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[1]" services from billing for interpretation of diagnostic or laboratory test results).

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

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

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

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

The General Preamble is divided into four interdependent sections:

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

B. DEFINITIONS

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

"Age categories"

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

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

"Antenatal visit"

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

“CPSBC”

College of Physicians and Surgeons of British Columbia

“Diagnostic Facility”

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

“Emergency department physician”

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

“Family Physician”

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

“Health care practitioner”

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

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

“Holiday”

New Year’s Day, Family Day, Good Friday, Easter Monday, Victoria Day, Canada Day, B.C. Day, Labour Day, National Day for Truth and Reconciliation, 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:

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

“Medical practitioner”

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

“Microsurgery”

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

“MSC”

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

a) 3 members appointed from among 3 or more persons nominated by the Doctors of BC;
b) 3 members appointed on the joint recommendation of the minister and the Doctors of BC to represent beneficiaries;
c) 3 members appointed to represent the government.

See Preamble C. 2. for additional details

“MSP”

Medical Services Plan

“No charge referral”

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

"Practitioner"

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

"PREFIXES TO FEE CODES"

Note: These Prefixes to fee services 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 surgical fee items that are exempt from the post-operative general preamble rule (D. 5. 1.). Therefore, fee item 71008 can be billed for post-operative care within the first 14 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 (e.g.: alternative payment practitioner), a written request for the referral must be sent to the practitioner being referred to and a copy retained in the patient's clinical record.

Referred to Practitioner:

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

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

- 99957 – referral by retired/deceased/moved out of province physician
- 99985 - referral by the BC Cancer Screening Program
- 99991 – referral by a chiropractor to an orthopaedic specialist
- 99992 – referral by an optometrist to an ophthalmologist and referral by an optometrist to a neurologist
- 99993 – referral by a salaried, sessional or contract physician
- 99994 – referral by a dentist
- 99996 – referred by public health for a TB x-ray
- 99997 – referred by a primary care organization
- 99998 – referred by an Out of Province physician

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

"Specialist"

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

"Third party"

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

"Transferral"

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

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

"Time categories"

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

- Month – a calendar month
- Week – any period of 7 consecutive days
- Calendar week – from Sunday to Saturday

“Uninsured service”

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

C. ADMINISTRATIVE ITEMS

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C. ADMINISTRATIVE ITEMS

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

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

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

C. 2. Setting and Modification of Fees

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

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

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

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

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 Fee Guide. 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 Fee Guide.

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 rational for the level of that fee

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

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

Miscellaneous Fee Items

00099	General Services
00199	Family Medicine
00299	Dermatology
00399	Internal Medicine
00499	Neurology
00599	Pediatrics
00699	Psychiatry
00999	Diagnostic Procedures
01499	Critical Care
01799	Physical Medicine and Rehabilitation
01899	Emergency Medicine
01999	Anesthesiology
02599	Otolaryngology
02999	Ophthalmology
03999	Neurosurgery
04999	Obstetrics and Gynecology
06999	Plastic Surgery
07999	General Surgery/Cardiac Surgery
08699	Diagnostic Radiology
08899	Miscellaneous Diagnostic Ultrasound
08999	Urology
09899	Nuclear Medicine
30999	Clinical Immunology and Allergy
31999	Rheumatology
32199	Respirology
32299	General Internal Medicine
33199	Cardiology
33299	Endocrinology and Metabolism
33399	Gastroenterology
33499	Geriatric Medicine
33599	Hematology and Oncology
33699	Infectious Diseases
33899	Nephrology
33999	Occupational Medicine
43999	Palliative Medicine
59999	Orthopaedics

77799	Vascular Surgery
78999	Cardiac Surgery
79199	Thoracic Surgery

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

C. 5. Inclusive Services and Fees

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

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

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

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

C. 6. Medical Research

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

Experimental Medicine

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

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

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

Coverage:

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

Process:

Where such a new therapy or procedure is being introduced into British Columbia and the medical practitioners performing the new therapy or procedure wish to have a new fee item inserted 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
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 enquiries of that home province after direct payment to the BC medical practitioner.

C. 12. Disputed Payments

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

C. 13. Extra Billing and Balance Billing

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

“Balance billing” denotes the practice of medical practitioners who are opted in under MSP billing MSP for the MSP fee and the patient for the amount of the difference between the payment made by MSP for an insured service and the fee for that service listed in the Doctors of BC Fee Guide, under the heading “Non-MSP-Insured 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 family physician visit fee and in addition may charge the patient a differential fee. This is not considered “extra billing.”

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

C. 15. Missed Appointments

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

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

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

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

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

1. Services related to motor vehicle accidents (e.g. visits, procedures, counselling, consultations) are no longer the responsibility of Insurance Corporation of BC (ICBC).
2. ICBC-related physician reports remain billable to ICBC via report or invoice using the applicable ICBC fee codes (see Doctors of BC ICBC Fee Guide).
3. ICBC claim numbers and a “yes” code in the Teleplan MVA field are not required.
4. If the patient is from another province, use the normal out-of-province billing process as noted in C. 11. Reciprocal Claims.
5. When the patient has not MSP coverage, the medical practitioner should bill the patient directly.
6. If the MVA is work-related, WorkSafeBC (WSBC) should be billed under their procedures.

C. 18. Guidelines for Payment for Services by Trainees, Residents and/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/Fee Guide and personally attends the patient.

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

C. 19. Services to Family and Household Members

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

    a) a spouse,

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

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

C. 20. Delegated Procedures

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

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

The foregoing limitations do not apply to approved procedures rendered in approved “diagnostic facilities”, as defined under the Medicare Protection Act and Regulations, or to services rendered in approved laboratory facilities, as defined under the *Laboratory Services Act and Regulation,* 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 Fee Guide. The fees listed under “MSP and WSBC Fee” have been accepted by the WorkSafeBC through negotiated agreements as the basis for their Fee Guide. WorkSafeBC supplies its own reporting and billing forms. To facilitate payment, WorkSafeBC requires the practitioner to include their MSP payment number on all forms.

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

C. 26. BC Transplant Society

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

C. 27. Business Cost Premium

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

The BCP does not apply to Alternative Payment Program (APP) or Longitudinal Family Payment (LFP) payment models, form fees, or to primary health program payments such as the Provincial Attachment System (PAS) and Community Longitudinal Family Physician (CLFP) payments.

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

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

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

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

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

To receive the BCP:

i) The physician is responsible for some or all of the lease, rental or ownership costs of that community-based office, and

ii) The community-based facility in which the eligible services are provided must be in an eligible location and have a unique Facility Number registered with MSP, and

iii) The physician must be registered with MSP as a physician practicing at that Facility, and

iv) The correct Facility Number must be entered on each claim where the eligible service is rendered.

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D. 1. Telehealth Services

"Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient through the use of video technology or telephone. "Video technology" means the recording, reproducing and broadcasting of live visual images utilizing a direct interactive video link with a patient. Services which are designated as telehealth services are payable by MSP. Consultations, office visits, and non-procedural interventions where there is no telehealth fee may be claimed under the face-to-face fee with a claim note record that the 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 family physician at the patient's site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate in the "Referred by" field that a request was made for a family physician assisted assessment.

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

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

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

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

The College of Physicians and Surgeons of British Columbia 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*, in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a medical practitioner competent to give advice in this field.

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

The referring practitioner is expected to provide the consulting physician with a letter of referral that includes the reason for the request and the relevant background information on the patient. The referring practitioner is also required to notify MSP of the referral by including the practitioner number of the specialist to 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 Family Medicine Section of this MSC Payment Schedule. Exceptions to this limitation will only be made in cases of geographic need, as recommended by the College of Physicians and Surgeons of BC.

D. 2. 3. Subsequent Consultation

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

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

i) The referring practitioner's referral letter specifically disallows an Implicit re-referral by stating: "This referral is for one consultation only and does not include a re-referral" or similar language, OR

ii) The referring practitioner disallows the Implicit re-referral via written response to the consultant within 14 days of receiving notification by the consultant of the scheduled date for a subsequent consultation.

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

Any additional subsequent consultations must follow the same rules. Another Implicit re-referral potentially exists following any subsequent consultation unless the referring

practitioner has explicitly excluded it as described above. A subsequent consultation may not be billed if the Implicit re-referral has been disallowed.

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

D. 2. 4. Limited Consultation

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

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

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

D. 2. 5. Special Consultation

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

D. 2. 6. Continuing Care by Consultant

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

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

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

D. 2. 7. Referral and Transferral

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

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

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

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

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

D. 3. Visits and Examinations

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

D. 3. 1. Complete Examination

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

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

D. 3. 2. Partial Examination

A visit for any condition(s) requiring partial examination or history includes both initial and subsequent examination for same or related condition(s). A partial examination includes a history of the presenting complaint(s), appropriate enquiry and examination of the affected part(s), region(s) and/or 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 Family Medicine and various specialty sections of the Schedule apply only when two or more patients are provided counselling

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

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

D. 4. Hospital and Institutional Visits

D. 4. 1. Hospital Admission Examination

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

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

D. 4. 2. Subsequent Hospital Visit

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

If it is medically required for a patient to be visited more than once per day at any time, or daily beyond the initial 30 day period (e.g.: if the patient is in one of the Intensive Care

wards), an explanation should be submitted with the claim and independent consideration will be given.

D. 4. 3. Surgery by a Visiting Doctor

If a surgeon operates outside of his/her geographical area, (for example as part of an outreach program or other such circumstances), and because of this, s/he is unable to render the usual post-operative care, the medical practitioner who performs this service for the patient may claim for necessary hospital visits at the usual frequency, as described under Preamble D. 4. 2. Claims for such post-operative care should be accompanied by a written explanation or an electronic note record. No such claims, however, should be made if the hospital at which the post-operative care is being rendered is within the same metropolitan area or within 32 km of the surgeon's home or office.

D. 4. 4. Long-Stay Hospitalization

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

D. 4. 5. Directive Care

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

D. 4. 6. Concurrent Care

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

D. 4. 7. Supportive Care

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

D. 4. 8. Newborn Care in Hospital

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

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

When visits are required to patients in long-term-care institutions (such as nursing homes, intermediate care facilities, extended care 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. Sub Acute Care

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

D. 4. 11. Emergency Department Examinations

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

D. 4. 12. House Calls

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

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

to manage the patient's condition;

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

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

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

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

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

D. 5 Surgery

D. 5. 1. General

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

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

D. 5. 2. Operation Only

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

D. 5. 3. Multiple Surgical Procedures

i) When two or more similar procedures (including bilateral procedures) are performed under the same anesthetic, or when two or more procedures are

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

ii) When two or more different procedures are performed through separate incisions under the same anesthetic, and 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 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).

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

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

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

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

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

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

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

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

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

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

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

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

D. 9. 2. Surface Pathology

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

D. 9. 2. 1. Trauma Scars

a. **Neck or Face**

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

b. **Scars in other Anatomical Areas**

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

D. 9. 2. 2. <u>Keloids and Hypertrophic Scars</u>

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. <u>Tattoos</u>

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. <u>Benign Skin Lesions</u>

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

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

a. **Exceptions**

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

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

b. When a patient presents with a surface pathology, the initial visit and or consultation and/or pathologic examination of a tissue specimen, when one is submitted, is regarded as medically necessary to establish the diagnosis, and therefore, is an insured service. Any use of dermoscopy and/or any other diagnostic technology (e.g.: use of Artificial Intelligence) is included within the visit and/or consultation.

D. 9. 2. 5. <u>Hair Loss</u>

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/MSC guidelines for significant defect.

c. MSP authorization is required.

D. 9. 3. Sub-Surface Pathology

D. 9. 3. 1. Congenital deformities

a. **Face or Neck**

Repair is a benefit of MSP except for:

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

b. **Other Anatomical Areas**

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

D. 9. 3. 2. Post-Traumatic Deformities

- Reconstructive procedures are a benefit at the acute stage; within a reasonable period of convalescence; or if part of a pre-planned staged process of repair.

- Repair procedures may include bone revision, tissue shifts and grafts, prosthesis implantation, etc.
- MSP authorization is required for repairs beyond the acute stage.

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

a. **Head or Neck**

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

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. <u>Excision of excess fatty tissue</u>

- 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. <u>Gender Affirming Surgery</u>

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

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

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

D. 9. 5. Complications and Revisions

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

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

D. 10. Out-of-Office Premiums

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

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

OUT-OF-OFFICE HOURS PREMIUMS
(Applicable to Family Physicians and Specialists)

EXPLANATORY NOTES

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

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

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

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

CALL-OUT CHARGES

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	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)	362.00	79.08
01201	Night (call placed and service rendered between 2300 hours and 0800 hours).....	508.00	111.05
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours).	362.00	79.08
	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	327.00	72.69
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	447.00	99.40
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof.....	327.00	72.69

NOTES:

i) Claim must state start and end times.

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

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

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) – 44.68% of surgical (or assistant) fee		
	– minimum charge	298.44	66.32

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	– maximum charge for surgeries under two hours.....	2058.57	457.46
	– maximum charge for surgeries of two hours or longer	5,607.00	1,246.00
01211	Night (2300 hours to 0800 hours) – 72.02% of surgical (or assistant) fee		
	– minimum charge.....	419.04	93.12
	– maximum charge for surgeries under two hours.....	3305.00	734.42
	– maximum charge for surgeries of two hours or longer	9,000.00	2,000.00
01212	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 44.68% of surgical (or assistant) fee		
	– minimum charge.....	298.44	66.32
	– maximum charge for surgeries under two hours.....	2058.57	457.46
	– maximum charge for surgeries of two hours or longer	5,607.00	1,246.00

NOTES:

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

ii) When emergency surgery commences prior to 1800 hrs, surgical surcharges are payable provided the major portion of surgical time is after 1800 hrs.

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

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

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	ANESTHESIOLOGY		
c)	Anesthesiology services are eligible for continuing care surcharges when an out-of-office hours call-out charge is applicable or when specially called for an emergency. Timing begins after the first 30 minutes for consultations, visits or anesthesiology evaluations. Payment is based on one half hour of care or major portion thereof. Therefore, the first surcharge is payable after 45 minutes of continuous care when a call-out charge is applicable. If a call-out charge is not applicable then the first continuing care surcharge is payable after 15 minutes of continuous care as long as the anesthetic service is rendered within the designated times. Applicable also, without the 30 minute time lapse and with timing continuing, to immediately subsequent patients seen on the same call-out, under the following conditions: i) as an emergency ii) to provide subsequent resuscitative care under fee code 01088. iii) to provide labour epidural insertion under fee code 01102. Surcharges do not apply to time spent standing by unless code 01112 is payable and are based on the amount of time providing care, regardless of the number of patients attended or services provided.		
01215	Evening (service rendered between 1800 hours and 2300 hours) - per half hour or major part thereof	334.00	72.69
01216	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	457.00	99.40
01217	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof.....	334.00	72.69
	NOTES: i) Claim must state start and end times. ii) Where timing is continuous submit an account for each patient, indicating "CCFPP" (continuing care from previous patient).		

(notes continued on next page)

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

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).

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

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

GENERAL SERVICES

These fees cannot be correctly interpreted without reference to the Preamble.
No additional visit fee should be charged unless extra service is rendered.

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 ($)	Anes. Lev.	MSP & WSBC Fee ($)
B00010	Intramuscular injections, including immunizations for patients 19 years or older	30.15		16.61
	NOTES: i) Payable per injection. ii) Up to 3 injections per patient on the same date of service are billable at 100%. iii) When performed in conjunction with a visit, the injection is included in the visit fee. iv) Not payable for immunizations required for travel, employment, and emigration. v) Not payable on the same day as 10010-10029.			
B00034	Subcutaneous injections, including desensitization treatments and immunizations for patients 19 years or older.....	30.15		16.61
	NOTES: i) Payable per injection. ii) Up to 3 injections per patient on the same date of service are billable at 100%. iii) When performed in conjunction with a visit, the injection is included in the visit fee. iv) Not payable for immunizations required for travel, employment, and emigration. v) Not payable on the same day as 10010-10029.			
B00011	Intravenous medications.....	35.95		16.61
	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	16.35		6.76

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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 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 00012 is billed with another service, such as an office visit, 00012 may be billed at 100%.			
B00013	Intra-arterial medications	52.10		17.65
Y00014	Intra-articular medications by injection - hip	77.60		28.98
	NOTES: i) For the initial injection, this fee code is payable at 100% in addition to a consultation or visit. ii) One injection per hip is payable at 100% on the same date of service. iii) For subsequent injections within 30 days, only the injection fee is payable. iv) For subsequent injections within 30 days, if the visit and injection(s) are for unrelated conditions, the visit is payable at 100% and the injection(s) at 50%. v) For subsequent injections beyond 30 days, both a subsequent visit fee and the injection(s)) are payable at 100%.			
Y00015	Intra-articular medications by injection - tendons, bursae and all other joints	52.20		19.27
	NOTES: i) For the initial injection, this fee code is payable at 100% in addition to a consultation or visit. ii) One injection per site up to a maximum of 3 injections are payable at 100% on the same date of service.			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) For subsequent injections within 30 days, only the injection fee is payable.			
	iv) For subsequent injections within 30 days, if the visit and injection(s) are for unrelated conditions, the visit is payable at 100% and injection(s) at 50%.			
	v) For subsequent injections beyond 30 days, both a subsequent visit fee and the injection(s) are payable at 100%.			
00016	Intrathecal medications by injection	153.00		37.87
00024	Vein dissection for intravenous therapy (Not paid in the immediate pre and post-operative phase of surgery)....	150.00		39.70
00019	Venesection for polycythaemia or phlebotomy – procedural fee	102.00		35.73
00018	Autologous ascitic infusion.....	238.00		52.61
00017	Insertion of central venous pressure catheter	116.00		26.63
B00030	Diagnostic skin tests Schick, Dick, TB., and Frei.).....	29.55		10.07

BLOOD TRANSFUSIONS

00020	Administered outside hospital	191.00		71.48
00021	Administered in hospital.....	174.00		40.79
00022	Serum transfusion.....	75.20		28.47
00023	With vein dissection - additional.....	241.00		59.08
	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.			

DIALYSIS FEES

(A) Acute Renal Failure

a) Hemodialysis:

33750	Blood dialysis - physician in charge	2470.00		543.29

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33751	Repeat blood dialysis - physician in charge.....	940.00		204.17
	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	624.00		137.35
	b) Peritoneal Dialysis:			
00308	Subsequent hospital visits (Preamble Clause B.4.e.ii) .	107.00		52.82
33756	Re-insertion of peritoneal catheter after 10 days from initial insertion.....	250.00		53.40
	NOTE: Item 00081 not to be charged in addition to Item 33723. Where an initial peritoneal dialysis is performed and for various reasons, hemodialysis initiated within next forty-eight (48) hours, the subsequent service should be charged under fee item 33758 plus fee item 33756 for the insertion of catheter.			
	(B) Chronic Renal Failure:			
	a) Hemodialysis:			
33758	Performance of hemodialysis - fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis for each dialysis	250.00		53.40
	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:			
77380	Insertion of permanent catheter, procedural fee only ..	646.00	3	194.99
33723	Performance of initial peritoneal dialysis, chronic or acute renal failure to include consultation and two (2) weeks care	1845.00		406.46

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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	250.00		53.40
	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.			
	Home Dialysis			
33761	Supervision of home dialysis - per week.....	307.00		64.56
	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.			

GYNECOLOGY

14541	Removal of intrauterine device (IUD) – operation only .	95.60		34.31
	NOTES: i) Not payable in addition to 14540 or 14560. ii) Not billable by Family Physicians			
14560	Pelvic examination	101.00		34.34
	NOTES: i) Includes cervical cancer screening, if clinically indicated. ii) Not billable by Family Physicians.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
IMMUNIZATIONS				
B00010	Intramuscular injections, including immunizations for patients 19 years or older NOTES: iii) Payable per injection. iv) Up to 3 injections per patient on the same date of service are billable at 100%. v) When performed in conjunction with a visit, the injection is included in the visit fee. vi) Not payable for immunizations required for travel, employment, and emigration. vii) Not payable on the same day as 10010-10029.	30.15		16.61
B00034	Subcutaneous injections, including desensitization treatments and immunizations for patients 19 years or older NOTES: i) Payable per injection. ii) Up to 3 injections per patient on the same date of service are billable at 100%. iii) When performed in conjunction with a visit, the injection is included in the visit fee. iv) Not payable for immunizations required for travel, employment, and emigration. v) Not payable on the same day as 10010-10029.	30.15		16.61
10040	Respiratory immunization for patients 19 years of age or older (with visit) NOTES: i) Payable for Influenza (using ICD-9 code V048) and Pneumococcal (using ICD-9 code V05), pertussis (using ICD-9 code V036), and COVID-19 (using ICD-9 code C19) immunizations. ii) Payable in full with an office visit. iii) If the primary purpose of the service is for immunization, bill fee item 10041.	16.45		6.54
B10041	Respiratory immunization for patients 19 years of age or older (without visit)	43.30		16.67

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Payable for Influenza (using ICD-9 code V048), pneumococcal (using ICD-9 code V05), pertussis using (ICD-9 code V036), and COVID-19 (using ICD-9 code C19) immunizations when the primary purpose of the service is for immunization. ii) Not payable with an office visit.			

IMMUNIZATIONS FOR PATIENTS 18 YEARS OF AGE OR YOUNGER

NOTES:
i) Payable per immunization.
ii) Payable in full with an office visit to a maximum of 4 immunizations per patient per day.
iii) Not payable on the same day as B00010, B00034.
iv) Not payable for immunizations required for travel, employment and emigration.

10047	Pediatric COVID-19 immunization NOTES: i) Payable for COVID-19 immunization (ICD-9 code C19 must be entered on claim). ii) Payable in full with an office visit. iii) Not payable on the same day with B00010, B00034.	16.45		
10010	DTaP-IPV (Diphtheria, Tetanus, Pertussis, Polio)	16.45		6.54
10011	DTaP-IPV-Hib (Diphtheria, Tetanus, Pertussis, Polio, Hib)……...	16.45		6.54
	NOTE: Not payable with 10010 or 10018 on the same day, same patient			
10012	Td (Tetanus, Diphtheria)…….	16.45		6.54
10013	Td/IPV (Tetanus, Diphtheria, Polio)	16.45		6.54
	NOTE: Not payable with 10012 or 10019 on the same day, same patient			
10014	TdaP (Tetanus, Diphtheria, Pertussis)……..	16.45		6.54
	NOTE: Not payable with 10013 on the same day, same patient			
10015	Influenza (Flu)……...	16.45		6.54
10016	Hepatitis A……	16.45		6.54
10017	Hepatitis B……	16.45		6.54
10018	Haemophilus influenza type b (Hib)……..	16.45		6.54
	NOTE: Not payable with 10011 on the same day, same patient			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10019	Polio (IPV)…….. ..... NOTE: Not payable with 10010, 10011 or 10013 on the same day, same patient	16.45		6.54
10020	Meningococcal C Conjugate (MEN-C)…….	16.45		6.54
10021	Meningococcal Quadrivalent Conjugate (Groups A, C, Y, W-135)	16.45		6.54
10022	MMR (Measles, Mumps, Rubella)…….	16.45		6.54
10030	MMR/V (Measles, Mumps, Rubella and Varicella)	16.45		6.54
10023	Pneumococcal Conjugate	16.45		6.54
10024	Pneumococcal Polysaccharide (PPV23)	16.45		6.54
10025	Rabies……	16.45		6.54
10026	Varicella (Chickenpox).....	16.45		6.54
10027	DTap-HB-IPV-Hib (Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib)..... NOTE: Not billable with fee items 10010, 10011. 10012, 10013, 10014, 10017, 10018	16.45		6.54
10028	HPV (Human Papillomavirus)	16.45		6.54
10029	Rotavirus	16.45		6.54

COVID-19

10046	Assessment for COVID-19 Therapeutics: This fee is payable for patient care related to COVID-19 treatment, including patient assessment, prescribing of COVID-19 therapeutics, completion of relevant documentation and forms, and arranging for treatment. May be provided either in-person and/or by telehealth – per 15 minutes or greater portion thereof	109.00		50.37

NOTES:

i) Payable to a maximum of 60 minutes (4 units) per patient/per day.

ii) Start and end times of the assessment must be entered both the billing claim and the patient's chart.

iii) Payable in addition to any visit or consult fee on the same day if medically required, provided the visit does not take place during a time interval that overlaps. Start and end times of the visit must be entered in the billing claim and the patient's chart.

iv) Other services such as patient management and conference fees are payable in addition on the same day by the same physician, provided it does not take place during a time interval that overlaps. Start and end times of the other service must be entered in the billing claim and the patient's chart.

