greater than age 12, not incarcerated or recurrent:</b>			
V71612 – open.....	2293.00	2	606.63
V71613 – laparoscopic.....	2293.00	4	667.08
<b>Repair initial incisional hernia :</b>			
NOTE: Lysis of adhesions not payable in addition.			
V71614 – reducible.....	1911.00	2	596.65
V71615 – incarcerated or strangulated.....	2209.00	3	596.65
V71616 – using prosthetic mesh.....	2048.00	3	596.65
V71623 Laparoscopic initial ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis.....	2395.00	5	697.44
<b>Repair recurrent incisional hernia:</b>			
V71617 – reducible.....	2387.00	2	608.86
V71618 – incarcerated or strangulated.....	2761.00	3	609.16
V71624 Laparoscopic recurrent ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis.....	3087.00	6	761.21
NOTE: Lysis of adhesions not payable in addition.			
CV71625 Myofascial abdominal wall advancement flaps (component separation procedure) for massive initial or recurrent incisional hernia repair.....	3829.00	7	866.70
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.			

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Repair umbilical hernia:</b>			
V71619 – reducible.....	1068.00	2	343.80
V71620 – incarcerated or strangulated.....	1348.00	3	343.80
V71621 Repair of hernia with resection of bowel; all performed through same incision.....	2589.00	5	758.16
V71622 Repair of hernia with resection of bowel requiring a separate incision.....	3122.00	5	809.05
07596 Hernia, incisional; repair following laparotomy (with operative report) (extra) - operation only .....	331.00	2	125.00
V07610 Epigastric.....	831.00	4	343.80
CV70604 Congenital diaphragmatic hernia .....	3107.00	9	1522.60

**PEDIATRIC PROCEDURES**

**Broviac type catheter:**

07139 – insertion of.....	561.00	2	162.55
V07140 – insertion of - less than 3 months of age or less than 3 kg. ....	1096.00	4	269.03
07141 – removal of - operation only .....	157.00	2	126.79
V07571 Pena posterior sagittal anal proctoplasty; primary surgeon.....	4682.00	6	1150.14
07593 Fee for second surgeon participating in Pena posterior sagittal anal proctoplasty .....	1385.00		339.13
NOTE: When 07571 and 07593 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.			
V07700 Total correction cloacal anomalies; primary surgeon....	9817.00	6	2150.54
07702 Fee for second surgeon participating in total correction cloacal anomalies .....	1798.00		507.54
NOTE: When 07700 and 07702 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.			
V07690 Anoplasty; for imperforate anus.....	2752.00	4	602.52
V07466 Anal stricture; plastic repair, child .....	2058.00	2	450.49
<b>Proctectomy; complete (for congenital megacolon) abdominal and perineal approach with pull through procedure and anastomosis (e.g.: Swenson, Duhamel or Soave type operation):</b>			
V72662 – synchronous - abdominal portion .....	5897.00	7	1314.90
CV07697 Excision of sacrococcygeal teratoma .....	4814.00	6	1522.60

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation for intestinal obstruction:</b>			
V72647 – single .....	2078.00	5	606.54
V72648 – multiple (two or more).....	2862.00	5	909.55
<b>Omphalocele or gastroschisis:</b>			
V07615 – permanent repair .....	2492.00	7	613.07
V07614 – temporary repair .....	1638.00	7	402.23
CV70604 Congenital diaphragmatic hernia .....	3107.00	9	1522.60
V07651 Reduction of volvulus, intussusception; internal hernia by laparotomy .....	2404.00	5	526.23
CV72751 Reduction of volvulus, intussusception, internal hernia – laparoscopic.....	2825.00	5	657.80
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 (Fredet- Ramstedt type operation).....	1638.00	5	505.35
V07552 Aortopexy for tracheomalacia .....	2598.00	9	1015.07
V07653 Atresia; small bowel .....	3000.00	6	1522.60
V07655 Excision of Meckel's diverticulum (diverticulectomy) or omphalo-mesenteric duct.....	1496.00	4	505.22
CV07692 Repair major anorectal anomalies with concurrent urogenital malformations via sacral approach.....	4126.00	7	1522.60
V71531 Repair tracheoesophageal fistula-cervical approach .....	3277.00	6	2000.00
NOTE: To include gastrostomy.			
V07630 Gastrostomy - open .....	1369.00	5	456.79
33394 Assistant fee for PEG procedure.....	433.00		112.47
NOTE: S33326, 33394 may be billed by any qualified physician.			
CV71532 Esophagoplasty (plastic repair or reconstruction); thoracic approach - without repair of tracheoesophageal fistula .....	3660.00	8	2000.00
CV71533 – with repair of tracheoesophageal fistula .....	4238.00	8	2250.00
NOTE: Includes gastrostomy.			
V71534 Division of tracheoesophageal fistula without esophageal anastomosis (thoracic approach) .....	3277.00	8	804.44
NOTE: Includes gastrostomy.			
Esophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill) antireflux procedures:			
CV71535 – laparoscopic .....	4198.00	6	920.65
V71536 – open .....	3000.00	6	736.52

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V71650 Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) .....	1909.00	5	505.61
V71651 Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic .....	2590.00	5	586.02
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 intraoperative injury to abdominal structures.

SV07150 Insertion of Thoracostomy Tube .....	523.00	4	203.01
NOTES:			
i) Restricted to General Surgeons and Respiriologists.			
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) .....	428.00	4	136.94
07430 Diagnostic peritoneal lavage (catheter) - operation only .....	419.00	3	102.83
V07432 Laparotomy in the trauma patient .....	1851.00	5	454.41
V07431 Repair diaphragmatic injury .....	3277.00	8	804.44
Hepatorrhaphy; suture of liver wound or injury:			
V07412 – simple .....	2239.00	8	609.04
V07413 – with packing .....	2631.00	8	644.63
V07440 – resectional debridement of liver .....	4110.00	8	1268.85
V07441 Hepatic artery ligation, to include resectional debridement where indicated.....	3863.00	8	1015.07
V07442 Hepatic lobectomy for trauma, to include resectional debridement where indicated.....	5246.00	9	2500.00
V07434 Laparotomy and splenic repair, any method.....	3038.00	7	758.60
V07433 Laparotomy to include removal of injured spleen .....	2631.00	7	850.00
V07435 Repair of lacerations to stomach .....	2330.00	7	750.00



## GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V07436 Exploration and mobilization of duodenum and pancreas .....	2631.00	7	644.63
V07437 Repair of laceration to duodenum .....	3490.00	7	857.71
V07438 Resection and debridement of duodenal injury; to include duodenal diverticulisation where indicated .....	4368.00	7	1522.60
V07445 Repair of lacerations to small bowel .....	2330.00	7	572.71
V07446 Resection of injured small bowel.....	2631.00	7	644.63
V07450 Exteriorization of colonic injury.....	2752.00	7	602.52
V07448 Repair of colonic injury with or without colostomy.....	4398.00	7	962.78
V07449 Resection of colonic injury .....	4398.00	7	962.78
V07452 Repair of extra-peritoneal rectum with or without colostomy.....	4398.00	7	962.78
V07447 Repair of mesenteric injury .....	07447b mc	6	572.71
V07443 Resection of distal pancreas for trauma.....	3490.00	8	1268.85
V07444 Pancreaticoduodenectomy (Whipple procedure) for trauma.....	6992.00	9	3045.21
77350 Supra renal aortic crossclamp – extra to abdominal vascular or major trauma cases (operation only) .... NOTE: Operative report required.			

## VASCULAR

### VENOUS

#### Chronic or Varicose Veins:

NOTE: Treatment of varicose vein pathology is a benefit under MSP only if the patient is symptomatic with varicose veins of at least 3 mm and has one or more of the following:

- i) Pain, aching, cramping, burning, itching and/or swelling during activity or after prolonged standing severe enough to impair mobility.
- ii) Recurrent episodes of superficial phlebitis.
- iii) Non-healing skin ulceration.
- iv) Bleeding from a varicosity.
- v) Stasis dermatitis.
- vi) Refractory dependent edema.

77045 Varicose veins, injection, each visit.....	37.80		13.46
NOTE: Treatment for cosmetic purposes is not a benefit under MSP.			

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
77046 Ultrasound directed (with image capture) foam sclerotherapy – initial .....	431.00		171.95
77047 Ultrasound directed (with image capture) foam sclerotherapy –repeat .....	431.00		171.95
<b>NOTES:</b>			
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.			
<b>Compression sclerotherapy:</b>			
77050 – initial .....	227.00	2	80.82
77060 – repeat .....	108.00	2	37.87
<b>NOTES:</b>			
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.....	405.00	2	223.03
V07108 Stripping long saphenous .....	1046.00	2	263.88
V07109 Stripping short saphenous .....	602.00	2	228.30
<b>Multiple ligations and stripping tributaries:</b>			
07110 – 3 to 5 incisions - operation only .....	449.00	2	278.91
V07111 – 6 or more incisions .....	784.00	2	304.28
V07112 Ligation of 2 or more perforators .....	811.00	2	278.91
77070 Complete fasciotomy with or without multiple ligations .....	899.00	2	319.25
NOTE: For decompression fasciotomy, see 77360.			
77075 Re-exploration, groin and/or popliteal fossa .....	848.00	2	300.19
V07116 Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy).....	2123.00	3	523.41
77077 Excision of ulcer and grafting - add full fee to venous procedures - operation only .....	339.00	3	120.28
77079 Venous crossover graft for iliac obstruction .....	1713.00	7	609.87
<b>Acute Venous:</b>			
77082 Ligation of femoral vein.....	420.00	2	148.84

## GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
77084 Ligation or fenestration of inferior vena cava (requires laparotomy).....	1393.00	5	495.27
77086 Thrombectomy for acute ilio-femoral thrombophlebitis ..	1748.00	5	620.60
<b>Portosystemic Shunting:</b>			
C77090 Spleno-renal shunt.....	2657.00	8	945.05
C77092 Porto-caval shunt.....	2657.00	8	945.05
Mesocaval graft:			
C77094 – Synthetic.....	2657.00	8	945.05
C77096 – autogenous.....	2827.00	8	1006.21

## 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 .....	1566.00	5	556.73
C77120 Embolectomy - trunk or extremities (subclassified by location and incision) .....	1748.00	5	620.60
C77125 – one side.....	1257.00	5	446.10

### Removal of Synthetic Graft:

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

*(see notes on next page)*

GENERAL SURGERY – Continued

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

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 or 77102, 77104, or to the replacement graft where removal also is claimed.
- iii) Initial graft procedure fee item 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:**

Bypass graft (synthetic) and/or thrombo-endarterectomy:

C77130 – carotid arteries .....	1848.00	8	981.24
C77135 – innominate.....	2192.00	5	779.13
C77140 – subclavian .....	2089.00	5	846.50
C77145 Ligation of carotid artery .....	720.00	5	255.38

**Groin Dissection:**

C77180 Resection of abdominal aneurysm with associated femoral dissection - one or both sides (extra fee to be added to procedure) - operation only.....	350.00	9	124.11
--	--------	---	--------

NOTE: Peripheral aneurysm - charge associated bypass graft procedure.

C77110 Re-exploration of groin for bleeding or hematoma - operation only .....	355.00	4	125.47
77112 Re-dissection of groin (after 21 days) - extra.....	372.00	4	132.47

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

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

NOTES:

- i) Payable once per side only.
- ii) For re-dissection of groin with revision of graft, item 77043 does not apply - see fee item 77112.
- iii) Not payable with fee items 77100, 77102, 77104, or 77112.

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Aortoiliac:</b>			
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) .....	2089.00	9	892.24
C77155 – aorta and/or iliac (bilateral) .....	2436.00	9	1400.80
C77160 – aorto-femoral and/or ilio-femoral (unilateral).....	2436.00	9	866.39
C77165 – aorta-femoral and/or ilio-femoral (bilateral).....	2790.00	9	1400.80
<b>Aneurysm:</b>			
NOTE: Peripheral aneurysm - charge associated bypass graft procedure.			
77170 Arteriovenous aneurysm .....	1393.00	9	495.27
C77175 Abdominal aneurysm, with grafting .....	2790.00	9	1397.15
C77185 Ruptured aneurysm, with grafting .....	3302.00	10	1598.26
<b>Mesenteric:</b>			
C77190 Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy .....	2262.00	7	892.23
C77195 Superior mesenteric bypass graft (autogenous vein).....	2262.00	7	892.23
<b>Renal:</b>			
C77200 Renal bypass graft (synthetic) and/or thromboendarterectomy .....	2433.00	7	892.23
C77205 Renal bypass graft (autogenous vein) .....	2433.00	7	892.23
<b>Axillo - Femoral:</b>			
Axillo-femoral bypass graft and/or thromboendarterectomy:			
C77210 – unilateral .....	2089.00	7	979.23
C77215 – bilateral .....	2436.00	7	1269.39
<b>Femoral Crossover:</b>			
C77230 Femoro-femoral crossover bypass graft (synthetic) and/or thromboendarterectomy .....	1748.00	5	930.69
C77235 Femoro-femoral crossover bypass graft (autogenous vein) .....	1953.00	5	930.69
<b>Infrainguinal:</b>			
C77240 Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy).....	1393.00	5	858.35
C77245 – popliteal (endarterectomy).....	1909.00	5	679.59
C77250 – popliteal (synthetic).....	1746.00	5	620.53
C77255 – anterior, posterior tibial or peroneal .....	2089.00	5	742.29

GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Bypass graft (Autogenous Vein):</b>			
C77260 – femoral .....	2017.00	5	859.23
C77265 – popliteal .....	2017.00	5	1072.16
C77270 – anterior, posterior tibial or peroneal.....	2368.00	5	1115.63
77275 – in situ vein graft (extra).....	619.00	7	257.02
77280 – non-ipsilateral long saphenous graft (extra) .....	718.00	7	254.66
77285 – short saphenous graft (extra) .....	718.00	7	254.66
77290 – superficial femoral vein graft (extra).....	718.00	7	254.66
77295 – arm vein graft (extra).....	718.00	7	254.66
77300 – A-V fistula with bypass graft in limb salvage (extra) .	522.00	7	185.56
<b>Profunda thromboendarterectomy:</b>			
77310 Profunda thromboendarterectomy without patch repair .	1553.00	5	553.02
77315 Profunda thromboendarterectomy with patch repair (synthetic or autologous) .....	2113.00	5	750.88
<b>Trauma:</b>			
Repair of injury of major vessel in extremity:			
C77330 – suture .....	1643.00	6	583.75
C77335 – graft.....	2113.00	6	750.88
Repair of injury of major vessel in trunk:			
C77340 – suture .....	2465.00	9	876.21
C77345 – graft.....	3289.00	9	1168.71
77350 Supra-renal aortic cross-clamp - extra to abdominal vascular or major trauma cases - operation only .....	322.00		114.21
NOTE: Operative report required.			
<b>Fasciotomy:</b>			
77360 Decompression fasciotomy - subcutaneous .....	692.00	3	334.57
NOTE: 77360 includes secondary closure.			
<b>Miscellaneous:</b>			
77370 Release of popliteal entrapment syndrome .....	812.00	3	334.57
NOTE: Not to be paid if full femoral popliteal bypass is performed.			
00722 Arteriography, operative - procedural fee .....	308.00		75.51
<b>Second Operator:</b>			
77025 Synchronous combined bypass graft – extremities .....	848.00		300.19
77030 – trunk .....	848.00		300.19
NOTE: Items 77025 and 77030, provide operative report by second operator when requested by MSP.			

**RENAL ACCESS**

77380 Insertion permanent peritoneal catheter (procedural fee only).....	536.00	3	190.68
---	--------	---	--------

## GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
77385 Removal by dissection of chronic peritoneal catheter (operation only).....	372.00	3	132.26
NOTE: For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.			
77395 Creation of internal arterio-venous fistula .....	1045.00	4	414.93
77396 Revision of AV fistula .....	1260.00	5	505.58
NOTES:			
i) Restricted to Vascular and General Surgeons.			
ii) Not paid with renal access fees (77380, 77385, 77395, 77400, 77402, 77403, 77405).			
iii) Not paid with the following vein graft fees (77275, 77280, 77285, 77290, 77295, 77300).			
iv) 77043 not paid with this fee.			
77400 Synthetic AV graft for hemodialysis .....	1288.00	4	707.49
NOTE: Not paid with 77295, 77395, 77396 and 77402.			
77402 Creation of brachiobasilic arteriovenous fistula with vein transposition .....	1885.00	5	707.74
NOTE: Not paid with 77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77330, 77395 and 77400.			
77403 Arm revascularization with distal revascularization and interval ligation (DRIL) .....	1763.00	5	707.73
NOTE: Not paid with C77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77300, 77395, and 77396.			
77405 Thrombectomy of arterio-venous fistula.....	984.00	3	349.01

### SYMPATHECTOMY

77420 Lumbar sympathectomy - unilateral .....	1045.00	4	371.15
77422 Cervical sympathectomy - unilateral .....	1287.00	5	501.87
77424 Preganglionic sympathectomy; upper dorsal region - unilateral .....	1287.00	7	458.38
77426 Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral .....	1287.00	7	458.38
<b>Lumbar sympathectomy with abdominal procedure:</b>			
77428 – unilateral (extra).....	350.00		124.12
77430 – bilateral (extra).....	697.00		248.26

### LYMPHATIC SYSTEM

V07360 Splenectomy.....	2631.00	6	808.57
-------------------------	---------	---	--------

## GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
CV07368 Laparoscopic splenectomy .....	3277.00	6	809.21
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%.			
V07361 TB glands - radical removal.....	1096.00	4	269.03
V07363 Radical femoral, inguinal and/or iliac dissection .....	2186.00	5	536.76
CV07365 Isolated limb perfusion to include groin dissection and laparotomy.....	3822.00	5	938.97
CV07366 Laparotomy and staging of lymphoma (to include splenectomy).....	3174.00	6	909.86

## LYMPHOEDEMA – LEG

Lymphoedema of limbs - excision and grafting:			
06127 – entire leg .....	2782.00	3	700.04
06128 – entire lower extremity .....	4161.00	3	1046.58

## ABDOMINAL SURGERY

### Miscellaneous:

V07603 Resuture abdominal wound evisceration.....	1096.00	5	406.03
07451 Thoracic extension of abdominal incision (extra).....	1161.00	8	285.69
V07600 Exploratory laparotomy (to include biopsy).....	1410.00	5	405.81
V07597 Post-operative hemorrhage; intra-abdominal management .....	1545.00	6	379.58
V07601 Intra-abdominal abscess excluding intrahepatic (stand-alone procedure) .....	1764.00	5	434.19
NOTE: Not paid for post operative hemorrhage (by any approach) which should be billed as fee item 07597.			
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).....	1487.00	5	376.25
<i>(see notes on next page)</i>			



GENERAL SURGERY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)	
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.				
S04001	Laparoscopy (operation only) .....	615.00	4	210.56
Removal of indwelling Enteral tubes with or without exploration of tube insertion site:				
S71280	– not requiring anesthesia (operation only) .....	132.00		30.65
S71281	– requiring local or regional anesthesia (operation only) .....	259.00		63.06
S71282	– requiring general anesthesia (operation only) .....	435.00	2	203.93
S71283	– replacement of tube - extra .....	132.00		30.65
NOTES:				
i) Tray fee is not paid when the procedure is performed in hospital or publicly-funded facilities (D&T Centres, psychiatric facilities).				
ii) Not paid with Fee Items 07517, 07518, 07519, 07562, 07781, 07782, 07783, 70637 and 33326.				
iii) Restricted to General Surgeons.				
iv) Paid at 50% with endoscopy.				
CV71290	Resection of retroperitoneal or intra-abdominal soft tissue tumour measuring 10 cm or greater - first 60 minutes. ....	2062.00	8	662.77
C71291	Resection of retroperitoneal or intra-abdominal soft tissue tumour measuring 10 cm or greater - each additional 15 minutes or greater portion thereof. ....	224.00		76.47
NOTES:				
i) Payment restricted to General Surgeons.				
ii) Not paid with fee items 51051, 51052, 04029 or 04628.				
iii) Start and end times are required in the claim and the patient's chart for the resection of the tumour and cannot be billed for time performing concurrent procedures.				
CV71292	Peritonectomy, with or without intraperitoneal chemotherapy – each hour (up to 8 hours).....	2832.00	7	662.77
CV71293	Peritonectomy, with or without intraperitoneal chemotherapy – each additional 15 minutes or greater portion thereof (maximum of 16 units per patient).....	218.00	7	75.60
<i>(see notes on next page)</i>				

GENERAL SURGERY – Continued

**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

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**

07764	Cholangiography; operative (extra) .....	268.00		80.86
07710	Pancreatogram with or without sphincterotomy done in conjunction with any of the biliary or pancreatic surgical procedures (extra) .....	272.00		67.19
S00869	Manometry, adult - anal .....	259.00	2	101.37
S00797	Esophageal, motility test.....	561.00		176.15
S00788	– technical fee .....	300.00		74.35
S00798	– professional fee .....	259.00		101.79
	Esophageal pH study for reflux (extra):			
S00817	– technical fee .....	54.40		12.44
S00818	– professional fee .....	177.00		40.82
S00826	Biopsy of pancreas - percutaneous .....	331.00	2	101.44
S00809	Retrograde pancreatography.....	937.00	3	216.54
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee.....	400.00	3	89.73
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing - procedural fee.....	332.00	3	74.74
S10763	Initial esophageal, gastric or duodenal biopsy .....	128.00	3	29.06
	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 .....	196.00	3	43.58
	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.....	330.00	4	195.57

GENERAL SURGERY – Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
SY00716 Sigmoidoscopy; flexible; diagnostic - procedural fee .....	263.00	2	76.09
SY00718 Sigmoidoscopy; flexible; diagnostic - with biopsy.....	335.00	2	77.34
33373 Colonoscopy with flexible colonoscope, biopsy .....	935.00	2	235.15
33374 – removal of polyp .....	1393.00	2	283.50
S00780 Schirmer's test (included in fee item 02015) .....	57.80		13.15
SY00789 Peritoneal lavage .....	281.00	2	85.74

# GERIATRIC MEDICINE

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
33410 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	570.00		184.76
33412 <b>Repeat or Limited Consultation:</b> Where a consultation for the same illness is repeated within six (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 .....	287.00		105.13
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.....	899.00		291.50
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:			
<ul style="list-style-type: none"> <li>• Assessment and management of medical condition(s)/syndrome(s) in patients 65 yrs. and over.</li> <li>• Assessment of failure to thrive and frailty.</li> <li>• Mobility decline and falls.</li> <li>• Polypharmacy, review of medication tolerability/response and compliance issues.</li> <li>• Incontinence.</li> <li>• Co-management with geriatric psychiatry, particularly where there is significant medical instability.</li> <li>• Elder abuse/neglect, caregiver stress.</li> <li>• Assessment/monitoring of functional status including issues of competency and “living at risk”.</li> </ul>			
<i>(notes continued on next page)</i>			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- ii) Minimum time requirement for service 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 .....	215.00	101.57
--	--------	--------

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.

P33403 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 .....	655.00	291.50
---	--------	--------

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.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>• Management of common psychiatric syndrome in the elderly, including depression, anxiety, insomnia, psychosis, bipolar disorder.</li> <li>• Substance abuse disorders.</li> <li>• Assessment/monitoring of functional status including issues of competency and "living at risk".</li> <li>• Issues identified in 33401 may enter into the picture.</li> </ul>			
ii) Minimum time requirement for services is 65 minutes clinical assessment time.			
iii) Start and end times must be entered in both the billing claims and the patient's chart.			
P33404 Geriatric reassessment subsequent to comprehensive consultation - for dementia or cognitive problems .....	228.00		101.57
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.			
P33440 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.....	449.00		200.00
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:			
<ul style="list-style-type: none"> <li>• Septicemia</li> <li>• Other HIV infection</li> </ul>			
<i>(notes continued on next page)</i>			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- 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

P33442 Complex 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 .....	270.00	120.00
--	--------	--------

NOTES:

- i) Payable only for Geriatric Medicine specialists.
- ii) See 33440 note ii) for billing criteria.

GERIATRIC MEDICINE - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
33414 Prolonged visit for counseling (maximum four (4) per year).....	287.00		53.21
NOTES:			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
33413 Group counseling for groups of two or more patients - first full hour .....	581.00		99.46
33415 - second hour, per 1/2 hour or major portion thereof	296.00		49.68
<b><u>Continuing Care by Consultant:</u></b>			
33406 Directive care .....	105.00		48.20
P33446 Comprehensive or complex directive care .....	163.00		72.00
NOTES:			
i) Payable only for Geriatric Medicine specialists.			
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations.			
33407 Subsequent office visit .....	111.00		55.00
P33447 Comprehensive or complex subsequent office visit ...	158.00		70.00
NOTES:			
i) Payable only for Geriatric Medicine specialists.			
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations.			
33408 Subsequent hospital visit .....	80.90		34.50
P33448 Comprehensive or complex subsequent hospital visit.....	96.50		43.00
NOTES:			
i) Payable only for Geriatric Medicine specialists.			
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations.			
33409 Subsequent home visit.....	162.00		140.00
33405 Emergency visit when specially called (not paid in addition to out-of-office hour premiums).....	327.00		122.15
NOTE: Claim must state time service rendered.			



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
33470 Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.	570.00		184.76
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. ....	287.00		105.13
33421 Telehealth Comprehensive geriatric consultation - limited to patients aged <b>65</b> 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. ....	899.00		291.50

## 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 75 minutes, with 65 minutes clinical assessment time and 10 minutes report preparation time.
- iii) Start and end times must be entered in both the billing claims and the patient's chart.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
33422 Telehealth Geriatric reassessment - subsequent to comprehensive consultation - limited to patients aged 65 years and over. ....	215.00		101.57
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.			
P33473 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.....	655.00		291.50
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.			

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- 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.

P33474 Telehealth Geriatric reassessment subsequent to comprehensive consultation - for dementia or cognitive problems ..... 228.00

101.57

NOTES:

- i) See 33473 note i) for billing criteria.
- ii) Minimum time requirement for services 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.

P33423 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 ..... 449.00

200.00

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:

*(notes continued on next page)*

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

- 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

GERIATRIC MEDICINE - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
P33424 Telehealth Complex repeat or limited consultation – for 2 condition: 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 .....	270.00		120.00
NOTES:			
i) Payable only for Geriatric Medicine Specialists.			
ii) See 33423 note ii) for billing criteria.			
33476 Telehealth directive care.....	105.00		48.20
P33426 Telehealth Comprehensive or complex directive care.....	163.00		72.00
NOTES:			
i) Payable only for Geriatric Medicine specialists.			
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations.			
33477 Telehealth subsequent office visit.....	111.00		55.00
P33427 Telehealth Comprehensive or complex subsequent office visit.....	158.00		70.00
NOTES:			
i) Payable only for Geriatric Medicine specialists.			
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations.			
33478 Telehealth subsequent hospital visit.....	80.90		34.50
P33428 Telehealth Comprehensive or complex subsequent hospital visit .....	96.50		43.00
NOTES:			
i) Payable only for Geriatric Medicine specialists.			
ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>MISCELLANEOUS</b>			
PG33445 Geriatric Care Conference (planning for patient), - per 15 minutes, or greater portion thereof.....	120.00		48.68
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 or complex consult (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 names and roles of those who participated in the meeting must be documented in patient's chart, and result communicated to the FP/GP, 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.....	109.00		43.55
NOTES:			
i) Restricted to Geriatric Medicine.			
ii) One or more family members/representatives must be present.			

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- iii) Billable after any comprehensive or complex consult (33401, 33403, 33421, 33423, 33440, 33473) or follow up (33402, 33404, 33422, 33424, 33442, 33474) by a Geriatrician in the last 6 months.
- iv) Maximum of four per patient, per sitting.
- v) Annual maximum of eight per patient.
- vi) The results of the conference, as well as the names and roles of those who participated in the meeting must be documented in the patient's chart, and result communicated to FP/GP.
- 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 / MEDICAL ONCOLOGY

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>REFERRED CASES</b>			
33510 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	570.00		173.27
33512 <b>Repeat or Limited Consultation:</b> Where a consultation for the same illness is repeated within six (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 .....	287.00		82.60
33520 <b>Complex Consultation:</b> To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report for complex patient.....	986.00		229.42

**NOTES:**

- i) Restricted to Hematology and Oncology.
- ii) Paid to a maximum of one per patient within six months of the last visit.
- iii) Not paid in addition to 33510, 33512, 33506, 33507, 33508, 33522 or 33527.
- iv) 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

*(notes continued on next page)*



	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<ul style="list-style-type: none"> <li>• Coagulation defects requiring factor concentrate, transfusion or other hemostatic therapy</li> <li>• Thrombocytopenia requiring immunosuppressive, transfusion or growth factor therapy</li> <li>• Venous thromboembolism (VTE) / Phlebitis and thrombophlebitis that is:               <ul style="list-style-type: none"> <li>○ unprovoked,</li> <li>○ in a patient with cancer,</li> <li>○ in a pregnant patient</li> <li>○ in a patient with a contraindication to anticoagulation</li> </ul> </li> </ul>			
<b>33522 Repeat or Limited Consultation, Complex Patient:</b> 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 .....	381.00		112.16
NOTES: i) Restricted to Hematology and Oncology. ii) Not paid in addition to 33510, 33512, 33506, 33507, 33508, 33520, or 33527. iii) Payable for complex patients (see notes for Complex Consultation – 33520).			
<b>33514</b> Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) .....	287.00		78.88
NOTES: i) See Preamble D. 3. 3. ii) Start and end times must be entered in both the billing claims and the patient's chart.			
<b>33513</b> Group counseling for groups of two or more patients - first full hour .....	581.00		113.76
<b>33515</b> – second hour, per 1/2 hour or major portion thereof .....	296.00		56.84
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
<b><u>Continuing Care by Consultant:</u></b>			
<b>33506</b> Directive care .....	105.00		77.12
<b>33507</b> Subsequent office visit .....	111.00		55.58
<b>33527</b> Subsequent Office Visit, Complex Patient .....	216.00		90.75

*(see notes on next page)*

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

NOTES:

- i) Restricted to Hematology and Oncology.
- ii) Not paid in addition to 33510, 33512, 33506, 33507, 33508, 33520 or 33522.
- iii) Payable for complex patients (see notes for Complex Consultation 33520).
- iv) Payment not contingent on whether or not a complex consultation was billed in the preceding 6 months.

33508 Subsequent hospital visit.....	80.90	55.68
33509 Subsequent home visit.....	162.00	52.04
33505 Emergency visit when specially called (not paid in addition to out-of-office hour premiums).....	327.00	145.13
NOTE: Claim must state time service rendered.		

**Telehealth Service with Direct Interactive Video Link with The Patient**

33570 Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report .	570.00	173.27
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.....	287.00	82.60
33577 Telehealth subsequent office visit .....	111.00	55.58

**EXAMINATION BY CERTIFIED HEMATOLOGIST AND ONCOLOGIST**

33538 Plasmapheresis.....	533.00	187.29
---------------------------	--------	--------

**PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS  
(When performed for diagnostic purposes)**

S00753 Marrow aspiration - procedural fee.....	145.00	2	43.77
--	--------	---	-------

**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.

HEMATOLOGY / MEDICAL ONCOLOGY - Continued

- 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.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p>33581 High intensity cancer chemotherapy: To include admission history and physical examination, review of pertinent laboratory and radiological data, counseling 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.....</p> <p>NOTE: This service is not payable more frequently than once every 28 days. The following treatments fall into this category:</p> <ul style="list-style-type: none"> <li>i) Chemotherapy for acute leukemia;</li> <li>ii) Chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m<sup>2</sup> per treatment;</li> <li>iii) Chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;</li> <li>iv) Chemotherapy using DTIC in a dose exceeding 100 mg/m<sup>2</sup>;</li> <li>v) Chemotherapy utilizing methotrexate in a dose exceeding 1 g/m<sup>2</sup> (and combined with the folic acid rescue regimen); and</li> <li>vi) Chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).</li> </ul>	587.00		203.27
<p>33582 Major cancer chemotherapy: To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counseling of patient and/or family, venesection and institution of an intravenous line, and administration of multiple parenteral chemotherapeutic agents .....</p> <p>NOTE: This service is not payable more than once every seven (7) days.</p>	368.00		119.21

HEMATOLOGY / MEDICAL ONCOLOGY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
33583 Limited cancer chemotherapy: To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counseling of patient and/or family, venesection and institution of an intravenous line and administration of a single parenteral chemotherapeutic agent .....	187.00		68.11
NOTE: This item is not payable more than once every seven days. Neither is it to be billed for routine IV push administration of 5-fluorouracil as a single agent.			
S00748 Bone biopsy under local/regional anesthetic.....	143.00		63.72

# INFECTIOUS DISEASES

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
33610 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	612.00		202.86
33612 <b>Repeat or Limited Consultation:</b> Where a consultation for the 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 .....	261.00		107.67
33614 Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) .....	171.00		55.95
NOTES:			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
33613 Group counseling for groups of two or more patients - first full hour .....	350.00		114.64
33615 – second hour, per 1/2 hour or major portion thereof .....	174.00		57.28
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
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. ....	1025.00		335.29

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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 33620 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.

**Continuing Care by Consultant:**

33606	Directive care.....	147.00	61.36
33607	Subsequent office visit.....	153.00	56.80
33608	Subsequent hospital visit.....	90.10	40.57
33609	Subsequent home visit.....	162.00	52.41
33605	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) .....	355.00	116.16

NOTE: Claim must state time service rendered.

**Telehealth Service with Direct Interactive Video Link**

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.....	612.00	202.86
NOTE: Restricted to FRCP Infectious Disease 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 .....	261.00	107.67
33636	Telehealth directive care.....	147.00	61.36
33637	Telehealth subsequent office visit.....	153.00	56.80
33638	Telehealth subsequent hospital visit.....	90.10	40.57

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS</b>			
<b>(When performed for diagnostic purposes)</b>			
SY00750 Lumbar puncture - procedural fee .....	209.00	2	54.99
S00753 Marrow aspiration - procedural fee.....	145.00	2	43.77
SY00757 Joint aspiration - procedural fee (not in addition to 00014 or 00015) - other joints .....	42.45	2	11.99
S00759 Paracentesis (thoracic) or transtracheal aspiration - procedural fee .....	96.40	2	84.00
S00760 Paracentesis (abdominal) - procedural fee .....	69.70	2	25.79
S00764 Intracutaneous test - per test .....	9.95		9.95
<b>NEEDLE BIOPSY PROCEDURES</b>			
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.			
S00749 Parietal pleural, including thoracentesis-procedural fee.....	200.00	2	130.41
<b>ELBOW, PROXIMAL RADIUS AND ULNA</b>			
<b>Incision: Diagnostic, Percutaneous:</b>			
S11302 Aspiration - bursa, tendon sheath. ....	90.10	2	23.23
<b>HAND AND WRIST</b>			
<b>Incision: Diagnostic, Percutaneous:</b>			
S11402 Aspiration - bursa, synovial sheath, etc.....	90.10	2	23.23
<b>PELVIS, HIP AND FEMUR</b>			
<b>Incision: Diagnostic, Percutaneous:</b>			
S11501 Aspiration hip joint.....	90.10	2	23.23
S11502 Aspiration - bursa, tendon sheath. ....	44.90	2	11.63
<b>FEMUR, KNEE JOINT, TIBIA AND FIBULA</b>			
<b>Incision: Diagnostic, Percutaneous:</b>			
S11602 Aspiration - bursa, tendon sheath or other peri- articular structures .....	90.10	2	23.23
<b>MISCELLANEOUS</b>			
13600 Biopsy of skin or mucosa - operation only.....	119.00	2	51.92
NOTE: Punch or shave biopsies not to be charged under fee items 13600 or 13601.			

INFECTIOUS DISEASES - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
PG33655 Home Parenteral Antibiotic Management Fee, for active antibiotic treatment only.....	45.30		18.78
NOTES:			
i) Restricted to Infectious Diseases specialists.			
ii) This fee may be billed for advice by telephone, fax, e-mail, 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 4 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.			

**MISCELLANEOUS VISITS**

33645 Infectious Disease Care Management of HIV/AIDS – in or out of office visit – per half hour or major portion thereof.....	252.00		102.36
NOTES:			
i) Payable to Infectious Diseases specialists only.			
ii) When performed in conjunction with visit, counselling or consultations, only the larger fee is paid.			
iii) Only applicable to services submitted under diagnostic codes 042, 043 and 044.			
iv) Start and end times must be included on claim, and in patient’s chart.			
Services that are less than 15 minutes should be billed under the appropriate visit fee item.			



# GENERAL INTERNAL MEDICINE

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
<b>There are now referred cases fee items for both Internal Medicine and General Internal Medicine. Where there is no specific fee item listed under General Internal Medicine, use applicable Internal Medicine fee.</b>			
<b>INTERNAL MEDICINE</b>			
00310 Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report .....	628.00		167.60
00312 Repeat or Limited Consultation: Where a consultation for the same illness is repeated within six (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 .....	317.00		80.97
00314 Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) .....	317.00		55.12
NOTES:			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
<b>Group counseling for groups of two or more patients</b>			
00313 - first full hour .....	637.00		112.89
00315 - second hour, per 1/2 hour or major portion thereof ..	326.00		56.40
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
<b><u>Continuing Care by Consultant:</u></b>			
00306 Directive care .....	115.00		71.85
00307 Subsequent office visit .....	122.00		53.48
00308 Subsequent hospital visit .....	89.20		28.93
00309 Subsequent home visit .....	177.00		51.64
00305 Emergency visit when specially called (not paid in addition to out-of-office hour premiums) .....	362.00		114.44
NOTE: Claim must state time service rendered.			

GENERAL INTERNAL MEDICINE (CRIM) - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Telehealth Service with Direct Interactive Video Link with the Patient:</b>			
32270 Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report...	628.00		167.60
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. ....	317.00		80.97
32276 Telehealth directive care .....	115.00		71.85
32277 Telehealth subsequent office visit.....	122.00		50.08
32278 Telehealth subsequent hospital visit .....	89.20		28.93

**GENERAL INTERNAL MEDICINE**

Note: Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

P32210 Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report .....	465.00		204.09
P32212 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 .....	207.00		90.68
00311 Complex Consultation – 3 medical conditions .....	1101.00		269.30

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.

*(notes continued on next page)*

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

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)

GENERAL INTERNAL MEDICINE (CRIM) - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Continuing care by consultant:</b>			
P32206 Directive care.....	195.00		85.64
P32207 Subsequent office visit .....	290.40		80.00
P32208 Subsequent hospital visit.....	115.00		50.38
PG32307 Subsequent follow-up office visit, complex patient – 3 medical conditions .....	306.00		90.00

NOTES:

- i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.
- ii) Payable only if 00311 paid within the previous 6 months.
- iii) Payable for patients that have 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart.

PG32308 Subsequent hospital visit, complex patient – 3 medical conditions .....	212.00		53.00
--	--------	--	-------

NOTES:

- i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.
- ii) Payable only if 00311 paid within previous 6 months.
- iii) Payable for patients that have 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart.
- iv) Payable only for an admitted patient.
- v) Payable for ongoing inpatient follow-up care, for each day hospitalized during the first ten days of hospitalization, thereafter bill 00308.
- vi) The total of all daily billing under this fee item that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. Daily totals will be paid as follows:
  - 1-15 visits paid at 100%
  - 16 or more visits paid at 50%.

GENERAL INTERNAL MEDICINE (CRIM) - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
	<b>Telehealth Service with Direct Interactive Video Link with the Patient:</b>			
P32370	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report ..	465.00		204.09
P32372	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 .....	207.00		90.68
32271	Telehealth Complex Consultation .....	1101.00		269.30

NOTES:

- i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.
- ii) Limited to one per patient in a 6 month period.
- iii) Written consultation report includes advice or recommendations for treatment regarding 3 or more of the conditions listed in note iv), below.
- iv) Payable for patients that have 3 or more of the following listed chronic diseases. Exceptions to this rule could be made if the patient has two diagnoses from this list and one alternative diagnosis not on the list can be submitted with correspondence/note record, outlining the medical necessity. Each case will be reviewed on an independent consideration basis.  
(Diagnostic codes in brackets):  
 Septicemia (038)  
 Other HIV infection (044)  
 DM including complications (250)  
 Disorders of Lipid Metabolism (272)  
 Thyroid disorders (246)  
 Purpura, thrombocytopenia and hemorrhagic conditions (287)  
 Anemia, unspecified (285.9)  
 Senile dementia, presenile dementia (290)  
 Acute confusional state (293)  
 Congestive Heart Failure (428)

*(notes continued on next page)*

GENERAL INTERNAL MEDICINE (CRIM) - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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)			
P32376 Telehealth directive care .....	195.00		85.64
P32377 Telehealth subsequent office visit .....	290.40		80.00
P32378 Telehealth subsequent hospital visit.....	115.00		50.38

**EXAMINATIONS BY CERTIFIED INTERNIST**

00322 Internists' part in cardioangiogram, per hour or fraction thereof.....	218.00		46.54
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 .....	1287.00		287.85
NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra.			
00343 Cardiac screening (maximum 3 per month within manufacturer's guarantee and one per week beyond manufacturer's guarantee).....	26.10		4.65
00344 – professional fee .....	15.00		2.33
00345 – technical fee .....	15.00		2.33

GENERAL INTERNAL MEDICINE (CRIM) - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
33032 Pacemaker standby and/or placement of the endocardial catheter - operation only.....	368.00		80.66
33033 Generator placement and venous cut-down .....	1191.00	4	80.66

**MISCELLANEOUS**

00319 Insertion of central catheter for total parenteral nutrition - operation only .....	224.00	2	56.54
S32031 Closed drainage of chest (operation only) .....	428.00	4	136.94

**ADULT CRITICAL CARE**

NOTE: Please refer to the Critical Care section of the Fee Guide 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 counseling; emergency resuscitation; intravenous lines; bronchoscopy; chest tubes; lumbar puncture; cutdowns; pressure infusion set and pharmacological agents; insertion of arterial CVP; 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-operative monitoring, or patients admitted for ECG monitoring or observation alone.

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

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
01411 1st day .....	848.00	340.05
01421 2nd to 7th day (inclusive) per diem .....	420.00	172.55
01431 8th day to 30th day.....	215.00	117.00
01441 31st day onward.....	177.00	135.47

2. VENTILATORY SUPPORT - Includes provision of ventilatory care; initial consultation and assessment of the patient; family counseling; cutdown; 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<sub>2</sub>; 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,

GENERAL INTERNAL MEDICINE (CRIM) - Continued

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 post-operative care by the surgeon.

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
01412 1st day .....	737.00	294.96
01422 2nd to 7th day (inclusive) per diem .....	370.00	152.26
01432 8th day to 30th day .....	246.00	120.00
01442 31st day onward.....	227.00	110.89

3. COMPREHENSIVE CARE - These fees apply to intensive care physicians who provide complete care, both critical care and ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment; subsequent examinations of the patient; family counseling; endotracheal intubation; tracheal toilet; artificial ventilation and all necessary measures for respiratory support; emergency resuscitation; insertion of intravenous lines; bronchoscopy; chest tubes; lumbar puncture; cutdowns; arterial and/or venous catheters; insertion of a 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 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.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
01413 1st day .....	1386.00	507.54
01423 2nd to 7th day (inclusive) per diem .....	632.00	256.61
01433 8th day to 30th day .....	318.00	142.11
01443 31st day onward.....	273.00	147.80

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



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>CARDIO-VASCULAR PROCEDURES</b>			
S00839 Direct intracoronary streptokinase thrombolysis .....	1447.00	4	360.09
NOTE: When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).			

**BLOOD TRANSFUSIONS**

00017 Insertion of central venous pressure catheter .....	96.40		23.77
00018 Autologous ascitic infusion .....	197.00		47.85
00021 Administered in hospital .....	145.00		37.10

**DIALYSIS FEES**

**Acute Renal Failure:**

**Peritoneal Dialysis:**

33756 Re-insertion of peritoneal catheter after 10 days from initial insertion .....	208.00		52.22
NOTE: Item 00081 not to be charged in addition to Item 33723. Where an initial peritoneal dialysis is performed and for various reasons, hemodialysis initiated within next forty-eight (48) hours, the subsequent service should be charged under fee item 33758 plus fee 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.

GENERAL INTERNAL MEDICINE (CRIM) - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<p>33581 High intensity cancer chemotherapy: To include admission history and physical examination, review of pertinent laboratory and radiological data, counseling 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.....</p> <p>NOTE: This service is not payable more frequently than once every 28 days. The following treatments fall into this category:</p> <ul style="list-style-type: none"> <li>i) Chemotherapy for acute leukemia;</li> <li>ii) Chemotherapy utilizing cisplatin given in a dose exceeding 50 mg/m<sup>2</sup> per treatment;</li> <li>iii) Chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;</li> <li>iv) Chemotherapy using DTIC in a dose exceeding 100 mg/m<sup>2</sup>;</li> <li>v) Chemotherapy utilizing methotrexate in a dose exceeding 1 g/m<sup>2</sup> (and combined with the folic acid rescue regimen); and</li> <li>vi) Chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).</li> </ul>	587.00		203.27
<p>33582 Major cancer chemotherapy: To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counseling of patient and/or family, venesection and institution of an intravenous line, and administration of multiple parenteral chemotherapeutic agents.....</p> <p>NOTE: This service is not payable more than once every seven (7) days.</p>	368.00		119.21
<p>33583 Limited cancer chemotherapy: To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counseling of patient and/or family, venesection and institution of an intravenous line and administration of a single parenteral chemotherapeutic agent.....</p> <p>NOTE: This item is not payable more than once every seven days. Neither is it to be billed for routine IV push administration of 5-fluorouracil as a single agent.</p>	187.00		68.11

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

**DIAGNOSTIC PROCEDURES****PULMONARY INVESTIGATIVE AND FUNCTION STUDIES**

S00930 Peak expiratory flow rate.....	26.10		5.54
NOTE: Fee item S00930 payable when performed in physician's 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.....	55.30		12.77
S00929 – before and after bronchodilators .....	82.90		18.90

**Exercise Studies:**

NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation.

S00958 Testing for exercise-induced asthma by serial flow measurements - professional fee .....	96.40		22.35
S00959 – technical fee.....	145.00		32.95

**Miscellaneous Pulmonary Tests:**

S00970 Precipitin tests - one or more antigens - professional fee.....	49.15		11.11
S00971 - technical fee.....	119.00		26.92

**PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS  
(When performed for diagnostic purposes)**

S00753 Marrow aspiration - procedural fee.....	145.00	2	43.77
S00755 Artery puncture - procedural fee.....	29.85	2	6.38
S00759 Paracentesis (thoracic) or transtracheal aspiration - procedural fee .....	96.40	2	84.00

# NEPHROLOGY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
33710 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	570.00		173.42
33712 <b>Repeat or Limited Consultation:</b> Where a consultation for the same illness is repeated within six (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 .....	287.00		81.98
33714 Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) .....	287.00		52.15
<b>NOTES:</b>			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
33713 Group counseling for groups of two or more patients - first full hour .....	581.00		106.78
33715 – second hour, per 1/2 hour or major portion thereof .....	296.00		53.36
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
<b><u>Continuing Care by Consultant:</u></b>			
33706 Directive care .....	105.00		60.17
33707 Subsequent office visit.....	111.00		47.46
33708 Subsequent hospital visit .....	80.90		48.32
33709 Subsequent home visit.....	162.00		48.85
33705 Emergency visit when specially called (not paid in addition to out-of-office hour premiums).....	327.00		108.26
NOTE: Claim must state time service rendered.			
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
33730 <b>Telehealth Consultation:</b> 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 .....	570.00		173.42
NOTE: Restricted to FRCP Nephrology Physicians.			

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
33732 <b>Telehealth Repeat or Limited Consultation:</b> 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 .....	287.00		81.98
33736 Telehealth directive care .....	105.00		60.17
33737 Telehealth subsequent office visit.....	111.00		47.46
33738 Telehealth subsequent hospital visit.....	80.90		48.32

**DIALYSIS FEES**

**Acute Renal Failure**

**a) Hemodialysis:**

33750 Blood dialysis - physician in charge.....	2048.00		531.27
33751 Repeat blood dialysis - physician in charge.....	779.00		199.65

NOTES:

- i) Maximum number of repeat dialysis on one patient is four (4). 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 cutdown by surgeon to be charged in addition to item 33750 or 33751 .....	517.00		134.31
--	--------	--	--------

**b) Peritoneal Dialysis:**

33756 Re-insertion of peritoneal catheter after 10 days from initial insertion .....	208.00		52.22
--	--------	--	-------

NOTE: Item 00081 not to be charged in addition to Item 33723. Where an initial peritoneal dialysis is performed and for various reasons, hemodialysis initiated within next forty-eight (48) hours, the subsequent service should be charged under fee item 33758 plus fee item 33756 for the insertion of catheter.

**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.....	208.00		52.22
--	--------	--	-------

NOTE: Other medical situations which may arise such as Septicemia, etc. to be covered by item 00081 and always to be accompanied by a letter of explanation when billing a payment agency.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b><u>b) Peritoneal Dialysis:</u></b>			
33723 Performance of initial peritoneal dialysis, chronic or acute renal failure, to include consultation and two (2) weeks care.	1530.00		397.47
33759 Performance of each peritoneal dialysis thereafter - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions and any other problem that may arise during dialysis.....	208.00		52.22
<b>NOTES:</b>			
i) Other situations requiring medical care such as bacteremias, etc. to be covered by item 00081 in the present Guide and always to be accompanied by a letter of explanation.			
ii) If a period greater than three (3) months elapses since last dialysis, then charge as an initial dialysis 33723.			
<b>Home Dialysis</b>			
33761 Supervision of home dialysis - per week.....	255.00		63.13
NOTE: Fee item 33761 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 charged in lieu of fee item 33761.			
<b>EXAMINATIONS BY CERTIFIED INTERNIST</b>			
33538 Plasmapheresis - therapeutic .....	533.00		187.29
<b>MISCELLANEOUS</b>			
33790 Care of renal transplant patient, including immediate preparation and fourteen (14) days post-operative care .....	4001.00		1182.14
77380 Insertion permanent peritoneal catheter (procedure fee only).....	536.00	3	190.68
77385 Removal by dissection of chronic peritoneal catheter (operation only).....	372.00	3	132.26
NOTE: For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.			

# NEUROLOGY

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

## 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).

- 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.

- 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 general practitioner 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 General Practice 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

NEUROLOGY - Continued

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.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>REFERRED CASES</b>		
00410 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	465.00	179.27
00411 <b>Repeat or Limited Consultation:</b> Where a consultation for the same illness is repeated within six (6) months of the last service by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee .....	232.00	87.21
PG00450 Complex Care – Extended Consultation – per 15 minutes or major portion thereof.....	146.00	58.10

**NOTES:**

- i) Paid in addition to 00410, 00411, 00470 and 00471, after 45 minutes.
- ii) Paid to a maximum of 3 units per patient, during same sitting.
- iii) Start and end times must be entered on patient's chart and on claim.



	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<p>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.....</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>i) Restricted to Neurologists.</li> <li>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.</li> <li>iii) Payable only for patients with established diagnosis of MS (ICD9 code 340 billed previously by any neurologist).</li> <li>iv) Repeat services payable after 42 days of a previous P00485.</li> <li>v) Maximum two per patient per calendar year.</li> <li>vi) Includes lumbar puncture (00750) if required.</li> <li>vii) Fee item 00486 payable in addition if assessment exceeds 30 minutes.</li> <li>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.</li> <li>ix) Start and end times must be submitted with the claim.</li> </ul>	534.00	201.37
<p>00486 Face to face assessment for acute deterioration in status of an MS patient - each additional half hour or major portion thereof.....</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>i) Paid only with 00485.</li> <li>ii) Maximum of 4 units per face to face assessment.</li> <li>iii) Payable for the ongoing assessment, clinical monitoring and treatment of an MS patient with acute deterioration.</li> <li>iv) Start and end times must be submitted with the claim.</li> </ul>	267.00	100.19
<p>P00487 Detailed cognitive assessment by Behavioral Neurologist – extra.....</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>i) Restricted to practitioners with a subspecialty in Behavioral Neurology.</li> <li>ii) Payable for documented MMSE or MOCA or similar standardized cognitive assessment.</li> </ul>	132.00	50.92

*(notes continued on next page)*

NEUROLOGY - Continued

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>iii) Limited to 2 assessments per patient per calendar year.</li> <li>iv) Limited to 40 assessments per practitioner per month.</li> <li>v) Minimum time between assessments is 4 months.</li> <li>vi) Payable only in addition to a consult or visit.</li> </ul>		
P00488 Detailed cognitive assessment – extra .....	132.00	50.92
NOTES:		
<ul style="list-style-type: none"> <li>i) Restricted to Neurologists.</li> <li>ii) Practitioners with a subspecialty in Behavioral Neurology must bill 00487.</li> <li>iii) Payable for documented MMSE or MOCA or similar standardized cognitive assessment.</li> <li>iv) Limited to 2 assessments per patient per calendar year.</li> <li>v) Limited to 24 assessments per practitioner per month.</li> <li>vi) Minimum time between assessments is 4 months.</li> <li>vii) Payable only in addition to a consult or visit.</li> </ul>		
P00491 Detailed Parkinson’s disease quantitative review for neurologists with a Movement Disorder (MD) fellowship – extra .....	150.00	65.50
NOTES:		
<ul style="list-style-type: none"> <li>i) Restricted to Neurologists with a fellowship in movement disorder.</li> <li>ii) Must be submitted with ICD9 for Parkinson’s disease (332) and include completion of a Parkinson’s Assessment Scale on a complex Parkinson’s patient.</li> <li>iii) Paid only in addition to a consult or visit.</li> <li>iv) Not payable on the same day with fee items 00487, 00488, 00900, 00901, 00902, 00441 and 40441 by the same practitioner.</li> <li>v) Limited to 2 assessments per patient per calendar year.</li> <li>vi) Limited to 24 assessments per practitioner per month.</li> <li>vii) Minimum time between assessments is 6 months.</li> </ul>		
P00492 Detailed Parkinson’s disease quantitative review – extra .	67.10	65.50
NOTES:		
<ul style="list-style-type: none"> <li>i) Restricted to Neurologists.</li> </ul>		

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>ii) Must be submitted with ICD9 for Parkinson’s disease (332) and include completion of a Parkinson’s Assessment Scale on a complex Parkinson’s patient.</li> <li>iii) Paid only in addition to a consult or visit.</li> <li>iv) Not payable on the same day with fee items 00487, 00488, 00900, 00901, 00902, 00441 and 40441 by the same practitioner.</li> <li>v) Limited to 2 assessments per patient per calendar year.</li> <li>vi) Limited to 4 assessments per practitioner per month.</li> <li>vii) Minimum time between assessments is 6 months.</li> </ul>		
<p>PG00460 Transfer of Care from Pediatrics – Extended Consultation: To consist of an examination, review of history, previous laboratory &amp; 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. ....</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>i) For patients 16 years to 21 years of age.</li> <li>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.</li> <li>iii) Paid once per patient in that patient’s lifetime.</li> <li>iv) Not paid with 00410, 00411, 00441, 40441, 00470, 00471, G00450 or 00457.</li> </ul>	961.00	388.18
<p><b><u>Continuing Care by Consultant:</u></b></p>		
00406 Directive care.....	85.00	72.24
00407 Subsequent office visit.....	88.20	70.60
00408 Subsequent hospital visit.....	66.00	71.80
00409 Subsequent home visit .....	131.00	41.02
00405 Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	268.00	81.88
NOTE: Claim must state time service rendered.		
P00457 Complex Care – Extended Visit – per 15 minutes or major portion thereof.....	90.70	36.88
<i>(see notes on next page)</i>		

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

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.

**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.....	465.00	179.27
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. ....	232.00	87.21
00476	Telehealth directive care .....	85.00	72.24
00477	Telehealth subsequent office visit.....	88.20	70.60
00478	Telehealth subsequent hospital visit.....	66.00	71.80
40441	Telestroke Consultation..... To consist of videoconference examination, review of history, laboratory, diagnostic imaging, and the rendering of a written report, including required BCSS registry data.	533.00	201.37

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. .... <i>(see notes on next page)</i>	267.00	100.19
-------	---	--------	--------

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

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.....	267.00	100.19
---	--------	--------

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.

*(notes continue on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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%		
Daily maximum per patient is six (6), unless note record indicates medical necessity for extended service.		
40444 Follow-up Telestroke ACVS relapse intervention, per ½ hour or major portion thereof .....	214.00	80.14
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.		

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
00441 Face to face ACVS Consultation .....	533.00	201.37
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.		
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.....	267.00	100.19
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 during the consultation.		
vii) Start and end times must be submitted with claim.		
viii) Restricted to Neurologists.		
ix) If billed in addition to 00441, paid at 100%.		
x) Daily maximum per patient is six (6), unless note record indicates medical necessity for extended service.		

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
00443 Face to face follow-up neurological clinical monitoring and treatment for persisting ACVS: <u>with</u> administration of tPA, per ½ hour or major portion thereof. ....	267.00	100.19
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 during the videoconference.		
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. ....	214.00	80.14
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.		
<i>(notes continued on next page)</i>		



**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

- 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 during the videoconference.
- 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.

**SPECIAL EXAMINATIONS**

00415	Electroencephalogram and interpretation .....	365.00	127.80
00416	Electroencephalogram - interpretation .....	74.50	49.18
00413	– technical fee .....	271.00	78.63
00417	Electrocorticography .....	846.00	229.48
00418	Intravenous activating agents given by a qualified electroencephalography .....	82.10	22.50
00419	Electroclinical detailed interpretation of a set of seizures .....	1471.00	405.04
00420	Short study of electroclinical interpretation of seizures - professional fee .....	750.00	208.56
00421	Electrocorticography with functional mapping in awake craniotomy .....	1702.00	494.52
00426	Electroencephalogram - sleep only..... NOTE: Not applicable to the segments of sleep, which may occur in the course of recording a standard EEG.	524.00	157.85
00427	– professional fee .....	126.00	42.56
00428	– technical fee .....	400.00	115.31

**DOPPLER ULTRASOUND**

PG00468	Neurology Outpatient Transcranial Doppler Ultrasound: To consist of static and dynamic insonation and definition of intracranial circulation, within 72 hours of stroke onset. This study is designed to assist with a CVA	295.00	118.86
	NOTES:		
	i) Restricted to Neurologists.		
	ii) Paid for outpatients at provincial stroke prevention clinics.		

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<ul style="list-style-type: none"> <li>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.</li> <li>iv) The physician must be present throughout the study.</li> <li>v) Start and end times must be entered on the patient's chart and on the claim.</li> <li>vi) Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation, as indicated by the clinical setting.</li> </ul>		
<p>PG00469 Neurology Outpatient Transcranial Doppler Ultrasound – Prolonged Study – per 15 minutes or greater portion thereof: To consist of prolonged study, which includes fitting of halo-type head brace or other device, and review of study.....</p>	73.70	29.71
<p>NOTES:</p> <ul style="list-style-type: none"> <li>i) Restricted to Neurologists.</li> <li>ii) Paid for outpatients at provincial stroke prevention clinics.</li> <li>iii) Paid after 45 minutes of G00468.</li> <li>iv) The physician must be present throughout the study.</li> <li>v) Start and end times must be entered on patient's chart and on the claim.</li> <li>vi) Paid to a maximum of 8 units per patient, per study.</li> <li>vii) Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation as indicated by the clinical setting.</li> </ul>		

## DIAGNOSTIC PROCEDURES

### ELECTRODIAGNOSIS

**Items Under:**

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

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<b>Bill According To:</b>		
S00900 Schedule A - extensive examination (8 or more items)....	465.00	121.85
S00901 Schedule B - limited examination (4 to 7 items).....	324.00	81.49
S00902 Schedule C - short examination (1 to 3 items).....	159.00	40.61
S00905 Daily measurements of nerve conduction thresholds in facial palsy .....	24.30	6.35
S00906 – maximum per course .....	161.00	44.15
S00922 Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests .....	168.00	57.26
S00923 Technical fee for electrodiagnostic testing .....	78.70	20.39
S00914 Insertion of sphenoidal electrodes temporal lobe epilepsy - E.E.G. recording .....	161.00	43.61
S00915 Intra-carotid injection of sodium amytal - speech localization test .....	357.00	98.01
S00926 Seizure activation with intravenous activating agents associated with insertion of sphenoidal and/or orbital electrodes .....	532.00	147.86
S00927 Decamethonium test - for attendance at and follow-up observation if necessary .....	152.00	34.34

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>MISCELLANEOUS</b>			
00424 Botulinum toxin injections .....	419.00	2	118.82
NOTE: Only applicable to cervical dystonia (spasmodic torticollis) in adults; adductor spasmodic dysphonia; jaw-closing oro-mandibular dystonia or hemifacial spasm; dynamic equines foot deformity due to spasticity in pediatric cerebral palsy patients, two years or older; and, focal spasticity, including the treatment of upper limb spasticity associated with strokes in adults.			
PG00462 Neurological Interpretation and written report of submitted x-ray films (including CT scan, TCD, MRI) – per case .....	129.00		52.48
<i>(see notes on next page)</i>			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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.