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

SUBSTANCE USE DISORDER CARE

13013 Assessment for Substance Use Disorder or OAT Induction
Includes complete medical history, including substance use history, and an appropriate targeted physician examination. In the case of Opioid Agonist Treatment (OAT) induction, if assessment and induction are done on the same day, withdrawal assessment using appropriate clinical scales and administration of first dose of OAT are included – per 15 minutes or greater portion thereof 151.00 50.35

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

13014 Management of OAT induction for Opioid Use Disorder. This fee is payable for individual interactions with the patient during the first three days of OAT induction for opioid use disorder within the limits described in the following notes 55.20 23.32

NOTES:
i) Billable in addition to 13013 or a same day visit fee (in-person, telephone or video conference) with a physician when not performed concurrently.
ii) Billable up to 3 times on day of first dose of OAT.
iii) Billable up to 2 times on day 2 of OAT induction

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iv) Billable once only on day 3 of OAT induction. v) May be provided in-person, by telephone or by video conference. vi) May be billed when delegated to a nurse (LPN, RN, NP) employed within the eligible physician practice. vii) Start time must be entered in both the billing claim and patient's chart.			
P13023	Management of Substance Use Disorder A monthly fee payable to the physician responsible for the continuous management of a patient's substance use disorder, other than opioid use disorder. Applicable only to patients with a documented diagnosis of substance use disorder.....	82.30		26.20
	NOTES: i) Payable only to the physician or physicians responsible for the provision of continuous care management of the patient's substance use disorder. ii) Applicable only to patients with a confirmed diagnosis of substance use disorder, the effects of which are significant enough to require active monitoring and management. iii) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid. iv) First payable after 30 days of care, including at least one physician visit service (office, telephone, video, home, facility visits). If the required physician visit was provided by a physician associated with a different payee number, a note record is required with this explanation. v) This fee is payable once every 31 days per patient. vi) The physician must have at least one visit service (office, telephone, video, home, facility visits) with the patient every 90 days. vii) Visit services are payable in addition. viii) Payable monthly as long as the patient requires ongoing management of their substance use disorder. ix) Claim must include ICD-9 code specific to the substance use disorder.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
P13024	Outpatient Management of Alcohol Withdrawal Applicable only to patients with a documented diagnosis of alcohol use disorder.....	82.30		26.20
	NOTES: i) Payable only to the physician or physicians responsible for the provision of outpatient management of alcohol withdrawal. ii) Payable in addition to 13013 or a same day visit fee (in-person, telephone or video). iii) Payable once daily for up to 5 consecutive days, per patient, beginning on the day of the first dose of medication. iv) May be provided in-person, by telephone, or by video. v) May be delegated to a nurse (LPN, RN, NP) employed within the eligible physician practice.			
00039	Management of Opioid Use Disorder. A weekly fee payable to the physician responsible for the continuous management of a patient's opioid use disorder. Applicable only to patients with a documented diagnosis of opioid use disorder.....	82.30		26.75
	NOTES: i) Payable only to the physician or physicians responsible for the provision of continuous care management of the patient's opioid use disorder. ii) Applicable only to patients with a confirmed diagnosis of opioid use disorder, the effects of which are significant enough to require active monitoring and management. iii) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid. iv) This fee is payable once per week per patient regardless of the number of services per week for management of the patient's opioid use disorder. v) First payable after one full week of care, including at least one physician visit service (office, telephone, video, home, facility visits). vi) The physician must have at least one visit service (office, telephone, video, home, facility visits) with the patient every 90 days. vii) Visit services are payable in addition. viii) Payable weekly as long as the patient requires ongoing management of their opioid use disorder.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
15039	Point of Care (POC) testing for oral opioid agonist treatment ..... NOTES: i) Restricted to patients in opioid agonist treatment. ii) Maximum billable: 26 per annum, per patient. iii) Confirmatory testing (reanalyzing a specimen which is positive on the initial POC test using a different analytic method) is expensive and seldom necessary once a patient is in treatment for opioid use disorder. Accordingly, confirmatory testing should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management. iv) This fee includes the adulteration test. v) Only POC urine testing kits that have met Health Canada Standards are to be used.	38.80		15.11
15040	Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone. ..... NOTES: i) Not billable for patients in opioid agonist treatment. i) 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. ii) This fee includes the adulteration test. iii) Only POC urine testing kits that have met Health Canada Standards are to be used.	38.80		15.11
00040	Stomach lavage and gavage	100.00		26.98
00042	Mileage, per kilometer one way (in the country beginning 8 kilometers from town centre, in the city from the boundary of the city) ..... NOTE: To be billed only in unusual emergencies; submit explanation with claim.	4.15		1.77
00043	Anticoagulation therapy by telephone.....	32.35		10.08

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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	334.00	7	83.68
00026	each additional 15 minutes	173.00		42.98
00027	physician outside chamber - 1st half hour	231.00	5	56.99
00028	each additional 15 minutes	123.00		30.26
00046	Additional charge to pertinent medical, anesthetic or surgical fee, per hour	135.00		29.09
EYE BANK SERVICES				
00050	Enucleation of eye(s) for corneal transplants	634.00		146.37
	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	1989.00		396.50
	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.			
CERTIFICATES AND FORMS				
00062	Initial "in-care" or adoption examination of a well baby or child (with report) - fee for each doctor	202.00		88.13
00064	Subsequent "in-care" or adoption examination by same doctor within six (6) months	94.00		39.64
00065	Investigation, with completion of B.C. Mental health Act Forms 3, 4.1, 4.2 or 6 (fee per doctor)	271.00		117.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
00066	Completion of B.C. Mental Health Act Forms 3, 4.1, 4.2 or 6, on previously assessed or treated cases.....	120.00		53.00
00067	Investigation with cancellation of B.C. Mental health Act Forms 4.1, 4.2 or 6, and subsequent voluntary treatment status.....	120.00		52.87
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		
96503	Medical Practitioners completion of MHR Medical Report – Persons with Persistent Multiple Barriers.....	50.00		
	Note: 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		
	Note: Includes full completion of part C 1-4 medical assessment in the detail prescribed by report format			
96505	MHR medical report – child	25.00		
	NOTE: Submit claims for 96400, 96501, 96502, 96503, 96504 and 96505 to MSP. Do not bill privately			

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 <u>not</u> be reimbursed by RoadSafetyBC for any charges they incur.

ROADSAFETYBC FORM FEES

		Non-MSP-Insured Fee ($)	Road Safety BC Fee ($)
96220	RoadSafetyBC Driver's Medical Examination Report (DMER) for any driver with a known or possible medical condition.....	258.00	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.

		Non-MSP-Insured Fee ($)	Road Safety BC Fee ($)
96221	RoadSafetyBC Diabetic Driver Report - standalone (no DMER): Diabetic Driver Report for commercial drivers with diabetes (known medical condition) ..... 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.	258.00	75.00
96222	RoadSafetyBC Diabetic Driver Report - sent out with DMER: Diabetic Driver Report for commercial drivers with diabetes (known medical condition)..... 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.	64.50	30.00

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

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.

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,

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.			
	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 ½ hour or major portion thereof NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	379.00		119.97
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary) – per ½ hour or major portion thereof ..... NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	188.00		71.88
	Crisis Intervention			
00083	Personal or family crisis intervention: Applies to situations where the attending physician is called upon to provide continuous medical assistance at the exclusion of all other services in periods of personal or family crisis caused by rape, sudden bereavement, suicidal behaviour or acute psychosis – per ½ hour or major portion thereof.....	379.00		119.82

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.....	581.00		250.72
	NOTES: 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. i) Time for standing by and return trip are included and may not be billed in addition. ii) 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. iii) Start and end times must be entered in both the billing claims and the patient's chart.			
	Trauma – General Services: These fees are intended for the Trauma Team Leader (TTL) within the facility (or facilities) that a trauma patient may arrive at, requiring treatment. Trauma Team Leader Assessment and Support fees (10087, 10088, and 10089) will be paid for services to patients demonstrating any one of the following criteria:			

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

Trauma team Activation Criteria:

i) Shock – confirmed Blood Pressure ≤ 90 at any time in adults.
ii) Airway Compromise including intubations.
iii) Transfer patients from other Emergency Departments receiving blood to maintain vital signs.
iv) Unresponsiveness – Glasgow Coma Score ≤ 8 with a mechanism suggestive of injury.
v) Gunshot or other penetrating wounds to head, neck, chest, abdomen or proximal extremity (at or above knee or elbow).
vi) Autolaunched Trauma Patient.
vii) Pediatric Trauma Patient under 16 years of age.
viii) Special consideration will be given for patients with significant 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
vii) - Partial thickness (2º) burn ≥ 10% and full thickness (3º) 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.

(notes continued on next page)

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

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
- 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

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	- 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	1659.00		308.71
	NOTES: i) Restricted to General Surgeons ii) Indicated for those patients experiencing any of the Trauma Team Activation Criteria. iii) Minimum of 2 hours of bedside care required on Day 1 (excluding stand by time). iv) Start and end times must be entered in both the billing claims and the patient's chart. v) Payable in addition to the adult and pediatric critical care fees at 100%. vi) Not paid with any consult, visit or emergency care fees, by the same practitioner on the same date of service. vii) Paid to only one physician for one patient, per facility, per day.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10088	Trauma Team Leader – Tertiary Assessment (after 24 hrs. and before 72 hrs.) 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.	573.00		106.35
10089	Trauma Team Leader Subsequent Hospital Visit (Days 3-15 inclusive) 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.	435.00		80.50

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

PERCUTANEOUS RADIOFREQUENCY NEUROTOMIES

NOTES:
i) Must be performed under medical imaging guidance (fluoroscopy or CT) with image capture.
ii) Must be performed by qualified physicians working in approved facilities.
iii) If neurotomies are performed in more than one anatomical region, the first branch in the second anatomical region will be paid at 50%.
iv) Limit of 6 branches in total for all anatomical regions when performed on the same day. Claims received over this limit will be given independent consideration upon receipt of an explanatory note record.
v) Maximum of 6 branches in total for any one region in any 6-month period. Claims received over this limit will be given independent consideration upon receipt of an explanatory note record.
vi) Includes anesthesia, sedation, or blocks if performed by the same physician.

	Cervical:			
P34101	– first branch	627.00		245.43
P34102	– second branch	314.00		122.72
P34103	– third to sixth branch (per branch)	157.00		61.36
	Thoracic:			
P34104	– first branch	523.00		204.53
P34105	– second branch	262.00		102.26
P34106	– third to sixth branch (per branch)	131.00		51.14
	Lumbar:			
P34107	– first branch	523.00		204.53
P34108	– second branch	262.00		102.26
P34109	– third to sixth branch (per branch)	131.00		51.14
	Sacral:			
P34110	– unilateral	864.00		337.47
P34111	– bilateral	1438.00		562.45

TRAY SERVICE FEE

00044	Mini Tray Fee	13.90		7.12

NOTE: 00044 is applicable to fee items 00190, 00217, S00744, 04681, 13640, 14560 and 14562 only.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
00080	Minor Tray Fee ..... The use of sterile tray suitable for cautery, cryotherapy, dilation or similar procedure.	28.30		14.24
00090	Major Tray Fee ..... 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 Doctors of BC Tariff Committee. iii) Tray fees are not applicable when the service is performed at a funded facility (e.g.: hospital, D&T Centre, Psychiatric Institution, etc.). iv) Applicable to 04111 only when rendered in private (non-funded) facilities. Not applicable when rendered in hospital or other publicly-funded facilities.	85.00		42.70

PROCEDURES ELIGIBLE FOR TRAY FEE SERVICE

Procedures Eligible for Major Tray Fee Service:

S00571 Pediatric Esophagogastroduodenoscopy in a patient 16 years of age and under
S00701 Direct laryngoscopy - procedural fee
S00704 Cystoscopy dilation and Panendoscopy
S00707 Esophagogastroduodenoscopy - 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
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 Nasopharnyx
SY00908 Endoscopic examination of the Nose and Nasopharnyx 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
S02322 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
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 marsupialization (operation only)
04312 Resection of labia minora
04317 Biopsy vulva, lesion <2 cm
04330 I&D of Bartholin's cyst with insertion of Word catheter (operation only)
04405 Removal of a vaginal cyst situated above the introitus (operation only)
04406 Operation for removal of vaginal septum
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)
06027 Repair of torn (split) earlobe (simple)
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
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
06182 Ganglia of tendon sheath or joint
06186 Tenoplasty
06187 Tenoplasty - 2 or more tendons
06188 Tenolysis
06193 Palmar fasciectomy more than one digit
06197 Tenosynovitis - finger
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
Y08206	Intravesical treatment instillation
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
SY10750	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
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)
13631	Removal of nail – simple (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
14542	Insertion of subdermal contraceptive implant
14543	Removal of subdermal contraceptive implant

20221	Single or multiple flaps under 2 cm in diameter used in repair of defect (except for special areas as in P20225) (operation only)
20222	Local tissue shifts - Single
20223	Local tissue shifts - Multiple
20224	Local tissue shifts - with free skin graft to secondary defect
20225	Local tissue shifts - Eyebrow, eyelid, lip, ear, nose - single
20226	Full-thickness grafts - Eyelid, nose, lips, ear
20227	Full-thickness grafts - Finger, more than one phalanx
20228	Full-thickness grafts - Sole or palm
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only
S33373	Colonoscopy with flexible colonoscope - biopsy
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)
S61250	Autologous Lipotransfer – Aspiration – Volume less than 20 ml
S61251	Autologous Lipotransfer – Aspiration – Volume between 21-60 ml
S61252	Autologous Lipotransfer – Aspiration – Volume greater than 60 ml
S61300	Wounds - Simple, or involving minor debridement of traumatic wounds - up to 5 cm - other than face, simple closure (operation only)
S61301	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)
S61302	Wounds - Simple, or involving minor debridement of traumatic wounds - 5.1 to 10 cm - other than face, simple closure (operation only)
S61303	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)
S61310	Trunk, Arms and Legs - Resulting in repair less than 5 cm (operation only)
S61311	Trunk, Arms and Legs - Resulting in a repair 5-10 cm (operation only)
S61313	Face, scalp, neck, genitalia, hands, feet, axilla - Resulting in repair less than 5 cm (operation only)
S61314	Face, scalp, neck, genitalia, hands, feet, axilla - Resulting in a repair 5-10 cm (operation only)
S61316	Eyelids, ears, lips, nose, mucous membrane, eyebrow - Resulting in repair less than 2 cm (operation only)
S61317	Eyelids, ears, lips, nose, mucous membrane, eyebrow - Resulting in a repair 2-4 cm (operation only)
S61318	Eyelids, ears, lips, nose, mucous membrane, eyebrow -Resulting in a repair greater than 4 cm (operation only)
61324	Defect up to 2 cm - Nose, Lids, Lips or Scalp (operation only)

S61325 Defect 2.1 to 5 cm - Nose, Lids, Lips or Scalp (operation only)
S61326 Defect 2.1 to 5 cm -other areas (operation only)
S61327 Defect 5.1 to 10 cm - Nose, Lids, Lips or Scalp
S61328 Defect 5.1 to 10 cm - other areas
61329 Defects more than 10 cm (such as a thoracic abdominal flap)
61330 Trunk - Defect up to 40 cm^2
61331 Trunk - Defect 40 cm^2 to 100 cm^2
61332 Trunk - Defect greater than 100 cm^2
S61333 Arms, legs and scalp - Defect up to 6 cm^2
61334 Arms, legs and scalp - Defect 6 cm^2 to 19 cm^2
61335 Arms, legs and scalp - Defect greater than 19 cm^2
S61336 Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck - Defect up to 6 cm^2
S61337 Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck - Defect 6 cm2 to 19 cm^2
61338 Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck - Defect greater than 19 cm^2
S61339 Ears, eyelids, lips and nose - Defect up to 6 cm^2
S61340 Ears, eyelids, lips and nose - Defect 6 cm^2 to 19 cm^2
S61341 Ears, eyelids, lips and nose - Defect greater than 19 cm^2
61342 Revision of Graft - Revision, less than 2 cm
61343 Revision of Graft -Revision, between 2 and 5 cm
61344 Revision of Graft - Revision, greater than 5 cm
61350 Full-thickness graft - Trunk (2 to 19 cm^2) (operation only)
61351 Full-thickness graft - Arms, legs, scalp (2 to 19 cm^2)
61352 Full-thickness graft - Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm^2)
61353 Full-thickness graft - Ears, eyelids, lips and nose (2 to 19 cm^2)
S61354 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)
61360 Eyebrow ptosis repair – simple skin excision – non-cosmetic - unilateral
61361 Eyebrow ptosis repair – simple skin excision – non-cosmetic - bilateral
61368 Extensor - primary or secondary repair - first tendon
70041 Fine needle aspiration of solid or cystic lesion
V70116 Removal of tumour (including intraoral) or scar revision - 2 to 5 cm (operation only)
V70117 Removal of tumour (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 flaps for lesion greater than 2 cm
V70123 Multiple flaps 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
S71281 Removal of indwelling enteral tubes with or without exploration of tube insertion site: - requiring local or regional anesthesia (operation only)
SV71682 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 Electrodessication 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
77142 Removal of totally implantable access device (e.g.: portacath), operation only

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
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
04682 Initial Pessary Fitting
04683 Pessary Maintenance
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
Y08339 Intracavernosal penile injection for test dosing
13605 Abscess, superficial opening, including furuncle
13610 Laceration or foreign body, minor (not requiring anesthesia)
13630 Paronychia
20231 Biopsy, not sutured
20232 Biopsy, not sutured, multiples same sitting, maximum of four (extra)
61291 Biopsy, not sutured
70469 Breast biopsy - needle core
70674 Destruction of anal lesion, anus fulguration and condylomata
S71280 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
04681 Vaginal Speculum Examination Procedure (extra)
13640 Add-on Procedure (extra)
14560 Routine pelvic examination including Papanicolaou smear
14562 Office Vaginal Speculum Exam (extra)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Individual Tray Fee Items:			
00094	YAG laser tray service fee	199.00		71.58

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.

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES

These listings 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 ($)	Anes. Lev.	MSP & WSBC Fee ($)
(A) DIAGNOSTIC PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION				
S00700	Bronchoscopy or bronchofibroscopy - procedural fee	348.00	4	138.87
S00702	Bronchoscopy with biopsy - procedural fee	641.00	4	218.67
10700	Endobronchial cautery - extra 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	233.00	6	80.08
10702	Endobronchial cryotherapy - extra NOTES: To a maximum of 3 lesions Second and third lesion payable at 50% Payable only with S00700 or S00702 and 10700, 10703, S00736 Not paid with 10739, 02450 and 02422	233.00	6	80.08
10703	Transbronchial Needle Aspiration (TBNA) NOTES: i) To a maximum of 3 separate stations or lesions ii) Second and third station or lesion payable at 100% iii) Payable with S00700, S00702 or 10739 and 10700, 10702, S00736 iv) Paid at 100% with other diagnostic procedures.	183.00	6	72.47
S00719	Thoracoscopy	862.00	7	351.12
S00701	Direct laryngoscopy - procedural fee	169.00	5	73.82

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) 00701 is not payable with 00907, 00908 and 00909. ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.			
S00717	Microlaryngoscopy - procedural fee.....	333.00	5	147.62
	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	147.00	3	33.81
SY00908	– procedure and biopsy.....	238.00	3	54.09
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy.....	186.00	3	45.30
	NOTES: i) 00909 is not payable with 00700, 00701, 00702, 00907 and 00908. ii) Payable only to certified Otolaryngologists.			
S00704	Cystoscopy to include dilation and panendoscopy - procedural fee	418.00	2	97.53
S00705	Cystoscopy with catheterization of ureters (with kidney function test and injection of solution for pyelogram) to include dilation and panendoscopy - procedural fee	448.00	2	153.40
	Upper Gastrointestinal System			
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	476.00	3	119.27
	NOTE: Not payable with 33341.			
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing - procedural fee	397.00	3	120.07
	NOTE: Not payable with 33341.			
S10763	Initial esophageal, gastric or duodenal biopsy.....	61.30	3	15.15
	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	237.00	3	44.56

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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 NOTE: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.	476.00		119.27
10708	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.	1159.00		262.44
	Lower Gastrointestinal System			
SY00715	Sigmoidoscopy with biopsy - procedural fee	174.00	2	38.83
SY10714	Proctosigmoidoscopy, rigid - diagnostic	169.00	2	36.20
SY00716	Sigmoidoscopy, flexible - diagnostic	352.00	2	77.81
SY00718	– with biopsy	404.00	2	79.09
S10730	Colonoscopy, flexible, via colostomy - single or multiple	1181.00	4	234.43
S10731	Colonoscopy, flexible, proximal to splenic flexure - diagnostic, with or without collection of specimen(s) by brushing or washing	1181.00	2	234.35
S10732	– with removal of foreign body	1336.00	2	278.22
S10733	– with control of bleeding, any method	1497.00	2	310.87
	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	512.00	4	208.31

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

(B) (I) 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	373.00		127.71
S00721	Myelogram - procedural fee	135.00	2	46.58
S00723	Sialogram (per duct) or galactograms (per blast) - procedure fee for injection	127.00	2	51.50
S00724	Presacral air insufflation - procedural fee	127.00	2	41.30
S00727	Salpingogram - procedural fee	211.00	2	82.17
S00730	Catheterization of bronchi for bronchogram - procedural fee NOTE: When performed in conjunction with a bronchoscopy (S00700) both fees are to be paid in full.	87.90	4	28.96
S00732	Voiding cystourethrogram - procedural fee NOTE: When done in conjunction with 08599	51.50	2	20.81
S00733	Venogram, intraosseous or intravenous - procedural fee	198.00	2	62.82
S00734	Lymphangiography or lymphography NOTE: Only payable with imaging capture such as x-ray, fluoroscopy and MRI.	437.00		138.06
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee (extra)	348.00	4	69.68
10739	Endobronchial Ultrasound (EBUS) NOTES: i) Not payable with S00700, S00702, 02450, 10700 or 10702. ii) Fee item 10703 an S00736 payable in addition	1157.00	6	399.81
S00743	Localizing of non-palpable breast lesion	315.00	2	132.33
S00811	Joint injection, aspiration or arthrogram, under radiological guidance - procedural fee 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.	140.00	2	56.19
S00826	Biopsy of pancreas - percutaneous	470.00	2	103.74
S00857	Percutaneous transhepatic cholangiogram - included in fee item S00980.	313.00	2	119.68

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	1258.00	2	291.74
10735	Rectal endoscopy utilizing ultrasound (radial/linear). Note: Includes mucosal biopsy	694.00		157.47
10740	Upper GI endoscopy utilizing radial ultrasound	1159.00		262.44
10741	Upper GI endoscopy utilizing linear ultrasound NOTES: i) 10740 and 10741 are payable only when done in publicly funded acute care facilities. ii) 10741 payable at 50% when done subsequent to 10740 (same patient/same day)	1159.00		262.44
10742	Upper GI endoscopy utilizing radial/linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 per lesion. NOTES: i) Payable with 10740 or 10741 only. ii) First biopsy paid at 100%. Second and third biopsies payable at 50%	232.00		52.49
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 10740 or 10741 only.	694.00		157.47
10744	Upper GI endoscopy utilizing radial/linear ultrasound – with drainage of pseudocyst (including stent insertion if performed) – extra NOTE: Payable with 10740 or 10741 only.	927.00		209.97

(B) (II) THERAPEUTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

S00738	Removal of biliary calculi by Burhenne technique	621.00	4	217.21
S00746	Reduction of intussusception using hydrostatic pressure, procedural fee NOTE: Fee item 08576 is payable in addition, when performed.	292.00	4	102.76
S00921	Varicocele and/or uterine artery embolization - unilateral	1273.00	3	490.15
S00925	Varicocele and/or uterine artery embolization - bilateral	1774.00	3	711.07

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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)	293.00	2	111.97
S00978	Percutaneous nephrostomy - procedural fee	784.00	2	317.46
S00979	Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation - procedural fee	1046.00	2	423.19
S00980	Transhepatic biliary drainage procedure (includes fee item S00857)	1108.00	3	448.48
S00981	Therapeutic radiological embolization	1108.00	3	448.48
S00982	Percutaneous transluminal angioplasty	1057.00	2	427.50
	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	722.00	2	292.00
S00984	Exchange of previously inserted catheter or tract dilatation for percutaneous biliary or renal drainage	349.00	2	133.75
S00989	Extra-corporeal shockwave lithotripsy	542.00	4	144.05
S00994	Extra-corporeal shockwave biliary lithotripsy - procedure only	519.00	4	176.17
	NOTES: i) 00994 generally is applicable to common bile duct stones, only. ii) 00994 is applicable to stones in the gall bladder only where cholecystectomy is contraindicated because of the medical condition of the patient. For other cases, Clause C. 6. of the Preamble applies. iii) Not payable with 33342 or 33345.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10320	Insertion of permanent pleural drainage catheter	655.00	5	242.68
	NOTES: i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter. Not paid with 32031, 00749, 07924 and 08646			
10321	Removal of permanent pleural drainage catheter.....	347.00	2	86.51
	NOTE: Not paid with 32031, 00749, 07924 and 08646.			
S00995	Embolization of brain and spinal cord AVM's.....	6144.00	3	2212.12
	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.....	4224.00	3	1383.23
	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	5211.00	3	1705.91
	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 ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.			
10900	Abdominal aortic aneurysm repair using endovascular stent graft – second operator	2871.00		521.36
	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.			
10901	Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery.....	1741.00	2	621.60
	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.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
P10902	Complex peripherally inserted image-guided central venous catheter line (PICC) NOTES: i) Restricted to Radiologists. ii) Not applicable if performed via other than peripheral access as required for complex PICC placements. iii) Includes placement, venogram/angiogram, and all medically required image guidance. iv) May not be delegated.	340.00	2	136.07
P10323	Simple peripherally inserted image-guided central venous catheter line (PICC) NOTES: i) Not applicable if performed via other than peripheral access. ii) Includes placement and medically required ultrasound image guidance. iii) May not be delegated.	213.00		84.36
10903	Percutaneous hemodialysis graft thrombolysis NOTES: i) Includes declotting and treatment of underlying cause of access failure. ii) Includes angioplasty and all necessary imaging and intervention	1741.00	2	621.60
10904	Percutaneous transcatheter arterial chemo-embolization (TACE) NOTES: i) Fee is per session/sitting regardless of number of lesions treated. ii) Includes all associated imaging necessary to complete procedure.	1741.00	3	621.60
10905	Cerebral intra-arterial thrombolysis 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.	3965.00	5	1383.23
10906	Image-guided percutaneous vertebroplasty – first level	1157.00	4	384.81

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10907	– each additional level (to a maximum of 3).....	271.00	4	88.82
	NOTES: i) Payable only when rendered on in-patient or day-care basis in acute care facility. ii) Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating. iii) Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure.			
10908	Percutaneous image-guided tumour ablation – first lesion.....	1741.00	3	558.91
	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.			
10909	Percutaneous intravascular/intracorporeal medical device/foreign body removal.....	1157.00	3	414.41
	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).....	1157.00	2	414.41
	NOTES: i) Hysterosalpingogram not payable in conjunction with the procedure. ii) Paid at 2/3 of the fee if unilateral.			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	1157.00	2	414.41
	NOTES: i) Ultrasound guidance, venous puncture, central access catheter are included in the fee. ii) Payable only for uncorrectable coagulopathy. iii) The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day. iv) If repeated within 6 months, payable at 50%.			
10913	Cerebral arterial balloon occlusion tolerance test	2082.00	5	842.15
	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	2675.00	9	1082.41
	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;			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.			
10915	Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique.....	5203.00	7	2105.39
	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.			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.			
10916	Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations - up to 4 hours procedural time	3747.00	5	1238.45
10917	– after 4 hours (extra to 10916)	769.00		309.63
	NOTES: i) Includes injection of six or more intracranial or extracranial vessels in the head, neck and/or spine, or if procedure requires use of microcatheters, injection of four or more vessels. ii) Start and end times must be entered in both the billing claims and the patient's chart. iii) This listing is not payable when performed concurrently with other interventional radiology procedures. iv) Subsequent consecutive interventional radiology procedures are payable at a) 50% if performed by same operator; b) 100% if performed by different operator.			
10918	Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance	1224.00	6	495.40
	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	373.00		136.59

(see notes on next page)

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

NOTES:
i) Includes all diagnostic imaging associated with stent placement.
ii) Payable once only when contiguous vessels are stented and/or where more than one stent is used per site.
iii) For non-Vascular surgery placement of second stent in a different site is payable at 50%.
iv) When 10919 is combined with another vascular surgery, multiple stents will be paid on anatomical named vessels as follows: 100% for the first and 50% for the second, to a maximum of 2 stents.
v) When 10919 is performed with 77113 or 77114 as an isolated endovascular procedure, multiple stents will be paid on anatomical named vessels as follows: 100% for the first, 50% for the second and 25% for the third, to a maximum of 3 stents.
vi) Procedures repeated within 30 days are payable at 50%.
vii) Not payable for Coronary stent placement.
viii) When done with 77177 (EVAR), payable to either the primary or the second operator

When performed with percutaneous angioplasty for the following anatomical named vessels

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

Lower extremity vessels
Anterior tibial artery
Posterior tibial artery
Peroneal artery
Tibioperoneal trunk
Right common femoral artery
Right superficial femoral artery
Right profunda femoral artery

(list continues on next page)

	Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
Right popliteal artery			
Left common femoral artery			
Left superficial femoral artery			
Left profunda femoral artery			
Left popliteal artery			
Intra-abdominal vessels			
Abdominal aorta			
Celiac axis			
Hepatic artery			
Splenic artery			
Superior mesenteric artery			
Inferior mesenteric artery			
Right common iliac artery			
Right external iliac artery			
Right internal iliac artery			
Left common iliac artery			
Left external iliac artery			
Left internal iliac artery			
Right renal artery			
Left renal artery			
Thoracic vessels			
Ascending thoracic aorta			
Transverse thoracic aorta			
Descending thoracic aorta			
Brachiocephalic artery			
Right common carotid artery			
Right subclavian artery			
Right vertebral artery			
Left common carotid artery			
Left subclavian artery			
Left vertebral artery			
Cervical vessels			
Right common carotid artery			
Right internal carotid artery			
Right external carotid artery			
Left common carotid artery			
Left internal carotid artery			
Left external carotid artery			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10920	Intracorporeal stent placement - extra	373.00		136.59
	NOTES: i) Includes all diagnostic imaging associated with stent placement. ii) Includes all associated tract dilation(s). iii) Second procedure same day payable at 50%. iv) Removal of stent within 6 months of insertion payable at 50%. v) Payable only when stents are placed in the same organ and/or where more than one stent is used per site or when repositioning of stent required. vi) Placement of second stent in non-contiguous site payable at 50%.			
10921	Transjugular Intrahepatic Porto-systemic shunt (TIPS)	3650.00	8	1173.73
	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	1721.00	3	662.11
	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)

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

iv) 10922 includes:
   a) Diagnostic angiograms done during the procedure.
   b) Angiograms performed as a separate procedure before or after the embolization are billable.
   c) Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted embolization procedure. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of $1,700. Claims must be accompanied by written details of vessels injected.
   d) Repeat procedures performed by the same physician and done within 30 days of the original procedure will be paid at 75% of the original fee.

v) Includes 10913 if performed on same day.

(C) NEEDLE BIOPSY PROCEDURES

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

S00739	Percutaneous lung or mediastinal biopsy - procedural fee	278.00	2	117.10
S00740	Liver biopsy - procedural fee	275.00	2	115.55
S00741	Splenic biopsy - procedural fee	275.00	2	115.55
S00742	Renal biopsy - procedural fee	293.00	2	117.10
S00744	Thyroid biopsy - procedural fee	269.00	2	79.32
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	210.00	2	56.20
S00747	Prostate biopsy - procedural fee	144.00	2	33.21
S00748	Bone biopsy under local/regional anesthetic	172.00		73.17
S00749	Parietal pleural, including thoracentesis - procedural fee	341.00	2	136.23
S00844	Biopsy of salivary gland, fine needle or core needle	265.00	3	55.25

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
(D) 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.	251.00	2	61.83
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.	378.00	2	92.73
S00751	Pericardial puncture - procedural fee	1118.00	3	258.25
S00752	Cisternal puncture - procedural fee	127.00	2	40.49
S00753	Marrow aspiration - procedural fee	174.00	2	44.76
S00755	Artery puncture - procedural fee	36.05	2	7.15
SY00757	Joint aspiration - procedural fee (not in addition to 00014 or 00015) - other joints	51.20	2	16.54
S00759	Paracentesis (thoracic) or transtracheal aspiration - procedural fee	220.00	2	103.74
S00760	Paracentesis (abdominal) - procedural fee	83.90	2	27.29
S00761	Cyst or bursa - procedural fee	150.00	2	16.54
(E) ALLERGY, PATCH AND PHOTOPATCH TESTS				
S00762	Scratch test - per antigen Note: Minor tray fee may be paid in addition if a minimum of 16 antigens are used.	8.40		1.08
S00763	– 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.	9.00		2.37
S00764	Intracutaneous test - per test	12.05		2.20
S00765	Annual maximum (to include scratch or intracutaneous tests) per patient for each physician	191.00		35.18
S00767	Patch testing (extra) - annual maximum is 80 tests - per test	7.75		2.00
S00768	Photopatch test - per test	45.60		8.81
S00769	Photopatch test - annual maximum	456.00		88.07
(F) EXAMINATION UNDER ANESTHESIA (when done as independent procedure)				
S00770	Pelvic examination under anesthesia when done as an independent procedure - procedural fee	624.00	2	255.79
S00771	Retinal examination under anesthesia - procedural fee	106.00	3	21.19

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
(G) GYNECOLOGICAL				
S00775	Hydrotubation NOTE: When S00775 is done in conjunction with laparoscopy, fee included in laparoscopy fee.	186.00		52.98
S00776	Fetal scalp sampling	416.00		106.15
S00782	Needle aspiration of pouch of Douglas - procedural fee	147.00	2	37.47
S00783	Huhner's Test - procedural fee	186.00		47.26
S00784	Cervix punch biopsy - procedural fee	80.00	2	20.38
S00785	Endometrial biopsy - procedural fee NOTE: Includes cervical cancer screening, if clinically indicated.	186.00	2	47.26
S00786	Pelvic examination with needle aspiration of Pouch Douglas under anesthesia when not followed by a surgical procedure by the same surgeon	198.00	2	50.73
S00787	Transabdominal amniocentesis	364.00	2	105.98
S00790	Antepartum fetal heart monitoring (not to be charged for intrapartum fetal heart monitoring nor when done in conjunction with a consultation) - professional fee	73.20		18.68
S00794	Chorionic villus sampling NOTE: Includes ultrasound guidance of the villus biopsy.	503.00	2	128.03
S00807	Diagnostic hysteroscopy NOTE: Not payable in addition to a D&C.	514.00	2	204.63
S00808	Diagnostic hysteroscopy with biopsy(s), includes D&C	778.00	2	255.79
S00815	Laparoscopically directed biopsies and/or lysis of adhesions (extra) NOTE: Not paid with 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048.	259.00	4	66.09
S00819	Diagnostic vaginoscopy, under general anesthetic... NOTES: i) Payable only for premenarchal patients unless medical necessity provided in the note record. ii) Not billable in addition to hysteroscopy.	514.00	2	255.79
(H) UROLOGICAL				
S00802	Urethrogram	173.00	2	50.66
S00792	Cystoureterogram - technical fee	43.00	2	13.20
S00793	– professional fee	22.80		6.61
S00799	Transurethral ureterorenoscopy to include C&P	693.00		161.71

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00800	Transurethral ureterorenoscopy with x-ray control to include C&P	1685.00	2	393.06
S00803	Loopogram	183.00		57.66
S00866	Dynamic cavernosometry and cavernosography. NOTE: Interpretation of x-ray is included in technical portion and is not billable in addition to procedure.	371.00	2	80.84
S00878	Cystometry, to include pelvic floor EMG	248.00		67.74
S00874	Urethral profilometry (water or gas)	87.40		20.22
S00875	Uroflowimetry (with sphincter EMG with or without pharmacologic manipulation)	141.00		32.36
S00876	Video uro-dynamics (full study) includes S00874, S00875 and S00878.	676.00		206.31

(I) MISCELLANEOUS

S00780	Schirmer's test (included in fee item 02015)	69.70		13.89
SY00789	Peritoneal lavage	337.00	2	87.68
S00797	Esophageal motility test	814.00		180.13
S00788	– technical fee	361.00		76.03
S00798	– professional fee	471.00		104.09
S00818	Esophageal pH study for reflux (extra) - professional fee	213.00		42.72
S00817	– technical fee	65.70		15.59
S00809	Retrograde pancreatography	1130.00	3	221.44
S00869	Manometry; anal - adult	469.00	2	103.67

(J) CARDIO-VASCULAR PROCEDURES

S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee	116.00		22.60
S00810	Right heart catheterization - by duly qualified specialist	873.00	4	169.19
S00812	Selective angiocardiogram (extra) - by duly qualified specialist	293.00	4	56.77
S00813	Ergonovine provocative testing for coronary artery spasm	423.00	4	80.93
S00814	Dye dilution studies (extra) - by duly qualified specialist	293.00	4	56.77
S00816	Hydrogen ion study	144.00	2	29.61
S00830	Trans-septal left heart catheterization - by duly qualified specialist	1068.00	4	263.46

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00839	Direct intracoronary streptokinase thrombolysis	1746.00	4	395.89
	(see note on next page) NOTE: When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).			
S33131	Diagnostic cardiac catheterization	1098.00	4	349.16
	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 annulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, and interpretation of aortic valve pullback gradient hemodynamics.			
S33132	Diagnostic cardiac catheterization with advanced arterial assessment	1589.00	4	494.19
	NOTES: i) Restricted to Cardiologists and Pediatric Cardiologists. ii) Not payable with 3131, 33133, 33134 and/or 00842. iii) Applies to per patient, not per vessel or lesion when advanced arterial assessment is performed. iv) Include arterial access, arterial pressure measurements and interpretations, direct coronary artery cannulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, interpretation of aortic valve pullback gradient hemodynamics, and advanced assessment of the coronary artery with Fractional Flow Reserve (FFR), Intravascular ultrasound (IVUS), and/or optical coherence tomography (OCT).			

Percutaneous coronary interventions:

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S33133	Percutaneous coronary intervention with diagnostic cardiac catheterization	1851.00	4	583.44

(see notes on next page)

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

S33134	Percutaneous coronary intervention alone	1234.00	4	384.02

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

S00842	Percutaneous coronary intervention – for additional vessel(s), per vessel.....	987.00		193.28

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Percutaneous coronary intervention anatomical named vessels (Including Coronary artery bypass graft to vessels below): **Right Coronary:** • Right coronary artery • Right posterior descending artery • Right posterior atrioventricular artery • First right posterolateral artery • Second right posterolateral artery • Acute marginal artery • Inferior septal artery **Left Coronary:** • Left main coronary artery • Left anterior descending artery • First diagonal artery • Second diagonal artery • Ramus artery • Circumflex artery • First obtuse marginal artery • Second obtuse marginal artery • Third obtuse marginal artery • Left atrioventricular artery • First left posterolateral artery • Second left posterolateral artery • Left posterior descending artery • First septal artery			
S00843	Selective arteriography or venography of any abdominal branch by catheter (extra) - first branch (each additional branch 50% extra)	305.00	2	106.45
S00847	Selective arteriography of any thoracic aortic branch, excluding coronaries (extra) - first branch (each additional branch 50% extra)	496.00	2	172.59
	Pulse tracing, including interpretation:			
S00871	– intravascular including both arterial and venous	293.00		56.77
	Portal pressures:			
S00880	– hepatic vein wedge pressure, by duly qualified specialist	293.00		69.46

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00881	– percutaneous splenic portal pressure	242.00	2	55.60
S00898	Balloon septostomy	1535.00	7	378.73
	Aortogram:			
S00890	– abdominal - procedural fee	349.00	2	122.58
S00897	– thoracic - procedural fee (extra except when part of a retrograde left heart catheterization)	506.00	2	176.21
	Arteriogram - procedural fee			
S00892	– carotid percutaneous; unilateral	387.00	3	121.14
S00891	– carotid percutaneous; bilateral	565.00	3	182.16
S00893	– femoral or axillary	279.00	2	93.79
S00894	– cerebral by dissection	629.00	3	204.19
S00853	Superior venacavogram by indirect means	94.20	2	25.57
S00854	Inferior venacavogram	349.00	2	122.58
S00855	Selective catheterization of branches of inferior vena cava or iliac system - first branch	271.00	2	95.21
S00856	– others	183.00	2	63.28
S00888	Ventriculogram, when no ventricular access device is present (i.e. ventricular reservoir, VP shunt or drain)	877.00	3	262.23
S00889	Ventriculogram, through previously placed ventricular access device, drain or catheter	439.00	3	131.12
S00896	Pulmonary arteriography	475.00	3	148.80
S00885	Digital angiography - peripheral injection NOTE: S00885 includes catheterization and contrast injection(s).	138.00	2	49.54
S00919	Impedance plethysmography - professional fee	29.20		7.05
S00920	– technical fee	144.00		35.33

CARDIOLOGY ASSIST FEES

00845	First hour or fraction thereof	760.00		175.08
00846	After one hour, for each 15 minutes or fraction thereof NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	190.00		43.78

(K) ELECTRODIAGNOSIS

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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)	562.00		130.77
S00901	Schedule B - limited examination (4 to 7 items)	391.00		87.47
S00902	Schedule C - short examination (1 to 3 items)	191.00		43.59
S00923	Technical fee for electrodiagnostic testing	95.00		20.85
S00905	Daily measurements of nerve conduction thresholds in facial palsy	29.30		6.81
S00906	– maximum per course	194.00		47.39
S00915	Intra-carotid injection of sodium amytal - speech localization test	430.00	2	105.19
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests	204.00		61.58
S00927	Decamethonium test - for attendance at and follow-up observation if necessary	184.00		36.24
S00944	Tilt table testing with continuous ECG monitoring and automatic BP recording - total fee	1528.00		296.72
S00947	– professional fee	830.00		182.61
S00948	– technical fee	629.00		114.11

NOTES:

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

POLYSOMNOGRAM

	Overnight home oximetry (continuous recording of oxygen and pulse)			
S00910	– professional fee	139.00		29.48

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00911	– technical fee	72.90		16.64
	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	540.00		174.28
S11916	Standard polysomnography - technical fee	1251.00		402.47
S11917	Two-night polysomnography - professional fee	811.00		261.17
S11918	Two-night polysomnography - technical fee	2497.00		804.93
	NOTE: Fee items S11917 and S11918 are restricted to the UBC Sleep Laboratory at this time.			
S11919	Multiple sleep latency test (MSLT) - professional fee	269.00		87.04
S11920	Multiple sleep latency test (MSLT) - technical fee	625.00		201.24
PS11925	Four channel home polysomnography – Professional fee	253.00		86.94
PS11926	Four channel home polysomnography – Technical fee	253.00		87.21

(L) PULMONARY INVESTIGATIVE AND FUNCTION STUDIES

S00930	Peak expiratory flow rate	31.45		6.22
	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	66.70		13.79
S00929	Simple screening spirometry as above but before and after bronchodilators	100.00		20.78
	Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume:			
S00931	– professional fee	76.60		17.28
S00932	– technical fee	76.60		14.75
	Spirometry - forced expiratory spirogram to include FVC, FEV(i), FEV/FVC ratio MMEFR, etc.			
S00933	– without bronchodilators - professional fee	59.30		13.21
S00934	– without bronchodilators - technical fee	59.30		12.48
S00935	– before and after bronchodilators - professional fee	66.70		15.24
S00936	– before and after bronchodilators - technical fee	76.60		14.86

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Spirometry - flow volume loops:			
S00937	– without bronchodilators - professional fee	59.30		13.21
S00938	– without bronchodilators - technical fee	100.00		18.93
S00940	– before and after bronchodilators - professional fee	76.60		15.76
S00941	– before and after bronchodilators - technical fee	144.00		28.00
	Diffusion Studies with Carbon Monoxide:			
S00942	– at rest or exercise - professional fee	81.00		17.04
S00943	– technical fee	48.10		13.38
	Detailed Pulmonary Function Studies:			
S00945	– professional fee (includes S00931, S00935 and S00942)	224.00		44.29
S00946	– technical fee (includes S00932, S00936 and S00943)	212.00		41.90
	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.			
	Progressive exercise test with at least three workloads, measuring ventilation and electro-cardiographic monitoring:			
S00950	– professional fee	116.00		27.03
S00951	– technical fee	174.00		33.89
	Exercise in a steady state at two or more workloads with measurements of ventilation, 0_2 and $C0_2$ exchange, and electro-cardiographic monitoring:			
S00954	– professional fee	428.00		98.64
S00955	– technical fee	274.00		61.41
	Exercise in a steady state at two or more workloads with measurements of ventilation, O_2 and CO_2 exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space:			
S00956	– professional fee	512.00		114.33
S00957	– technical fee	361.00		73.13
	Testing for exercise-induced asthma by serial flow measurements:			
S00958	– professional fee	116.00		22.86
S00959	– technical fee	174.00		33.69

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Miscellaneous Pulmonary Tests:			
	Plethysmography and airway resistance:			
S00964	– professional fee	69.20		14.74
S00965	– technical fee	144.00		28.00
	Inhalation challenge - assessed by serial flow measurements, per day:			
S00968	– professional fee	191.00		42.20
S00969	– technical fee	191.00		37.85
	NOTE: For fee items 00968 and 00969, serial spirometric measurement before and after inhalation of pharmacologic agents or agents encountered in working environment or antigen exposure for the diagnosis of Asthma. The protocols/agents used as described for but not limited to the standardized agents of Methacholine, Histamine, Mannitol. For Occupational / Asthma antigen challenge to include peak expiratory flow rate recording hourly x 8 hours following exposure.			
	Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:			
SY11964	professional fee	53.70		21.40
SY11965	technical fee	192.00		46.13
	NOTES: i) Restricted to Respirologists. ii) Maximum of one assessment per patient per day. iii) Annual maximum four per year. Two additional tests will be considered if accompanied by a note record. iv) Not payable in addition to bronchoscopy 00700, 00702.			
	Precipitin tests - one or more antigens:			
S00970	– professional fee	59.30		12.44
S00971	– technical fee	144.00		30.17
	CO_2/O_2 responsiveness of respiratory centres by steady state test or rebreathing test:			
S00972	– professional fee	100.00		21.30
S00973	– technical fee	59.30		11.54
	Inspiratory and expiratory muscle strength:			
S00974	– professional fee	57.60		16.77
S00975	– technical fee	57.60		13.23

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S11960	Oximetry at rest, with or without Oxygen – professional fee	21.95		6.22
S11961	Oximetry at rest, with or without Oxygen – technical fee	23.75		5.30
S11962	Oximetry at rest and exercise, with or without Oxygen – professional fee	47.55		12.54
S11963	Oximetry at rest and exercise, with or without Oxygen – technical fee	74.30		16.59

(M) EVOKED RESPONSE PROCEDURES

S00985	Brainstem auditory evoked response, supra threshold testing for integrity of brainstem function	255.00		52.22
S00986	Somatosensory evoked response - upper extremity	174.00		43.55
S00987	– upper and lower extremity	345.00		75.29
S00988	Visual evoked response	387.00		75.88

(N) ORTHOPAEDIC DIAGNOSTIC PROCEDURES

SHOULDER GIRDLE, CLAVICLE AND HUMERUS

Incision: Diagnostic, Percutaneous:

S11200	Arthroscopy shoulder joint	1396.00	2	305.53

Incision: Diagnostic, Open:

11215	Arthrotomy shoulder joint or bursa	869.00	2	190.94

Excision: Diagnostic, Percutaneous:

S11230	Needle biopsy, under general anesthetic	869.00	2	190.94
S11232	Arthroscopy - biopsy, shoulder	1131.00	2	248.23

Excision: Diagnostic, Open:

11245	Biopsy - open	1133.00	2	248.23

ELBOW, PROXIMAL RADIUS AND ULNA

Incision: Diagnostic, Percutaneous:

S11300	Arthroscopy elbow joint	1251.00	2	274.51
S11302	Aspiration - bursa, tendon sheath.	108.00	2	23.76

Incision: Diagnostic, Open:

11315	Arthrotomy elbow joint	869.00	2	190.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Excision: Diagnostic, Percutaneous:			
S11330	Needle biopsy, under general anesthetic	869.00	2	190.94
S11332	Arthroscopy and biopsy	1383.00	2	303.15
	Excision: Diagnostic, Open:			
11345	Open biopsy NOTE: Not billable with other procedures on the same joint.	1133.00	2	248.23
HAND AND WRIST				
	Incision: Diagnostic, Percutaneous:			
S11400	Arthroscopy wrist joint	1104.00	2	294.13
S11402	Aspiration - bursa, synovial sheath, etc.	108.00	2	23.76
	Incision: Diagnostic, Open:			
11415	Arthrotomy wrist joint (isolated procedure)	869.00	2	190.94
11416	Arthrotomy - MP, PIP, DIP joints (isolated procedure)	869.00	2	190.94
	Excision: Diagnostic, Percutaneous:			
S11430	Needle biopsy, under general anesthetic	869.00	2	190.94
S11432	Arthroscopy and biopsy, wrist /hand joint(s)	869.00	2	190.94
	Excision: Diagnostic, Open:			
11445	Open biopsy, hand or wrist	1133.00	2	265.66
PELVIS, HIP AND FEMUR				
	Incision: Diagnostic, Percutaneous:			
S11500	Arthroscopy hip joint	2425.00	3	529.91
S11501	Aspiration hip joint	108.00	2	23.76
S11502	Aspiration - bursa, tendon sheath.	54.00	2	11.90
	Incision: Diagnostic, Open:			
11515	Arthrotomy hip joint	1389.00	3	305.53
	Excision: Diagnostic, Percutaneous:			
S11530	Needle biopsy, under general anesthetic	869.00	2	190.94
S11532	Arthroscopy and biopsy, hip	2425.00	3	529.91
	Excision: Diagnostic, Open:			
11545	Arthrotomy and biopsy, hip	1133.00	3	248.23
11546	Biopsy open, soft tissue or bone	1133.00	2	248.23
FEMUR, KNEE JOINT, TIBIA AND FIBULA				
	Incision: Diagnostic, Percutaneous:			
S11600	Arthroscopy knee joint	1001.00	2	219.58

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S11602	Aspiration - bursa, tendon sheath or other peri-articular structures	108.00	2	23.76
	Incision: Diagnostic, Open:			
11615	Arthrotomy knee joint	1131.00	3	248.23
	Excision: Diagnostic, Percutaneous:			
S11630	Needle biopsy, under general anesthetic	869.00	2	190.94
S11632	Arthroscopy - biopsy	1001.00	2	219.58
	Excision: Diagnostic, Open:			
11645	Biopsy - open	1133.00	2	248.23
TIBIAL METAPHYSIS (DISTAL), ANKLE AND FOOT				
	Incision: Diagnostic, Percutaneous:			
S11700	Arthroscopy - ankle joint/subtalar joint	869.00	2	190.94
S11702	Aspiration - bursa, tendon sheath	108.00	2	23.76
	Incision: Diagnostic, Open:			
11715	Ankle joint	869.00	2	190.94
11716	Subtalar joint	869.00	2	190.94
11717	Midtarsal joint	869.00	2	190.94
11718	Tarso-metatarsal, metatarsal-phalangeal, interphalangeal joint	869.00	2	190.94
	Excision: Diagnostic:			
S11730	Needle biopsy, under general anesthetic	869.00	2	190.94
11745	Open biopsy, under general anesthetic	1133.00	2	248.23
VERTEBRA, FACET AND SPINE				
	Excision: Diagnostic, Percutaneous:			
S11830	Needle biopsy, soft tissue/bone - thoracic spine, under general anesthetic	1001.00	2	219.58
S11831	Needle biopsy, soft tissue/bone - lumbar spine, under general anesthetic	869.00	2	190.94
	Excision: Diagnostic, Open:			
11845	Biopsy, under general anesthetic	1131.00	3	248.23
	NOTE: Not payable with definitive spinal surgery.			

CRITICAL CARE

Complete understanding of the following paragraphs is essential to appropriate billing of the critical care fees. Members of the team billing the Critical Care 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.

- 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 Fee Guide".

"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/Fee Guide and personally attends the patient.

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

Out-of-office hours 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	**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)	777.00	329.50
	Note: Restricted to Critical Care Physicians		
01402	**Repeat or Limited Consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee (not for ICU patients)	398.00	155.70
	Note: Restricted to Critical Care physicians		
	<u>Continuing Care by Consultant:</u>		
01408	Subsequent hospital visit (not for ICU patients).....	418.00	163.07
	Note: Restricted to Critical Care Physicians		
01469	Direction of care/end of life assessment.....	757.00	253.11
	Notes:		
	i) Restricted to Critical Care physicians who have not treated the patient in the previous seven days.		
	ii) This fee includes an examination, review of history, laboratory, X-ray findings necessary to write a report as well as any and all meetings with family and ICU team required to formulate and perform end-of-life and/or direction of care, e.g.: withdrawal of life sustaining measures and filling out forms for comfort care orders.		
	iii) Patient must be in ICU with life threatening illness.		
	iv) Not intended for use for advance-care planning.		
	v) Limited to one assessment per patient per ICU admission.		

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
Telehealth Service with Direct Interactive Video Link with the Patient			
01470	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report (not for ICU patients) ..... Note: Restricted to Critical Care physicians.	777.00	329.50
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) ... Note: Restricted to Critical Care Physicians.	398.00	155.70

MISCELLANEOUS

01450	Adult and Pediatric Critical Care 1st day modifier – extra.. NOTES: i) Restricted to Critical Care physicians. ii) Payable only in addition to 01411, 01412 or 01413 by the same practitioner.	160.00	43.84
01455	Adult and Pediatric Critical care modifier (2nd day onward) – extra..... 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.	19.70	13.38

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 ICUs, 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
01411	1st day.....	1023.00	347.74
01421	2nd to 7th day (inclusive) per diem.....	506.00	174.38
01431	8th day to 30th day.....	307.00	133.01
01441	31st day onward.....	354.00	138.53

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 $C0_2$, transcutaneous blood gas application and assessment and maximum inspiratory pressure monitoring and non-invasive metabolic measurements. There is an expectation of at least 1-hour of bedside care on Day 1. This is the fee to use when one physician is providing the ventilatory care and another physician, the critical care. This service may also be billed by a physician other than the operating surgeon or associate, for critical care required in addition to post-operative care by the surgeon.