P00480 DMT (Disease Modifying Treatment) management for active inflammatory disease of the Central Nervous System (CNS).....	394.00	152.77
--	--------	--------

**NOTES:**

- i) Payable every 6 months to prescribing Neurologists responsible for continuing care of patients with active CNS inflammatory disease, who are on DMT's.
- ii) Under this code the prescribing Neurologist is responsible for all associated drug monitoring, drug related complication management and communication to the patient and care providers with respect to the particular drug.
- iii) Payable in addition to face-to-face services and physician-to-physician phone calls.
- iv) Includes organization of all treatment plans, drug initiation algorithms, medication review, MRI assessment and lab review (including CSF) if required.
- v) Includes monitoring of all investigations for subsequent 6 months, including imaging and lab work, and conversations with allied health professionals as required.
- vi) Maximum number of services payable per neurologist per month is 40.

**EVOKED RESPONSE PROCEDURES**

S00985 Brainstem auditory evoked response, supra threshold testing for integrity of brainstem function.....	212.00	48.66
S00986 Somatosensory evoked response - upper extremity ...	145.00	37.08

NEUROLOGY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
S00987 – upper and lower extremity.....	285.00		64.10

# NEUROSURGERY

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

**\* Items are operation only. Refer to Orthopaedic Preamble 1.**

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
03010 <b>Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, and a written report .....	433.00		172.86
03011 <b>Repeat or Limited Consultation:</b> 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 judgement of the consultant the consultative service does not warrant a full consultative fee .....	207.00		78.97
<b><u>Continuing Care by Consultant:</u></b>			
03007 Subsequent office visit .....	122.00		47.16
03008 Subsequent hospital visit.....	76.70		29.63
03009 Subsequent home visit .....	157.00		54.82
03005 Emergency visit when specially called (not paid in addition to out-of-office hour premiums).....	321.00		112.94
NOTE: Claim must state time service rendered.			
03315 Pre-Operative Assessment .....	400.00		172.86
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.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
03310 Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, and a written report.....	376.00		172.86
03312 Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.....	189.00		78.97
03317 Telehealth subsequent office visit.....	122.00		47.16
03318 Telehealth subsequent hospital visit.....	76.70		29.63
<b>CRANIAL NERVES</b>			
03101 Supra or infra orbital nerve avulsion.....	642.00	3	225.93
03102 Decompression of Gasserian ganglion.....	3390.00	8	1195.79
03103 Pre-ganglionic rhizotomy, 5th nerve.....	2941.00	3	1037.96
S03104 Percutaneous rhizotomy, 5th nerve.....	2907.00	3	1024.33
03106 Posterior fossa exploration with rhizotomy, 5th nerve...	4883.00	8	1722.07
03232 Microsurgical anastomosis of intracranial portion of cranial nerve in conjunction with other craniotomy - with graft (extra to craniotomy).....	2079.00		733.22
NOTE: 03232 includes harvesting of graft.			
03233 – without graft (extra to craniotomy).....	1273.00		449.18
<b>TRAUMA</b>			
03111 Elevation of simple depressed skull fracture.....	2069.00	5	729.98
03112 Elevation of compound depressed skull fracture.....	2694.00	6	1027.67
03113 – with repair of dura, debridement of cerebral laceration and sinuses.....	4232.00	8	1667.71
03110 Elevation or "attempted" elevation of depressed skull fracture in infant under the age of one year, by neurosurgeon, using vacuum extractor (operation only).....	403.00	6	142.29
03115 Exploration of subdural space for chronic subdural hematoma - unilateral or bilateral.....	2337.00	6	914.11
03116 Craniotomy for evacuation of intracranial hematoma (cerebral, subdural, extradural or abscess).....	4455.00	8	1719.76
03118 Craniotomy for repair of CSF leak.....	4569.00	8	1612.18
03119 Craniotomy for microvascular decompression of cranial nerve.....	5236.00	8	1999.53

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>CEREBRAL PROCEDURES</b>			
03094 Anterior decompressing craniovertebral junction, using operating microscope .....	8354.00	8	2947.49
Posterior decompression of Chiari malformation or foramen magnum:			
03095 – no dural repair.....	3917.00	8	1549.63
03096 – with dural repair .....	4654.00	8	1874.56
03097 – with fourth ventricular exploration .....	5388.00	8	2124.50
03121 Cranioplasty .....	2694.00	7	950.12
03145 – using autologous bone graft.....	3235.00	7	1141.20
03053 Craniotomy for combined plastic surgical/neuro-surgical cranioplasty (neurosurgical component) .....	1946.00	8	685.59
03122 Craniectomy for osteomyelitis or skull tumour.....	3008.00	7	1061.40
03123 – with cranioplasty .....	4232.00	7	1493.23
03320 Removal of skull tumour without craniectomy .....	1188.00	6	418.78
03124 Linear craniectomy or craniotomy for cranial stenosis - 1st suture .....	2929.00	7	1032.86
03127 Linear craniectomy or craniotomy for cranial stenosis - additional sutures to a maximum of 3 - each extra.....	721.00	7	253.50
03147 Cranial reconstruction for complex deformity in a child .	5890.00	8	2078.06
NOTE: 03147 requires that the procedure take place more than three (3) months after a previous cranial reconstruction procedure. The operation must be bilateral and involve at least two (2) of the major cranial vault bones, namely frontal, parietal and occipital bones.			
03120 Neurosurgical fee for facial craniotomy reconstruction..	3821.00	9	1347.34
03080 Bilateral orbital advancement -intracranial approach for correction of hypertelorism when done as a team procedure with a Neurosurgeon and Plastic Surgeon ...	5430.00	8	2235.25
03081 Unilateral orbital advancement - intracranial approach when done as a team procedure with a Neurosurgeon and Plastic Surgeon .....	5038.00	8	2073.65
03082 Bilateral orbital advancement – intracranial approach - when done as a team procedure with a Neurosurgeon and Plastic Surgeon .....	6741.00	8	2773.64
03146 Morcellation of skull for craniosynostosis .....	4949.00	8	1745.53
03125 Bilateral craniectomies for cranial expansion or delayed treatment of synostosis (patient must be older than one year) .....	5420.00	8	1913.31
03148 Forehead reconstruction, extra to linear craniectomies for craniosynostosis.....	809.00		285.85



NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Lateral canthal advancement or similar procedure for coronal synostosis:			
03137 – unilateral .....	3388.00	8	1195.69
03143 – bilateral .....	3631.00	8	1280.35
03126 Re-opening or removal of bone flap .....	1849.00	6	693.26
03128 Stereotactic biopsy for intracranial pathology via frame-based or frameless techniques .....	2578.00	7	1474.65
NOTE: Fee item 03189 is not payable in addition.			
Craniotomy:			
03129 – for tumour .....	4404.00	8	1701.87
03130 – for removal of extra-axial brain tumour using operating microscope when procedure is prolonged more than 8 hours (to include operative report) .....	11542.00	8	4490.32
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
03135 Craniotomy or laminectomy using operating microscope when procedure is prolonged more than 8 hours (to include operative report) .....	10019.00	9	3924.59
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
03222 Craniotomy lasting more than 12 hours and requiring operating microscope .....	15132.00	9	5337.81
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 assistance fees.			
iv) Other surgical specialists required because of their specific expertise should claim separately in accordance with Preamble Clause D. 5. 3.) of the Guide.			
03066 – for microsurgical resection of extra-axial tumour, extra to 03222, per hour or major portion thereof, after 12 hours .....	548.00		193.16
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			

NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
03133 Craniotomy for removal of extra-axial brain tumour using operating microscope.....	8249.00	8	2909.46
NOTE: May be billed as the neurosurgical portion of a team procedure with fee item 02610 when done for extra-axial skull based procedures.			
03114 Craniotomy and microsurgical removal of tumour of ventricle, brain stem, thalamus, hypothalamus, or basal ganglia .....	8249.00	8	2909.46
03131 Transsphenoidal removal of pituitary tumour or hypophysectomy - one surgeon .....	5734.00	8	2022.48
03132 – two surgeons, Neurosurgeon .....	4155.00	8	2019.98
02437 – two surgeons, Otolaryngologist.....	2220.00	8	1233.76
03055 Craniotomy with microsurgical cortical resection for epilepsy, under general anesthesia.....	6438.00	6	2474.42
03056 Craniotomy with microsurgical cortical resection for epilepsy, in awake patient .....	7958.00	6	3249.23
03057 Craniotomy with cortical resection for epilepsy .....	4648.00	8	2149.49
03058 Hemispherectomy .....	6340.00	8	2235.64
03059 Craniotomy and microsurgical hemispherotomy for epilepsy .....	7350.00	8	2592.93
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.			
03235 Intraoperative cortical localization SSEP or stimulation, under general anesthesia (extra to craniotomy) .....	669.00		235.48
03236 Insertion of subdural strip electrodes - unilateral (epilepsy surgery, to include burrhole(s)) .....	3117.00	8	1099.02
03237 Removal of subdural strip electrodes - unilateral.....	1336.00	6	471.01
03238 Cortical or deep brain localization with SSEP or stimulation in an awake patient (extra to craniotomy)....	1336.00		471.01
03239 Craniotomy and insertion of subdural grid electrodes with or without additional strip electrodes - unilateral ....	4155.00	7	1465.22
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 .....	2239.00	6	789.19
NOTE: Isolated procedure - not payable in addition to other epilepsy surgical listings.			

NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
03144 Section of corpus callosum .....	5669.00	8	1998.14
03136 Craniotomy for intracranial aneurysm or angioma .....	6903.00	9	2435.78
03138 Unilateral stereotaxic intracranial procedures .....	3388.00	7	1195.69
03189 Stereotactic localization during neurosurgery in association with craniotomy and spinal fusion/stabilization procedures - extra.....	1249.00		481.50
NOTE: Applicable to procedures involving cranium or spine.			
03139 Implantation of stimulator .....	1312.00	3	985.00
03140 Insertion of intracranial stimulating electrodes .....	4126.00	7	2450.00
Single Channel Neural Stimulator Implant Testing			
03274 Professional fee .....	107.00		46.08
03275 Technical fee .....	53.20		46.08
Dual Channel Neural Stimulator Implant Testing			
03276 Professional fee .....	160.00		69.11
03277 Technical fee .....	107.00		46.08
NOTES:			
i) Restricted to Neurosurgeons and Neurologists.			
ii) 03274, 03275, 03276 and 03277 is included on the same day and for six weeks post-operative of fee item 03140 whether performed by the same or different physician and at any location.			
03250 Microelectrode recording (MER) - electrophysiological (EP) mapping of the basal ganglia and thalamus, intra- operatively (extra) .....	8863.00		3127.23
03224 Neurosurgical component of microsurgical removal of cerebellar pontine angle tumour.....	5345.00	8	1885.07
NOTE: Not billable for exposure only.			
03221 Implantation of vagal nerve stimulator - to include electrodes and stimulator .....	1382.00	4	531.34
03223 Replacement of stimulator component of vagal nerve stimulator .....	918.00	3	221.49
03225 Removal of vagal nerve stimulator and electrodes .....	1034.00	4	391.52

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Ventriculoscopic Procedures:</b>			
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 Fee Guide (i.e. 50%).			
03030	Ventriculoscopy .....	2385.00	6 840.73
03031	Ventriculoscopy, third ventriculostomy .....	3659.00	6 1324.72
03032	Ventriculoscopy/endoscopy biopsy of intraventricular or intracranial lesion .....	3659.00	6 1909.66
03033	Ventriculoscopic retrieval of foreign body .....	3659.00	6 1638.85
03034	Ventriculoscopy and fenestration of cyst or septum pellucidum, or lysis of adhesions.....	3659.00	6 1475.45
03035	Ventriculoscopic resection of intraventricular tumour ....	7304.00	6 2576.95
03036	Ventricular shunt with ventriculoscopic guidance .....	3049.00	6 1074.87
S03037	Removal of ventricular shunt (operation only) .....	776.00	6 288.15

**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	812.00	6 380.65
-------	--	--------	----------

**NOTES:**

- i) Restricted to Neurosurgeons.
- ii) Paid only in addition to 03181, 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.

**SKULL BASE PROCEDURES**

02262	Translabyrinthine approach for neurosurgical access - exposure, closure with microscope .....	4369.00	8 2429.48
02622	Infra-temporal fossa approach to skull base, Otolaryngology fee .....	7002.00	8 2224.40

NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02623 Infra-temporal fossa approach to skull base, Otolaryngology fee for procedure lasting longer than 8 hours.....	8752.00	8	2582.14
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.			
02612 Middle cranial fossa approach, petrosectomy .....	7002.00	8	1929.76
02613 Middle cranial fossa approach, petrosectomy - procedure lasting longer than 8 hours.....	8752.00	8	2412.08
NOTE: 02612 and 02613 to include exposure, extra-dural removal and closure with microscope.			
02610 Middle cranial fossa approach without petrosectomy for trauma, neoplasm resection, nerve section/decompression .....	4369.00	8	1440.32
NOTES:			
i) To include exposure, removal and closure with microscope.			
ii) May include extra-dural resection of lesion by Otolaryngologist.			
02614 Retrolabyrinthine approach for neurosurgical access - exposure, closure with microscope .....	4369.00	8	2206.00
02618 Repair of CSF leak following skull base approach with mastoid obliteration - to include exposure, dissection and closure with microscope.....	3500.00	8	1400.00

**CRANIAL PROCEDURES**

03065 Neurosurgical component of cranial facial resection for tumour of ethmoid, frontal sinus or orbit, as a combined procedure with ENT. (See also fee item 02280).....	4648.00	7	1639.46
NOTE: Not billable for exposure only.			

**EXTRA-CRANIAL VASCULAR PROCEDURES**

03141 Cerebral re-vascularization procedure with extracranial-intracranial anastomosis.....	5308.00	9	1872.19
03142 Application of Silverstone clamps (operation only).....	1592.00	5	561.66

**SPINE**

**Miscellaneous**

03152 Bischoff's or longitudinal myelotomy .....	2655.00	5	936.10
03176 Cordotomy, percutaneous.....	2792.00	4	984.04

NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
03177 Cordotomy.....	2244.00	5	791.17
03178 Operative microsurgical rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic.....	2643.00	5	932.43
NOTE: Restricted to Neurosurgery and Orthopaedic Surgery.			
03108 Operative facet rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic .....	2069.00	4	450.00
NOTE: Restricted to Neurosurgery and Orthopaedic Surgery.			
03150 Laminectomy for selective posterior rhizotomy .....	3561.00	5	1256.01
03153 Laminectomy, with DREZ lesion for pain.....	3997.00	6	1408.69
03155 Laminectomy for hematoma, tumour or vascular malformation.....	2689.00	6	948.86
03160 Laminectomy for congenital spinal malformation or tethered spinal cord.....	3854.00	5	2027.87
03168 Laminectomy for intradural spinal cord or extra- medullary tumour or vascular malformation by microsurgical technique.....	5160.00	7	2013.98
S03165 Insertion of intracranial pressure monitoring device, operation only.....	844.00	6	296.11
S03167 Insertion of skull tongs (operation only) .....	362.00	4	126.29
03169 Fracture of spine without cord injury, open reduction and fusion.....	1948.00	7	686.74
03170 – in conjunction with Orthopaedic Surgeon (operation only).....	1843.00		649.23
03172 Fracture of spine with cord injury, open reduction and fusion.....	2657.00	7	937.07
03173 – in conjunction with Orthopaedic Surgeon (operation only).....	1843.00		649.23
03183 Microsurgical repair of meningomyelocele .....	4977.00	6	1754.52
03175 Repair of meningocele or encephalocele .....	2837.00	6	1001.39
03215 Insertion of spinal subarachnoid catheter (operation only) .....	134.00	2	46.62
03218 Replacement of spinal subarachnoid catheter access device with infusion pump for spinal subarachnoid infusion (operation only).....	1312.00	3	462.00
03219 Insertion of spinal subarachnoid device-reservoir in paraspinal region (operation only).....	1110.00	3	391.54
NOTE: 03219 to include insertion of spinal subarachnoid catheter.			

NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
03220 Insertion of spinal subarachnoid catheter access device-reservoir/pump in anterior chest wall or abdominal wall (operation only) .....	1776.00	3	626.46
NOTE: 03220 to include insertion of spinal subarachnoid catheter.			
03231 Repair of spinal CSF leak or pseudo-meningocele .....	1699.00	5	598.96
03301 Laminotomy for insertion of spinal stimulator electrode for chronic pain (operation only).....	798.00	5	472.93
03302 Percutaneous fluoroscopically controlled insertion of spinal stimulator electrode for chronic pain (operation only) .....	453.00	2	353.75
03303 Implantation of pulse generator or receiver for chronic pain stimulation (operation only) .....	1023.00	3	605.71
03304 Implantation of spinal stimulator (complete system), to include implantation pulse generator/receiver, using percutaneous electrode (operation only).....	1438.00	3	851.71
03305 Implantation of spinal stimulator (complete system), to include implantation of pulse/generator receiver - using laminotomy electrode (operation only).....	1607.00	5	951.90
03306 Revision of spinal/cranial stimulator pulse generator ....	1023.00	3	605.71
03307 Removal of spinal/brain stimulator system.....	679.00	3	400.79
03368 Discogram (operation only) .....	363.00	2	92.97
03369 Abscess or hematoma, extraspinal, under GA (operation only) .....	720.00	4	186.72
03361 Percutaneous discectomy .....	1048.00	3	270.75
03367 Removal of spinal instrumentation .....	1983.00	5	513.50

**CERVICAL**

**Decompression Procedures**

Laminectomy for cervical disc:

03156 – one level .....	2089.00	6	1524.64
03157 – multiple levels .....	2292.00	6	1874.56
03180 Multiple level laminectomy for cervical cord compression - three or more levels.....	3704.00	6	1430.75
Anterior cervical discectomy and fusion:			
03163 – one level .....	2292.00	6	1429.88
03164 – multiple levels .....	2921.00	6	1936.16
03362 Cervical - single level .....	2417.00	6	625.53
03363 Cervical - two or more levels .....	3118.00	6	807.58

**Vertebral Body Resection**

03365 Cervical.....	6304.00	6	1633.84
---------------------	---------	---	---------

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)	
<b>Instrumented Procedures</b>				
<b>Stabilization - Anterior:</b>				
03347	Cervical - stabilization alone (with Neurosurgeon) .....	1948.00	6	504.14
03348	Cervical - with plates and discectomy .....	3822.00	6	1574.63
03349	Cervical - with plates and vertebrectomy.....	6834.00	6	1769.22
<b>Stabilization - Posterior:</b>				
03340	Cervical - simple, single or multiple level (includes Gallie fusion) .....	2090.00	6	541.49
03341	Cervical segmental (includes C1-2 transarticular screws).....	4201.00	6	1087.67
<b>Posterior Osteotomy with Instrumentation:</b>				
03354	Cervical .....	9448.00	6	2446.08
<b>Cervical</b>				
03358	ORIF.....	3895.00	7	1008.32

**THORACIC**

<b>Decompression Procedures</b>				
03166	Removal of thoracic disc.....	2445.00	8	2349.45
03185	Postero-lateral microsurgical thoracic discectomy.....	3657.00	8	1915.56
03174	Trans-thoracic or trans-abdominal removal of thoracic disc, team procedure, Neurosurgeon .....	3512.00	8	1239.79
03179	– Chest Surgeon or General Surgeon.....	1335.00	8	470.49

**THORACOLUMBAR**

<b>Decompression Procedures</b>				
Laminectomy for lumbar disc:				
03158	– one level .....	1738.00	5	670.94
03159	– multiple levels .....	1893.00	5	1333.43
03161	Laminectomy for localized spinal stenosis - two levels or less.....	2018.00	5	789.13
03162	Laminectomy for generalized spinal stenosis - more than two levels.....	3143.00	5	1213.99
Posterior lumbar interspinous/interlaminar stabilization/instrumentation (extra):				
P03371	– Single level (extra) .....	673.00		201.50



NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
P03372 – Multiple level (extra).....	1345.00		403.00
NOTES:			
i) Paid only in addition to 03158, 03161 or 03162.			
ii) Restricted to Neurosurgery and Orthopaedic Surgeons.			
 <b>Decompression - Anterior</b>			
Discectomy with or without fusion:			
03364 Thoracolumbar, includes decompression.....	5569.00	8	1442.43
Vertebral body resection:			
03366 Thoracolumbar.....	7358.00	8	1904.58
 <b>Instrumented Procedures</b>			
Anterior Release/Osteotomy:			
03352 Thoracolumbar.....	5569.00	8	1442.43
03353 Thoracolumbar - with anterior instrumentation and correction .....	6615.00	8	1713.19
03351 Thoracolumbar - instrumentation with anterior release or vertebrectomy .....	7880.00	8	2449.42
NOTE: 03350 and 03351 are payable in full when done in conjunction with posterior instrumentation and fusion.			
Posterior Instrumentation and Fusion:			
03356 Adult.....	6834.00	7	1769.22
03357 Pediatric.....	5569.00	7	1442.43
Thoracolumbar:			
03359 ORIF with segmental fixation alone .....	5045.00	7	1307.07
03360 ORIF with segmental fixation and decompression .....	6092.00	7	1577.82
03342 Thoracolumbar - without instrumentation.....	1896.00	5	490.15
03343 Thoracolumbar - simple instrumentation (Harrington, wires or screw, etc.).....	2990.00	7	774.90
03350 Thoracolumbar - approach and stabilization alone (with Neurosurgeon) .....	3674.00	8	952.30
03344 Thoracolumbar - segmental instrumentation and spinal fusion .....	4833.00	7	1251.05
03345 Thoracolumbar - segmental instrumentation and fusion with decompression - single level.....	6092.00	7	2058.13
03346 Thoracolumbar - multiple levels .....	7135.00	7	2411.31

NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
PC03355 Thoracolumbar Spinal Fusion – including posterior osteotomy via Smith-Peterson, pedicle subtraction or vertebral column resection with fusion of greater than four (4) vertebral segments .....	9448.00	7	3526.25
NOTE: Restricted to Neurosurgery and Orthopaedic Surgeons.			
P03370 Thoracolumbar Spinal Fusion (lasting longer than 6 hours) – per 15 minutes or greater portion thereof (maximum of 16 units per patient).....	170.00		50.79
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.			
Posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF) (extra):			
P03373 Single level (extra).....	1345.00		403.00
P03374 Multiple level (extra) .....	2017.00		604.50
NOTES:			
i) Paid only in addition to 03345, 03346, 03355, 03356 or 03357.			
ii) Restricted to Neurosurgery and Orthopaedic Surgeons.			

**HYDROCEPHALUS**

03181 Shunt for ventricular obstruction.....	2867.00	6	1011.31
03182 – revision .....	2867.00	6	1011.31
03184 Lumbar peritoneal shunt for hydrocephalus .....	2867.00	5	1011.31
S03188 Ventriculostomy or insertion of external ventricular drain (operation only) .....	820.00	6	289.44
S03240 Implantation of totally implantable ventricular access device (e.g.: Ommaya reservoir), (operation only) .....	1331.00	6	467.81
NOTE: S03240 not to be used for external ventricular drain.			
S03216 Puncture of ventricular shunt for CSF aspiration (operation only) .....	104.00	2	36.20
S03217 Percutaneous ventricular puncture (operation only) .....	368.00	2	129.36

**PERIPHERAL NERVE**

S03196 Exploration, mobilization and transposition .....	798.00	2	281.48
03198 Neurectomy of major nerve .....	628.00	2	222.43

NEUROSURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
03200 Secondary suture including transposition.....	1631.00	3	575.24
03201 Secondary suture of major nerve .....	1244.00	3	437.73
03204 Hypoglossal facial anastomosis .....	1934.00	4	681.78
03205 Nerve graft .....	1221.00	3	431.81
03207 Microsurgical removal of neoplasm - major peripheral nerve .....	2313.00	3	815.19
<b>Brachial Plexus Surgery:</b>			
03045 Brachial plexus exploration for neurolysis, primary repair or tumour removal.....	2751.00	3	1500.00
03046 Post traumatic delayed or repeat exploration in brachial plexus surgery (extra).....	684.00	3	550.00
03047 Intraoperative diagnostic monitoring in brachial plexus surgery (extra).....	606.00		213.42
03048 Nerve graft done in addition to brachial plexus exploration - extra per graft.....	552.00		194.02
NOTE: Includes harvesting of graft.			
03049 Neurotization in brachial plexus surgery (extra).....	1283.00		452.71

**VERTEBRA, FACET AND SPINE**

**Incision - Therapeutic, Percutaneous:**

*58205 Injection/aspiration facet joint.....	363.00	2	92.97
--	--------	---	-------

**Excision - Diagnostic, Percutaneous:**

Needle biopsy, soft tissue/bone:

S11831 – lumbar spine, under general anesthesia.....	720.00	2	186.72
S11830 – thoracic spine, under general anesthesia .....	830.00	2	214.73

**Excision - Diagnostic, Open:**

11845 Biopsy, with general anesthesia.....	938.00	3	242.74
--	--------	---	--------

NOTE: Not payable with definitive spinal surgery.

**Fracture and/or Dislocation (Cervical Spine):**

**Cervical:**

*58710 Application of halo.....	720.00	4	186.72
---------------------------------	--------	---	--------

**MICROSURGERY**

**Microneural Surgery:**

Neurolysis:

06210 – external.....	1146.00	2	288.08
06211 – intraneural.....	1747.00	2	438.94
Microfascicular neurorrhaphy, primary:			
06212 – digital or palmar .....	1146.00	2	288.08
06213 – major nerve.....	2444.00	2	614.93

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Interfascicular nerve graft (to include harvest of graft):			
06214 – digital or palmar .....	1716.00	2	533.59
06215 – major nerve .....	4998.00	4	1600.00

**MISCELLANEOUS**

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% of the listed fee may be claimed for qualifying procedures, under fee item 03230.
- iii) Applicable only to the following neurosurgical procedures:

Cranial:

- Re-operation for residual or recurrent brain tumour.

Spinal:

- Re-operation for residual or recurrent spinal tumour (intradural or extradural).
- Re-operation for recurrent lumbar disc or spinal stenosis.
- Spinal re-operation for tethering of myelomeningocele, or lipomyelomeningocele.

iv) Not applicable to shunt revisions or reopening of cranial wound for removal of bone flap.

v) Not applicable to fee items 03130 or 03135.

03211 Muscle biopsy.....	159.00	2	55.80
03227 Neurosurgical interpretation and written report of submitted x-ray films (including CT scan, MRI) .....	137.00		59.43

NOTE: Not payable in addition to a consultation rendered within 2 months (+/-) on the same patient on referral by the same physician.

**PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS**

**(When performed for diagnostic purposes)**

SY00750 Lumbar puncture in a patient 13 years of age and over.....	209.00	2	54.99
--	--------	---	-------

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

# OBSTETRICS AND GYNECOLOGY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
04010 <b>Consultation:</b> To include complete history and gynecological examination, review of x-ray and laboratory findings, if required, and a written report or consultation during labour.....	485.00		140.70
04012 <b>Repeat or Limited Consultation:</b> 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 judgement of the consultant the consultative services do not warrant a full consultative fee .....	243.00		77.25
<b><u>Continuing Care by Consultant:</u></b>			
04007 Subsequent office visit (for gynecology visits only, all pregnant patients and routine pre-natal patients billed under fee item 14091).....	106.00		48.22
04008 Subsequent hospital visit .....	79.20		48.22
04009 Subsequent home visit.....	179.00		116.08
04005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	386.00		127.37
NOTE: Claim must state time service rendered.			
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
04070 Telehealth Consultation: To include complete history and gynaecological examination, review of X-ray and laboratory findings, if required, and a written report or consultation during labour.....	485.00		140.70
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.....	243.00		77.25
04077 Telehealth subsequent office visit (for gynecology visits only.) .....	106.00		48.22
04078 Telehealth subsequent hospital visit .....	79.20		48.22

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**OBSTETRICAL PROCEDURES**

04038 Repeat intrapartum assessment by consultant at request of primary care physician.....	668.00	222.21
---	--------	--------

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.....	2210.00	667.15
---	---------	--------

NOTES:

- i) Requires completion of written record
- ii) Payable only after at least one hour of attendance at bedside
- iii) Start and end times must be entered in both the billing claims and the patient's chart.
- iv) Not payable with 04038, 04050, 14104, 14109, or 14199
- v) Payable x 1 only, regardless of multiple gestation
- vi) Payable only for the following conditions:
  - 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

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<u>Placental or amniotic fluid conditions:</u>			
(a) Placental abruption			
(b) Severe oligohydramnios (AFI<6)			
(c) Severe polyhydramnios (AFI>25)			
<u>Maternal Conditions:</u>			
(a) Cardiovascular disease where the management of labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction, severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrhythmia requiring pharmacological treatment, any lesion with pulmonary hypertension or ventricular dilatation).			
(b) Renal disease (e.g.: renal failure, renal transplant)			
(c) Pulmonary disease (e.g.: pulmonary fibrosis, severe asthma, cystic fibrosis)			
(d) Endocrine disease (e.g.: Addison's disease, clinical hyperthyroidism, Type 1 Diabetes Mellitus)			
(e) Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia)			
(f) Infectious disease (AIDS, severe pneumonia, systemic sepsis)			
(g) Severe pre-eclampsia (attempt made to deliver vaginally)			
(h) Maternal obesity – BMI > 40			
14091 Prenatal visit - subsequent examination .....	83.70		31.62
NOTES:			
i) Uncomplicated pre-natal 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 written explanation.			

*(notes continued on next page)*

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

- ii) Where a patient transfers her total on-going uncomplicated pre-natal care to another physician, the second physician also may charge a complete examination (item 14090) 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, etcetera, should not be considered as a patient transfer.
- iii) Other than during pre-natal or post-natal visits, it is proper to charge separately for all visits, (including counseling) 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.
- iv) Other than procedures, services for the care of unrelated conditions, during a pre-natal or post-natal visit are included in the pre-natal (14091) or post-natal visit fee (14094), and are not to be billed under fee item 04007. Procedures rendered for unrelated conditions are chargeable as set out in Preamble D. 8. d.

PG04717	Prenatal office visit for complex obstetrical patient.....	116.00	46.89
---------	--	--------	-------

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

*(notes continued on next page)*



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<p>(b) Maternal conditions:</p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• Renal disease (e.g.: renal failure, renal transplant)</li> <li>• Endocrine disease (e.g.: Addison's disease, clinical hyperthyroidism, Type 1 Diabetes Mellitus)</li> <li>• Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia)</li> <li>• Infectious disease (HIV, severe pneumonia, systemic sepsis)</li> </ul>			
<p>(c) Pulmonary disease (e.g.: pulmonary fibrosis, severe asthma, cystic fibrosis)</p>			
<p>(d) <u>Pregnancy qualifying conditions:</u> hypertension on medication, IUGR with growth less than 10%, oligohydramnios AFI less than 8, hydramnios AF1 greater than 23, Type 1 Diabetes Mellitus.</p>			
<p>(e) <u>Current pregnancy conditions:</u> preterm labour, cervical incompetence, or abruption occurring in this pregnancy; (the high risk antenatal visit fee reverts to 14091 after 36 weeks gestation).</p>			
<p>(f) <u>Previous pregnancy conditions:</u> 2 preterm births, or 1 previous preterm birth less than 30 weeks (reverts to 14091 after 36 weeks gestation).</p>			
<p>ii) Restricted to Obstetrics and Gynecology specialists.</p>			
PG04718	Care of complex antepartum patient prior to transfer to higher level of care facility for delivery .....	695.00	280.53
<p>NOTES:</p>			
<p>i) Restricted to Obstetrics and Gynecology specialists.</p>			
<p><i>(notes continued on next page)</i></p>			

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
ii) Not paid with 04038, 04039, 04025, 04050, 04052, 14104, 14105.			
iii) Start and end times required in claim submission and patient's chart.			
iv) Paid only when time spent stabilizing patient by obstetrician exceeds 60 minutes, and patient is transferred to a higher level of care.			
v) Payable on the same date as a GP is paid for 14105.			
vi) Payable for pre-eclampsia, preterm labour, and for serious maternal condition(s) that requires stabilization prior to transfer.			
14104 Delivery and post-natal care (1-14 days in-hospital).....	1401.00		584.78
NOTES:			
i) Care of new-born in hospital (see fee item 00119).			
ii) Repair of cervix is not included in fee item 14104. Charge 50% of listed fee when done on same day as delivery.			
iii) When medically necessary additional post-partum office visit(s) are payable under fee item P14094.			
P14094 Post-natal office visit.....	83.70		31.62
NOTE:			
i) P14094 may be billed in the six weeks following delivery (vaginal or Caesarean Section)			
ii) Not payable to physician performing Caesarean Section			
14199 Management of prolonged second stage of labour, per 30 minutes or major portions thereof.....	221.00		84.94
NOTES:			
i) This item is billable in addition to fee item 14104, only when the second stage of labour exceeds two hours in length.			
ii) Not billable with 04000, 04014, 04017, 04018 or 04085.			
iii) Timing ends when constant personal attendance ends, or at the time of delivery.			
04085 Trial of Forceps/Vacuum Delivery.....	614.00	4	211.95
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.			

(notes continued on next page)

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
iv) Not payable with complicated delivery fees 04000, 04017 or 04018 (for single births).			
v) Maximum of one payable per pregnancy.			
04000 Complicated vaginal delivery - includes shoulder dystocia, premature delivery less than 37 weeks or less than 2500 grams (operation only).....	1048.00	4	341.16
NOTES:			
i) Complicated delivery fees will be paid at 50% when 14104 is payable to the same physician.			
ii) Only one of fee items 04014, 04017, 04018 or 04000 is payable at any one time (for single births).			
04014 Complicated delivery - midcavity surgical delivery (operation only).....	1319.00	4	427.12
04017 Midcavity rotation from OP or OT to OA, surgical delivery (operation only) .....	1561.00	4	505.20
04018 Breech vaginal birth (operation only).....	1561.00	4	505.20
NOTE: Fee item 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%.			
04022 Repair of complete separation of external sphincter (operation only).....	659.00	3	215.03
NOTE: Not paid in addition to 04024.			
04023 Repair of extensive cervical and/or vaginal lacerations (operation only).....	659.00	3	215.03
NOTE: Not paid in addition to 04022 and 04024.			
04024 Repair of 4th degree laceration (operation only).....	792.00	3	257.41
04026 Manual removal of retained placenta (operation only) ..	659.00	3	215.03
04049 External cephalic version .....	377.00		123.88
NOTE: Administration of IV tocolytic agent and fetal heart monitoring included.			
04116 Curettage for post-partum hemorrhage (>20 weeks)....	541.00	3	177.20
Multiple births, each additional child:			
04092 – natural birth .....	492.00		161.31
04093 – Caesarean section.....	246.00		82.15
NOTE: Fee item 04093 is to be billed in full in addition to fee items 04025, 04050, 04052 or 04106.			
14108 Post-natal care after elective Caesarean section (1-14 days in-hospital).....	288.00		120.31
NOTE: When medically necessary additional post-partum office visit(s) are payable under fee item P14094.			

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
14109 Primary management of labour and attendance at delivery and post-natal care associated with emergency Caesarean section (1-14 days in-hospital)..	1167.00		487.10
NOTES:			
i) Surgical assistant is extra to fee item 14108 and 14109.			
ii) When medically necessary additional post-partum office visit(s) are payable under fee item P14094.			
04107 Supervision of labour and vaginal delivery in a case of previous Caesarean section - operation only .....	404.00		133.01
NOTE: Fee item 04107 is a standby fee only and is not payable in addition to delivery fees 14104, 04000, 04014, 04017, 04018, 04050, 04052 and 04025.			
Caesarean section:			
04050 – elective .....	1490.00	5	483.59
04052 – emergency .....	1669.00	6	540.18
04025 – high risk, fetus less than 1500 grams .....	1935.00	6	625.07
04106 Caesarean hysterectomy.....	2283.00	8	738.21
Therapeutic abortion (vaginal) by whatever means:			
04111 – less than 14 weeks gestation (operation only) .....	439.00	2	150.00
04110 – 14 -18 weeks gestation (operation only) .....	615.00	2	200.90
PG04716 Obstetrical surcharge therapeutic abortion (D&E) at 14 to 18 weeks (extra).....	153.00		61.48
NOTE: Paid only with 04110.			
04114 Therapeutic abortion by D & E, 18 weeks and over ( <i>operation only</i> ) .....	861.00	3	280.06
PG04715 Obstetrical surcharge therapeutic abortion (D&E) at 18 weeks and over (extra).....	204.00		81.97
NOTES:			
i) Paid only with 04114.			
ii) Restricted to Obstetrics and Gynecology specialists.			
S04080 Insertion of Multiple Osmotic Dilators with Paracervical Block, prior to second trimester pregnancy termination.	412.00		141.36
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.			

(notes continued on next page)

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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.			
04118 Induction or stimulation of labour by oxytocin intravenous drip, where attendance by the physician is readily available - first hour .....	121.00		41.98
04119 – subsequent hours .....	80.90		28.93

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.

**ABDOMINAL OPERATIONS**

04228 Hysterectomy - total .....	1935.00	5	655.21
NOTE: Includes salpingectomy/oophorectomy (04003), ovarian cystectomy (04201) and abdominal enterocele repair.			
04229 Removal of complicated pelvic disease .....	1935.00	6	655.21
04204 Abdominal hysterotomy, with or without sterilization.....	1053.00	5	358.76
04203 Myomectomy .....	1319.00	5	447.72
04208 Ectopic pregnancy removal by salpingotomy or salpingectomy (open procedure) .....	1316.00	5	446.24
04206 Suspension of uterus .....	706.00	4	240.19
04230 Sterilization - abdominal open .....	880.00	4	299.44
04216 Presacral neurectomy .....	1232.00	5	418.08
04217 Post-operative hemorrhage - intra-abdominal management.....	1053.00	6	358.76
04003 Oophorectomy and/or salpingectomy (unilateral or bilateral).....	1053.00	5	358.76
04201 Ovarian cystectomy (to include ovary repair) .....	1319.00	5	447.72
04605 Vault prolapse - abdominal approach (includes oophorectomy when applicable) .....	1741.00	5	655.21
P04141 Insertion of intra-peritoneal catheter for chemotherapy under general anesthetic .....	914.00	4	320.00

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

NOTES:

- i) Restricted to Obstetrics and Gynecology specialists.
- ii) Includes fee item 04001.

P04142 Removal of intra-peritoneal catheter for chemotherapy.	400.00	3	140.00
---	--------	---	--------

NOTES:

- i) Restricted to Obstetrics and Gynecology specialists.
- ii) For removal of catheter not requiring surgical dissection, use visit fees.

**SURGICAL FEE MODIFIERS**

PG04708 Prolonged laparoscopic surgery, per 15 minutes or major portion thereof (extra) .....	177.00		71.72
---	--------	--	-------

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 laparoscopic surgical procedures when surgical time exceeds 2 hours.
- v) Not payable if multiple surgical procedures are billed.
- vi) Start and end times (for total time of surgery) must be entered on the claim and in the patient's chart.

PG04714 Prolonged surgery – Open procedure per 15 minutes or major portion thereof (extra) .....	177.00		71.72
--	--------	--	-------

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).

*(notes continued on next page)*

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>v) When an open case results from conversion of a laparoscopic procedure, G04714 is paid after 2 hours total surgical time.</li> <li>vi) Start and end times (for total time of surgery) must be entered on the claim and patient's chart.</li> </ul>			
PG04719 Gynecology surgical surcharge for patients 75 years and older.....	160.00		64.05
NOTES:			
<ul style="list-style-type: none"> <li>i) Restricted to Obstetrics and Gynecology specialists.</li> <li>ii) Fee item G04719 will only be paid once whether single or multiple procedures are performed under the same anesthetic.</li> <li>iii) Paid with the following surgical procedures: 04701, G04702, G04703, G04704, G04705, G04706, C04707, C04709, 00704, 00705, 00807, 00808, 00874, 00875, 00878, 04001, 04003, 04011, 04029, 04032, 04033, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04201, 04202, 04203, 04204, 04206, 04212, 04217, 04218, 04219, 04220, 04221, 04222, 04223, 04224, 04225, 04227, 04228, 04229, 04230, 04232, 04233, 04301, 04303, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 4401, 04402, 04405, 04406, 04408, 04410, 04411, 04421, 04422, 04424, 04427, 04429, 04500, 04502, 04503, 04508, 04509, 04510, 04512, 04515, 04516, 04517, 04530, 04531, 04536, 04551, 04602, 04605, 04620, 04621, 04622, 04623, 04624, 04625, 04626, 04627, 04628, 04660, 04662, 06063, 07027, 07597, 07634, 08178, 08250, 08254, 08255, 08257, 08263, 08278, 08282, 08283 or 70120.</li> <li>iv) Applies to procedures performed in hospital operating room, ambulatory care or office setting.</li> </ul>			

**ABDOMINAL OPERATIONS FOR CANCER**

04011 Debulking operation for cancer of ovary or fallopian tubes.....	2634.00	6	892.35
NOTES:			
<ul style="list-style-type: none"> <li>i) Excluding stage one disease.</li> <li>ii) Includes omentectomy and hysterectomy if done.</li> </ul>			
04218 Radical abdominal hysterectomy for carcinoma, including partial vaginectomy.....	2893.00	6	981.28

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
04212 Pelvic lymphadenectomy.....	1754.00	6	595.90
Para-aortic lymphadenectomy:			
04219 – total .....	1754.00	6	595.90
04220 – partial .....	773.00	5	263.91
04029 Omentectomy and/or removal of extra pelvic soft tissue mass, 5 -10 cm.....	1053.00	5	358.76
NOTE: Not billed in addition to 04011.			
04628 Removal of extra pelvic soft tissue mass, greater than 10 cm.....	1402.00	5	477.33
P04630 Sentinel lymph node biopsy vulva (SLN-V) – unilateral.	1371.00	3	474.13
P04631 Sentinel lymph node biopsy vulva (SLN-V) – bilateral...	2057.00	3	711.19
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.			
PC04640 Laparoscopic Sentinel lymph node biopsy (SLN-L) – unilateral.....	1371.00	3	474.13
PC04641 Laparoscopic Sentinel lymph node biopsy (SLN-L) – bilateral.....	2057.00	3	711.19
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.			

**HYSTEROSCOPY – SURGICAL**

**Hysteroscopic Division of Intrauterine Adhesions (IUA).**

NOTE: Billable only for patients with menstrual disturbance, infertility or recurrent pregnancy loss.

Hysteroscopic division of intrauterine adhesions:			
04221 – simple.....	573.00	2	196.95
NOTE: Intended for procedures performed under direct vision, but less than 1/2 of uterine cavity involved with IUA.			
04222 – complicated.....	967.00	2	328.58
NOTE: Intended for procedures performed under direct vision using either operative hysteroscope and hysteroscopic scissors or rectoscope, and more than 1/2 of uterine cavity involved with IUA.			



OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
04223 Resection of myoma - includes diagnostic hysteroscopy.....	1338.00	2	455.19
NOTE: Billable only when done under direct vision.			
04224 Endometrial ablation - includes diagnostic hysteroscopy.....	1338.00	2	455.19
04225 Hysteroscopic division of uterine septum.....	967.00	2	328.58
04226 Hysteroscopic tubal occlusion (bilateral).....	553.00		195.31

**OPERATIONS (VULVA)**

04300 Incision of hymen (operation only).....	123.00	2	150.00
04301 Excision or marsupialization of a Bartholin's cyst - operation only .....	350.00	2	150.00
04303 Excision of hydrocele or canal of Nuck .....	530.00	2	180.90
04304 Urethral caruncle - cautery or excision in hospital - operation only .....	175.00	2	62.32
04305 Venereal warts - cautery or excision (operation only) ...	106.00		38.61
04306 Excision of venereal warts under general anesthesia in hospital - operation only.....	350.00	2	150.00
04309 Labium Varicocele - operation only.....	386.00	2	133.47
04311 Operation of atresia of vulva or enlargement of vaginal introitus for stenosis - operation only .....	386.00	2	150.00
04312 Labia minora resection - operation only .....	350.00	2	150.00
04316 Vulvovaginoplasty.....	706.00	2	240.18
NOTE: This item is payable for genetic females only.			
Biopsy of vulva:			
04317 – excisional lesion less than 2 cm .....	48.00	2	19.22
04032 – excisional lesion greater than or equal to 2 cm. ....	266.00	2	92.00
Vulvectomy:			
04307 – simple .....	1144.00	3	388.42
04318 – radical.....	2501.00	3	847.00
Inguinal and femoral lymphadenectomy:			
04320 – unilateral.....	1094.00	4	371.34
04322 – bilateral.....	1817.00	4	616.82
P04632 Vulvar wide local excision .....	818.00	3	282.60

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.

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
P04633 Radical partial/hemi Vulvectomy (RPV).....	961.00	3	332.48
NOTES:			
i) Restricted to Obstetrics and Gynecology specialists.			
ii) Payable for the radical excision of vulvar carcinoma.			
iii) Payable for radical excision of verrucous cancers, melanomas, or vulvar soft tissue sarcomas.			
<b>OPERATIONS (VAGINA)</b>			
04202 Hysterectomy - vaginal .....	1935.00	4	655.21
Oophorectomy/ovarian cystectomy and/or adnexectomy (vaginal route), extra to vaginal hysterectomy:			
04232 - unilateral- operation only .....	257.00	5	89.21
04233 - bilateral.....	510.00	5	175.40
04033 Vaginectomy for VAIN (partial) .....	1053.00	4	358.76
04411 Vaginectomy - total.....	1584.00	4	536.63
04401 Fistula recto-vaginal repair .....	1584.00	3	536.63
04402 Colpotomy with drainage pelvic abscess - operation only .....	439.00	2	151.30
04404 Removal of vaginal inclusion cyst - operation only .....	106.00	2	150.00
04405 Removal of other vaginal cyst - operation only .....	458.00	2	157.22
04406 Septum vaginal removal - operation only .....	350.00	2	150.00
04408 Vault prolapse following hysterectomy .....	1584.00	4	536.63
04410 Post-operative hemorrhage, vaginal management requiring general anesthetic - operation only .....	458.00	5	157.22
<b>PLASTIC OPERATIONS FOR GENITAL PROLAPSE AND INCONTINENCE</b>			
04227 Cystocele and/or urethrocele repair.....	1114.00	2	378.73
04421 Rectocele repair .....	1114.00	2	378.73
04422 Enterocele repair .....	1361.00	2	461.51
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.			
04424 Complete repair of prolapse (Manchester or Fothergill types).....	1741.00	3	590.76
04427 Le Fort's operation.....	973.00	2	330.50
04429 Repair of old 3rd degree perineal laceration.....	1157.00	2	394.37
04432 Repeat vaginal plastic procedure (extra).....	386.00	2	133.19

OBSTETRICS AND GYNECOLOGY - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
P04701	Repeat urinary incontinence procedure for cases of a previously failed retropubic or vaginal procedure.....	1034.00	4	420.25
	NOTES:			
	i) Restricted to Obstetrics and Gynecology specialists.			
	ii) Fee items 00704, 00705, 08202, 08282, or 08283 not paid in addition.			
PG04702	Transection or removal of suburethral mesh sling .....	1034.00	4	417.12
	NOTES:			
	i) Restricted to Obstetrics and Gynecology specialists.			
	ii) Fee items 00704, 00705 or 08232 not paid in addition.			
PG04703	Augmented anterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to Arcus Tendinous .....	1032.00	2	415.99
	NOTES:			
	i) Fee items 00704, 00705 or 04227 not paid in addition.			
	ii) Restricted to Obstetrics and Gynecology specialists.			
PG04704	Augmented posterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to sacrospinous ligament .....	1032.00	2	415.99
	NOTES:			
	i) Fee items 04421 or 04422 not paid in addition.			
	ii) Restricted to Obstetrics and Gynecology specialists.			
PG04705	Removal of trans-vaginal placed synthetic mesh where indicated, form anterior or posterior compartment, due to pain or complications .....	1238.00	2	499.19
	NOTES:			
	i) Fee items 00704, 00705 are not paid in addition.			
	ii) Paid at 50% when done with 04605 or 04408.			
	iii) Restricted to Obstetrics and Gynecology specialists.			
PG04706	Vaginal vault suspension – Apical support procedure ..	1006.00	2	405.64
	<i>(see notes on next page)</i>			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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 (CERVIX AND UTERUS)**

S04500 Cervix dilation and curettage (pelvic examination not billable in addition when done as an isolated procedure) - operation only .....	350.00	2	150.00
04502 Cervix - repair of - operation only .....	350.00	2	150.00
Cervical incompetence:			
04517 – elective repair .....	706.00	2	240.18
04516 – emergency repair .....	880.00	2	299.45
04515 Removal of buried cervical ligature under anesthesia - operation only .....	175.00	2	150.00
04509 Cervical polypectomy - operation only .....	48.00	2	19.23
04508 Biopsy cervix, under general anesthetic .....	196.00	2	150.00
04510 Biopsy of cervix with dilation and curettage (operation only).....	350.00	2	150.00
04536 Cone biopsy of cervix with endocervical curettage (dilation and curettage included in the fee).....	773.00	2	263.90
Cauterization cervix:			
04533 – electric, in office - operation only .....	106.00		38.61
04530 – under general anesthesia - operation only .....	175.00	2	150.00
S04531 – with dilation and curettage, if done - operation only .	350.00	2	150.00
04503 Cryosurgery of cervix - operation only .....	211.00	2	74.22
04551 Cervical stump removal .....	773.00	3	263.90
04512 Myomectomy, vaginal - operation only .....	439.00	4	151.29
04545 Artificial insemination (operation only).....	88.00		32.71
14540 Insertion intrauterine contraceptive device (operation only).....	99.80	2	43.15
Note: Includes Pap smear if required.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00770 Pelvic examination under anesthesia – when done as an independent procedure - procedural fee .....	322.00	2	150.00
<b>LAPAROSCOPIC OPERATIONS</b>			
PC04707 Laparoscopic sacrocolpopexy, includes oophorectomy and/or salpingectomy .....	1941.00	5	980.80
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.			
PC04709 Laparoscopic total or supracervical hysterectomy, and/or laparoscopic assisted vaginal hysterectomy (LAVH) (includes oophorectomy and/or salpingectomy) .....	2154.00	5	980.80
NOTES:			
i) Fee items 00815, 04001, 04003, 04041, 04042, 04048, 40202, 04228, 04229, 04232 and 04233 are not paid in addition.			
ii) Fee items 04043, 04044, 04047, 04660 and 04662 are payable in addition, but the maximum payable under these items shall not exceed the value of fee item 04229.			
iii) Other items listed under laparoscopic operations are not payable in addition to this item.			
iv) In cases where conversion to open surgery is necessary, 04001 paid at 50%, plus open procedure.			
v) G04708 will apply after 2 hours.			
vi) Restricted to Obstetrics and Gynecology specialists.			

OBSTETRICS AND GYNECOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
NOTE: The following fee items for individual laparoscopic procedures are billable in addition to fee item S04001.			
S04001 Laparoscopy (operation only) .....	615.00	4	210.56
04660 Tubal interruption - sterilization (paid in addition to laparoscopy or Cesarean section) - operation only .....	266.00	4	92.00
04662 Removal of foreign body - operation only .....	266.00	4	92.00
04664 Ectopic pregnancy, removal via scope .....	1003.00	4	342.55
Salpingolysis via laparoscope:			
04034 – unilateral - operation only .....	204.00	4	71.24
04035 – bilateral - operation only .....	404.00	4	139.41
Salpingostomy via laparoscope:			
04036 – unilateral - operation only .....	439.00	4	151.29
04037 – bilateral .....	880.00	4	299.45
04040 Cautery of endometriosis - operation only .....	175.00	4	62.31
Oophorectomy and/or salpingectomy:			
04041 – unilateral - operation only .....	439.00	5	151.28
04042 – bilateral .....	880.00	5	299.45
Ovarian cystectomy:			
04043 – unilateral .....	706.00	5	240.22
04044 – bilateral .....	1319.00	5	447.74
04045 Ventral suspension of uterus - operation only .....	439.00	4	151.29
04046 Presacral neurectomy.....	615.00	4	210.57
04047 Excision of extensive peritoneal endometriosis including pelvic sidewall dissection and unilateral ureterolysis .....	968.00	6	329.13
04048 Removal of complicated pelvic disease.....	1319.00	6	447.73

NOTES:

- i) Fee items 04047 and 04048 are composite fees.
- ii) When performed together, the fee items for laparoscopic procedures are billable at 100%, except for composite fees which are inclusive fees, and subject to iii) and iv) below.
- iii) When more than one laparoscopic procedure is performed, fee item S04001 is payable once only at 100%.
- iv) Maximum billable for multiple laparoscopic operations (listed above) is up to the rate payable for 04229.

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>MICRO-SURGICAL OPERATIONS</b>			
04602 Salpingolysis and removal of adhesions - loupes or microscope (unilateral or bilateral).....	1319.00	5	447.72
Micro salpingostomy:			
04616 – unilateral.....	1817.00	5	616.67
04617 – bilateral.....	2365.00	5	800.77
Tubo-cornual anastomosis:			
04626 – unilateral (micro-surgical) .....	2634.00	5	892.33
04627 – bilateral (micro-surgical) .....	3425.00	5	1159.11
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.			
<b>LASER VAPORIZATION</b>			
04620 Cervical neoplasia - operation only.....	449.00	2	155.00
04621 Vaginal neoplasia, with or without GA - operation only .	449.00	2	155.00
04622 Vulvar condylomata - operation only.....	449.00	2	155.00
04623 Extensive vulvar or vaginal condylomata, under general anesthesia .....	676.00	2	230.97
Vulvar intraepithelial lesion:			
04624 – diffuse with perianal extension .....	1124.00	2	382.87
04625 – diffuse or multifocal.....	900.00	2	306.95
<b>SURGICAL ASSISTANCE</b>			
NOTES:			
i) In those rare situations where an assistant is required for minor surgery, a detailed explanation of need must accompany the account to the payment agency.			
ii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anesthetic, he/she may charge a separate assistant fee for each operation, except for bilateral procedures, procedures within the same body cavity or procedures on the same limb.			
<b>Total Operative Fee(s) for Procedure(s):</b>			
00195 Less than \$317.00 inclusive.....	339.00		134.22
00196 \$317.01 - \$529.00 inclusive .....	477.00		189.24
00197 Over \$529.00 .....	624.00		260.35

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Certified Surgical Assistant:</b>			
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 .....	1048.00		256.63
NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020 Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof .....	119.00		32.23
NOTES:			
i) After 3 hours of continuous 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 .....	27.05		8.39
04699 Fern Test .....	21.95		9.51
15137 Hemoglobin - cyanmethemoglobin method and/or hematocrit.....	8.25		3.12
NOTE: See the Laboratory Services Payment Schedule for additional hematology information.			
15000 – other methods .....	4.40		1.62
15139 Seminal examination for presence or absence of sperm .....	47.25		14.78
15141 Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination .....	21.95		5.65
15142 Urinalysis, complete diagnostic, semi-quantitative and microscopic .....	17.05		5.62
15120 Pregnancy test, immunologic - urine .....	28.70		11.65



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>DIAGNOSTIC ULTRASOUND</b>			
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.			
Obstetrical B-scan:			
08651 – 14 weeks gestation or over (for singles) .....	257.00		109.70
08655 – under 14 weeks gestation .....	208.00		82.30
NOTE: Where an obstetrical B-scan (08651, 08655 or P86055) 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) .....	219.00		81.63
08652 B-scan I.U.D. localization .....	137.00		55.12
08653 Pelvic B-scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal Doppler .....	267.00		109.70
NOTES:			
i) 08653 billable 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 .....	267.00		110.30
04680 Ultrasonic guidance for amniocenteses .....	399.00		131.52
NOTE: The professional/technical split is as follows: Professional fee - \$47.32, Technical Fee - \$84.20.			

# OCCUPATIONAL MEDICINE

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
33910 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	416.00	166.57
33912 <b>Repeat or Limited Consultation:</b> Where a consultation for the 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 .....	209.00	83.80
<b><u>Continuing care by consultant:</u></b>		
33907 Subsequent office visit .....	79.80	51.90

# OPHTHALMOLOGY

## GUIDELINES FOR BILLING EYE EXAMINATIONS

Guide to Payments under the Medical Services Plan of BC (MSP) for insured services of consultations and eye examinations by ophthalmologists to insured patients as agreed to by the section of Ophthalmology of the Doctors of BC.

### 1. CONSULTATIONS

- a) The definition of a consultation as outlined in D. 2. of the Preamble to the Fee Guide 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 he/she indicated definite symptoms of which he/she 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 his/her examination or he/she does not provide satisfactory information regarding pathology he/she 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 as consulting ophthalmologists only. It is the responsibility of such 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 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 committee) 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 judgement 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 general practice 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.

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

## CLINICAL EXAMINATION

### REFERRED CASES:

02010	<b>Consultation:</b> 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 .....	324.00	97.94
02011	<b>Repeat or limited consultation:</b> To apply where a consultation is repeated for same condition within six (6) months of the last visit to the consultant, or where in the judgement of the consultant, the consultative service does not warrant a full consultative fee.....	215.00	48.83
02012	<b>Special consultation:</b> To apply when an 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 is requested, charge an ordinary consultation.	536.00	135.53
 <b><u>Continuing Care by Consultant:</u></b>			
02007	Subsequent office visit .....	124.00	35.66
02008	Subsequent hospital visit .....	97.40	48.72
02009	Subsequent home visit.....	206.00	60.27
02005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)..... NOTE: Claim must state time service rendered.	392.00	89.84

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>			
22010 <b>Telehealth Consultation:</b> 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, and keratometry, where indicated and necessary to prepare a written report. ....	324.00		96.69
22011 <b>Telehealth repeat or limited consultation:</b> To apply where a consultation is repeated for same condition within six (6) months of the last visit to the consultant, or where in the judgement of the consultant, the consultative service does not warrant a full consultative fee .....	215.00		48.83
22007 Telehealth subsequent office visit.....	124.00		35.66
22008 Telehealth subsequent hospital visit.....	97.40		48.72

**BASIC EYE EXAMINATIONS**

**Eye examinations included in consultation or visit fee when applicable.**

NOTE: When two or more examinations are performed by specialist ophthalmologist on the same subsequent 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.**

*02015 Eye examinations to include measurement of refractive error, ophthalmoscopy, and any or all of biomicroscopy, tonometry, eye balance test, keratometry, where indicated .....	220.00		50.86
NOTE: Fee items 02015, 02018, and 02019 are payable to certified ophthalmologists only.			
02014 Complete orthoptic evaluation with written report to include history, sensory assessment, motor evaluation in all cardinal gaze situations, and any or all of Hess Screen, Troposcope and Visuscope where indicated.....	211.00		60.87
NOTE: Item 02014 includes 02007 and 02017.			
*02017 Oculo-motor function tests.....	119.00		34.51
*02018 Biomicroscopy .....	111.00		31.95
*02019 Tonometry .....	111.00		31.95
*02020 Ophthalmo-dynamometry .....	126.00		28.61
02028 Examination for low visual aid at low vision clinic .....	219.00		49.50
*02038 Keratometry .....	68.70		15.63
02040 Retinoscopy, keratometry, tonometry, indirect funduscopy, fundus photography and prosthetic fitting, under general anesthetic .....	585.00	3	133.06

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02048 Exophthalmometry.....	58.90		13.45
22016 Pachymetry – extra (when billed with other eye examinations) .....	48.05		10.21
NOTES:			
i) Payable once per lifetime for patients with glaucoma or elevated IOP (≥ 24 mm Hg.) Other diagnoses limited to once per year per patient.			
ii) Repeats within one year for other diagnoses must be substantiated by diagnostic code or note record.			
iii) Not payable for post-refractive (Lasik) patients.			
iv) Included in daily limit for eye examinations per day per patient.			

### DIAGNOSTIC EXAMINATIONS

All eye examination fees cover both eyes unless otherwise indicated.

NOTE: Do not bill professional or technical fee separately to the Plan: for institutional information only.

22046 Posterior segment contact lens examination .....	49.40	2	11.20
22047 Anterior segment gonioscopy .....	55.00	2	15.01

NOTES:

- i) Fee items 22046 and 22047 are not payable with P02011, 02012, S22113, S22114, S22115, S22116, S22117, S02116, or for non-contact lens examination of posterior segment.
- ii) Fee items 22046 and 22047 are not payable together.
- iii) Fee items 22046 and 22047 are not payable in the post-op laser surgical period unless they are performed for a diagnosis distinct from the surgical diagnosis.