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
01412	1st day.....	889.00	326.60
01422	2nd to 7th day (inclusive) per diem.....	448.00	174.65
01432	8th day to 30th day.....	323.00	134.95
01442	31st day onward.....	291.00	130.11

3. COMPREHENSIVE CARE - These fees apply to intensive care physicians who provide complete care, both critical care and ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment, 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
01413	1st day	1671.00	519.02
01423	2nd to 7th day (inclusive) per diem	763.00	262.42
01433	8th day to 30th day	383.00	145.33
01443	31st day onward	386.00	151.15

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

NEONATAL INTENSIVE CARE

These listings may be used for patients receiving neonatal intensive care and are intended for use by the Neonatologist or Pediatrician (or Team) in charge of the patient. These listings may be used by physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment such as ventilatory support, 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 Fee Guide” 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/Fee Guide and personally attends the patient.

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

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included are: family 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.

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	LEVEL A - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all procedures.		
01511	Day 1	2885.00	716.38
01521	Day 2 - 10	1155.00	288.18
01531	Day 11 onward	770.00	193.65
	LEVEL B - Infants in a Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive and requiring IV therapy or parenteral alimentation but without ventilator support.		
01512	Day 1	2117.00	550.09
01522	Day 2 - 10	770.00	202.59
01532	Day 11 onward	573.00	146.48
	LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.		
01513	Day 1	1830.00	474.76
01523	Day 2 - 10	566.00	149.74
01533	Day 11 onward	448.00	132.05

EMERGENCY MEDICINE

PREAMBLE

1. The following listings apply only to examinations rendered by the emergency physician designated by the medical staff who is on hospital Emergency Department duty and on-site. Other physicians (e.g.: on-call) who choose to attend their patients in the Emergency Department, but who are not the designated emergency physicians as defined above, shall not bill these listings, but shall refer to other sections of the Payment Schedule for billing the appropriate examinations. The physicians working in hospital Emergency Departments that are covered on a call-in basis as opposed to an on-site basis shall not bill these listings but shall refer to the Section of Family Medicine. Physicians working in diagnostic treatment centers or free-standing emergency clinics should also refer to the listings in the Section of Family Medicine. 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 certified emergency physicians either by the Royal College of Physician and Surgeons of Canada (FRCPC) or the Canadian College of Family Physician (CCFP-EM).

b) An emergency medicine consultation (billed as 01810) applies only when a patient is referred by another physician or nurse practitioner (other than an emergency physician or nurse practitioner within the same institution's department) who has seen and examined the patient and, because of the complexity, obscurity or seriousness of the problem, the referring physician or nurse practitioner has requested a consultation. Exception: If the consulting physician is an emergency physician who is 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.

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	**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	450.00		148.42
	Level I:			
01811	Level I, Day	98.00		44.35
01821	Level I, Evening	124.00		49.14
01831	Level I, Night	189.00		73.67
01841	Level I, Saturday, Sunday or Statutory Holiday	155.00		59.23
	Level II:			
01812	Level II, Day	199.00		93.48
01822	Level II, Evening	232.00		102.88
01832	Level II, Night	320.00		148.93
01842	Level II, Saturday, Sunday or Statutory Holiday	326.00		123.02
	Level III:			
01813	Level III, Day	251.00		118.23
01823	Level III, Evening	290.00		128.14
01833	Level III, Night	449.00		186.43
01843	Level III, Saturday, Sunday or Statutory Holiday	406.00		153.80

		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	383.00	2	107.99
01851	Fibula - shaft or malleolus not requiring reduction	331.00		93.40
	Dislocations: Must be performed in the Emergency Department (location code E)			
01860	Temporo-mandibular joint, dislocation - closed reduction	249.00	3	70.51
01861	Patella - closed reduction	241.00	2	67.55
01862	Toe - closed reduction	180.00	2	50.66
	Resuscitation:			
01870	Emergency Medicine Resuscitation fee: Treatment of acute life-threatening, limb or organ saving emergency that requires constant bedside care– per 5 minutes or part thereof	74.90		31.56

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, limb or organ saving 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 majority of time may be claimed on one patient while a minimum of one unit must be claimed on all other patients. No more than 12 units may be claimed within a 60 minute period.

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

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

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

01871	Trauma Team Leader Resuscitation fee: Treatment of acute life-threatening, limb or organ saving emergency that requires constant bedside resuscitative care – per 5 minutes or part thereof	74.90		31.56

NOTES:

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

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

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

(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 majority of time may be claimed on one patient; while a minimum of one unit must be claimed on all other patients. No more than 12 units may be claimed within a 60 minute period.

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

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

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

ADVICE AND PATIENT MANAGEMENT / FOLLOW-UP

P01880	Emergency Medicine Specialist Patient Management / Follow-up	110.00		44.35

NOTES:

i) For verbal, real-time telephone and video technology communication (including other forms of electronic verbal communication) only. Not payable for written communication (i.e.: fax, letter, email).

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

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Patient management requires two-way communication about clinical matters between the patient or patient's representative and the physician; this fee is only billable for follow-up deemed necessary and urgent to alter a patient's management plan from a visit within 14 days preceding this service. iv) Not payable in addition to another service on the same day for the same patient by the same physician. v) Payable to a maximum of 25 services per practitioner per day. vi) Requires documentation in the medical record to show that the patient or patient's representative understood and acknowledged the information provided.			
P01881	Emergency telehealth advice from an emergency physician when requested by a physician or allied health provider – per 15 minutes or part thereof	138.00		60.00
	NOTES: i) Payable to FRCP, CCFP-EM and ABEM emergency physicians only for emergent two-way telephone or video communication necessary for the management of a patient when requested by another physician or allied health provider. ii) Not payable when the only purpose of the call is to: a) Arrange for transfer of care that occurs within 24 hours. b) Arrange for an expedited consultation or procedure within 24 hours. c) Arrange for laboratory or diagnostic investigations. d) Convey the results of diagnostic investigations. e) Arrange a hospital bed for the patient. iii) Not payable to provider initiating call. iv) No claim may be made where communication is with a proxy for either provider (for example, ED support staff). v) A chart entry including reason for call, advice given and to whom, is required. vi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.			

(notes continued on next page)

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

vii) Include the practitioner number of the provider requesting advice in the “referred by” field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note in the record specifying type of provider).
viii) Maximum of one additional unit of time may be billed if call time exceeds 22 minutes.
ix) Maximum of 2 services per patient per day.
x) Maximum of 12 services per practitioner per day.
xi) Emergent telehealth advice fees apply if patient seen subsequently on the same day by same practitioner.

MISCELLANEOUS VISITS

P01882	Emergency medicine reassessment	83.50		32.33

NOTES:
i) Payable for essential additional visits by the same physician to a patient in the emergency department at least two hours after 01810, Level III emergency care fee (01812, 01822, 01832, or 01842), out-of-office visit (12200, 13200, 15200, 16200, 17200, 18200), out-of-office consultation (12210, 13210, 15210, 16210, 17210, 18210), or 01882; or three hours after a Level III emergency care fee (01813, 01823, 01833, or 01843).
ii) Not payable for observation alone or for review of laboratory results/imaging without further reassessment of the patient and/or modification of the treatment plan.
iii) The claim must include an explanation of the medical necessity for the visit in the note record.

P01883	Trauma-informed comprehensive gynecologic assessment in an Emergency Department (extra)	126.00		40.00

NOTES:
i) Payable only to emergency physicians.

(notes continued on next page)

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

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

FAMILY MEDICINE

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.

NOTE: DAILY VOLUME PAYMENT RULES APPLYING TO DESIGNATED OFFICE CODES

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

Office Visits:	12100, 00100, 15300, 16100, 17100, 18100
Office Counselling:	12120, 00120, 15320, 16120, 17120, 18120
Office Complete Examinations:	12101, 00101, 15301, 16101, 17101, 18101

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

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

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

iv) Payment discounts will not be applied to services designated by the physician as being the responsibility of WorkSafe BC.

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

BILLING FOR IN-OFFICE AND OUT-OF-OFFICE VISITS

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

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

OUT-OF-OFFICE FEE ITEMS: 12210, 13210, 15210, 16210, 17210, 18210, 12200, 13200, 15200, 16200, 17200, 18200, 12201, 13201, 15201, 16201, 17201, 18201, 12220, 13220, 15220, 16220, 17220, and 18220 apply to consultation, visit, complete examination and counselling services provided in either a patient's home, at the scene of an illness or accident, in a hospital in-patient area, palliative care facility, long term care institution or in a hospital emergency department, unless the circumstance of the service is specifically covered by the definition of either fee item 00103, 00108, 00109, 13109, 00127, 00128, 13028, 00111, 00112, 00114, 00115, 00113, 00105, 00123, 13228, or one of the 01800 series.

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

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

CONSULTATIONS

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
12110	Consultation - in office (Age 0 - 1).....	255.00	103.02
00110	Consultation - in office (Age 2 - 49).....	232.00	95.95
15310	Consultation - in office (Age 50 – 59).....	255.00	103.02
16110	Consultation - in office (Age 60 - 69).....	268.00	107.77

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
17110	Consultation - in office (Age 70 - 79)	292.00	121.20
18110	Consultation - in office (Age 80+)	303.00	139.50
00116	Special in-hospital consultation NOTES: i) This Item applies to consultations on in-hospital patients of an acute or extended care *(or when the patient is in the ER with a complex problem as described below and a decision has been made to admit),* who are referred to a family physician by a certified specialist (FRCP, FRCS or CCFP-EM) for advice about and/or the continuing care of complex problems for which the management is complicated and requires extra consideration. Examples of such problems include *(but are not restricted to)* the assessment of terminal illness, the planning of activation/rehabilitation programs and the management of patients with AIDS. ii) 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 family physician or another family physician in the same group during the preceding six months.	455.00	169.72
12210	Consultation - out of office (Age 0 – 1)	359.00	118.77
13210	Consultation - out of office (Age 2 – 49)	327.00	112.88
15210	Consultation - out of office (Age 50 – 59)	359.00	118.77
16210	Consultation - out of office (Age 60 – 69)	379.00	124.40
17210	Consultation - out of office (Age 70 – 79)	410.00	140.34
18210	Consultation - out of office (Age 80+)	427.00	161.89

COMPLETE EXAMINATIONS

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

NOTES:

i) A complete physical examination shall include a complete detailed history and 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
12101	Complete examination - in office (Age 0 - 1)	236.00	82.84
00101	Complete examination - in office (Age 2 - 49)	209.00	77.24
15301	Complete examination - in office (Age 50 – 59)	236.00	82.84
16101	Complete examination - in office (Age 60 - 69)	244.00	86.57
17101	Complete examination - in office (Age 70 - 79)	265.00	97.52
18101	Complete examination - in office (Age 80+)	274.00	112.93

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)	278.00	98.99
13201	Complete examination - out of office (Age 2 - 49)	251.00	94.48
15201	Complete examination - out of office (Age 50 – 59)	278.00	98.99
16201	Complete examination - out of office (Age 60 - 69)	293.00	103.69
17201	Complete examination - out of office (Age 70 - 79)	318.00	116.98
18201	Complete examination - out of office (Age 80+)	329.00	134.96

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

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)	107.00	41.42
00100	Visit - in office (Age 2 - 49)	97.20	38.61
15300	Visit - in office (Age 50 - 59)	107.00	41.42
16100	Visit - in office (Age 60 - 69)	111.00	43.29
17100	Visit - in office (Age 70 - 79)	120.00	48.76
18100	Visit - in office (Age 80+).....	127.00	56.47

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

13070	Assessment of an unrelated condition(s) in association with a WorkSafeBC service.....	50.00	20.06

NOTES:

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

12200	Visit - out of office (Age 0 - 1)	129.00	49.69
13200	Visit - out of office (Age 2 - 49)	116.00	46.53
15200	Visit - out of office (Age 50 - 59)	129.00	49.69
16200	Visit - out of office (Age 60 - 69)	135.00	52.05
17200	Visit - out of office (Age 70 - 79)	144.00	58.71

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
18200	Visit - out of office (Age 80+)	150.00	67.73

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

FAMILY MEDICINE GROUP MEDICAL VISIT

Eligibility

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.

(notes continued on next page)

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 patients in the group are receiving medically required treatment (i.e. each member of the group is a patient). Family Medicine Group Medical Visits are not intended for activities related to attempting to persuade patients 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	78.30	28.34
13764	Four patients	63.10	22.86

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
13765	Five patients	54.30	19.66
13766	Six patients	48.40	17.51
13767	Seven patients	44.05	15.96
13768	Eight patients	40.90	14.83
13769	Nine patients	38.40	13.89
13770	Ten patients	36.30	12.63
13771	Eleven patients	31.85	11.65
13772	Twelve patients	29.85	10.95
13773	Thirteen patients	27.70	10.23
13774	Fourteen patients	27.20	9.63
13775	Fifteen patients	26.10	9.07
13776	Sixteen patients	25.35	8.81
13777	Seventeen patients	24.20	8.42
13778	Eighteen patients	23.75	8.24
13779	Nineteen patients	22.95	7.95
13780	Twenty patients	22.50	7.60
13781	Greater than 20 patients (per patient)	21.50	7.32

(see notes on next page)

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 this service.

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

vi) A minimum of a full thirty (30) minutes 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 claim note-record is required.
viii) Service is not payable with other consultation, visit or complete examination services, for the same patient, on the same day.
ix) Concurrent billings for any other MSP services for any patient during the time interval for which the GMV fee is billed will not be paid.
x) Where two physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate per patient for the reduced group size. Each claim should indicate "Group medical visit" and also identify the other physician.

COUNSELLING - INDIVIDUAL

For a prolonged visit for counselling (minimum time per visit - 20 minutes).
NOTES:
i) MSP will pay for up to four (4) individual counselling visits (any combination of age-appropriate in-office, out-of-office and telehealth), per patient, per year (see Preamble, D. 3. 3).
ii) Start and end times must be entered in both the billing claims and the patient's chart.
iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

12120	Individual counselling - in office (Age 0 - 1).....	191.00	82.84
00120	Individual counselling - in office (Age 2 - 49).....	174.00	77.24
15320	Individual counselling - in office (Age 50 - 59).....	191.00	82.84
16120	Individual counselling - in office (Age 60 - 69).....	202.00	86.57
17120	Individual counselling - in office (Age 70 - 79).....	227.00	97.52
18120	Individual counselling - in office (Age 80+).....	262.00	112.93
	NOTE: 12120, 00120, 15320, 16120, 17120 and 18120 are subject to the daily volume payment rules described earlier in this section.		
12220	Individual counselling - out of office (Age 0 - 1).....	278.00	98.99
13220	Individual counselling - out of office (Age 2 - 49).....	251.00	94.48

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
15220	Individual counselling - out of office (Age 50 - 59)	278.00	98.99
16220	Individual counselling - out of office (Age 60 - 69)	293.00	103.69
17220	Individual counselling - out of office (Age 70 - 79)	318.00	116.98
18220	Individual counselling - out of office (Age 80+)	328.00	134.96

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

00121	first full hour	418.00	199.49
00122	second hour, per 1/2 hour or major portion thereof.....	209.00	99.75
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		

Telehealth Service with Direct Interactive Video Link with the Patient

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

13236	Telehealth FP Consultation (age 0-1)	255.00	103.02
13436	Telehealth FP Consultation (age 2-49)	232.00	95.95
13536	Telehealth FP Consultation (age 50-59)	255.00	103.02
13636	Telehealth FP Consultation (age 60-69)	268.00	107.77
13736	Telehealth FP Consultation (age 70-79)	292.00	121.20
13836	Telehealth FP Consultation (age 80+)	303.00	139.50
13237	Telehealth FP Visit (age 0-1)	107.00	41.42
13437	Telehealth FP Visit (age 2-49)	97.20	38.61
13537	Telehealth FP Visit (age 50-59)	107.00	41.42
13637	Telehealth FP Visit (age 60-69)	111.00	43.29
13737	Telehealth FP Visit (age 70-79)	120.00	48.76
13837	Telehealth FP Visit (age 80+)	127.00	56.47
13238	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 0-1)	191.00	82.84
13438	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 2-49)	174.00	77.24
13538	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 50-59)	191.00	82.84
13638	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit- 20 minutes) (age 60-69)	202.00	86.57
13738	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 70-79)	227.00	97.52
13838	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 80+)	262.00	112.93

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	NOTES: i) MSP will pay for up to four (4) individual counselling visits (any combination of age-appropriate in-office, out-of-office and telehealth) per patient per year (see Preamble D. 3. 3.) ii) Start and end times must be entered into both the billing claims and the patient's chart. iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.		
	Telehealth FP Group Counselling For groups of two or more patients		
13041	First full hour.....	418.00	199.44
13042	Second hour, per ½ hour or major portion thereof..... NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	209.00	99.73
13020	Telehealth Family Physician Assistant – Physical Assessment as requested by receiving specialist – for each 15 minutes or major portion thereof..... NOTES: i) Applicable only if the family physician is required at the referring end to assist with essential physical assessment, without which the specialist service would be ineffective. ii) Applies only to period spent during consultation with specialist. iii) Start and end times must be entered in both the billing claims and the patient's chart.	94.00	50.35

FAMILY CONFERENCE

P13121	Family Conference – per 15 minutes or greater portion thereof	133.00	50.35

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

NOTES:
i) Restricted to family physicians.
ii) Payable for in-person or telehealth participation in a family conference with one or more family members, representatives, or substitute decision makers.
iii) Payable only for family conferences for the purpose of:
  a) Obtaining informed consent for care related to an acute medical event or a significant change in the patient's condition; or
  b) Developing and reviewing the patient's care plan, including advanced care planning and goals of care discussions.
iv) Not payable when communication occurs as a part of routine communication with a family member, representative, or substitute decision maker.
v) Payable in addition to a patient visit or 14067/14077 on the same day if clinically required, provided that this service does not take place concurrently with the family conference (i.e., the visit time must be separate from the family conference time).
vi) Payable to a maximum of 2 units per patient per physician per calendar day.
vii) Payable to a maximum of 100 units per physician per calendar year.
viii) Details of the family conference must be documented in the patient's chart, including the participants, their roles, information about the discussion, and decisions made.
ix) Start and end times must be entered in both the billing claim and the patient's chart.

SUBSTANCE USE DISORDER CARE

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
13013	Assessment for Substance Use Disorder or OAT Induction Includes complete medical history, including substance use history, and an appropriate targeted physician examination. In the case of Opioid Agonist Treatment (OAT) induction, if assessment and induction are done on the same day, withdrawal assessment using appropriate clinical scales and administration of first dose of OAT are included – per 15 minutes or greater portion thereof ..... NOTES: i) Payable to a maximum of 4 units per patient/per day/per intended induction. ii) Payable only to the physician who intends to provide or share management of the patient's substance use disorder. iii) Payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day). iv) Payable for assessment for change of OAT with discussion of transition to a different OAT medication. v) Start and end times must be entered in both the billing claim and the patient's chart. vi) No other visit fees billable same day except 13014, 13024, 14018 and 14077. 13014, 13024, 14018 and 14077 payable in addition to 13013 only when not performed concurrently.	151.00	50.35
13014	Management of OAT induction for Opioid Use Disorder. This fee is payable for individual interactions with the patient during the first three days of OAT induction for opioid use disorder within the limits described in the following notes 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.	55.20	23.32

(notes continued on next page)

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

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.

P13023 Management of Substance Use Disorder
A monthly fee payable to the physician responsible for the continuous management of a patient's substance use disorder, other than opioid use disorder. Applicable only to patients with a documented diagnosis of substance use disorder..... 82.30 26.20

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

P13024 Outpatient Management of Alcohol Withdrawal
Applicable only to patients with a documented diagnosis of alcohol use disorder..... 82.30 26.20

(see notes on next page)

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

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

00039	Management of Opioid Use Disorder A weekly fee payable to the physician responsible for the continuous management of a patient's opioid use disorder. Applicable only to patients with a documented diagnosis of opioid use disorder	82.30	26.75

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

15039	Point of Care (POC) testing for oral opioid agonist treatment	38.80	15.11

(see notes on next page)

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

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

15040 Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone. 38.80 15.11

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.

MISCELLANEOUS VISITS

13501 MAiD Assessment (Prescriber) – per 15 minutes or greater portion thereof..... 50.35

Includes all requirements of a medical assistance in dying (MAiD) assessment, including review of medical records, patient encounter and completion of the MAiD Assessment Record (Prescriber). The assessment may be provided either in-person or by video conference

(see notes on next page)

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

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

13502 MAiD Assessment (Assessor)– per 15 minutes or greater portion thereof 50.35
Includes all requirements of a medical assistance in dying (MAiD) assessment, including review of medical records, patient encounter, and completion of the MAiD Assessment Record (Assessor). The assessment may be provided either in-person or by video conference.
NOTES:
i) Payable to a maximum of 105 minutes (7 units) for the assessment of patients whose natural death is reasonably foreseeable (Track 1 patients). Services which exceed the maximum will be given independent consideration with an explanatory letter.
ii) Payable to a maximum of 150 minutes (10 units) for the assessment of patients whose natural death is not reasonably foreseeable (Track 2 patients). “Track 2” must be entered in both the claim note record and the patient’s chart. Services which exceed the maximum will be given independent consideration with an explanatory letter.
iii) Start and end time for the assessment must be entered in both the billing claim and the patient’s chart.

(notes continued on next page)

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

iv) Additionally, start and end time for the patient encounter must be entered in the patient's chart.
v) Not payable with 13501 by same physician.
vi) Only one service for 13501 or 13502 may be performed by video conference.

13503 Physician witness to video conference MAiD Assessment – Patient Encounter 50.35
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 .....
NOTES:
i) Maximum payable is 105 minutes (7 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.
ii) Start and end time for the witnessed encounter must be entered in both the billing claim and patient's chart.
iii) Not payable with 13501 or 13502 by same physician.

13504 MAiD Event Preparation and Procedure..... 327.48
NOTES:
i) Payable only to Assessor Prescriber.
ii) Includes all necessary elements: establishment of IV, administration of meds, pronouncement of death.
iii) Includes pharmacy visits for procedures provided in facilities with on-site pharmacies.
iv) Fee 13505 billable in addition for procedures provided in facilities with no on-site pharmacy.
v) A same day visit fee is payable in full in addition under fee item 00103 (home) or out of office visit fee items 13200, 15200, 16200, 17200 and 18200 (all other locations). Fee items 00108, 00127 and 00114 are not payable.

13505 MAiD Medication Pick-up and Return..... 146.18
NOTES:
i) Payable when a physician picks up medication for a medical assistance in dying (MAiD) event and returns the unused/partially used medications to a pharmacy.

(notes continued on next page)

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

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

P13506 MAiD Expert Case Review
When death is not reasonably foreseeable. Includes all activities necessary to complete an expert case review including patient assessment when required. The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof — 43.67
NOTES:
i) Maximum payable is 105 minutes (7 units).
ii) Payable once per patient, except where patient reapplies as previous MAiD request was declined.
iii) Not payable with 13501 or 13502 by the same physician.
iv) Not payable with a consult or visit on the same day by the same physician.
v) Start and end time for the assessment must be entered in both the billing claim and patient's chart.

P13507 MAiD Waiver of Final Consent
Includes explanation and review of the Waiver of Final Consent with the patient as well as completing the waiver form. May be provided in-person or by video conference – per 15 minutes or greater portion thereof.. — 43.67
NOTES:
i) Maximum payable is 60 minutes (4 units) (see note iv. for exception).

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	ii) Payable only to the Assessor Prescriber who provides the MAiD assessment fee 13501. iii) Payable in addition to fee 13501. iv) A second waiver may be paid if the original waiver has expired. If second waiver performed by the same assessor as the first waiver, only one additional unit may be billed. v) Start and end time must be entered in both the billing claim and patient's chart.		
P13508	Oral MAiD extension (extra) For provision of oral MAiD when the procedure takes longer than 90 minutes or conversion to IV MAiD is necessary – per 15 minutes or greater portion thereof..		43.67
	NOTES: i) Maximum payable is 90 minutes (6 units). ii) Only payable when MAiD provision is by oral medication. iii) Only payable in addition to fee 13504. iv) Timing begins after 90 minutes has passed since administration of the oral agent. v) Start and end time must be entered in both the billing claim and patient's chart. vi) No other surcharge is payable.		
13015	HIV/AIDS Primary Care Management - in or out of office - per 1/2 hour or major portion thereof	269.00	87.89
	NOTES: i) When performed in conjunction with visit, counselling, consultations or complete examinations, only the larger fee is billable. ii) Only applicable to services submitted under diagnostic codes 042, 043 and 044. iii) Services that are less than 15 minutes duration should be billed under the appropriate visit fee item. iv) Start and end times must be entered in both the billing claims and the patient's chart.		

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

HOME VISITS

00103	Home visit.....	386.00	147.69

NOTES:

i) Payable for a home visit between 0800 and 2300 hours any day of the week.

ii) 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). Please see Preamble D. 4. 12.

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

HOSPITAL AT HOME

P13010	Hospital at Home Virtual Visit	149.00	56.87

NOTES:

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

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

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

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

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

(notes continued on next page)

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

vii) For urgent or emergent care when the attending physician is specially called back because the patient's condition has changed requiring the physician's attendance, an in-person visit can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.
   a) When the physician must immediately leave home, office, or hospital to render care, an additional weekday daytime in-person emergency visit can be billed as fee item 00112, if the billing criteria are met.
   b) When the physician is specially called on an evening, nighttime, or weekend to render emergency or non-elective services and must travel from one location to another to attend the patient, call out charges can be billed under fee items 01200, 01201, 01202 in addition to fee item 13011. Continuing care fee surcharges 01205, 01206, 01207 can be billed if the billing criteria are met.

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

13011	Hospital at Home In-Person Visit	200.00	72.43

NOTES:

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

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

iii) For essential and non-emergent care, a subsequent Hospital at Home visit on the same calendar day can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required.
   a) An additional in-person visit on the same calendar day for a Hospital at Home patient must be billed under fee item 13011 with submission code D.
   b) A subsequent virtual visit on the same calendar day for a Hospital at Home patient must be billed as fee item 13010.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	iv) For urgent or emergent care when the attending physician is specially called back because the patient's condition has changed requiring the physician's attendance, an in-person visit can be billed as noted below. The claim note record for the subsequent visit must include the time of each visit and the reason why the subsequent visit was required. a) When the physician must immediately leave home, office, or hospital to render care, an additional weekday daytime in-person emergency visit can be billed as fee item 00112, if the billing criteria are met. b) When the physician is specially called on an evening, nighttime, or weekend to render emergency or non-elective services and must travel from one location to another to attend the patient, call-out charges can be billed under fee items 01200, 01201, 01202 in addition to fee item 13011. Continuing care fee surcharges 01205, 01206, 01207 can be billed if the billing criteria are met. v) Fee item 00103 (home visit) is not payable for a patient admitted under a Hospital at Home program.		
13012	Hospital at Home FP Conference with Allied Care Provider and/or Physician – per 15 minutes or greater portion thereof NOTES: i) Payable only for a patient admitted under a Hospital at Home program. ii) Payable for two-way collaborative conferencing, either by telephone, video conferencing or in-person, between the Family Physician and an allied care provider and/or a physician. iii) Conferencing cannot be delegated. No claim may be made where communication is with a proxy for either provider. iv) Details of the care conference must be documented in the patient's chart as well as information on clinical discussion and decisions made.	133.00	50.35

(notes continued on next page)

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

v) Not payable for simple advice to a non-physician allied care provider about the patient or where the primary purpose of the call is to:
   a) Book an appointment
   b) Arrange for an expedited consultation or procedure
   c) Arrange for laboratory or diagnostic investigations
   d) Convey the results of diagnostic investigations
   e) Arrange a hospital bed for a patient.

vi) payable in addition to any visit fee on the same day if medically required and does not take place during a time interval that overlaps with the patient conference (i.e. Visit time is separate from conference time).

vii) Payable to a maximum of 2 units (30 minutes) per patient on any single day.

viii) If multiple patients are discussed, the billings must be for consecutive, non-overlapping time periods.

ix) Start and end times must be included with the claim and documented in the patient chart. If conferencing takes place as a series of separate phone calls, use the start time of the first call and calculate the “end time” based on total time spent conferencing.

x) 14018 or 14077 are not payable for a patient admitted under a Hospital at Home program.

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

FP FACILITY VISITS

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

00109	Acute care hospital admission examination	213.00	83.46

(see notes on next page)

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

NOTES:

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

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

iii) Fee item 00109 is not applicable if fee item 12101, 00101, 15301, 16101, 17101, 18101, 12201, 13201, 15021, 16201, 17201 or 18201 has been billed by the same physician within the week preceding the patient’s admission.

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

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

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

00108	Hospital visit	83.50	32.65

NOTES:

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

(notes continued on next page)

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

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

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

00128	Supportive care hospital visit.....	91.50	35.00

NOTES:

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

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

(see notes on next page)

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

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

00127	Palliative Care In-Person Facility Visit	178.00	68.00

NOTES:

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

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

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

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

(notes continued on next page)

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

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

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

vii) Chemotherapy fee items (00578, 00579, 00580, 33581, 33582, and 33583) are not payable to the same physician for the same patient on the same day. Not payable if the patient dies unexpectedly during a hospitalization and was not considered palliative.

Community Based FP Hospital Visits

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

Physician Eligibility:

- Payable only to FPs who maintain an active family practice in the community, accepting the role of being Most Responsible Physician (MRP) for the longitudinal coordinated care of their patients.

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

- Not payable to physicians who have been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).
- Not payable to physicians who are employed by, or who are under contract, whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

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

13109	Community based FP: Acute care hospital admission examination.....	340.00	130.00

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

NOTES:

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

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

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

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

v) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient’s condition has changed, requiring the physician’s attendance or due to a condition unrelated to the hospitalization. If 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 FP, first facility visit of the day bonus, extra (active hospital privileges) (for routine, supportive or palliative care)	233.00	89.05

(see notes on next page

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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
13008	Community based FP: hospital visit (active hospital privileges).....	178.00	68.00

NOTES:

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

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need 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 FP: supportive care hospital visit (active hospital privileges)	103.00	44.31

NOTES:

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

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	ii) Essential non-emergent additional visits to a hospitalized patient by the physician providing supportive care for diagnosis unrelated to the admission diagnosis, during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record. iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.		
	Community Based FP With Courtesy or Associate Hospital Privileges		
13339	Community based FP, first facility visit of the day bonus, extra (courtesy/associate privileges) ..... 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.	233.00	89.05
13228	Community based FP: hospital visit (courtesy/associate privileges) ..... 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.	82.40	33.82

(notes continued on next page)

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

iii) Not payable with any other visit fee including 00108, 13008, 00109, 13109, 00114, 00115, 00113, 00105, 00123, 00127, 12200, 13200, 15200, 16200, 17200, 18200, 12201, 13201, 15201, 16201, 17201, 18201, 00128, 13028,13015, 12220, 13220, 15220, 16220, 17220, 18220, 00121, 00122, 12210, 13210, 15210, 16210, 17210, 18210, 00116, 00112, 00111.

iv) If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable.

v) A written record of the visit must appear in either in patient's hospital or office chart.

vi) If a hospitalist or FP member of an Unassigned In-Patient Care Network is providing FP care to the patient, the community based FP with courtesy or associate hospital privileges may bill 13228.

vii) Note vi) also applies to Community based FPs with active hospital privileges at a hospital other than the one to which the patient is admitted.

ON-CALL, ON-SITE HOSPITAL VISITS

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

00113	Evening (between 1800 hours and 2300 hours).....	174.00	58.64
00105	Night (between 2300 hours and 0800 hours)	231.00	81.51
00123	Saturday, Sunday or Statutory Holiday	174.00	58.64

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

LONG TERM CARE FACILITY VISITS

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

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

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

The LTCI promotes three system-level outcomes:

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

The five LTCI Best Practice Expectations are:

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

P13115 Long-Term Care Admission 340.00 130.00

NOTES:

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

00114 Long-Term Care In-Person Visit..... 149.00 57.00

NOTES:

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

13334 Community based FP, long term care facility visit - first visit of the day bonus, extra 233.00 89.05

(see notes on next page)

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

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

00115 Long-Term Care Urgent Assessment..... 386.00 147.69

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

EMERGENCY VISITS

00112 Emergency visit (call placed between hours of 0800 and 1800 hrs - weekdays)..... 313.00 134.69

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

(continued on next page)

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

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.

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	327.00	134.69

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
TELEPHONE ADVICE			
00043	Anticoagulation therapy by telephone	32.35	10.08
13000	Telephone advice to a Community Health Representative in First Nation's Communities	48.60	21.08

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	48.60	21.08

NOTES:

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

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

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

(notes continued on next page)

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

iv) Claims should be submitted under the personal health number of the patient and should indicate the time of day the request for advice was received.
v) Dates of services under this item should be documented in the patient's record together with the name and position of the enquiring allied health care worker and a brief notation of the advice given. Alternatively the original of a fax or a copy of written advice will suffice to document these services.
vi) This fee may not be claimed in addition to visits or other services provided on the same day by the same physician for the same patient with the exception of 14076.
vii) This fee may be billed to a maximum of one per patient per physician per day.
viii) This fee may not be claimed for advice in response to enquiries from a patient or their family.
ix) Not payable to physicians who are employed by or who are under contract to a facility, working under salary, service contract or sessional arrangements whether on-duty or on call when these duties would otherwise include provision of this care.

T13706	FP Delegated Patient Telehealth Management Fee....	50.20	21.86

NOTES:
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.
i) 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.
ii) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	iii) Only one service payable per patient per day. iv) Not payable on the same calendar day as a visit or service fee by same physician for same patient. v) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.		
T13707	FP Email/Text/Telephone Medical Advice Relay or ReRx Fee	17.60	10.19
	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.		

OBSTETRICAL CARE

14199	Management of prolonged second stage of labour, per 30 minutes or major portion thereof	266.00	98.72

(see notes on next page)

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

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	FP Prenatal visit - complete examination	226.00	99.69
14091	FP - Prenatal visit - subsequent examination	101.00	42.90

NOTES:
i) Restricted to Family Physicians
ii) 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.
iii) Where a patient transfers their total ongoing uncomplicated prenatal care to another physician, the second physician also may charge a prenatal visit complete examination and subsequent examinations, as rendered. To facilitate payment the reason for transfer should be stated with the claim. Temporary substitution of one physician for another during days off, annual vacation, etc., should not be considered as a patient transfer.
iv) Other than during 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.
v) Other than procedures, services for the care of unrelated conditions, during a prenatal or postnatal visit are included in the prenatal (14091) or post-natal visit fee (14094). Procedures rendered for unrelated conditions are chargeable as set out in Preamble D. 8. d.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
14094	FP - Postnatal office visit..... NOTE: i) Restricted to Family Physicians. ii) 14094 may be billed in the six weeks following delivery (vaginal or caesarean section). iii) Not payable to physician performing caesarean section.	101.00	42.88
14104	Delivery and postnatal care (1-14 days in-hospital) ..... NOTES: i) Restricted to Family Physicians. ii) Care of newborn 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 14094.	1689.00	679.70
14105	Management of labour and transfer to an alternate facility for delivery..... NOTES: i) This fee includes all usual hospital care associated with the delivery provided by the referring physician. ii) May be claimed by the referring physician when they intended to conduct the delivery and when the referring physician: a) Attends the patient during active labour, defined as regular painful contractions, occurring at least once in five minutes, lasting at least 40 seconds, accompanied by either spontaneous rupture of the membranes, or full cervical effacement and dilatation of at least two centimetres. b) Provides assessment of the progress of labour, as evidenced by documentation in the patient's chart. c) Documents the reason for referral in the patient's chart. d) Transfers the patient to another facility. iii) Not payable with an assessment fee, visit fee, 14104, 14109, 04414, 04419, or generally 14199, for the same patient on the same day. (Provide a claim note record if claiming for 14199 in addition.)	706.00	283.05

(see notes on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	iv) Continuing Care Surcharges do not apply to maternity services in the first stage of labour only. v) When medically necessary additional post-partum office visit(s) are payable under 14094 or 04194.		
P14106	Additional attendant at an out-of-hospital birth ..... NOTES: i) Restricted to Family Physicians. ii) Payable for in-person assistance at an out-of-hospital birth by a physician acting as an additional attendant. iii) Call-out charges (01200, 01201, 01202) and non-operative continuing care surcharges (01205, 01206, 01207) are payable in addition when appropriate. Non-operative continuing care surcharges are payable only for the second and third stage of labour. Please see the Out-of-Office Hours Premiums Explanatory Note (g) for more information. iv) Postnatal office visits (14094) and accompanying patient(s) to a distant hospital (00084) are payable in addition. v) Not payable in addition to 14104, 14105, 14109 or 14199 on the same day to the same physician for the same patient.	1568.00	600.00
14108	Postnatal care after caesarean section (1-14 days in-hospital)..... NOTES: i) Restricted to Family Physicians. ii) Postnatal office visits are payable under fee item 14094. iii) Not payable in addition to 14109.	348.00	139.85
14109	Primary management of labour, attendance at delivery, and postnatal care associated with emergency caesarean section (1-14 days in-hospital)..... NOTES: i) Restricted to Family Physicians ii) Postnatal office visits are payable under fee item 14094. iii) Not payable in addition to 14108.	1408.00	566.16
15120	Pregnancy test, immunologic - urine	34.60	14.09

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
INFANT CARE			
00118	Attendance at cesarean section (if specifically requested by surgeon for care of baby only)..... NOTE: Not payable if a pediatrician is present at the caesarean section to care for the baby)	287.00	104.76
00119	Routine care of new-born in hospital.....	243.00	107.08

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
GYNECOLOGY				
14540	Insertion of intrauterine device (IUD) (operation only).. NOTES: i) Includes cervical cancer screening, if clinically indicated. ii) Not payable in addition to 14541.	153.00	2	55.77
14542	Insertion of subdermal contraceptive implant.....	158.00		58.47
14543	Removal of subdermal contraceptive implant	202.00		74.72
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.	432.00		186.90
P14562	Office Vaginal Speculum Exam (extra) ..... NOTES: iii) Restricted to Family Physicians. iv) Payable at 100% in addition to an in-office service on the same date of service. v) Payable with a mini tray fee (00044). vi) When the vaginal speculum exam is provided by a physician, this fee must be billed in conjunction with a consultation, visit, counselling, complete examination, prenatal visit, or postnatal visit.	88.80		15.15

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	vii) ....Wh en the vaginal speculum exam is delegated to a College-certified allied care provider employed by a physician practice, this fee can be billed as a stand-alone fee when no physician consultation or visit is provided on the same day to the same patient.			
	viii) ....Not payable in addition to 00784, 00785, 04509 or 14540.			
14563	Gynecologic Cervical Block – extra..... NOTES:	69.30		25.25
	i) Restricted to Family Physicians.			
	ii) Payable only when billed with 00784, 00785, 04509, 14540, or 14562 on the same date of service.			
	iii) Payable at 100% in addition to 00784, 00785, 04509, 14540, and 14562.			

UROLOGY

PY13655	FP Vasectomy bonus associated with bilateral vasectomy - extra..... NOTES:	125.00		45.45
	i) Restricted to Family Physicians.			
	ii) Payable only in addition to fee item S08345.			
	iii) Maximum of one bonus per vasectomy procedure.			

SURGICAL ASSISTANCE

	Surgical assist code based on total operative fee(s) for procedure(s):			
00195	– less than $317.00 inclusive.....	680.00		147.95
00196	– $317.01 - $529.00 inclusive.....	964.00		209.92
00197	– $529.01 to $869.00 inclusive	1421.00		309.31
P13197	– greater than $869.00	2068.00		450.00
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof.....	157.00		34.10

(see notes on next page)

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

NOTES:
i) Surgical assist fees are based on the total operative fee(s) for the associated surgical procedure(s). Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s).
ii) When a physician provides surgical assistance for two surgeries at different operative sites under one anesthetic, they may charge a separate surgical assistance fee for each surgery. This applies whether the two surgeries were performed by the same surgeon or by different surgeons. This does not apply to bilateral procedures, procedures within the same body cavity, or procedures on the same limb.
iii) Visit fees are not payable to the same physician on the same day as surgical assistance fees, unless each service is performed at a distinct/separate time. When this occurs, start and end times must be noted on each billing claim.
iv) When a surgical assistant is required for minor surgery, a detailed explanation of the need for the surgical assistant is required in the claim note record.

13194	First Surgical Assist of the Day	463.00		110.67

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

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

NOTES:
i) Payable for any surgical assist provided when the patient has a Body Mass Index (BMI) greater than or equal to 35.
ii) Payable for all surgeries for which surgical assist fee codes 00193, 00195, 00196, 00197, and 13197are billable.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) The patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report. iv) Maximum of one BMI surcharge per operation unless two surgical assistants are providing concurrent surgical assistance during the same surgery. v) Out-of-office hours operative surcharges (01210, 01211 and 01212) are not payable on the BMI surgical assist surcharge.			
	Open Heart Surgery			
00193	Non-CVT certified surgical assistance at open-heart surgery, per quarter hour or major portion thereof ..... 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.	107.00		34.05

ANESTHESIA

13052	Anesthetic evaluation, non-certified Anesthesiologist .. NOTE: See Anesthetic Preamble regarding Pre-Anesthetic Evaluation Fees.	146.00		64.41

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 ..... 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 Alteration of Appearance".	101.00		35.87
Y10710	In-office Anoscopy.....	24.35		11.71

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Anoscopy is the examination of the anus and anal sphincter, for evaluating patients with anal and/or peri-anal symptoms (pain or bleeding) or used as an adjunct to the DRE. ii) Not payable in addition to 00715, 00716, 00718, 10714, 10731, 10732 or 10733. iii) Restricted to Family Physicians.			
13660	Metatarsal bone – closed reduction - operation only ...	147.00	2	59.85
13600	Biopsy of skin or mucosa - operation only	144.00	2	59.26
13601	Biopsy of facial area - operation only	144.00	2	59.26
	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)	126.00	2	50.75
13610	Minor laceration or foreign body – not requiring anesthesia (operation only)	99.60		40.64
	NOTES: i) Intended for primary treatment of injury ii) Not applicable to dressing changes or removal of sutures iii) Applicable for steri-strips or glue to repair a primary laceration			
13611	Minor laceration or foreign body requiring anesthesia – (operation only)	188.00	2	75.71
13612	Extensive lacerations over 5 cm (maximum charge 35 cm) – (operation only) - per cm	36.80	2	15.19
	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	188.00	2	75.70
13621	– additional lesions removed at the same sitting (maximum per sitting – five) – each - operation only	92.20		37.87

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	204.00	2	87.72
13623	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic – face (operation only) NOTE: Not billable by Plastic Surgery, Orthopaedics or Otolaryngology.	249.00		102.12
13624	Removal of extensive scars – 5 cm or more – per cm over 5 cm (in addition to 13623 or 13620) NOTES: i) Payment for scar revision based on length of scar, not length of incision. ii) A note record is required for scars >30 cm. iii) Not billable by Plastic Surgery, Orthopaedics or Otolaryngology.	23.85		9.77
13630	Paronychia (operation only)	99.30	2	40.50
13631	Removal of nail – simple (operation only)	99.30	2	40.50
13632	– with destruction of nail bed - operation only	199.00	2	81.96
13633	Wedge excision or Vandenbos procedure of one nail – (operation only)	178.00	2	72.32
P13640	Add-on Procedure (extra) NOTES: i) Restricted to family physicians. ii) Payable at 100% in addition to an in-person service provided in a clinic or a patient's home on the same date of service.	26.15		10.00

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Payable for one of the following minor procedures: a) Ear syringing b) Suture and staple removal c) Wound care and dressing change d) Frenotomy e) Treatment of epistaxis, including nasal packing and silver nitrate f) Procedures for therapeutic foot care, including symptomatic callus debridement, use of a Dremel for dystrophic toenails, debridement of diabetic foot ulcers, silver nitrate to granulomas. Not payable for foot examination and monofilament testing. iv) When the procedure is provided by a physician, this fee is payable at 100% in addition to a consultation, visit, counselling, complete examination, prenatal visit or postnatal visit. v) When the procedure is delegated to a college-certified allied care provider employed by a physician practice, this fee can be billed as a stand-alone fee when no physician consultation or visit is provided on the same day to the same patient. vi) Payable with a mini tray fee (00044). vii) Details of the procedure must be documented in a procedure note in the patient's chart.			
13650	Enucleation or excision of external thrombotic hemorrhoid - operation only	146.00	2	59.13

		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 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%.	16.35	6.76
15132	Candida culture	21.90	6.82
15136	Fungus, direct microscopic examination, KOH preparation	32.60	8.57
15100	Glucose – semiquantitative (dipstick analysed visually or by reflectance meter)	12.05	5.02
15137	Hemoglobin - cyanmethemoglobin method and/or hematocrit	9.95	3.19
15000	Hemoglobin – other methods NOTE: 15137 and 15000 – see the Laboratory Services Payment Schedule for additional hematology information.	5.30	1.66
15110	Occult blood – feces Note: Applies only to guaiac methods.	15.90	5.49
15120	Pregnancy test, immunologic, urine	34.60	14.09

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
30015	Secretion smear for eosinophils.....	34.55	7.45
15139	Sperm, Seminal examination for presence or absence	57.00	15.11
15141	Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination	26.55	6.55
15130	Urinalysis – Chemical or any part of (screening)	7.00	3.67
15131	Urinalysis – microscopic examination of centrifuged deposit	13.90	5.03
15142	Urinalysis – Complete diagnostic, semi-quant and micro.	20.55	5.78
	The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:		
93120	ECG tracing, without interpretation (technical fee).....	49.10	17.38

INVESTIGATION

00117	Interpretation of electrocardiogram by non-internist.....	35.40	11.15

NO CHARGE REFERRAL

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

SEE NEXT PAGE FOR FPSC INITIATED LISTINGS.

FAMILY MEDICINE - FPSC

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

Family Practice Services Committee (FPSC) Initiated Listings

Preamble

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

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

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

Unless otherwise identified in the individual fee description, physicians are NOT eligible to bill FPSC 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 been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

Additional detailed eligibility requirements are identified in each section.

Definitions in FPSC Initiated Listings:

(1) Physicians

Community Longitudinal Family Physician (CLFP)
For the purpose of FPSC incentives, a family physician is working as a "Community Longitudinal Family Physician" (CLFP) when they do all of the following:

- Assume the role of Most Responsible Physician/Provider (MRP) for a known panel of patients.
- Confirm patient-physician relationship with their patients through a standardized conversation or "compact", as outlined in G14070.

- Provide, or coordinate delivery of, longitudinal full scope family medicine primary care services to a patient panel that is inclusive of patients of diverse demographics and medical needs.
- Work in community settings such as physician offices or health care clinics where patients are seen in person. CLFP may also provide some virtual services to their patient panel via telephone, video or other virtual care modality. CLFP may also provide some services to patient panel in facility settings such as hospitals, long-term care, hospices, assisted living, or group homes.
- Maintain the comprehensive longitudinal medical records of each patient on patient panel.

A family physician is not considered to be working as a CLFP while they are working solely in one or more of the following health care settings:

- Episodic care settings such as (but not limited to) walk-in clinics, urgent care centres, and hospitals, where physician does not assume the role of MRP for patients.
- Virtual care settings where patient care is delivered via telephone, video, or other virtual care modalities.
- Focused practices serving a specific patient population or providing subspecialty services such as (but not limited to) maternity care, palliative care, sports medicine, chronic pain, and addiction care.
- Facility settings such as (but not limited to) hospitals, long-term care, hospices, assisted living, or group homes.

Family Physician with Consultative Expertise

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

Locum Tenens

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

Most Responsible Physician/Provider (MRP)

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

(2) Allied Care Providers

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

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

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

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

(3) Payment Models

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

Longitudinal Family Physician (LFP) Payment Model:
The LFP Payment Model is a compensation option for family physicians who provide longitudinal, relationship-based, family medicine care to a known panel of patients, aligned with the attributes of a Patient Medical Home. It is grounded in a commitment to increase patient access to community-based, longitudinal family medicine care, and expand primary care capacity across British Columbia.

The LFP Payment Model is designed as a comprehensive payment model for longitudinal family physicians, incorporating several aspects of family medicine care. It includes clinic-based services that are provided via longitudinal family physician clinics, pregnancy & newborn clinics, and patients' home settings. It also includes facility-based care in long-term care facilities and palliative care facilities, as well as inpatient care and pregnancy & newborn care in hospital.

(4) Miscellaneous

Assisted Living:
For the purpose of its incentives when referring to assisted living, FPSC utilizes the ministry 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, FPSC requires documentation of the following core elements in the patient's chart, as follows:

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

Face to Face:
For the purpose of its incentives, FPSC defines “face to face” to mean in-person.

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

Patient’s Medical Representative:
For the purpose of its incentives, FPSC defines Patient’s Medical Representative as outlined in the “Health Care (Consent) and Care Facility (Admission) Act”.

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

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

a) the adult's spouse;
b) the adult's child;
c) the adult's parent;
d) the adult's brother or sister;
d1) the adult's grandparent;
d2) the adult's grandchild;
e) anyone else related by birth or adoption to the adult;
f) a close friend of the adult;
g) a person immediately related to the adult by marriage.

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

Patient Panel:
For the purpose of its incentives, the FPSC defines a “patient panel” as the group of patients for which a family physician has assumed the role of MRP and has confirmed their ongoing patient-physician relationship.

Reciprocal Claims:
All Provinces and Territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid Provincial health Registration Card. There are some services excluded under the Inter-Provincial Agreements as pe the MSC Payment Schedule Preamble C. 11 regarding Reciprocal Claims.

Claims for FPSC fees must first meet the FPSC Preamble and the fee criteria and may then be billed through the MSP claims system (with the exception of Quebec) as follows:

a) FPSC fees payable for services provided to resident of other provinces (with the exception of Quebec) are:

- G14021, G14022, G14023 FP with Consultative Expertise Fees
- G14018 FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise
- G14019 FP Advice to a Nurse Practitioner/Registered Midwife Fee
- G14004, G14005, G14008, G14009 FP Obstetrical Premiums
- G14063 Palliative Care Planning
- H14088 FP Unassigned Inpatient Care Fee

b) FPSC fees payable for services provided to residents of Alberta or Yukon by a physician who has successfully submitted and met the requirements of 14070/14071/14072:

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

c) FPSC fees payable for services provided to residents of Alberta or Yukon by a physician who is a MRP Family Physician under Alternate Payment/Funding Model Programs:

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

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

1. COMMUNITY LONGITUDINAL FAMILY PHYSICIAN PORTALS (G14070, G14071)

Submitting code G14070 provides access to the following fee codes:

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

Submitting G14070 signifies that:

- You are community longitudinal family practice (as defined in the FPSC Preamble), with an office from which you provide in-person medical services to a known panel of patients;
- You are the MRP for the majority of the patient's longitudinal primary medical care, providing continuous comprehensive coordinated family practice services to your patients, and will continue to do so for the duration of that calendar year;
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'Compact'; and
- You are able to produce a list of active patients for whom you are the MRP.

Family Physician-Patient 'Compact'

The standardized wording of the Family Physician-Patient 'Compact' was developed in consultation with physicians and members of the Patient Voices Network. The FPSC believes this compact appropriately describes the relationship between a FP and their patients.