02025 Fluorescein angiography of retina, with interpretation .....	471.00		106.96
02026 – professional fee .....	118.00		26.90
02027 – technical fee .....	350.00		80.07
02030 Electro-retinogram, professional and technical .....	353.00		94.19
02031 – professional fee .....	118.00		34.98
02032 – technical fee .....	238.00		59.20
02034 Dark adaptation, per eye.....	94.00		21.39
02035 Colour vision assessment (to include a screening test and at least one quantitative test of hue discrimination) .....	179.00		41.04
02036 – professional fee .....	118.00		26.91
02037 – technical fee .....	62.50		14.14
02039 Fundus photography (limitations - glaucomatous disc changes, tumour progression and potentially progressive retinal disease) .....	58.70		13.40

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
02041 Limited visual field examination, i.e. tangent screen, autoplots, arc perimeter, or single level automated test (such as OCTOPUS program 3 or 7 or equivalent) .....	138.00		32.59
NOTES:			
i) Gross field testing (e.g.: confrontation testing) is included in the consultation, visit and eye examination fees.			
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 OCTOPU	203.00		45.70
NOTES:			
i) 02042 includes 02041.			
ii) Fee includes examination of both eyes whether at one time or two separate visits.			
iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 120 days without written justification.			
02043 Comprehensive quantitative perimetry examination (Oculus visual fields): More extensive examination than under fee item 02042 - comprehensive automated static perimetry with multilevel threshold testing, such as OCTOPUS programs 31 & 32, or 31 & 41, or SQUID programs 310, 311, 410 or 411, or programs of equivalent informative value .....	268.00		63.32

*(see notes on next page)*



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
NOTES:			
i) Item 02043 includes 02042 and 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	337.00		76.33
02045 – professional fee	118.00		26.91
02047 Dacryocystogram	275.00		62.57
02049 Potentiometry	138.00		31.31
22023 10 or 24-hour diurnal tension curve	155.00		35.27

NOTE: Fee items 02018 and 02019 are not billable in addition to 22023 if the physician is required to perform a final intraocular pressure measurement and microscopic assessment of the anterior segment and a review of the trend of the previous hourly pressures taken. This is considered as included in the fee for 22023.

22050 Specular Microscopy – total fee	326.00		78.13
22051 Specular Microscopy – professional fee	85.00		20.39
22052 Specular Microscopy – technical fee	241.00		57.74

NOTES:

- i) Paid for post-operative corneal transplant assessment, maximum 6 per patient, per each 12 month period.
- ii) Daily maximum of 1 per patient/day.
- iii) In cases of corneal failure or rejection, additional tests may be paid, if accompanied by a note.
- iv) This fee includes specular microscopy for one eye.
- v) Not paid for pre- or post-operative cataract patients.
- vi) Paid once prior to intraocular surgery when affected by:
- vii) 22050 (total fee) and 22052 (technical fee) paid only when service performed in a physician's office.

02067 Manual retinal nerve fibre layer photography and neuro-retinal rim assessment	284.00		65.18
02068 – Professional fee	55.00		12.52
02069 – Technical fee	229.00		52.65

NOTES:

- i) Fee items 02067–02069 include examination of both eyes whether at one time or two separate visits.
- ii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
22067 Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g.: Heidelberg, GDX) .....	278.00		55.54
22068 – Professional fee .....	54.10		12.52
22069 – Technical fee .....	225.00		43.02
<b>NOTES:</b>			
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 .....	277.00		58.70
22076 - professional fee .....	72.50		15.92
22077 - technical fee .....	204.00		42.78

**NOTES:**

- i) Payable for post-operative corneal transplant assessment, maximum six per year per patient. In cases of problematic corneal transplant or unresolved astigmatism, additional tests may be paid, if accompanied by the following code (9968).
- ii) This fee includes both eyes, whether at one time or two separate visits.
- iii) Payable for corneal thinning disorders, including keratoconus and pellucid marginal degeneration, where progressive astigmatic change greater than 1 diopter in a year has been documented, corneal epithelial or stromal scarring, where the visual central axis of the cornea is affected. Payable once per year per patient. In cases where there is documented progression of any of these conditions, additional tests may be paid, if accompanied by the following code (V80).
- iv) Not payable for pre- or post-operative cataract patients except where there is documented evidence of irregular astigmatism resulting from the cataract surgery.
- v) Payable with following fee items if medically necessary: 02015, 02018, 02019, 22169, 02010 and 02012.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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.			
S00780 Schirmer's test (included in fee item 02015) .....	57.80		13.15
S00771 Retinal examination under anesthesia - procedural fee (when done as an independent procedure) .....	88.20	3	20.08

### 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) .....	282.00		64.34
--	--------	--	-------

**NOTES:**

- a) Eligible indications for billing 22399 include:
- b) Intraocular lens (IOL) implant surgery following cataract removal
- c) Any procedure where a peribulbar or retrobulbar
  - i. Injection is needed and risk of eyeball perforation by the injection needle is a potential danger such as:  
Any ocular surgery requiring local anesthetic with peribulbar or retrobulbar block  
e.g.: Pterygium surgery  
Corneal transplant  
Retinal surgery
  - ii. Retrobulbar injection of therapeutic agents
- d) Axial or pathological myopia-serial assessments
- e) Diagnosis of conditions where axial myopia is a diagnostic criteria (e.g.: Marfan's)
- f) Posterior staphyloma-serial assessments
- g) Pre-operative assessment for radioactive plaque implant – Brachytherapy for ocular melanoma.

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- ii) Provide indication in note record with 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.

08641 Ophthalmic B-scan (immersion and contact technique) .....	247.00	100.82
---	--------	--------

**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**

A02050 Hard lenses .....		I.C.
A02051 Soft lenses.....		I.C.
A02052 Unilateral cases - hard lenses .....		I.C.
A02053 – soft lenses .....		I.C.
A02054 Evaluation of lenses not fitted by practitioner - first visit .....		I.C.
A02055 – subsequent visits.....		I.C.

**NOTES:**

- i) Refundable costs to patients on failure of satisfactory fitting - professional fees should be refundable.
- ii) Patients should be informed clearly, prior to the fitting of lenses, of the separate professional and technical cost of fitting lenses.

22056 Contact lens - bandage - unilateral.....	350.00	79.83
02058 Contact lens - aphakia - unilateral .....	1166.00	266.12
NOTE: Fee item 02058 includes follow-up visits for three (3) months.		
22059 Contact lens – Keratoconus – unilateral .....	1166.00	266.12

**SURGICAL FEES**

**Unless otherwise noted, all fees apply to single eye.**

**Second eye is billable as per operative surgical fee preamble (D. 5. 3.)**

**Special Therapy:**

S02108 Beta radiation .....	91.40	20.74
S02109 Injections - subconjunctival - operation only .....	98.50	22.36

NOTE: Not to be billed at the time of any intraocular surgery.

OPHTHALMOLOGY – Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S02110 Radioactive plaque placement.....	3547.00	5	1002.34
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 .....	600.00		136.66
S02075 Botulinum toxin injections for entropion .....	331.00		74.69
S02076 Botulinum toxin injections for strabismus in patients aged 12 or older.....	913.00		207.99
<b>Lacrimal Apparatus:</b>			
S02111 En bloc micro-dissection lacrimal gland for tumour with excision by lateral approach with levator dissection .....	4918.00	6	1119.48
S02118 Snip procedure, two or three - operation only .....	211.00	3	47.95
S02120 Punctum dilation and syringing sac .....	113.00	3	25.54
S22121 Duct probing, under GA - unilateral or bilateral.....	779.00	3	176.44
NOTE: Not to be billed with S02123 on the same eye.			
S02122 – under local anesthetic - operation only .....	113.00	3	25.54
S02123 Quickert tube, insertion of.....	905.00	3	206.18
S02129 Lester Jones tube, insertion of.....	1547.00	3	423.43
S02119 Dacryocystostomy, under local anesthetic - operation only	157.00	3	35.29
S02112 Dacryocystectomy with unroofing of bony lacrimal canal and removal of lacrimal duct for tumour.....	4650.00	4	1058.61
S02126 Dacryocystorhinostomy.....	2460.00	3	560.17
NOTE: Not to be billed with S02123 on the same eye.			
S02127 Repair of canaliculi .....	1807.00	3	494.00
<b>Orbit:</b>			
S02132 Retrobulbar injection - operation only .....	397.00	2	90.93
NOTE: Not to be paid in addition to intraocular surgery.			
S02133 Enucleation or evisceration.....	1938.00	4	529.70
S02134 Orbit - enucleation with insertion of complicated implant (e.g.: dermis fat graft and/or scleral wrapped porous implant).....	2851.00	4	776.31
S22136 Biopsy or excision of anterior orbital tumour .....	1290.00	4	352.88
S22140 Orbital exploration (posterior route) - to biopsy posterior orbital tumour, or to fenestrate optic nerve sheath.....	4140.00	6	1129.17
NOTE: Not billable with fee item S22138.			
S22138 Posterior orbitotomy for removal of posterior orbital tumour not involving the orbital apex or optic nerve.....	5167.00	6	1411.49
NOTE: Not billable with fee item S22140.			
S02144 Aspiration needle biopsy of orbit under scan control .....	594.00	3	135.62

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S02101 Posterior orbitotomy with microscopic dissection for lesions of optic nerve or orbital apex .....	7751.00	7	1764.34
S02135 Exenteration of orbit .....	3691.00	4	1008.31
S02145 Orbital exenteration with en bloc resection of bony orbital walls - ophthalmologist .....	6149.00	7	1679.65
NOTE: Fee from neurosurgeon and plastic surgeon in addition.			
S22141 Orbital decompression - 1 wall .....	2326.00	6	635.16
S22142 – 2 wall .....	3591.00	6	980.91
S22143 – 3 wall .....	5167.00	6	1411.49
NOTE: Orbital decompression is not paid in addition to fee items S22140 or S22138.			

## EYE LIDS

NOTE: For removal of foreign bodies from surface of eye, the appropriate fee item to charge in non-referred cases is 13610, 13611, or 06063. For properly referred cases it is expected the ophthalmologist will charge only the consultation fee.

S02146 Trichiasis - epilation - forceps - operation only .....	98.50	3	22.36
S02147 – electric - operation only .....	282.00	3	64.38
S02106 Microscopic repair of trichiasis including muscular graft or mucosal membrane graft .....	2558.00	3	582.57
S02148 Cryotherapy of eyelids for trichiasis or tumour - operation only .....	520.00	3	117.64
S02149 Meibomian gland evacuation - operation only .....	98.50		22.36
S02150 Chalazion excision - operation only .....	251.00	3	78.90
S02152 Tarsorrhaphy - operation only .....	516.00	3	116.92
S02153 Ectropion/Entropion - Ziegler or simple procedure, involves simple skin incision but does not require associated lid shortening and/or skin grafting - operation only .....	251.00	3	56.35
S02154 Ectropion/Entropion - complicated, including neoplasms and plastic repair - requires both repair and associated lid shortening and/or skin grafting .....	1472.00	3	334.98
S02155 Ptosis repair - frontalis sling using synthetic material .....	1290.00	3	294.05
S02159 – frontalis sling using autologous material .....	2406.00	3	547.30
S02160 – levator resection .....	2364.00	3	537.77
S02158 Fasanella Servat .....	1162.00	3	265.00
S02166 Lid elevation and scleral graft for lower lid retraction .....	2067.00	3	470.48
S02100 Graded Muellerectomy with levator recession - under local anesthetic .....	2067.00	3	470.48
S02156 Excision of tumour of lid margin or conjunctiva - benign - operation only .....	388.00	3	88.57

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S02157	Excision of tumour of eyelid - benign - operation only ..... 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., " <u>Surgery for Alteration of Appearance.</u> "	168.00	3	38.32
S02103	Minor lid repair - operation only .....	388.00	3	88.57
S02104	Major lid reconstruction (one or two stages) ..... 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.	3880.00	3	882.17
S02105	Eyelid - 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.	6463.00	3	1470.29
S02107	Eyelid - repair of margin defect requiring layered closure ...	1290.00	3	352.88
<b>Eye Muscles:</b>				
S02161	Strabismus - 1 or 2 muscles .....	1642.00	3	374.20
S02162	– 3 or more muscles .....	2326.00	3	529.31
S22165	– 5 or more muscles .....	3359.00	4	764.54
S02163	– complicated re-operation .....	2584.00	4	588.12
S22166	Adjustable suture fee - extra to strabismus surgery .....	779.00		176.44
S22167	Prism adaptation therapy and/or amblyopia therapy for correction of fusional disturbances and/or amblyopia ..... NOTE: Billable at full value, only during pre/post-operative period in association with strabismus surgery (S02161, S02162, S02163, S22165). Minimum of three visits required to bill single fee.	608.00		138.39
<b>CORNEA AND SCLERA</b>				
S22171	Pterygium excision with mucous membrane graft.....	1846.00	4	420.13
S22172	Complicated pterygium excision (re-operation) or cancer excision, with mucous membrane graft..... NOTE: Record of previous pterygium surgical excision (operative report or referral letter) must be available on request.	2215.00	4	604.99
S02167	Cautery or cryotherapy of corneal ulcer - operation only ....	143.00	3	31.83
S02171	Pterygium or limbus tumour excision - operation only.....	559.00	3	126.95
S02172	Gundersen-type flap .....	1290.00	3	294.05
S02173	Keratoplasty - Lamellar .....	3280.00	3	850.60
S02175	– penetrating .....	3737.00	4	851.47

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
S02168 – complicated re-operation .....	4205.00	4	956.76
NOTE: S02168 applicable only when there is previous anterior segment surgery (with record) or major anterior segment trauma to same eye.			
S22169 Suture removal at slit lamp following keratoplasty - operation only.....	97.40	4	22.15
NOTES:			
i) S02168, S02173 and 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.			
S02174 Suture of cornea and/or sclera, with or without iridectomy - simple .....	1361.00	4	309.98
S02169 – complicated .....	3083.00	4	701.33
Collagen Cross-Linking for Keratoconus			
S22175 – Professional fee .....	1667.00		404.61
S22176 – Technical fee .....	2084.00		505.77
NOTES:			
i) Paid only for Keratoconus.			
ii) In order to be eligible for the procedure, patients age 25 or older must show progression of greater than 1 Dioptre change in refractive astigmatism or a greater than one line loss of corrected acuity documented over a minimum of two examinations. Patients under the age of 25 with Keratoconus do not need to show progression.			
iii) CXL may not be claimed in association or in relationship with refractive surgery for shape improvement.			
iv) Includes: both corneal pachymetry (pre and post), corneal de-epithelization, all the isometric riboflavin drops, any other drops, the technician's time, use of the UV-A light.			
v) When performed in a publically-funded facility, the technical fee is not paid.			
vi) Second eye paid at 50% if performed the same day. Post refractive ectasia is not a benefit.			

**GLAUCOMA / IRIS / ANTERIOR CHAMBER**

S22070 Molteno implant (includes phase 1 and 2).....	4286.00	5	1072.16
NOTE: Includes placement of scleral graft if indicated.			
S02176 Sclerotomy - posterior, with or without insufflation of gas (isolated procedure).....	576.00	4	131.46
S02177 Glaucoma - peripheral iridectomy (isolated procedure)	1519.00	4	345.26



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S02178 – filtering procedure, non-microscopic.....	2189.00	4	598.26
S02180 – goniotomy.....	1993.00	4	543.84
S02183 – goniotomy - repeat within 3 months.....	995.00	4	225.87
S02184 – cycloablation.....	1472.00	4	334.98
S22185 – cycloablative procedures.....	1361.00	4	309.98
S02187 – filtering procedure, microscopic.....	2584.00	4	644.24
S22187 – complicated trabeculectomy.....	3691.00	4	939.34
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.....	2769.00	4	631.00
S02197 Surgical evacuation of a hyphema.....	2277.00	4	518.72

**CATARACT / LENS**

S02188 Cataract - senile, traumatic, congenital, or linear extraction.....	1994.00		279.16
S22191 – capsulotomy, needling or discission (isolated procedure).....	916.00		208.26
Pediatric cataract extraction			
22188 – 0 to 7 years.....	4774.00		1122.62
22189 – 8 to 16 years.....	3183.00		748.41
S02190 Primary intraocular lens implantation to include repositioning of lens within the 42-day post-operative period (extra).....	529.00		73.47
S02192 Secondary intraocular lens implantation to include repositioning of lens within the 42-day post-operative period.....	2117.00		481.75
S02196 Surgical repositioning of implant lens.....	995.00		225.87
NOTE: For non-surgical repositioning, use visit fees.			

**RETINAL PROCEDURES**

S02181 Foreign body intraocular - magnetic extraction (isolated procedure).....	2270.00	4	620.22
S02182 – non-magnetic extraction (isolated procedure).....	2748.00	4	750.18
S02090 Intravitreal injection of vitreous paracentesis.....	589.00	4	134.43
NOTE: Not to be billed with S02199 or S02194.			
S02091 Paracentesis, anterior chamber.....	589.00	4	134.23
S02092 Intravitreal biopsy (microbiology, cytology) or intraocular tumour needle biopsy.....	952.00	4	215.18
S02194 Buckling procedure.....	3547.00	5	807.76

**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 fee item S02199.

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S02195 Diathermy or cryopexy for retinal tear or other retinal disorder .....	997.00	5	226.99
NOTE: Not to be billed in addition to S02199 or S02194.			
S02198 Anterior vitrectomy.....	1536.00	4	349.55
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.			
S02199 Posterior vitrectomy with 2 or 3 port infusion-cutting device (includes membrane peel and/or dissection).....	4004.00	5	910.84
NOTE: A maximum of two of the following fee items (S22199, S22200, S22201, S22202 or S22203) may be billed at 100% in addition to S02199. Fee item 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.....	295.00	5	67.23
S22200 Pan retinal endolaser greater than 200 burns when done with a posterior vitrectomy .....	912.00	5	207.26
S22201 Scleral buckle done with posterior vitrectomy - operation only .....	247.00	5	56.01
S22202 Intraocular lens removal and/or lensectomy when done with posterior vitrectomy - operation only .....	247.00	5	56.01
S22203 Removal of intraocular foreign body at the time of posterior vitrectomy .....	987.00	5	224.07
S22196 Pneumato retinopexy with air or gas (isolated procedure)..	1704.00	5	387.65
NOTE: Includes cryopexy or laser.			
S22195 Removal of buckle material or sponge. ....	763.00	5	173.65
NOTE: Not paid with any other fee item on the same eye.			
S22197 Additional gas (C3F8 or SF6) or air injection .....	440.00	5	99.69
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).....	4312.00	5	981.42

**LASER PROCEDURES**

S02072 Laser interferometry .....	145.00	4	32.49
S22113 Laser iridotomy, per eye - operation only .....	520.00	4	117.64

OPHTHALMOLOGY – Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S22114	Laser trabeculoplasty, per eye.....	566.00	4	128.40
	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.....	467.00	4	106.44
00094	YAG laser tray service fee.....	165.00		65.33
	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.			
S22116	Retinal photocoagulation - left.....	566.00	4	128.40
S22117	Retinal photocoagulation - right.....	566.00	4	128.40
S02116	Panretinal photocoagulation - defined as greater than 700 burns. Maximum fee for one eye for any 6-month period..	2307.00	4	524.72
	NOTES:			
	i) All laser procedures include all follow-up visits in the six (6) 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.....	148.00		33.20
	NOTES:			
	i) Can be billed once only during six (6) weeks following laser treatment.			
	ii) Includes examination of lasered site, and may include refraction and vision check, and intraocular pressure check.			
S22125	Photodynamic therapy for age-related wet macular degeneration - professional fee.....	3390.00		279.77
	Note: Payable to retinal physicians certified in PDT treatment only.			

# ORTHOPAEDICS

## PREAMBLE

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 an \* are operation only items and are exempt from the 14-day in hospital post-operative rule (Preamble 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 (Preamble 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, and 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 such and billed in full.

**7. Fasciotomy Wound Management**

Fasciotomy wound management fee(s) are for procedures done under general anesthetic and are payable within 14 days of 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 orthopaedic 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 (eg. 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 5 days following the index procedure.

**10. Non-operative Management**

Non-operative management of injuries not itemized are chargeable on a per visit basis.

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

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**PROFESSIONAL FEES**

*51010 <b>Consultation:</b> (in office or hospital) To include a history and physical examination, review of x-ray and laboratory findings and a written report .....	310.00	106.40
*51012 <b>Repeat or limited consultation:</b> 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 judgement of the consultant, the consultative service does not warrant a full consultative fee .....	179.00	58.33

ORTHOPAEDICS - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
*51015 <b>Orthopaedics special consultation:</b> 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 .....	619.00		160.37
NOTE: If an orthopaedic specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation service are met, a claim may be submitted under *51015 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.			
51005 Pre-Operative Assessment.....	357.00		106.40
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.			
*51007 Orthopaedics office visit.....	109.00		49.61
*51008 Orthopaedics hospital visit.....	72.30		30.70
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.....	131.00		46.07

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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.

**SURGICAL ASSISTANCE**

**NOTES:**

- i) In those rare situations where an assistant is required for minor surgery, a detailed explanation of need must accompany the account to the payment agency.
- ii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anesthetic, he/she may charge a separate assistant fee for each operation, except for bilateral procedures within the same body cavity or procedures on the same limb.

51194	First Surgical Assist of the Day - Orthopaedics .....	282.00		76.71
-------	---	--------	--	-------

**NOTES:**

- i) Restricted to Orthopaedic Surgeons.
- ii) Maximum of one per day per physician, payable in addition to 00195, 00196, 00197.

**TOTAL OPERATIVE FEE(S) FOR PROCEDURE(S):**

00195	Less than \$317.00 inclusive .....	339.00		134.22
00196	\$317.01 - \$529.00 inclusive.....	477.00		189.24
00197	Over \$529.00.....	624.00		260.35
00198	Time, after 3 hours of continuous surgical assistance, for one patient, each 15 minutes or fraction thereof .....	71.30		28.52

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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 .....	1048.00		256.63
NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020 Time after one hour of continuous certified surgical assistance, for one patient, up to and including 3 hours of continuous surgical assistance, each 15 minutes or fraction thereof .....	119.00		32.23
NOTES:			
i) After 3 hours of continual surgical assistance for one patient, bill under fee item 00198 (time after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof).			
ii) Please indicate start and end time of service on claim.			

**CERTIFICATES AND FORMS**

A00060 Written certificate, including time loss benefit form (extra to examination) and death certificates .....	45.70		
A00061 Medical advice by letter .....	156.00		
A00069 Insurance company form to include review of records – short report .....	156.00		
A00059 – extensive report .....	204.00		
96501 Physician completion of Section 2, Physician Report of MHR Person with Disabilities (Application or Review Form) .....	130.00		
96502 Physician completion of Section 3, Assessor Report of MHR Person with Disabilities (Application or Review Form) .....	75.00		
NOTE: Submit claims for 96400, 96501, 96502 and 96505 to MSP. Do not bill privately.			

**SHOULDER GIRDLE, CLAVICLE AND HUMERUS**

**Incision - Diagnostic, Percutaneous:**

S11200 Arthroscopy shoulder joint.....	1157.00	2	298.77
SY00757 Aspiration, other joints.....	42.45	2	11.99

**Incision - Diagnostic, Open:**

11215 Arthrotomy shoulder joint or bursa .....	720.00	2	186.72
--	--------	---	--------



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Incision - Therapeutic, Drainage:</b>			
51039 Bursa aspiration - operation only .....	90.10		23.23
51040 Joint aspiration - operation only .....	90.10		23.23
*52215 Abscess, I and D, under general anesthetic.....	720.00	2	186.72
*52210 Bursa, I and D, under general anesthetic.....	720.00	2	186.72
52220 Hematoma, drainage, under GA, when sole procedure.....	938.00	2	242.74
NOTE: Payable at 50% in post-op period.			
*52225 Shoulder joint arthrotomy, I and D .....	720.00	2	186.72
<b>Incision - Therapeutic, Release:</b>			
52255 Major release (shoulder contracture) .....	2090.00	2	541.49
52250 Soft tissue release (muscle, tendon).....	1472.00	2	380.44
<b>Excision - Diagnostic, Percutaneous:</b>			
S11232 Arthroscopy - biopsy, shoulder.....	938.00	2	242.74
S11230 Needle biopsy, under general anesthetic.....	720.00	2	186.72
<b>Excision - Diagnostic, Open:</b>			
11245 Biopsy, open .....	939.00	2	242.74
<b>Excision - Therapeutic, Endoscopic:</b>			
52310 Debridement, synovectomy - total or subtotal .....	1358.00	2	410.88
NOTE: Includes debridement of articular surface and/or synovium, and/or debridement of partial tears of the rotator cuff.			
52306 Drilling osteochondral defect, with or without loose body .....	938.00	2	287.62
52330 Endoscopic acromioplasty .....	1351.00	2	410.88
52320 Excision labrum tear .....	938.00	2	242.74
52307 Pinning osteochondral fragment .....	1351.00	2	350.12
52305 Removal loose body .....	938.00	2	287.62
52315 Shoulder, abrasion.....	1351.00	2	350.12
52325 Stabilization procedure.....	2199.00	2	569.50
52335 Arthroscopic clavicle excision-medial/lateral (extra) ...	381.00		106.57
NOTES:			
i) Paid only with 52330.			
ii) Not paid with 52505, 52506, 52515, 52516, 52525, 52526, 52535, 52540, 52541, 52545, 52602.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Excision - Therapeutic, Open:</b>			
52356 Acromionectomy, acromioplasty, with or without resection of coraco-acromial ligament.....	1351.00	2	350.12
52360 Arthrotomy, shoulder: synovectomy, capsulectomy ....	1568.00	2	406.12
52355 Bursa, excision, subacromial.....	830.00	2	214.73
52357 Clavicle, excision lateral/medial.....	830.00	2	214.73
*52380 Osteomyelitis, acute, decompression.....	720.00	2	186.72
*52385 Osteomyelitis, debridement with or without reconstruction.....	1246.00	3	322.10
NOTE: *52380 and *52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.			
52370 Bone Tumour, benign.....	1568.00	2	406.12
52365 Benign soft tissue Tumour (sub-fascial) .....	1568.00	2	406.12
<b>Introduction and/or Removal, Therapeutic:</b>			
*52410 Injection bursa, tendon sheath, other peri articular structures .....	44.90		11.63
*52405 Injection joint .....	44.90		11.63
52415 Removal of internal fixation device(s), with GA .....	938.00	2	242.74
*52420 Removal of internal fixation device(s), without GA .....	270.00	2	70.02
<b>Repair, Revision, Reconstruction (Soft Tissue):</b>			
When fee items 52505, 52506, 52310, 52517, 52518, 52520, 52521 are performed arthroscopically, the following services are not paid in addition: removal of symptomatic loose body(ies) (52305), drilling of defect and/or micro fracture (52306), pinning of osteochondral fragment (52307), debridement and/or synovectomy (52310), synovial biopsy, shoulder abrasion (52315), excision labral tear (52320), stabilization procedure (52325), endoscopic acromioplasty (52330), and 52555 (tendon transplant).			
SLAP/Biceps tenodesis: (Superior Labrum Anterior Posterior) repair (reattachment of the biceps anchor utilizing an anchoring device).			
Bankart repair: (reattachment of labrum to the rim of the glenoid).			
52515 Acromioclavicular joint stabilization, acute (within six weeks post injury).....	1048.00	2	270.75

ORTHOPAEDICS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
52516 Acromioclavicular joint stabilization, chronic (beyond six weeks post injury).....	1568.00	2	406.12
52517 Open or arthroscopic SLAP/Biceps tenodesis repair (reattachment of the biceps anchor utilizing an anchoring device) (isolated procedure).....	2282.00	3	630.18
NOTES:			
i) Not paid with 52506, 52518, 52519, 52520 and 52521.			
ii) Includes 52505, 52550, 52555, 52526, 52535 and 52541.			
52518 Open or arthroscopic SLAP/Biceps tenodesis repair and anterior or posterior glenohumeral stabilization and/or Bankart repair (isolated procedure).....	3313.00	3	914.94
NOTES:			
i) Not paid with 52519, 52520 and 52521.			
ii) Includes 52505, 52506, 52550, 52555, 52526, 52535, 52541 and 52517.			
52519 Open or arthroscopic SLAP/Biceps tenodesis or Bankart repair, and rotator cuff reconstruction, complex.....	3744.00	3	1033.99
NOTES:			
i) Not paid with 52520 and 52521.			
ii) Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517 and 52518.			
52520 Open or arthroscopic SLAP/Biceps tenodesis repair, and Bankart repair including tendon transfer, and Rotator cuff repair .....	4886.00	3	1349.06
NOTE:			
i) Not paid with 52521.			
ii) Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517, 52518 and 52519.			
52521 Open or arthroscopic SLAP/Biceps tenodesis repair, and Bankart repair and tendon transfer, and Rotator cuff repair, and anterior glenohumeral stabilization and/or posterior glenohumeral stabilization.....	5720.00	3	1578.96
NOTE: Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517, 52518, 52519 and 52520.			
52506 Rotator cuff reconstruction, complex (rotation flap or muscle transfer to include acromioplasty).....	2778.00	4	718.88
52505 Rotator cuff repair, simple (to include acromioplasty) .	1679.00	3	434.15
52526 Shoulder instability: Bankart.....	2432.00	3	630.18

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
52535 Shoulder instability: other anterior repairs .....	1778.00	3	459.80
52525 Shoulder instability: inferior capsular shift .....	2199.00	3	569.50
52540 Shoulder instability, posterior: glenoid osteotomy .....	2778.00	3	718.88
52541 Shoulder instability, posterior: soft tissue.....	2312.00	3	597.51
52545 Shoulder instability, revision, stabilization (post previous stabilization).....	2778.00	3	718.88
52550 Tendon repair, proximal, biceps, pectoralis major .....	1679.00	3	434.15
52555 Tendon transfer, transplant .....	1983.00	3	513.50
<b>Repair, Revision, Reconstruction (Bone, Joint): Osteotomy, Malunion/Non-union With or Without Internal Fixation:</b>			
52602 Clavicle.....	1568.00	2	513.60
52601 Proximal humerus .....	2778.00	3	718.88
<b>Glenohumeral Joint Arthroplasty:</b>			
52603 Hemi-arthroplasty shoulder .....	2400.00	4	620.86
52605 Removal prosthesis shoulder .....	1783.00	3	462.14
NOTE: Includes repair of rotator cuff and/or soft tissues.			
52607 Revision total shoulder arthroplasty .....	4523.00	5	1335.36
52606 Revision total shoulder arthroplasty to hemi- arthroplasty .....	3102.00	5	802.93
52604 Total shoulder prosthesis .....	3102.00	5	991.26
<b>Bone Grafting (i.e. onlay grafting):</b>			
52652 Clavicle.....	576.00	2	149.38
52651 Proximal humerus .....	938.00	2	242.74
<b>Fracture and/or Dislocation: Clavicle, Acromion, Coracoid:</b>			
*52708 Open injury, primary wound care.....	363.00	2	102.26
*52709 Open injury, secondary wound management .....	720.00	2	186.72
52710 Sterno-clavicular joint stabilization .....	1436.00	2	513.60
NOTES:			
i) Restricted to Orthopaedic Surgeons.			
ii) Not paid with 52357, 52602, 52652, 52705, 52708 or 52709.			
52705 Open reduction, internal fixation.....	1360.00	2	436.58
<b>Scapula:</b>			
*52718 Open injury, primary wound care.....	363.00	2	102.26
*52719 Open injury, secondary wound management .....	720.00	2	186.72
52715 Open reduction, internal fixation.....	3572.00	3	924.30

**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

**Glenohumeral Dislocation - Acute:**

52722	Closed reduction, with general anesthetic.....	938.00	2	242.74
*52721	Closed reduction, without general anesthetic .....	363.00	2	93.37
52725	Open reduction .....	1568.00	2	406.12

**Proximal Humerus:**

*52731	Closed reduction, with general anesthetic .....	720.00	2	186.72
*52732	Closed reduction, with GA, traction/pin .....	720.00	2	186.72
52735	Open reduction, internal fixation - two part.....	2090.00	2	541.49
52736	Open reduction, internal fixation - three or more parts .....	2312.00	2	654.53
NOTE: 52735 and 52736 include repair of rotator cuff if required.				
52737	Hemiprosthesis and wiring for fracture.....	3102.00	3	802.93
*52738	Open injury, primary wound care .....	363.00	2	102.26
*52739	Open injury, secondary wound management.....	720.00	2	186.72

**Humerus - Shaft:**

52742	Closed reduction, external fixation .....	1368.00	2	354.78
52741	Closed reduction, with general anesthetic .....	938.00	2	242.74
52745	Open reduction, internal fixation/intramedullary nailing.....	2199.00	2	569.50
*52748	Open injury, primary wound care .....	363.00	2	102.26
*52749	Open injury, secondary wound management.....	720.00	2	186.72

**Manipulation: Shoulder Joint:**

*S52800	Manipulation under general anesthetic .....	363.00	2	93.37
---------	---	--------	---	-------

**Arthrodesis:**

52811	Scapulo-thoracic joint.....	2882.00	4	746.91
52810	Shoulder joint.....	3674.00	4	952.30

**Amputation:**

52981	Forequarter .....	3572.00	5	924.30
52982	Humeral shaft.....	2090.00	3	541.49
52980	Shoulder disarticulation.....	2990.00	4	774.90
*52998	Open injury, primary wound care .....	363.00	3	102.26
*52999	Open injury, secondary wound management.....	720.00	3	186.72

**ELBOW, PROXIMAL RADIUS AND ULNA**

**Incision - Diagnostic, Percutaneous:**

S11300	Arthroscopy elbow joint.....	1037.00	2	268.43
S11302	Aspiration, bursa, tendon sheath. ....	90.10	2	23.23

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
SY00757 Aspiration, other joints.....	42.45	2	11.99
<b>Incision - Diagnostic, Open:</b>			
11315 Arthrotomy elbow joint.....	720.00	2	186.72
<b>Incision - Therapeutic, Drainage:</b>			
51039 Bursa aspiration - operation only.....	90.10		23.23
51040 Joint aspiration - operation only .....	90.10		23.23
*53215 Abscess, I and D, under general anesthetic.....	720.00	2	186.72
*53210 Bursa, I and D (olecranon, etc.), under GA .....	720.00	2	186.72
*53225 Elbow joint arthrotomy, I and D .....	720.00	2	186.72
53220 Hematoma, drainage, under GA, when sole procedure .....	938.00	2	242.74
NOTE: Payable at 50% in post-op period.			
<b>Incision - Therapeutic, Release:</b>			
53250 Decompression, neurolysis, nerve .....	938.00	2	242.74
53255 Decompression, neurolysis, submuscular transposition of nerve .....	1568.00	2	406.12
*53260 Fasciotomy, compartment syndrome .....	830.00	2	214.73
*53269 Fasciotomy, secondary wound management .....	720.00	2	186.72
<b>Excision - Diagnostic, Percutaneous:</b>			
S11332 Arthroscopy and biopsy.....	1146.00	2	296.44
S11330 Needle biopsy under general anesthetic .....	720.00	2	186.72
<b>Excision - Diagnostic, Open:</b>			
11345 Biopsy, open .....	939.00	2	242.74
NOTE: Not billable with other procedures on the same joint.			
<b>Excision - Therapeutic, Endoscopic:</b>			
53310 Debridement, synovectomy - total.....	2199.00	2	642.00
53305 Removal loose body.....	1146.00	2	333.85
<b>Excision - Therapeutic, Open:</b>			
53360 Arthrotomy, elbow; open synovectomy with or without radial head resection.....	1568.00	2	406.12
53355 Bursa/ganglion, excision .....	830.00	2	214.73
*53380 Osteomyelitis - acute, decompression.....	720.00	2	186.72
*53385 Osteomyelitis - debridement, with or without reconstruction.....	1246.00	2	322.10
53386 Radial head resection with or without replacement .....	938.00	2	242.74
53370 Bone Tumour, benign.....	1048.00	2	270.75
53365 Benign soft tissue Tumour, subfascial.....	1048.00	2	270.75

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Introduction and/or Removal, Therapeutic:</b>			
*53410 Injection bursa, tendon sheath, other peri articular structures .....	44.90		11.63
*53405 Injection joint .....	44.90		11.63
53415 Removal of internal fixation device(s), with GA.....	830.00	2	214.73
*53420 Removal of internal fixation device(s), without GA.....	270.00	2	70.02
<b>Repair, Revision, Reconstruction (Soft Tissue):</b>			
53521 Biceps tendon, distal insertion .....	2199.00	2	569.50
53520 Biceps tendon, longhead, tenodesis .....	1048.00	2	270.75
53505 Elbow instability, chronic.....	2614.00	2	676.86
53540 Epicondylitis, fascial stripping .....	830.00	2	214.73
53510 Recurrent dislocating radial head.....	2199.00	2	569.50
53530 Tendon transfer, major.....	2778.00	2	718.88
NOTE: Includes latissimus/pectoralis to biceps transfer.			
53531 Tendon transfer, minor (Steindler or triceps).....	1679.00	2	434.15
53515 Triceps tendon, acute.....	1360.00	2	352.44
53516 Triceps tendon, fascial reconstruction.....	1568.00	2	406.12
<b>Repair, Revision, Reconstruction (Bone, Joint): Osteotomy, Malunion/Non-union; With or Without Internal Fixation:</b>			
53602 Distal humerus .....	2778.00	2	718.88
53601 Humeral shaft.....	2090.00	2	711.89
53605 Radius and ulnar shafts .....	2778.00	2	718.88
53603 Radius shaft .....	2298.00	2	595.16
53604 Ulnar shaft.....	1679.00	2	520.94
53606 Epiphysiodesis .....	1048.00	2	270.75
53607 Physeal Bar excision.....	1731.00	2	448.14
NOTE: Includes harvest, with or without insertion of fat graft, cement, or other material.			
<b>Arthroplasty:</b>			
53641 Interposition/distraction arthroplasty .....	3572.00	3	924.30
NOTE: Includes harvest and insertion of local fascial graft, application of distraction device and neurolysis, if applicable.			
53642 Total elbow arthroplasty .....	2882.00	3	991.26
53643 Total elbow arthroplasty revision.....	4416.00	3	1335.36
NOTE: 53642 and 53643 include ligament balancing, neurolysis and nerve transposition.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
53644 Osteocapsular arthroplasty (elbow, open or arthroscopic) .....	3484.00	4	924.49
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.			
<b>Bone Grafting (i.e. onlay grafting):</b>			
53651 Humerus.....	938.00	2	242.74
53653 Olecranon.....	576.00	2	149.38
53652 Radius and/or ulna .....	938.00	2	242.74
<b>Fracture and/or Dislocation:</b>			
<b>Humeral Epicondyle:</b>			
53702 Closed reduction, percutaneous fixation .....	1048.00	2	270.75
53701 Closed reduction, with GA, cast .....	938.00	2	242.74
53705 Open reduction, internal fixation.....	1048.00	2	270.75
*53708 Open injury, primary wound care.....	363.00	2	102.26
*53709 Open injury, secondary wound management .....	720.00	2	186.72
<b>Distal Humerus: Supracondylar:</b>			
53712 Closed reduction, external fixation/percutaneous fixation.....	1365.00	2	386.07
*53711 Closed reduction, with GA, cast/traction.....	720.00	2	186.72
53715 Open reduction, internal fixation.....	1578.00	2	444.88
*53718 Open injury, primary wound care.....	363.00	2	102.26
*53719 Open injury, secondary wound management .....	720.00	2	186.72
<b>Distal Humerus: Intra-articular:</b>			
53722 Closed reduction, external fixation .....	1368.00	2	354.78
*53721 Closed reduction, with GA, cast/traction and/or percutaneous fixation .....	720.00	2	186.72
53726 Open reduction, internal fixation - bicondylar with or without olecranon osteotomy.....	3352.00	2	868.26
NOTE: Includes ulnar nerve transposition, if required.			
53725 Open reduction, internal fixation - unicondylar/osteochondral.....	1568.00	2	406.12



	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
*53727 Open injury, primary wound care .....	363.00	2	102.26
*53728 Open injury, secondary wound management.....	720.00	2	186.72
<b>Olecranon:</b>			
53735 Open reduction, internal fixation .....	1151.00	2	416.76
*53738 Open injury, primary wound care .....	363.00	2	102.26
*53739 Open injury, secondary wound management.....	720.00	2	186.72
<b>Radial Head/Neck:</b>			
53742 Closed reduction, percutaneous fixation .....	1048.00	2	270.75
53741 Closed reduction, with GA, cast .....	938.00	2	242.74
53745 Open reduction, internal fixation .....	1568.00	2	406.12
*53748 Open injury, primary wound care .....	363.00	2	102.26
*53749 Open injury, secondary wound management.....	720.00	2	186.72
<b>Elbow Joint Dislocation:</b>			
53752 Closed reduction, with general anesthetic.....	938.00	2	242.74
53751 Closed reduction, without general anesthetic.....	576.00	2	149.38
53755 Open reduction .....	1151.00	2	298.77
<b>Radius and Ulna Shaft:</b>			
53762 Closed reduction, with GA, cast .....	1151.00	2	298.77
*53761 Closed reduction, without GA, cast .....	363.00	2	93.37
53765 Open reduction, internal fixation .....	2090.00	2	541.49
*53768 Open injury, primary wound care .....	363.00	2	102.26
*53769 Open injury, secondary wound management.....	720.00	2	186.72
<b>Radius or Ulna Shaft/Monteggia:</b>			
53772 Closed reduction, external fixation .....	1048.00	2	270.75
53771 Closed reduction, with GA, cast .....	1048.00	2	270.75
53775 Open reduction internal fixation .....	1472.00	2	416.76
NOTES:			
i) Includes closed reduction of an 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 .....	363.00	2	102.26
*53779 Open injury, secondary wound management.....	720.00	2	186.72
<b>Manipulation: Elbow Joint:</b>			
*S53800 Manipulation, under general anesthetic .....	363.00	2	93.37
<b>Arthrodesis:</b>			
53810 Elbow joint.....	2778.00	3	718.88

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Amputation:</b>			
53980 Elbow .....	1568.00	3	406.12
53981 Forearm.....	1568.00	3	406.12
*53998 Open injury, primary wound care.....	363.00	3	102.26
*53999 Open injury, secondary wound management .....	720.00	3	186.72
<b>HAND AND WRIST</b>			
<b>Incision - Diagnostic, Percutaneous:</b>			
S11400 Arthroscopy wrist joint .....	720.00	2	287.62
S11402 Aspiration bursa, synovial sheath, etc.....	90.10	2	23.23
SY00757 Aspiration, other joints.....	42.45	2	11.99
<b>Incision - Diagnostic, Open:</b>			
11416 Arthrotomy MP, PIP, DIP joints - (isolated procedure)	720.00	2	186.72
11415 Arthrotomy wrist joint - (isolated procedure).....	720.00	2	186.72
<b>Incision - Therapeutic, Drainage:</b>			
51039 Bursa aspiration - operation only.....	90.10		23.23
51040 Joint aspiration - operation only .....	90.10		23.23
<b>Excision - Diagnostic, Percutaneous:</b>			
S11432 Arthroscopy and biopsy, wrist /hand joint(s).....	720.00	2	186.72
S11430 Needle biopsy, under general anesthetic .....	720.00	2	186.72
<b>Excision - Diagnostic, Open:</b>			
11445 Open biopsy, hand or wrist.....	939.00	2	242.74
<b>Excision - Therapeutic, Endoscopic:</b>			
54310 Debridement synovectomy, total .....	1252.00	2	324.44
54315 Excision triangular fibro cartilage complex (TFCC) .....	1252.00	2	324.44
54305 Removal loose body.....	938.00	2	242.74
<b>Excision - Therapeutic, Open:</b>			
54350 Foreign body from wound, under general anesthetic ..	830.00	2	214.73
54351 Meniscus, radiocarpal .....	1252.00	2	324.44
V07055 Ganglia, of wrist.....	561.00	2	202.23
<b>Bone Tumour, Benign:</b>			
54372 Carpals, distal radius.....	1252.00	2	324.44
54386 Excision of radial or ulnar styloid .....	830.00	2	214.73
NOTE: Not payable with other wrist procedures.			
*54380 Osteomyelitis, acute, decompression.....	720.00	2	186.72

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
*54385 Osteomyelitis, debridement with or without reconstruction .....	1246.00	2	322.10
54387 Proximal row carpectomy.....	2090.00	2	541.49
NOTE: Not payable with wrist arthrodesis.			
<b>Introduction and/or Removal, Therapeutic:</b>			
*54410 Injection bursa, tendon sheath, other peri-articular structures .....	90.10		23.23
*54405 Injection joint.....	90.10		23.23
54415 Removal of internal fixation device(s), with GA.....	830.00	2	214.73
*54420 Removal of internal fixation device(s), without GA.....	179.00	2	46.68
<b>Repair, Revision, Reconstruction (Soft Tissue):</b>			
<b>Ligament:</b>			
54505 Carpal instability: acute .....	2312.00	2	597.51
54510 Carpal instability: chronic .....	2542.00	2	658.20
54515 Distal radio-ulnar instability: chronic.....	1885.00	2	487.81
<b>Repair, Revision, Reconstruction (Bone, Joint):</b>			
<b>Osteotomy, Malunion or Non-union:</b>			
54603 Carpal bone (scaphoid).....	2090.00	2	541.49
54601 Distal radius .....	2542.00	2	658.20
54602 Distal ulna .....	1259.00	2	326.77
NOTE: A Darrach resection or limited resection/hemiresection arthroplasty are not payable under this item.			
54604 Epiphysiodesis, epiphysioplasty, radius and/or ulna, or hand.....	1568.00	2	406.12
<b>Arthroplasty Joint:</b>			
54634 Removal prosthesis .....	1048.00	2	270.75
54635 Revision total wrist arthroplasty .....	3674.00	3	952.30
54633 Silastic wrist arthroplasty, includes tenosynovectomy and distal ulnar reconstruction .....	2090.00	2	541.49
54632 Total wrist joint replacement, includes tenosynovectomy and distal ulnar reconstruction .....	2778.00	2	718.88
54631 Ulna, distal excision, with or without silastic.....	938.00	2	242.74
<b>Bone Grafting (i.e. onlay grafting):</b>			
54651 Distal radius and/or ulna .....	938.00	2	242.74
54652 Metacarpal or phalanx - operation only .....	467.00	2	121.36

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)	
<b>Fracture and/or Dislocation:</b>				
<b>Radius With or Without Ulna - Distal, Fracture:</b>				
54703	Closed reduction, external or percutaneous fixation....	1259.00	2	326.77
54702	Closed reduction, with general anesthetic .....	1151.00	2	298.77
54701	Closed reduction, without general anesthetic .....	977.00	2	252.09
54705	Open reduction, internal fixation.....	2009.00	2	518.18
*54708	Open injury, primary wound care.....	179.00	2	51.13
*54709	Open injury, secondary wound management .....	363.00	2	93.37
<b>Carpal Bone Fracture (Scaphoid):</b>				
54715	Open reduction, internal fixation.....	1679.00	2	434.15
<b>Carpus: Dislocations: With or Without Fracture:</b>				
54722	Closed reduction, percutaneous fixation .....	1151.00	2	298.77
54721	Closed reduction, without general anesthetic .....	977.00	2	252.09
54725	Open reduction, internal and/or external fixation .....	2312.00	2	597.51
*54728	Open injury, primary wound care.....	179.00	2	51.13
*54729	Open injury, secondary wound management .....	363.00	2	93.37
<b>Manipulation: Hand/Wrist Joint:</b>				
*S54800	Manipulation, under general anesthetic.....	363.00	2	93.37
<b>Arthrodesis/Tenodesis:</b>				
54810	Wrist arthrodesis, limited or total .....	2542.00	2	658.20
<b>Amputation:</b>				
06218	Transmetacarpal .....	1013.00	2	254.92
06219	Finger, any joint or phalanx - operation only .....	1013.00	2	254.92
<b>PELVIS, HIP AND FEMUR</b>				
<b>Incision - Diagnostic, Percutaneous:</b>				
S11500	Arthroscopy hip joint.....	2009.00	3	518.18
S11502	Aspiration bursa, tendon sheath.....	44.90	2	11.63
S11501	Aspiration hip joint.....	90.10	2	23.23
<b>Incision - Diagnostic, Open:</b>				
11515	Arthrotomy hip joint .....	1151.00	3	298.77
<b>Incision - Therapeutic, Drainage:</b>				
51039	Bursa aspiration - operation only.....	90.10		23.23
51040	Joint aspiration - operation only .....	90.10		23.23
*55215	Abscess, I and D, under general anesthetic.....	720.00	2	186.72
*55225	Hip Joint - Arthrotomy, I and D .....	1246.00	3	322.10
*55210	Bursa, I and D (trochanteric, etc.) under GA .....	720.00	2	186.72

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
55220	Hematoma, drainage under GA (when sole procedure)..... NOTE: Payable at 50% in post-op period.	1151.00	2	298.77
<b>Incision - Therapeutic, Release:</b>				
55275	Major release hip, two or more.....	1568.00	3	406.12
55270	Minor release hip, one tendon.....	1151.00	2	298.77
55255	Soft tissue release, percutaneous.....	1048.00	2	270.75
<b>Excision - Diagnostic, Percutaneous:</b>				
S11532	Arthroscopy and biopsy, hip.....	2009.00	3	518.18
S11530	Needle biopsy, under general anesthetic.....	720.00	2	186.72
<b>Excision - Diagnostic, Open:</b>				
11545	Arthrotomy and biopsy, hip.....	939.00	3	242.74
11546	Biopsy, open, soft tissue or bone.....	939.00	2	242.74
<b>Excision - Therapeutic, Endoscopic:</b>				
55310	Debridement or synovectomy, total.....	2312.00	3	597.51
55305	Removal loose body.....	1458.00	3	378.11
<b>Excision - Therapeutic, Open:</b>				
55360	Arthrotomy, hip – open synovectomy, total.....	2199.00	3	569.50
55355	Bursa, excision, trochanteric, etc.....	830.00	2	214.73
*55380	Osteomyelitis, acute, decompression.....	720.00	3	186.72
*55385	Osteomyelitis, debridement with or without reconstruction.....	1246.00	3	322.10
55370	Bone Tumour, benign.....	1679.00	3	434.15
S55371	Heterotopic bone resection..... NOTE: Paid only for heterotopic bone resection which meets the criteria for Brooker Classification III or IV.	2001.00	3	515.94
55365	Benign soft tissue Tumour, subfascial.....	1568.00	3	406.12
<b>Introduction and/or Removal, Therapeutic:</b>				
*55410	Injection bursa, tendon sheath, other peri articular structures.....	44.90		11.63
*55405	Injection joint.....	44.90		11.63
55415	Removal of internal fixation device(s), with GA.....	938.00	3	242.74
*55420	Removal of internal fixation device(s), without GA.....	270.00	3	70.02

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Repair, Revision, Reconstruction (Soft Tissue):</b>				
55505	Hip instability, soft tissue repair .....	2524.00	3	653.54
55515	Tendon avulsion repair .....	1259.00	3	326.77
55510	Tendon-muscle transfer, hip.....	2542.00	3	658.20
<b>Repair, Revision, Reconstruction (Bone, Joint):</b>				
<b>Osteotomy:</b>				
55605	Femoral shaft, adult.....	2990.00	4	774.90
55606	Femoral shaft, pediatric.....	1679.00	4	774.90
55607	Multiple for osteogenesis imperfecta .....	3455.00	6	891.61
55601	Pelvis, adult.....	2882.00	6	746.91
55602	Pelvis, pediatric .....	2312.00	6	597.51
55603	Proximal femur, adult .....	2882.00	4	746.91
55604	Proximal femur, pediatric.....	2090.00	4	746.91
<b>Malunion or Non-union:</b>				
55632	Acetabulum .....	7135.00	4	1848.57
55635	Femoral lengthening, open.....	3461.00	4	896.29
55636	Femoral shortening, closed .....	3461.00	4	896.29
C55631	Pelvis (including Sacroiliac joint arthrodesis) .....	5263.00	4	1363.10
	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.			
55633	Proximal femur (i.e. subtrochanteric).....	3461.00	4	896.29
55634	Shaft, femur (includes closed femoral lengthening and open femoral shortening) .....	2990.00	4	774.90
<b>Bone Grafting (i.e. onlay grafting):</b>				
55651	Femur – intertrochanteric, shaft.....	1048.00	4	270.75
55652	Epiphysiodesis, greater trochanter .....	1259.00	4	326.77
<b>Arthroplasty:</b>				
55661	Hip resection arthroplasty.....	1896.00	5	490.15
55662	Hemi-arthroplasty - hip .....	2002.00	5	567.62
55663	Total hip prosthesis .....	3102.00	5	802.93

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Revision, Total Hip Arthroplasty:</b>				
55671	Components, removal only (isolated procedure).....	3102.00	5	802.93
55672	Exchange of modular component .....	1679.00	5	434.15
55675	Proximal femoral replacement, allograft or custom prosthesis and/or acetabular reconstruction with internal fixation.....	6334.00	6	1633.84

**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 plus 50% of 55785 for open reduction and fixation of the fracture of the proximal femur.
- ii) When fracture of the femur occurs during a revision total hip, the procedure will be paid at the rate for revision total hip only.

55674	Revision femur and acetabulum, includes PROSTALAC .....	5064.00	6	1307.07
55673	Revision femur or acetabulum .....	3835.00	6	989.64

NOTE: 55673 and 55674 include trochanteric osteotomies if required.

**Fracture With or Without Dislocation:**

**Pelvis: Operative Rx Unstable:**

55702	Closed reduction, external fixation .....	1911.00	4	494.83
*55701	Closed reduction, skeletal traction .....	363.00	3	93.37
55705	External fixation and open reduction internal fixation..	4215.00	5	1092.35
55707	Open reduction internal fixation, anterior and posterior.....	4523.00	5	1171.69
55706	Open reduction internal fixation, anterior or posterior .	2952.00	5	765.57

**Hip: Dislocation, Traumatic (Includes Total Hip Arthroplasty):**

55715	Open reduction .....	1896.00	4	490.15
*55712	Reduction hip, with general anesthetic .....	720.00	2	186.72
*55711	Reduction hip, without anesthetic .....	363.00	2	93.37

**Hip: Dislocation, Congenital: Conservative Management:**

55721	Closed reduction under GA, with or without tenotomy	1048.00	2	270.75
-------	---	---------	---	--------

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Hip: Dislocation, Congenital: Operative Management:</b>			
55725	Open reduction..... 2760.00	2	714.22
55726	Open reduction, femoral or pelvic osteotomy ..... 4043.00	4	1047.97
55727	Open reduction, femoral and pelvic osteotomy ..... 5094.00	4	1318.75
<b>Hip: Fracture, Dislocation (Includes Lip and/or Head Fractures):</b>			
*55738	Open injury, primary wound care..... 363.00	2	102.26
*55739	Open injury, secondary wound management ..... 720.00	2	186.72
55735	Open reduction..... 1896.00	4	490.15
55736	Open reduction, internal fixation..... 3674.00	5	952.30
*55732	Reduction hip, with general anesthetic..... 720.00	2	186.72
*55731	Reduction hip, without anesthetic..... 363.00	2	93.37
<b>Hip: Acetabulum Fracture (One or Two Column Fractures):</b>			
*55741	Closed reduction ..... 720.00	2	186.72
55745	Open reduction, internal fixation - one approach..... 5045.00	5	1307.07
55746	Open reduction, internal fixation - two approach/ extensile approach ..... 7135.00	6	1848.57
<b>Hip: Fracture Femoral Neck or Subcapital:</b>			
55751	Closed reduction, internal fixation ..... 2009.00	5	518.18
55755	Open reduction, internal fixation (with supporting documentation)..... 3208.00	5	830.94
*55758	Open injury, primary wound care..... 363.00	2	102.26
*55759	Open injury, secondary wound management ..... 720.00	2	186.72
55760	SCFE in situ fixation ..... 1885.00	5	518.18
<b>Hip: Fracture, Intertrochanteric With or Without Subtrochanteric Extension:</b>			
*55768	Open injury, primary wound care..... 363.00	2	102.26
*55769	Open injury, secondary wound management ..... 720.00	2	186.72
55761	Reduction internal fixation ..... 2524.00	5	653.54
<b>Hip: Fracture, Subtrochanteric:</b>			
55771	Internal fixation ..... 3442.00	5	891.61
*55778	Open injury, primary wound care..... 363.00	2	102.26
*55779	Open injury, secondary wound management ..... 720.00	2	186.72
<b>Femur: Shaft:</b>			
55782	Closed reduction, external skeletal fixation ..... 1368.00	4	354.78
55783	Closed reduction, IM nail ..... 2990.00	5	774.90



ORTHOPAEDICS - Continued

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
*55781	Closed reduction, with GA, cast/traction .....	834.00	2	214.73
*55780	Closed reduction, without GA, cast/traction .....	469.00	2	121.36
	NOTE: If *55780 or *55781 is followed by an ORIF/IM nailing after 48 hours, both are paid in full.			
55785	Open reduction, internal fixation .....	2990.00	5	774.90
*55788	Open injury, primary wound care .....	363.00	2	102.26
*55789	Open injury, secondary wound management.....	720.00	2	186.72
<b>Manipulation: Hip Joint:</b>				
*S55800	Manipulation, under general anesthetic .....	363.00	2	93.37
<b>Arthrodesis:</b>				
55810	Hip joint.....	4741.00	6	1227.71
<b>Amputation:</b>				
55983	Above knee .....	2524.00	4	653.54
55980	Hemicorporectomy .....	9448.00	6	2446.08
55981	Hemipelvectomy .....	5263.00	6	1363.10
55982	Hip disarticulation.....	4004.00	6	1036.32
55984	Knee disarticulation.....	2524.00	4	653.54
55985	Revision, amputation, below knee, after 14 days .....	1785.00	3	518.18
	NOTE: Restricted to Orthopaedic Surgeons.			
*55998	Open injury, primary wound care .....	363.00	4	102.26
*55999	Open injury, secondary wound management.....	720.00	4	186.72
<b>FEMUR, KNEE JOINT, TIBIA AND FIBULA</b>				
<b>Incision - Diagnostic, Percutaneous:</b>				
S11600	Arthroscopy knee joint.....	830.00	2	214.73
S11602	Aspiration bursa, tendon sheath or other peri-articular structures .....	90.10	2	23.23
SY00757	Aspiration, other joints.....	42.45	2	11.99
<b>Incision - Diagnostic, Open:</b>				
11615	Arthrotomy knee joint .....	938.00	3	242.74
<b>Incision - Therapeutic, Drainage:</b>				
51039	Bursa aspiration - operation only .....	90.10		23.23
51040	Joint aspiration - operation only .....	90.10		23.23
*56215	Abscess, I and D, under general anesthetic.....	720.00	2	186.72
*56225	Knee joint, arthrotomy, I and D .....	720.00	3	186.72
*56210	Bursa, I and D (prepatellar, etc.), under GA.....	720.00	2	186.72
56220	Hematoma, drainage under GA, (when sole procedure).....	1151.00	2	298.77
	NOTE: Payable at 50% in post-op period.			

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Incision - Therapeutic, Release:</b>				
56250	Decompression, neurolysis, nerve .....	830.00	2	214.73
*56260	Fasciotomy, compartment syndrome .....	830.00	3	235.21
*56269	Fasciotomy, secondary closure wound, with or without graft.....	720.00	2	186.72
<b>Soft Tissue Release:</b>				
56275	Major release knee - includes posterior capsulotomy, unilateral or bilateral .....	1885.00	3	487.81
56280	Knee liberation/major release (post ligament reconstruction).....	2977.00	3	770.24
56270	Minor release knee - tendons only, unilateral or bilateral.....	1335.00	2	345.45
56290	Open lateral/medial retinacular release .....	938.00	2	242.74
56285	Quadriceps plasty.....	2417.00	3	625.53
<b>Excision - Diagnostic, Percutaneous:</b>				
S11632	Arthroscopy, biopsy .....	830.00	2	214.73
S11630	Needle biopsy, under general anesthetic .....	720.00	2	186.72
<b>Excision - Diagnostic, Open:</b>				
11645	Biopsy, open .....	939.00	2	242.74
<b>Excision - Therapeutic, Endoscopic:</b>				
56330	Abrasion/debridement (isolated procedure) .....	938.00	2	287.62
56335	Lateral or medial release, endoscopic (isolated procedure).....	938.00	2	287.62
56325	Meniscal repair .....	1360.00	2	410.88
NOTES:				
i) Includes 56320, debridement of attachment site.				
ii) Not paid for trimming of the meniscus.				
56315	Resection 'plica' (isolated procedure).....	830.00	2	287.62
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.....	403.00	2	143.81

*(see notes on next page)*

**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

**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 .....	203.00		71.91
-------	--	--------	--	-------

**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.

**Excision - Therapeutic, Open:**

56355	Bursa, prepatellar.....	830.00	2	214.73
56353	Ganglion or cyst.....	830.00	2	214.73
56354	Popliteal cyst.....	1151.00	2	298.77

**Excision – Therapeutic, Knee Arthroscopic**

Synovial biopsy is included in 56305, 56306, 56310, 56315, 56320, 56325, 56330 and 56322.

56305	Removal symptomatic loose body .....	938.00	2	287.62
-------	--------------------------------------	--------	---	--------

NOTE: Not paid for removal of iatrogenic loose body(ies).

56306	Pinning/drilling osteochondral fragment(s) for osteoarthritic cartilage deficiency .....	1252.00	2	410.88
-------	--	---------	---	--------

NOTE: Includes removal of loose body(ies).