The compact states:

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

- Provide you with the best care that I can

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

- 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

G14070	Community Longitudinal Family Physician Portal Code The Community Longitudinal Family Physician Portal should be submitted once at the beginning of each calendar year by CLFP who maintain a comprehensive longitudinal practice OR at any time during the year when the CLFP begins their comprehensive longitudinal practice. Successful submission of 14070 allows access to fees listed in the notes below during the calendar year. Submit fee item 14070 Community Longitudinal Family Physician Portal Code using the following “Patient” demographic information: **PHN: 9753035697** **Patient Surname: Portal** **First name: FPSC** **Date of Birth: January 1, 2013** **ICD-9 code: 780** NOTES: i) Submit once per calendar year per physician. ii) Submission provides access to the following fee codes: • 14076 FP Patient Telephone Management Fee *(notes continued on next page)*	0.00	0.00

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

- 14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
- 14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- 14078 FP Email/Text/Telephone Medical Advice Relay Fee
- 14050, 14051, 14052, 14053 Chronic Disease Management Fees
- 14033 Complex Care Planning & Management Fees – 2 Diagnoses
- 14075 FP Frailty Complex Care Planning and Management Fee
- 14043 Mental Health Planning Fee
- 14044, 14045, 14046, 14047 and 14048 Mental Health Management Fees
- 14063 Palliative Care Planning Fee
- 14066 Personal Health Risk Assessment (Prevention) Fee
- 14041 CLFP New Patient Intake Fee
- H14002 Maternity Risk Assessment Fee
- G14004, G14005, G14008 and G14009 FP Obstetrical Premiums

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

iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Locum Community Longitudinal Family Physician Portal

The Locum Community Longitudinal Family Physician Portal Code (G14071) provides access to the following incentive fee codes:

G14076 FP Patient Telephone Management Fee

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

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

- G14033, 14075 Complex Care Planning & Management Fees
- G14043, G14044, G14045, G14046, G14047 and G14048 Mental Health Planning & Management Fees
- G14063 Palliative Care Planning
- G14066 Personal Health Risk Assessment (Prevention)

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

The host CLFP must have submitted G14070 in the same calendar year. The locum tenens and host FP should discuss and mutually agree which of the services accessed through the Community Longitudinal Family Physician Portal may be provided and billed by the locum. However, locums have their own annual allotment of H14067 (FP Brief Clinical Conference with Allied Care Provider and/or Physician), G14076 (FP Patient Telephone Management Fee) and G14078 (FP Patient Email/Text/Telephone Medical Advice Relay Fee).

G14071	Locum Community Longitudinal Family Physician Portal Code..... The Community Longitudinal Family Physician Portal Code may be submitted by the FP who provides locum coverage for Family Physicians who have submitted G14070. G14071 should be submitted once at the beginning of each calendar year or prior to the start of the first locum for a host FP who has submitted G14070 in the same calendar year. Once processed by MSP, the locum may access the fees listed in note ii) below. Submit fee item G14071 Locum Community Longitudinal Family Physician Portal Code using the following “Patient” demographic information: **PHN: 9753035697** **Patient Surname: Portal** **First name: GPSC** **Date of Birth: January 1, 2013** **ICD-9 code: 780**	0.00	0.00

(see notes on next page)

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

Submission of this code signifies that:

- You are providing continuous comprehensive coordinated family practice services to the patients of the host physician who has submitted G14070 and will continue to do so for the duration of locum coverage.

NOTES:

i) Submit once per calendar year at the beginning of the year or prior to the first locum for a family physician who has submitted G14070 in the same calendar year.

ii) Submission provides access to the following fee codes:
- G14076 FP Patient Telephone Management Fee
- G14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
- H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- G14078 FP Email/Text/Telephone Medical Advice Relay Fee
- G14050, G14051, G14052, G14053 Chronic Disease Management Fees
- G14033, G14075 Complex Care Planning & Management Fees
- G14043, G14044, G14045, G14046, G14047 and G14048 Mental Health Planning and Management Fees
- G14063 Palliative Care Planning Fee
- G14066 Personal Health Risk Assessment (Prevention)

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

iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

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

2. LONG-TERM CARE PORTAL

Effective January 1, 2021, family physicians who have a focused practice in long term care facilities and are not working as a Community Longitudinal Family Physician (as defined in the FPSC Preamble) in a community-based physician office or clinic will not be eligible to submit the Community Longitudinal Family Physician Portals (G14070, G14071).

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

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

G14072 Long-Term Care Portal Code 0.00 0.00

The Long-Term Care Portal Code should be submitted once at the beginning of each calendar year by a family physician who has a focused practice in a long-term care facility and is not working as a Community Longitudinal Family Physician (as defined in the FPSC Preamble) in a community-based physician office or clinic.

When a family physician first begins a long-term care focused practice, the Long-Term Care Portal Code should be submitted when the focused practice begins. Successful submission of the G14072 allows access to fees listed in the notes below during the calendar year.

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

PHN:	**9753035697**
Patient Surname:	**Portal**
First name:	**FPSC**
Date of Birth:	**January 1, 2013**
ICD-9 code:	**780**

NOTES:

i) Submit once per calendar year per physician.

(notes continued on next page)

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

ii) Submission provides access to the following fee codes:
- G14076 FP Patient Telephone Management Fee
- G14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
- H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- G14078 FP Email/Text/Telephone Medical Advice Relay Fee
- G14050, G14051, G14052, G14053 Chronic Disease Management Fees

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

iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

3. CHRONIC DISEASE MANAGEMENT FEES (G14050, G14051, G14052, G14053, G14029)

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

To confirm an ongoing doctor-patient relationship, there must be at least 2 visits billed over the previous 12 months.

- Visits provided by a locum or colleague covering for the MRP FP may be counted toward these 2 visits. A claim note record indicating the locum or colleague coverage must be submitted with the claim.

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

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

(notes continued on next page)

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

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

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

G14050 Annual chronic disease management fee (diabetes mellitus)..... 314.00 137.89

NOTES:

i) Payable only to Family Physicians who have successfully submitted 14070 or on behalf of Locum Family Physicians who have successfully submitted 14071 on the same or a prior date in the same calendar year.

ii) Payable to Family Physicians who have successfully submitted 14072.

iii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.

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

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

vi) Claim must include the ICD-9 code for diabetes (250).

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

(notes continued on next page)

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

viii) Payable in addition to fee items 14051 or 14053 for same patient if eligible.
ix) Not payable once 14063 has been billed and paid.
x) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

G14051	Annual chronic disease management fee (heart failure)	314.00	137.89

NOTES:
i) Payable only to Family Physicians who have successfully submitted 14070 or on behalf of Locum Family Physicians who have successfully submitted 14071 on the same or a prior date in the same calendar year.
ii) Payable to Family Physicians who have successfully submitted 14072.
iii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.
iv) This item may only be billed after one year of care has been provided including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team. (See FPSC Preamble definition of "working within" and "College-certified ACP")
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.
vi) Claim must include the ICD-9 code for congestive heart failure (428).
vii) Payable once per patient in a consecutive 12-month period.
viii) Payable in addition to items 14050 or 14053 for the same patient if eligible.

(notes continued on next page)

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

ix) Not payable once 14063 has been billed and paid.
x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

G14052 Annual chronic disease management fee (hypertension) 126.00 55.17

NOTES:

i) Payable only to Family Physicians who have successfully submitted 14070 or on behalf of Locum Family Physicians who have successfully submitted 14071 on the same or a prior date in the same calendar year.
ii) Payable to Family Physicians who have successfully submitted 14072.
iii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.
iv) This item may only be billed after one year of care has been provided including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical or telehealth visits qualify.
    1. Only one of the qualifying visits may be a group medical visit.
    2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team. (See FPSC Preamble definition of "working within" and "College-certified ACP").
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.
vi) Claim must include the ICD-9 code for hypertension (401).
vii) Payable once per patient in a consecutive 12-month period.
viii) Not payable if 14050, or 14051 paid within the previous 12 months.
ix) Not payable once 14063 has been billed and paid.
x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
G14053	Annual chronic disease management fee (Chronic Obstructive Pulmonary Disease – COPD).....	314.00	137.89

NOTES:

i) Payable only to the family Physicians who have successfully submitted 14070 or on behalf of Locum Family Physicians who have successfully submitted 14071 on the same or a prior date in the same calendar year.

ii) Payable to Family Physicians who have successfully submitted 14072.

iii) Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.

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

1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (14029). (See FPSC Preamble definition of "working within" and "College-certified ACP").

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

vi) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).

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

viii) Payable in addition to fee items 14050, 14051 or 14052 for the same patient if eligible.

ix) Not payable once 14063 has been billed and paid.

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
G14029	Allied Care Provider Practice Code.....	0.00	0.00

NOTES:

i) Applicable for medical services (office, prenatal, home or long-term care) provided by a College-certified allied care provider working within the family physician's practice team where the family physician has accepted responsibility for the provision of the care. (See FPSC Preamble definition of "working within" and "College-certified ACP").

ii) A College-certified allied care provider may provide one of the two visits required for billing chronic disease management fees.

iii) Visits may be provided in-person or by telehealth (G14029, G14076).

iv) Payable for care provided to a patient with a condition eligible for one of the chronic disease management fees.

v) Not payable in addition to a visit fee on the same day to the same physician for the same patient, except for H14067 or G14077.

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

4. CHRONIC DISEASE MANAGEMENT FEES FOR MRP FAMILY PHYSICIANS BILLING UNDER ALTERNATE PAYMENT/FUNDING MODEL PROGRAMS (G14250, G14251, G14252, G14253, G14276)

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

G14250	Annual chronic disease management fee (diabetes mellitus) for MRP FPs on alternate payment/funding models.....	353.00	137.89

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 ($)	MSP & WSBC Fee ($)

ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.

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

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

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

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

vi) Claim must include the ICD-9 code for diabetes (250).

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

viii) Payable in addition to fee items 14251 or 14253 for same patient if eligible.

ix) Not payable once 14063 has been billed and paid.

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

G14251	Annual chronic disease management fee (heart failure) for MRP FPs on alternate payment/funding models	353.00	137.89

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 ($)	MSP & WSBC Fee ($)

ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.
iii) This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
1. Only one of the qualifying visits may be a group medical visit.
2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the family physician's practice team. (See FPSC Preamble definition of "working within" and "College-certified ACP").
iv) Only payable to physicians who are on an alternate payment/funding model as described in the FPSC Preamble.
v) Not payable to physicians remunerated under the LFP Payment Model.
vi) Claim must include the ICD-9 code for heart failure (428).
vii) Payable once per patient in a consecutive 12-month period.
vii) Payable in addition to fee items 14250 or 14253 for same patient if eligible.
viii) Not payable once 14063 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 Annual chronic disease management fee (hypertension) for MRP FPs on alternate payment/funding models 353.00 55.17

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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	iii) This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical or telehealth visits qualify. 1. Only one of the qualifying visits may be a group medical visit. 2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the family physician's practice team. (See FPSC Preamble definition of "working within" and "College-certified ACP"). iv) Only payable to physicians who are on an alternate payment/funding model as described in the FPSC Preamble. v) Not payable to physicians remunerated under the LFP Payment Model. vi) Claim must include the ICD-9 code for hypertension (401). vii) Payable once per patient in a consecutive 12-month period. viii) Not payable if fee items 14250 or 14251 paid within the previous 12 months. ix) Not payable once 14063 has been billed and paid. x) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.		
G14253	Annual chronic disease management fee (Chronic Obstructive Pulmonary Disease – COPD) for MRP FPs on alternate payment/funding models..... NOTES: i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care. ii) Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.	353.00	137.89

(notes continued on next page)

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

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

iv) Only payable to physicians who are on an alternate payment/funding model as described in the FPSC Preamble.
v) Not payable to physicians remunerated under the LFP Payment Model.
vi) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).
vii) Payable once per patient in a consecutive 12-month period.
viii) Payable in addition to fee items 14250, 14251 or 14252 for the same patient if eligible.
ix) Not payable once 14063 has been billed and paid.
x) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

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

NOTES:
i) Billable only by MRP Family Physicians who are employed or under contract to a facility or working under an alternate payment/funding model to demonstrate one of the two required visits as per fees 14250, 14251, 14252 and/or 14253.
ii) Not payable to physicians remunerated under the LFP Payment Model.

(notes continued on next page)

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

iii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician. Alternatively, telephone management may be billed when delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed by the eligible physician practice (see FPSC Preamble for definition of allied care provider "employed by" a physician practice and "College-certified ACP").
iv) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.
v) Not billable for prescription renewal alone.
vi) Not billable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
vii) Billable to a maximum of 1500 services per physician per calendar year.
viii) Not billable on the same calendar day as a visit or service by same physician for same patient, with the exception of 14250, 14251, 14252, 14253.

5. COMPLEX CARE PLANNING AND MANAGEMENT FEES (G14033, G14075)

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

Both G14033 and G14075 are available only to MRP Family Physicians who have submitted G14070 or G14071. G14033 and G14075 are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing calendar year.

Only one Complex Care Planning and Management Incentive may be billed for an individual patient in any given calendar year, even if the patient meets eligibility requirements for both G14033 and G14075. When patients meet eligibility requirements for both Complex Care Incentives, choose either G14033 or G14075 – whichever best reflects the cause of their medical complexity.

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
G14033	Complex Care Planning and Management Fee - 2 Diagnoses ..... The Complex Care Planning and Management Fee is payment for the creation of a care plan (as defined in the FPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions. It is payable upon the completion and documentation of a care plan in the patient's chart. **Patient Eligibility:** • Eligible patients must be living at home or in assisted living. • Patients in Acute and Long-Term Care Facilities are not eligible.	791.00	337.28

G14033 Complex Care Planning & Management Fee – 2 Diagnoses

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

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

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

(see notes on next page)

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

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 14070 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 14071 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 14033.

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).

(notes continued on next page)

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

vii) 14018, 14077, or 14067 payable on same day for same patent if all criteria met. Time spent on conferencing does not apply to time requirement for 14033.
viii) 14050, 14051, 14052, 14053 payable on same day for same patient, if all other criteria met.
ix) Not payable once 14063 has been billed and paid.
x) 14043, 14063, 14076 and 14078 not payable on the same day for the same patient.
xi) Maximum daily total of 5 of any combination of 14033 and 14075 per physician.
xii) 14075 is not payable in the same calendar year for same patient as 14033.
xiii) Eligible patients must be living at home or in assisted living. patients in Acute or Long-Term Care facilities are not eligible.
xiv) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model whose duties that includes payment for this service.

Diagnostic codes submitted with G14033 billing must be from Table 1. If the patient has multiple comorbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

Table 1: Complex Care Diagnostic Codes

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease
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

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

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

G14075 Complex Care Planning and Management Fee - Frailty 791.00 337.28

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

Patients of any age who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for G14075.

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

Patient eligibility:

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

(see notes on next page)

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

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 14070 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 14071 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 14075.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").

(notes continued on next page)

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

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)

vii) 14018, 14077 or 14067 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for 14075.

viii) Maximum daily total 5 of any combination of 14033 and 14075 per physician.

ix) 14075 not payable once 14063 has been billed and paid.

x) 14033 is not payable in the same calendar year for same patient as 14075.

xi) 14043, 14063, 14076, 14078 not payable on the same day for the same patient.

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

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

6. PREVENTION FEE (G14066)

G14066	Personal Health Risk Assessment (Prevention) ..... This fee is payable to the family physician who is most responsible for the majority of the patient's longitudinal primary medical care and who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, tobacco use, physically inactive, unhealthy eating, or at risk for substance use disorder). The FP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative.	126.00	54.12

G14066 is payable only to MRP Family Physicians who have submitted G4070 or G14071.

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

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/lifetime-prevention and the BC Prevention Guidelines https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines.

NOTES:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for 14070 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 14701 in the same calendar year.

ii) Payable only for patients with one or more of the following risk factors: Tobacco Use/Smoking, unhealthy eating, physical inactivity, medical obesity, or at risk for substance use disorder.

iii) Diagnostic code submitted with 14066 must be one of the following: Tobacco Use/Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783), at risk for substance use disorder (V82).

iv) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.

v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under G14066.

vi) 14077 or 14067 payable on same day for same patient if all criteria met.

vii) 14033, 14043, 14063, 14002, 14076 and 14078 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.

(notes continued on next page)

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

x) Not payable once 14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.
xi) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

7. MENTAL HEALTH PLANNING FEE (G14043)

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

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

G14043 is payable only to Family Physicians who have submitted G14070 or G14071. The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing year.

Patient eligibility:

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
G14043	FP Mental Health Planning Fee.....	251.00	110.30

NOTES:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for 14070 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 14071 in the same calendar year.

(notes continued on next page)

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

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 14043.
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)
vii) 14077 or 14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for 14043.
viii) 14044, 14045, 14046, 14047, 14048, 14033, 14063, 14075, 14076 and 14078 not payable on the same day for the same patient.
ix) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

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

Table 1

The following list of eligible diagnoses and ICD-9 codes is to be used when billing the Mental Health Planning Fee:

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

8. MENTAL HEALTH MANAGEMENT FEES (G14044, G14045, G14046, G14047, G14048)

G14044	FP Mental Health Management Fee age 2–49	174.00	76.88
G14045	FP Mental Health Management Fee age 50–59	191.00	82.49
G14046	FP Mental Health Management Fee age 60–69	202.00	86.20
G14047	FP Mental Health Management Fee age 70–79	227.00	97.13
G14048	FP Mental Health Management Fee age 80+	262.00	112.44

(see notes on next page)

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

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients. The four MSP counselling fees (any combination of in-person or telehealth counselling) must first have been paid in the same calendar year.

NOTES:

i) Payable only to:
   a) MRP Family Physicians who have successfully submitted and met the requirements of 14070 in the same calendar year.
   b) Locum Family Physicians who are covering for such a MRP FP when using this fee code, and have successfully submitted and met the requirements for 14071 on the same or a prior date in the same calendar year;
ii) Payable a maximum of 4 times per calendar year per patient.
iii) Not payable unless the four in-person or telehealth counselling fees have already been paid in the same calendar year in any combination.
iv) For a prolonged visit for counselling (minimum time pe visit - 20 minutes) (see Preamble D.3.3.).
v) Start and end times must be included with the claim and documented in the patient chart.
vi) Counselling may be provided face to face or by videoconferencing.
vii) 14077 or 14067, payable on same day for same patient if all criteria met.
viii) 14043, 14076, 14078 not payable on same day for same patient.
ix) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.
x) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

9. PALLIATIVE CARE PLANNING FEE (G14063)

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

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

Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy. This fee requires a face to face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent.

G14063 is payable only to Family Physicians who have submitted G14070 or G14071 in the same calendar year.

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

Patient Eligibility:

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

G14063	FP Palliative Care Planning Fee.....	251.00	110.30

NOTES:

i) Payable only to Family Physicians who have successfully submitted and met the requirements for 14070. 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 14071 in the same calendar year.

ii) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.

iii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).

iv) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new FP who is assuming the ongoing palliative care for the patient.

v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under 14063.

(notes continued on next page)

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

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) 14077 or 14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14063.

ix) Not payable if 14033 or 14075 has been paid within 6 months.

x) Not payable on same day as 14043, 14076 or 14078.

xi) 14050, 14051, 14052, 14053, 14250, 14251, 14252, 14253, 14033, 14066, 14075 not payable once Palliative Care Planning fee is billed and paid.

xii) The FPSC Mental Health Initiative Fees (14043, 14044, 14045, 14046, 14047, 14048), are still payable once 14063 has been billed provided all requirements are met, but are not payable on same day.

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

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

10. FP EMAIL, TEXT & TELEPHONE FEES: MEDICAL ADVICE TO PATIENTS (G14076, G14078)

G14076	FP Patient Telephone Management Fee.....	37.65	22.14

NOTES:

i) Payable only to:
   a) MRP Family Physicians who have successfully submitted and met the requirements for 14070 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 14071 on the same or a prior date in the same calendar year; or
   c) Family Physicians who have successfully submitted and met the requirements for 14072 in the same calendar year; or
   d) Family Physicians Registered in a Maternity Network, Long Term Care Network, or FP Unassigned Inpatient 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 FPSC Preamble for definition of allied care provider "employed by" a physician practice and "College-certified ACP").

iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

iv) Not payable for prescription 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.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	vii) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of 14077, 14067, 14018, 14050, 14051, 14052, 14053, 13005. viii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.		
G14078	FP Email/Text/Telephone Medical Advice Relay Fee .. G14078 is payable for 2-way communication of medical advice from the MRP Family Physician to eligible patients, or the patient's medical representative, via email/text or telephone relay. This fee is not payable for prescription renewals, 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 14070 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 14071 on the same or a prior date in the same calendar year; or c. Family Physicians who have successfully submitted and met the requirements for 14072 in the same calendar year; or d. Family Physicians Registered in a Maternity Network, Long Term Care Network, or FP Unassigned Inpatient network on a prior date.	19.75	9.43

(notes continued on next page)

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

ii) Email/Text/Telephone Relay Medical Advice requires 2-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. Alternatively, the task of relaying the physician's advice may be delegated to any allied care provider or MOA working within the physician practice.(See FPSC Preamble for definition of allied care provider "working within" a physician practice team).
iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.
iv) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
v) Payable to a maximum of 200 services per physician per calendar year.
vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of 14077 or 14067.
vii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

11. CONFERENCING AND ADVICE FEES (G14077, H14067 G14018, G14019)

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

G14077 pays for two-way case conferencing about a patient with at least one allied care provider or physician. The fee is billable regardless of where the patient is located or how the conference occurs. Time spent talking to the patient or family member does not count towards conferencing time under G14077.

As start and end times must be submitted, consider:
a) If conferencing takes place as a series of separate phone calls, use the start time of the first call and calculate the "end time" based on total time spent conferencing.
b) If billing a same day out-of-office hour's visit fee code (which also requires start/end times), the time submitted must either be before or after the G14077 start/end time.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
G14077	FP Conference with Allied care Provider and/or Physician – per 15 minutes or greater portion thereof..	100.00	50.35

NOTES:

i) Payable only to:
   a) MRP Family Physicians who have successfully submitted and met the requirements for 14070 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 14071 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 Inpatient network on a prior date.

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

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

iv) Details of care conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.

v) Conference to include the clinical and social circumstances relevant to the delivery of care.

vi) When multiple patients are discussed, billing must be for consecutive non-overlapping time periods. Each individual patient conference must meet the time requirement of 15 minutes or greater portion thereof. For brief clinical conferences, fee code H14067 is payable if all criteria are met.

vii) Payable in addition to any visit fee on the same day if medically required, provided that the visit does not take place during a time interval that overlaps with the conference (i.e.: Visit time must be separate from conference time).

(notes continued next page)

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

viii) Payable to a maximum of 18 units (270) minutes per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.
ix) Start and end times must be included with the claim and documented in the patient chart.
x) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility, or communications which occur as part of regular work flow within a physician's community practice.
xi) Not payable for situations where the purpose of the call is to:
    a) book an appointment
    b) arrange for an expedited consultation or procedure
    c) arrange for laboratory or diagnostic investigations
    d) convey the results of diagnostic investigations
    e) arrange a hospital bed for the patient
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 14018 or 14067 on the same day to the same physician for the same patient.
xiv) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.
xv) Not payable for a patient admitted under a Hospital at Home program.

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

H14067 is payable for two-way case conferencing about a patient with at least one allied care provider or physician. This fee is billable regardless of where the patient is located or how the conference occurs. Time spent talking to the patient or family member is not billable as H14067.

H14067 should not be billed for conferencing activities that can be billed as 13005 or G14077. Eligible physicians are advised to bill:

- 13005 for advice by telephone, fax or in written form about a patient in community care given in response to an enquiry initiated by an allied health care worker.
- G14077 for two-way conferencing about a patient with at least one allied care provider or physician per 15 minutes or greater portion thereof.

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

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

H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician..... 55.40 18.45

NOTES:

i) Payable only to:
   a) MRP Family Physician who have successfully submitted and met the requirements for 14070 in the same calendar year; or
   b) Locum Family Physicians who are covering for such a MRP FP when using this fee code, and have successfully submitted and met the requirements for 14071 on the same or a prior date in the same calendar year; or
   c) Family Physicians who have successfully submitted and met the requirements for 14072 in the same calendar year; or
   d) Family Physicians registered in a Maternity Network, or FP Unassigned Inpatient network on a prior date.

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

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

iv) Details of clinical discussion and decisions made must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference and their role(s) in care.

v) Not payable for situations where the purpose of the call is to:
   a) book an appointment
   b) arrange for laboratory or diagnostic investigations
   c) convey the results of diagnostic investigations
   d) arrange a hospital bed for a patient

vi) Payable in addition to any visit fee on the same day if medically required, provided the visit does not take place during a time interval that overlaps with the conference (i.e. Visit time must be separate from conference time).

(notes continued on next page)

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

vii) Payable to a maximum of 150 per physician per calendar year.
viii) Payable to a maximum of 1 per patient per physician per day.
ix) Not payable in addition to 14077 or 14018 on the same day for the same patient by the same physician.
x) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

FP Urgent Telephone Advice from a Physician with Consultative Expertise

G14018 is billable when the severity of the patient's condition justifies urgent advice (within 2 hours of request) from a Specialist or Physician with Consultative Expertise (as defined in the FPSC Preamble), in order to develop and implement a plan to keep the patient stable in their current environment. The intent of G14018 is to improve the management of patients with acute needs, and reduce unnecessary ER or hospital admissions/transfers. This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

G14018	FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise	100.00	50.44

14018 is payment for telephone advice that is needed on an urgent basis (within 2 hours of request) from a Specialist or Family Physician with Consultative Expertise (as defined in the Preamble). Includes the creation, documentation, and implementation of a plan for the care of patients with acute needs (i.e. requiring attention within the next 24 hours) and communication of that plan to the patient or patient's representative.

NOTES:

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

(notes continued on next page)

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

iii) Fee includes:
   a) Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.
   b) Developing, documenting and implementing a plan to manage the patient safely in their care setting.
   c) Communication of the plan to the patient or the patient's representative.
   d) The plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.

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

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

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

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

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

(notes continued on next page)

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

x) Out-of-Office Hours Premiums are not payable in addition.
xi) Not payable to a physician who has been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).
xii) Not payable for a patient admitted under a Hospital at Home program.
xiii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

FP Advice to Nurse Practitioner/Registered Midwife Fee

The intent of G14019 is to support collaboration between nurse practitioners, registered midwives and community family physicians. This fee is billable when providing advice by telephone or in person to a Nurse Practitioner who is an independent practitioner providing care to patients under their MRP care. This fee is not billable for providing advice to a NP when the patient is attached to a FP. This fee is also billable when providing advice by telephone or in person to a Registered Midwife who is an independent practitioner providing maternity care to patients under their MRP care.

G14019	FP Advice to a Nurse Practitioner/Midwife Fee - Telephone or In person	119.00	50.35

NOTES:
i) Payable to:
   a. the FP who provides advice by telephone or in person in response to a request from a Nurse Practitioner (NP) in independent practice on patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care; or
   b. the FP who provides advice by telephone or in person in response to a request from a Registered Midwife in independent practice on patients for whom the Midwife has accepted the responsibility of being the Most Responsible Provider for that patient's maternity care.

(notes continued on next page)

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

ii) Excludes advice to an NP about patients who are attached to the FP; excludes advice to a Registered Midwife about patients being cared for in a shared care model with a FP.
iii) Payable for advice regarding assessment and management by the NP/Midwife and without the responding physician seeing the patient.
iv) Not payable for written communication (i.e. fax, letter, email).
v) A chart entry, including advice given and to whom, is required.
vi) NP/Midwife Practitioner number required in referring practitioner field when submitting fee through Teleplan.
vii) Not payable for situations where the purpose of the call is to:
    a. Book an appointment
    b. Arrange for transfer of care that occurs within 24 hours
    c. Arrange for an expedited consultation or procedure within 24 hours
    d. Arrange for laboratory or diagnostic investigations
    e. Convey the results of diagnostic investigations
    f. Arrange a hospital bed for the patient.
viii) Limited to 1 (one) claim per patient per day with a maximum of 6 (six) claims per patient per calendar year.
ix) Limit of 5 (five) 14019 units may be billed by a FP on any calendar day.
x) Not payable in addition to another service on the same day for the same patient by same FP.
xi) Out-of-Office Hours Premiums may not be claimed in addition.
xii) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

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

12. FAMILY PHYSICIANS WITH CONSULTATIVE EXPERTISE FEES (G14021, G14022, G14023)

FP with Consultative Expertise Telephone Advice Fees (G14021, G14022, G14023) support tele/videoconferencing between FP's with Consultative Expertise and other Family Physicians, Specialists or Allied Care Providers for the purpose of improving patient care.

The FPSC Preamble defines Family Physicians with Consultative Expertise as:

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

Eligibility for FP with Consultative Expertise Telephone Advice Fees:
In addition to meeting the definition of FP with Consultative Expertise listed above and in the FPSC Preamble, the following criteria must be met:

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

G14021	FP with Consultative Expertise Telephone/Video Advice - Initiated by a Specialist, Family Physician, or Allied Care Provider, Response within 2 hours	151.00	69.64

NOTES:

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

(notes continued on next page)

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

iv) Not payable for situations where the purpose of the call is to:
   a) book an appointment
   b) arrange for transfer of care that occurs within 24 hours
   c) arrange for an expedited consultation or procedure within 24 hours
   d) arrange for laboratory or diagnostic investigations
   e) convey the results of diagnostic investigations
   f) arrange a hospital bed for the patient

v) Not payable to provider initiating call.

vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).

vii) Limited to one claim per patient per physician per day.

viii) A chart entry, including advice given and to whom, is required.

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

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

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

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

xiii) Include the practitioner number of the provider requesting advice in the “referred by” field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note record specifying the type of provider).

G14022	FP with Consultative Expertise Telephone/Video Advice - Initiated by a Specialist, Family Physician or Allied Care Provider, Response within one Week – per 15 minutes or portion thereof	100.00	50.35

(see notes on next page)

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

NOTES:

i) Payable to a FP with Consultative Expertise (as defined in the FPSC Preamble) for two-way telephone/video communication regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Conversation must take place within 7 days of initiating provider's request. Initiation may be by phone or referral letter.

iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iv) Not payable for situations where the purpose of the call is to:
    a) book an appointment
    b) arrange for transfer of care that occurs within 24 hours
    c) arrange for an expedited consultation or procedure within 24 hours
    d) arrange for laboratory or diagnostic investigations
    e) convey the results of diagnostic investigations
    f) arrange a hospital bed for the patient

v) Not payable to provider initiating call.

vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).

vii) Limited to two services per patient per physician per week.

viii) A chart entry, including advice given and to whom, is required.

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

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

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

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

(note continued on next page)

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

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 50.20 23.19

NOTES:

i) This fee applies to two-way telephone/video communication between the FP with consultative expertise (as defined in the FPSC Preamble) and patient, or a patient’s representative. Not payable for written communication (i.e. fax, letter, 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.

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

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

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

13. FAMILY PHYSICIAN OBSTETRICAL PREMIUMS (G14004, G14005, G14008, G14009 AND MATERNITY CARE RISK ASSESSMENT H14002)

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

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

H14002	Maternity Care Risk Assessment..... This fee is payable to a CLFP who is the patient's MRP, OR a family physician who will be providing the majority of the patient's maternity care and is registered in a Maternity Network. This fee is payment for the increased time, intensity and complexity required to undertake a Maternity Care Risk Assessment with a pregnant patient based on the BC Antenatal Record including the review of gestationally appropriate screening interventions, pregnancy risks, and patient comorbidities. This fee requires a face-to-face visit. A Maternity Care Risk Assessment includes, but is not limited to the following: • Reviewing history including present pregnancy, medical history, family history, lifestyle/social concerns, and medications/supplements. • Screening for use of alcohol, tobacco, cannabis and other substances. • Informed consent discussion of options for prenatal genetic screening, discussion of results, and follow up testing as appropriate for the patient's age, gestational age and local resources available.	146.00	50.63

(see notes on next page)

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

NOTES:

i) Payable only to:
   a) MRP family physician who have successfully submitted and met the requirements for 14070 in the same calendar year; or
   b) Locum family physicians who are covering for MRP family physicians when using this fee code, and have successfully submitted and met the requirements for 14071 on the same or a prior date in the same calendar year; or
   c) Family physicians registered in a Maternity Network
ii) Payable once per pregnancy per patient except in the case where a patient transfers their total ongoing prenatal care to another physician, the second physician also may charge a Maternity Care Risk Assessment, as rendered. To facilitate payment, the reason for transfer should be stated with the claim. Temporary substitution of one physician for another physician (e.g.: days off, vacation) is not to be considered as a patient transfer.
iii) Payable to a maximum of two per patient per pregnancy.
iv) Payable in addition to a visit fee (home or office) on the same day if medically required provided the visit does not take place during a time interval that overlaps with the face-to-face planning included under 14002.
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.
vi) 14033, 14043, 14063, 14066, 14076 and 14078 not payable on the same day for the same patient.

G14004	Obstetric Delivery Incentive for Family Physicians - associated with vaginal delivery and postnatal care.....	844.00	430.48

(see notes on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	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 14070, or on behalf of Locum Family Physicians who have successfully submitted code 14071 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 14004, 14008, 14009 per patient delivered. iv) Maximum of 25 incentives per calendar year per physician under fee item 14004, 14005, 14008, 14009 or a combination of these items. v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.		
G14005	Obstetric Delivery Incentive for Family Physicians - associated with management of labour and transfer to an alternate facility.....	353.00	179.28
	NOTES: i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care and who has successfully: a) Submitted 14070, or on behalf of Locum Family Physicians who have successfully submitted code 14071 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 14004 or 14009 when billed and paid to a different FP attending delivery in the receiving hospital.		

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	iv) Maximum of 25 incentives per calendar year per physician under fee item 14004, 14005, 14008, 14009 or a combination of these items. v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.		
G14008	Obstetric Delivery Incentive Family Physicians - associated with postnatal care after an elective caesarean section	174.00	88.57
	NOTES: i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care and who has successfully: a) Submitted 14070, or on behalf of Locum Family Physicians who have successfully submitted code 14071 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 14004, 14008, 14009 per patient delivered. iv) Maximum of 25 incentives per calendar year per physician under fee item 14004, 14005, 14008, 14009 or a combination of these items. v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.		
G14009	Obstetric Delivery Incentive for Family Physicians – associated with attendance at delivery and postnatal care associated with emergency caesarean section	706.00	358.58

(see notes on next page)

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

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 14070, or on behalf of Locum Family Physicians who have successfully submitted code 14071 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 14004, 14008, 14009 per patient delivered.

iv) Maximum of 25 incentives per calendar year per physician under fee item 14004, 14005, 14008, 14009 or a combination of these items.

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

14. FPSC INCENTIVES FOR INPATIENT CARE (H14088)

The FPSC Inpatient 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 inpatient journey as well as in transitions between hospital and community FP offices. This initiative includes funding aimed at better supporting and compensating FPs who provide this important aspect of care.

This initiative will support family physicians who provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned Inpatients). The FP Unassigned Inpatient Care Fee (H14088) is for family physicians who are a part of a network, provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned Inpatients):

To participate in the FPSC Inpatient Initiative, it is expected that these FPS agree to the following expectations:

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

A. They are members of the active or equivalent medical staff category and have hospital privileges in the identified acute care hospital.

B. That their on-call colleagues (Network) are also members of the active or equivalent medical staff category and have hospital privileges.

C. That they will:

- Coordinate and manage the care of hospitalized patients (assigned and/or unassigned), admitted under them as the MRP.
- Provide supportive care when their hospitalized patient is admitted under a specialist as MRP.
- See all acute patients under their MRP care on a daily basis and document a progress note in the medical record.
- Work with the interdisciplinary team, as appropriate, to develop a care plan and a plan for discharge.
- When care is transferred to another physician, ensure that this is documented in the medical record and ensure there is a verbal or written handover plan provided to the accepting physician.
- Ensure availability through their network to expedite discharges of patients daily during the normal working day which includes early morning, daytime, and early evening.
- On weekends ensure the covering physician is made aware of those discharges that could occur over the weekend.
- Provide a discharge note to an unassigned inpatient for their FP or communicate directly with the FP on discharge.
- Respond to requests from members of the interdisciplinary inpatient care team by phone as per hospital bylaws.
- The Network Call Group will accept responsibility for their newly admitted inpatients 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 Inpatient 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.

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

- Participate in utilization management within the hospital.
- Patient care improvement discussions that would reasonably be covered under the improved FP hospital care incentives.

FP Unassigned Inpatient Care Fee (H14088)

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

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

H14088	FP Unassigned Inpatient Care Fee	377.00	151.88

NOTES:

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

ii) Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.

iii) Payable once per unassigned patient per in-hospital admission in addition to hospital visit (00109, 13109, 13008, 13010, 13011, 00127) or delivery fee.

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

15. CLFP NEW PATIENT INTAKE FEE (H14041)

H14041	CLFP New Patient Intake Fee	42.00	15.19

(see notes on next page)

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

Payable in addition to a visit fee for confirming the addition of a new patient to the physician's panel where the longitudinal doctor-patient relationship has been confirmed through a standardized conversation or 'compact'.

By billing 14041, the FP commits to assuming the role of Most Responsible Provider (MRP) for the patient.
NOTES:

i) Payable to the family physician who will be most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for 14070 in the same calendar year. Not payable to locum physicians.
ii) Must be billed within the first 3 months of the MRP onboarding the new patient into their ongoing care.
iii) A visit must have been provided by the billing physician on the same day or within 3 months prior to the billing of 14041.
iv) Payable to a maximum of 1 per patient per calendar year.
v) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this fee.

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 ($)	MSP & WSBC Fee ($)
			Per 15 min or part thereof
2	01172	152.00	51.66
3	01173	161.00	51.66
4	01174	172.00	51.66
5	01175	179.00	55.09
6	01176	187.00	55.09
7	01177	192.00	55.09
8	01178	199.00	57.14
9	01179	207.00	57.14
10	01180	215.00	57.14
11	01181	228.00	57.14

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 physician has an increased overhead factor.
f) Continuing care items, **01107, 01108** and **01109,** cannot be billed with any other listings.

3. ANESTHETIC PROCEDURAL FEES

a) **The anesthetic procedural fee** is calculated by multiplying the anesthetic intensity/complexity level by the anesthetic time calculated in 15 minute increments.

b) **The anesthetic intensity/complexity** level is listed opposite the specific surgical, diagnostic and/or therapeutic procedure in the schedule. The anesthetic intensity/complexity level time units are indicated in the 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, 01093, 01164, 01165, 01166, 01168 and 01192** are fixed fees which are paid in addition to the anesthetic procedural fee. They are not included in the anesthetic procedural fee for the application of 01080.

c) **01169** is a time-based fee modifier which is paid in addition to the anesthetic procedural fee. It is not included in the anesthetic procedural fee for the application of 01080.

d) **01080** is a multiplier and applies only to the anesthetic procedural fee. When **01080** is applicable, multiply the total anesthetic procedural fee (including routine **P.A.R**. care as in 3.d) i) by 20%.
e) **01080** can only be used once per case, even if it qualifies more than once (e.g.: ASA 5E cardiac surgical case with an I.A.B.P. lasting 12 hours will be paid at 20%).
f) Emergency cardiac surgery is defined for this purpose as surgery, which is so urgent that it has to be done outside normal elective operating time, or necessitates "bumping" cases previously booked on the elective slate.

5. RESUSCITATION FEES

These fees refer to resuscitation by 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**). 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.

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 ($)	Anes. Lev.	MSP & WSBC Fee ($)
VISIT / EVALUATION				
01107	Office visit NOTE: Not paid with other listings.	250.00		58.03
01108	Hospital visit (weekday) NOTE: i) Not paid with other listings. ii) Applies only on weekdays, excluding statutory holidays. iii) Out-of-Office Hour Premiums are not applicable.	208.00		51.88
01109	Hospital visit (Saturday, Sunday, or statutory holiday) 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.	264.00		90.63
01151	**Pre-anesthetic Evaluation:** Applies to standard pre-anesthetic evaluation NOTE: Applicable to certified anesthesiologist only.	181.00		62.23
REFERRED CASES				
01015	**Consultation:** 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	452.00		150.00
01115	**Repeat or Limited Consultation:** 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	292.00		90.00

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
01016	**Consultation:** By a certified specialist in anesthesiology **for diagnostic opinion and/or therapeutic management of complicated chronic pain, and/or related problems**. To include comprehensive history and physical examination, review of radiological and laboratory findings and a written report. If followed by a diagnostic or therapeutic nerve block, the consultation may be charged in addition to the nerve block fees on the first occasion	909.00		245.42
01116	**Repeat or Limited Consultation:** 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.	450.00		122.71
	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.			
01118	In-patient Extended Consultation – 40 to 54 minutes ...	109.00		30.30
	NOTES: i) Applies only to patients seen while in the emergency department or while admitted to hospital (Service Location Code E or I).			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	ii) Paid only in addition to an in-person consultation (01015).			
	iii) Not applicable for services performed in a "pre-admission" clinic.			
	iv) Start and end times of the service must be entered in both the billing claim and the patient's chart.			
	v) Service must be performed in one continuous session.			
01119	In-patient Extended Consultation – exceeding 54 minutes	218.00		60.60
	NOTES:			
	i) Applies only to patients seen while in the emergency department or while admitted to hospital (Service Location Code E or I).			
	ii) Paid only in addition to an in-person consultation (01015).			
	iii) Not applicable for services performed in a "pre-admission" clinic.			
	iv) Start and end times of this service must be entered in both the billing claim and the patient's chart.			
	v) Service must be performed in one continuous session.			
Telehealth Service with Direct Interactive Video Link with the Patient				
01155	Telehealth Anesthesiology Consultation: By a certified specialist in Anesthesiology because of the complexity, obscurity and/or seriousness of the case. Includes appropriate history and an appropriate physical examination, review of pertinent radiological and laboratory findings and a written report	427.00		150.00

ANESTHETIC PROCEDURAL FEE MODIFIERS

01168	Neonates (less than 42 gestational weeks and/or 4000 grams or less)	362.00		186.24
01169	BMI ≥ 35 – per 15 minutes or part thereof.....	41.40		12.50

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to certified specialists in Anesthesiology. ii) Payable only when fee items 01172, 01173, 01174, 01175, 01176, 01177, 01178, 01179, 01180, 01181, 01005, 01106, 01110, or 01111 are also payable. iii) Applicable to all patients ≥ 19 years of age with a BMI ≥ 35 and to all patients < 19 years of age with a BMI ≥ 97th percentile adjusted for age and gender. iv) The patient's BMI must be provided in the claim note record and documented on the patient's anesthetic record.			
01164	Patients 70 - 79 years of age	90.10		20.84
01165	Patients 80 years of age and over	187.00		42.50
01065	Patients under one year of age NOTE: Not to be billed in addition to 01168.	183.00		93.12
01059	Prone position	137.00		60.36
01166	Sitting position where there is a danger of venous air embolism	269.00		70.86
01070	Controlled hypotension in neurosurgical anesthesia to lower mean blood pressure to 60 mm Hg or less, or the appropriate safe lower limit	269.00		85.62
01093	Spinal cord monitoring (interpretation of SSEP during anesthetic)	183.00		41.68
01071	Thoracic epidural catheter insertion during anesthesia, to include initial injection and/or infusion set-up	242.00		55.51
01072	Lumbar epidural catheter insertion during anesthesia, to include initial injection and/or infusion set-up	187.00		42.69
01192	Awake intubation by any means in the patient with a suspected or proven difficult airway NOTE: Applicable only when airway score is 3 or 4.	269.00		62.51
01080	In the following cases an additional 20% of the procedural fee will be paid: a) All patients (except cardiac surgery patients) who have an incapacitating, systemic disease which is a constant threat to life, or who are not expected to survive for 24 hours, i.e. ASA 4 or 5. b) Cardiac surgery patients who have emergency surgery, i.e. ASA 4E or 5E. c) Cardiac or transplant surgery patients who require an 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.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	258.00		85.63
	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	258.00		85.63
	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.	587.00		184.07
	NOTES: i) Applicable to removal and reinsertion of ET tube. ii) Consultations will not be paid in addition.			
01094	Pulmonary artery catheter placement (not associated with an anesthetic)	741.00		170.87
01095	Intra-arterial catheter placement (isolated procedure)	152.00		35.24
00017	Insertion of central venous pressure catheter	116.00		26.63

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.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
01022	Nerve plexus	601.00		138.55
01124	Peripheral nerve block - single	292.00		65.62
01125	Peripheral nerve block - multiple	436.00		99.16
01035	Gasserian ganglion	1126.00		260.17
	Epidural Blocks:			
01135	Lumbar	670.00		153.76
01036	Thoracic	1038.00		233.19
01037	Cervical	1199.00		269.07
01138	Caudal block	670.00		153.76
	Nerve Root or Facet Blocks:			
01140	Cervical – single	811.00		187.27
01141	Cervical – multiple	1080.00		249.69
01142	Thoracic – single	740.00		171.52
01143	Thoracic – multiple	994.00		228.66
01144	Lumbar – single	673.00		155.75
01145	Lumbar – multiple	898.00		207.69
	NOTE: Fee items 01140, 01141, 01142, 01143, 01144 and 01145 must be performed under medical imaging guidance (ultrasound, fluoroscopy or CT) with image capture.			
	Subarachnoid (Spinal) Blocks:			
01032	Subdural - spinal	709.00		163.63
01034	Differential - spinal	944.00		218.19
	Sympathetic Nerves:			
01040	Stellate ganglion	519.00		120.58
01042	P.A.R avertebral (lumbar sympathetic)	865.00		198.25
01044	Celiac plexus	1194.00		275.94
	Permanent Cryosection and/or Neurolysis:			
01146	Major plexus or nerve root	1559.00		360.84
01147	Single peripheral nerves	740.00		170.65
01148	Multiple peripheral nerves	994.00		228.66
01149	Epidural or subarachnoid neurolysis	1755.00		406.02
01150	Gasserian ganglion neurolysis	1755.00		406.02
	Injection Tendon Sheath, Ligaments, Trigger Points:			
01156	Single injections	269.00		62.13
01157	Multiple Injections	335.00		77.92
01159	IV injections for diagnosis and/or therapeutic management of chronic pain syndromes - local anesthetic only	269.00		62.13

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
01160	IV injections for diagnosis and/or therapeutic management of chronic pain syndromes – ketamine only	478.00		124.27

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	300.00		103.31
01026	Thoracic epidural catheter insertion, to include initial injection and/or infusion set-up	742.00		233.19
01025	Lumbar or caudal epidural catheter insertion (to include initial injection and/or infusion set-up)	561.00		153.76
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.	192.00		62.23
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.	119.00		41.49
01074	Axillary catheter insertion, to include initial injection and/or infusion set-up	324.00		74.19
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.	192.00		62.23
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.	119.00		41.49
01007	Intrapleural catheter insertion, to include initial injection and/or infusion set-up	370.00		85.43

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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.	192.00		62.23
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.	119.00		41.49
01012	Hospital visit for supervision of patient controlled analgesia during second and subsequent days, to a maximum of two visits per day - per visit..... NOTE: Where more than 2 visits per day are necessary, an explanatory note in the claim note record is required.	119.00		41.49
01186	Major peripheral nerve block - single	207.00		46.88
01187	Major peripheral nerve block - multiple	313.00		70.85

OBSTETRIC ANALGESIA FEES

01102	Insertion of epidural catheter. To include initial injection and/or set up of infusion for analgesia during labour	581.00		149.20
	Supervision of Labour Epidural Analgesia			
01047	Medical supervision of labour epidural analgesia: Daytime (Monday to Friday, 0800-1800 hours), per 5 minutes (or major portion thereof)	33.95		9.79
01048	Medical supervision of labour epidural analgesia: Evening (Monday to Friday, 1800-2300 hours), and Weekends (Saturday & Sunday, 0800 – 2300 hours) and Statutory holidays (0800-2300 hours, per 5 minutes (or major portion thereof).....	50.90		14.71
01049	Medical supervision of labour epidural analgesia: night (Monday to Sunday, 2300-0800 hours), per 5 minutes (or major portion thereof)	67.70		19.59

(see notes on next page)

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

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.....	161.00		51.58
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.	172.00		51.58

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
01105	Anesthesia for cataract surgery – per 1 minute increment Note: This item applies to fee codes S02188, S02190, S02192, S02196 and S22191.	10.10		2.00
01106	Anesthesia for electroconvulsive therapy (ECT) - per 15 minutes or part thereof	152.00		53.98
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.	248.00		85.63
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.	144.00		51.58
01158	Epidural blood patch	561.00		185.93

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
Repeat intra-abdominal surgery in the hepatic transplant recipient during initial hospitalization	10

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

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 ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
00210	**Consultation:** To include history, and dermatological examination, with review of any previous x-ray and laboratory findings and written report.....	341.00		87.98
00214	**Repeat or Limited Consultation:** 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)	256.00		62.07
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.	503.00		87.98
	NOTES: i) Restricted to Dermatologists. ii) Referral is required. iii) Not payable within 6 months of a consultation, visit or initial Teledermatology assessment by the same practitioner. iv) Not paid with another service on the same day by the same practitioner.			
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.	270.00		49.04
	NOTES: i) Restricted to Dermatologists. ii) Referral is required. iii) Payable within 6 months of a consultation, visit or initial Teledermatology assessment by the same practitioner. iv) Not paid with another service on the same day by the same practitioner.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Continuing Care by Consultant:			
00204	Directive care	313.00		36.00
00207	Subsequent office visit	166.00		36.00
00208	Subsequent hospital visit	313.00		36.00
00209	Subsequent home visit	499.00		71.12
00205	Emergency visit when specially called out of office (not paid in addition to out-of-office hours premiums) NOTE: Claim must state time service rendered.	646.00		124.91
	Telehealth Service with Direct Interactive Video Link with the Patient			
20210	**Telehealth Consultation:** To include history and dermatological examination, with review of any previous x-ray and laboratory findings and written report	341.00		87.98
20214	**Telehealth repeat or limited consultation**: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where, in the judgement of the consultant, the consultative service does not warrant a full consultative fee (laboratory test and biopsy, when necessary, extra)	256.00		62.07
20207	Telehealth subsequent office visit	166.00		36.00
20208	Telehealth subsequent hospital visit	313.00		36.00

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	642.00		184.03

SPECIAL THERAPY

00217	Treatment of skin disorders and lesions other than ultraviolet, x-ray, Grenz ray (such as cryosurgery, electrosurgery, etc.) extra - operation only 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".	236.00		19.39
*00218	Curettage and electrosurgery of skin carcinoma proven histopathologically - operation only	303.00		80.00
*00219	– for each additional lesion – to a maximum of two additional lesions per day - operation only	227.00		40.00

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
00222	Psoralen ultra violet A treatment - whole body	133.00		20.79
00223	– partial body	133.00		20.79
	NOTE: Both 00222 and 00223 include an office visit and have a maximum of 40 treatments per year.			
00224	Ultra violet B treatment, whole or partial body - includes office visit	100.00		20.79
00235	Pulsed laser surgery of the face and/or neck, treatment area less than 50 cm^2 - operation only	564.00	3	70.65
00236	Pulsed laser surgery of the face and/or neck, treatment area greater than or equal to 50 cm^2 or treatment of the eyelids with eye shield insertion - operation only	1219.00	3	105.84
00237	Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia	236.00		57.35

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	102.00		35.73

SURGICAL PROCEDURES AND REPAIRS

Mohs' Technique

00225	Initial cut, including debulking	1332.00		354.55
00226	One or more additional cuts (extra)	1072.00		307.11
00227	Special overhead and technical component (extra)	1153.00		330.60

(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.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Local Tissue Shifts:			
	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)	1280.00	2	208.58
20222	Single	1280.00	2	322.61
20223	Multiple	2240.00	2	582.30
20224	– with free skin graft to secondary defect	2308.00	2	662.29
20225	Eyebrow, eyelid, lip, ear, nose - single	1482.00	3	303.23
	NOTE: Repair of torn earlobe to be claimed under 06027.			
	FREE SKIN GRAFTS (INCLUDING MUCOSA)			
	Full-thickness grafts:			
20226	Eyelid, nose, lips, ear	1280.00	2	317.52
20227	Finger, more than one phalanx	1280.00	2	303.23
20228	Sole or palm	1280.00	2	303.23
	TUMOURS OF THE SKIN			
13600	Biopsy of skin or mucosa - operation only	144.00	2	59.26
13601	Biopsy of facial area - operation only	144.00	2	59.26
	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	204.00		30.34
20232	Biopsy, not sutured, multiples same sitting, maximum of four (extra)	151.00		15.17
	NOTES: i) Restricted to Dermatologists. ii) Paid at 100% in addition to 00207, 00210 or 00214 only.			
13605	Opening superficial abscess, including furuncle - (operation only)	126.00	2	50.75
13620	Excision of tumour of skin or subcutaneous tissue or small scar, under local anesthetic - up to 5cm - operation only	188.00	2	75.70
13621	– additional lesions removed at the same sitting (maximum 5 per sitting) - operation only	92.20		37.87
	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	204.00	2	87.72
06146	Lip shave - vermilionectomy	1915.00	3	408.16

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
DIAGNOSTIC PROCEDURES				
	Allergy, Patch and Photo Patch Tests:			
S00762	Scratch test, per antigen Note: Minor tray fee may be paid in addition if a minimum of 16 antigens are used.	8.40		1.08
S00763	– 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.	9.00		2.37
S00764	Intracutaneous test, per test	12.05		2.20
S00765	Annual maximum (to include scratch or intracutaneous tests) for each physician per patient	191.00		35.18
S00767	Patch testing (extra) - annual maximum is 80 tests, per test	7.75		2.00
S00768	Photopatch test, per test	45.60		8.81
S00769	Photopatch test - annual maximum	456.00		88.07

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 <u>not</u> 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 <u>not</u> 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 family medicine office visit.