56310	Synovectomy, knee, for diseased synovium, anterior, posterior or complete total.....	1783.00	2	487.92
-------	--	---------	---	--------

56320	Meniscectomy, knee, partial or total for symptomatic meniscal tear.....	938.00	2	287.62
-------	---	--------	---	--------

56321	Drilling of defect or Microfracture and/or abrasion arthroplasty. ....	807.00	2	287.62
-------	--	--------	---	--------

**Arthrotomy Knee:**

56362	Meniscal repair.....	1360.00	3	352.44
56361	Meniscectomy, knee .....	939.00	3	242.74
56357	Pinning/drilling osteochondral fragment(s).....	1360.00	3	352.44
56356	Removal loose body .....	938.00	3	242.74
56360	Synovectomy, knee, total.....	1798.00	3	464.48

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
*56380 Osteomyelitis, acute, decompression.....	720.00	3	186.72
*56385 Osteomyelitis, debridement, with or without reconstruction.....	830.00	3	214.73
56390 Patellectomy.....	1259.00	3	326.77
56370 Bone Tumour, benign.....	1048.00	3	270.75
56365 Benign soft tissue Tumour, subfascial.....	1259.00	3	326.77

**Introduction (With or Without Removal,  
Therapeutic):**

*56410 Injection bursa, tendon sheath, other peri-articular structures .....	90.10		23.23
*56405 Injection joint .....	90.10		23.23
56415 Removal of internal fixation device(s), with GA .....	938.00	2	242.74
*56420 Removal of internal fixation device(s), without GA .....	270.00	2	70.02

**Repair, Revision, Reconstruction (Soft Tissue):  
Knee Ligament, Instability (With or Without  
Arthroscopy):**

*56528 Open injury, primary wound care.....	363.00	2	102.26
*56529 Open injury, secondary wound care .....	720.00	2	186.72
56505 One ligament repair/reconstruction, acute or chronic..	2090.00	3	616.34
56515 Two ligament repair/reconstruction, acute or chronic..	2410.00	3	718.62
56520 Three ligament repair/reconstruction, acute or chronic (includes PCL) .....	3226.00	3	835.59
56510 Posterior cruciate repair/reconstruction, acute or chronic.....	2882.00	3	746.91
56525 Revision knee ligament reconstruction (post previous ligament reconstruction) .....	2778.00	3	718.88

NOTE: 56505 to 56525 include meniscectomy, graft harvest plus use of synthetic device. Meniscus repair is payable in addition at 50%.

**Recurrent Subluxation/Dislocation Patella:**

56530 Extensor re-alignment procedures, soft tissue/bone ...	1679.00	3	434.15
56531 Lateral release, open or endoscopic .....	938.00	2	242.74
56540 Quadriceps tendon rupture, acute (within 6 weeks post injury).....	1335.00	2	345.45
56541 Quadriceps tendon rupture, chronic (beyond 6 weeks post injury).....	1896.00	2	490.15
56542 Patellar tendon repair .....	1715.00	2	480.90

**NOTES:**

- i) Restricted to Orthopaedic Surgeons.
- ii) Not paid with 56540, 56541 or 56545.

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
56545 Tendon transfer, transplant.....	1259.00	2	326.77
<b>Repair, Reconstruction (Bone/Joint):</b>			
<b>Os Osteotomy and/or Internal Fixation:</b>			
<b>Arthritis, Malunion or Non-union:</b>			
56601 Distal femur.....	3102.00	3	802.93
56604 Fibula.....	1048.00	3	270.75
56602 Proximal tibia.....	2199.00	3	569.50
56603 Tibia, shaft, includes fibula.....	2882.00	3	746.91
<b>Bone Grafting (i.e. onlay grafting):</b>			
56651 Femur.....	1048.00	3	270.75
56652 Tibia, with or without fibular osteotomy.....	1048.00	3	270.75
56653 Epiphysiodesis.....	1151.00	3	298.77
56654 Physeal Bar excision.....	1964.00	3	508.83
<b>Arthroplasty: Knee Joint:</b>			
56663 Total knee, removal prosthesis knee, includes PROSTALAC.....	1896.00	4	490.15
56661 Knee replacement, unicompartmental.....	2635.00	4	802.93
56662 Total knee replacement.....	3102.00	4	802.93
56664 Revision, total knee.....	4263.00	4	1104.00
56665 Revision, patellar component.....	1578.00	3	406.12
C56666 Meniscal Allograft Transplant.....	4429.00	5	1301.86
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.			
<b>Fracture and/or Dislocation:</b>			
<b>Metaphysis Femur: Supracondylar:</b>			
56703 Closed reduction, external fixation/percutaneous fixation.....	1368.00	2	354.78
56704 Closed reduction, IM nail.....	2990.00	5	774.90
*56702 Closed reduction, with GA, cast/traction.....	834.00	2	214.73
*56701 Closed reduction, without GA, cast/traction.....	469.00	2	121.36
56705 Open reduction, internal fixation.....	2990.00	4	774.90
*56708 Open injury, primary wound care.....	363.00	2	102.26
*56709 Open injury, secondary wound management.....	720.00	2	186.72

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Metaphysis Femur: Condyle or Intracondylar:</b>				
56713	Closed reduction, external fixation/ percutaneous fixation.....	1368.00	2	354.78
*56712	Closed reduction, with GA, cast/traction.....	720.00	2	186.72
*56711	Closed reduction, without GA, cast/traction.....	363.00	2	93.37
56715	Open reduction, internal fixation - unicondylar .....	2990.00	4	774.90
56716	Open reduction, internal fixation - bicondylar .....	4309.00	4	1115.69
*56718	Open injury, primary wound care.....	363.00	2	102.26
*56719	Open injury, secondary wound management .....	720.00	2	186.72
<b>Patellar Dislocation:</b>				
56725	Open reduction and repair.....	938.00	2	242.74
*56728	Open injury, primary wound care.....	363.00	2	102.26
*56729	Open injury, secondary wound management .....	720.00	2	186.72
<b>Patellar Fractures:</b>				
*56738	Open injury, primary wound care.....	363.00	2	102.26
*56739	Open injury, secondary wound management .....	720.00	2	186.72
56735	Open reduction, internal fixation.....	1783.00	2	462.14
56734	Patellectomy.....	1259.00	2	326.77
<b>Tibial Plateau Fractures:</b>				
56742	Closed reduction, external fixation, with or without minimal internal fixation.....	1479.00	2	382.78
*56741	Closed reduction, with GA, cast/traction.....	720.00	2	186.72
56746	Open reduction, internal fixation - bicondylar .....	3580.00	3	924.30
56745	Open reduction, internal fixation - unicondylar .....	2524.00	3	653.54
*56748	Open injury, primary wound care.....	363.00	2	102.26
*56749	Open injury, secondary wound management .....	720.00	2	186.72
<b>Tibial Shaft Fractures:</b>				
56753	Closed reduction, external fixation, with or without minimal internal fixation.....	1368.00	2	354.78
56754	Closed reduction, IM nail.....	2648.00	3	686.20
*56752	Closed reduction, with GA, cast/traction.....	834.00	2	214.73
*56751	Closed reduction, without GA, cast/traction.....	363.00	2	93.37
56755	Open reduction, internal fixation.....	2199.00	3	569.50
*56758	Open injury, primary wound care.....	363.00	2	102.26
*56759	Open injury, secondary wound management .....	720.00	2	186.72

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Fibular Shaft Fractures:</b>			
*56769 Open injury, primary/secondary wound care .....	720.00	2	186.72
<b>Manipulation: Knee Joint:</b>			
*S56800 Manipulation, with general anesthetic .....	363.00	2	93.37
<b>Arthrodesis:</b>			
56810 Knee joint .....	3102.00	3	802.93
<b>Amputation:</b>			
56980 Below knee .....	2002.00	3	518.18
*56998 Open injury, primary wound care .....	363.00	3	102.26
*56999 Open injury, secondary wound management.....	720.00	3	186.72
<b>TIBIAL METAPHYSIS (DISTAL), ANKLE AND FOOT</b>			
<b>Incision - Diagnostic, Percutaneous:</b>			
S11700 Arthroscopy, ankle joint/subtalar joint .....	720.00	2	186.72
SY00757 Aspiration, other joints.....	42.45	2	11.99
S11702 Aspiration bursa, tendon sheath .....	90.10	2	23.23
<b>Incision - Diagnostic, Open:</b>			
11715 Ankle joint .....	720.00	2	186.72
11717 Midtarsal joint.....	720.00	2	186.72
11716 Subtalar joint.....	720.00	2	186.72
11718 Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint.....	720.00	2	186.72
<b>Incision - Therapeutic, Drainage:</b>			
51039 Bursa aspiration - operation only .....	90.10		23.23
51040 Joint aspiration - operation only .....	90.10		23.23
*57215 Abscess, I and D, under general anesthetic.....	720.00	2	186.72
*57225 Ankle/foot joint, I and D, under general anesthetic.....	720.00	2	186.72
*57210 Bursa, I and D (tendo-achilles, etc.), under GA.....	720.00	2	186.72
57220 Hematoma, drainage under GA, (when sole procedure).....	1151.00	2	298.77
NOTE: Payable at 50% in post-op period.			
<b>Incision - Therapeutic, Release:</b>			
57250 Decompression, neurolysis, nerve (isolated procedure).....	1151.00	2	298.77
*57260 Fasciotomy, compartment syndrome .....	830.00	2	214.73
*57269 Fasciotomy, secondary wound closure .....	720.00	2	186.72

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Soft Tissue Release: Musculo-tendonous:</b>			
57280 Achilles tendon lengthening, percutaneous, unilateral or bilateral .....	830.00	2	214.73
57270 Plantar fascia: open release or partial excision, unilateral or bilateral .....	1048.00	2	270.75
57275 Plantar fasciectomy - total .....	1568.00	2	406.12
57285 Posterior hindfoot release .....	1679.00	2	434.15
57286 Posteromedial release (club foot /vertical talus) .....	2778.00	2	718.88
57290 Tendon lengthening, open.....	1048.00	2	270.75
57295 Tenosynovectomy .....	1048.00	2	270.75
<b>Excision - Diagnostic:</b>			
S11730 Needle biopsy, under general anesthetic .....	720.00	2	186.72
11745 Open biopsy, under general anesthetic.....	939.00	2	242.74
<b>Excision - Therapeutic, Endoscopic:</b>			
57330 Abrasion or debridement .....	938.00	2	287.62
57306 Pinning/drilling osteochondral fragments.....	1360.00	2	410.88
57305 Removal loose body .....	938.00	2	287.62
57310 Synovectomy ankle, total .....	1679.00	2	462.24
<b>Excision - Therapeutic, Open:</b>			
57373 Excision, accessory navicular .....	938.00	2	242.74
57355 Bursa, excision, Achilles.....	830.00	2	214.73
57375 Excision, nail bed, under GA, single or multiple .....	830.00	2	214.73
57354 Ganglion, tendon sheath or joint.....	830.00	2	214.73
57356 Neuroma (i.e. sensory, digital, etc.).....	830.00	2	214.73
*57380 Osteomyelitis, acute, decompression.....	720.00	2	186.72
*57385 Osteomyelitis, debridement with or without reconstruction .....	1246.00	2	322.10
57372 Sesamoidectomy.....	938.00	2	242.74
57360 Total synovectomy/debridement .....	1368.00	2	354.78
57374 Talectomy.....	2090.00	2	541.49
57371 Tarsal coalition .....	1360.00	2	352.44
NOTE: Includes harvesting of interposition material, if required.			
57370 Bone Tumour, benign.....	1360.00	2	352.44
57365 Benign soft tissue Tumour.....	830.00	2	214.73
<b>Introduction and/or Removal, Therapeutic:</b>			
*57410 Injection bursa, tendon sheath, other peri articular structures .....	44.90		11.63
*57405 Injection joint .....	44.90		11.63



	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
57415 Removal of internal fixation device(s), with general anesthetic.....	830.00	2	214.73
*57420 Removal of internal fixation device(s), without GA.....	179.00	2	46.68
<b>Repair, Revision, Reconstruction (Soft Tissue):</b>			
<b>Ankle Instability: Capsule or Ligament Repair:</b>			
57505 Acute ligament repair, medial and/or lateral.....	938.00	2	242.74
57510 Reconstruction for ankle instability.....	1472.00	2	380.44
<b>Tendon-muscle Repair:</b>			
57526 Extensor tendon(s), single, under GA .....	938.00	2	242.74
57527 Extensor tendon(s), multiple, under GA .....	1299.00	2	336.10
57525 Extensor tendon(s), without GA - operation only.....	467.00	2	121.36
57520 Flexor tendon repair, ankle or foot, single or multiple .	1360.00	2	352.44
57515 Tendo Achilles repair, acute (within 6 weeks post injury) .....	1360.00	2	352.44
57516 Tendo Achilles repair, chronic (beyond 6 weeks post injury) .....	2090.00	2	541.49
57535 Repair/reconstruction of tendon sheath .....	1472.00	2	380.44
<b>Tendon Muscle Transfer, Transplant, Tenoplasty:</b>			
57555 Jones' procedure .....	1259.00	2	326.77
57550 Tendon transfer.....	1679.00	2	434.15
<b>Repair, Revision, Reconstruction (Bone, Joint):</b>			
<b>Osteotomy/Malunion:</b>			
57601 Distal tibial.....	2508.00	2	648.87
57602 Malleolus, lateral and/or medial .....	1679.00	2	434.15
57605 Metatarsals, base, shaft, neck .....	1360.00	2	352.44
57603 Calcaneal Osteotomy (not to include Hagelund's) .....	1679.00	2	520.99
57604 Midtarsal Osteotomy .....	2312.00	2	597.51
57606 Phalanges, open osteotomy.....	938.00	2	242.74
<b>Osteotomy/Non-union:</b>			
57631 Distal tibial.....	2090.00	2	541.49
57632 Malleolus, lateral and/or medial .....	1259.00	2	326.77
57634 Metatarsals, base, shaft, neck .....	830.00	2	214.73
57635 Phalanges .....	830.00	2	214.73
57633 Tarsals .....	1472.00	2	380.44
57636 Epiphysiodesis .....	1151.00	2	298.77
57637 Physeal Bar excision.....	1568.00	2	406.12
<b>Bone Grafting (i.e. onlay grafting):</b>			
57651 Distal tibia .....	938.00	2	242.74

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
57652 Malleolus, medial and/or lateral - tarsals, metatarsals, phalanges .....	576.00	2	149.38
<b>Arthroplasty: Ankle Joint:</b>			
57661 Total ankle prosthesis .....	3102.00	3	991.26
*57663 Removal of total ankle arthroplasty .....	720.00	3	186.72
57662 Revision total ankle .....	3895.00	3	1335.36
<b>Metatarsal Phalangeal Joint: Arthroplasty:</b>			
57671 Excision arthroplasty great toe (Keller's cheilectomy) .	1048.00	2	270.75
57675 Implant arthroplasty .....	1151.00	2	298.77
57676 Interphalangeal joint arthroplasty, single or multiple....	1048.00	2	270.75
57673 Distal metatarsal osteotomy .....	1151.00	2	298.77
57674 Proximal metatarsal osteotomy with distal realignment	1679.00	2	434.15
57677 Minor forefoot reconstruction (lesser toes) .....	1472.00	2	380.44
57678 Major forefoot reconstruction (includes excision arthroplasty, stabilization with or without implant, and great toe) .....	2298.00	2	595.16
57672 Resection, soft tissue reconstruction .....	1151.00	2	298.77
<b>Fracture and/or Dislocation:</b>			
<b>Ankle Fracture:</b>			
<b>Intra-articular Tibial Metaphysical (PILON):</b>			
57702 Closed reduction, external fixation with or without percutaneous fixation, with or without minimal internal fixation, with or without open reduction internal fixation distal fibula .....	1896.00	2	490.15
*57701 Closed reduction, with GA, cast/traction.....	720.00	2	186.72
57705 Open reduction internal fixation (include fibular fracture).....	3461.00	2	896.29
*57708 Open injury, primary wound care.....	363.00	2	102.26
*57709 Open injury, secondary wound management .....	720.00	2	186.72
<b>Ankle (Malleolar) Fracture:</b>			
57713 Closed reduction, external fixation/percutaneous fixation .....	1048.00	2	270.75
*57712 Closed reduction, with GA, application of cast .....	1048.00	2	270.75
*57711 Closed reduction, without GA, application of cast .....	363.00	2	93.37
57715 Open reduction, internal fixation - one malleolus .....	1360.00	2	352.44
NOTE: Injuries requiring opposite side soft tissue repairs (i.e. deltoid ligament repair with lateral malleolar fracture ORIF) are payable under 57716.			
57716 Open reduction, internal fixation - two or more.....	1568.00	2	406.12
*57718 Open injury, primary wound care.....	363.00	2	102.26

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
*57719 Open injury, secondary wound management.....	720.00	2	186.72
<b>Hindfoot/Midfoot/Lisfranc Dislocation With or Without Fracture:</b>			
57723 Closed reduction, fixation.....	1151.00	2	298.77
*57722 Closed reduction, with GA, cast.....	720.00	2	186.72
*57721 Closed reduction, without GA, cast.....	363.00	2	93.37
57725 Open reduction, with or without internal fixation.....	1679.00	2	475.56
*57728 Open injury, primary wound care.....	363.00	2	102.26
*57729 Open injury, secondary wound management.....	720.00	2	186.72
<b>Os Calcis: Fracture:</b>			
57733 Closed reduction, fixation.....	1151.00	2	298.77
*57732 Closed reduction, with GA, cast.....	720.00	2	186.72
57735 Open reduction, internal fixation.....	2417.00	2	625.53
*57738 Open injury, primary wound care.....	363.00	2	102.26
*57739 Open injury, secondary wound management.....	720.00	2	186.72
<b>Talus Fracture:</b>			
57743 Closed reduction, fixation.....	1259.00	2	326.77
*57742 Closed reduction, with GA, cast.....	720.00	2	186.72
*57741 Closed reduction, without GA, cast.....	363.00	2	93.37
57745 Open reduction, internal fixation.....	1885.00	2	487.81
*57748 Open injury, primary wound care.....	363.00	2	102.26
*57749 Open injury, secondary wound management.....	720.00	2	186.72
<b>Tarsal Fracture:</b>			
57753 Closed reduction, fixation.....	1151.00	2	298.77
*57752 Closed reduction, with GA, cast.....	720.00	2	186.72
*57751 Closed reduction, without GA, cast.....	363.00	2	93.37
57755 Open reduction, internal fixation.....	1259.00	2	326.77
*57758 Open injury, primary wound care.....	363.00	2	102.26
*57759 Open injury, secondary wound management.....	720.00	2	186.72
NOTE: Multiple tarsal fractures are payable under hind/midfoot Lisfranc dislocation with or without fracture items *57721 to *57729.			
<b>Metatarsal Fractures:</b>			
57761 Closed reduction, fixation.....	1048.00	2	270.75
57765 Open reduction, internal fixation, one.....	1151.00	2	298.77
57766 Open reduction, internal fixation, two or more.....	1360.00	2	352.44
*57768 Open injury, primary wound care.....	363.00	2	102.26
*57769 Open injury, secondary wound management.....	720.00	2	186.72

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Metatarso-phalangeal Dislocation:</b>			
57773 Closed reduction, fixation, single or multiple .....	834.00	2	214.73
*57772 Closed reduction, with GA, cast, single or multiple.....	720.00	2	186.72
*57771 Closed reduction, without GA, cast, single or multiple.	363.00	2	93.37
57775 Open reduction, internal fixation.....	1151.00	2	298.77
*57778 Open injury, primary wound care.....	363.00	2	102.26
*57779 Open injury, secondary wound management .....	720.00	2	186.72
<b>Phalangeal Fracture:</b>			
57781 Closed reduction, fixation, single or multiple .....	1048.00	2	270.75
57785 Open reduction, internal fixation.....	1151.00	2	298.77
*57788 Open injury, primary wound care.....	179.00	2	51.13
*57789 Open injury, secondary wound management .....	363.00	2	93.37
<b>Interphalangeal Dislocations With or Without Fracture:</b>			
57793 Closed reduction, fixation, single or multiple .....	1048.00	2	270.75
*57792 Closed reduction, with GA, cast, single or multiple.....	720.00	2	186.72
*57791 Closed reduction, without GA, cast, single or multiple.	179.00	2	46.68
57795 Open reduction, with or without fixation.....	1151.00	2	298.77
*57798 Open injury, primary wound care.....	179.00	2	51.13
*57799 Open injury, secondary wound management .....	363.00	2	93.37
<b>Manipulation: Ankle/Foot:</b>			
*S57800 Manipulation, with general anesthetic .....	363.00	2	93.37
<b>Arthrodesis:</b>			
57812 Ankle joint.....	2778.00	3	718.88
57817 Interphalangeal, single or multiple.....	1048.00	2	270.75
57816 Metatarsophalangeal.....	1360.00	2	352.44
57814 Midtarsal joint .....	2090.00	2	541.49
57811 Pantalar.....	3243.00	2	840.26
57813 Subtalar joint/triple.....	2312.00	2	717.01
57815 Tarso-metatarsal joints .....	2542.00	2	658.20
57810 Tibiocalcaneal .....	2312.00	2	597.51
<b>Amputation:</b>			
57981 Midtarsal.....	1896.00	2	490.15
57983 Single metatarsal/Ray resection.....	1368.00	2	354.78
57980 SYME .....	2057.00	2	532.14
57984 Toe .....	727.00	2	186.72
57982 Transmetatarsal .....	1578.00	2	406.12
*57998 Open injury, primary wound care.....	179.00	2	51.13

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
*57999 Open injury, secondary wound management.....	363.00	2	93.37
<b>VERTEBRAE, FACET AND SPINE</b>			
<b>Incision - Diagnostic, Percutaneous:</b>			
SY00757 Aspiration, other joints.....	42.45	2	11.99
<b>Incision - Therapeutic, Percutaneous:</b>			
03368 Discogram (operation only).....	363.00	2	92.97
*58205 Injection/aspiration, facet joint.....	363.00	2	92.97
<b>Incision - Therapeutic, Drainage:</b>			
51039 Bursa aspiration - operation only .....	90.10		23.23
03369 Abscess or hematoma, extraspinal, under GA (operation only) .....	720.00	4	186.72
<b>Excision - Diagnostic, Percutaneous:</b>			
S11831 Needle biopsy, soft tissue/bone - lumbar spine, under general anesthetic.....	720.00	2	186.72
S11830 Needle biopsy, soft tissue/bone - thoracic spine, under general anesthetic.....	830.00	2	214.73
<b>Excision - Diagnostic, Open:</b>			
11845 Biopsy, with general anesthetic.....	938.00	3	242.74
NOTE: Not payable with definitive spinal surgery.			
<b>Excision - Therapeutic, Endoscopic</b>			
03361 Percutaneous discectomy .....	1048.00	3	270.75
<b>Decompression - Anterior:</b>			
Discectomy, With or Without Fusion:			
03362 Cervical, single level .....	2417.00	6	625.53
03363 Cervical, two or more levels .....	3118.00	6	807.58
03364 Thoracolumbar (includes decompression) .....	5569.00	8	1442.43
<b>Vertebral Body Resection:</b>			
03365 Cervical .....	6304.00	6	1633.84
03366 Thoracolumbar .....	7358.00	8	1904.58
<b>Introduction and/or Removal, Therapeutic:</b>			
S03167 Insertion of skull tongs (operation only).....	362.00	4	126.29
58410 Removal of spinal instrumentation .....	1945.00	5	509.68

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Repair, Revision, Reconstruction (Bone, Joint):</b>			
<b>Stabilization - Posterior:</b>			
03341 Cervical, segmental (includes C1-2 transarticular screws).....	4201.00	6	1087.67
03340 Cervical, simple, single or multiple level (includes Gallie fusion) .....	2090.00	6	541.49
03345 Thoracolumbar, segmental instrumentation and fusion with decompression - single level .....	6092.00	7	2058.13
03346 Thoracolumbar, segmental instrumentation and fusion with decompression - multiple levels .....	7135.00	7	2411.31
03344 Thoracolumbar, segmental instrumentation and spinal fusion .....	4833.00	7	1251.05
03343 Thoracolumbar, simple instrumentation (Harrington or wires or screws etc.) .....	2990.00	7	774.90
03342 Thoracolumbar, without instrumentation .....	1896.00	5	490.15
<b>Stabilization - Anterior:</b>			
03347 Cervical, stabilization alone (with Neurosurgeon).....	1948.00	6	504.14
03348 Cervical, with plates and discectomy.....	3822.00	6	1574.63
03349 Cervical, with plates and vertebrectomy.....	6834.00	6	1769.22
03350 Thoracolumbar, approach and stabilization alone (with Neurosurgeon).....	3674.00	8	952.30
03351 Thoracolumbar, instrumentation with anterior release or vertebrectomy .....	7880.00	8	2449.42
NOTE: 03350 and 03351 are payable in full when done in conjunction with posterior instrumentation and fusion.			
<b>Deformity Correction: Anterior Release/ Osteotomy:</b>			
03352 Thoracolumbar .....	5569.00	8	1442.43
03353 Thoracolumbar - with anterior instrumentation and correction .....	6615.00	8	1713.19
<b>Posterior Osteotomy With Instrumentation:</b>			
03354 Cervical .....	9448.00	6	2446.08
PC03355 Thoracolumbar Spinal Fusion – including posterior osteotomy via Smith-Peterson, pedicle subtraction or vertebral column resection with fusion of greater than four (4) vertebral segments .....	9448.00	7	3526.25
NOTE: Restricted to Neurosurgery and Orthopaedic Surgeons.			

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
P03370 Thoracolumbar Spinal Fusion (lasting longer than 6 hours) – per 15 minutes or greater portion thereof (maximum of 16 units per patient).....	170.00		50.79
<b>NOTES:</b>			
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.			
Posterior lumbar interspinous/interlaminar stabilization/instrumentation (extra)			
P03371 Single level (extra) .....	673.00		201.50
P03372 Multiple level (extra).....	1345.00		403.00
<b>NOTES:</b>			
i) Paid only in addition to 03158, 03161 or 03162.			
ii) Restricted to Neurosurgery and Orthopaedic Surgeons.			
Posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF) (extra)			
P03373 Single level (extra) .....	1345.00		403.00
P03374 Multiple level (extra).....	2017.00		604.50
<b>NOTES:</b>			
i) Paid only in addition to 03345, 03346, 03355, 03356 or 03357.			
ii) Restricted to Neurosurgery and Orthopaedic Surgeons.			
<b>Posterior Instrumentation and Fusion:</b>			
03356 Adult.....	6834.00	7	1769.22
03357 Pediatric.....	5569.00	7	1442.43
<b>Fracture and/or Dislocation (Cervical Spine):</b>			
<b>Cervical:</b>			
*58710 Application of halo.....	720.00	4	186.72
S03167 Application of skull tongs.....	362.00	4	126.29
03358 ORIF .....	3895.00	7	1008.32
<b>Thoracolumbar:</b>			
03359 ORIF with segmental fixation alone .....	5045.00	7	1307.07
03360 ORIF with segmental fixation and decompression .....	6092.00	7	1577.82

**MUSCULOSKELETAL ONCOLOGY**

51057 Reconstruction of shoulder/pelvis or sacrum.....	4215.00	6	1092.35
--	---------	---	---------

ORTHOPAEDICS - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
51054 Reconstruction of skeletal defect following excision .....	4215.00	6	1092.35
*51053 Resection of malignant bone Tumour limb, limb sparing.....	4185.00	6	1083.01
*51056 Resection of malignant girdle Tumour, pelvis and/or sacrum.....	6273.00	6	1624.50
51055 Resection of malignant girdle Tumour, scapula.....	4185.00	6	1083.01
51058 Resection of malignant Tumour, rotation plasty.....	8398.00	6	2175.33
51051 Resection of subfascial malignant soft tissue Tumour, simple .....	2312.00	5	597.51
51052 Resection of subfascial malignant soft tissue Tumour, complex (involvement of neuro/vascular structures).....	4937.00	6	1279.05
NOTE: Fee items 51053 to 51058. Reconstruction items are payable in full with the resection, if applicable.			

**APPLICATION OF CAST (INCLUDES EXTERNAL STIMULATOR)**

*51019 Below knee .....	90.10	2	23.23
*51024 Body (shoulder to hips).....	339.00	2	86.95
*51025 Cast brace .....	179.00	5	46.49
*51022 Hip spica - child .....	339.00	2	86.95
*51023 Hip spica - adult.....	339.00	2	86.95
*51017 Long arm (axilla to hand).....	90.10	2	23.23
*51021 Long leg.....	90.10	2	23.23
*51020 Long leg cylinder .....	90.10	2	23.23
*51016 Short arm (elbow to hand) .....	90.10	2	23.23
*51018 Shoulder spica.....	339.00	2	86.95

**MISCELLANEOUS**

*51035 Application of skeletal traction .....	363.00	2	93.37
*51036 Compartment pressure monitoring (extra).....	363.00	2	92.97
*51037 Harvesting of iliac crest autograft (extra) .....	363.00	2	93.37
*51038 Harvesting of skin graft (extra) - for orthopaedic procedures only .....	400.00	2	102.68
*51030 Orthopaedic interpretation and written report of submitted x-ray films including CT scan and MRI .....	109.00		39.38
NOTE: Not payable in addition to consultation rendered within 2 months on the same patient on referral by the same physician.			

**Ilizarov Instrumentation (Any Bone/Joint to Include Corticotomy):**

51065 Simple construction - lengthening/angular correction, with or without lengthening/non-union stabilization/fracture stabilization .....	4215.00	3	1092.35
--	---------	---	---------



**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

51066	Complex construction - multiplanar corrections/ multiple level lengthening/ elevator technique.....	5787.00	4	1498.46
*51067	Extension/revision of frame .....	830.00	3	214.73

**MINOR PROCEDURES**

13610	Minor laceration or foreign body - not requiring anesthesia (operation only) .....	82.60		35.62
13611	– requiring anesthesia (operation only).....	156.00	2	66.35
13630	Paronychia (operation only).....	82.40		35.53
13631	Removal of nail, simple (operation only) .....	82.40		35.53
13632	– with destruction of nail bed - operation only .....	165.00		71.89
13633	Wedge excision of one nail - operation only .....	147.00		63.44

**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).....	1754.00	5	411.80
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area .....	990.00	3	235.72
V70159	Debridement of skin and subcutaneous tissue; for each additional 5% of body surface area or major portion thereof – extra .....	497.00		117.87
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area .....	1110.00	4	261.93
V70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each additional 5% of body surface area or major portion thereof – extra.....	559.00	3	130.96
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area.....	1228.00	4	288.10
V70166	Debridement of skin, fascia, muscle and bone; for each additional 5% of body surface area or major portion thereof – extra .....	431.00		144.06
70168	Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area.....	331.00		78.57

*(see notes on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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 .....	386.00	4	125.72
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.			
<b>PERIPHERAL NERVE</b>			
S06258 Exploration of peripheral nerve and neurolysis.....	1020.00		256.65
NOTE: Multiple neurolyses are paid in accordance with Preamble Clause B.9.e. to a maximum of four neurolyses per sitting.			
S03196 Exploration, mobilization and transposition.....	798.00	2	281.48
03198 Neurectomy of major nerve .....	628.00	2	222.43
<b>HAND AND WRIST</b>			
<b>Excision, Therapeutic, Open:</b>			
V07055 Ganglia, of the wrist.....	561.00	2	202.23
<b>Incision, Open:</b>			
06051 Finger tip - operation only .....	651.00	2	250.72
06050 Regions of major joints and hands - early.....	1721.00	2	432.65
<b>SPINAL</b>			
03151 Stereotaxic surgery - spine .....	2201.00	5	791.17
03152 Bischoff's or longitudinal myelotomy.....	2655.00	5	936.10
03153 Laminectomy, with DREZ lesion for pain .....	3997.00	6	1408.69
03155 Laminectomy for hematoma, Tumour or vascular malformation.....	2689.00	6	948.86
Laminectomy for cervical disc:			
03156 – one level.....	2089.00	6	1524.64
03157 – multiple levels.....	2292.00	6	1874.56

ORTHOPAEDICS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
Laminectomy for lumbar disc:			
03158 – one level.....	1738.00	5	670.94
03159 – multiple levels .....	1893.00	5	1333.43
03160 Laminectomy for congenital spinal malformation or tethered spinal cord.....	3854.00	5	2027.87
03161 Laminectomy for localized spinal stenosis (two levels or less) .....	2018.00	5	789.13
03162 Laminectomy for generalized spinal stenosis (more than two levels) .....	3143.00	5	1213.99
03168 Laminectomy for intradural spinal cord or extra- medullary Tumour or vascular malformation by microsurgical technique.....	5160.00	7	2013.98
03180 Multiple level laminectomy for cervical cord compression, three or more levels .....	3704.00	6	1430.75
03163 Anterior cervical discectomy and fusion – one level .....	2292.00	6	1429.88
03164 – multiple levels .....	2921.00	6	1936.16
03166 Removal of thoracic disc .....	2445.00	8	2349.45
03185 Postero-lateral microsurgical thoracic discectomy.....	3657.00	8	1915.56
S03167 Insertion of skull tongs (operation only).....	362.00	4	126.29
03169 Fracture of spine without cord injury, open reduction and fusion.....	1948.00	7	686.74
03231 Repair of spinal CSF leak or pseudo-meningocele .....	1699.00	5	598.96

# OTOLARYNGOLOGY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
02510 <b>Consultation:</b> To include history, detailed examination of the ear, nose and throat, review of x-ray and laboratory findings and written report .....	241.00		77.84
02511 <b>Consultation:</b> With pure tone audiogram .....	295.00		93.45
02514 <b>Repeat or limited consultation:</b> 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 judgement of the consultant the consultative service does not warrant a full consultative fee .....	147.00		45.81
02512 <b>Special Consultation, for dizziness:</b> To apply where a patient has been referred by an Otolaryngologist, Neurologist or Neurosurgeon and to include all special examinations and an appropriate neurological assessment and a written report.....	484.00		166.27
02513 <b>Consultation:</b> For management of malignancy .....	363.00		108.85
NOTES:			
i) Billable by the surgeon in charge.			
ii) Not billable for minor or superficial skin malignancies.			
iii) Applicable to new malignancy or recurrence of malignancy in remission.			
02517 Consultation for management of complex laryngeal disorder .....	399.00		137.56
NOTES:			
i) To apply where a patient has been referred by another Otolaryngologist, Neurologist or Respiriologist.			
ii) To include self-assessment, perceptual analysis, aerodynamic measures and acoustic analysis.			
02515 Otolaryngic Allergy Consultation: To include a detailed history and physical exam with review of laboratory and other relevant investigations, plus appropriate otolaryngic allergy management and additional visits necessary to render a written report . (see note on next page)	484.00		145.14

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
NOTE: 02515 includes appropriate diagnostic skin testing (by conventional method or titration technique).			
02215 Pre-Operative Assessment .....	221.00		77.84
NOTES:			
i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances.			
ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.			
iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition.			
iv) Maximum of one pre-operative assessment per patient per procedure.			
v) Only paid to the surgeon who performs the procedure.			
<b><u>Continuing Care by Consultant:</u></b>			
02507 Subsequent office visit .....	98.50		32.67
02508 Subsequent hospital visit .....	81.00		24.41
02509 Subsequent home visit.....	162.00		48.92
02505 Emergency visit when specially called (not paid in addition to out-of-office hour premiums) .....	323.00		122.35
NOTE: Claim must state time service rendered.			

**MISCELLANEOUS**

02519 Complex Laryngeal Disorder Conference Fee.....	87.80		30.35
NOTES:			
i) Restricted to Otolaryngology.			
ii) Restricted to laryngeal pathology.			
iii) Payable only if 02517 (consult for management of complex laryngeal disorder) has been paid for the same patient by the same practitioner in the previous 6 months.			
iv) Requires interdisciplinary team meeting with at least one allied health professional.			
v) Maximum of four paid per patient, per day.			
vi) Maximum of eight paid per patient, per calendar year.			
<i>(notes continued on next page)</i>			

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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 FP/GP 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.			

**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) .....	57.10		15.44
02521 Audiogram - speech (SRT, PB, MCL) .....	62.10		16.85
02525 Impedance test.....	33.35		9.04
02531 Impedance test, including contra-lateral reflex.....	66.80		17.79
02532 PI-PB test.....	21.90		6.24
02533 Play audiometry .....	90.20		24.10
02534 Free field audiometry .....	90.20		24.10
02536 Brainstem evoked response audiometry .....	175.00		47.21

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02539 Brainstem evoked response audiometry with electrocochleography .....	255.00		68.22
NOTE: Only one additional specialist examination can be billed in addition to this item.			
02541 Electrocochleography .....	196.00		51.42
<b>Vestibular Tests:</b>			
02526 Cold calorics test.....	41.70		11.11
02527 Bithermal test.....	90.20		24.10
02528 E.N.G. (Electronystagmography) .....	179.00		47.54
NOTE: To control the total cost involved in extensive patient investigation, the following recommendation applies: Vestibular tests performed on a subsequent visit should have a maximum fee limitation equal to the value of fee item 02528, to be billed directly in lieu of return visit.			
<b>Functional Tests:</b>			
02530 Stenger .....	90.20		24.10
02542 Measurement of otoacoustic emissions .....	121.00		32.14
<b>Miscellaneous Tests:</b>			
NOTE: See also SY00907, SY00908 under Diagnostic and Selected Therapeutic Procedures.			
02538 Laryngostroboscopy.....	272.00		84.80
02535 Maxillary sinus endoscopy via canine fossa, with or without biopsy .....	428.00	3	116.87
02540 Flexible nasopharyngoscopy with video fluoroscopy ..	229.00	3	62.83

**EAR**

Item	Removal of foreign body or aerating tubes from ear - simple .....	Per Visit		
02206	Removal of ear canal osteoma (operation only) .....	299.00	2	82.94
02209	Removal of obstructing exostosis of ear canal.....	1757.00	3	484.78
02210	Paracentesis of the ear drum (operation only) .....	162.00	2	44.65
P02221	Microscopic debridement, foreign body removal, or aural polyp removal - with local anesthetic - operation only .....	98.50	2	27.11
02223	– under general anesthetic - operation only .....	229.00	2	63.76
NOTE: 02221, 02223 are not billable with 02254, 02274, 02228 and 02229.				

OTOLARYNGOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Transmastoid facial nerve decompression:			
02233 – vertical and horizontal segment .....	4091.00	4	1127.78
02234 – vertical segment.....	2130.00	4	586.86
02224 Transcanal labyrinthotomy transmastoid for posterior semicircular canal occlusion.....	792.00	4	218.88
02241 Labyrinthectomy - drill out of petrous bone .....	2079.00	4	574.07
02243 Repair atresia external ear canal, complete, bony .....	3843.00	3	1058.85
02244 Repair stenosis external ear canal, bony .....	2220.00	3	612.35
02245 Microsurgical repair and reconstruction soft tissue stenosis - external ear canal .....	2409.00	3	663.38
NOTE: Includes skin grafting or flap.			
02231 Microsurgical revision and reconstruction, soft tissue stenosis - external ear .....	1927.00	3	530.69
NOTE: Includes skin grafting or flap.			
02247 Mastoidectomy - partial, canal wall up (cortical).....	2220.00	3	612.35
02248 Radical mastoidectomy .....	2820.00	4	778.18
02249 Stapes - reconstruction .....	2220.00	3	612.35
02250 – mobilization of.....	1295.00	3	357.19
02246 – reconstruction with laser .....	2409.00	3	663.38
02251 Myringoplasty repair of drum - without exploration of middle ear .....	692.00	3	191.35
02239 Tympanotomy - with ossicular chain reconstruction..	1295.00	3	357.19
02252 Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of a tympanotomy) .....	1617.00	3	446.51
02264 – with ossicular chain reconstruction .....	2454.00	3	676.13
02276 – lateral graft, homograft tympanic membrane .....	2454.00	3	676.13
NOTE: Applicable to adhesive otitis media or total perforation.			
S02277 Tympanoplasty with excision of middle ear cholesteotoma – first 90 minutes.....	1462.00	3	507.54
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
S02278 Tympanoplasty with excision of middle ear cholesteotoma – each additional 15 minutes or greater portion thereof (to a maximum of 16 units) ....	147.00	3	50.76
NOTES:			
i) Restricted to Otolaryngologists. (notes continued on next page)			



OTOLARYNGOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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.			
02238 Tympanoplasty with excision of bony canal stenosis – microscopic open .....	2969.00	3	832.28
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.			
02253 Tympanomastoidectomy - complete, canal wall down, including tympanoplasty .....	3747.00	3	1033.35
02265 – partial, canal wall down (atticotomy).....	2220.00	3	612.35
02263 Trans-tympanic polyneurectomy .....	1203.00	3	331.68
02254 Myringotomy with insertion of aerating tube (operation only) - unilateral - operation only.....	299.00	2	82.94
02274 – bilateral - operation only .....	465.00	2	127.57
Myringotomy with insertion of aerating tube, under GA			
P02228 – unilateral (operation only) .....	288.00	2	103.09
P02229 – bilateral (operation only) .....	440.00	2	157.79
02255 Exploratory tympanotomy .....	860.00	2	236.02
02261 – with chemical control, tac procedure, cryosurgical control, ultrasound .....	1412.00	3	389.10
02266 Myringoplasty - paper patch or synthetic - operation only .....	162.00	2	44.65
02256 Endolymphatic shunt (any procedure) .....	3144.00	6	867.48
02259 Excision of glomus - by tympanotomy approach.....	2454.00	3	676.13
02260 – where extensive dissection is required .....	3178.00	4	1039.57
02267 Conchal cartilage graft .....	1157.00	3	318.91
02268 Intra-cochlear implant .....	3518.00	4	1383.29
02269 Implantable bone conductor.....	1709.00	4	469.68
02242 Microsurgical repair and reconstruction soft tissue atresia, external ear canal - complete .....	2884.00	3	796.06
NOTE: Includes skin grafting or flap.			
C02225 Middle Fossa Approach for Repair of Superior Canal Dehiscence .....	2652.00	5	920.76
NOTE: To include approach and plugging or repair of canal.			

OTOLARYNGOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02270 Transmastoid - posterior semi-circular canal occlusion or repair of superior canal dehiscence .....	2884.00	4	1383.29
NOTES:			
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 .....	7218.00	5	1990.13
NOTES:			
i) Includes resection and removal of tumour with facial nerve preservation.			
ii) Billable only by certified Otolaryngologists.			
02272 Transmastoid microsurgical removal of middle ear/mastoid tumour .....	4331.00	5	1194.08
NOTES:			
i) Requires extensive dissection, ossicular disarticulation and reconstruction, and extended facial recess approach to the hypotympanum.			
ii) Applicable to tympanomastoid glomus and facial nerve tumours requiring resection of the facial nerve.			
02273 Microsurgical tympanomastoidectomy - complete, canal wall up .....	4091.00	5	1127.78
NOTE: Includes tympanoplasty and ossicular reconstruction.			

**NOSE AND SINUSES**

Removal of foreign body from nose:			
Item – simple .....	Per Visit		
02301 – complicated with anesthetic - operation only .....	229.00	3	63.76
Cauterization of septum:			
Item – chemical.....	Per Visit		
02303 – electric - operation only.....	141.00	3	38.25
Cryosurgical treatment of turbinates:			
02298 – unilateral .....	559.00	3	153.09
02299 – bilateral .....	692.00	3	191.35
Turbinectomy:			
02304 – unilateral - operation only.....	350.00	3	95.67
02305 – bilateral .....	508.00	3	140.31
02306 Submucous resection of septum .....	601.00	3	165.83
Naso-antral window:			
02307 – single - operation only.....	418.00	3	114.81
02308 – double .....	652.00	3	178.61

OTOLARYNGOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02309 Radical antrostomy .....	1157.00	3	318.91
02310 – with closure of alveolar fistula .....	1666.00	4	459.27
Intranasal ethmoidotomy to include polypectomy, posterior:			
02360 – unilateral .....	1295.00	3	357.19
02361 – bilateral .....	1993.00	3	548.56
02362 Intranasal ethmoidotomy, anterior - unilateral .....	692.00	3	191.35
02363 – bilateral .....	1157.00	3	318.91
02315 External radical fronto - ethmoidotomy .....	2130.00	4	586.86
Electrocoagulation of turbinates:			
02317 – one side - operation only .....	188.00	3	51.03
02318 – both sides - operation only .....	277.00	3	76.53
02319 Trepining frontal sinus.....	931.00	3	255.15
02321 Sinus sphenoidotomy (intranasal).....	973.00	3	267.90
Removal of nasal polyp:			
S02322 – unilateral - operation only .....	370.00	3	102.06
S02323 – bilateral .....	601.00	3	165.83
Antral lavage:			
02324 – unilateral - operation only .....	122.00	3	33.58
02325 – bilateral - operation only .....	185.00	3	50.35
Choanal atresia; definitive repair of:			
02326 – unilateral .....	1757.00	3	484.78
02327 – bilateral .....	2454.00	4	676.13
Choanal atresia; perforation of:			
02328 – unilateral .....	601.00	3	165.83
02329 – bilateral .....	833.00	4	229.62
Submucous turbinectomy:			
02330 – unilateral .....	601.00	3	165.83
02331 – bilateral .....	931.00	3	255.15
Lateral rhinotomy and excision of tumour:			
02332 – benign.....	2130.00	3	586.86
02333 – Lateral rhinotomy and/or medial maxillectomy for excision of nasal tumour .....	2268.00	3	625.11
NOTES:			
i) To include open or endoscopic techniques			
ii) Not payable for polyps			
02334 Transantral ethmoidectomy .....	1757.00	3	484.78
02335 Transantral ligation, internal maxillary artery .....	1852.00	6	510.30
02337 Ligation of anterior and posterior ethmoid arteries.....	1157.00	6	318.91
02338 Removal of angiofibroma - nasal pharynx.....	2688.00	6	739.92
02342 Maxillectomy with exenteration of ethmoid .....	2920.00	5	803.71
02339 Palatal fenestration .....	937.00	3	257.82
02343 Septal reconstruction .....	1388.00	3	382.72
02341 Posterior nasal packing (operation only) to include balloon control of epistaxis - operation only .....	229.00	3	63.76

OTOLARYNGOLOGY - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02346	Posterior nasal packing with transoral gauze pack, under local, topical, or general anesthetic (operation only) .....	363.00	3	99.49
02345	Drainage of abscess or hematoma of septum (operation only) .....	418.00	3	114.81
02347	External osteoplastic frontal flap operation.....	3378.00	4	931.30
02364	Nasal fracture, simple reduction - operation only .....	229.00	3	63.76
S02365	Nasal fracture, reduction and splinting - operation only .....	465.00	3	127.57
06123	Comminuted nasal fractures - transosseous wire plate fixation .....	1221.00	3	307.05
02348	Operative closure of oral nasal fistula .....	1295.00	3	357.19
02349	Operative closure of nasal septal perforation.....	1852.00	3	510.30
02358	Revision endoscopic frontal sinusotomy with or without C arm .....	1686.00	3	464.38
02357	Endoscopic sinus surgery: functional endoscopic sinus surgery in children under 14 years of age NOTES: i) Extra to fee items 02307, 02308, 02360, and 02361. ii) Payable at an additional 50% of applicable surgical fee.			
02336	Laser revision of choanal stenosis .....	484.00	4	132.68
02359	Revision endoscopic intranasal sphenoidotomy (anterior, middle and posterior cells including sphenoid) .....	1927.00	3	530.69
25300	Endoscopic stereotactic resection of intranasal or sinus tumour – up to 7 hours operating time .....	3595.00	6	1046.36
	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 .....	887.00	6	261.58
	NOTES: i) Fee items 25300 and 25301 are payable only when pre-operative radiological imaging indicates either distorted anatomy of the sinuses secondary to disease or injury, or revised complex anatomy resulting from prior surgery, such that without stereotactic guidance, the surgery could not be performed. ii) Not payable for ethmoid disease, polypectomy or tumours affecting only one sinus. iii) Includes all surgery necessary to access tumour.			

*(notes continued on next page)*

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
	iv) Payable only when rendered in acute-care facility.			
	v) Time over seven hours is payable under fee item 25301.			
	vi) Minimum of 3 hours surgery duration required to bill fee item 25300.			
	vii) Start and end times must be entered in both the billing claims and the patient's chart.			
	viii) A written report must be submitted with claims billed under these items.			
25305	Endoscopic ligation – sphenopalatine artery.....	1426.00	6	418.55
	NOTES:			
	i) Not payable in addition to fee item 02335.			
	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.....	3300.00	8	976.07
	NOTES:			
	i) Includes harvest of any tissue needed for the repair, including closure of any donor site.			
	ii) Includes complete sphenoidectomy or frontal sinusotomy or sinus trephine if required			
	iii) Iatrogenic injuries payable at 50%.			
25315	Primary frontal sinusotomy .....	805.00	3	232.29
	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.			
25100	Laser photocoagulation of hereditary hemorrhagic telangiectasia lesions for nasal cavities (HHT) .....	1563.00	6	446.09
	<i>(see notes on next page)</i>			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

NOTES:

- i) Not payable with fee items SY00907, SY00908, SY00909, 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.

**RHINOPLASTY**

02351	Nasal refracture requiring lateral osteotomies.....	1295.00	3	357.19
02352	Reconstruction of nasal tip, ala and columella .....	1527.00	3	420.98
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma).....	2046.00	3	563.88
02354	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and reconstruction of nasal tip without skin grafting .....	2220.00	3	612.35
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and external reconstruction of nasal tip without skin grafting.....	2814.00	3	776.17

**THROAT**

Incision of peritonsillar abscess:				
02447	– under local anesthetic - operation only .....	188.00	4	95.00
02444	– under general anesthetic - operation only.....	466.00	6	128.81
Tonsillectomy:				
02403	– under local anesthetic.....	937.00	4	257.70
02445	– adult or child, over the age of 14 years .....	692.00	4	250.73
02446	– child, age 14 years and under (to include neonate).....	652.00	4	224.46
02413	Operative control of post-tonsillectomy or post-adenoidectomy hemorrhage requiring local or general anesthetic.....	601.00	6	263.45
02399	Cryotherapy of tonsils and oral lesions - operation only .....	418.00	3	114.81
02442	Adenoidectomy - adult or child, over 14 years .....	466.00	4	128.81
02443	– child 14 years and under (to include neonate).....	574.00	4	158.22
02448	Retropharyngeal abscess or hematoma - drainage under local anesthetic- operation only.....	465.00	4	127.57

OTOLARYNGOLOGY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
02406 Retropharyngeal abscess or hematoma - drainage under local anesthetic requiring lateral pharyngotomy .....	881.00	6	315.73
02409 Uvulo-palato-pharyngoplasty for obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy .....	1527.00	5	420.98
<b>NOTES:</b>			
The following two indications are requirements:			
i) Patient is unable to use Continuous Positive Airway Pressure (CPAP). This may be due to:			
a) Failure to adapt to the wearing of a mask of any kind after a trial of at least 30 days supervised by a qualified sleep therapist.			
b) Failure of CPAP to improve symptoms directly related to OSA after CPAP delivery has been optimized by a titration Polysomnogram (PSG).			
ii) Patient has, on level 1 Polysomnography in a certified sleep lab, an Apnea Hyponea Index (AHI) of 15 or greater. (Home sleep studies (level 2 or 3 PSG) may be substituted for level 1 PSG only if they are done through a certified sleep lab).			
02408 Removal of tumour from larynx or trachea .....	692.00	5	191.35
02410 Thyrotomy (including cordectomy) .....	1852.00	5	510.30
02431 Hemilaryngectomy .....	5251.00	6	1447.59
02432 Supraglottic laryngectomy.....	5718.00	6	1575.30
02433 Vocal cord implant - injection .....	1157.00	5	318.91
02434 – external approach.....	2316.00	5	637.88
02414 Repair laryngo tracheal stenosis (to include skin grafting, stenting and associated endoscopy).....	5234.00	8	1441.57
02418 Repair of fractured larynx - external approach.....	3006.00	8	829.22
02449 Rigid esophagoscopy for removal of foreign body .....	692.00	4	191.35
02450 Bronchoscopy or microlaryngoscopy with removal of foreign body .....	931.00	6	255.15
02422 – in a child under the age of 3 years - operation only.....	1385.00	6	380.57
02420 Dilation of trachea - operation only .....	299.00	5	152.64
02421 – repeat within one month - operation only.....	537.00	5	152.43
02425 Arytenoidectomy .....	2316.00	5	637.88
02436 Arytenoid adduction .....	1324.00	5	812.06

**NOTES:**

- i) Payable only to certified Otolaryngologists.
- ii) Includes fee item 02434.

OTOLARYNGOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02437 Transphenoidal removal of pituitary tumour or hypophysectomy, two surgeons - Otolaryngologists ..	2220.00	8	1233.76
02438 Trans-oral cricopharyngeal myotomy .....	1527.00	5	420.98
02424 Tracheo-oesophageal puncture and insertion of voice prosthesis following laryngectomy .....	1295.00	5	357.19
02440 Bilateral micro-transposition of submandibular salivary ducts when done with or without a microscope.....	1230.00	4	338.35
02441 OR standby fee for the ENT surgeon in the operating room for management of acute airway obstruction (for example, epiglottitis, allergic laryngeal edema, malignancy) .....	1085.00	11	298.53
NOTE: 02441 is not billable when tracheostomy is performed by the same surgeon at the same time. Bill under 02407.			
02451 Excision of congenital cyst or fistula from neck .....	1527.00	4	420.98
02452 Sialolithotomy - simple - in duct - operation only .....	229.00	3	63.76
02453 – complicated - in gland .....	692.00	3	191.35
02455 Submandibular gland, excision .....	1157.00	4	318.91
02456 Salivary fistula, plastic to Stenson's duct .....	1527.00	4	420.98
02454 Alveolectomy.....	692.00	3	191.35
02457 Tongue tie - under general anesthetic - operation only .....	299.00	3	82.94
02458 Tongue; local excision - under general anesthetic .....	601.00	3	165.83
02459 Cystic hygroma, excision.....	1993.00	4	548.56

**LARYNGEAL ENDOSCOPY AND SURGERY**

02412 Biopsy of larynx and/or cauterization (including laryngoscopy) - operation only .....	465.00	5	127.57
02419 Direct or indirect laryngoscopy with foreign body removal .....	559.00	5	153.09
02428 Micro-laryngoscopy - with biopsy of larynx and/or cauterization.....	652.00	5	178.61
02423 Micro-laryngoscopy with removal of non-pedunculated malignancy or extensive submucosal lesion.....	1616.00	5	445.46
02429 Micro-laryngoscopy and removal of tumour from larynx or trachea .....	744.00	5	204.12
Micro-surgery with use of CO <sub>2</sub> laser for removal of tumour(s) of larynx or trachea:			
02430 – first procedure.....	1616.00	6	445.46
02435 – subsequent procedure, each .....	1601.00	6	445.46

*(see notes on next page)*



<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

NOTES:

- i) Maximum of 5 subsequent procedures in six (6) month period, otherwise support with written letter.
- ii) Microsurgery treatment with CO<sub>2</sub> laser other than removal of tumour(s) of larynx or trachea, bill under 02599 with operative report.

**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 .....	6992.00	6	1926.37
02281	Conservative radical neck dissection .....	4556.00	6	1255.22
	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 .....	3835.00	6	1056.28
02471	Parotidectomy; subtotal with complete facial nerve dissection .....	3059.00	4	842.01
02472	Total parotidectomy with nerve dissection for malignancy or deep lobe tumour .....	3518.00	4	969.55
02407	Tracheostomy .....	1067.00	5	390.00
	NOTE: Not applicable to cricothyrotomy puncture.			
02411	Laryngectomy, total .....	4787.00	6	1659.94
02431	Hemilaryngectomy .....	5251.00	6	1447.59
02432	Supraglottic laryngectomy .....	5718.00	6	1575.30
C02473	Laryngo-pharyngo-esophagectomy (primary excision only) .....	5749.00	6	1900.00
C02474	Transoral maxillectomy with skin graft .....	3835.00	5	1056.25
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon .....	2316.00	5	637.88
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy .....	6992.00	7	1926.37
02477	Contralateral suprahyoid dissection .....	1757.00	5	484.78
02600	Complete temporal bone resection, ENT fee .....	8752.00	8	2412.31

OTOLARYNGOLOGY - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02601	Temporal bone resection for neoplasm; subtotal and lateral, to include mastoidectomy and excision of external auditory canal .....	4378.00	8	1506.13
02275	Glossectomy subtotal with either division of mandible or transcervical resection .....	3835.00	6	1056.22
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) .....	8752.00	8	2412.31
	NOTE: 02280 includes rhinotomy, ethmoidectomy, cibiform plate, and orbital exenteration.			
02478	Glossectomy - partial for carcinoma .....	1343.00	6	369.96
C02479	Transpalatal ethmoidectomy, maxillectomy, sphenoidectomy .....	4787.00	6	1320.23
C02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy .....	4787.00	7	1320.23

**SKULL BASE PROCEDURES**

02262	Translabyrinthine approach for neurosurgical access exposure, closure with microscope .....	4369.00	8	2429.48
02622	Infra-temporal fossa approach to skull base - Otolaryngology fee .....	7002.00	8	2224.40
02623	Infra-temporal fossa approach to skull base - Otolaryngology fee for procedure lasting longer than 8 hours .....	8752.00	8	2582.14

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.

02612	Middle cranial fossa approach, petrosectomy .....	7002.00	8	1929.76
02613	Middle cranial fossa approach, petrosectomy - procedure lasting longer than 8 hours .....	8752.00	8	2412.08

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.

OTOLARYNGOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
02610 Middle cranial fossa approach without petrosectomy - for trauma, neoplasm resection, nerve section/decompression .....	4369.00	8	1440.32
NOTES:			
i) To include exposure, removal and closure with microscope.			
ii) May include extra-dural resection of lesion by Otolaryngologist.			
02614 Retrolabyrinthine approach for neurosurgical access - exposure, closure with microscope .....	4369.00	8	2206.00
02618 Repair of CSF leak following skull base approach with mastoid obliteration (to include exposure, dissection and closure with microscope).....	3500.00	8	1400.00
<b>DIAGNOSTIC PROCEDURES</b>			
S00701 Direct laryngoscopy - procedural fee .....	141.00	5	37.70
NOTE: S00701 is not billable with bronchoscopy, except when done under general anesthetic.			
S00717 Micro-laryngoscopy - procedural fee.....	277.00	5	75.39
NOTE: S00717 to be charged at 50% if performed with a surgical procedure (not payable in addition to 02423, 02428, or 02429).			
S00745 Peripheral or subcutaneous lymph node biopsy - procedural fee .....	174.00	2	48.94
SY00907 Endoscopic flexible or rigid examination of the nose and nasopharynx - procedure only.....	122.00	3	33.07
SY00908 – procedure and biopsy .....	197.00	3	52.89
SY00909 Flexible fiberoptic nasopharyngolaryngoscopy .....	145.00	3	39.06
NOTES:			
i) SY00909 is not payable with S00700, S00702, SY00907, SY00908 and 02540.			
ii) Payable only to Certified Otolaryngologists.			
S10762 Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee .	332.00	3	74.74

# PEDIATRICS

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

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>		
00510 <b>Consultation:</b> To consist of an examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report .....	845.00	223.78
00550 <b>Extended Consultation – exceeding 53 minutes</b> (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 .....	1159.00	329.37
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 <b>Extended Consultation – exceeding 68 minutes</b> (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 .....	1426.00	391.02
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 <b>Consultation for Complex Behavioural Development or Psychiatric Condition in a Child:</b> To consist of a physical and neurological examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	1695.00	450.18

*(see notes on next page)*

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

**NOTES:**

- i) Not to be billed when there is 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.
- 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, dyscalculia, 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..... 532.00      140.68

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 (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 ..... 388.00      102.86

00585 Diabetic Ketoacidosis (DKA) – 1<sup>st</sup> day management – in hospital ..... 1736.00      459.42

**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 counseling..... 340.00      89.85

**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 Counseling:**

00513 Group counseling for groups of two or more patients - first full hour ..... 472.00      124.75

00515 – second hour, per 1/2 hour or major portion thereof ..... 236.00      62.37

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b><u>Continuing Care by Consultant:</u></b>		
00506 Directive care .....	370.00	99.47
00507 Subsequent office visit .....	298.00	79.03
00552 Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient). .....	311.00	98.55
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, 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).....	570.00	151.34
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 or 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		
00554 Extended subsequent office visit – exceeding 38 minutes (at least 30 minutes spent with patient) .....	811.00	215.26
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		
00597 <b>Antenatal follow-up visit</b> .....	141.00	37.09
NOTE: Payable in cases of prematurity or fetal anomaly.		
00508 Subsequent hospital visit .....	370.00	99.47
00509 Subsequent home visits.....	579.00	153.14

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
00505 Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	479.00	126.69
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.		
<b>Telehealth Service with Direct Interactive Video Link with The Patient</b>		
50510 <b>Telehealth Consultation:</b> To consist of an examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report. ....	845.00	223.78
50511 <b>Telehealth consultation for complex behavioural, developmental or psychiatric condition in a child:</b> To consist of a physical and neurological examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report. ....	1695.00	450.18
NOTES:		
i) Not to be billed when no change in condition from previous assessment.		
ii) Minimum time required 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, dyscalculia, 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.		
50512 <b>Telehealth repeat or limited consultation:</b> 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.....	388.00	102.86
50514 Telehealth prolonged visit for counselling.....	340.00	89.85
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.		

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
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 .....	1103.00	329.37
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.		
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 .....	1358.00	391.02
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.		
50517 Telehealth Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient).....	311.00	81.69
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 Complex subsequent office visit – exceeding 23 minutes (at least 20 min. spent with patient).....	542.00	151.34
NOTES:		
i) Applicable to patients with chronic and complex medical needs.		
ii) Includes a review of extensive documentation regarding the patient.		
Not payable in addition to 00507, 00552, 00553, 00554, 50507, 50517 or 50519.		
<i>(notes continued on next page)</i>		



	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p>iii) For time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.</p>		
50519 Telehealth Complex subsequent office visit – exceeding 38 minutes (at least 20 min. spent with patient) .....	773.00	215.26
NOTES:		
i) Applicable to patient 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.		
50506 Telehealth directive care .....	370.00	99.47
50507 Telehealth subsequent office visit.....	298.00	79.03
50508 Telehealth subsequent hospital visit.....	370.00	99.47

**SPECIAL SERVICES**

A00516 Newborn care in hospital, without complications .....	282.00
A00517 Periodic health examinations - infants .....	148.00
A00519 children and adolescents .....	164.00
A00520 Assessment and examination prior to adoption .....	586.00

**MISCELLANEOUS**

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 1/4 hour or major portion thereof. .	268.00	71.12
--	--------	-------

*(see notes on next page)*

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 (i.e. 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 or by phone.
- 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) 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.
- xii) Start and end times must be included in time fields.

PEDIATRICS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
P50571 Pediatric evening surcharge (service rendered between 1800 hours and 2300 hours) .....	116.00	30.80
P50572 Pediatric Saturday, Sunday and Statutory Holiday surcharge (service rendered between 0800 hours and 2300 hours)	116.00	30.80
P50573 Pediatric night surcharge (service rendered between 2300 hours and 0800 hours) .....	358.00	95.00
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.		

**SPECIAL PROCEDURES**

00525 Insertion of intra-arterial infusion line in infants - extra to consultation .....	361.00	95.20
00523 Exchange transfusion - procedural fee .....	1723.00	456.23
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 .....	216.00	56.94
00527 Electrocardiogram and interpretation - (office) - each.....	132.00	34.76
00528 – (home) - each.....	183.00	48.32
00529 Electrocardiogram - professional fee .....	45.65	12.17
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) .....	40.75	16.90
00532 Electrocardiogram and interpretation for children under 2 years of age.....	216.00	56.94
00533 – professional fee.....	51.00	13.36
00534 – technical fee .....	165.00	43.58

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
00530 Graded exercise test - technical fee .....	163.00	42.90
00535 – professional fee .....	237.00	62.59
00531 – total fee.....	399.00	105.50
NOTE: The note following fee items 33034, 33035 and 33036 in the Internal Medicine section of this Guide apply to items 00530, 00531 and 00535.		
00539 Rectal suction biopsy in children.....	400.00	105.79
00540 24 hour intraesophageal pH study in children (to include probe and monitoring).....	923.00	244.27
SY00541 Pediatric urethral catheterization in child under 5 years – isolated procedure .....	74.30	19.81
Notes:		
i) Procedure not payable if delegated to a non-physician.		
ii) Not payable with critical care listings or diagnostic urological procedures (e.g.: voiding cystourethrogram.)		
iii) Restricted to Pediatricians.		

**CHEMOTHERAPY**

- a. Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.
- b. Hospital visits are not payable on the same day.
- c. Visit fees are payable on subsequent days, when rendered.
- d. A consultation, when rendered, is payable in addition to fee item 00578, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.
- e. The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<p><b>00578 High Intensity Cancer Chemotherapy for patients 16 years of age and under:</b>                      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 .....</p>	914.00	242.00
<p>Notes: This service is not payable more frequently than once every 28 days. The following treatments fall into this category:</p> <ul style="list-style-type: none"> <li>a) chemotherapy for acute leukemia;</li> <li>b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment;</li> <li>c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;</li> <li>d) chemotherapy using DTIC in a dose exceeding 100 mg/m2;</li> <li>e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen);</li> <li>f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol.)</li> </ul>		
<p><b>00579 Major Intensity Cancer Chemotherapy for patients 16 years of age and under:</b>                      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.</p>	706.00	186.99
<p>Note: This service is not payable more frequently than once every 7 days.</p>		
<p><b>00580 Limited Intensity Cancer Chemotherapy for patients 16 years of age and under:</b>                      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 .....</p>	416.00	109.99
<p>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.</p>		

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>CARDIOVASCULAR PROCEDURES</b>			
S50520 Pediatric right heart catheterization – patients 0-6 years of age .....	1348.00	4	356.97
Note: Restricted to BC Children’s Hospital			
S50521 Pediatric right heart catheterization – patients 7-16 years of age .....	1011.00	4	267.71
Note: Restricted to BC Children’s Hospital			
PS50522 Pediatric myocardial biopsy for ages 0-16 years of age, extra .....	387.00		102.55
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.			
S50527 Pediatric retrograde left heart catheterization, extra – patients 0-6 years of age.....	1079.00	4	285.51
Note: Restricted to BC Children’s Hospital			
S50528 Pediatric retrograde left heart catheterization, extra – patients 7-16 years of age.....	809.00	4	214.11
Note: Restricted to BC Children’s Hospital			
S50530 Pediatric trans-septal left heart catheterization – patients 0-6 years of age.....	1453.00	4	384.73
Note: Restricted to BC Children’s Hospital			
S50531 Pediatric trans-septal left heart catheterization – patients 7-16 years of age.....	1091.00	4	288.55
Note: Restricted to BC Children’s Hospital			
S50539 Pediatric percutaneous transluminal coronary angioplasty – patients 0-6 years of age.....	3070.00	4	812.63
Note: Restricted to BC Children’s Hospital			
S50540 Pediatric percutaneous transluminal coronary angioplasty – patients 7-16 years of age.....	2302.00	4	609.48
Note: Restricted to BC Children’s Hospital			
S50541 Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 0-6 years of age .....	1619.00	4	428.40
Note: Restricted to BC Children’s Hospital			
S50542 Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 7-16 years of age .....	1213.00	4	321.29
Note: Restricted to BC Children’s Hospital			

PEDIATRICS - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S50545 Pediatric therapeutic radiological embolization – patients 0-6 years of age ..... Note: Restricted to BC Children’s Hospital	2815.00	3	745.14
S50546 Pediatric therapeutic radiological embolization – patients 7-16 years of age ..... Note: Restricted to BC Children’s Hospital	2112.00	3	558.88
50550 Percutaneous cardiac stenting in pediatric patients (0-18 years of age) – composite fee (operation only) ..... Notes: i) Applicable to placement of stents in vena cava pulmonary or coronary arteries and veins and aorta. ii) Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary angiograms and/or angioplasty, coronary or elsewhere and stent implantation to include any declotting or treatment of underlying cause of access failure. iii) Not payable with fee items 00898 and 00871. This composite also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance. iv) Payable to Pediatricians only. v) Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.	3947.00	7	1044.94
50551 – Additional stents – extra .....	832.00		220.00
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) .....	3947.00	7	1044.94

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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 arrest fee items 00845 and 00846.

**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.	209.00	2	54.99
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.	313.00	2	82.49
S00571	Pediatric esophagogastroduodenoscopy in a patient 16 years of age and under ..... Note: Restricted to Pediatricians.	748.00	3	197.97
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.	1371.00	2	362.98
S00755	Artery puncture - procedural fee .....	29.85	2	6.38



## **CRITICAL CARE**

### **Neonatal Intensive Care**

Please refer to the Critical Care Section of the Payment Schedule/Guide to Fees 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, hemodynamic support including vasoactive medications or prolonged resuscitation. They are to be billed only on sick or pre-term 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/Guide to Fees" applies.

### **“C. 18. Guidelines for Payment for Services by Trainees, Residents and/or 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.

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 counseling, 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 re-admitted, 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.

**NEONATAL INTENSIVE CARE**

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>LEVEL A</b> - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all procedures.		
01511 Day 1 .....	2392.00	633.46
01521 Day 2 - 10 .....	957.00	253.36
01531 Day 11 onward.....	638.00	168.95
 <b>LEVEL B</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 .....	1755.00	464.58
01522 Day 2 - 10 .....	638.00	168.95
01532 Day 11 onward.....	475.00	125.53
 <b>LEVEL C</b> - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.		
01513 Day 1 .....	1516.00	401.20
01523 Day 2 - 10 .....	469.00	123.99
01533 Day 11 onward.....	370.00	99.47

## PHYSICAL MEDICINE AND REHABILITATION

These fees cannot be correctly interpreted without reference to the Preamble. Letter prefix 'A' designates services not payable by payment agencies.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>REFERRED CASES</b>		
01710 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	485.00	208.53
01712 <b>Repeat or Limited Consultation:</b> Where a consultation for the 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.....	245.00	110.93
01714 Prolonged visit for counseling (up to four annually).....	245.00	80.91
NOTES:		
i) See Preamble D. 3. 3.		
ii) Start and end times must be entered in both the billing claims and the patient's chart.		
 <b>Group Counseling:</b>		
01713 Group counseling for groups of two or more patients - first full hour.....	354.00	144.18
01715 – second hour, per 1/2 hour or major portion thereof.....	175.00	72.05
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		
 <b><u>Continuing Care by Consultant:</u></b>		
01706 Directive care .....	121.00	71.52
01707 Office.....	163.00	106.60
01708 Hospital .....	80.10	71.52
01709 Home .....	179.00	150.00
01705 Emergency visit when specially called (not paid in addition to out-of-office hour premiums).....	275.00	107.90
NOTE: Claim must state time service rendered.		
 <b>Telehealth Service with Direct Interactive Video Link with the Patient</b>		
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 .	485.00	208.53

PHYSICAL MEDICINE AND REHABILITATION - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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. ....	245.00	110.93
01776 Telehealth directive care .....	121.00	71.52
01777 Telehealth subsequent office visit .....	163.00	106.60
01778 Telehealth subsequent hospital visit .....	80.10	71.52

**MISCELLANEOUS**

01728 Biofeedback for neurological and/or muscular retraining ..	57.80	21.33
NOTES:		
i) Payment for this listing is restricted to physicians 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 .....	99.50	34.07
01731 – Professional fee .....	145.00	49.73
01732 – Total fee .....	242.00	83.79
NOTE: The notes following fee items 33034, 33035 and 33036 in the Internal Medicine Section of this schedule also apply to fee items 01730, 01731 and 01732.		
A01720 Advice on the medical requirements of one or more patients at a formally scheduled multi-disciplinary rehabilitative conference of at least one (1) hour duration, per half hour or major portion thereof.....	166.00	
NOTE: Where more than one certified specialist in physical medicine and rehabilitation required, each to submit separate accounts.		
01721 Family rehabilitation conference where a certified specialist in Physical Medicine and Rehabilitation is involved with two (2) or more members of a family - per half hour or greater portion thereof, to a maximum of two (2) hours for any one rehabilitative case .....	207.00	90.66
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		

# PLASTIC SURGERY

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

## PLASTIC SURGERY - Continued

- 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 angiomas 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 lentiginous melanocytic proliferation or premalignant melanosis).
- ii) actinic/solar keratosis
- iii) chemical and other premalignant keratosis
- 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.
- viii)

### **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 of 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 visual field is restricted within 20° of fixation above the horizontal meridian, due to excess upper eyelid skin or brow ptosis.

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**REFERRED CASES**

06010 <b>Major Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report.....	306.00	98.50
06012 <b>Repeat or Limited Consultation:</b> To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgement of the consultant the consultative service does not warrant a full consultative fee .....	196.00	48.27



PLASTIC SURGERY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
66015 Pre-Operative Assessment.....	315.00		98.50
<b>NOTES:</b>			
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.			
<b><u>Continuing Care by Consultant:</u></b>			
06007 Subsequent office visit .....	102.00		25.43
06008 Subsequent hospital visit.....	148.00		36.71
06009 Subsequent home visit .....	185.00		46.86
06005 Emergency visit when specially called..... (not paid in addition to out-of-office hour premiums) NOTE: Claim must state time service rendered.	381.00		104.23

**Telehealth Service with Direct Interactive Video Link with the Patient**

66010 <b>Telehealth Major Consultation:</b> To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report .....	306.00		98.50
66012 <b>Telehealth repeat or limited consultation:</b> 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 .....	196.00		48.27
66007 Telehealth subsequent office visit .....	102.00		25.43
66008 Telehealth subsequent hospital visit.....	148.00		36.71

**SKIN AND SUBCUTANEOUS TISSUES**

**Biopsy**

61291 Biopsy, not sutured.....	102.00		25.53
61292 Biopsy, not sutured, multiples same sitting, maximum of four (extra).....	20.25		5.12

*(see notes on next page)*

PLASTIC SURGERY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>	
NOTES:				
i) 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) .....	322.00	2	140.69
07028	Biopsy of sural nerve – operation only .....	299.00	2	177.27
Excision – Diagnostic, Open:				
11445	Open biopsy, hand or wrist .....	939.00	2	242.74
Incisional or excisional biopsy, includes suture closure				
13600	Biopsy of skin or mucosa (operation only) .....	119.00	2	51.92
13601	Biopsy of facial area (operation only) .....	119.00	2	51.92
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) .....	192.00	2	76.01
Hand and Wrist				
Incision – Diagnostic, Percutaneous:				
S11402	Aspiration bursa, synovial sheath, etc. ....	90.10	2	23.23

**ABSCESS – INCISION AND DRAINAGE**

Abscess:				
07059	– deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only) ....	232.00	2	81.46
07027	– under general anesthesia (operation only) .....	520.00	2	203.59
07061	– deep, post-operative wound infection under general anesthesia (operation only) .....	331.00	2	203.37
07045	Anterior closed space abscess – operation only .....	160.00	2	101.44
13605	Opening superficial abscess, including furuncle operation only .....	104.00	2	44.48

**PILONIDAL CYST OR SINUS**

70084	– incision and drainage abscess (operation only) .....	232.00	2	101.36
07685	– excision or marsupialization – operation only .....	1124.00	2	277.43

**HAND AND WRIST ABSCESS**

06028	Web space abscess – (operation only) .....	284.00	2	71.53
06029	– under general anesthetic (operation only) .....	1013.00	2	290.00

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
06042 Mid palmar, thenar, and dorsal: subaponeurotic space abscess – (operation only) .....	1013.00	2	254.92
06197 Acute tenosynovitis – finger – (operation only).....	1013.00	2	290.00
06198 – ulnar or radial bursa – (operation only) .....	1013.00	2	290.00
13630 Paronychia – operation only .....	82.40	2	35.53

**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).....	1754.00	5	411.80
V70158 Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area .....	990.00	3	235.72
V70159 Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof .....	497.00		117.87
V70162 Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area .....	1110.00	4	261.93
V70163 Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof .....	559.00		130.96
V70165 Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area .....	1228.00	4	288.10
V70166 Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof .....	431.00		144.06
70168 Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area – operation only.....	331.00		78.57

NOTES:

- i) Payable when rendered at the bedside but only when performed by a medical practitioner.
- ii) Requires wound assessment and dressing change and may include VAC application.
- iii) Applicable with or without anesthesia.

70169 Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area (operation only) .....	386.00	4	125.72
---	--------	---	--------

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

NOTES:

- i) Payable only when performed by a medical practitioner in the operating room under general anesthesia or conscious sedation.
- ii) Requires wound assessment and dressing change and may include VAC application.
- iii) Debridement not payable in addition.

**FOREIGN BODY AND MINOR LACERATION**

In cases where a foreign body was simply extracted but the wound was not closed bill (13610 without anesthetic) or (13611 with anesthetic)

06063	Removal of foreign body – requiring general anesthesia – operation only .....	608.00	2	250.72
13610	Minor laceration or foreign body – not requiring anesthesia – operation only .....	82.60		35.62

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 .....	156.00	2	66.35
-------	--	--------	---	-------

**ABLATION**

**Abrasive Surgery**

06112	Abrasive surgery – less than quarter face (operation only).....	503.00	3	126.70
S06113	– between quarter and half-face.....	979.00	3	246.18
S06114	– full face.....	2082.00	3	523.79

**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).....	83.70		31.62
-------	---	-------	--	-------

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.”

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
00218 Curettage and electrosurgery of skin carcinoma proven histopathologically (operation only) .....	251.00		61.38
00219 For each additional lesion – to a maximum of two additional lesions per day (operation only) .....	188.00		30.69
*These items are subject to the general regulations covering surgical procedures.			
<b>Laser Therapy</b>			
00235 Pulsed laser surgery of the face and/or neck, treatment area less than 50 cm <sup>2</sup> (operation only).....	467.00	3	67.92
00236 Pulsed laser surgery of the face and/or neck, treatment area greater than or equal to 50 cm <sup>2</sup> , or treatment of the eyelids with eye shield insertion (operation only) .....	1011.00	3	101.87
00237 Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia.....	195.00		56.08

**NOTES:**

(a) Only the following conditions qualify for payment under 00235, 00236, 00237:

- i) Port wine stains involving the face and/or neck;
- ii) Complicated superficial haemangiomas:
  - lesions interfering with function (vision, breathing or feeding).
  - lesions which are ulcerated, bleeding, or prone to infections
  - Where standard wound care has failed.
- iii) Facial naevus of Ota
- iv) Disfiguring facial pigmentary anomalies (eg: segmental or systematized).

(b) Only the following types of lasers qualify for payment under 00235, 00236, 00237:

- i) Pulsed dye laser
- ii) Q-Switched Ruby laser
- iii) Q-Switched YAG laser

(c) Restricted to Dermatology and Plastic Surgery.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>SPECIAL CASE – SKIN AND SOFT TISSUE</b>			
06166 Excision of axillary sweat glands for hyperhidrosis – unilateral.....	1293.00	4	325.14
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.....	563.00	2	137.99
<b>Excision of skin and subcutaneous tissue of hidradenitis suppurativa:</b>			
Note: Direct closure included.			
<b>Foreign Body:</b>			
Excision of skin and subcutaneous tissue of hidradenitis suppurativa:			
07072 – axillary (operation only) .....	497.00	2	250.00
07075 – inguinal (operation only).....	497.00	2	250.00
07076 – perianal (operation only).....	497.00	2	250.00
07082 – perineal (operation only).....	497.00	2	250.00
<b>NAIL SURGERY</b>			
13631 Removal of nail – simple operation only .....	82.40	2	35.53
13632 – with destruction of nail bed (operation only).....	165.00	2	71.89
13633 Wedge excision of one nail (operation only).....	147.00	2	63.44
<b>GANGLIA</b>			
06182 Ganglia of tendon sheath or joint.....	726.00	2	182.27
<b>TORN EAR LOBE</b>			
06027 Repair of torn (split) earlobe (simple) (operation only)...	472.00	3	118.31
NOTES:			
i) Single flap only, under 2 cm.			
ii) Paid only for complete tear of lobe through margin.			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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) .....	265.00	2	137.54
S61301 – up to 5 cm – on face and/or requiring tying of bleeders and/or closure in layers (operation only) ...	300.00	2	203.77
S61302 – 5.1 to 10 cm – other than face, simple closure (operation only) .....	362.00	2	244.52
S61303 – 5.1 to 10 cm – on face and/or requiring tying of bleeders and/or closure in layers (operation only) ...	439.00	2	254.72
S61304 – 10.1 to 15 cm – other than face, simple closure (operation only) .....	395.00	2	285.29
S61305 – 10.1 to 15 cm – on face and/or requiring tying of bleeders and/or closure in layers (operation only) ...	493.00	2	356.60
S61306 – 15.1 cm or more – other than face, simple closure (operation only) .....	427.00	2	305.66
S61307 – 15.1 cm or more – on face and/or closure in layers (operation only) .....	571.00	2	407.55

**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.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC 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 .....	206.00	2	203.77
NOTES:			
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.			
ii) Paid in addition to 61300-61307 and 61310-61322.			
<b>Wounds – avulsed and complicated (in special areas)</b>			
V70150 Complicated lacerations of tongue, floor of mouth.....	1100.00	3	270.50
06238 Repair of complicated fingertip injury under digital block or anesthetic (regional/general).....	799.00	2	201.05
Note: Requires nail bed repair (includes removal of nail plate, suturing of nail bed laceration and replacement of nail plate) including associated management of distal phalangeal fracture.			
06075 Lips and eyelids .....	1349.00	3	339.41
06076 Nose and ear .....	1696.00	3	426.36
06077 Complicated lacerations of the scalp, cheek and neck ..	1324.00	3	333.13
NOTES: The following conditions are necessary for 06075, 06076 or 06077 to apply:			
i) A layered closure* is required and at least one of:			
ii) Injuries involving necrotic tissue requiring debridement such that simple suture closure is precluded; or			
iii) injuries involving tissue loss such that simple suture is precluded; or			
iv) Wounds requiring tissue shifts for closure aside from minor undermining or advancement flaps; or			
<i>(notes continued on next page)</i>			



<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- v) Skived, ragged or stellate wounds where excision of tissue margins is necessary to obtain 90 degree closure; or
- vi) Contaminated wounds that require excision of foreign material, or
- vii) Lacerations requiring layered closure and key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or
- viii) Lacerations into the subcutaneous tissue requiring alignment and repair of cartilage and layered closure.
- ix) 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.

## 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%, 2<sup>nd</sup> to 5<sup>th</sup> – 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).....	264.00	122.27
S61311	Resulting in repair 5-10 cm (operation only).....	436.00	157.92
S61312	Resulting in repair greater than 10 cm (operation only).	701.00	234.35

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Face, scalp, neck, genitalia, hands, feet, axilla</b>			
S61313 Resulting in repair less than 5 cm (operation only).....	379.00		169.13
S61314 Resulting in repair 5-10 cm (operation only).....	458.00		224.15
S61315 Resulting in repair greater than 10 cm (operation only)	742.00		275.10

<b>Eyelids, ears, lips, nose, mucous membrane, eyebrow</b>			
S61316 Resulting in repair less than 2 cm (operation only).....	478.00		178.30
S61317 Resulting in repair 2-4 cm (operation only).....	655.00		213.97
S61318 Resulting in repair greater than 4 cm (operation only)	981.00		290.38
61319 For excision of lesion (in hospital), to achieve tumour-free margin with frozen section, (extra).....	206.00		101.89

**NOTES:**

- i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
- ii) Paid once per sitting
- iii) Paid with 61310-61318, 61320-61322 and 61325-61341.

**SKIN FLAPS AND GRAFTS**

**Excision of Malignant and Pre-malignant Lesions**

NOTE: For excision of malignant and pre-malignant lesions, when the recipient area requires skin flaps, full thickness grafts or split thickness grafts for closure, use the following fee items for excision in addition to the fees for skin flaps or grafts. For defects less than 10 cm<sup>2</sup> (3cm x 3cm), payment is made for closure only.

61320 Area 10-50 cm <sup>2</sup> (minimum 10 cm <sup>2</sup> ) – extra (operation only).....	166.00	2	61.13
61321 Area 51-100 cm <sup>2</sup> (minimum 51 cm <sup>2</sup> ) – extra (operation only).....	356.00	2	132.45
61322 Area over 100 cm <sup>2</sup> (minimum 101 cm <sup>2</sup> ) – extra (operation only).....	544.00	2	183.40

**NOTES:**

- i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
- ii) Not paid with direct linear closure fees (61310-61318).

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- iii) For areas  $\geq 10$  cm<sup>2</sup>. Maximum 3 services paid per patient, per sitting, regardless of number performed.
- iv) Paid in addition to skin flaps, split-thickness graft or full-thickness grafts (where applicable).
- v) 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:
  - ii) 1 cm (nose, ear, eyelid, lip, eyebrow)
  - iii) 1.5 cm (other face and neck)
  - iv) 3 cm (rest of body)
- v) Fee items 61324 to 61329 are restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
- vi) 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)	507.00	2	185.44
61325 – 2.1 to 5 cm (operation only) .....	363.00	2	234.35
61327 – face, neck or scalp .....	995.00	2	355.27

**Other areas:**

61326 – 2.1 to 5 cm (operation only) .....	413.00	2	182.38
61328 – 5.1 to 10 cm (operation only) .....	652.00	2	233.47
61329 Defects more than 10 cm (such as a thoracic abdominal flap).....	1569.00	2	393.85

**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.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Trunk</b>			
61330 Defect up to 40 cm <sup>2</sup> .....	973.00	2	243.61
61331 Defect 40 cm <sup>2</sup> to 100 cm <sup>2</sup> .....	1292.00	2	324.82
61332 Defect greater than 100 cm <sup>2</sup> .....	1686.00	2	423.66
<b>Arms, legs and scalp</b>			
61333 Defect up to 6 cm <sup>2</sup> .....	611.00	2	305.76
61334 Defect 6 cm <sup>2</sup> to 19 cm <sup>2</sup> .....	813.00	2	307.76
61335 Defect greater than 19 cm <sup>2</sup> .....	1824.00	2	458.84
<b>Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck</b>			
61336 Defect up to 6 cm <sup>2</sup> .....	1216.00	2	305.76
61337 Defect 6 cm <sup>2</sup> to 19 cm <sup>2</sup> .....	1377.00	2	346.78
61338 Defect greater than 19 cm <sup>2</sup> .....	1865.00	2	469.01
<b>Ears, eyelids, lips and nose</b>			
61339 Defect up to 6 cm <sup>2</sup> .....	1382.00	2	347.03
61340 Defect 6 cm <sup>2</sup> to 19 cm <sup>2</sup> .....	1821.00	2	457.92
61341 Defect greater than 19 cm <sup>2</sup> .....	2025.00	2	509.26
<b>Revision of Graft</b>			
61342 Revision, less than 2 cm .....	579.00	2	203.01
61343 Revision, between 2 and 5 cm .....	1415.00	2	243.61
61344 Revision, greater than 5 cm .....	1468.00	2	284.22
<b>Specialized Flaps</b>			
06026 Arterial island flap .....	1409.00	2	353.91
06177 Neurovascular pedicle flap .....	2962.00	3	744.43
<b>Flaps from a distance for defects under 10 cm<sup>2</sup>, requiring two stages (e.g.: groin flap, deltopectoral flap or cross leg flap):</b>			
06030 Upper extremity – initial stage (with free skin graft) – over 10 cm <sup>2</sup> .....	2352.00	2	591.47
06031 – second stage – over 10 cm <sup>2</sup> .....	1875.00	2	471.50
06032 Lower extremity (plaster cast included) – initial stage - over 10 cm <sup>2</sup> .....	2824.00	2	710.26
NOTE: Second stage for lower extremity paid at 50% (of 06032).			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**Flaps from a distance for defects under 10 cm<sup>2</sup>, 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 <sup>2</sup> .....	1409.00	4	353.91
06034	Minor Second stage - per operation - under 10 cm <sup>2</sup> .....	937.00	3	235.39
06035	Delaying a flap (operation only) – under 10 cm <sup>2</sup> .....	651.00	3	163.48

**Specific areas:**

**Eyebrow**

06148	Hair bearing scalp vascular island flap to eyebrow.....	1925.00	3	483.98
-------	---	---------	---	--------

**Hand**

06171	Syndactyly, local flaps – first cleft.....	1013.00	2	254.92
06172	– with skin grafts – first cleft.....	1804.00	2	453.55

**FREE SKIN GRAFTS (INCLUDING MUCOSA)**

**Full-thickness grafts:**

**NOTES:**

- i) Full thickness fees, 2 to 19 cm<sup>2</sup>, include direct closure of donor site.
- ii) Each additional 19 cm<sup>2</sup> 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 <sup>2</sup> ) (operation only).....	491.00	2	228.39
61351	Arms, legs, scalp (2 to 19 cm <sup>2</sup> ).....	840.00	2	289.29
61352	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm <sup>2</sup> ) .....	1059.00	2	355.27
61353	Ears, eyelids, lips and nose (2 to 19 cm <sup>2</sup> ) .....	1237.00	2	395.89
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) .....	503.00	2	253.77

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**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).....	413.00	2	250.72
06047 – 65 sq.cm. (operation only).....	773.00	2	304.13
06048 – 650 sq.cm.....	1545.00	2	388.27
06049 For each 6.5 sq. cm. over 650 sq. cm. (operation only).	29.45	3	7.42

NOTE: Refrigerated graft – 50% of appropriate fee

**Functional areas:**

NOTE: Multiple operations to functional areas [see Preamble, Clause D. 5. 3]

06051 Fingertip (operation only).....	651.00	2	250.72
06050 Regions of major joints and hands – early.....	1721.00	2	432.65
06058 – late – with scar excision graft .....	2082.00	2	523.79
06052 Head and neck – 65 sq.cm. or less .....	1241.00	3	312.18
06053 – in excess of 65 sq.cm. ....	1658.00	3	416.93
06054 – in excess of 195 sq.cm. ....	4111.00	3	1033.97

**MAJOR FLAP PROCEDURES**

06151 Decubitus ulcers – excision and treatment of bone, rotation flaps, and skin grafts to secondary defect.....	3446.00	4	866.70
C06159 TRAM Flap reconstruction of mastectomy defect.....	4064.00	5	1021.77

NOTE:

- 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 two pedicled TRAM flaps is payable at 150%.

61152 Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment. ....	3154.00	4	910.00
---	---------	---	--------

NOTE: To include umbilicoplasty where medically indicated.

PLASTIC SURGERY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
C61156 Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving small muscles .....	1763.00	5	444.79
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 .....	2498.00	5	630.91
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 .....	3033.00	5	765.60

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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 abdominous 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).....	2588.00	3	650.54
06110	– dynamic slings with local functional muscle transfer (unilateral) .....	3125.00	3	785.69
06120	Complete repair for facial paralysis, plication of paralyzed muscles, meloplasty, and resection of overactive muscles – bilateral.....	3333.00	3	838.07
06129	Combined complete repair as above and rhytidectomy- unilateral.....	3759.00	3	945.41

**CELL-ASSISTED LIPOTRANSFER FOR SOFT DEFECTS (ASPIRATION AND INJECTIONS)**

**Cell-assisted Lipotransfer – Aspiration**

S61250	– Volume less than 20 ml .....	325.00	3	81.88
S61251	– Volume between 21-60 ml.....	405.00	3	102.34
S61252	– Volume greater than 60 ml .....	568.00	3	143.28

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%

*(notes continued on next page)*



<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- 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.....	487.00	3	122.81
S61261 – Volume greater than 20 ml.....	730.00	3	184.23

Non-Functional area:

S61270 – less than 20 ml.....	405.00	3	102.34
S61271 – 21 to 60 ml .....	568.00	3	143.28
S61272 – greater than 60 ml.....	730.00	3	184.23

NOTES:

- i) For the purpose of cell-assisted 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 .....	2012.00	3	559.83
---	---------	---	--------

PLASTIC SURGERY - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
06086	Tissue expansion – minor areas.....	1400.00	2	351.98
	<b>Blepharoplasty</b>			
06125	Blepharoplasty, simple, non-cosmetic (unilateral) .....	1043.00	3	261.90
	NOTE:			
	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) .....	1562.00	3	392.82
	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). .....	1562.00	3	392.82
	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)... ..	2343.00	3	589.27
	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.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Eyebrow ptosis</b>			
61360 Eyebrow ptosis repair – simple skin excision – non-cosmetic – unilateral.....	1042.00		261.90
61361 Eyebrow ptosis repair – simple skin excision – non-cosmetic – bilateral.....	1562.00		392.82

**NOTES:**

- i) Significant eyebrow ptosis is defined as present when the visual field is restricted to within 20 degrees of fixation above the horizontal meridian.
- ii) Includes resection of any amount of forehead skin and upward brow advancement required to correct the functional deficit.
- iii) For upper lid skin excess secondary to severe brow ptosis as opposed to primary upper lid skin excess.
- iv) Not paid with 06125 or 61025 on the same patient, same date of service.

**Tenotomy**

**NOTES:**

- i) Tenotomy fees paid once per tendon only. Two repairs on the same tendon will be paid as one repair.
- ii) Restricted to Plastic Surgery, General Practice, Orthopaedics, General Surgery and Emergency Medicine.

**Flexor – primary or secondary repair**

61363 – first tendon .....	1500.00	2	377.06
61364 – second to sixth tendon repair (extra).....	750.00	2	188.53
61365 – seventh to eleventh tendon repair (extra).....	375.00	2	94.27
61366 – twelfth and over tendon repair (extra) .....	188.00	2	47.14

**Extensor – primary or secondary repair**

61368 – first tendon .....	943.00	2	237.02
61369 – second to sixth tendon repair (extra).....	473.00	2	118.51
61370 – seventh to eleventh tendon repair (extra).....	235.00	2	59.24
61371 – twelfth and over tendon repair (extra) .....	118.00	2	29.62

**Tenoplasty – tenodesis, tenovaginitis, shortening or lengthening, stenosing tenosynovitis:**

06186 – one tendon, any location .....	922.00	2	231.62
06187 – two or more tendons .....	1500.00	2	377.06
06188 Tenolysis .....	1560.00	2	392.14
06189 – each additional, to a maximum of three (extra) (operation only) .....	579.00	2	145.44

PLASTIC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
06185 Tendon graft .....	2807.00	2	705.63
06203 Tendon transfer in hand and wrist .....	1784.00	2	448.72
06204 – each additional, to a maximum of three (extra) .....	651.00	2	163.48
06175 Pollicization.....	4575.00	4	1150.59
06176 Digital transplant.....	2775.00	5	952.71
S61230 Needle Aponeurectomy - Dupuytren's Disease .....	574.00		151.13

NOTES:

- i) Restricted to Plastic Surgery and Orthopaedics.
- ii) Not paid in addition to fee items 06193 and 06194.
- iii) Bilateral services paid at 150%.

57270 Plantar Fascia: open release or partial excision, uni- or bilateral.....	1048.00	2	270.75
---	---------	---	--------

06193 Extensive palmar – fasciectomy involving one or more digits .....	1725.00	2	433.71
--	---------	---	--------

06194 – with skin grafting.....	2232.00	2	561.51
---------------------------------	---------	---	--------

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 .....	1839.00	3	462.17
---	---------	---	--------

**CAVITY GRAFTING**

06055 Eye socket.....	1754.00	3	441.02
-----------------------	---------	---	--------

06056 – with mucosa .....	2689.00	3	675.68
---------------------------	---------	---	--------

06057 Nose .....	1567.00	3	393.90
------------------	---------	---	--------

06060 Mouth.....	2082.00	3	523.79
------------------	---------	---	--------

06061 Lining pedicle flaps .....	1197.00	3	300.67
----------------------------------	---------	---	--------

06062 Bone cavity over 7.5 cm in diameter in large bone, e.g.: femur .....	1754.00	4	441.02
---	---------	---	--------

06065 Bone cavity up to 7.5 cm in diameter in large bone .....	1238.00	3	311.13
--	---------	---	--------

06064 Bone cavity in small bone, e.g.: hand or foot.....	1013.00	2	254.92
--	---------	---	--------

06066 Operation for congenital absence of vagina (McIndoe) plastic surgery and care.....	2317.00	4	582.45
---	---------	---	--------

**BURNS (WITH OR WITHOUT GENERAL ANESTHESIA – PER OPERATION)**

**General care, severe only:**

06083 – first hour .....	1013.00		254.92
--------------------------	---------	--	--------

06084 – subsequent hour (per hour).....	811.00		203.93
---	--------	--	--------

Item – subsequent visits.....Per Visit

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>Local care:</b>			
Minor burns – per visit:			
06078 – dressing (in-hospital care only) .....	228.00	4	57.62
06079 – surgical debridement – for each 5% of body surface (operation only) .....	487.00	5	122.35
06080 – subsequent debridement – for each 5% of body surface (operation only) .....	120.00	5	30.37
06081 Surgical excision of burnt tissue prior to immediate skin grafting – for first 5 percent of body surface, extra (operation only) .....	1043.00	5	376.08
06082 – for each subsequent 5 percent of body surface, extra (operation only) .....	811.00	5	203.93

**OSTEOMYELITIS**

06087 Incision subperiosteal abscess (operation only).....	1013.00	2	254.92
--	---------	---	--------

**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 (e.g.: degloving of the maxilla or mandible).

PLASTIC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Fracture - Mandible:</b>			
06240 Interdental and intermaxillary wiring .....	1492.00	6	445.96
06241 Wiring with Gunning splints or dentures .....	1821.00	6	457.87
Open reduction:			
06242 – unilateral.....	2230.00	6	662.31
06243 – bilateral.....	3040.00	6	866.25
Open reduction and intermaxillary wiring:			
06244 – unilateral.....	2637.00	6	764.28
06245 – bilateral.....	3446.00	6	968.21
06246 Removal of sutures, intra-oral splints, etc. (under general anesthetic) - operation only .....	476.00	4	301.47
<b>Fracture-Maxilla (Central Mid-Third):</b>			
06250 Le Fort I - horizontal fractures.....	3446.00	6	968.21
06251 Le Fort II - pyramidal fractures.....	3852.00	6	1070.17
06252 Le Fort III - cranio-facial dysjunction .....	4421.00	6	1213.31
06253 Open reduction and internal or external craniomaxillary wire suspension with or without intermaxillary fixation .....	4421.00	6	1111.81
<b>Fracture-Zygomatic (Lateral Mid-Third) Zygomatico-Maxillary (including Orbital Floor):</b>			
06260 Temporal elevation - operation only.....	1013.00	3	328.22
06261 Open reduction and interosseous wiring (to include antral packing where necessary) .....	2510.00	4	637.40
06262 Reduction via transantral approach and antral packing - operation only .....	1013.00	4	457.93
<b>Zygomatic Arch:</b>			
06265 Temporal elevation - operation only.....	1013.00	3	356.42
06266 Open reduction and interosseous wiring.....	1370.00	4	446.25
<b>Orbital Floor Fractures (Blow-out Fractures):</b>			
06270 Open reduction (to include antral packing where necessary) .....	2637.00	4	743.98
<b>Fracture - Alveolus:</b>			
06271 Alveolar fracture with one tooth extraction - operation only .....	510.00	3	128.20
06272 – each additional tooth - operation only.....	318.00	3	79.71
06273 Arch bar fixation of teeth.....	1227.00	3	409.62
<b>Temporo-mandibular Joint:</b>			
06280 Meniscectomy.....	1370.00	3	446.25

PLASTIC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
06281 Condylectomy.....	2031.00	3	510.65
06282 Arthroplasty .....	2886.00	3	726.12
<b>Mandibular Resection:</b>			
06291 Tumours - enucleation, partial or complete resection....	2412.00	4	606.54
06292 – with bone graft .....	3424.00	4	860.78
Bone graft to jaw or face:			
06293 – autologous .....	2155.00	4	541.89
06294 – non-autologous .....	1987.00	4	499.88

**MAXILLO-FACIAL**

**Osteotomies:**

C06300 Le Fort I - horizontal .....	4494.00	6	1130.11
C06301 Le Fort II - pyramidal .....	5566.00	6	1399.45
C06302 Le Fort III - intracranial .....	11561.00	8	2907.70
C06303 Le Fort III - extracranial.....	9849.00	7	2476.77
C06310 Unilateral orbital advancement, intracranial approach...	11135.00	8	2799.96
C06311 Intracranial orbital advancement and correction of hypertelorism.....	12419.00	8	3123.16
C06312 Intracranial correction of hypertelorism .....	14988.00	8	3769.56
61380 Bilateral orbital advancement – intracranial approach for correction of hypertelorism when done as a team procedure with a Neurosurgeon and Plastic Surgeon ...	5430.00	8	2235.25
61381 Unilateral orbital advancement – intracranial approach when done as a team procedure with a Neurosurgeon and Plastic Surgeon .....	5038.00	8	2073.65
61382 Bilateral orbital advancement – intracranial approach - when done as a team procedure with a Neurosurgeon and Plastic Surgeon .....	6741.00	8	2773.64
C06313 Unilateral orbital expansion by osteotomy for macrophthalmia.....	11990.00	8	3015.43
06314 Canthopexy .....	2244.00	3	564.52
C06304 Malar maxillary .....	5137.00	6	1291.71
Mandibular - for prognathism, micrognathism, malocclusion, etc.:			
C06305 – unilateral with intermaxillary fixation.....	3208.00	6	806.91
C06306 – bilateral with intermaxillary fixation.....	3851.00	6	968.51
C06307 Premaxillary set back .....	3208.00	6	806.91
Mandibular osteotomy with rigid internal fixation:			
C06308 – unilateral .....	3273.00	6	823.07
C06309 – bilateral .....	4709.00	6	1183.97

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>NOSE AND SINUSES</b>			
<b>Cryosurgical treatment of turbinates:</b>			
02298 – unilateral.....	559.00	3	153.09
02299 – bilateral.....	692.00	3	191.35
02306 Submucous resection of septum .....	601.00	3	165.83
<b>Rhinoplasty</b>			
06109 Removal of hump .....	948.00	3	238.09
06118 Bone graft to nose -autologous.....	2389.00	3	601.15
06119 – non-autologous .....	1963.00	3	493.41
06115 Forehead rhinoplasty - 2 operations .....	3649.00	3	917.68
NOTE: Partial forehead rhinoplasties, charge under item 61339, 61340 or 61341.			
02351 Nasal refracture requiring lateral osteotomies .....	1295.00	3	357.19
02352 Reconstruction of nasal tip, ala and columella.....	1527.00	3	420.98
02353 External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma) .....	2046.00	3	563.88
02354 Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture and reconstruction of nasal tip without skin grafting.....	2220.00	3	612.35
02355 Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture and external reconstruction of nasal tip without skin grafting .....	2814.00	3	776.17
06116 Composite graft .....	1316.00	3	331.03
06117 Rhinophyma .....	1334.00	3	335.05
<b>Fractures:</b>			
06123 Comminuted nasal fractures - transosseous wire plate fixation .....	1221.00	3	307.05
06124 Naso-orbital fractures - open reduction and interosseous wiring or transosseous wire plate fixation .	2121.00	3	533.27
Nasal Fracture:			
02364 – simple reduction - operation only .....	229.00	3	63.76
S02365 – reduction and splinting - operation only.....	465.00	3	127.57
<b>EARS</b>			
06131 Outstanding ears - unilateral otoplasty .....	1263.00	3	317.82
61031 Outstanding ears - bilateral otoplasty .....	1896.00	3	476.72
06132 Microtia or loss of ear - partial - per stage .....	1500.00	3	377.06
06133 – total - major stage.....	3732.00	3	938.36
06134 – total - minor stage.....	1221.00	3	307.05
06130 Accessory auricle (operation only).....	1013.00	3	254.92
06135 Preauricular sinus - simple .....	1013.00	3	254.92
06180 – complicated .....	937.00	3	304.33



	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>MOUTH</b>			
06181 Lip adhesion procedure for cleft palate .....	1563.00	3	393.22
06146 Lip shave - vermilionectomy .....	1588.00	3	399.13
06136 Plastic repair - e.g.: Abbe operation - 2 stages.....	2549.00	4	641.12
06137 Full lip thickness transfer by rotation flap .....	2183.00	4	548.93
06139 Unilateral cleft lip .....	2219.00	4	558.04
06138 Bilateral cleft lip - complete.....	4220.00	4	1061.16
06144 – incomplete.....	2985.00	4	750.90
06140 Wedge resection of lip - vermilion (operation only).....	446.00	3	200.57
06141 – to sulcus.....	936.00	3	250.72
06142 Pharyngoplasty or pharyngeal flap .....	2160.00	6	542.97
06143 Push-back of palate with pharyngeal flap or similar procedure .....	2985.00	6	750.90
06145 Cleft palate .....	2203.00	6	553.74
06147 Bone graft to palatal cleft.....	2437.00	4	612.99
<b>ORBIT</b>			
06153 Bone graft to orbit - autologous .....	2437.00	4	612.99
06154 – non-autologous implant.....	1839.00	4	462.17
<b>BREAST</b>			
NOTE: See Preamble regarding cosmetic surgery.			
06150 Reduction mammoplasty - for hypermastia - unilateral .	2100.00	4	527.85
NOTE: For ptosis - cosmetic only.			
61050 Reduction mammoplasty for hypermastia - bilateral .....	3148.00	4	791.76
NOTE: For Ptosis, cosmetic only.			
61045 Immediate Breast Reconstruction – extra .....	425.00		202.31
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.			
61046 Biologic tissue for breast reconstruction – extra.....	637.00		303.46
<i>(see notes on next page)</i>			

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
NOTES:			
i) Payable only in addition to fee items 06164 or 06165.			
ii) Also payable in addition to fee item 06085 when a patient requires post mastectomy radiation and there is a concern for the long term pliability of the mastectomy flap(s), (BC Cancer Agency registration number must be provided in the note record).			
iii) Paid at 100% for unilateral and 150% for bilateral reconstruction.			
iv) Payable only to Plastic Surgeons.			
61047	Filling of tissue expander .....	164.00	43.77
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.			
06085	Tissue expansion – major areas – breast scalp and tibial areas, regions of major joints .....	2012.00	3 559.83
C61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles .....	3033.00	5 765.60
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 abdominous 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			

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
C06159 TRAM Flap reconstruction of mastectomy defect.....	4064.00	5	1021.77
NOTE:			
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 .....	12359.00	5	3108.09

**CELL-ASSISTED LIPOTRANSFER FOR SOFT DEFECTS (ASPIRATION AND INJECTIONS)**

**Cell-assisted Lipotransfer – Aspiration**

PS61250 – Volume less than 20 ml.....	325.00	3	81.88
PS61251 – Volume between 21-60 ml .....	405.00	3	102.34
PS61252 – Volume greater than 60 ml.....	568.00	3	143.28

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:

PS61270 – less than 20 ml.....	405.00	3	102.34
PS61271 – 21 to 60 ml .....	568.00	3	143.28
PS61272 – greater than 60 ml.....	730.00	3	184.23

(see notes on next page)

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**NOTES:**

- i) For the purpose of cell-assisted 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 gynecomastia .....	912.00	3	305.89
P61053 Bilateral breast construction in the context of gender affirming surgery, male to female (MtF) .....	2895.00	3	772.73

**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.

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).....	5870.00	3	1476.26
--	---------	---	---------

**NOTES:**

- i) For MSP-approved, transgender patients meeting the clinical criteria for FtM surgery.
- ii) Not billable in addition to V07498 (Mastectomy, subcutaneous), 06157 (nipple-areolar reconstruction), and 61330, 61331 or 61332 (local tissue shifts, multiple).
- iii) Otherwise subject to General Preamble rules for multiple surgery.

Prosthetic breast replacement in unilateral agenesis or following mastectomy:

06164 – unilateral.....	1175.00	3	405.66
-------------------------	---------	---	--------

PLASTIC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
06165 – bilateral .....	1875.00	3	608.76
61166 Mastopexy, balancing unilateral (isolated procedure) ...	1277.00	3	458.02
61167 Mastopexy, balancing — when performed at same time as contralateral breast surgery .....	956.00	3	305.44
06178 Excision of breast implant and associated pathologic capsule .....	1376.00	2	410.00
06179 Excision of breast implant only (operation only) .....	503.00	2	245.70
06157 Nipple-areolar reconstruction .....	1350.00	2	339.52
NOTE: This procedure is to result in a pigmented areolar complex using pigmented epithelium.			
61057 Nipple areolar reconstruction and tattooing .....	1820.00	2	457.84
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.			

**LEG**

06127 Lymphoedema of limbs - excision and grafting - entire leg .....	2782.00	3	700.04
06128 – entire lower extremity .....	4161.00	3	1046.58
06167 Treatment of lymphoedema using the Thompson procedure - upper extremity forearm .....	1409.00	4	353.91
06168 – arm .....	937.00	4	235.39
(Total of \$577.96 whether one or two stages)			
06169 – lower extremity leg .....	2352.00	4	591.48
06170 – thigh .....	2352.00	4	591.48
(Total of \$1,160.18 whether one or two stages)			

**MICROSURGERY**

06259 Microsurgical removal of neoplasm - digital or palmar ..	1337.00	2	336.04
<b>Microneural Surgery:</b>			
Neurolysis:			
06210 – external .....	1146.00	2	288.08
06211 – intraneural .....	1747.00	2	438.94
Microfascicular neuroorrhaphy, primary:			
06212 – digital or palmar .....	1146.00	2	288.08
06213 – major nerve .....	2444.00	2	614.93
Interfascicular nerve graft (to include harvest of graft):			
06214 – digital or palmar .....	1716.00	2	533.59
06215 – major nerve .....	4998.00	4	1600.00

PLASTIC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
03207 Microsurgical removal of neoplasm - major peripheral nerve.....	2313.00	3	815.19
<b>Microvascular Surgery:</b>			
06216 Artery or vein - primary repair (to include operative report).....	2688.00	6	675.48
NOTE: If a major artery in trunk, anesthetic IC level 9.			
P61210 Certified Plastic Surgeon Assist - Complex Case (extra). Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof .....	109.00		50.58
NOTES:			
i) Restricted to Plastic Surgery.			
ii) Paid only for assisting microsurgical surgeries; fee items 06217 or 06220.			
iii) Paid in addition to fee items 70020 and 00198.			
iv) Maximum payable is 20 units per surgery.			
v) Any additional assistants, if required, are paid under fee items 00197 and 00198 only.			
vi) This fee is intended for plastic surgeons in active practice to compensate for lost office or operating room time in taking the day to assist a colleague on complex procedures. Fellowship trainees and short term locums (<6 months) are not eligible.			
vii) Start and end times must be entered in both the billing claims and the patient's chart.			
C06220 Free flap, including closure of defect at donor site .....	12359.00	5	3108.09
<b>Microreplantation:</b>			
C06217 Digit or extremity (to include operative report) .....	11566.00	4	3108.88
<b>AMPUTATIONS</b>			
06218 Transmetacarpal.....	1013.00	2	254.92
06219 Finger, any joint or phalanx - operation only .....	1013.00	2	254.92
<b>BONE GRAFTING</b>			
06221 Metacarpal, phalanx .....	1013.00	2	254.92
<b>FRACTURES</b>			
06222 Finger phalanx, requiring reduction (operation only) .....	503.00	2	126.70
06223 Metacarpal, requiring reduction (operation only) .....	503.00	2	126.70
61222 CRIF of phalangeal (middle or proximal) or metacarpal fracture .....	778.00	2	196.24

PLASTIC SURGERY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
61223 ORIF of phalangeal (middle or proximal) or metacarpal fracture .....	1061.00	2	267.69
Note: Multiple fractures paid in accordance with Preamble D. 6.			
61224 Open (compound) hand fractures—Primary wound management (operation only).....	164.00	2	41.11
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 .....	326.00	2	82.15
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 flaps.			
ii) includes removal of beads			
iii) This listing is exempt from the 14-day rule (Preamble D. 5. 2.)			
iv) Payable only when procedure performed in operating room			
Distal phalanges open reduction and wiring:			
06224 – first .....	600.00	2	150.64
06225 – each additional (extra) - operation only .....	503.00	2	126.70

**JOINTS – INTERPHALANGEAL OR METACARPOPHALANGEAL**

06228 Arthroplasty of metacarpophalangeal or interphalangeal (hand) joint.....	1370.00	2	344.75
06229 Arthrodesis of metacarpophalangeal or interphalangeal (hand) joint.....	1221.00	2	344.75

PLASTIC SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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 .....	3945.00	3	992.21
Note: Only applicable when performed on more than 2 joints			
06232 Finger joint prosthesis - first joint .....	1033.00	2	259.64
06233 – subsequent joints same sitting - each (operation only) .....	587.00	2	147.59
06234 Synovectomy - of flexor or extensor tendons in wrist and hand for rheumatoid disease .....	1397.00	2	351.20
06235 Intrinsic release .....	1013.00	2	254.92
<b>Dislocations:</b>			
06236 Metacarpophalangeal or interphalangeal joint – closed reduction (operation only) .....	291.00	2	125.35
06237 – open reduction - operation only .....	1013.00	2	254.92

**NERVES**

<b>Peripheral nerve:</b>			
06255 Minor, digital, primary suture or secondary .....	1013.00	2	254.92
06256 Repair of palmar nerve .....	1013.00	2	254.92
06257 Major, primary suture .....	1604.00	3	403.31
S06258 Exploration of peripheral nerve and neurolysis .....	1020.00	2	256.65
NOTE: Multiple neurolyses are paid in accordance with Preamble, Clause D. 5. 3. to a maximum of 4 neurolyses per sitting.			
S03196 Exploration, mobilization and transposition .....	798.00	2	281.48
03198 Neurectomy of major nerve .....	628.00	2	222.43
03200 Secondary suture including transposition .....	1631.00	3	575.24
03201 Secondary suture of major nerve .....	1244.00	3	437.73
03205 Nerve graft .....	1221.00	3	431.81
06156 Transplant of neuroma .....	1013.00	2	254.92

**TATTOOING SURGERY  
(FOR HAEMANGIOMATA, VITILIGO, LENTIGINES, ETC.)**

<b>Facial area:</b>			
S06200 Less than 1/4 of face - operation only .....	456.00	3	114.69
S06201 1/4 to 1/2 of face .....	937.00	3	235.39
S06202 Full face .....	1409.00	4	353.91



PLASTIC SURGERY - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--	-----------------------	--

**Nonfacial area:**

06205	Less than 6.5 sq. cm - operation only .....	237.00	2	59.75
S06206	Less than 65 sq. cm - operation only.....	472.00	2	118.31
S06207	Less than 650 sq. cm .....	937.00	2	235.39

NOTE: Fee items 06205-06207 are not payable for nipple areolar tattooing.

**SALIVARY GLAND AND DUCTS – EXCISION**

07522	Local excision of parotid tumour, without nerve dissection - operation only.....	544.00	3	203.62
-------	--	--------	---	--------

**ARTERIES**

**Trauma:**

Repair of injury of major vessel in extremity:

77330	– suture.....	1643.00	6	583.75
77335	– graft.....	2113.00	6	750.88

**ELBOW, PROXIMAL RADIUS AND ULNA**

Incision – Therapeutic, Release:

53250	Decompression, neurolysis, nerve .....	938.00	2	242.74
53255	Decompression, neurolysis, submuscular; transposition of nerve .....	1568.00	2	406.12

**Repair, Revision, Reconstruction (Soft Tissue):**

53520	Biceps tendon, longhead, tenodesis.....	1048.00	2	270.75
-------	---	---------	---	--------

**SHOULDER GIRDLE, CLAVICLE AND HUMERUS**

**Repair, Revision, Reconstruction (Soft Tissue):**

52555	Tendon transfer, transplant .....	1983.00	3	513.50
-------	-----------------------------------	---------	---	--------

# PSYCHIATRY

## 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 (i.e. 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; and
- 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 (1) 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 situation;
- c) extended time required due to nature of clinical problem (explanation needed in each such case); and
- 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 (2) 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. Referral For Prolonged Psychiatric Treatment**

1. Continuation of payment of specialist fees beyond six (6) months is dependent on re-referral by a physician. This procedure is required in all specialties and is, in fact, a requirement of the BC Medical Association rather than of the Medical Services Commission who, however, have agreed to accept this as an adequate procedure for ensuring the need for continuing medical care by the specialist.
2. While the judgment concerning the medical necessity of continuation of psychiatric treatment may, in effect, be that of the psychiatrist, the referring physician must concur to ensure continued payment at specialist rates. In practice, it would be advisable for the specialist who sees the need to continue treatment beyond six (6) months to ensure that the referring physician is contacted just prior to that time and to maintain contact with the referring physician's office until he/she is sure that a referral has been sent.
3. Re-referral at the six (6) month interval does not necessarily require a visit by the patient to the referring physician, who can, in effect, send in a "no charge" re-referral. It is obvious; however, that the referring physician must be aware of the need for continuing care by the specialist, and this would be best achieved by the specialist sending the referring physician a written report of his/her treatment, of the present status of the patient and of the prognosis.
4. In cases where confusion is likely to arise; for example, where the patient has changed his/her general physician from the time of the original referral, or when the specialist is unable to ensure that a re-referral is being made, it would be advisable for the specialist to cover the situation by writing directly to the Medical Advisor of MSP concerned, indicating the circumstances and supplying whatever information he/she thinks necessary to ensure continued payment at specialist rates.

#### **5. 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 fees cannot be correctly interpreted without reference to the Preamble.

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<b>FULL CONSULTATIONS</b>		
<u>Individual</u> : Diagnostic interview or examination, including history, mental status exam and treatment recommendation and written report.		
00610 Private office or hospital out-patient.....	483.00	241.18
00611 Extended Adult Psychiatry Consultation > 68 minutes.....	705.00	316.81
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 .....	532.00	241.18
00613 Geriatric consultation (patients 75 years or older).....	738.00	364.75
<u>Emotionally disturbed child</u> : Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report.....		
00622 .....	828.00	430.67
<u>Multiple disturbed family</u> : (3 or more members) - Simultaneous diagnostic interviews or examination, including mental status of the members, their interactions and written report .....		
00623 .....	1011.00	430.68
<b>REPEAT OR LIMITED CONSULTATIONS</b>		
Where a formal consultation for the 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.		
00625 Individual (see 00610 & 00615) .....	242.00	127.83
00614 Geriatric (see 00613) .....	411.00	182.38
00626 Emotionally disturbed child (see 00622) .....	420.00	215.32
00627 Multiple disturbed family (see 00623) .....	506.00	215.34
<b>PSYCHIATRIC TREATMENT</b>		
00607 Office visit to include services such as chemotherapy management and/or minimal psychotherapy .....	117.00	54.21
00608 Hospital visit.....	128.00	54.21
00609 Home visit .....	160.00	72.96

PSYCHIATRY - Continued

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
00605 Emergency visit when specially called (not paid in addition to out-of-office hours premiums) .....	322.00	141.88
NOTE: Claim must state time service rendered.		
<u>Individual:</u> (office or hospital out-patient)		
00630 – per 1/2 hour .....	231.00	107.42
00631 – per 3/4 hour .....	323.00	153.32
00632 – per 1 hour .....	413.00	194.70
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		
<u>Individual:</u> (hospital or institution in-patient or home)		
00650 – per 1/2 hour .....	259.00	107.42
00651 – per 3/4 hour .....	357.00	153.32
00652 – per 1 hour .....	459.00	194.73
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.).		
<u>Family/conjoint therapy:</u> (2 or more family members)		
00633 – per 1/2 hour .....	204.00	107.42
00635 – per 3/4 hour .....	302.00	153.32
00636 – per 1 hour .....	403.00	194.70
00638 – per 1 ¼ hour .....	441.00	253.15
00639 – per 1 ½ hour .....	523.00	303.78
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.		
<u>Group Psychotherapy:</u> (fee per patient), per 1/2 hour		
00663 – three patients .....	69.30	48.09
00664 – four patients .....	53.90	38.41
00665 – five patients.....	44.30	33.39
00666 – six patients.....	39.10	29.70
00667 – seven patients.....	34.70	27.10
00668 – eight patients .....	31.45	25.16
00669 – nine patients .....	29.20	23.60
00670 – ten patients .....	27.05	22.34
00671 – eleven patients.....	28.35	19.59
00672 – twelve patients .....	26.60	18.40
00673 – thirteen patients .....	24.75	17.05
00674 – fourteen patients .....	24.10	16.73
00675 – fifteen patients .....	23.35	16.06
00676 – sixteen patients.....	22.50	15.58

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
00677 – seventeen patients .....	21.55	14.93
00678 – eighteen patients .....	21.15	14.70
00679 – nineteen patients .....	20.50	14.07
00680 – twenty patients.....	19.85	13.72
00681 – Greater than 20 patients (per patient).....	19.20	13.26

NOTES:

- i) A separate claim should be submitted for each patient.
- ii) Where two co-therapists are involved in a group of eight (8) 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 twenty 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.

**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 .....	105.00	52.80
---	--------	-------

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 .....	187.00	89.17
---------------------------------------	--------	-------

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 in-patient) 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..... <i>(see notes on next page)</i>	104.00	52.77
---	--------	-------

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

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.

A00643	Environmental intervention by the physician on a psychiatric patient's behalf with agencies, employers or institutions - per 1/2 hour .....	160.00	
A00644	Environmental intervention by the psychiatrist on a disturbed child's behalf with agencies, schools or institutions - per 1/2 hour .....	160.00	
A00655	Interpreting or explaining results of psychological psychiatric or other medical examinations and procedures to family or other responsible persons or advising them how to assist patient - per 1/2 hour .....	160.00	
96301	<i>Mental Health Act</i> second opinion, performed by specialist - first assessment .....	178.00	
96302	<i>Mental Health Act</i> second opinion, performed by specialist - follow-up .....	81.40	
96201	<i>Mental Health Act</i> second opinion, performed by general practitioner - first assessment or follow-up .....	59.00	

NOTE: Submit claims for 96301, 96302 and 96201 to MSP. Do not bill privately.

**Telehealth Service with Direct Interactive Video Link with the Patient  
Full Telehealth Consultations**

60610	<b>Telehealth Individual Consultation:</b> Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report .....	483.00	241.18
60613	Telehealth Geriatric consultation (patients 75 years or older) ..	738.00	364.75



	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
60622 <b>Telehealth consultation:</b> Emotionally disturbed child: Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report .....	828.00	430.67
<b>Repeat or Limited Telehealth Consultations:</b> Where a formal consultation for the 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.		
60625 Telehealth—Individual consultation .....	242.00	127.83
60614 Telehealth—Geriatric consultation.....	411.00	182.38
60626 Telehealth—Emotionally disturbed child.....	420.00	215.32
<b>Telehealth Psychiatric Treatment</b>		
60607 Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy	117.00	54.21
60608 Telehealth hospital in-patient visit.....	115.00	54.21
<b>Individual Telehealth Psychiatric Treatment</b>		
60630 – per 1/2 hour .....	231.00	107.42
60631 – per 3/4 hour .....	323.00	153.32
60632 – per 1 hour .....	413.00	194.70
NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		
<b>Family/conjoint Telehealth Therapy: (two or more family members):</b>		
60633 – per 1/2 hour .....	204.00	107.42
60635 – per 3/4 hour .....	302.00	153.32
60636 – per 1 hour .....	403.00	194.70
60638 – per 1 ¼ hour .....	441.00	253.15
60639 – per 1 ½ hour .....	523.00	303.78
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.		
<b>Telehealth—Miscellaneous</b>		
60624 Telehealth clinical evaluation/interview of family member/close acquaintance/knowledgeable professional involved in the patient's care - per 15 minutes or greater portion thereof.....	105.00	52.80

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

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.

<p>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 in-patient) 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.....</p>	104.00	52.77
--	--------	-------

NOTES:

- i) Not to exceed a maximum of four (4) 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.

# RESPIROLOGY

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

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>			
32010 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report .....	570.00		225.91
32012 <b>Repeat or Limited Consultation:</b> Where a consultation for same illness is repeated within six (6) 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 .....	287.00		119.23
32014 Prolonged visit for counselling (maximum four (4) per year applies to MSP and WSBC only) .....	287.00		82.05
NOTES:			
i) See Preamble D. 3. 3.			
ii) Start and end times must be entered in both the billing claims and the patient's chart.			
 <b><u>Continuing Care by Consultant:</u></b>			
32006 Directive care .....	105.00		66.35
32007 Subsequent office visit .....	111.00		72.13
32008 Subsequent hospital visit .....	80.90		56.82
32005 Emergency visit when specially called (not paid in addition to out-of-office hour premiums) .....	327.00		101.87
NOTE: Claim must state time service rendered.			
 <b>RESPIRATORY MEDICINE ASSESSMENT</b>			
PG32011 Complex Respiratory Medicine Assessment, for patients with advanced multi-system disease, per 15 minutes or greater portion thereof.....	150.00		68.00
<i>(see notes on next page)</i>			

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

NOTES:

- i) Restricted to Respiratory Medicine specialists who provide care in the following clinics:  
 Adult Cystic Fibrosis: St. Paul's and Royal Jubilee Hospital  
 Interstitial Lung Disease: Vancouver General and Saint Paul's  
 Severe Asthma: Vancouver General, Saint Paul's and Surrey Memorial  
 Lung Transplant Clinic (includes pre and post lung transplant assessment)  
 Pulmonary Hypertension: Vancouver General and Saint Paul's.
- ii) Maximum of 7 hours per day, per physician.
- iii) When consult, repeat or limited consult or visit is charged in addition to G32011, for billing purposes, the consultation fee shall constitute the first ½ hour and the repeat or limited consult or visit will constitute the first 15 minutes of the time spent with the patient.
- iv) Includes time spent in multidisciplinary case conferencing and teleconferencing with other health care providers and/or patients.
- v) A written consultation report is required for each patient seen in the clinic.
- vi) Start and end times must be included on claims.
- vii) Paid to a maximum of one service per patient per visit.

**Telehealth Service with Direct Interactive Video Link with the Patient**

32110	<b>Telehealth Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report..	570.00	225.91
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.	287.00	119.23
32114	Telehealth prolonged visit for counselling (maximum four per year) .....	287.00	82.05

NOTES:

- i) See Preamble D. 3. 3.
- ii) Start and end times must be entered in both the billing claims and the patient's chart.

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
32106 Telehealth directive care.....	105.00		66.35
32107 Telehealth subsequent office visit.....	111.00		72.13
32108 Telehealth subsequent hospital visit .....	80.90		56.82

### PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION

S00700 Bronchoscopy or bronchofibroscope – procedural fee	288.00	4	117.42
S00702 Bronchoscopy with biopsy – procedural fee.....	531.00	4	207.08
10700 Endobronchial cauterization - extra .....	193.00	6	76.47

#### NOTES:

- i) To a maximum of 3 lesions.
- ii) Second and third lesion payable at 50%
- iii) Payable only with S00700 or S00702 and 10702, 10703, S00736
- iv) Not payable with 10739 or 02450

10702 Endobronchial cryotherapy - extra .....	193.00	6	76.47
---	--------	---	-------

#### NOTES:

- i) To a maximum of 3 lesions
- ii) Second and third lesion payable at 50%
- iii) Payable only with S00700 or S00702 and 10700, P10703, S00736
- iv) Not paid with 10739, 02450 and 02422

10703 Transbronchial Needle Aspiration (TBNA).....	127.00	6	69.64
--	--------	---	-------

#### NOTES:

- i) To a maximum of 3 separate stations or lesions
- ii) Second and third station or lesion payable at 100%
- iii) Payable with S00700, S00702 or 10739 and 10700, 10702, S00736
- iv) Paid at 100% with other diagnostic procedures.

### 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 on contrast material.

S00736 Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) – procedural fee (extra).....	288.00	4	66.73
10739 Endobronchial Ultrasound (EBUS).....	959.00	6	387.16

#### NOTES:

- i) Not payable with S00700, S00702, 02450, 10700 or 10702
- ii) Fee item 10703 and S00736 payable in addition

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>DIAGNOSTIC PROCEDURES OR ENDOSCOPY</b>			
S00818 Oesophageal pH study for reflux, extra – professional fee .....	177.00		40.82
S00817 – technical fee .....	54.40		12.44
<b>Polysomnogram</b>			
Overnight home oximetry (continuous recording of oxygen and pulse):			
S00910 – professional fee .....	114.00		27.90
S00911 – technical fee .....	60.40		15.62
NOTE: Fee items S00910 and S00911 are limited to Category III pulmonary function diagnostic facilities and/or polysomnography diagnostic facilities with the established personnel qualifications for such facilities.			
S11915 Standard polysomnography – professional fee .....	448.00		167.40
S11916 Standard polysomnography – technical fee .....	1037.00		387.02
S11919 Multiple sleep latency test (MSLT) – professional fee	223.00		83.70
S11920 Multiple sleep latency test (MSLT) – technical fee .....	518.00		193.51
S11925 Four channel home polysomnography – Professional fee .....	210.00		83.61
S11926 Four channel home polysomnography – Technical fee .....	210.00		83.86
<b>PULMONARY INVESTIGATIVE AND FUNCTION STUDIES</b>			
<b>Diagnostic Procedures</b>			
S00928 Peak expiratory flow rate with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus - without bronchodilators .....	55.30		12.77
S00929 Peak expiratory flow rate before and after bronchodilators .....	82.90		18.90
S00931 Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume – professional fee .....	63.40		14.18
S00932 – technical fee .....	63.40		14.18
S00933 Spirometry - forced expiratory spiogram to include FVC, FEV(i), FEV/FVC ratio MMEFR, etc. - without bronchodilators – professional fee .....	49.15		11.61
S00934 – technical fee .....	49.15		11.11
S00935 – before and after bronchodilators – professional fee .....	55.30		13.27
S00936 – technical fee .....	63.40		14.18
S00937 Spirometry - flow volume loops - without bronchodilators – professional fee .....	49.15		11.61

## RESPIROLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S00938 – technical fee .....	82.90		18.20
S00940 – before and after bronchodilators – professional fee .....	63.40		14.68
S00941 – technical fee .....	119.00		26.92
S00942 Diffusion studies with carbon monoxide - at rest or exercise – professional fee .....	67.10		15.11
S00943 – technical fee .....	39.90		12.87
<b>Detailed Pulmonary Function Studies</b>			
S00945 – professional fee (includes S00931, S00935 and S00942).....	185.00		42.06
S00946 – technical fee (includes S00932, S00936 and S00943) .....	176.00		40.29
NOTE: Fee Items S00931 - S00936, S00942, S00943 will be paid at 100%.			
<b>Exercise Studies</b>			
NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation.			
S00950 Progressive exercise test with at least three workloads, measuring ventilation and electro- cardiographic monitoring – professional fee .....	96.40		22.10
S00951 – technical fee .....	145.00		32.59
S00954 Exercise in a steady state at two or more workloads with measurements of ventilation, O <sub>2</sub> and CO <sub>2</sub> exchange, and electro-cardiographic monitoring – professional fee .....	355.00		91.95
S00955 – technical fee .....	228.00		59.06
S00956 Exercise in a steady state at two or more workloads with measurements of ventilation, O <sub>2</sub> and CO <sub>2</sub> exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space – professional fee .....	424.00		109.46
S00957 – technical fee .....	300.00		70.32
<b>Miscellaneous Pulmonary Tests</b>			
S11960 Oximetry at rest, with or without oxygen – professional fee .....	18.25		4.72
S11961 – technical fee .....	19.65		5.10
S11962 Oximetry at rest and exercise, with or without oxygen – professional fee .....	39.40		10.21
S11963 – technical fee .....	61.70		15.94

RESPIROLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:			
SY11964 – professional fee .....	37.65		20.57
SY11965 – technical fee.....	160.00		44.36
NOTES:			
i) Restricted to Respiriologists.			
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.			
S00964 Plethysmography and airway resistance			
– professional fee .....	57.40		13.47
S00965 – technical fee.....	119.00		26.92
S00968 Inhalation challenge - assessed by serial flow measurements, per day – professional fee .....	159.00		36.41
S00969 – technical fee.....	159.00		36.41
S00972 CO <sub>2</sub> /O <sub>2</sub> responsiveness of respiratory centres by steady state test or rebreathing test – professional fee .....	82.90		18.20
S00973 – technical fee.....	49.15		11.11
S00974 Inspiratory and expiratory muscle strength			
– professional fee .....	47.75		12.25
S00975 – technical fee.....	47.75		12.72
<b>Miscellaneous</b>			
10320 Insertion of permanent pleural drainage catheter .....	543.00	5	231.19
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 .....	287.00	2	68.71
NOTE: Not paid with S32031, 00749, 07924 and 08646.			
S32031 Closed drainage of chest (operation only).....	428.00	4	136.94



# RHEUMATOLOGY

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

	Non-MSP- Insured Fee (\$)	MSP & WSBC Fee (\$)
<b>REFERRED CASES</b>		
31010 <b>Consultation:</b> To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report .....	416.00	210.32
31012 <b>Repeat or Limited Consultation:</b> 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 services do not warrant a full consultative fee .....	279.00	120.96
31014 Prolonged visit for counseling (maximum, four (4) per year) .....	209.00	49.06
NOTES:		
i) See Preamble D. 3. 3.		
ii) Start and end times must be entered in both the billing claims and the patient's chart.		
PG31050 Extended Consultation – exceeding 53 minutes (actual physician time spent with patient). To consist of examination, review of history, laboratory, x-ray findings, necessary to initiate care. ....	671.00	270.47
NOTES:		
i) Restricted to Rheumatology.		
ii) Applicable to patients with chronic and complex medical needs. Paid with the following diagnostic codes:		
a. Diffuse Diseases of Connective Tissue (710), Systemic Lupus Erythematosus (710.0), Systemic Sclerosis (710.1), Sicca Syndrome (710.2), Dermatomyositis (710.3), Polymyositis (710.4), Other (710.8), Unspecified (710.9);		

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	--

- 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 Polyarthrits (714.3), Chronic Postrheumatic Arthropathy (714.4), other (714.8), Unspecified (714.9);
- c. Polyarteritis Nodosa and Allied Conditions (446), Polyarteritis Nodosa (446.0), Acute Febrile Mucocutaneous Lymphnode Syndrome (MCLS) (446.1), Hypersensitivity Angiitis (446.2), Lethal Midline Granuloma (446.3), Wegener’s Granulomatosis (446.4), Giant Cell Arteritis (446.5), Thrombotic Microangiopathy (446.6), Takayasu Disease (446.7);
- d. Ankylosing Spondylitis and Other Inflammatory Spondylopathies (720), Ankylosing Spondylitis (720.0), Spinal Enthesopathy (720.1), Sacroiliitis, not Elsewhere Classified (720.2), Other Inflammatory Spondylopathies (720.8), Unspecified Inflammatory Spondylopathy (720.9);
- e. Psoriasis and Similar Disorders (696), Psoriatic Arthropathy (696.0), other Psoriasis (696.1), Parapsoriasis (696.2), Pityriasis rosea (696.3), Pityriasis Rubra Pilaris (696.4), Other Unspecified Pityriasis (696.5), Other (696.8).
- f. Arthropathy associated with infections (711)
- g. Polymalgia rheumatic (725)
- iii) Paid to a maximum of one per patient within six months of the last visit.
- iv) Not paid in addition to 31010, 31012, 31006, 31007, 31008, 31110, 31112, 31106, 31107 or 31108.
- v) Start and end times must be recorded on claim and in the patient’s chart.
- vi) Not paid when there is no change in condition from previous assessment.

31015 Rheumatology Management of Complex Joint(s) requiring Aspiration and/or Injection..... (see notes on next page)	63.70	25.29
--	-------	-------

**Non-MSP-  
Insured  
Fee (\$)**      **MSP &  
WSBC  
Fee (\$)**

**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.

**Continuing Care by Consultant:**

31006	Directive care.....	123.00	104.90
31007	Subsequent office visit.....	107.00	87.40
31008	Subsequent hospital visit.....	58.50	51.57
31005	Emergency visit when specially called (not paid in addition to out-of-office hours premium) .....	235.00	97.21

Note: Claim must state time service rendered.

**Telehealth Service with Direct Interactive Video Link with the Patient**

31110	<b>Telehealth Consultation:</b> To consist of an examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report.	416.00	210.32
31112	<b>Telehealth Repeat or Limited Consultation:</b> 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 services do not warrant a full consultative fee .....	279.00	120.96
31106	Telehealth directive care.....	123.00	104.90
31107	Telehealth subsequent office visit.....	114.00	87.40
31108	Telehealth subsequent hospital visit.....	58.50	51.57

**MISCELLANEOUS**

PG31055	Rheumatology Immunosuppressant Review.....	102.00	30.00
---------	--	--------	-------

**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.

*(notes continued on next page)*

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
iv) Not applicable for patients prescribed hydroxychloroquine, chloroquine, or anti-inflammatories.		
v) Annual maximum – one per patient.		
vi) Immunosuppressant tool must be recorded in patient’s chart.		
PG31060 Multidisciplinary Conference for community-based patients. To consist of assessment, written treatment plan and any other counselling the patient needs for management of their particular diagnosis.....	560.00	225.96
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 a 6 month period.		
vi) Not paid in addition to 31010, 31012, 31007 or G31050.		
vii) Not paid if a consultation has been paid within 3 months prior by the same practitioner.		

# UROLOGY

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

## PREAMBLE

In cases where conversion to open is necessary, bill the appropriate open fee, plus 50% of 04001.

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

## REFERRED CASES

NOTE: Consultation and office visit include aspiration of hydrocele/spermatocele, and prostatic massage if required.

08010 <b>Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report .....	324.00	89.01
08012 <b>Repeat or limited consultation:</b> To apply where a consultation is repeated for the same condition within six (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.....	185.00	50.66

### Continuing Care by Consultant:

08007 Subsequent office visit .....	130.00	35.53
08008 Subsequent hospital visit.....	157.00	42.86
08009 Subsequent home visit.....	218.00	59.66
08005 Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	447.00	122.90

NOTE: Claim must state time service rendered.

## Telehealth Service with Direct Interactive Video Link with the Patient

08070 Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report. ...	324.00	89.01
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.....	185.00	50.66
08077 Telehealth subsequent office visit .....	130.00	35.53

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
08078 Telehealth subsequent hospital visit .....	157.00		42.86
<b>KIDNEY AND PERINEPHRIUM</b>			
08100 Drainage of perinephric abscess.....	1760.00	5	484.34
08117 Nephrolithotomy and/or pyelolithotomy .....	2754.00	5	758.42
08118 Nephrolithotomy or pyelolithotomy with x-ray control with or without nephroscopy.....	2544.00	5	768.15
08119 Nephrolithotomy or pyelolithotomy with renal cooling, with or without x-ray control, with or without nephroscopy .....	2685.00	6	739.23
08104 Partial nephrectomy .....	4907.00	5	1350.91
08105 Nephrectomy .....	4536.00	5	1248.95
08106 – ectopic kidney .....	3182.00	5	875.87
08108 – thoraco-abdominal .....	4814.00	8	1325.42
08109 – radical with gland dissection .....	4628.00	6	1274.43
C81104 Laparoscopic partial nephrectomy for suspected renal malignancy, with or without ipsilateral adrenalectomy, includes excision of perinephric fat. ..	7082.00	5	1950.06
NOTE: Restricted to Urologists.			
C81105 Laparoscopic radical nephrectomy for suspected renal malignancy, with or without ipsilateral adrenalectomy, includes excision of perinephric fat. ..	5554.00	7	1529.46
NOTES:			
i) Restricted to Urologists.			
ii) Not paid with open nephrectomy fee items (08105, 08106, 08108, 08109).			
08110 Nephro-ureterectomy to include bladder cuff.....	5463.00	6	1503.98
C81110 Laparoscopic nephroureterectomy (including excision of bladder cuff).....	6827.00	6	1879.95
NOTE: Not paid with 08105, 08106, 08109, 08110, C81104, C81105.			
08112 Open renal biopsy (as independent procedure) .....	1149.00	5	316.22
08113 Symphysiotomy and nephropexy or nephrectomy in horseshoe kidney .....	1579.00	5	434.81
08114 Pyeloplasty including management of aberrant vessels and nephropexy .....	3147.00	5	866.47
C81114 Laparoscopic pyeloplasty, with or without insertion of ureteral stent, includes management of aberrant vessels and nephropexy, cystoscopy or retrograde pyelogram. ....	4743.00	7	1352.04
NOTES:			
i) Includes nephrolithotomy (08117) if done at same time.			
<i>(notes continued on next page)</i>			

UROLOGY - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
	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.			
08116	Ruptured or lacerated kidney - repair or removal .....	4592.00	6	1264.25
S08123	Extra-corporeal shock wave lithotripsy (ESWL) (operation only) .....	809.00	4	222.55

**ENDUROLOGY**

S08146	Ureterscopy and basket manipulation of ureteral calculus with or without lithopaxy (operation only).....	1867.00	3	513.90
S08155	Insertion of internal ureteral stent to include C&P and ureterscopy (operation only).....	468.00	3	128.46
	NOTE: Additional stents to be paid at 50%.			
08168	Nephroscopy and stone removal - to include lithopaxy (operation only) .....	2249.00	4	618.92
	NOTE: Not payable in addition to 00800.			
PS08185	Endoscopic Treatment of upper Tract Transitional Cell Carcinoma.....	3269.00	6	900.00
	NOTES:			
	i) Restricted to Urologists.			
	ii) Includes fee items 00704, 00800, 08146 and 08155.			
	iii) Not payable with 08168, 08117, 08118 and 08119.			

**URETER**

S08145	Subureteric endoscopic injection for vesicoureteral reflux (VUR).....	647.00	2	177.87
	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 .....	1489.00	5	409.61
08151	Ureterotomy or removal of stump .....	1928.00	5	530.87
08152	Uretero-vesical reanastomosis - unilateral .....	3147.00	5	866.47
08148	– bilateral .....	3674.00	5	1011.34
08153	Unilateral ureteral tailoring - extra to 08152 or 08148 .	845.00	5	232.58
08154	Bilateral ureteral tailoring - extra to 08148.....	1195.00	5	328.66
08156	Uretero - ureterostomy .....	2408.00	5	662.77
08157	Uretero-cutaneous-anastomosis - unilateral.....	1338.00	5	368.09
08158	Ureteral sigmoid anastomosis - bilateral .....	2297.00	5	632.05

UROLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
08159 Ureterolysis .....	2001.00	5	550.61
08160 Reconstruction lower segment ureter by bladder flap .	3333.00	5	917.67
08161 Transurethral manipulation of ureteral calculus with recovery of calculus .....	790.00	3	217.40
08163 Ureterovesical anastomosis in the presence of ureterocele or ureteral duplication.....	2847.00	5	783.72

**URINARY DIVERSION AND CYSTECTOMY**

08170 Preparation of intestinal segment and reanastomosis.	1874.00	5	515.76
08174 – and ureteral transplantation (same surgeon).....	3857.00	6	1061.94
08177 Cystectomy and ileal loop diversion (includes preparation of intestinal segment and ureteral transplantation - same surgeon) .....	5925.00	6	1985.38
08178 Radical cystectomy and ileal loop urinary diversion (to include preparation of intestinal segment and ureteral transplantation - same surgeon) .....	7406.00	7	2391.99
08184 Cystectomy (isolated procedure), with or without urethrectomy .....	2020.00	6	1212.48
08173 Radical cystectomy with pelvic lymphadenectomy (isolated procedure) .....	4040.00	7	1906.51
08181 Bladder augmentation with bowel segment.....	4408.00	5	1213.49
08182 Continent urinary diversion .....	4307.00	6	1481.31
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) .....	9367.00	7	2790.74

**BLADDER**

S08200 Bladder fulguration with cystoscopy .....	575.00	2	158.13
08201 Cystostomy (isolated procedure) .....	801.00	2	220.24
S08202 – by trochar (isolated procedure) - operation only ....	371.00	2	101.96
08203 Cystolithotomy .....	1111.00	2	305.89
08204 Cystectomy - partial for tumour or diverticulum.....	2120.00	5	711.34
PS08205 Intravesical botulinum toxin injection(s).....	1035.00	2	285.00
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 .....	2592.00	5	713.74



UROLOGY - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
08255	Closure of fistula - suprapubic, vesico-vaginal, vesico-rectal or vesico-sigmoid .....	2592.00	5	713.74
<b>Endoscopy:</b>				
S08250	Transurethral resection of bladder or urethral tumour and adjacent muscle and electro-coagulation as necessary .....	1169.00	3	321.78
S08251	Transurethral resection bladder neck, female .....	625.00	3	201.30
S08257	Transurethral removal of foreign body (excluding ureteric stents)..... NOTE: Removal of ureteric stents is paid under fee item S00704.	883.00	3	242.75
S08256	Transurethral resection of external urinary sphincter ..	1010.00	3	278.07
08253	Y-V vesical neck plasty .....	1249.00	4	343.81
S08254	Litholapaxy and removal of fragments.....	1019.00	2	280.41
<b>URETHRA</b>				
S08232	Periurethral collagen injections .....	647.00	2	187.30
	NOTES: Includes cystoscopy. i) Applicable for females only. ii) Additional training at recognized centre required.			
S08260	Urethrotomy, external or internal .....	745.00	2	204.95
S08261	Urethrostomy.....	808.00	2	251.70
S08262	Meatotomy and plastic repair - operation only.....	280.00	2	106.37
08263	Urethrectomy - total.....	1287.00	3	353.96
S08264	Stricture of urethra - office dilation - operation only .....	72.50		19.77
S08265	Stricture of urethra - dilation in hospital (isolated procedure) - with or without anesthesia - operation only.....	144.00	2	49.38
08266	– first stage plastic repair (excluding urethrostomy)..	3889.00	3	1070.62
08259	– first stage plastic repair requiring pedicle graft.....	3703.00	3	1019.64
08267	– second stage plastic repair (excluding urethrostomy).....	3703.00	3	1019.64
81159	Buccal mucosa graft harvest, extra .....	834.00		229.42
	NOTES: i) Restricted to Urologists. ii) Paid only with fee item 08259 (stricture of urethra first stage plastic repair).			
08268	Urethral diverticulectomy, male or female .....	1593.00	2	467.02
S08269	TUR posterior urethral valves.....	1286.00	2	353.92
08283	Retropubic or transvaginal tape (TVT) or transobturator tape (TOT) operation for urinary incontinence .....	1207.00	4	332.03

UROLOGY - Continued

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
C81153	Male suburethral sling, including cystoscopy .....	2592.00	4	713.74
	NOTES:			
	i) Daily maximum is one per patient.			
	ii) Repeats within 30 days are paid at 50%. A note record is required.			
81154	Transection or removal of sub-urethral mesh sling .....	1523.00	4	510.47
	NOTES:			
	i) Restricted to Urology specialists.			
	ii) Fee items 00704, 00705 or 08232 not paid in addition.			
S08271	Catheterization, complex-male patient (operation only) .....	741.00		203.93
	NOTES:			
	i) Restricted to Urologists and General Surgeons.			
	ii) Procedure must involve the use of Filiforms and Followers, or introducers (stylet or catheter guide).			
	iii) Not paid in addition to the critical care fees, or diagnostic urological procedures (e.g.: voiding cystourethrogram).			
08272	Urethral fistula (penile excision) .....	1111.00	2	305.89
08274	Hypospadias (excluding urethrostomy) - 1st stage chordee .....	1359.00	2	374.14
08275	– 2nd stage (penile) .....	1746.00	2	480.35
08276	– penoscrotal .....	3674.00	2	1011.46
08277	– epispadias plastic repair .....	2388.00	2	657.31
08278	Suprapubic cystostomy and primary repair of urethra. ....	1149.00	3	316.22
S08282	Excision prolapse of urethra or caruncle (includes cystoscopy) - operation only .....	432.00	2	168.07

**PENIS**

08300	Priapism - sapheno-cavernous shunt.....	1889.00	2	569.16
S08301	Dorsal slit (isolated procedure) - operation only.....	280.00	2	76.69
S08312	Circumcision (excluding clamp or bell technique) - operation only .....	698.00	2	204.77
	NOTE: Routine circumcision of the newborn for non-medical reasons is not a benefit under MSP.			
08305	Simple amputation of penis .....	1593.00	2	462.03
08299	Radical amputation of penis .....	2205.00	2	606.84
08306	Clitoral recession .....	920.00	2	252.82
08309	Excision of femoral and inguinal glands, with or without iliac glands - bilateral .....	4814.00	4	1325.53
08308	– unilateral .....	3333.00	4	917.67

		Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
08307	Excision of Peyronie's plaque, with replacement graft (tissue or synthetic) .....	2267.00	2	796.60
08296	Insertion of semi-rigid or self-contained inflatable prosthesis following traumatic or surgical injury .....	2222.00	3	611.78
08363	Revision of penile prosthesis (includes removal, correction of any mechanical failure, and replacement) .....	3133.00	3	862.64
	NOTE: 08296, 08363, in cases where impotence is not the direct result of surgery or trauma, prior authorization should be obtained from MSP.			
08297	Deep dissection of inter-crural region with ligation of deep dorsal and cavernosal veins, with or without ligation of crural veins (venous ligation for impotence).....	1470.00	2	404.57
	NOTE: Must be preceded by colour flow Doppler or duplex sonogram.			

## PROSTATE

Only one prostatectomy fee item is payable per date of service.

Item	Prostatectomy (including meatoplasty, dorsal slit, urethral dilation, panendoscopy, cystoscopy, retrograde pyelography, vasectomy or bladder neck surgery done while patient is under anesthetic for the prostatectomy):			
08311	- perineal, suprapubic, retropubic and transurethral approaches .....	1725.00	5	474.92
08314	- radical perineal retropubic prostateseminal vesiculectomy .....	4722.00	7	1380.84
	NOTE: No charge for repeat prostatectomies done within a period of three (3) months by the same operator, except where radical prostatectomy is required subsequently for cancer.			
08318	- radical to include lymphadenectomy .....	5000.00	7	1410.23
C81305	Laparoscopic radical prostatectomy .....	7555.00	7	2080.06
	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) .....	8702.00	7	2396.16
	NOTE: Restricted to Urologists			

UROLOGY - Continued

		<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
S81311	Holmium laser enucleation of prostate (HoLEP) .....	3446.00	5	948.67
	NOTES:			
	i) For bladder outlet obstruction secondary to benign prostate hypertrophy.			
	ii) For prostates larger than 60 grams.			
	iii) Holmium laser only (not intended for KTP a.k.a. green light).			
	iv) Under the same anesthetic, includes meatotomy (S08262), dorsal slit (S08301), urethral dilation (08264, 08265), cystoscopy and panendoscopy (00704), retrograde pyelogram (08593), vasectomy (08345), and transurethral resection of bladder or urethral tumour and adjacent muscle and electrocoagulation (08250).			
	v) Fee item 08254 will be paid at 50% when done with HoLEP.			
S08319	Balloon dilation of prostate (includes cystoscopy).....	827.00	2	227.26
08317	Anti-incontinence procedure (artificial urinary sphincter) .....	2801.00	4	771.28

**TESTIS**

S08329	Simple orchidectomy - operation only .....	804.00	2	242.52
08330	Orchidectomy via inguinal approach .....	1242.00	2	341.58
	NOTE: Includes excision of spermatic cord to level of internal inguinal ring.			
08322	Orchidopexy - one or two stages .....	1415.00	2	389.50
S08323	Exploration of scrotal contents - unilateral - operation only .....	741.00	2	223.25
08324	Exploration of undescended testicle, without orchidopexy.....	862.00	2	237.17
08328	Recurrent undescended testis .....	1379.00	2	379.23
S08325	Reduction of torsion of testis and spermatic cord, repair - bilateral .....	1482.00	2	407.86
08326	Ruptured testicle - repair .....	1011.00	2	406.85
S08327	Biopsy of testis.....	371.00	2	151.50
08349	Retroperitoneal lymphadenectomy for carcinoma of testis.....	7406.00	4	2039.27
08354	Retroperitoneal lymphadenectomy for carcinoma of testis, post chemotherapy node dissection only.....	8425.00	4	2319.68

**EPIDIDYMIS**

S08340	Abscess, incision, complete care - operation only .....	649.00	2	195.36
S08341	Spermatocele or hydrocele - excision .....	904.00	2	252.90
08342	Epididymectomy - unilateral .....	927.00	2	279.07

UROLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
SA08343 Epididymovasostomy or re-anastomosis of vas - unilateral.....	3570.00	2	778.03
NOTE: MSP will pay only when a previous vasectomy has not been performed.			
S08345 Vasectomy - bilateral - operation only .....	370.00	2	101.51
S08344 Vas cannulation - unilateral or bilateral .....	461.00	2	126.41
08346 Varicocele - resection.....	1065.00	2	392.06
08347 Avulsion of penile skin and scrotum - repair.....	1149.00	2	365.11
08350 Urethro-vesical neck plasty for congenital incontinence	1723.00	4	517.76
08353 Plastic repair of exstrophy and plastic repair of bladder with skin.....	2297.00	5	689.95

**DIAGNOSTIC ULTRASOUND**

08399 Doppler evaluation of penile blood flow wave from evaluation of dorsal and cavernosal arteries. (Blood pressure recordings and calculation of penile brachial index.).....	173.00		47.43
--	--------	--	-------

**DIAGNOSTIC PROCEDURES**

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.

S00866 Dynamic cavernosometry and cavernosography.....	288.00	2	79.05
NOTE: Includes interpretation of x-ray is included in technical portion and is not billable in addition to procedure.			

**MISCELLANEOUS**

**Surgical Assistance**

81194 First Surgical Assist of the Day - Urology .....	279.00		76.47
--	--------	--	-------

NOTES:

- i) Restricted to Urology Surgeons
- ii) Maximum of one per day per physician, payable in addition to 00195, 00196, 00197.

# VASCULAR SURGERY

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

**Note:** Asterisk Items (\*) operation only – refer to the 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.

### **Hybrid vascular surgery (open combined with endovascular procedures)**

Open surgical procedures are considered separate billable procedures from endovascular procedures in the context of hybrid revascularization. The initial open procedures with the greater fee may be claimed in full and additional open surgical procedures are reduced to 50%. Additional endovascular procedures 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 (77113, 77114) and/or two stents (10919).

Example:

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%.

When combined with open vascular procedures in the setting of hybrid revascularization, any subsequent 77113 or 77114 angioplasty and 10919 intraoperative stenting is to be paid at 50% for the first additional and 25% for the second additional anatomical named vessel to a maximum of two additional 77113 or 77114 and two additional 10919 per operation.

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 code includes any and all diagnostic imaging required to complete the procedure.

### **Endovascular surgery**

When angioplasty 77113 or 77114 is performed as isolated endovascular procedure (not in combination with open 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.

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 code includes 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



VASCULAR SURGERY - Continued

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

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

**REFERRED CASES (CONSULTATIONS OR VISITS)**

77010 <b>Consultation:</b> To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report.....	339.00	136.64
77012 <b>Repeat or Limited Consultation:</b> 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 .....	159.00	70.97
77015 Pre-Operative Assessment.....	341.00	136.64

**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.

**Continuing Care by Consultant:**

77007 Subsequent office visit.....	66.90	25.96
77008 Subsequent hospital visit .....	57.30	22.17
77009 Subsequent home visit.....	117.00	44.63

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
77005 Emergency visit when specially called (not paid in addition to out-of-office hour premiums nor within 10 post-operative days from a surgical procedure) .....	235.00		89.07
NOTE: Claim must state time service rendered.			
77006 Directive care in emergent surgical conditions, per visit.....	66.00		24.25
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.			
<b>Telehealth Service with Direct Interactive Video Link with the Patient:</b>			
77710 <b>Telehealth Consultation:</b> to include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report .....	339.00		136.64
77712 <b>Telehealth Repeat or Limited Consultation:</b> 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.....	173.00		70.97
77707 Telehealth subsequent office visit .....	66.90		25.96
77708 Telehealth subsequent hospital visit .....	57.30		22.17

**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 hemodynamic compromise;
  - (g) Hypothermia; and
  - (h) Other immediate life threatening situations.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
3. 00081 includes the following procedure items where required: defibrillation, cardioversion, peripheral intravenous lines, arterial blood gases, neogastric 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.			
00081 Emergency care, per half hour or major portion thereof..	314.00		105.79
00082 Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof.....	156.00		63.47

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**OUT-OF-OFFICE HOURS PREMIUMS**

These fees cannot be correctly interpreted without reference to the Explanatory Notes in the Out-of-Office Hours Premiums section of the Fee Guide.

**CALL-OUT CHARGES**

Extra to consultation or other visits 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) .....	147.00	72.17
01201	Night (call placed and service rendered between 2300 hours and 0800 hours) .....	206.00	101.35
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours).....	147.00	72.17

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 callout, under the following conditions:

- i) As an emergency;
- ii) To provide "top-ups" under fee item 01103 or for obstetrical epidural anesthesia; and
- iii) To provide subsequent resuscitative care under fee code 01088.

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 .....	135.00	66.36
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof .....	185.00	90.73

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
01207 Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof .....	135.00		66.36
NOTES:			
i) Claim must state start and end times.			
ii) Where timing is continuous, submit an account for each patient, indicating " <b>CCFPP</b> " (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.			
b) <b>OPERATIVE</b>			
Applicable only to emergency surgery or to elective surgery which, because of intervening emergency surgery, commences within the designated times.			
Applicable only to surgical procedure(s) requiring general, spinal or epidural anesthesia and/or requiring at least 45 minutes of surgical time.			
01210 Evening (1800 hours to 2300 hours) – 44.46% of surgical (or assistant) fee:			
– minimum charge .....	131.00		64.32
– maximum charge .....	905.00		443.67
01211 Night (2300 hours to 0800 hours) – 71.37% of surgical (or assistant) fee:			
– minimum charge .....	185.00		90.32
– maximum charge .....	1271.00		623.05
01212 Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 44.46% of surgical (or assistant) fee:			
– minimum charge .....	131.00		64.32
– maximum charge .....	905.00		443.67
NOTES:			
i) The appropriate item for billing is determined by the period in which the major portion of the surgical time is spent.			
ii) State time surgery commenced.			

**SURGICAL ASSISTANT OR SECOND OPERATOR**

**Total Operative Fee(s) for Procedures:**

00195 Less than \$317.00 inclusive.....	339.00	134.22
00196 \$317.01 - \$529.00 inclusive .....	477.00	189.24
00197 Over \$529.00 .....	624.00	260.35

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
00198 Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof.....	71.30		28.52
NOTES:			
i) In those rare situations where an assistant is required for minor surgery a detailed explanation of need must accompany the account to the Plan.			
ii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anesthetic, he/she may charge a separate assistant fee for each operation, except for bilateral procedures, procedures within the same body cavity or procedures on the same limb.			
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.....	1048.00		256.63
NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020 Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof.....	119.00		32.23
NOTES:			
i) After 3 hours of continual surgical assistance for one patient, bill under fee item 00198 (time after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof).			
ii) Please indicate start and end time of service on claim.			

**SECOND OPERATOR**

77025 Second operator, synchronous combined bypass graft - extremities - operation only.....	848.00		300.19
77030 – trunk.....	848.00		300.19
NOTE: Items 77025 and 77030 provide operative report by second operator when requested from payment agency.			

**ABSCESS AND INFECTION**

13605 Opening superficial abscess, including furuncle - (operation only).....	104.00	2	44.48
07041 Aspiration - abdomen or chest - operation only.....	192.00	2	76.01

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Abscess:</b>			
07059 – deep (complex, subfascial, and/or multi-locular) with local or regional anesthesia - operation only .....	232.00	2	81.46
07027 – under general anesthesia - operation only .....	520.00	2	203.59
07061 – deep post-operative wound infection, under GA - operation only .....	331.00	2	203.37
07045 Anterior closed space abscess (operation only) .....	160.00	2	101.44
06028 Web space abscess (operation only).....	284.00	2	71.53
06029 – under general anesthetic - operation only .....	1013.00	2	290.00
Pilonidal cyst or sinus:			
07685 – excision or marsupialization (operation only).....	1124.00	2	277.43
<b>Osteomyelitis:</b>			
*52380 Osteomyelitis, acute, decompression .....	720.00	2	186.72
*52385 Osteomyelitis, debridement with or without reconstruction .....	1246.00	3	322.10
NOTE: *52380 and *52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.			
<b>Wounds - Simple:</b>			
13610 Minor laceration or foreign body - not requiring anesthesia (operation only).....	82.60		35.62
13611 Minor laceration or foreign body - requiring anesthesia (operation only).....	156.00	2	66.35
06063 Removal of foreign body - requiring general anesthesia (operation only).....	608.00	2	250.72
13612 Extensive lacerations over 5 cm (maximum charge 35 cm) (operation only), per cm .....	30.55		13.32

**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) .....	1754.00	5	411.80
V70158 Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area .....	990.00	3	235.72
V70159 Debridement of skin and subcutaneous tissue; for each additional 5% of body surface area or major portion thereof – extra.....	497.00		117.87
V70162 Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area.....	1110.00	4	261.93

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
V70163 Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each additional 5% of body surface area or major portion thereof – extra .....	559.00	3	130.96
V70165 Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area.....	1228.00	4	288.10
V70166 Debridement of skin, fascia, muscle and bone; for each additional 5% of body surface area or major portion thereof – extra .....	431.00		144.06
70168 Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area .....	331.00		78.57
NOTES:			
i) Payable when rendered at the bedside but only when performed by a medical practitioner.			
ii) Requires wound assessment and dressing change and may include VAC application.			
iii) Applicable with or without anesthesia.			
70169 Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area - operation only.....	386.00	4	125.72
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.			
<b>Wounds - Avulsed and Complicated:</b>			
06075 Lips and eyelids .....	1349.00	3	339.41
06076 Nose and ear.....	1696.00	3	426.36
06077 Complicated lacerations of the scalp, cheek and neck .....	1324.00	3	333.13
NOTES: The following conditions are necessary for 06075, 06076 or 06077 to apply:			
i) A layered closure* is required and at least one of:			
i) Injuries involving necrotic tissue requiring debridement such that simple suture closure is precluded; or			
ii) injuries involving tissue loss such that simple suture is precluded; or			
iii) Wounds requiring tissue shifts for closure aside from minor undermining or advancement flaps; or			
<i>(notes continued on next page)</i>			



**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

- iv) Skived, ragged or stellate wounds where excision of tissue margins is necessary to obtain 90 degree closure; or
- v) Contaminated wounds that require excision of foreign material, or
- vi) Lacerations requiring layered closure and key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or
- vii) Lacerations into the subcutaneous tissue requiring alignment and repair of cartilage and layered closure.
- viii) 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.....	1100.00	3	270.50
--------	--	---------	---	--------

**Tumours of Skin - Removal not Requiring Skin Graft:**

Excisional biopsy of lymph glands for suspected malignancy:

70023	– neck - operation only .....	541.00	3	203.62
V70024	– axilla .....	965.00	2	237.34
70025	– groin .....	331.00	2	203.37

Excision of skin and subcutaneous tissue of hidradenitis suppurativa:

07072	– axillary - operation only.....	497.00	2	250.00
07075	– inguinal - operation only .....	497.00	2	250.00
07076	– perianal - operation only .....	497.00	2	250.00
07082	– perineal - operation only .....	497.00	2	250.00
06166	Excision of axillary sweat glands for hyperhidrosis - unilateral .....	1293.00	4	325.14

NOTES:

- i) Direct closure included when open procedure used.
- ii) Aggressive removal of apocrine sweat glands by any means.

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Tenotomy:			
07073 – congenital torticollis .....	544.00	3	304.16
V07074 – resection .....	1052.00	3	257.99
(Section of transverse carpal ligament - bill under S06258)			
13630 Paronychia (operation only) .....	82.40	2	35.53
13631 Removal of nail - simple (operation only) .....	82.40	2	35.53
13632 – with destruction of nail bed - operation only .....	165.00	2	71.89
13633 Wedge excision of one nail - operation only .....	147.00	2	63.44
V07053 Excision of nail bed, complete, with shortening of phalanx .....	563.00	2	137.99
<b>Biopsy of Nerve or Artery:</b>			
07025 Temporal artery biopsy - operation only .....	322.00	2	140.69
07028 Biopsy of sural nerve .....	299.00	2	177.27

**FREE SKIN GRAFTS AND MYELOPLASTY**

**Split Thickness Grafts:**

Non-functional areas: (total area treated, whether at one operation or at staged intervals):

06046 – less than 6.5 sq. cm - operation only .....	413.00	2	250.72
06047 – 65 sq. cm - operation only .....	773.00	2	304.13
06048 – 650 sq. cm .....	1545.00	2	388.27
06049 For each 6.5 sq. cm over 650 sq. cm - operation only ...	29.45	3	7.42

NOTE: Refrigerated graft - 50% of appropriate fee.

**VASCULAR ACCESS**

Broviac type catheter:

07139 – insertion of .....	561.00	2	162.55
V07140 – insertion of - less than 3 months of age or less than 3 kg. ....	1096.00	4	269.03
07141 – removal of- operation only .....	157.00	2	126.79
Totally implantable venous access port with subcutaneous reservoir (port-a-cath type device):			
07142 – insertion of .....	1027.00	2	255.98
V07143 – revision (removal and reinsertion) .....	1200.00	2	350.00
77142 Removal of totally implantable access device (e.g.: portacath), operation only. ....	341.00	2	127.95

*(see notes on next page)*

VASCULAR SURGERY - Continued

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

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.)

00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation .....	216.00		56.94
07145	Intra osseous - access- operation only .....	164.00	2	101.29
V07134	Peritoneal venous shunt for ascites .....	1592.00	6	390.37
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee .....	96.40		22.10
00319	Insertion of central catheter for total parenteral Nutrition - operation only .....	224.00	2	56.54

**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..... NOTE: Treatment for cosmetic purposes is not a benefit under MSP.	37.80		13.46
77046	Ultrasound directed (with image capture) foam sclerotherapy – initial .....	431.00		171.95
77047	Ultrasound directed (with image capture) foam sclerotherapy –repeat .....	431.00		171.95

NOTES:

- i) 77046 and 77047 may each be charged only once per patient per leg per lifetime.
- ii) One additional repeat per leg may be billed under fee item 77060 in the same 12 month period.
- iii) Services in subsequent 12 month periods should be billed in accordance with the notes following fee item 77050 and 77060.

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
Compression sclerotherapy:			
77050 – initial .....	227.00	2	80.82
77060 – repeat .....	108.00	2	37.87
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 .....	405.00	2	223.03
V07108 Stripping long saphenous.....	1046.00	2	263.88
V07109 Stripping short saphenous .....	602.00	2	228.30
Multiple ligations and stripping tributaries:			
07110 – 3 to 5 incisions - operation only .....	449.00	2	278.91
V07111 – 6 or more incisions.....	784.00	2	304.28
V07112 Ligation of 2 or more perforators.....	811.00	2	278.91
77070 Complete fasciotomy with or without multiple ligations .....	899.00	2	319.25
NOTE: For decompression fasciotomy, see 77360.			
77075 Re-exploration, groin and/or popliteal fossa .....	848.00	2	300.19
V07116 Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy) .....	2123.00	3	523.41
77077 Excision of ulcer and grafting - add full fee to venous procedures - operation only .....	339.00	3	120.28
77079 Venous crossover graft for iliac obstruction .....	1713.00	7	609.87
<b>Acute Venous:</b>			
77082 Ligation of femoral vein .....	420.00	2	148.84
77084 Ligation or fenestration of inferior vena cava (requires laparotomy) .....	1393.00	5	495.27
77086 Thrombectomy for acute ilio-femoral thrombophlebitis....	1748.00	5	620.60
V07146 Insertion of inferior vena cava filter; percutaneous placement or cutdown (e.g.: Kimray Greenfield filter) .....	1492.00	2	367.84
<b>Portosystemic Shunting:</b>			
C77090 Spleno-renal shunt.....	2657.00	8	945.05
C77092 Porto-caval shunt .....	2657.00	8	945.05
Mesocaval graft :			
C77094 – synthetic.....	2657.00	8	945.05
C77096 – autogenous .....	2827.00	8	1006.21

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**ARTERIAL**

**Repeat Vascular Surgery:**

NOTES:

- i) Same procedure within 24 hours - 75% of listed fee.
- ii) Same procedure after 24 hours - see repeat surgery items 77043 and 77112 and applicable notes.

**Removal of Synthetic Graft :**

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

NOTES:

- i) 77100, 77102 and 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, or 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 and 77104).

**REPEAT SURGERY**

**Groin Dissection:**

C77110	Re-exploration of groin for bleeding or hematoma - operation only .....	355.00	4	125.47
77112	Re-dissection of groin (after 21 days) - extra .....	372.00	4	132.47

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

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**Re-operation:**

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

**NOTES:**

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

**CARDIO-VASCULAR PROCEDURES**

S00919 Impedance plethysmography - professional fee.....	24.20	6.89
S00920 – technical fee .....	119.00	34.55

**ARTERIAL PROCEDURES**

**Therapeutic procedures utilizing radiological equipment**

10900 Abdominal aortic aneurysm repair using endovascular stent graft - second operator .....	2380.00	509.83
---	---------	--------

**NOTES:**

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

**Thrombectomy, Embolectomy:**

S77113 Intraoperative open or percutaneous tibial artery angioplasty .....	1654.00	2	697.42
--	---------	---	--------

**NOTES:**

- i) Restricted to Vascular Surgeons.
- ii) When S77113 is combined with another vascular surgery, multiple angioplasties will be paid as follows: 50% for the first, 25% for the second and 12.5% for the third angioplasty.
- iii) When angioplasty is performed as an isolated procedure, multiple angioplasties done during the same procedure are paid as follows: the first is paid at 100%, second at 50%, third at 25%.
- iv) Payable to a maximum of 3 angioplasties.
- v) Any and all diagnostic imaging required to complete the procedure is considered included.

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
S77114 Intraoperative open or percutaneous angioplasty .....	1539.00	3	589.40
NOTES:			
i) Restricted to Vascular Surgeons.			
ii) When S77114 is combined with another vascular surgery, multiple angioplasties will be paid as follows: 50% for the first angioplasty, 25% for the second angioplasty and 12.5% for the third angioplasty.			
iii) When angioplasty is performed as an isolated procedure, multiple angioplasties done during the same procedure are paid as follows: first is paid at 100%, second at 50%, third at 25%.			
iv) Payable to a maximum of three angioplasties.			
v) Any and all diagnostic imaging required to complete the procedure is considered included.			
vi) When done with 77177, payable once, to either the primary or second operator.			
C77115 Thrombectomy with or without angioplasty .....	1566.00	5	556.73
C77120 Embolectomy - trunk or extremities (subclassified by location and incision) .....	1748.00	5	620.60
C77125 – one side .....	1257.00	5	446.10
<b>Neck or Thoracic:</b>			
Bypass graft (synthetic) and/or thromboendarterectomy:			
C77130 – carotid arteries .....	1848.00	8	981.24
C77135 – innominate .....	2192.00	5	779.13
C77140 – subclavian .....	2089.00	5	846.50
C77145 Ligation of carotid artery .....	720.00	5	255.38
<b>Aortoiliac:</b>			
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) .....	2089.00	9	892.24
C77155 – aorta and/or iliac (bilateral) .....	2436.00	9	1400.80
C77160 – aorto-femoral and/or ilio-femoral (unilateral) .....	2436.00	9	866.39
C77165 – aorta-femoral and/or ilio-femoral (bilateral) .....	2790.00	9	1400.80

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Aneurysm:</b>			
NOTE: Peripheral aneurysm - charge associated bypass graft procedure.			
77170 Arteriovenous aneurysm .....	1393.00	9	495.27
C77175 Abdominal aneurysm, with grafting .....	2790.00	9	1397.15
77177 Abdominal aortic aneurysm repair using endovascular stent graft – vascular surgery component .....	2736.00	9	1397.15
NOTES:			
i) In order to bill 77177, vascular surgeon must be present throughout the entire procedure.			
ii) Includes the femoral endarterectomy/femoral artery repair.			
iii) Fem-fem crossover payable in addition at 50% of 77230 or 77235 when done.			
iv) When done with 77177, if second operator present, primary operator cannot bill 00982, 77114 or 10919.			
C77180 Resection of abdominal aneurysm with associated femoral dissection - one or both sides (extra fee to be added to procedure) - operation only. ....	350.00	9	124.11
NOTE: Peripheral aneurysm - charge associated bypass graft procedure.			
C77185 Ruptured aneurysm, with grafting .....	3302.00	10	1598.26
<b>Mesenteric:</b>			
C77190 Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy .....	2262.00	7	892.23
C77195 Superior mesenteric bypass graft (autogenous vein) .....	2262.00	7	892.23
<b>Renal:</b>			
C77200 Renal bypass graft (synthetic) and/or thromboendarterectomy .....	2433.00	7	892.23
C77205 Renal bypass graft (autogenous vein) .....	2433.00	7	892.23
<b>Axillo - Femoral:</b>			
Axillo-femoral bypass graft and/or thromboendarterectomy:			
C77210 – unilateral .....	2089.00	7	979.23
C77215 – bilateral .....	2436.00	7	1269.39
<b>Femoral Crossover:</b>			
C77230 Femoro-femoral crossover bypass graft (synthetic) and/or thromboendarterectomy .....	1748.00	5	930.69



VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
C77235 Femoro-femoral crossover bypass graft (autogenous vein).....	1953.00	5	930.69
<b>Infrainguinal:</b>			
C77240 Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy).....	1393.00	5	858.35
C77245 – popliteal (endarterectomy).....	1909.00	5	679.59
C77250 – popliteal (synthetic).....	1746.00	5	620.53
C77255 – anterior, posterior tibial or peroneal.....	2089.00	5	742.29
<b>Bypass Graft (Autogenous Vein):</b>			
C77260 – femoral.....	2017.00	5	859.23
C77265 – popliteal.....	2017.00	5	1072.16
C77270 – anterior, posterior tibial or peroneal.....	2368.00	5	1115.63
C77275 – in situ vein graft (extra).....	619.00	7	257.02
77280 – non-ipsilateral long saphenous graft (extra).....	718.00	7	254.66
77285 – short saphenous graft (extra).....	718.00	7	254.66
77290 – superficial femoral vein graft (extra).....	718.00	7	254.66
77295 – arm vein graft (extra).....	718.00	7	254.66
77300 – A-V fistula with bypass graft in limb salvage (extra) ..	522.00	7	185.56
<b>Profunda thromboendarterectomy:</b>			
77310 Profunda thromboendarterectomy without patch repair ..	1553.00	5	553.02
77315 Profunda thromboendarterectomy with patch repair (synthetic or autologous).....	2113.00	5	750.88
<b>Trauma:</b>			
Repair of injury of major vessel in extremity:			
C77330 – suture.....	1643.00	6	583.75
C77335 – graft.....	2113.00	6	750.88
Repair of injury of major vessel in trunk:			
C77340 – suture.....	2465.00	9	876.21
C77345 – graft.....	3289.00	9	1168.71
77350 Supra-renal aortic cross-clamp - extra to abdominal vascular or major trauma cases - operation only .....	322.00		114.21
NOTE: Operative report required.			
V07447 Repair of mesenteric injury .....	2330.00	6	572.71
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.			

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<b>Operative repair – arteriography – for iatrogenic injury during percutaneous endovascular aortic valve implantation:</b>			
77352 Repair of major vessel in extremity – suture .....	1601.00	6	563.58
77353 Repair of major vessel in extremity – graft .....	2061.00	6	724.93
77354 Repair of major vessel in trunk – suture .....	2404.00	9	845.95
77355 Repair of major vessel in trunk – graft.....	3207.00	9	1128.31

**Fasciotomy:**

77360 Decompression fasciotomy - subcutaneous.....	692.00	3	334.57
NOTE: 77360 includes secondary closure.			

**Tibial Metaphysis (Distal), Ankle and Foot:  
Incision - Therapeutic, Release (Fasciotomy  
& Nerve Release):**

57250 Decompression, neurolysis, nerve (isolated procedure)	1151.00	2	298.77
*57260 Fasciotomy, compartment syndrome .....	830.00	2	214.73
*57269 Fasciotomy, secondary wound closure .....	720.00	2	186.72

**Miscellaneous:**

77370 Release of popliteal entrapment syndrome .....	812.00	3	334.57
NOTE: Not to be paid if full femoral popliteal bypass is performed.			
S00722 Arteriography, operative - procedural fee .....	308.00		75.51

**RENAL ACCESS**

77380 Insertion permanent peritoneal catheter (procedure fee only) .....	536.00	3	190.68
77385 Removal by dissection of chronic peritoneal catheter (operation only) .....	372.00	3	132.26
NOTE: For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.			
77395 Creation of internal arterio-venous fistula.....	1045.00	4	414.93
77400 Synthetic AV graft for hemodialysis.....	1288.00	4	707.49
NOTE: Not paid with 77295, 77395, 77396 and 77402.			
77396 Revision of AV fistula .....	1260.00	5	505.58

*(see notes on next page)*

VASCULAR SURGERY - Continued

**Non-MSP-  
Insured  
Fee (\$)**      **Anes.  
Lev.**      **MSP &  
WSBC  
Fee (\$)**

**NOTES:**

- i) Restricted to Vascular and General Surgeons
- ii) Not paid with renal access fees (77380, 77385, 77395, 77400, 77402, 77403, 77405).
- iii) Not paid with the following vein graft fees (C77275, 77280, 77285, 77290, 77295, 77300).
- iv) 77043 not paid with this fee.

77402	Creation of brachiobasilic arteriovenous fistula with vein transposition .....	1885.00	5	707.74
	Note: Not paid with 77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77330, 77395 and 77400.			
77403	Arm revascularization with distal revascularization and interval ligation (DRIL) .....	1763.00	5	707.73
	Note: Not paid with C77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77300, 77395, and 77396.			
77405	Thrombectomy of arterio-venous fistula .....	984.00	3	349.01

**SYMPATHECTOMY**

77420	Lumbar sympathectomy - unilateral .....	1045.00	4	371.15
77422	Cervical sympathectomy - unilateral .....	1287.00	5	501.87
77424	Preganglionic sympathectomy; upper dorsal region - unilateral .....	1287.00	7	458.38
77426	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral .....	1287.00	7	458.38
	Lumbar sympathectomy with abdominal procedure:			
77428	– unilateral (extra).....	350.00		124.12
77430	– bilateral (extra).....	697.00		248.26

**LYMPHATIC SYSTEM**

V07361	TB glands - radical removal .....	1096.00	4	269.03
V07363	Radical femoral, inguinal and/or iliac dissection .....	2186.00	5	536.76
V07360	Splenectomy .....	2631.00	6	808.57
VC07366	Laparotomy and staging of lymphoma to include splenectomy.....	3174.00	6	909.86
VC07365	Isolated limb perfusion to include groin dissection and laparotomy .....	3822.00	5	938.97

**LYMPHOEDEMA - LEG**

**Lymphoedema of Limbs - Excision and Grafting:**

06127	Entire leg.....	2782.00	3	700.04
-------	-----------------	---------	---	--------

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
06128 Entire lower extremity.....	4161.00	3	1046.58

**ABDOMINAL SURGERY**

**Miscellaneous:**

V07603 Resuture abdominal wound evisceration .....	1096.00	5	406.03
V07451 Thoracic extension of abdominal incision (extra) .....	1161.00	8	285.69
V07600 Exploratory laparotomy to include biopsy.....	1410.00	5	405.81

**TRANSPLANTATION**

**Implantation of Kidney Graft:**

77440 Vascular surgeon .....	2355.00	7	836.46
------------------------------	---------	---	--------

**AMPUTATION**

**Hand and Wrist:**

06218 Transmetacarpal .....	1013.00	2	254.92
06219 Finger, any joint or phalanx - operation only .....	1013.00	2	254.92

**Pelvis, Hip, and Femur:**

55983 Above knee .....	2524.00	4	653.54
55980 Hemicorporectomy .....	9448.00	6	2446.08
55981 Hemipelvectomy .....	5263.00	6	1363.10
55982 Hip disarticulation .....	4004.00	6	1036.32
55984 Knee disarticulation .....	2524.00	4	653.54
*55998 Open injury, primary wound care .....	363.00	4	102.26
*55999 Open injury, secondary wound management.....	720.00	4	186.72

**Femur, Knee Joint, Tibia and Fibula:**

56980 Below knee.....	2002.00	3	518.18
*56998 Open injury, primary wound care .....	363.00	3	102.26
*56999 Open injury, secondary wound management.....	720.00	3	186.72

**Tibial Metaphysis (Distal), Ankle and Foot:**

57981 Midtarsal .....	1896.00	2	490.15
57982 Transmetatarsal .....	1578.00	2	406.12
57983 Single metatarsal/Ray resection.....	1368.00	2	354.78
57980 SYME .....	2057.00	2	532.14
57984 Toe.....	727.00	2	186.72
*57998 Open injury, primary wound care .....	179.00	2	51.13
*57999 Open injury, secondary wound management.....	363.00	2	93.37

**THORACIC OUTLET SYNDROME**

**Ribs and Chest Wall:**

79125 Cervical rib resection.....	805.00	5	359.33
-----------------------------------	--------	---	--------

VASCULAR SURGERY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
79130 Trans-axillary resection of first rib .....	1259.00	5	865.45

	Non-MSP- Insured Fee \$	A Tech Fee \$	B Prof Fee \$	C Total Fee \$
--	-------------------------------	---------------------	---------------------	----------------------

**DOPPLER STUDIES**

NOTE: The Doppler Vascular listings are applicable to hospital-based, accredited and approved ultrasound vascular studies (laboratories only).

08660 Abdominal duplex of native or transplant liver and/or kidney .....	299.00	87.80	34.33	122.13
--	--------	-------	-------	--------

**Peripheral Arterial:**

08664 Resting arterial assessment - To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index.....	151.00	48.65	11.54	60.19
--	--------	-------	-------	-------

NOTE: Not chargeable when done in conjunction with 08665 or 08666.

08665 Treadmill stress examination with or without ECG monitoring - To include sequential post stress measurement and calculations - with monitoring physician present.....	264.00	60.51	46.20	106.71
08666 – without monitoring physician present...	175.00	60.66	11.53	72.19

08668 Vasospastic assessment - To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis.....	175.00	60.66	11.53	72.19
--	--------	-------	-------	-------

08669 Sympathetic tone response - To include resting arterial assessment plus plethysmography and/or impedance monitoring and/or digital wave forms, response to Valsalva manoeuvres or other stimuli.....	109.00	32.43	11.53	43.96
--	--------	-------	-------	-------

NOTE: 08669 not chargeable when done in conjunction with 08668.

## DIAGNOSTIC RADIOLOGY

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

\* Service is payable to Certified Radiologists only.

**COLUMN A:** This fee only for technical services that include the cost of materials, labour, equipment, general office expenses, etc.

**COLUMN B:** This fee only for professional services of a certified diagnostic radiologist for supervision, direction and participation in the radiological examination. This includes consultation with the referring physician and rendering of a radiological report.

**COLUMN C:** This fee for the radiological examination and includes both A and B above, but does not include procedural fees listed separately in the Guide.

NOTE: Payment agencies accept billings under Column C (Total Fee) 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 Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients
- the services are billed in accordance with the Telemetry Billing Guidelines

#### 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

DIAGNOSTIC RADIOLOGY - Continued

- 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.

		<b>MSP and WSBC</b>		
	<b>Non-MSP- Insured Fee (\$)</b>	<b>A Tech Fee (\$)</b>	<b>B Prof Fee (\$)</b>	<b>C Total Fee (\$)</b>
<b>HEAD AND NECK</b>				
08500 Skull - routine .....	127.00	39.90	13.33	53.23
08501 Skull - special studies additional .....	85.10	26.48	8.72	35.20
08503 Paranasal sinuses .....	85.10	26.48	8.72	35.20
08504 Facial bones - orbit .....	85.10	26.48	8.72	35.20
08505 Nasal bones .....	85.10	26.48	8.72	35.20
08506 Mastoids .....	127.00	39.90	13.33	53.23
08507 Mandible .....	85.10	26.48	8.72	35.20
08508 Temporo-mandibular joints .....	85.10	26.48	8.72	35.20
08509 Salivary gland region .....	85.10	26.48	8.72	35.20
08510 Sialogram.....	127.00	41.15	13.77	54.92
08511 Eye - for foreign body.....	85.10	26.48	8.72	35.20
08512 – for foreign body localization - additional .....	127.00	35.00	17.70	52.70
08513 Dacryocystogram.....	85.10	26.19	8.63	34.82
08514 Nasopharynx and/or soft tissue, neck - single lateral view .....	42.85	16.96	5.89	22.85
08515 Laryngogram (excluding procedural fee) .	127.00	34.99	17.72	52.71
08518 Pre-MRI view(s) of orbits to rule out metallic foreign body .....	58.30	18.22	5.99	24.21
<b>UPPER EXTREMITY</b>				
08520 Shoulder girdle.....	85.10	26.48	8.72	35.20
08521 Humerus .....	85.10	26.48	8.72	35.20
08522 Elbow .....	85.10	26.48	8.72	35.20
08523 Forearm .....	85.10	26.48	8.72	35.20
08524 Wrist.....	85.10	26.48	8.72	35.20
08525 Hand (any part).....	85.10	26.48	8.72	35.20
08526 Special requested views in upper extremity .....	42.85	13.17	4.57	17.74
<b>LOWER EXTREMITY</b>				
08530 Hip .....	85.10	26.48	8.72	35.20

DIAGNOSTIC RADIOLOGY - Continued

		MSP and WSBC			
		Non-MSP- Insured Fee (\$)	A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
08531	Femur.....	85.10	26.48	8.72	35.20
08532	Knee.....	85.10	26.48	8.72	35.20
08533	Tibia and fibula.....	85.10	26.48	8.72	35.20
08534	Ankle .....	85.10	26.48	8.72	35.20
08535	Foot (any part).....	85.10	26.48	8.72	35.20
08536	Leg length films - whatever method .....	98.50	26.62	14.83	41.45
08537	Special requested additional views for lower extremity .....	42.85	13.17	4.57	17.74
<b>SPINE AND PELVIS</b>					
08540	Cervical spine.....	105.00	31.32	10.82	42.14
08541	Thoracic spine.....	85.10	26.48	8.72	35.20
08542	Lumbar spine .....	127.00	39.90	13.33	53.23
08543	Sacrum and coccyx.....	85.10	26.48	8.72	35.20
08549	Spine - requested additional views (flexion, bending views, etc.).....	79.80	24.42	8.73	33.15
NOTE: Fee item 08549 is not intended to cover normal oblique projections.					
08544	Pelvis .....	85.10	26.48	8.72	35.20
08545	Sacro-iliac joints .....	85.10	26.48	8.72	35.20
08546	Scoliosis films - single AP or lateral - 14 x 36 film taken at 6 feet .....	111.00	31.76	14.30	46.06
08547	Pelvis and additional requested views, i.e. sacroiliac joints, hip, etc. ....	104.00	31.32	10.82	42.14
08548	Myelogram and/or posterior fossa positive contrast (excluding procedural fee).....	255.00	63.76	40.49	104.25
<b>CHEST</b>					
08550	Thoracic viscera.....	86.90	26.29	8.63	34.92
08551	Thoracic inlet.....	86.90	26.29	8.63	34.92
08552	– additional requested views.....	42.85	13.17	4.57	17.74
08553	Fluoroscopy, when requested .....	42.85	12.03	5.84	17.87
08554	Ribs - one side .....	85.10	26.48	8.72	35.20
08555	– both sides .....	127.00	39.90	13.33	53.23
08556	Sternum or sterno - clavicular joints .....	85.10	26.48	8.72	35.20
08557	Sternum and sterno - clavicular joints .....	127.00	39.90	13.33	53.23
<b>ABDOMEN</b>					
08570	Abdomen.....	85.10	26.48	8.72	35.20
08571	Abdomen, multiple views .....	127.00	39.90	13.33	53.23



DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
<b>GASTRO-INTESTINAL TRACTS</b>				
08572 Esophagus, only .....	151.00	43.03	16.99	60.02
08573 Esophagus, stomach and duodenum .....	210.00	58.28	27.46	85.74
08574 Small bowel .....	215.00	66.94	18.80	85.74
08576 Colon or double contrast air studies .....	220.00	59.48	37.15	96.63
08577 Hypotonic duodenography .....	215.00	64.05	21.69	85.74
08578 Pancreatography (excluding procedural fee).....	127.00	39.68	12.77	52.45
08579 Glucagon assisted contrast study (in addition to routine fee) .....	92.60	30.60	7.13	37.72
<b>GALL BLADDER</b>				
08581 Intravenous cholangiogram.....	196.00	53.76	22.35	76.11
08582 Operative cholangiogram (transhepatic also).....	144.00	40.06	17.15	57.21
08583 Direct post-operative cholangiogram or pyelogram .....	151.00	36.60	25.10	61.70
08584 Removal of biliary calculi by Burhenne technique or equivalent including necessary cholangiogram and fluoroscopy (excluding procedural fee) ....	159.00	48.01	16.44	64.45
<b>GENITO-URINARY SYSTEM</b>				
08590 K.U.B .....	85.10	26.48	8.72	35.20
08591 Pyelogram - intravenous .....	215.00	59.22	20.07	79.29
08593 Pyelogram - retrograde or antegrade.....	127.00	39.51	13.19	52.70
08594 Intravenous pyelogram with voiding cystourethrogram .....	259.00	75.63	28.62	104.25
08595 Cystogram or retrogradeurethrogram (not including catheterization) .....	127.00	39.51	13.19	52.70
08596 Hysterosalpingogram (excluding injection) .....	215.00	64.05	21.69	85.74
08597 Pelvimetry .....	172.00	52.56	20.16	72.72
08599 Voiding cystourethrogram .....	215.00	58.86	28.25	87.11

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)

**MISCELLANEOUS**

08575 Video Fluoroscopy - 50% to be added to fee items 08572 and 08573.....

NOTES:

- i) Applicable to the following indications only: complicated oesophageal motility, aspiration, abnormal swallowing, dysphagia or webs.
- ii) A note record of the indication is required.

08601 Radiographic study of sinus, fistula, etc. with contrast media, including injection and fluoroscopy, if necessary.....	160.00	36.34	29.91	66.25
08602 Body section radiography - Applies to all tomographic procedures (including polytomography when done in one plane-per plane series, including orthopantomogram).....	122.00	36.18	14.02	50.20
08603 Bone age - whatever method .....	88.10	26.46	10.42	36.88
08604 Bone survey - first anatomical area.....	85.10	26.48	8.72	35.20
08605 – each subsequent anatomical area.....	42.85	13.17	4.57	17.74
08606 Arthrogram - shoulder (excluding injection of contrast).....	92.60	26.46	11.41	37.87
08607 hip (excluding injection of contrast).....	85.10	26.20	8.63	34.83
08608 knee (excluding injection of contrast).....	191.00	56.12	18.61	74.73
08609 ankle (excluding injection of contrast).....	85.10	26.20	8.63	34.83
08631 wrist (excluding injection of contrast).....	79.40	26.20	8.63	34.83
08637 elbow (excluding injection of contrast) ...	79.40	26.20	8.63	34.83
08610 Mammography - unilateral .....	137.00	75.72	27.32	103.04
08611 – bilateral .....	220.00	108.14	36.26	144.40

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.
- (notes continued on next page)*

DIAGNOSTIC RADIOLOGY - Continued

		<b>MSP and WSBC</b>			
		<b>Non-MSP- Insured Fee (\$)</b>	<b>A Tech Fee (\$)</b>	<b>B Prof Fee (\$)</b>	<b>C Total Fee (\$)</b>
<ul style="list-style-type: none"> <li>c) Short-term follow-up of an abnormality, within one year of a previous bilateral mammogram.</li> <li>d) Follow-up of surgery/radiotherapy, within one year of a previous bilateral mammogram.</li> <li>e) Absence of other breast.</li> <li>f) Visualization for fine wire localization or stereotactic biopsy.</li> </ul>					
<ul style="list-style-type: none"> <li>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.</li> </ul>					
08615	Cerebral angiography - unilateral.....	330.00	94.22	40.88	135.10
08616	– bilateral.....	570.00	150.47	81.34	231.81
08617	Peripheral angiography (arteriography and venography) - unilateral .....	170.00	52.52	17.41	69.93
08618	– bilateral.....	259.00	78.36	25.89	104.25
08620	Aortography (aortography plus peripheral angiography).....	444.00	133.80	45.83	179.63

The entry "Thoracic or abdominal angiogram" is intended to include the following:

- |                          |                                    |
|--------------------------|------------------------------------|
| Thoracic aortogram       | Renal arteriogram                  |
| Mediastinal angiogram    | Celiac arteriogram                 |
| Angiocardiogram          | Mesenteric 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 |                                    |

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
Thoracic or abdominal angiogram (cine or videotape surcharge not applicable)				
08626 – using multiple sequential views - non-selective.....	353.00	100.07	37.20	137.27
08627 – using multiple sequential views - selective .....	330.00	94.22	40.88	135.10
*08628 Interpretation of submitted films - per examination .....	119.00	0.00	51.39	51.39
NOTE: This item to be charged only in those situations where a third party requests a second written radiological opinion, and is billable only when medically required.				
*08629 Radiologist performing fluoroscopy for various clinical procedures .....	71.30	17.75	22.97	40.72
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; and injection or aspiration.				
iii) This item may be billed in facilities, either hospital or non-hospital, which are accredited to perform fluoroscopy.				
*08630 Percutaneous transluminal angioplasty ...	756.00	299.41	17.96	317.37

**RADIOLOGY ASSISTANT FEE**

*08632 Radiology assistant fee - first hour or fraction thereof .....	259.00	0.00	112.52	112.52
*08633 – each 15 minutes or fraction thereof after one hour.....	73.60	0.00	28.16	28.16
<i>(see notes on next page)</i>				

Non-MSP- Insured Fee (\$)	MSP and WSBC		
	A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)

NOTE: \*08632 and \*08633 may be applicable:

- i) When a radiology assistant is required in conjunction with 00738, 00979, 00980, 00981, 00982, 00995, 00997, 00998, 10913, 10914 and 10915;
- ii) In lieu of 08629 performed in conjunction with endoscopic retrograde cholangio-pancreatography (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.....	164.00	50.86	18.15	69.01
08689	Bone density - second area .....	114.00	29.07	18.14	47.21
08696	Bone density - whole body .....	297.00	85.65	38.60	124.25

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 (i.e. Fosamax)
  - b) weaning patient off glucocorticosteroids (i.e. prednisone)
  - c) adequate ongoing monitoring (in cases of primary hyperparathyroidism)
- iii) Not payable for the following indications:
  - a) chronic back pain
  - b) kyphosis
  - c) menopause
  - d) Routine bone density screening

*(notes continued on next page)*

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
v) 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.				
vi) 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.				
vii) Claims for whole body bone density must be accompanied by written explanation of need.				
viii) 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.				
ix) Restricted to certified radiologists or nuclear medicine physicians and individuals who have received approval from Diagnostic Accreditation Program (DAP) to perform these tests, and the tests are provided in a DAP accredited and MSC approved facility.				

**COMPUTERIZED TOMOGRAPHY**

*08690 Head scan - without contrast .....	127.00	0.00	45.79	45.79
*08691 – with contrast .....	185.00	0.00	63.86	63.86
*08692 – double scan or 2 planes .....	235.00	0.00	82.48	82.48
*08693 Body scan - one region without contrast.....	264.00	0.00	91.38	91.38
*08694 – one region with contrast .....	288.00	0.00	101.00	101.00
*08695 – double scan or 2 regions .....	389.00	0.00	138.07	138.07

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
83090 Cardiac CT/CT Coronary Angiography, professional fee .....	252.00	0.00	169.63	169.63

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.

*(notes continued on next page)*

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
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) <i>(see notes on next page)</i>	134.00	0.00	61.99	61.99



Non-MSP- Insured Fee (\$)	MSP and WSBC		
	A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)

NOTES:

- i) Paid only as a diagnostic procedure, only in circumstances where optical colonoscopy is not technically possible, or clinically unsafe.
  - ii) Restricted to Radiologists
  - iii) Restricted to referrals by Gastroenterologists, General Surgeons and General Internal medicine specialist.
  - iv) Rural GP's (in RSA communities) can refer patients for this procedure in communities where a specialist referral is not available.
  - v) Paid on out-patients only.
  - vi) Paid in addition to 08695, same patient, same day.
- 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 .....	207.00	83.73
-------	--	--------	-------

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.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
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 and IR consultation.				

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

**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.....	207.00	83.73
---	--------	-------

**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 and IR consultation.

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

**THERAPEUTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT**

S00978 Percutaneous nephrostomy - procedural fee.....	631.00	2	300.12
S00979 Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation - procedural fee .....	834.00	2	400.08
S00980 Transhepatic biliary drainage procedure (includes fee item S00857) .....	883.00	3	423.99
S00981 Therapeutic radiological embolization .....	883.00	3	423.99
S00982 Percutaneous transluminal angioplasty .....	842.00	2	404.15

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 .....	514.00	2	276.05
00995 Embolization of brain and spinal cord AVM's .....	5094.00	3	2091.29

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.....	3502.00	3	1307.68
---	---------	---	---------

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 .....	4321.00	3	1612.74
---	---------	---	---------

NOTES:

- i) 00995, S00997, and 00998 include the consultations associated with the procedure performed, preparation of the embolizing agent(s) and catheter(s), catheterization(s) and follow-up care of the patient by the radiologist.
- ii) 00995, S00997 and 00998 are billable only by physicians with appropriate training in interventional neuroradiology.
- iii) 00995, S00997 and 00998 are payable once per day, regardless of the number of embolizations or catheterizations performed, or balloons inserted.

*(notes continued on next page)*

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
<ul style="list-style-type: none"> <li>iv) 00995 and 00998 include:                             <ul style="list-style-type: none"> <li>a) Diagnostic angiograms done during the procedure.</li> <li>b) Angiograms performed as a separate procedure before or after the embolization are billable.</li> <li>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.</li> <li>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.</li> </ul> </li> <li>v) Includes 10913 if performed on same day as 00995, S00997 or 00998.</li> </ul>			
10900 Abdominal aortic aneurysm repair using endovascular stent graft – second operator.....	2380.00		509.83
NOTES:			
<ul style="list-style-type: none"> <li>i) Intraoperative renal artery angioplasty payable in addition at 50% of fee item 00982 when done.</li> <li>ii) Intravascular stent placement – extra (10919) paid in addition under 10919 at 100%.</li> <li>iii) This fee will not be paid to the primary operator.</li> </ul>			
10901 Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery .....	1443.00	2	587.65
NOTES:			
<ul style="list-style-type: none"> <li>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.</li> <li>ii) Payable at 100% for the first 12 hours of care and 50% for each additional 12 hours of care, up to 36 hours.</li> <li>iii) Start and end times must be entered in both the billing claims and the patient's chart.</li> </ul>			

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10902 Peripherally inserted image-guided central venous catheter line (PICC).....	273.00	2	111.94
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 .....	1443.00	2	587.65
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) .....	1443.00	3	587.65
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.....	3288.00	5	1307.68
NOTES:			
i) Payable only once, 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.....	959.00	4	363.79
10907 – each additional level (to a maximum of 3).....	225.00	4	83.96
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.			

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10908 Percutaneous image-guided tumour ablation – first lesion .....	1443.00	3	528.39
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 the 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 .....	959.00	3	391.78
NOTES:			
i) All angiography, angioplasty and/or intravascular stenting included.			
ii) If a second or third foreign body/medical device is removed, payable at 50% each to a total maximum of three.			
10911 Selective salpingography/fallopian tube recanalization (FTR) .....	959.00	2	391.78
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 it is 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 .....	959.00	2	391.78
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%.			

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10913 Cerebral arterial balloon occlusion tolerance test.....	1695.00	5	796.15
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;			
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 (10915) or embolization (00995, S00997, 00998) if performed on the same day.			
10914 Percutaneous balloon angioplasty for cerebral vasospasm .....	2172.00	9	1023.28
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 S00982.			
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% for the first angiogram and 50% 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.			

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
10915 Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique .....	4239.00	7	1990.40
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: 2 <sup>nd</sup> - 50%; 3 <sup>rd</sup> - 25% (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% for the first angiogram and 50% for subsequent angiograms, to a maximum of 75% of fee item 10915. Claims must be accompanied by written details of vessels injected.			
10918 Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance.....	996.00	6	468.33
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 .....	308.00		129.12
NOTES:			
i) Includes all diagnostic imaging associated with stent placement.			
ii) Payable when follows angioplasty procedure (S00982) where stent is not initially deployed. <i>(notes continued on next page)</i>			



Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

- iii) For non-Vascular surgery, placement of second stent in 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 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

Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
---------------------------------	---------------	---------------------------

**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

10920 Intracorporeal stent placement - extra .....	308.00	129.12
--	--------	--------

NOTES:

- i) Includes all diagnostic imaging associated with stent placement.

*(notes continued on next page)*

DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	Anes. Lev.	MSP & WSBC Fee (\$)
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).....	3026.00	8	1109.62
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 .....	1427.00	3	628.08
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.			

*(notes continued on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
--	-----------------------	--

- 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.

**CARDIO-VASCULAR PROCEDURES**

S00880 Portal pressures - hepatic vein wedge pressure - by duly qualified specialist.....	242.00		65.66
S00881 – percutaneous splenic portal pressure.....	200.00	2	52.55
10916 Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations - up to 4 hours procedural time.....	3107.00	5	1170.81
10917 – after 4 hours (extra to 10916).....	637.00		292.72

**NOTES:**

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

	<b>Non-MSP- Insured Fee (\$)</b>	<b>Anes. Lev.</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>BREAST</b>			
These listings cannot be correctly interpreted without reference to the Preamble.			
<b>Incision</b>			
70041 Fine needle aspiration of solid or cystic lesion – operation only .....	177.00	2	46.33
70042 – each additional cyst or lesion (maximum of 3) – operation only.....	44.95	2	11.60
<b>Stereotactic or ultrasound-guided core needle biopsy:</b>			
70472 – 1 to 5 core samples – operation only .....	331.00	2	87.38
70473 – 6 to 10 core samples – operation only .....	469.00	2	123.36
<b>Post biopsy marker</b>			
P83045 Post biopsy radiological marker (clip) placement .....	337.00		150.00
NOTES:			
i) Restricted to Radiologists who work at approved Community Imaging Clinics only.			
ii) Paid only in addition to 86047; or 86048 when combined with 86047.			
iii) Maximum two clips per patient per day, either unilateral or bilateral.			
<b>DIAGNOSTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT</b>			
S00868 Percutaneous gastrostomy/gastrojejunostomy - procedural fee .....	1043.00	2	275.79
<b>MAGNETIC RESONANCE IMAGING</b>			
08697 Standard 2-sequence or 2-plane study.....	841.00		
08698 – additional sequences or planes.....	349.00		

# DIAGNOSTIC ULTRASOUND

NOTES: Payment agencies accept billings under Column C (Total Fee) only.

## 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 Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients
- the services are billed in accordance with the Telemetry Billing Guidelines

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.

### Telemetry Billing Guidelines:

- g) Services must be billed by the facility where the image was taken using the practitioner number of the physician who did the interpretation.
- h) Facility number field – the facility number of the diagnostic facility where the image was taken
- i) 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
- j) 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.
- k) The original site should ensure that only one interpretation is billed to MSP.

DIAGNOSTIC RADIOLOGY - Continued

- l) 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.

		<b>MSP and WSBC</b>		
	<b>Non-MSP- Insured Fee(\$)</b>	<b>A Tech Fee (\$)</b>	<b>B Prof Fee (\$)</b>	<b>C Total Fee (\$)</b>
<b>HEAD AND NECK</b>				
A08480 Transcranial Doppler.....	131.00			
08641 Ophthalmic B-scan (immersion and contact)...	247.00	56.51	44.31	100.82
NOTES:				
i) No additional charge for second eye when both eyes examined concurrently.				
ii) Includes 22399 when done at the same sitting.				
08642 B-scan – soft tissues of neck.....	164.00	37.04	31.50	68.54
NOTE: To include thyroid, parathyroid, parotid and submandibular glands.				
<b>HEART</b>				
08638 Echocardiography – real time.....	269.00	59.48	42.38	101.86
08644 Ultrasonic guidance for pericardio-centesis.....	267.00	68.82	40.88	109.70
08662 Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis .....	654.00	132.87	101.59	234.46
NOTE: Where the exercise stress test (00530, 00531, 00535, 01730, 01731, 01732, 33034, 33035 and 33036) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent.				
<b>THORAX</b>				
08645 B-scan .....	210.00	54.86	31.52	86.38
08646 Ultrasonic guidance for thoracentesis.....	241.00	68.63	31.54	100.17
Breast Sonogram:				
86047 – unilateral .....	137.00	42.30	27.61	69.91
86048 – additional side .....	67.60	21.31	13.94	35.25
<i>(see notes on next page)</i>				

Non-MSP- Insured Fee (\$)	MSP and WSBC		
	A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)

NOTES:

- i) Additional side billable 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 are:
  - 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 .....	267.00	65.44	44.28	109.72
08649 Renal B-scan .....	247.00	54.86	31.52	86.38
NOTE: 08649 not chargeable when done in conjunction with 08648 and/or 08653.				
08650 Ultrasonic guidance for biopsy or cyst puncture .	257.00	79.11	42.66	121.77
08684 Prostate scan using rectal probe .....	267.00	65.42	44.28	109.70

**OBSTETRICS AND GYNECOLOGY**

08651 Obstetrical B-scan - 14 weeks gestation or over.....	257.00	65.42	44.28	109.70
08655 – under 14 weeks gestation.....	208.00	50.76	31.54	82.30
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) .....	219.00	43.96	37.67	81.63
08652 B-scan I.U.D. localization.....	137.00	33.02	22.10	55.12



DIAGNOSTIC RADIOLOGY - Continued

	Non-MSP- Insured Fee (\$)	MSP and WSBC		
		A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)
08653 Pelvic B-scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal Doppler.....	267.00	65.42	44.28	109.70
NOTES:				
i) 08653 billable 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.....	267.00	68.26	42.04	110.30
86055 Obstetrical B scan less than 14 weeks with Nuchal Translucency measurement (for singles).....	335.00	73.42	53.12	126.54
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 intracytoplasmic sperm injection.				
86056 Obstetrical B scan less than 14 weeks with Nuchal Translucency measurement (for multiples – each additional fetus).....	296.00	53.12	41.77	94.89
<b>BRAIN</b>				
08659 B-scan.....	257.00	60.61	44.28	104.89
<b>EXTREMITIES</b>				
08658 Extremity B-scan.....	145.00	37.14	22.26	59.40

(see notes on next page)

Non-MSP- Insured Fee (\$)	MSP and WSBC		
	A Tech Fee (\$)	B Prof Fee (\$)	C Total Fee (\$)

**NOTES:**

- i) Includes, but not restricted to, assessment of tendons, joint infusions, 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 .....	299.00	87.80	34.33	122.13
--	--------	-------	-------	--------

**Peripheral Arterial:**

08664 Resting arterial assessment - To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index.....	151.00	48.65	11.54	60.19
--	--------	-------	-------	-------

NOTE: Not chargeable when done in conjunction with 08665 or 08666.

08665 Treadmill stress examination with or without ECG monitoring - To include sequential post stress measurement and calculations - with monitoring physician present .....	264.00	60.51	46.20	106.71
--	--------	-------	-------	--------

08666 – without monitoring physician present .....	175.00	60.66	11.53	72.19
--	--------	-------	-------	-------

08668 Vasospastic assessment - To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis .....	175.00	60.66	11.53	72.19
---	--------	-------	-------	-------

08669 Sympathetic tone response - To include resting arterial assessment plus plethysmography and/or impedance monitoring and/or digital wave forms, response to Valsalva manoeuvres or other stimuli .....	109.00	32.43	11.53	43.96
---	--------	-------	-------	-------

NOTE: 08669 not chargeable when done in conjunction with 08668.

DIAGNOSTIC RADIOLOGY - Continued

		<b>MSP and WSBC</b>			
		<b>Non-MSP- Insured Fee (\$)</b>	<b>A Tech Fee (\$)</b>	<b>B Prof Fee (\$)</b>	<b>C Total Fee (\$)</b>
<b>Peripheral Venous:</b>					
08670	Diagnostic facility assessment for deep venous system .....	109.00	32.95	11.73	44.68
<b>Heart:</b>					
08679	Doppler echocardiography .....	121.00	28.46	18.27	46.73
<b>Extracranial:</b>					
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 .....	269.00	87.64	34.32	121.96
08677	Periorbital assessments, either oculo-plethysmography (OPG) or photoplethysmography (PPG) and/or Doppler directional determination with extracranial artery compression manoeuvres .....	109.00	32.95	11.73	44.68
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 .....	152.00	49.00	12.21	61.21

## LABORATORY MEDICINE

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

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 Doctors of British Columbia before Medical Services Plan will consider honouring accounts submitted for these fee items.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
<b>CONSULTATIONS AND VISITS</b>		
94010 <b>Consultation:</b> To consist of examination, review of history and laboratory findings with a written report .....	282.00	148.18
94012 <b>Repeat or Limited Consultation:</b> Where a consultation for the same illness is repeated within six (6) months of last visit by consultant or where, in the judgment of the consultant, the consultative service does not warrant a full consultative fee .....	158.00	82.34
<b><u>Continuing Care by Consultant:</u></b>		
94006 Directive care.....	62.40	31.31
94007 Subsequent office visit.....	62.40	32.01
94008 Subsequent hospital visit.....	62.40	31.90
94009 Subsequent home visit .....	124.00	63.62
94005 Emergency visit when specially called (not paid in addition to out-of-office hour charges) .....	251.00	127.08
NOTE: Claim must state time service rendered.		
<b>Telehealth Service with Direct Interactive Video Link with the Patient</b>		
94070 <b>Telehealth Consultation:</b> To consist of examination, review of history and laboratory findings with a written report.....	282.00	148.18
94072 <b>Telehealth repeat or Limited Consultation:</b> 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 .....	158.00	82.34
94076 Telehealth directive care .....	62.40	31.31
94077 Telehealth subsequent office visit.....	62.40	32.01
94078 Telehealth subsequent hospital visit.....	62.40	31.90

NON-INSURED ITEMS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP &amp; WSBC Fee (\$)</b>
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) .....	40.75	16.90

## NON-INSURED ITEMS ONLY

### PREAMBLE

The fee schedule addresses the direct service performed and the additional activities involved in the provision of each item. These additional activities include the time spent interacting with technologists and transcriptionists, telephoning other health professionals, attending rounds, conferences and continuing education. These activities do not include the administrative services provided by Anatomic Pathologists to the facilities they serve.

### SURGICALS

#### **Categorization Microscopically:**

Except for Category I specimens which are submitted to the laboratory for identification and documentation of the type and source of the tissue or material, surgical specimens are ordinarily submitted for histological examination. Consequently, the categorization of specimens in Categories II to VI should be made after microscopic examination. The categorization depends on the final diagnosis and should be determined by the pathologist.

#### **One Fee Per Consultation:**

One fee per consultation is the general guide as the majority of consultations represent one specimen and one specimen container. It is traditional to accession all biopsied material from one patient for any day, under one laboratory accession number. When multiple specimens are submitted the following conventions apply:

- 1. Multiple specimens from pathologically unrelated sites in one container.** Any number of biopsies that are submitted in one container, and not separately identified by the submitted physician, are interpreted as one specimen and one fee. This would apply to six endoscopic biopsies from the stomach in one specimen container. However, if two skin biopsies were submitted in one container and the history stated “larger lesion right cheek, query melanoma; smaller lesion left temple, query actinic keratosis”, these lesions would be treated individually as two distinct specimens and would warrant two billings. (Submitting multiple specimens in this manner is bad practice and should be discouraged).
- 2. Multiple specimens from pathologically unrelated sites in separate containers.** Multiple tissue samples submitted in separate containers from separate body sites are regarded as separate specimens and are billed separately. For example, a hysterectomy for fibroids received along with an anterior resection of colon for cancer in separate containers are separately billable items despite the convention of lumping them under one accession number and one report.
- 3. Multiple specimens from pathologically identical or closely related sites in separate containers.** Based on the principle that these represent one consultation and in general one disease, these are billed as one fee. When four or more biopsies of Category IV are processed separately, they may be billed as one complex specimen of Category V. This would include multiple needle core biopsies of breast or prostate, multiple skin dysplastic nevi, multiple bronchopulmonary biopsies, multiple gastrointestinal biopsies and multiple

## NON-INSURED ITEMS - Continued

bladder biopsies. Similarly, if a hysterectomy for uterine cancer with one attached adnexa is submitted in one container and the second detached adnexa in a second container, the two specimens are billed as one Category VI item since both adnexae are regarded as components of the radical hysterectomy specimen.

4. **Special histochemical and immunohistochemical stains and immunofluorescence.** Simple histochemical or immunohistochemical stains performed to confirm a histologic diagnosis should not be reflected in the fee (e.g.: PAS or Giemsa for skin or GI biopsies). Complex histochemical or immunohistochemical stains requiring extensive pathologic assessment are reflected in the classification of the specimen within the categories below (e.g.: AFB and fungal stains for granulomatous lymphadenitis, multiple IHC stains for malignant lymphoma, immunofluorescence and electron microscopy for primary diagnosis of glomerulonephritis).

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

\* **Does not include technical component.**

	Code	Non- MSP- Insured Fee* (\$)
<b>CONSULTATIONS</b>		
Consultation fees are designed for a formal consultation from an outside laboratory on a case which requires evaluation of clinical information, reading of slides and submission of a formal written report. Procedures that may be required (e.g.: special stains) are not included in this professional fee.		
Referred histology slides for opinion and letter .....	A94504 .....	156.00
– Multiple or complex specimens (Category VI specimens) .....	A94505 .....	314.00
<b>Intra-operative Consultation:</b>		
Operative consult with or without frozen section - first.....	A94500 .....	195.00
– each additional (no limit) .....	A94502 .....	61.50
NOTES:		
This fee is billed in conjunction with fee A94500 when:		
i) The surgeon requests consultation on second or subsequent specimens when more than one specimen is obtained during one operative procedure (e.g.: multiple biopsies to identify parathyroid gland tissue at parathyroidectomy), or		
ii) Multiple sequential specimens must be obtained to confirm diagnosis (e.g.: confirmation of intracranial tumour).		
<b>AUTOPSY</b>		
Autopsy - complete .....	A94506 .....	1195.00
Autopsy - partial.....	A94508 .....	362.00

(see note on next page)

NON-INSURED ITEMS – continued

**Code**                      **Non-  
MSP-  
Insured  
Fee\* (\$)**

NOTE: To be billed when an autopsy examination is limited either by signed family consent, or by choice of the pathologist, to one organ system or one body cavity (e.g.: thoracic cavity only). Includes both gross and microscopic examination.

**SURGICAL**

**Category I** - Identification by gross examination only ..... A94510 ..... 15.25

NOTE: Specimens submitted to the Pathology Laboratory for identification and documentation of the type and source of the tissue of specimens removed (e.g.: amputated fingers or toes; aneurysm contents; atheromatous plaque; bone for identification; calculus; foreskin from children (under age 16); intervertebral disc fragments; meniscus; nasal cartilage; other plastic procedures; prosthesis; skin from rhitidectomy; teeth; tonsils (under age 16); varicose veins; etc.). If the pathologist deems that microscopic examination is required, the specimen will not belong here.

**Category II** - Confirmation of normality ..... A94512 ..... 46.35

NOTE: Small specimens submitted for confirmation of normality by gross and microscopic examination (e.g.: appendix, incidental removal; brain/meninges from traumatic injury; carpal tunnel tissue; cartilage shavings; fallopian tube, sterilization; fingers/toes, amputation, traumatic, requiring histology; hernia sac, any location; hydrocele sac; intervertebral disc; joint loose body, meniscus; nerve, vagotomy; products of conception - therapeutic abortion; skin, plastic repair; spleen, traumatic injury; sympathetic ganglion; tendon; testicular appendage; testis, castration for carcinoma prostate; vaginal mucosa, incidental to vaginal repair; vas deferens, sterilization; vein and varicosity; etc.).

**Category III** - Confirmation of common degenerative and inflammatory conditions and common benign tumours ..... A94514 ..... 59.40

NOTE: Specimens submitted to pathology for confirmation of the clinical diagnosis of a wide variety of common degenerative and inflammatory conditions as well as common benign tumours (e.g.: abscess; aneurysm - arterial/venous; appendix, other than incidental; artery, atheromatous plaque requiring histology; Bartholin's gland cysts; bone fragment(s) and exostoses, other than pathologic fracture; bursa/synovial cyst; cholesteatoma; colon, colostomy stoma; conjunctiva for pterygium; cornea; diverticulum - esophagus/small bowel; Dupuytren's contracture tissue; femoral head, nontumour; fingers and toes - nontraumatic amputation;

*(notes continued on next page)*



NON-INSURED ITEMS - Continued

	Code	Non- MSP- Insured Fee* (\$)
fissure/fistula in ano; foreskin - other than newborn; gall bladder; ganglion cyst; heart valve; hematoma; hemorrhoids; hydatid of Morgagni; material passed per vagina or other orifice; mucocele - salivary; neuroma - Morton's/traumatic; pilonidal cyst/sinus; polyps, inflammatory - nasal/sinusoidal; products of conception - missed/spontaneous abortion; skin - cyst/tag, debridement; or common benign neoplasm (seborrheic keratosis, basal cell carcinoma, benign intradermal nevus); soft tissue - debridement; soft tissue - lipoma; spermatocele; thrombus or embolus; tonsil and/or adenoids (over 16 years of age); varicocele; etc.).		

<b>Category IV</b> - Small specimens for diagnosis .....	A94516 .....	111.00
--	--------------	--------

NOTE: Small specimens for diagnosis to include all endoscopic biopsies as well as small organs removed for benign conditions (e.g.: artery, biopsy; bone fragments for metastatic tumour; breast biopsy, needle core; breast, reduction mammoplasty; bronchus, biopsy; cell block, any source; cervix, biopsy; endocervix, endometrium, curettings/biopsy; esophagus, biopsy; extremity, amputation, traumatic; fallopian tube, ectopic pregnancy; femoral head, metastatic tumour; GI biopsy; gingiva/oral mucosa, biopsy; larynx, biopsy; leiomyomas(s), uterine myomectomy - w/o uterus; lip, biopsy/wedge resection; lung, transbronchial biopsy; lymph node, biopsy for metastatic tumour; nasal mucosa, biopsy; nasopharynx/oropharynx, biopsy; odontogenic/dental cyst; omentum, biopsy; ovary w/wo tube, non-neoplastic; ovary, biopsy/wedge resection; pancreas, biopsy; parathyroid gland, biopsy; peritoneum, biopsy; placenta; pleura/pericardium - biopsy/tissue; polyp, cervical/endometrial; polyp, colorectal; polyp, stomach/small bowel; prostate, needle biopsy (less than 5 specimens); prostate, TUR; salivary gland, biopsy; sinus, paranasal, biopsy; skin, for dysplastic/atypical nevi, melanomas, inflammatory processes, other tumours, wide excisions; soft tissue, benign tumours; synovium; testis, other than tumour/biopsy/castration; thyroglossal duct/branchial cleft cyst; tongue, biopsy; trachea, biopsy; urogenital tract, biopsy or TUR; uterus w/wo tubes and ovaries, for prolapse; vagina, biopsy; vulva/labia, biopsy; etc).

<b>Category V</b> - Complex biopsies or small whole organs.....	A94518 .....	156.00
---	--------------	--------

NOTE: These specimens include specialized biopsies and excisions. (Specimens of Category IV that are multiple (4 or more) may be elevated to this Category). Examples include: adrenal, resection; bone-biopsy/curettings, for primary bone tumours;

*(notes continued on next page)*

NON-INSURED ITEMS – continued

	Code	Non- MSP- Insured Fee* (\$)
bone marrow, biopsy; brain, biopsy; brain/meninges, spinal cord, tumour resection; breast, lumpectomy alone; cervix, cone biopsy or LEEP; colon, segmental resection, other than for tumour; extremity, amputation, non-traumatic; eye, enucleation; kidney, biopsy for allograft rejection; kidney, partial/total nephrectomy; larynx, partial/total resection; liver, biopsy - needle/wedge; liver, partial resection; lung, wedge biopsy or wedge excision; lymph nodes, for hematolymphoid neoplasm or infectious process, or regional resection; mediastinum, mass; muscle, biopsy; nerve, biopsy; myocardial biopsy not requiring electron microscopy; neck dissection alone; odontogenic tumour, resection; ovary w/wo tube, neoplastic; pituitary tumour, biopsy; prostate, sextant biopsies or simple prostatectomy; salivary gland, major; skin with immunofluorescence; small intestine, resection, other than for tumour (e.g.: Crohn's ischemia); soft tissue mass, malignant tumour; stomach - partial gastrectomy other than for tumour; testis, tumour resection; thymus, tumour; thyroid, lobectomy or total thyroidectomy without neck dissection; ureter, resection; uterus, w/wo tubes and ovaries; other than neoplastic/prolapse.		

<b>Category VI</b> - Large complex organ requiring extensive gross dissection and microscopic assessment .....	A94520 .....	314.00
--	--------------	--------

NOTE: Specimens in this category include: bone tumour, resection; breast, mastectomy (partial or full, w/wo regional lymph nodes); colon, segmental resection for tumour; colon, total resection; esophagus, partial/total resection; extremity, disarticulation; fetus, w/dissection; kidney, nerve, muscle, liver or myocardial biopsy requiring electron microscopy, for primary diagnosis; larynx, partial/total resection for tumour - with regional lymph nodes; lung - total/lobe/segment resection; pancreas - total/subtotal resection; prostate, radical resection; small intestine, resection for tumour; soft tissue tumour, extensive resection or amputation; stomach - subtotal/total resection, tumour; thyroidectomy plus neck dissection; tongue/tonsil - resection for tumour, complex resection with lymph nodes; urinary bladder, partial/total resection; uterus w/wo tubes and ovaries, neoplastic; vulva - total/subtotal resection.

NON-INSURED ITEMS - Continued

**Non-MSP-  
Insured**

<b>Code</b>	<b>Prof. Fee (\$)</b>	<b>Total Fee (\$)</b>
-------------	---------------------------	---------------------------

**FORENSIC TOXICOLOGY**

Forensic toxicological testing includes a number of distinct areas: postmortem toxicological testing, human performance drug testing and other forensic drug testing. In all instances, there is a requirement for attention to the legal ramifications such as chain of custody, expert testimony and acceptability of scientific evidence that exceeds that required for clinical practice.

**Postmortem Toxicology:**

Post mortem toxicological testing usually involves multiple specimens. Testing may involve multiple analytic procedures depending on the direction received from the coroner/pathologist. Consequently, billing is usually per procedure per case rather than per specimen. Legally acceptable criteria for identification usually require substance demonstration by two independent methods.

Screening by radioimmunoassay for drug class without identification/quantitation .....	A94570	15.06	54.20
Screening by immunoassay for drug class without identification/quantitation .....	A94572	15.06	54.20
Screening by gas chromatography (GC) for drug class (acidic drugs) with identification but not quantitation .....	A94574	15.06	73.10
Screening by gas chromatography (GC) for drug class (basic drugs) with identification but not quantitation .....	A94576	15.06	73.10
Screening by thin layer chromatography for drug class(es) with identification but not quantitation.....	A94578	15.06	164.00
Drug identification and/or quantitation by Gas Chromatography Mass Spectrometry (GCMS) (applies primarily to basic drugs)...	A94580	15.06	127.00
Drug identification and/or quantitation by Liquid Chromatography Mass Spectrometry (LCMS) (applies to acidic drugs and to a large number of other drugs that will not go through a GCMS).....	A94582	15.06	253.00
Comprehensive drug screen (includes screening by GC and radioimmunoassay and drug identification/quantitation by GCMS (applies primarily to basic drugs).....	A94584	15.06	281.00
Ethanol.....	A94586	15.06	74.80
Carbon monoxide.....	A94588	15.06	157.00

## **SESSIONAL ARRANGEMENTS**

These payment rates are applicable to all sessional arrangements compensated by funds provided by the Government of British Columbia. These rates are effective April 1, 2020.

### **SESSIONAL RATES**

	<b>Sessional Rate</b>	<b>Per hour Rate</b>
General Practitioner .....	\$509.77	\$145.64
Specialist.....	\$601.31	\$171.80

### **FORENSIC PSYCHIATRIC SERVICES COMMISSION RATE**

	<b>Psychiatric Services Rate</b>	<b>Per Hour Rate</b>
General Practitioner .....	\$552.92	\$157.97
Specialist.....	\$796.94	\$227.69

**NOTE:**

*A session, for the purpose of this agreement, is 3.5 hours of a physician's professional clinical services. A session may be an accumulation of lesser time intervals adding up to 3.5 hours or other amounts of a full quarter of an hour will be recognized.*

### **ON-CALL/AVAILABILITY/CALL-BACK**

1. "Call-back" is where a Physician is not on-call but is called in by the Agency to provide a service.
2. Sessional Physicians shall be entitled to on-call/call-back payments in accordance with the Working Agreement.
3. In addition to the payments described above, a Physician will be paid for the services provided while on-call or call-back at the appropriate hourly rate, but for not less than one hour.

## SCHEDULE A DESCRIPTION OF SERVICES

### 1.0 INTRODUCTION

- 1.1 Almost all Workers in BC are covered under the Worker's Compensation Act. WorkSafeBC provides coverage for the treatment of injuries and diseases that it has accepted as work caused. As such, medical services provided to Injured Workers covered and accepted under the Act are not insured by the Medical Services Plan.
- 1.2 Working with Physicians and employers in the community, WorkSafeBC's goal is to facilitate a safe, timely, and durable return to work for Injured Workers. Prolonged absences from the workplace often result in de-conditioning, a reduced likelihood of recovery, increased pressure on family and personal relationships and a loss of self-esteem, as well as costly uses of health care and social services.
- 1.3 The issue of causation is important to WorkSafeBC as the Act refers to personal injury, disease or death "arising out of and in the course of employment". Employment factors need not be the sole cause, or even the predominant cause, in order for the injury or disease to be accepted. In order for the injury or occupational disease to be compensable, the employment has to be of 'causative significance', which means it has to be more than a trivial or insignificant cause of the injury or disease.
- 1.4 To be considered work-related, there must be a fifty-percent (50%) or greater probability that a condition arose out of work. It is not sufficient that it is "possible" that the condition arose out of work.
- 1.5 Doctors of BC recognizes the Physicians' role in rehabilitating Injured Workers and assisting WorkSafeBC in returning them to work. To this end, where reasonable, Physicians will advise Injured Workers that a safe and timely return to work may hasten their recovery. The concept of "hurt vs. harm" is important in occupational medicine.
- 1.6 It is not possible to provide a specific diagnosis in every case. It may, however, be possible to exclude serious or progressive conditions that may be worsened by work.

### 2.0 PHYSICIANS ROLE IN FACILITATING A RETURN TO WORK

- 2.1 Doctors of BC will encourage Physicians to assist Injured Workers in receiving benefits they are entitled to under the Act.
- 2.2 Physicians will provide care to Injured Workers under this Agreement and will support the principles of disability management with employers and Injured Workers to optimize recovery and facilitate a safe early return to work.

- 2.3 Physicians will provide appropriate support and encouragement to Injured Workers in order to facilitate their participation in appropriate rehabilitation programs, provided by employers or by WorkSafeBC, directed at early recovery and return to work.
- 2.4 Physicians will encourage Workers, with assistance of the Workers' employers, to recognize the evidence based principle that early return to their work or a modified version of their work (Therapeutic Return to Work) offers the most effective route to recovery from many injuries, in particular soft tissue injuries.
- 2.5 Physicians will endeavor to communicate effectively through established reporting mechanisms, and contact with WorkSafeBC staff and rehabilitation providers, to facilitate exchange of claim related information which is directed at achieving early return to work and providing necessary benefits to Injured Workers.
- 2.6 Physicians will, if making recommendations for job modification, take into account any detailed fitness assessment and job evaluation information made available to them and recognize that, in order of effectiveness:
- 1) return to original work with original employer,
  - 2) return to modified work with original employer,
  - 3) return to similar work with another employer,
  - 4) return to modified work within the same industry,
  - 5) are all options which should be beneficially explored before formal retraining to a new occupation is considered?
- 2.7 In most cases it is advisable for Physicians to limit recommendations they make with respect to suitability to return to other than the original employment, to factual statements about any physical limitations present or recommended restrictions of specific activities which may be necessary pending full recovery.
- 2.8 The return to work consultation (Fee Code 19950) is described in Schedule A, Article 8.0

### **3.0 OCCUPATIONAL HEALTH EDUCATION**

- 3.1 WorkSafeBC undertakes to liaise with Doctors of BC regarding occupational health care issues.
- 3.2 Rehabilitation initiatives will be discussed with Doctors of BC during development, providing Doctors of BC with an opportunity to contribute its expertise.
- 3.3 Advances in occupational medicine and changes to WorkSafeBC policies and procedures with respect to occupational diseases will be communicated to Doctors of BC in a timely manner.
- 3.4 WorkSafeBC will raise the profile of occupational medicine and ensure that it is represented in Continuing Medical Education within the Province.

#### **4.0 DOCUMENTATION REQUIRED TO INITIATE AND MANAGE A CLAIM**

4.1 A Board Officer determines entitlement and acceptance of a claim. Entitlement decisions are reliant upon the prompt receipt of information in supporting documentation from:

Employer/Worker Information

Separate forms are completed by the employer and Worker.

- **Form 6** - Workers' Application for Compensation
- **Form 6** is completed and signed by the Injured Worker. If this report has not been sent to WorkSafeBC the claim may be suspended and may not be paid. WorkSafeBC provides Physicians with a supply of these forms upon request.

- **Form 7** - Employer Report

Physician Information

- **Form 8** – Physician Report (treating Physician) – first report of injury
- **Form 11** – Progress Report

#### **5.0 ELECTRONIC SERVICE REQUIREMENTS**

5.1 Only one (1) Form 8 will be paid on a claim with payment being made to the first received. Any subsequent Form 8 will be paid at a Form 11 rate.

5.2 Any submitted Forms 8 and 11 that are missing mandatory field(s) or are illegible will be rejected without any cost to WorkSafeBC.

5.3 Fees will be reimbursed based on electronic submission or fax transmission and timeliness of receipt from date of service as described in Schedule B.

#### **6.0 MEDICAL TREATMENT - FORMS, REPORTS AND SERVICES**

6.1 Current service and submission requirements for Forms 8 and 11 are described at Schedule A – Article 5.0:

Form 8 - First Report of Injury

6.1.1 The Physician of first contact or attending Physician must complete a Form 8 where the Physician suspects the Worker may be disabled beyond the day of injury or if the claim is for a hernia, back condition, shoulder or knee strain/sprain, occupational disease or mental disorder.

6.1.2 The Parties agree that if WorkSafeBC requests a First Report of Injury (Form 8), when a Form 8 was not initially required, and/or a copy of other medical records after a patient is seen, WorkSafeBC will pay Fee Code 19927. The time limit for the submission of this form and/or medical records is ten (10) business days from the date the request is faxed or telephoned by WorkSafeBC.

6.1.3 WorkSafeBC will reimburse the Physician for a Form 8 and an office visit for the first visit where the Physician suspects the Worker may be disabled beyond the

day of injury or if the claim is for a hernia, back condition, shoulder or knee strain/sprain, occupational disease, or mental disorder.

6.1.4 Only one Form 8 shall be paid on a claim, with status paid to the first received not date of service. Any subsequent Form 8 will be paid at a Form 11 rate.

6.1.5 Form 8 shall not be billed by a specialist submitting an expedited consultation.

6.1.6 There will be no payment for forms received after the time limits described in this Agreement in Schedule B.

#### Form 11 - Progress Report

6.1.7 Follow-up examination visits shall be conducted by the attending Physician as medically necessary, as a result of Worker requirement or at the request of a Board Officer.

6.1.8 Form 11 will only be supplied for a change of medical condition or as an accompaniment to fee codes 19509, 19510, 19511 and 19950. A Form 11 where there is no change in the Worker's medical condition, treatment plan, or return to work status is not payable unless an interval of at least four (4) weeks has passed since the Physician last billed a Form 11.

6.1.9 Follow-up examination visits will be paid regardless of whether a Form 11 has been submitted.

6.1.10 There will be no payment for forms received after the time limits described in this Agreement as indicated in Schedule B.

### **7.0 EXPEDITED COMPREHENSIVE CONSULTATION REPORT**

7.1 Referrals for Initial and Repeat Expedited Comprehensive Consultations can be made to a Specialist Physician by WorkSafeBC or a referring physician.

7.1.1 Physicians With Areas of Expertise will receive referrals for Initial and Repeat Expedited Comprehensive Consultations only from WorkSafeBC.

7.2 Specialist Physicians and Physicians With Areas of Expertise are entitled to the Expedited Comprehensive Consultation fee if the following criteria are met:

#### 7.2.1 Reporting Timeliness:

7.2.1.1 The Initial Expedited Comprehensive Consultation (includes Trauma and Emergency cases) report must be received by WorkSafeBC within fifteen (15) business days from the referral.



- 7.2.1.2 Referrals other than the Initial Consultation: The report must be received within fifteen (15) business days of the referral.
  - 7.2.1.3 For any other Consultations: The report must be received within five (5) business days of the consultations.
  - 7.2.1.4 Where following a consultation the physician concludes the Worker is fit to return to work, this information must be received within three (3) days of the consultation.
- 7.3 Initial Expedited Comprehensive Consultation:
- 7.3.1 The Physician is entitled to the Initial Expedited Comprehensive Consultation fee for the first consultation on each claim and a new Initial Expedited Comprehensive Consultation when both of the following conditions occur:
    - 7.3.1.1 more than six (6) months lapsed since the physician last saw the Worker;  
**and**
    - 7.3.1.2 the consultation is as a result of a new referral.
  - 7.3.2 Where the consultation occurs as a result of an emergency (e.g.: trauma), the Specialist is entitled to receive the Initial Expedited Comprehensive Consultation fee.
- 7.4 Repeat Expedited Comprehensive Consultation: The Physician is entitled to the Repeat Expedited Comprehensive Consultation fee for one (1) repeat consultation when the repeat consultation occurs within twelve (12) weeks of the first Consultation following the referral. Any other repeat consultation is not entitled to expedited fees.
- 7.4.1 In the case of a post-operative consultation, that follow up visit and report are to be invoiced as the post-operative consultation service as described in Fee Schedule B, using fee code 19931. The post-operative consultation is not considered a Repeat Expedited Comprehensive Consultation.
- 7.5 For expedited consultative services, only Specialists providing services within WorkSafeBC designated Visiting Specialist Clinic (the "VSC") site(s) are able to bill sessionally; all others must bill fee-for-service for expedited consultation services.
- 7.6 Expedited consultations requiring diagnostic investigations will be expedited using WorkSafeBC services as required.
- 7.7 The Fees include the physical examination and report. No other report fees may be billed in addition.
- 7.8 Standards for reporting for an expedited comprehensive consultation shall contain the following core information:
- Purpose of examination;
  - Nature of injury;
  - Present complaints;
  - Objective findings;
  - Diagnosis or differential diagnosis;

- It is not possible to provide a specific diagnosis in every case. It may, however be possible to exclude serious or progressive conditions that may be worsened by work.
- Information regarding causation including risk factors other than work; and
- Recommendations regarding work restrictions as related to the work injury/disease.

7.9 If the report is found to be deficient in one of the core areas of information, WorkSafeBC shall return the report to the Physician promptly (within five business days of receipt) identifying the area(s) of deficiency. The Physician shall supply the deficient information within five (5) business days of WorkSafeBC's request.

7.10 WorkSafeBC reserves the right to discontinue payment for reports that do not meet WorkSafeBC requirements and standards and shall inform the Physician in writing of any decision to discontinue such payments.

## **8.0 RETURN TO WORK CONSULTATION (FEE CODE 19950)**

8.1 A return to work consultation, to facilitate a safe, early return to work, may be billed under Fee Code 19950 on Fee Schedule B. The services compensated for by this Fee Code are for the express purpose of facilitating an early return to work through identification of suitable modified, gradual or transitional return to work opportunities in conjunction with the employer, taking into account the functional limitations of the Injured Worker, the nature of the Injured Worker's regular work and available alternatives in his/her workplace.

8.2 The consultation may be initiated by a Board Officer or delegate, Board Physician, employer or treating Physician. The steps included in the return to work plan are as follows:

8.2.1 Contact with WorkSafeBC Officer (may include Nurse Advisor, Vocational Rehabilitation Consultant, Medical Advisor or Claims Officer) by treating physician to initiate process and to obtain the employer's contact information.

8.2.2 Discussion between treating Physician and employer, or employer representative including discussion of the return to work plan.

8.2.3 Follow up with Injured Worker to discuss return to work plan.

8.2.4 A WorkSafeBC Nurse Advisor may coordinate, facilitate and document a return to work consultation between the physician, a WorkSafeBC representative and the employer.

8.3 Consultation and return to work plan must be documented and submitted on a Form 11.

8.4 In the event of an unsuccessful return to a modified, gradual or transitional return to work after this, one further consultation cycle may be approved by a WorkSafeBC Officer. This further consultation will be invoiced as Fee Code 19950.

8.5 This Fee Code includes visit and phone calls related to the direct evaluation and reporting in order to complete the return to work plan. A Form 11 is billable in addition to fee code 19950.

**9.0 DISALLOWED/ SUSPENDED CASES**

- 9.1 Where a claim for medical treatment is disallowed or suspended by WorkSafeBC, WorkSafeBC shall notify all attending/consulting Physicians in writing or electronically within three (3) days of such decision.
- 9.2 WorkSafeBC will pay for all accepted reports in respect of disallowed or suspended claims submitted by Physicians, up until the time the Physician is informed that the claim has been disallowed or suspended.
- 9.3 To avoid a possible suspension of a claim, Physicians' offices will be supplied with Forms 6 on request.
- 9.4 Interest will be paid in accordance with Article 7.8 on outstanding accounts pertaining to disallowed or suspended claims up to the time that the Physician is notified.

**10.0 ACCOUNTS INITIALLY REJECTED BUT FOUND TO BE WORKSAFEBC RESPONSIBILITY (FEE CODE 19952)**

- 10.1 Fee Code 19952, on Fee Schedule B, will be billable as an additional charge, upon resubmission, for an account submitted and initially rejected for payment by WorkSafeBC for one of the following reasons:
  - 10.1.1 WorkSafeBC entitlement decision was delayed beyond twenty-two (22) days from date of injury for reasons unrelated to the Physician services provided;
  - 10.1.2 Due to data entry errors in the original submission that were determined to be the responsibility of WorkSafeBC;
  - 10.1.3 Due to incorrect application of payment rules by WorkSafeBC;
  - 10.1.4 Any other reasons that are the fault of WorkSafeBC; or,
  - 10.1.5 When WorkSafeBC has failed to provide notice in writing (including fax transmission) within seventy-two (72) hours of a decision to close, disallow or suspend a claim. Note: WorkSafeBC cannot be responsible for notification to consultants for services under this provision when documentation provided to WorkSafeBC does not identify the specialist.
- 10.2 It is the responsibility of the Physician to identify this claim and the reasons for it. Once such a claim has been filed WorkSafeBC will manually adjudicate it and, if necessary, it will be referred to the fee payment dispute resolution procedures of the Agreement for final resolution.

**WORKSAFE BC  
FEE ITEMS**

These fees cannot be correctly interpreted without reference to the WorkSafeBC Schedule A – Description of Services

**WSBC  
Fee (\$)**

**SCHEDULE B FEE SCHEDULE FOR WORKSAFEBC UNIQUE FEES AND FORM FEES**

This fee schedule includes fees for: Form Fees, WorksafeBC Unique Fees

**1.0 FORM FEES**

19937	Form 8 - Report of First Injury, received by WorkSafeBC within three (3) business days of date of service and transmitted electronically. Paid in addition to office visit.....	54.20
	If Form 8 is received by WorkSafeBC within four (4) to six (6) business days of the date of service and transmitted electronically, then a reduced fee is paid. Paid in addition to office visit.....	38.25
	If Form 8 is received seven (7) business days or later following the date of service, the fee paid is \$0. The office visit will be paid.	
19900	Form 8 - Report of First Injury, received by WorkSafeBC within three (3) business days of date of service and submitted via fax transmission. Paid in addition to office visit.....	35.78
	If Form 8 is received by WorkSafeBC within four (4) to six (6) business days of the date of service and submitted via fax transmission, then a reduced fee is paid. Paid in addition to office visit.....	23.85
	If Form 8 is received seven (7) business days or later following the date of service, the fee paid is \$0. The office visit will be paid.	
19927	First Report of Injury (Form 8) that is requested by WorkSafeBC after the Injured Worker is seen where the form is not initially required (See Form 8 Rules), received within ten (10) business days of the faxed or telephone request. Paid in addition to office visit. ....	59.64
	Submissions received after ten (10) business days of request will not be paid. Fee code 19904 may not be billed in addition as this fee includes copying of any existing reports or chart notes from an Injured Worker's file. The office visit will be paid.	
19940	Form 11 - Progress Report Physical Examination, received within three (3) business days of date of service by WorkSafeBC and transmitted electronically. Paid in addition to office visit .....	44.20
	If Form 11 is received by WorkSafeBC within four (4) to six (6) business days of the date of service and transmitted electronically, then a reduced fee is paid. Paid in addition to office visit.....	20.07

	<b>WSBC Fee (\$)</b>
If Form 11 is received seven (7) business days or later following the date of service, the fee paid is \$0. The office visit will be paid.	
19902 Form 11 - Progress Report Physical Examination, received within three (3) business days of date of service by WorkSafeBC and submitted via fax transmission. Paid in addition to office visit. ....	32.20
If Form 11 is received by WorkSafeBC within four (4) to six (6) business days of the date of service and submitted via fax transmission, then a reduced fee is paid. Paid in addition to office visit. ....	
	16.09
If Form 11 is received seven (7) business days or later following the date of service, the fee paid is \$0. The office visit will be paid.	
<b>2.0 WORKSAFEBC UNIQUE FEES</b>	
19904 WorkSafeBC request for copy of a consultation, operative, chart notes or other existing report – first twenty pages, received within three (3) business days of request. Not to be paid in addition to other Fee Codes except 19906 .....	44.23
19905 WorkSafeBC requested copy of consultation, operative, or other existing report – first five (5) pages or less sent by mail.....	27.64
19919 Office Consultation with a WorkSafeBC Officer or designate (up to fifteen (15) minutes) .....	61.94
19906 Continuation of 19904 – over twenty (20) pages, additional per page .....	1.33
19907 A factual written summary or reasoned medical opinion upon written request from WorkSafeBC (19904 may not be billed in addition). If extractions included over five (5) pages – may bill 19906.....	282.04
19930 Telephone Consultation with WorkSafeBC Claims Adjudicator/Case Manager or designate or allied health care provider* in fifteen (15) minute increments (not to be billed for routine inquiries) up to a maximum of forty-five (45) minutes (i.e. to a daily maximum of three (3) units) per claim.....	55.30
*Community allied health care providers include providers involved in the care of an Injured Worker, such as physiotherapist, occupational therapist, psychologist, WorkSafeBC-sponsored treatment program physician or other program staff.	
00129 Emergency call-out when a Physician (General Practice or Specialist) has to immediately leave his or her home or office (outside of hospital) to attend an Injured Worker. This fee is billed over and above medical service fees.....	74.31
19942 WorkSafeBC Job-site meeting .....	326.27
19922 Materials used in conjunction with sterile tray fees. Bill the actual cost of materials.....	Actual Cost
19908 Non-expedited specialist consultation report, initial or repeat, for consultation services that do not include a report in the fee item description. Report must be received by WorkSafeBC within seven (7) business days following date of service or following request by WorkSafeBC .....	29.85

19929 **EXCESSIVELY PROLONGED OR COMPLEX CASES**

Excessively prolonged or complex cases. At the request of WorkSafeBC, a Physician will review the file(s), examine the Injured Worker, and develop a report on an Injured Worker whose recovery is prolonged or complicated. The Parties agree that, unless it is not practical, such cases should be referred to the WorkSafeBC medical rehabilitation program for appropriate review, assessment and case planning.

In situations where WorkSafeBC requires information about a Worker who is not under active treatment but who continues to have an injury claim, WorkSafeBC may request a Physician, who had treated the Worker, to review the file(s) and develop a report describing the details of the injury, diagnosis, and treatment.

Report must be received within twenty (20) business days of service.  
Submissions received after twenty (20) business days will not be paid .... 177.94

19931 **POST-OPERATIVE CONSULTATION**

In recognition of WorkSafeBC’s need to have surgeons involved in disability management, WorkSafeBC agrees to pay a post operative visit and a Form 11 or a consultation report fee for a total value as indicated on the right to assess a Worker’s potential to return to work on a graduated or full time basis; or to refer the Worker to the appropriate treatment program in the WorkSafeBC continuum of care; or if neither are appropriate, to recommend a treatment plan with an estimate of recovery and return to work.

This WorkSafeBC unique service would occur within the forty-two (42) day post-operative period, usually at four (4) weeks post surgery.

Report must be received within five (5) business days of service.  
Submissions received after five (5) business days will not be paid..... 82.95

19950 **RETURN TO WORK CONSULTATION**

Purpose is to facilitate a safe, early return to work. Can be initiated by WorkSafeBC Officer or delegate, WorkSafeBC Physician, employer or by treating Physician.

Must include consultation by Physician with employer and WorkSafeBC Officer, and follow up to discuss RTW with Worker.

Consultation and RTW plan must be documented and submitted on Form 11. One further consultation cycle may be billed if the initial attempt at RTW is unsuccessful. Fee all-inclusive .....

		313.18
19952	Accounts initially rejected but found to be WorkSafeBC responsibility. Bill directly to WorkSafeBC by fax transmission .....	22.13

19953 **WorkSafeBC Request For Existing Report or Chart Notes - ISOLATING SPECIFIC INFORMATION**

When WorkSafeBC requests a copy of an existing report or chart notes and where complying with that request requires the Physician to review the chart or report for the purpose of severing identified personal information not relevant to the claim prior to submission of photocopied material, or identifying previous injury or illness relevant to the current claim, or area of injury in question from prior records and separating that information from other clinical information prior to submission to WorkSafeBC.

The Physician may bill Fee Code 19953. Fee Codes 19904, 19905 or 19906 may not be billed in addition to this Fee Code.

	Must be received within ten (10) business days of request of service and includes all courier charges .....	132.72
19976	Return to Work planning request. A request initiated by a WorkSafeBC Officer or designated rehabilitation provider to a Physician to endorse a one (1) page Return to Work planning request form .....	26.08
19508	Telephone consultation between a WorkSafeBC Medical Advisor and a community Physician which takes place within 24 hours of being initiated by the Medical Advisor .....	78.53
19509	Complex Spinal Cord Injury initial visit or yearly assessment. Visit to include a complete physical exam and updated care plan documented and presented on a form 8/11. Only payable once per patient per year, by noted regular physician. Form 8/11 will be paid in addition. ....	162.64
19510	Complex Spinal Cord Injury office visit, cannot bill in addition to a yearly assessment fee (19509) for one visit. Form 8/11 may be reimbursed if changes in condition. ....	108.43

	<b>WSBC Fee (\$)</b>
19511 Complex Spinal Cord injury home visit. The physician must also complete and bill for a Form 8/11. This fee cannot be billed with office visit (19510) .....	216.86
19556 Image-guided diagnostic and therapeutic injection. New fee code to be billable only when the injection requires imaging guidance (e.g.: CT, fluoro, ultrasound) and is arranged at a WorkSafeBC-contracted private surgical facility, or where the physician utilizes their own imaging equipment within their own office.....	240.47
19557 Use of physician’s own imaging equipment for image-guided diagnostic and therapeutic injection. This fee code cannot be invoiced in addition to a surgical facility fee code. This item is billed in addition to the injection fee code 19556.....	140.82

**3.0 STANDARDIZED ASSESSMENT FEE**

Standard Assessment Form is to be completed by Physician only when requested by WorkSafeBC or a surgeon. This Service is to be provided for specific assessments upon request. Standard Assessment Fee includes the physical examination and completion of the report form. Refer to the Physicians Reference Guide for guidelines on specific reports for unique assessment types.

The Physician shall not complete a Form 11 for the examination when a Standard Assessment form is requested. The Standard Assessment Form must be completed and received by WorkSafeBC and/or surgeon (if applicable) within fifteen (15) business days of the request.

	<b>WSBC Fee (\$)</b>
19909 Standardized Assessment Form received by WorkSafeBC and surgeon (if applicable) within fifteen (15) business days of request by WorkSafeBC .....	82.94
19910 Standardized Assessment Form received by WorkSafeBC and surgeon (if applicable) after fifteen (15) business days of request by WorkSafeBC .....	77.42

**4.0 MEDICAL-LEGAL MATTERS**

The requirements for receiving fees 19932 and 19933 are as follows:

1. Medical-Legal Report is applicable to all medical Physicians.
2. Medical-Legal Opinion is applicable only to Specialists with relevant qualifications, or other Physicians with recognized expert knowledge.



WORKSAFE BC - Continued

3. These fees require prior approval by the Review Board or Appeal Division, or Senior Medical Advisor or Director of the Board or Client Service Manager.
4. These fees include examination, review of records, and other processes leading to completion of the written Opinion/Report.

	<b>WSBC Fee (\$)</b>
19932 <b>Medical-Legal Report:</b> A report which will recite symptoms, history and records and give diagnosis, treatment, results and present condition. This is a factual summary of all the information about when the Injured Worker will be able to return to work and might mention whether there will be a permanent disability.....	946.73
19933 <b>Medical-Legal Opinion:</b> An opinion will usually include the information contained in the Medical-Legal Report and will differ from it primarily in the field of expert opinion. This may be an opinion as to the course of events when these cannot be known for sure. It can include an opinion as to long-term consequences and possible complications in the further development of the condition. All the known facts will probably be mentioned, but in addition there will be the extensive exercise of expert knowledge and judgment with respect to those facts with a detailed prognosis .....	1581.57

5.0 **EXPEDITED CONSULTATIONS**

	<b>WSBC Fee (\$)</b>
19911 Initial expedited comprehensive consultation from Specialists in Internal Medicine, Neurology, Neurosurgery, Orthopaedics, Physical Medicine, General Surgery, Plastic Surgery, Psychiatry, Urology, Otolaryngology, Ophthalmology and Dermatology.	365.76
19912 Repeat Expedited Comprehensive Consultation after 19911 .....	177.72
19934 Initial expedited comprehensive consultation from an Anesthesiologist for diagnostic opinion and/or therapeutic management. To include a physical examination 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 .....	365.76
19935 Repeat Expedited Comprehensive Consultation after 19934.	177.72
19936 Cancellation Fee – fee to be billed if an Expedited Consultation is cancelled by patient with less than 24 hours notice ....	55.30
19945 Initial expedited comprehensive consultation from a Physician With Areas of Expertise, only when requested by WorkSafeBC	292.32
19946 Repeat Expedited Comprehensive Consultation after 19945	142.16

## **SCHEDULE C SERVICES PROVIDED TO WORKSAFEBC ON A SESSIONAL AND EXPEDITED BASIS**

### **1.0 SESSIONAL SERVICES**

- 1.1 WorkSafeBC will seek appropriate solutions to address specific service needs under which WorkSafeBC will enter into agreements with individual Physicians to provide services to WorkSafeBC on a sessional basis.
- 1.2 WorkSafeBC has the sole responsibility to determine the programs, location, number and type of service arrangements according to caseload needs and to varying regional conditions affecting care.
- 1.3 The programs in number and scope shall be sufficient to meet the needs as determined by WorkSafeBC and notwithstanding Article 1.8 of Schedule C, Sessional Services agreed upon during negotiations for this Agreement with respect to Physicians, may include only non fee-for-service funding arrangements and individual contracts for services.
- 1.4 The specific terms and conditions for the provision of the services shall be described in the individual contract(s) between WorkSafeBC and the individual Physician or group of Physicians who are providing the service(s). Any Sessional Agreements entered into shall equal or exceed fee-for-service payment levels for comparable services delivered in similar settings.
- 1.5 Individual service contracts, while similar in detail, do not constitute identification of a group of Physicians.
- 1.6 The format, language, and content of individual agreements will be consistent with standard WorkSafeBC contracts.
- 1.7 Individual contracts must contain the following standard WorkSafeBC terms and conditions:
  - A statement the individual contract is subject to the terms and conditions contained in this Agreement;
  - Names and contact information for the Parties to the contract;
  - The term of the contract, including any renewal option;
  - Statement of services to be provided (by whom, where and when);
  - Terms of payment and invoicing;
  - A provision requiring WorkSafeBC, when it is defending against an action involving the contracted Physician, to take into consideration, and to take appropriate steps, to avoid any adverse impact on the professional status or reputation of the Physician(s) involved by its decision with respect to settlement;
  - Language incorporating WorkSafeBC's policies and processes with respect to confidentiality and the *Freedom of Information and Protection of Privacy Act*, records and audit rights, technology and data requirements, criminal records check, conflict

of interest and harassment, right of set-off, occupational health and safety, threats and hazards, registration and assessment with WorkSafeBC, compliance with laws and regulations, insurance requirements, indemnification, force majeure, independence, assignment, scheduling, standards of conduct, dispute resolution, general notice, termination, laws, headings, singular/plural, survivability, severability, entire agreement, corporate ethics statement and a confidentiality agreement, privacy protection schedule;

- 1.8 WorkSafeBC shall pay the Physician a sessional rate based upon three and a half (3.5) hours per session, according to the WorkSafeBC-Doctors of BC Agreement in effect at the time the Physician provides Services. Each three and a half (3.5) hour session shall not include any breaks or meal periods.
- 1.9 For services provided that are greater or less than a 3.5 hour session, WorkSafeBC shall pay the Physician the prorated session rate to the nearest thirty (30) minutes for the actual period of time the Physician provides the services.
- 1.10 For services that are pre-arranged and agreed upon with a Physician prior to the scheduled sessions, WorkSafeBC shall pay the Physician the prorated session rate to the nearest thirty (30) minutes for the actual period of time the Physician provides the services.
- 1.11 Medical Advisors shall not deviate from the three and a half (3.5) hour session without prior approval from their direct report at WorkSafeBC. Upon approval, prorating detailed in Article 1.09 and 1.10 of Schedule C shall apply.

## **2.0 MEDICAL ADVISORS**

- 2.1 WorkSafeBC will exercise its sole discretion in identification of the number and nature of Medical Advisor assignments.
- 2.2 Refer to Schedule E – Fee Schedule for Medical Advisors for the rate for Medical Advisors.
- 2.3 WorkSafeBC will determine the rate available for individual agreements with due consideration as to individual qualifications and the nature of the assignment of Medical Advisor services.

## **3.0 EXPEDITED SERVICES**

### **3.1 Scope of Services**

- 3.1.1 There are circumstances under which WorkSafeBC will enter into Sessional Agreements with individual Physicians that may include but not be limited to surgical, anaesthetic, diagnostic and medical services.
- 3.1.2 For those Physicians providing consultation and procedures to Injured Workers on an expedited basis (i.e. “visiting specialists”) rates may, with the

prior approval of WorkSafeBC, be “blended” in response to a combination of procedural and consulting services within one (1) sessional period.

- 3.1.3 Expedited surgical fees will be available to all interested community Physicians/surgeons. Non-VSC individuals will not be required to enter into an agreement with WorkSafeBC. They will however need to identify themselves and participate in the business processes so they can be educated in program parameters/requirements around documentation, billings and payment.
- 3.1.4 No additional surgical/consult fees will be levied to any WorkSafeBC Injured Workers during this Agreement.
- 3.1.5 For expedited consultation services, only Specialists providing services within WorkSafeBC designated VSC site(s) are able to bill sessionally; all others must bill fee-for-service for expedited consultation services.

### 3.2 **Expedited Consultation Service Fees**

- 3.2.1 Refer to Schedule D – Fee Schedule for Expedited Services, Article 1.0, for the expedited consultation sessional rate for VSC.
- 3.2.2 Refer to Schedule B – Fee Schedule for WorkSafeBC Unique Fees and Form Fees for the expedited consultation rate for non VSC Physicians.
- 3.2.3 Expedited consultation sessional payments for VSC Specialists shall be processed in the current WorkSafeBC format.

### 3.3 **Expedited Surgical Service Requirements and Fees**

- 3.3.1 Refer to Schedule D – Fee Schedule for Expedited Services, Article 2.0 for the expedited surgical procedural rate.
- 3.3.2 All expedited surgical procedures, with the exception of extensive spinal surgery, shall be compensated on a block billing basis and billed through Teleplan using a billing model consisting of two fee codes per surgery performed:
  - a) The appropriate MSP surgical fee code; and
  - b) A time based fee code as described in Fee Schedule D, Article 2.0 and listed by Fee Codes:
    - Level 1 (surgery time up to 1.5 hours)
    - Level 2 (surgery time 1.51 to 2.0 hours)
    - Level 3 (surgery time 2.01 to 2.5 hours)
    - Level 4 (surgery time 2.51 to 3.0 hours)
    - Level 5 (surgery time 3.01 to 3.5 hours)
    - Level 6 (surgery time 3.51 to 5.99 hours)
    - Level 7 (surgery time 6.00 hours plus)

- 3.3.2.1. **NEW MODEL FOR EXPEDITED SURGICAL PROCEDURES:**  
The Parties agree to transition to a new model for expedited surgical procedures as referenced in Appendix B – Memorandum of Agreement. The current model shall remain in effect from April 1, 2014, until an implementation date for the new model has been identified. This implementation date may be adjusted by mutual agreement of the Parties.

- The new model shall incorporate applicable fee schedule increases. Effective thirty (30) days from the date of the system changes required, the applicable MSP surgical procedure fees shall receive a one hundred and ninety-four percent (194%) increase;
  - The one hundred and ninety-four percent (194%) premium shall be automatically applied to payments only for surgeries that meet the expedited surgical timelines.
  - With this new model Physicians may bill for multiple procedures that are consistent with the current practice of MSP billing for surgical procedure fee codes in the public system;
  - The Parties agree that fee codes 19500 through 19506 shall be deleted upon implementation of the new expedited surgical model.
- 3.3.3 All surgical procedures that are performed on WorkSafeBC clients will be billable at the expedited procedural rate provided that:
- The prescribed Authorization for Surgery Form (Form 83D6 – Authorization Request for Surgery) is submitted within five (5) business days following WorkSafeBC's receipt of the comprehensive consultation report recommending expedited surgery.
  - Expedited surgery is performed within twenty (20) business days from the date of the last consultation. Where it is not possible to schedule a surgery within the twenty (20) business days, the surgeon may seek approval from Health Care Services to extend the time frame in order to ensure that the surgery will be performed on an expedited basis and will be billable as such, if approved.
- 3.3.4 Procedures performed outside the limitation period as specified in Article 3.3.3 of Schedule C will only be billed at the MSP surgical fee code rates, unless the Health Care Services Program Manager determines otherwise.
- 3.3.5 Any surgery delayed due to the lack of return of the claims Authorization for Surgery form by WorkSafeBC may be directed to the Health Care Services Program Manager for adjudication of the expedited fee.
- 3.3.6 Only the first three (3) elective surgeries per patient will be considered for expedited payment per each surgeon. This applies only to repeat surgeries performed on the same site. Any subsequent surgical consideration for additional surgery requires a second opinion by a Richmond VSC Specialist and further surgery will require authorization from the Health Care Services Program Manager.
- 3.3.7 Expedited payment may be extended beyond the first three elective procedures for multiple non-emergent reconstructive procedures (both surgical and anesthesia services) when the following process occurs:
- A letter is submitted providing early identification of the complexity by outlining the patient details, volume and proposed procedures, and timeline to completion;
  - A Surgical Authorization form is directed to the Claims Officer for entitlement approval; and

- A letter is directed to the Health Care Services Program Manager for payment approval and system activation.
- 3.3.8 Referrals for surgery from Family Physicians and not WorkSafeBC, must first be approved by WorkSafeBC. In that case WorkSafeBC approval will initiate the start date for calculating the number of business days till surgery. Refer to Article 3.3.3 of Schedule C for service timeliness requirements.
- 3.3.9 Expedited consultations requiring diagnostic investigations will be expedited using WorkSafeBC services as required.
- 3.3.10 The operative report must be received within twenty (20) business days of the date of surgery, and is a requirement for WorkSafeBC to process payment.
- 3.3.11 All appropriate out-of-office hour service and surcharges (as per MSP Guide to Fees) will apply to expedited billing payments.
- 3.3.12 For surgery scheduled in public facilities the surgeon will not displace a booked non-WorkSafeBC patient in order to comply with the business day limit constraint for expedited rates. Any surgeon found violating this principle would be excluded from this Agreement.

### 3.4 **Anaesthesia Expedited Fees**

- 3.4.1 Refer to Schedule D – Fee Schedule for Expedited Services, Article 3.0 for the procedural anaesthesiology rate. These fees shall be billed through Teleplan, except for Extensive Spine Surgery anaesthesia.
- 3.4.2 All expedited anesthesiology procedural services, with the exception of Extensive Spine Surgery and expedited chronic pain management services nerve blocks provided by anaesthesiologists under a personal services agreement shall be billed through Teleplan using a billing model consisting of two fee codes per surgery performed:
- a) The appropriate MSP anesthesiology surgical fee code; and
  - b) A time based fee code as described in Fee Schedule D, Article 3.0.
- 3.4.3 WorkSafeBC shall pay expedited rates when an Anesthesiologist provides anaesthetic for an Injured Worker undergoing expedited surgery and the surgical procedure meets the timeline requirements in Article 3.3.3 of Schedule C. Otherwise, the anesthesiology services must be billed at the MSP anesthesiology code rates only, unless the Health Care Services Program Manager determines otherwise.
- 3.4.4 Anaesthesia consultations must be billed fee-for-service (Fee Code 19934). The consultative report shall be comprehensive.
- 3.4.5 The anaesthetic time includes a pre-operative assessment, as well as the time from induction until the Anaesthesiologist is no longer in attendance and the Injured Worker can be safely discharged for the postanesthetic recovery (PAR). If the pre-operative and PAR times are significantly longer than fifteen (15) minutes, respectively, or a total of thirty (30) minutes then an explanatory note shall accompany the record of anaesthesia.
- 3.4.6 The Anaesthesiologist will provide the Record of Anaesthesia, and is a requirement for WorkSafeBC to process payment.
- 3.4.7 Notwithstanding the above, WorkSafeBC will pay only once for each surgical procedure except when the Injured Worker's care warrants the attendance of more than one Anaesthesiologist. The Anaesthesiologist must support the

- need with written statements to WorkSafeBC explaining why there was a medical requirement to have two (2) in attendance.
- 3.4.8 The Anaesthesiologist's fee covers all services rendered by the Anaesthesiologist during the procedure.
- 3.4.9 Except for life or limb threatening circumstances, an Anaesthesiologist may not bill for two (2) patients during the same time period. The Anaesthesiologist must support the need with a written statement to WorkSafeBC providing explanation as to the medical requirement for the circumstance.
- 3.4.10 Anaesthesiologists operating under a personal services agreement with WorkSafeBC for the provision of Expedited Chronic Pain Management services, at the request of WorkSafeBC, shall be compensated at a rate which is at least equivalent to the Anesthesiology expedited procedural rate.

### 3.5 **Surgical Assist Fees**

- 3.5.1 Refer to Schedule D – Fee Schedule for Expedited Services, Article 4.0, for the expedited surgical assist rate. These fees shall be billed through Teleplan, except for Extensive Spine Surgery surgical assist.
- 3.5.2 A list of procedures which WorkSafeBC approves for a Surgical Assist shall be maintained and posted on the WorkSafeBC internet site. If a procedure is not listed, the Physician must contact the Health Care Services Department for prior approval.
- 3.5.3 Surgical Assists are to be billed electronically through Teleplan and at the rates outlined in Schedule D Article 4.0. The Surgical Assists will invoice the applicable MSP surgical assist (related to procedure) fee code plus the applicable time-based WorkSafeBC fee code for one of the following levels:  
Level 1 (surgery time up to 1.5 hours)  
Level 2 (surgery time 1.51 to 2.0 hours)  
Level 3 (surgery time 2.01 to 2.5 hours)  
Level 4 (surgery time 2.51 to 3.0 hours)  
Level 5 (surgery time 3.01 to 3.5 hours)  
Level 6 (surgery time 3.51 to 5.99 hours)  
Level 7 (surgery time 6.00 hours plus)

### 3.6 **Expedited Extensive Spinal Surgery Fees**

- 3.6.1 These fees are designed for surgeons performing difficult and extensive spinal procedures requiring stabilization or multilevel procedures or revisions discectomy (one level index discectomy is not meant to be covered by these fees).
- 3.6.2 Pre-approval by WorkSafeBC is required.
- 3.6.3 The business day limitations at Article 3.3.3 of Schedule C are waived for these services.
- 3.6.4 Refer to Schedule D – Fee Schedule for Expedited Services, Article 2.0, for the extensive spine surgical rates.

Fee Code	Description	Fee (\$) (Effective April 1, 2017)	Fee (\$) (Effective April 1, 2018)
<b>1.0 EXPEDITED SESSIONAL SERVICES</b>			
1150464	Initial Expedited Consultation Service Fees / Sessional Rate (VSC ONLY)..... NOTE: Bill as per contract.	2187.84	2220.66
1150465	Repeat Expedited Consultation Service Fees / Sessional Rate (VSC ONLY)..... NOTE: Bill as per contract.	2187.84	2220.66
19519	Expedited Sessional Interventional Pain management Services under personal services agreement..... NOTE: Bill as per contract.	1675.06	1700.19
<b>2.0 EXPEDITED SURGICAL PROCEDURE RATES</b>			
MSP Fee Code	Expedited procedural surgery. Invoice one (1) MSP fee code applicable to procedure, plus applicable block billing time-based fee code below. Bill through Teleplan.		
19516	Expedited Extensive Spine Surgery – Sessional fee (no MSP fee code applicable) Bill by fax to WorkSafeBC .....	4015.67	4075.91
<b>3.0 EXPEDITED ANAESTHESIA RATES FOR EXPEDITED SURGICAL PROCEDURES</b>			
MSP Fee Code	Expedited Anaesthesia Services: Invoice one (1) appropriate MSP fee code plus applicable number of units of block billing time-based fee code 19507. Bill through Teleplan.		
19507	Expedited Anaesthesia Time. One unit equals 15 minutes – per unit Bill through Teleplan .....	79.62	80.82
19518	Expedited Extensive Spine Anaesthesia – Sessional fee (no MSP fee code applicable) Bill by fax to WorkSafeBC.....	2442.09	2478.72
19405	Expedited Anesthesiology, Out of Office Surcharge, Operative Evening (6 to 11 pm) – applied to 19507..... NOTE: Bill same number of units as is billed for fee code 19507	32.77%	32.77%



Fee Code	Description	Fee (\$) (Effective April 1, 2017)	Fee (\$) (Effective April 1, 2018)
19406	Expedited Anesthesiology, Out of Office Surcharge, Operative Evening (11 pm to 8 am) – applied to 19507 ..... NOTE: Bill same number of units as is billed for fee code 19507	52.54%	52.54%
19407	Expedited Anesthesiology, Out of Office Surcharge, Operative Sat/Sun/Holidays – applied to 19507 ..... NOTE: Bill same number of units as is billed for fee code 19507	32.77%	32.77%

#### 4.0 EXPEDITED SURGICAL ASSIST RATES FOR EXPEDITED SURGICAL PROCEDURES

MSP Fee Code	Description	Fee (\$)	Fee (\$)
	Invoice one (1) appropriate MSP surgical assist fee code related to surgical procedure, plus applicable block billing time-based fee code below. Bill through Teleplan.		
19545	Expedited Surgical Assist – Level 1 (Surgery time up to 1.5 hours) Bill through Teleplan.....	242.50	246.14
19546	Expedited Surgical Assist – Level 2 (Surgery time 1.51 to 2.0 hours) Bill through Teleplan.....	350.40	355.66
19547	Expedited Surgical Assist – Level 3 (Surgery time 2.01 to 2.5 hours) Bill through Teleplan .....	480.72	487.93
19548	Expedited Surgical Assist – Level 4 (Surgery time 2.51 to 3.0 hours) Bill through Teleplan.....	587.56	596.37
19549	Expedited Surgical Assist – Level 5 (Surgery time 3.01 to 3.5 hours) Bill through Teleplan.....	699.72	710.22
19551	Expedited Surgical Assist – Level 6 (Surgery time 3.51 to 5.99 hours) Bill through Teleplan.....	1030.89	1046.35
19552	Expedited Surgical Assist – Level 7 (Surgery time 6.00 hours plus) Bill through Teleplan .....	1581.06	1604.78
19517	Expedited Extensive Spine Surgical Assist – Sessional fee (no MSP fee code applicable). Bill by fax to WorkSafeBC .....	1566.10	1589.59
19410	Expedited surgical assist, Out of Office Surcharge, Operative evening (6pm to 11pm) .....	32.77%	32.77%
19411	Expedited surgical assist, Out of Office Surcharge, Operative night (11pm to 8am).....	52.54%	52.54%

<b>Fee Code</b>	<b>Description</b>	<b>Fee (\$) (Effective April 1, 2017)</b>	<b>Fee (\$) (Effective April 1, 2018)</b>
19412	Expedited surgical assist, Out of Office Surcharge, Operative Sat/sun/Holidays..... NOTE: Fee items 19410, 19411 and 19412 apply to the expedited surgical assist levels only.	32.77%	32.77%
	NOTE: Bill this percentage applied to applicable Level fee code billed.		

**SCHEDULE E FEE SCHEDULE FOR MEDICAL ADVISORS**

**1.0 MEDICAL ADVISORS**

Not applicable	Medical Advisor, sessional rate – per session..... NOTE: Billing as instructed	552.91	561.20
Not applicable	Specialist Medical Advisor, sessional rate – per session .....	694.92	705.34
	NOTE: Billing as instructed		

# SPECIALIST SERVICES COMMITTEE (SSC) INITIATED LISTINGS

## 1. Preamble

The following Specialist Services Committee (SSC) fee items are billable only by Specialists certified by the Royal College of Physicians and Surgeons of Canada.

The objectives of SSC fees are to reduce unnecessary face to face encounters, to reduce care gaps, and to provide more timely care from the most appropriate physician, thereby improving patient care.

1. For the purposes of this section, face-to-face services include consultation; office, home or hospital visit; and any diagnostic, therapeutic, anesthetic or surgical procedure with both physician and patient in the same room.
2. SSC fees are not payable for situations where the sole purpose of the communication is to:
  - a) book an appointment
  - b) arrange for transfer of care that occurs within 24 hours
  - c) arrange for an expedited consultation or procedure within 24 hours
  - d) arrange for laboratory or diagnostic investigations
  - e) inform the referring physician of results of diagnostic investigations
  - f) arrange a hospital bed for the patient
  - g) renew prescriptions with a pharmacist
3. For Fee items G10001, G10002, G10003, G10004 refer to section D-1 Telehealth Services of the General Preamble.
4. G10002, G10004 and G10005: All registered and regulated health care providers can serve as referral sources. When advice is requested by an Allied Care Provider not registered with MSP use the generic practitioner number 99987: Advice requested by an Allied Care Provider. (Not applicable to referred case fee items such as consultations or Specialist visits).
5. At minimum, the following is required, and the practitioner is responsible for keeping their practice consistent with any new guidelines which may be published by the Canadian Medical Protective Association (CMPA) and/or the College of Physicians and Surgeons of British Columbia (CPSBC).

Electronic communication as part of patient care must ensure that security and patient confidentiality are maintained and guarded in the same way that paper records are protected.

## SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

- The CMPA and 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: <https://www.cmpa-acpm.ca/>
  - Document discussion & advice for all communications.
  - The email record should be included in the patient record.
  - Develop clear, written policies around use of email.
  - Communication between providers should clearly identify the most responsible physician (MRP).
  - Information should be encrypted as an attachment, or, at a minimum, password protected. Send password or cryptographic key separately.
  - Use secure communication modalities (i.e. Health Authority email addresses) if possible.
  - Email addresses need to be double-checked.
6. SSC fees are payable for face-to-face, telephone, video conference and email communication. Review the individual fee notes which identify their respective eligible communication modality. SSC fees are not eligible for communication by instant message, text or short message service (SMS) modality.
  7. SSC fees are not payable to physicians for services provided within time periods when working on salary, service contract or sessional arrangement.
  8. No claim may be made where communication or service is with a proxy for the billing physician.
  9. These fees were previously administered by the Specialist Services Committee (SSC). Note that the SSC Preamble governs the SSC initiated listings in this section, however, the SSC Preamble does not apply to the rest of the MSP fees listings.
  10. Out-of-Office Hours Premiums may not be claimed in addition.
  11. G10001, G10002, G10004 and G10005 are not payable for the same patient on the same date of service if adult or pediatric critical care team fees have been paid to the same practitioner or a practitioner who belongs to the same critical care team.

**2. SSC Fees**

Note: These fees cannot be correctly interpreted without reference to the Preamble for SSC Fees above, and the Eligibilities preceding each set of fee items below.

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
<p><b>SPECIALIST ADVICE FEES PG10001, PG10002, PG10005, T10008, T10000, T10009</b></p> <p><b>Eligibility</b>                      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.</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>i) Payable to Specialists for communication regarding assessment and management of a patient but without the consulting physician seeing the patient.</li> <li>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.</li> <li>iii) An adequate medical record/chart, including times as specified under each fee item, is required.</li> <li>iv) Not payable to physician initiating communication.</li> <li>v) The Specialist is responsible for the confidentiality and security of all records, and electronic transmissions. For video technology, see Section D. 1. of the Preamble.</li> <li>vi) G10001, G10002, G10005 may not be delegated to resident physicians.</li> </ul>		
<p>T10000 Urgent Specialist Advice on patient with previous visit/service – Initiated by a Specialist, General Practitioner or Health care Practitioner. Verbal, real-time response within 2 hours of the initiating physician’s or practitioner’s request.....</p>	N/A	60.00

*(see notes on next page)*

SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
--	-------------------------

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 same practitioner.
- v) Limited to one claim per patient per physician per day.

PG10001 Urgent Specialist Advice – Initiated by a Specialist, General Practitioner or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician’s or practitioner’s request.....	132.00	60.00
--	--------	-------

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 same practitioner.
- v) Limited to one claim per patient per physician per day.
- vi) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 180 days.

PG10002 Specialist Advice for Patient Management – Initiated by a Specialist, General Practitioner, Allied Care Provider, or coordinator of the patient’s care. Verbal real-time response in 7 days of initiating request – per 15 minutes or portion thereof .....	88.00	40.00
---	-------	-------

NOTES:

- i) Payable for telephone, video technology or face-to-face communication only. Not payable for written communication (i.e. fax, letter, email.)

*(notes continued on next page)*

SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

	Non-MSP- Insured Fee (\$)	MSP Fee (\$)
<ul style="list-style-type: none"> <li>ii) Document date of initiating request, date of the response, as well as advice given and to whom.</li> <li>iii) Document start and end times in the medical record, and in time fields when submitting claim.</li> <li>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.)</li> <li>v) Not payable in addition to another service on the same day for the same patient by the same practitioner.</li> <li>vi) Limited to two services per patient per physician per week.</li> <li>vii) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 30 days.</li> </ul>		
<p>PG10005 Specialist Email Advice for Patient Management – Initiated by a Specialist, General Practitioner or Allied Care Provider. Response within 7 days of request.....</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>i) Payable for email communication only. Maximum 3 services per patient per physician per day.</li> <li>ii) Document date of request, date of the response, as well as advice given and to whom.</li> <li>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).</li> <li>iv) Not payable in addition to another service on the same day, for the same patient by same practitioner.</li> <li>v) Limited to 3 services per patient per physician per day.</li> <li>vi) Limited to maximum of 12 services per patient per physician per year.</li> <li>vii) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 30 days.</li> </ul>	24.50	10.10
<p>T10008 Urgent Specialist COVID-19 Advice - Initiated by a Specialist, General Practitioner or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request .....</p> <p><i>(see notes on next page)</i></p>	N/A	60.00

SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
--	-------------------------

NOTES:

- i) Payable for telephone, video technology or face-to-face communication only about a patient regarding COVID-19. 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 same practitioner.
- v) Limited to two claims per patient per physician per day.
- vi) Not payable in addition to G10001 on the same day for the same patient.

T10009 Specialist Advice for Patient Management on patient with previous visit/service – Initiated by a Specialist, General Practitioner, Allied Care Provider, or coordinator of the patient’s care. Verbal real-time response within 7 days of initiating request .....

N/A	40.00
-----	-------

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) 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 the same practitioner.
- v) Limited to one claim per patient per physician per day and two services per patient per physician per week.



	Non-MSP- Insured Fee (\$)	MSP Fee (\$)
<b>SPECIALIST PATIENT FOLLOW-UP FEES PG10003, PG10006, T10007</b>		

**Eligibility**

The purpose of these fees is for the Specialist to provide advice when the intent of communication is to replace the need for the Specialist to see their own patient in person. The consulting Specialist is responsible for ensuring that appropriate communication is used to meet the medical needs of the patient.

**NOTES:**

- i) These fees apply to communication between the Specialist and his/her own patient or patient's representative.
- ii) Patient management requires two-way communication about clinical matters between the patient or patient's representative and the physician; the fee is not billable for administrative tasks such as appointment booking or notification.
- iii) An adequate medical record/chart entry is required.
- iv) Not payable in addition to a different service on the same day for the same patient by the same practitioner.

**Specialist Patient Follow-up Fees G10003, G10006, T10007**

PG10003 Specialist Patient Management / Follow-up – per 15 minutes or portion thereof .....	44.00	24.05
---	-------	-------

**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, e-mail).
- ii) Documentation in the medical record to show that the patient understood and acknowledged the information provided.
- iii) Include start and end times in the medical record, and in time fields when submitting claim.
- iv) Face-to-face service must have been billed for the same patient by the same physician within the preceding 18 months.

PG10006 Specialist Email Patient Management / Follow-up .....	24.50	10.10
---	-------	-------

*(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
--	-------------------------

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.

T10007 Specialist Email/Text/Telephone Medical Advice Relay or ReRX Fee.....

N/A

10.10

NOTES:

- i) Email/Text/Telephone Relay Medical Advice requires two-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician's practice.
- ii) 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.
- iii) Payable for prescription renewals without patient interaction.
- iv) Not payable for notification of appointments or referrals.
- v) Only one service payable per patient per day.
- vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient.
- vii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**MULTIDISCIPLINARY CONFERENCING FOR COMPLEX PATIENTS PG10004**

**Eligibility**

This fee is only billable for a scheduled meeting to discuss and plan medical management of patients with serious and complex problems under extraordinary circumstances that the Specialist cannot manage by him/herself. Payable only when coordination of care is required via a collaborative conference with at least two of the following in addition to the Specialist billing: Specialists, GPs, Allied Care Providers and/or coordinators of the patient's care. *(see notes on next page)*

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
--	-------------------------

**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, G1002, 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 on 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

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
--	-------------------------

Document complexity in the medical record using the ICD9 code for one of the major disorders when billing. If patient has non-medical co-morbidity use the ICD9 code M04 when billing.

**Specialist Multidisciplinary Conferencing for Complex Patients PG10004**

PG10004	Multidisciplinary Conferencing for Complex Patients – per 15 minutes, maximum one hour .....	121.00	46.23
---------	---	--------	-------

**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 ICD9 code for one of the major disorders when billing.
- viii) If patient has non-medical co-morbidity (see Eligibility) use the ICD9 code M04 when billing.

**GROUP MEDICAL VISITS PG78763 – PG78781 INCLUSIVE  
Eligibility**

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

SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

**Non-MSP-  
Insured  
Fee (\$)**                      **MSP  
Fee (\$)**

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, 00666, 00667, 00668, 00669, 00670, 00671, 00672, 00673, 00674, 00675, 00676, 00677, 00678, 00679, 00680, 00681).

**Referred Cases**

Group Medical Visit applies only when all patients in the group are receiving medically required treatment. These fees are not for efforts to persuade patients to alter diet or other lifestyle behavioral patterns, other than in the context of the individual medical condition.

Fee per patient, per ½ hour

PG78763	Three patients .....	69.20	47.16
PG78764	Four patients .....	55.90	37.67
PG78765	Five patients.....	48.05	32.75
PG78766	Six patients .....	42.75	29.13
PG78767	Seven patients .....	39.00	26.58
PG78768	Eight patients .....	36.20	24.66
PG78769	Nine patients .....	33.95	23.15
PG78770	Ten patients .....	32.15	21.90
PG78771	Eleven patients .....	28.15	19.19
PG78772	Twelve patients .....	26.50	18.05
PG78773	Thirteen patients .....	24.55	16.71
PG78774	Fourteen patients.....	24.10	16.41
PG78775	Fifteen patients .....	23.10	15.75
PG78776	Sixteen patients .....	22.40	15.27
PG78777	Seventeen patients .....	21.50	14.64
PG78778	Eighteen patients .....	21.00	14.41
PG78779	Nineteen patients .....	20.25	13.80
PG78780	Twenty patients.....	19.80	13.47

SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
PG78781 Greater than 20 patients (per patient).....	19.10	13.01
NOTES:		
i) Submit a separate claim for each patient.		
ii) Each patient must have an active referral.		
iii) Start and end times required in both the medical record and time fields in the claim.		
iv) Not payable with any other services, for the same patient, on the same day by the same physician.		
v) If multiple physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate for only the patients in their own fraction of the group. The claim note and patient chart should specify:		
a. Number of people in entire group.		
b. Number of patients billed by billing physician.		
c. Of the patients billed by the billing physician, how many were to each insurer.		
d. Name of any other billing physicians.		

**SPECIALIST DISCHARGE CARE PLAN FOR COMPLEX PATIENTS PG78717**

**Eligibility**

This fee premium is intended to support clinical coordination leading to effective discharge and community-based management of complex patients. It is to be billed for provision of a care plan for patients who require community support upon discharge, and who are otherwise at risk of readmission.

NOTES:

- i) Primary health care provider must be notified by phone, fax or electronic means within 24 hours of admission.
- ii) Care Plan must:
  - a. Be developed in consultation with the providers identified in the plan
  - b. Include record of appropriate clinical information, interventions, co-morbidities and safety risks
  - c. Include re-referral triggers and description of arranged follow-up care
  - d. Include expectation of symptom progression/remission and patient progress
  - e. Be included in the patient's medical record.

*(notes continued on next page)*

SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

**Non-MSP-  
Insured  
Fee (\$)**                      **MSP  
Fee (\$)**

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 ICD9 code for one of the major disorders when billing. If patient has non-medical co-morbidity use the ICD9 code M04 when billing.

PG78717 Specialist Discharge Care Plan for Complex Patients – extra.....	165.00	75.00
--	--------	-------

**NOTES:**

- i) Payable to the Specialist Physician who is the MRP for the majority of the patient’s in-hospital care and 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.

*(notes continued on next page)*

Non-MSP- Insured Fee (\$)	MSP Fee (\$)
---------------------------------	-----------------

- 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 ICD9 code for one of the major disorders when billing.
- viii) If patient has non-medical co-morbidity (see Eligibility) use the ICD9 code M04 when billing.

## **ADVANCE CARE PLANNING PG78720**

### **Eligibility**

Advance Care Planning occurs when a capable adult forms his/her beliefs, values and wishes for health care, in the event of future incapacity. Advance care planning discussions may take place with family, trusted friends, and/or health care providers.

This fee premium is for a Specialist to discuss advance care planning based on the patient's beliefs, values and wishes for future health care.

#### **NOTES:**

- i) The advance care planning discussion should include sharing information and resources on how a patient can create an advance care plan, including Advance Directives.
- i) 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](http://www.sscbc.ca)).
- ii) The care plan template form must be shared with:
  - a) The patient; and
  - b) The patient's primary health care provider.
- iii) The message to the patient and the plan must be consistent with the Practice Support Program's End of Life Module resources.
- iv) Not payable in the same hospital admission during which adult or pediatric critical care (01400 series) or neonatal intensive care (01500 series) fees are claimed.



SPECIALIST SERVICES (SSC) INITIATED LISTINGS - Continued

	<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
<b>Specialist Advance Care Planning</b>		
PG78720 Specialist Advance Care Planning Discussion – extra.....	81.60	40.00
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%.		

## NUCLEAR MEDICINE PROCEDURES

These fees cannot be correctly interpreted without reference to the 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:
  - i) Fee item 00016 (intrathecal medications by injection) is billable with fee item 09886 (cisternography).
  - ii) 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:
  - i) 09824 - Testicular imaging - isolated procedure.
  - ii) 09834 - Bone scan (only for indications listed under this fee item).
  - iii) 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 - same day, 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:
  - i) 09806 Parathyroid imaging.
  - ii) 09807 MIBG imaging (I131 - metaiodobenzyl-guanidine).
  - iii) 09817 Receptor imaging.
  - iv) 09826 Tumour imaging.
  - v) 09829 Adrenal imaging.
  - vi) 09844 Red cell survival study.

## NUCLEAR MEDICINE - Continued

- vii) 09867 Brain scan, static.
- viii) 09869 Pancreas scan, static.
- ix) 09886 Cisternography.
- x) 95015 Iodine 131 - whole body scan.
- xi) 95055 Renal imaging with pharmaceuticals (isolated procedure).
- xii) 95060 Renal imaging without pharmaceuticals (isolated procedure).
- xiii) 95065 White blood cell labeled with radioisotope (if views are performed on separate days or 24 hours apart).
- xiv) 09834 Bone scan (only if 24 hour views are performed).
- xv) 09878 Liver clearance of HIDA (biliary scan) (if 24 hour views are performed).
- xvi) 95025 Liver clearance of HIDA with pharmaceutical (if 24 hour views are performed).
- xvii) 09854 Thallium myocardial scan
- xviii) 95053 Thallium Body Imaging

## 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

### **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.

		<b>MSP and WSBC</b>		
	<b>Code</b>	<b>Non-MSP- Insured Fee (\$)</b>	<b>Prof. Fee (\$)</b>	<b>Total Fee (\$)</b>
<b>SCANNING AND LOCALIZATION PROCEDURES</b>				
Adrenal imaging (isolated procedure).....	09829 ...	1018.00	61.40	445.93
Blood pool joint scan .....	09832 ...	330.00	34.11	166.13
NOTE: Not payable with joint scan.				
Bone marrow scan.....	09833 ...	348.00	39.44	171.06
Bone scan .....	09834 ...	531.00	62.05	232.50
NOTES:				
i) Includes SPECT.				
ii) Fee item 09866 is the only Nuclear Medicine listing payable in addition to a bone scan and is payable only in cases of suspected infection or trauma, possible osteomyelitis, evaluation of reflex sympathetic dystrophy, heterotopic ossification, arthropathy, avascular necrosis, metabolic bone disease, primary bone tumours and insufficiency and stress fractures. Note record indicating reason required when billing 09866 in addition to bone scan.				
Brain scan - regional cerebral blood flow (isolated procedure) .....	09871 ...	603.00	130.13	358.49
Brain scan, static .....	09867 ...	417.00	52.53	205.81
Carbon-14 glycinecholate breath analysis .....	09805 ...	267.00	27.93	117.28
Cardiac first pass.....	95000 ...	208.00	26.25	91.09
NOTE: Not paid with 95005.				
Cardiac scan, static .....	09864 ...	348.00	39.88	152.89
Cardiac shunt .....	95005 ...	208.00	26.26	103.07
NOTE: Not paid with 95000.				
Cisternography .....	09886 ...	686.00	82.46	341.60
CNS shunt .....	09813 ...	357.00	37.00	175.65

NUCLEAR MEDICINE - Continued

	Code	MSP and WSBC		
		Non-MSP-Insured Fee (\$)	Prof. Fee (\$)	Total Fee (\$)
Coronary perfusion with radio particles, per radionuclide .....	09898...	443.00	69.55	197.92
Coronary administration of radio particles, transcatheter .....	09897...	66.70	0.00	28.75
Oesophageal motility - utilizing an orally administered radioisotope .....	09802...	419.00	43.66	206.07
Gallium scan .....	09838...	651.00	65.98	282.91
– each repeat with no additional radionuclide .....	09839...	208.00	18.85	102.59
NOTE: 09877 not payable same day.				
Gastric emptying (liquid).....	09879...	576.00	34.31	286.11
Gastric emptying (solid).....	09808...	576.00	33.87	249.44
NOTE: If both liquid and solid phases are performed on the same day, charge 09877 for the second test.				
Gastro-oesophageal reflux .....	09895...	576.00	33.87	249.44
NOTE: Not payable with fee items 09808 or 09879.				
Gastro-intestinal blood loss study .....	09859...	270.00	27.37	119.62
Gastro-intestinal protein loss study .....	09858...	348.00	39.88	152.89
GFR (In-Vitro).....	09848...	272.00	27.67	127.35
GI bleeding - red cell label.....	09804...	680.00	70.35	336.24
NOTE: 09859 and 95045 are not payable with 09804.				
Thyroid scan (Iodine - 123) .....	09823...	441.00	21.23	187.36
Iodine - 131 whole body scan.....	95015...	552.00	65.69	242.01
Joint scan .....	95020...	552.00	65.69	242.01
NOTE: Not payable with blood pool joint scan.				
Lacrimal duct scan .....	09814...	299.00	28.66	147.93
Liver clearance of HIDA (biliary scan) .....	09878...	617.00	67.81	270.35
NOTE: Included in 95025 when performed same day.				
Liver clearance of HIDA with pharmaceutical.....	95025...	909.00	101.70	397.70
Liver scan, static .....	09850...	372.00	39.22	164.61
NOTE: When performed in conjunction with spleen scan, static (09873), bill as 09851 only (liver and spleen scan, static).				
Liver and spleen scan, static .....	09851...	517.00	65.66	227.25
Lumbar administration of radionuclide.....	09896...	68.30	0.00	33.11
Lung quantification .....	95030...	517.00	65.68	256.86

NOTES:

- i) Fee item 95030 not payable with 09868.
- ii) 09855 payable in addition only if both ventilation and perfusion are quantified.
- iii) Provide details in note record if billing associated procedures on same day.

	Code	MSP and WSBC		
		Non-MSP-Insured Fee (\$)	Prof. Fee (\$)	Total Fee (\$)
Lung scan, static.....	09868 ...	517.00	65.64	227.02
NOTE: Fee item 09866 not to be billed in addition to this item.				
Lymphoscintigraphy (isolated procedure).....	09816 ...	606.00	37.14	298.30
Meckel's localization (ectopic gastric mucosa) .....	09853 ...	686.00	78.90	341.13
MIBG imaging (I131-metaiodobenzyl-guanidine).....	09807 ...	2045.00	117.54	967.45
Rest myocardial perfusion .....	95062 ...	614.00	49.44	269.76
Stress myocardial perfusion .....	95063 ...	614.00	50.24	274.15
NOTE: 95062 and 95063 (as well as stress test) are billable same day, if performed.				
Ocular tumour localization .....	09870 ...	418.00	66.45	185.72
Pancreas scan, static .....	09869 ...	670.00	77.66	296.86
Parathyroid imaging.....	09806 ...	838.00	87.70	413.66
Perfusion study (dynamic scan), regional or organ - when done alone .....	09865 ...	277.00	26.26	120.05
Perfusion study (dynamic scan), regional or organ - in addition to major scan .....	09866 ...	105.00	13.16	45.63
Plasma volume (with plasma label), total blood volume, and red-cell mass by calculation .....	09835 ...	82.40	5.36	36.15
Platelet survival .....	09849 ...	686.00	84.82	305.56
Radioiron:				
– clearance.....	09840 ...	348.00	41.70	153.11
– turnover.....	09841 ...	333.00	40.63	149.09
– red cell utilization.....	09842 ...	348.00	39.88	152.89
– combined study at one time of above three .....	09843 ...	671.00	81.26	297.32
Radionuclide cardiac ventriculography .....	09863 ...	600.00	73.53	263.25
– with stress .....	95040 ...	882.00	110.36	387.62
NOTES:				
i) Only one of the following items is payable when requested and rendered with a radionuclide cardiac ventriculography (gated study MUGA) – (fee items 09863, 95040):				
a) Cardiac first pass (fee item 95000), or				
b) Cardiac shunt (fee item 95005)				
ii) 95040 includes 09863.				
Radionuclide venogram alone .....	09809 ...	394.00	41.92	197.63
Receptor imaging (isolated procedure).....	09817 ...	596.00	86.98	265.54
RBC (red blood cell) liver scan .....	95045 ...	667.00	70.33	290.26
NOTE: 09859 is not payable with 95045.				
Red cell mass determination (with red cell label), to include whole blood and plasma volume by calculation .....	09836 ...	492.00	36.96	238.34

NUCLEAR MEDICINE - Continued

	Code	MSP and WSBC		
		Non-MSP-Insured Fee (\$)	Prof. Fee (\$)	Total Fee (\$)
Red cell mass (with RBC label) and plasma volume (with plasma label) combined study .....	09837...	323.00	24.96	159.43
Red cell survival study.....	09844...	586.00	41.82	233.43
Renal imaging - with pharmaceuticals (isolated procedure).....	95055...	781.00	79.24	340.66
– without pharmaceuticals (isolated procedure).....	95060...	707.00	70.11	308.58
NOTE: 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.				
Repeat of major scan, no additional radionuclide - charge 50% of scheduled fee for primary procedures	09877...			
Salivary gland study .....	09818...	368.00	34.42	181.68
SeCHAT .....	09819...	529.00	29.02	261.40
Spleen scan, static .....	09873...	348.00	39.88	152.89
NOTE: When performed in conjunction with liver scan, static (09850), bill as 09851 only (liver and spleen scan, static).				
Testicular imaging (isolated procedure) .....	09824...	389.00	52.17	173.34
Thallium myocardial scan.....	09854...	848.00	65.96	416.43
Thallium body imaging .....	95053...	830.00	66.78	421.56
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:				
– single determination.....	09820...	104.00	13.15	45.47
– double determination .....	09821...	138.00	19.76	68.77
Thyroid scan (pertechnetate) .....	09825...	175.00	16.42	74.93
Transfer of radionuclide from CSF to blood.....	09876...	170.00	13.32	75.54
Tumour Imaging with metabolic or biological imaging agent (excluding Thallium-201 or Gallium-67).....	09826...	3146.00	91.39	1408.23
NOTE: Includes imaging of the entire torso with tomographic and planar images as indicated.				

	Code	MSP and WSBC		
		Non-MSP-Insured Fee (\$)	Prof. Fee (\$)	Total Fee (\$)
Ventilation lung scan .....	09855 ...	537.00	48.42	234.79
NOTES:				
i) 09868 payable in addition, if applicable.				
ii) Ventilation-perfusion scan to rule out pulmonary embolism is billable under 09855 and 09868.				
iii) 09866 not paid in addition.				
Vitamin B12 absorption study (e.g.: Schilling test):				
– without intrinsic factor.....	09856 ...	309.00	13.20	133.84
– with intrinsic factor.....	09857 ...	372.00	19.75	160.76
– with blood radioactive determination .....	09852 ...	165.00	13.56	73.63
– with two radionuclides .....	09860 ...	208.00	26.56	92.14
Voiding cystography .....	09828 ...	376.00	45.87	186.77
White blood cell labeled with radioisotope .....	95065 ...	1848.00	187.40	780.13

**THERAPEUTIC PROCEDURES**

Joint injection with isotope - therapeutic.....	09890 ...	1151.00	87.45	759.17
Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (iodine therapy).....	09880 ...	517.00	135.13	392.02
Treatment for polycythemia vera with P32 - per course of treatment.....	09881 ...	517.00	79.76	231.35
Treatment for thyroid cancer - per course of treatment .....	09882 ...	1030.00	105.15	509.49
Treatment for prostate cancer - per course of treatment .....	09883 ...	1037.00	202.20	467.28
Treatment for metastatic carcinoma of bone - per course of treatment.....	09884 ...	675.00	129.77	300.25



## PREAMBLE

The purpose of this Guide is to outline both the new processes associated with ICBC billing and the new fee structure. Tables 1 & 2 below outline new family physician services and compensation for physicians treating patients injured in a motor vehicle accident. These services and fees are enshrined in Schedule 3.2 of the [Insurance \(Vehicle\) Regulation](#).

This Guide has four sections:

1. Family Physician Services
2. Registered Care Advisor Services
3. Communication Fees
4. Miscellaneous

### When do I fill out an ICBC Report?

- Fill in either a Standard or Extended Report for each new motor vehicle accident claim and with patient consent, send it to ICBC, or
- Wait for a request from ICBC to fill in and send in the Report. Pursuant to the Insurance (Vehicle) Act, section 28.1, upon request from ICBC, regardless of patient consent, you are required to provide, as soon as reasonably practicable, an initial medical report (either the Standard Assessment & Report (CL489) or the Extended Assessment & Report (CL489A) as applicable).

### Why do I need patient consent to pro-actively send a Report to ICBC?

- If you are sending an initial medical Report to ICBC without a formal request from them, you must have patient consent to pro-actively share their personal information.
- ICBC is encouraging physicians to send information to them this way as it will help streamline workflow and payment.
- Early awareness will help ICBC support the recommended care plan.
- One way to collect patient consent is to have your patient fill out a consent form. Doctors of BC created a consent template for this purpose that may be accessed here: <https://www.doctorsofbc.ca/sites/default/files/consenttoreleasereportsicbc.pdf>

### What is a Registered Care Advisor (RCA)? How do I find one?

- A new physician role has been created by the Insurance (Vehicle) Regulations to provide expedited medical consultations to patients of motor vehicle accidents. The purpose of a RCA is to help advise family physicians in situations when the patient is not recovering as expected.
- Please see [ICBC's Health Services webpage on RCAs](#) for more information.
- A list of RCA providers will be made available through Pathways in addition to the [RCA page](#) hosted by ICBC.

### Which Report should I choose?

- Each Report is designed to meet the specific needs of your patient; physicians are not expected to fill out all three Reports for every motor vehicle accident claim.
- If your patient's injuries do not result in missed work or significantly affect their usual activities, a Standard Assessment and Report would be applicable.
- If your patient's injuries result in missed work or significant impairment of their ability to participate in usual activities an Extended Assessment and Report would be applicable.
- If your patient is not recovering as expected within 90 days of the accident, the regulations require you to consider a referral to a Registered Care Advisor. If a referral is warranted, physicians should complete the Reassessment and Report form. The Report is intended to flow from the Initial or Extended Assessment Report, act as your medical record documentation and the referral letter to the RCA in addition to serving as an invoice to ICBC.

### Where do I find ICBC Report templates?

- ICBC Report templates are embedded into most Electronic Medical Record (EMR) solutions. If your EMR vendor has not integrated the new set of ICBC Report templates, they may also be found on:
  - ICBC Health Services/Reports templates webpage
  - The Forms Repository in Pathways
  - Registered Care Advisor Reports do not require a prescribed template, however, ICBC's RCA Information Guide has a suggested guideline for the RCA Report.

### What is the process for billing ICBC?

- The Reports serve as both your medical record documentation and the invoice to ICBC.
- Please send Reports and relevant invoices to ICBC by one of the following:
  - Fax to: 1-877-686-4222
  - Mail to: ICBC, PO Box 2121, Stn Terminal, Vancouver BC V6B 0L6

### Questions

For all policy and process related questions, to validate a claim number or coverage and for general ICBC questions please contact:

#### **ICBC Health Care Inquiry Unity (HCIU)**

604-587-7150

1-888-717-7150

For all payment related issues including outstanding invoices, partially paid invoices, requests to resubmit invoices and confirmation of process, or to correct, cancel or reissue a cheque, please contact:

#### **ICBC Claims Vendor Inquiry Unit**

[claimsvendorinquiry@icbc.com](mailto:claimsvendorinquiry@icbc.com)

Please be sure to include claim number, patient name, payee name, and invoice number, if applicable.

**ICBC  
FEE ITEMS**

**ICBC Fee  
(\$)**

**TABLE 1: FAMILY PHYSICIAN FEES AS PER BC’S INSURANCE (VEHICLE) REGULATION**

A94564	Standard Physician Assessment & Report – CL489..... For patients who are not off work and/or not significantly impacted in performing their typical activities of daily living (ADLs). Includes patient assessment and completion of report	123.00
A94565	Extended Physician Assessment & Report – CL489A..... For patients who are off work/school, on a modified work plan, or are experiencing significant functional impairment and unable to perform their typical ADLs. Includes patient assessment and completion of report.	333.00
A94566	Physician Re-assessment, Report & Registered Care Advisor (RCA) Referral – CL489B..... For patients who are not recovering as expected from the MVA and/or for whom the family physician requests a consultation from an RCA. It will be the family physician’s discretion to refer to an RCA or continue/modify treatment. Includes patient assessment and completion of report.	215.00

**Billing Rules:**

- The report is the invoice.
- A clinic/physician should not send a separate invoice for the Standard, Extended or Re-assessment Reports. There is space on the report to include an invoice number for personal tracking purposes.
- All Family Physician Services outlined above include payment for the office visit and completion of the report.
- Any follow-up patient visits outside the services outlined in the above table are billed as usual via Teleplan, with ICBC named as the insurer, using the standard MSP visit codes. ICBC is responsible for payment of all visits related to MVA injuries billed via Teleplan until the ICBC claim is closed.

**How to Bill:**

The physician’s office completes the following steps to send a standard, extended or re-assessment report to ICBC:

1. Complete the report in its entirety.
2. Send the report to ICBC by one of the following:
  - Fax to 1-877-686-4222
  - Mail to ICBC, PO Box 2121, Stn Terminal, Vancouver BC V6B 0L6

**TABLE 2: REGISTERED CARE ADVISOR SERVICES (RCA) AS PER BC’S INSURANCE (VEHICLE) REGULATION**

A94567	Initial RCA Assessment & Report .....	389.00
	For patients who are not recovering as expected and/or when there is diagnostic uncertainty, family physicians may request a specialty consultation from a RCA for the purpose of supporting care management and recovery. Referrals to a RCA will be initiated by the family physician, and the patient must be seen within 15 business days from referral.	
A94568	Follow-up RCA Assessment.....	120.00
	For patients who need a follow-up visit with the RCA because information was missing at initial assessment or further diagnostic testing is required in order for the RCA to complete the consultation.	

This fee may also be submitted for one missed appointment or cancellations with less than 24 hours’ notice. ICBC will pay the RCA physician for the first missed appointment. The patient will be responsible to pay for subsequent missed RCA appointments

**Billing Rules:**

- These RCA services require an invoice.
- Both RCA Services outlined above include payment for the patient assessment and written consultation report.

**How to Bill:**

1. Prepare the invoice. The following must be included in the invoice:
  - ICBC Claim number
  - Patient name
  - Physician providing the service
  - Payee where this differs from the Physician providing the service.

*(notes continued on next page)*

2. Send the invoice to ICBC by one of the following:
  - Fax to 1-877-686-4222
  - Mail to: ICBC, PO Box 2121 Stn Terminal, Vancouver BC V6B 0L6

**TABLE 3: FEES TO SUPPORT COMMUNICATION**

<p>A94569 Physician Conference Fee.....</p> <p>Calls between most responsible provider (MRP) and RCA; MRP or RCA and ICBC or other treatment providers. This fee will support either written or telephone correspondence.</p> <p>Telephone or written consultation per 15 minutes (or portion thereof) up to a maximum of forty-five (45) minutes (i.e. to a daily maximum of three (3) units per claim).</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>• Not for arranging expedited consults or diagnostic investigations.</li> <li>• Not for conveying the results of diagnostic investigations.</li> </ul>	<p>60.00</p>
<p>A94571 Physician Telephone Management Fee .....</p> <p>Calls between physician (MRP or RCA) and the patient.</p> <p>Telephone clinical discussion with patient or patient’s medical representative.</p> <p>NOTES:</p> <ul style="list-style-type: none"> <li>• Not for appointment reminders or Rx renewals.</li> <li>• The telephone call can be made by the physician or a college-certified allied health professional employed by the eligible physician’s practice.</li> </ul>	<p>25.00</p>

**Billing Rules:**

- These services will require an invoice.

**How to Bill:**

1. Prepare the invoice. The following must be included in the invoice:
  - ICBC claim number
  - Patient name
  - Physician providing the service
  - Payee where this differs from the Physician providing the service
2. Send the invoice to ICBC by one of the following:
  - Fax to 1-877-686-4222
  - Mail to ICBC, PO Box 2121 Stn Terminal, Vancouver BC V6B 0L6

<b>Non-MSP- Insured Fee (\$)</b>	<b>MSP Fee (\$)</b>
--	-------------------------

**TABLE 4: MISCELLANEOUS**

13075 In office assessment of an unrelated condition(s) in association with an ICBC service .....	41.45	16.44
---	-------	-------

**NOTES:**

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