3. DEINSURANCE OF ROUTINE EYE EXAMINATIONS

A routine eye examination is not a benefit for individuals 19 – 64 years of age when not associated with an ocular or systemic disease or condition, trauma or injury, or if the patient is using medication which could reasonably be expected to cause a change in refractive status. Exceptional circumstances may be given independent consideration when supported by documentation.

An eye examination is still an insured service if medically required. Medically required eye examination may include the following:

- Ocular disease, trauma or injury
- Systemic diseases associated with significant ocular risk (e.g.: diabetes)
- Medications associated with significant ocular risk.

4. RURAL RETENTION PROGRAM PREMIUM ADJUSTMENTS

The Rural Retention Program applies a fee premium based on a community's isolation points.
This fee premium is adjusted for Ophthalmology fee codes by a factor of 1.273.

OPHTHALMOLOGY

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

* See fee item 02012.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CLINICAL EXAMINATION				
REFERRED CASES:				
02010	**Consultation:** To include history, eye examination, review of X-rays and laboratory findings and in addition where indicated and necessary, any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test and keratometry, in order to prepare and render a written report	449.00		104.76
02011	**Repeat or limited consultation:** 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.	259.00		51.54
02012	**Special consultation:** 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.	646.00		139.21
	Continuing Care by Consultant:			
02007	Subsequent office visit	162.00		38.15
02008	Subsequent hospital visit	224.00		51.43
02009	Subsequent home visit	275.00		63.62
02005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums). NOTE: Claim must state time service rendered.	473.00		94.83

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
Telehealth Service with Direct Interactive Video Link with the Patient				
22010	**Telehealth Consultation:** To include history, eye examination, review of x-rays and laboratory findings and any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test, and keratometry, where indicated and necessary to prepare a written report.	441.00		104.30
22011	**Telehealth repeat or limited consultation:** 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	259.00		51.54
22007	Telehealth subsequent office visit	162.00		37.98
22008	Telehealth subsequent hospital visit	224.00		51.43

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 NOTE: Fee items 02015, 02018, and 02019 are payable to certified ophthalmologists only.	265.00		53.69
02014	Complete orthoptic evaluation with written report to include history, sensory assessment, motor evaluation in all cardinal gaze situations, and any or all of Hess Screen, Troposcope and Visuscope where indicated NOTE: Item 02014 includes 02007 and 02017.	277.00		64.25
*02017	Oculo-motor function tests	158.00		36.42
*02018	Biomicroscopy	146.00		33.72
*02019	Tonometry	146.00		33.72
*02020	Ophthalmo-dynamometry	152.00		30.20
02028	Examination for low visual aid at low vision clinic	264.00		52.26
*02038	Keratometry	82.90		16.50
02040	Retinoscopy, keratometry, tonometry, indirect fundoscopy, fundus photography and prosthetic fitting, under general anesthetic	707.00	3	140.43

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02048	Exophthalmometry	71.10		14.20
22016	Pachymetry – extra (when billed with other eye examinations)	57.90		10.78

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	59.50	2	11.83
22047	Anterior segment gonioscopy	68.60	2	15.84

NOTES:

i) Fee items 22046 and 22047 are not payable with 02011, 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	568.00		112.90
02026	– professional fee	143.00		28.39
02027	– technical fee	422.00		84.51
02030	Electro-retinogram, professional and technical	432.00		99.42
02031	– professional fee	160.00		36.93
02032	– technical fee	289.00		62.48
02034	Dark adaptation, per eye	113.00		22.58
02035	Colour vision assessment (to include a screening test and at least one quantitative test of hue discrimination)	215.00		43.32
02036	– professional fee	143.00		28.40
02037	– technical fee	75.20		14.93
02039	Fundus photography (limitations - glaucomatous disc changes, tumour progression and potentially progressive retinal disease)	70.90		14.15

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02041	Limited visual field examination, i.e. tangent screen, autoplot, arc perimeter, or single level automated test (such as OCTOPUS program 3 or 7 or equivalent)	166.00		34.39
	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	245.00		48.23
	NOTES: i) 02042 includes 02041. ii) Fee includes examination of both eyes whether at one time or two separate visits. iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 120 days without written justification.			
02043	Comprehensive quantitative perimetry examination (Oculus visual fields): More extensive examination than under fee item 02042 - comprehensive automated static perimetry with multilevel threshold testing, such as OCTOPUS programs 31 & 32, or 31 & 41, or SQUID programs 310, 311, 410 or 411, or programs of equivalent informative value	324.00		66.83

(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	Electro-oculogram	407.00		80.56
02045	– professional fee	143.00		28.40
02047	Dacryocystogram	331.00		66.04
02049	Potentiometry	166.00		33.05
22023	10 or 24-hour diurnal tension curve	187.00		37.24
	NOTE: Fee items 02018 and 02019 are <u>not</u> 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	394.00		82.46
22051	Specular Microscopy – professional fee	102.00		21.53
22052	Specular Microscopy – technical fee	292.00		60.95
	NOTES: i) Paid for post-operative corneal transplant assessment, maximum 6 per patient, per each 12 month period. ii) Daily maximum of 1 per patient/day. iii) In cases of corneal failure or rejection, additional tests may be paid, if accompanied by a note. iv) This fee includes specular microscopy for one eye. v) Not paid for pre- or post-operative cataract patients. vi) Paid once prior to intraocular surgery when affected by: 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	344.00		68.80
02068	– Professional fee	66.30		13.22
02069	– Technical fee	275.00		55.57
	NOTES: i) Fee items 02067–02069 include examination of both eyes whether at one time or two separate visits. ii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
22067	Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g.: Heidelberg, GDX)	334.00		57.02
22068	– Professional fee	65.20		13.22
22069	– Technical fee	271.00		45.41

NOTES:

i) Requires both qualitative and quantitative assessments.
ii) Includes examination of both eyes whether at one time or two separate visits.
iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.
iv) Includes 02007, 02018, 02019

22075	Computerized Corneal Topography	333.00		61.97
22076	- professional fee	87.40		16.80
22077	- technical fee	246.00		45.15

NOTES:

i) Payable for post-operative corneal transplant assessment, maximum six per year per patient. In cases of problematic corneal transplant or unresolved astigmatism, additional tests may be paid, if accompanied by the following code (9968).
ii) This fee includes both eyes, whether at one time or two separate visits.
iii) Payable for corneal thinning disorders, including keratoconus and pellucid marginal degeneration, where progressive astigmatic change greater than 1 diopter in a year has been documented, corneal epithelial or stromal scarring, where the visual central axis of the cornea is affected. Payable once per year per patient. In cases where there is documented progression of any of these conditions, additional tests may be paid, if accompanied by the following code (V80).
iv) Not payable for pre- or post-operative cataract patients except where there is documented evidence of irregular astigmatism resulting from the cataract surgery.
v) Payable with following fee items if medically necessary: 02015, 02018, 02019, 22169, 02010 and 02012.

(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)	69.70		13.89
S00771	Retinal examination under anesthesia - procedural fee (when done as an independent procedure)	106.00	3	21.19

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)	340.00		67.92

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)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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)	298.00		106.17
	NOTES: i) No additional charge for second eye when both eyes examined concurrently. ii) 08641 includes 22399 when done at the same sitting. iii) Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.			

FITTING OF CONTACT LENSES

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.....	422.00		84.25
02058	Contact lens - aphakia - unilateral	1406.00		280.88
	NOTE: Fee item 02058 includes follow-up visits for three (3) months.			
22059	Contact lens – Keratoconus – unilateral	1406.00		280.88

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	110.00		21.89
S02109	Injections - subconjunctival - operation only	118.00		23.59
	NOTE: Not to be billed at the time of any intraocular surgery.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S02110	Radioactive plaque placement 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.	4585.00	5	1057.94
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	724.00		144.24
S02075	Botulinum toxin injections for entropion	399.00		78.83
S02076	Botulinum toxin injections for strabismus in patients aged 12 or older	1102.00		219.54
	Lacrimal Apparatus:			
S02111	En bloc micro-dissection lacrimal gland for tumour with excision by lateral approach with levator dissection	5933.00	6	1181.57
S02118	Snip procedure, two or three - operation only	254.00	3	50.60
S02120	Punctum dilation and syringing sac	138.00	3	26.97
S22121	Duct probing, under GA - unilateral or bilateral NOTE: Not to be billed with S02123 on the same eye.	940.00	3	186.23
S02122	– under local anesthetic - operation only	138.00	3	26.97
S02123	Quickert tube, insertion of	1092.00	3	217.63
S02129	Lester Jones tube, insertion of	1937.00	3	446.92
S02119	Dacryocystostomy, under local anesthetic - operation only	189.00	3	37.26
S02112	Dacryocystectomy with unroofing of bony lacrimal canal and removal of lacrimal duct for tumour	5609.00	4	1117.35
S02126	Dacryocystorhinostomy NOTE: Not to be billed with S02123 on the same eye.	2968.00	3	591.24
S02127	Repair of canaliculi	2259.00	3	521.40
	Orbit:			
S02132	Retrobulbar injection - operation only NOTE: Not to be paid in addition to intraocular surgery.	479.00	2	95.98
S02133	Enucleation or evisceration	2425.00	4	559.08
S02134	Orbit - enucleation with insertion of complicated implant (e.g.: dermis fat graft and/or scleral wrapped porous implant)	3552.00	4	819.37
S22136	Biopsy or excision of anterior orbital tumour	1615.00	4	372.45
S22140	Orbital exploration (posterior route) - to biopsy posterior orbital tumour, or to fenestrate optic nerve sheath NOTE: Not billable with fee item S22138.	5166.00	6	1191.81
S22138	Posterior orbitotomy for removal of posterior orbital tumour not involving the orbital apex or optic nerve NOTE: Not billable with fee item S22140.	6457.00	6	1489.79
S02144	Aspiration needle biopsy of orbit under scan control	716.00	3	143.15

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S02101	Posterior orbitotomy with microscopic dissection for lesions of optic nerve or orbital apex	9349.00	7	1862.21
S02135	Exenteration of orbit	4613.00	4	1064.25
S02145	Orbital exenteration with en bloc resection of bony orbital walls - ophthalmologist NOTE: Fee from neurosurgeon and plastic surgeon in addition.	7686.00	7	1772.82
S22141	Orbital decompression - 1 wall	2906.00	6	670.39
S22142	– 2 wall	4488.00	6	1035.33
S22143	– 3 wall NOTE: Orbital decompression is not paid in addition to fee items S22140 or S22138.	6457.00	6	1489.79

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	118.00	3	23.59
S02147	– electric - operation only	340.00	3	67.96
S02106	Microscopic repair of trichiasis including muscular graft or mucosal membrane graft	3085.00	3	614.89
S02148	Cryotherapy of eyelids for trichiasis or tumour - operation only	627.00	3	124.16
S02149	Meibomian gland evacuation - operation only	118.00		23.59
S02150	Chalazion excision - operation only	360.00	3	83.27
S02152	Tarsorrhaphy - operation only	623.00	3	123.42
S02153	Ectropion/Entropion - Ziegler or simple procedure, involves simple skin incision but does not require associated lid shortening and/or skin grafting - operation only	303.00	3	59.48
S02154	Ectropion/Entropion - complicated, including neoplasms and plastic repair - requires both repair and associated lid shortening and/or skin grafting	1776.00	3	353.56
S02155	Ptosis repair - frontalis sling using synthetic material	1555.00	3	310.37
S02159	– frontalis sling using autologous material	2903.00	3	577.66
S02160	– levator resection	2851.00	3	567.62
S02158	Fasanella Servat	1401.00	3	279.71
S02166	Lid elevation and scleral graft for lower lid retraction	2493.00	3	496.58
S02100	Graded Muellerectomy with levator recession - under local anesthetic	2493.00	3	496.58
S02156	Excision of tumour of lid margin or conjunctiva - benign - operation only	469.00	3	93.48

		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., "Surgery for Alteration of Appearance."	204.00	3	40.45
S02103	Minor lid repair - operation only	469.00	3	93.48
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.	4680.00	3	931.10
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.	7795.00	3	1551.86
S02107	Eyelid - repair of margin defect requiring layered closure ...	1615.00	3	372.45
	Eye Muscles:			
S02161	Strabismus - 1 or 2 muscles	1981.00	3	394.96
S02162	– 3 or more muscles.....	2806.00	3	558.67
S22165	– 5 or more muscles.....	4051.00	4	806.95
S02163	– complicated re-operation	3117.00	4	620.75
S22166	Adjustable suture fee - extra to strabismus surgery.....	940.00		186.23
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.	733.00		146.07

CORNEA AND SCLERA

S22171	Pterygium excision with mucous membrane graft.....	2227.00	4	443.43
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.	2767.00	4	638.55
S02167	Cautery or cryotherapy of corneal ulcer - operation only	172.00	3	33.60
S02171	Pterygium or limbus tumour excision - operation only.....	674.00	3	133.99
S02172	Gundersen-type flap	1555.00	3	310.37
S02173	Keratoplasty - Lamellar.....	3955.00	3	897.78
S02175	– penetrating	4508.00	4	898.70

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S02168	– complicated re-operation	5071.00	4	1009.83
	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	117.00	4	23.37
	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	1642.00	4	327.18
S02169	– complicated	3717.00	4	740.24
	Collagen Cross-Linking for Keratoconus			
S22175	– Professional fee	2011.00		427.05
S22176	– Technical fee	2514.00		533.83
	NOTES: i) Paid only for Keratoconus. ii) In order to be eligible for the procedure, patients age 25 or older must show progression of greater than 1 Dioptre change in refractive astigmatism or a greater than one line loss of corrected acuity documented over a minimum of two examinations. Patients under the age of 25 with Keratoconus do not need to show progression. iii) CXL may not be claimed in association or in relationship with refractive surgery for shape improvement. iv) Includes: both corneal pachymetry (pre and post), corneal de-epithelization, all the isometric riboflavin drops, any other drops, the technician's time, use of the UV-A light. v) When performed in a publicly-funded facility, the technical fee is not paid. vi) Second eye paid at 50% if performed the same day. Post refractive ectasia is not a benefit.			

GLAUCOMA / IRIS / ANTERIOR CHAMBER

S22070	Molteno implant (includes phase 1 and 2)	5169.00	5	1131.65
	NOTE: Includes placement of scleral graft if indicated.			
S02176	Sclerotomy - posterior, with or without insufflation of gas (isolated procedure)	694.00	4	138.75
S02177	Glaucoma - peripheral iridectomy (isolated procedure)	1833.00	4	364.42

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S02178	– filtering procedure, non-microscopic	2737.00	4	631.46
S02180	– goniotomy	2489.00	4	574.00
S02183	– goniotomy - repeat within 3 months	1200.00	4	238.40
S02184	– cyclodialysis	1776.00	4	353.56
S22185	– cycloablative procedures	1642.00	4	327.18
S02187	– filtering procedure, microscopic	3117.00	4	679.97
S22187	– complicated trabeculectomy	4451.00	4	991.46
	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	3340.00	4	666.00
S02197	Surgical evacuation of a hyphema	2745.00	4	547.50

CATARACT / LENS

S02188	Cataract - senile, traumatic, congenital, or linear extraction	2405.00		294.65
S22191	– capsulotomy, needling or discission (isolated procedure)	1105.00		219.82
	Pediatric cataract extraction			
22188	– 0 to 7 years	5759.00		1184.90
22189	– 8 to 16 years	3840.00		789.93
S02190	Primary intraocular lens implantation to include repositioning of lens within the 42-day post-operative period (extra)	638.00		77.55
S02192	Secondary intraocular lens implantation to include repositioning of lens within the 42-day post-operative period	2554.00		508.47
S02196	Surgical repositioning of implant lens	1200.00		238.40
	NOTE: For non-surgical repositioning, use visit fees.			

RETINAL PROCEDURES

S02181	Foreign body intraocular - magnetic extraction (isolated procedure)	2839.00	4	654.64
S02182	– non-magnetic extraction (isolated procedure)	3433.00	4	791.80
S02090	Intravitreal injection of vitreous paracentesis	711.00	4	137.47
	NOTE: Not to be billed with S02199 or S02194.			
S02091	Paracentesis, anterior chamber	711.00	4	137.27
S02092	Intravitreal biopsy (microbiology, cytology) or intraocular tumour needle biopsy	1148.00	4	227.12
S02194	Buckling procedure	4278.00	5	852.57
	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	1202.00	5	239.58
	NOTE: Not to be billed in addition to S02199 or S02194.			
S02198	Anterior vitrectomy.....	1852.00	4	368.94
	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).....	4829.00	5	961.37
	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.....	355.00	5	70.97
S22200	Pan retinal endolaser greater than 200 burns when done with a posterior vitrectomy.....	1101.00	5	218.77
S22201	Scleral buckle done with posterior vitrectomy - operation only.....	298.00	5	59.11
S22202	Intraocular lens removal and/or lensectomy when done with posterior vitrectomy - operation only	298.00	5	59.11
S22203	Removal of intraocular foreign body at the time of posterior vitrectomy	1190.00	5	236.50
S22196	Pneumato retinopexy with air or gas (isolated procedure)..	2055.00	5	409.16
	NOTE: Includes cryopexy or laser.			
S22195	Removal of buckle material or sponge.	920.00	5	183.27
	NOTE: Not paid with any other fee item on the same eye.			
S22197	Additional gas (C3F8 or SF6) or air injection	532.00	5	105.22
	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).....	5201.00	5	1035.86

LASER PROCEDURES

S02072	Laser interferometry	174.00	4	34.29
S22113	Laser iridotomy, per eye - operation only	627.00	4	124.16

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S22114	Laser trabeculoplasty, per eye NOTE: If laser trabeculoplasty (22114) to the same eye is done at multiple sittings within 6 weeks of the initial treatment, then subsequent treatments will be included in the original fee.	682.00	4	135.53
S22115	YAG laser capsulotomy, per eye - operation only	564.00	4	112.35
00094	YAG laser tray service fee NOTES: i) Applicable to fee items S22113 and S22115 only. ii) Hospitals and physicians who use hospital-based YAG lasers are not eligible to bill this fee.	199.00		71.58
S22116	Retinal photocoagulation - left	682.00	4	135.53
S22117	Retinal photocoagulation - right	682.00	4	135.53
S02116	Panretinal photocoagulation - defined as greater than 700 burns. Maximum fee for one eye for any 6-month period. NOTES: i) All laser procedures include all follow-up visits in the six (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.	2783.00	4	553.82
S22118	Laser follow-up visit. 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.	179.00		35.05
S22125	Photodynamic therapy for age-related wet macular degeneration - professional fee Note: Payable to retinal physicians certified in PDT treatment only.	4090.00		295.29

OTOLARYNGOLOGY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
02510	**Consultation:** To include history, detailed examination of the ear, nose and throat, review of x-ray and laboratory findings and written report.....	292.00		86.23
02511	**Consultation:** With pure tone audiogram	355.00		103.15
02514	**Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee.....	178.00		50.71
02512	**Special Consultation, for dizziness:** 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	584.00		189.81
02513	**Consultation:** For management of malignancy	437.00		117.54
	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.....	481.00		146.05
	NOTES: i) To apply where a patient has been referred by another Otolaryngologist, Neurologist or Respirologist. ii) To include self-assessment, perceptual analysis, aerodynamic measures and acoustic analysis.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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 report. ..... NOTES: i) Restricted to Otolaryngologists who have completed advanced training in Otolaryngic Allergy through the AAOA. ii) Appropriate diagnostic allergy skin testing is a requirement for billing 02515. iii) Skin scratch and patch testing fee items (00762, 00763, 00764, 00765, 00767) are not payable in addition.	584.00		153.91
02215	Pre-Operative Assessment ..... NOTES: i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances. ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent. iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition. iv) Maximum of one pre-operative assessment per patient per procedure. v) Only paid to the surgeon who performs the procedure.	266.00		87.56
	Continuing Care by Consultant:			
02507	Subsequent office visit	118.00		39.74
02508	Subsequent hospital visit.....	97.70		37.68
02509	Subsequent home visit	195.00		94.22
02505	Emergency visit when specially called (not paid in addition to out-of-office hour premiums)..... NOTE: Claim must state time service rendered.	392.00		125.12
Telehealth Service with Direct Interactive Video Link with the Patient				
25010	Telehealth consultation: To include history, detailed examination of the ear, nose and throat, review of X-ray and laboratory findings, and written report	292.00		86.23

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
25012	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.....	178.00		50.71
25013	Telehealth consultation for management of malignancy	437.00		117.54
	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.			
25007	Telehealth subsequent office visit.....	150.00		39.74

MISCELLANEOUS

02519	Complex Laryngeal Disorder Conference Fee.....	106.00		31.04
	NOTES: i) Restricted to Otolaryngology. ii) Restricted to laryngeal pathology. iii) Payable only if 02517 (consult for management of complex laryngeal disorder) has been paid for the same patient by the same practitioner in the previous 6 months. iv) Requires interdisciplinary team meeting with at least one allied health professional. v) Maximum of four paid per patient, per day. vi) Maximum of eight paid per patient, per calendar year. vii) The results of the assessment, as well as the names and roles of those who participated in the meeting must be documented in patient's chart, and result communicated to Family Physician or referring physician. viii) Start and end times must be entered in both the billing claims and patient's chart. ix) Not paid to physicians who are employed by, or who are under contract to a facility; or physician working under salary, service contract or sessional arrangements. x) Consult or visit on the same day paid in addition if medically required and does not take place concurrently with the conference fee.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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)	68.80		17.39
02521	Audiogram - speech (SRT, PB, MCL)	74.80		19.13
02525	Impedance test	40.25		10.19
02531	Impedance test, including contra-lateral reflex	80.60		19.84
02532	PI-PB test	26.45		6.38
02533	Play audiometry	109.00		24.64
02534	Free field audiometry	109.00		24.64
02536	Brainstem evoked response audiometry	211.00		48.28
02539	Brainstem evoked response audiometry with electrocochleography	307.00		69.76
	NOTE: Only one additional specialist examination can be billed in addition to this item.			
02541	Electrocochleography	237.00		52.58
	Vestibular Tests:			
02526	Cold calorics test	50.30		11.36
02527	Bithermal test	109.00		24.64
02528	E.N.G. (Electronystagmography)	215.00		53.42
	NOTE: To control the total cost involved in extensive patient investigation, the following recommendation applies: Vestibular tests performed on a subsequent visit should have a maximum fee limitation equal to the value of fee item 02528, to be billed directly in lieu of return visit.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Functional Tests:			
02530	Stenger	109.00		24.64
02542	Measurement of otoacoustic emissions	146.00		36.20
	Miscellaneous Tests:			
	NOTE: See also SY00907, SY00908 under Diagnostic and Selected Therapeutic Procedures.			
02538	Laryngostroboscopy	328.00		86.72
02535	Maxillary sinus endoscopy via canine fossa, with or without biopsy	516.00	3	119.51

EAR

Item	Removal of foreign body or aerating tubes from ear - simple	Per Visit		
02206	Removal of ear canal osteoma (operation only)	359.00	2	92.38
02209	Removal of obstructing exostosis of ear canal	2119.00	3	619.69
02210	Paracentesis of the ear drum (operation only)	195.00	2	54.70
02221	Microscopic debridement or aural polyp removal	118.00	2	27.72
	Note: Can be billed as an extra at 100% with fee item 02507.			
02223	– under general anesthetic - operation only	275.00	2	78.12
	NOTE: 02221, 02223 are not billable with 02254, 02274, 02228 and 02229.			
	Transmastoid facial nerve decompression:			
02233	– vertical and horizontal segment	4933.00	4	1153.30
02234	– vertical segment	2569.00	4	600.14
02224	Transcanal labryinthotomy transmastoid for posterior semicircular canal occlusion	955.00	4	223.84
02241	Labyrinthectomy - drill out of petrous bone	2508.00	4	587.06
02243	Repair atresia external ear canal, complete, bony	4635.00	3	1082.81
02244	Repair stenosis external ear canal, bony	2677.00	3	626.20
02245	Microsurgical repair and reconstruction soft tissue stenosis - external ear canal	2906.00	3	678.39
	NOTE: Includes skin grafting or flap.			
02231	Microsurgical revision and reconstruction, soft tissue stenosis - external ear	2325.00	3	542.69
	NOTE: Includes skin grafting or flap.			
02247	Mastoidectomy - partial, canal wall up (cortical)	2677.00	3	626.20
02248	Radical mastoidectomy	3401.00	4	795.79

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
T25273	Mastoid cavity obliteration with autologous bone dust, bone chip, and/or abdominal adipose tissue (extra)	2711.00		750.00
	NOTES: i) Payable only with 02253, 02273, 02268, 02272 or 22268. ii) If bilateral mastoid cavity obliterations are performed on the same date of service, the second mastoid cavity obliteration (25273) is payable at 50%. iii) Must include obliteration with autologous bone pate, bone chips, and/or abdominal adipose tissue (palva flap rotation or cartilage placement only is not sufficient). iv) Includes autologous adipose tissue harvesting and grafting.			
02249	Stapes - reconstruction	2677.00	3	701.97
02250	– mobilization of	1562.00	3	409.46
02246	– reconstruction with laser	2906.00	3	760.47
02251	Myringoplasty repair of drum - without exploration of middle ear	834.00	3	213.11
02239	Tympanotomy - with ossicular chain reconstruction	1562.00	3	441.58
02252	Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of a tympanotomy)	1950.00	3	511.85
02264	– with ossicular chain reconstruction	2961.00	3	775.08
02276	– lateral graft, homograft tympanic membrane	2961.00	3	775.08
	NOTE: Applicable to adhesive otitis media or total perforation.			
S02277	Tympanoplasty with excision of middle ear cholesteotoma – first 90 minutes	1763.00	3	581.82
	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)	178.00	3	58.19
	NOTES: i) Restricted to Otolaryngologists. ii) If the cholesteatoma extends into the mastoid, bill fee items 02253 or 02273 only. iii) Not payable with fee items 02252, 02253, 02264, 02273 or 02276. iv) Start and end times must be entered in both the billing claims and the patient's chart.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02238	Tympanoplasty with excision of bony canal stenosis – microscopic open	3582.00	3	851.11
	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	4520.00	3	1184.59
02265	– partial, canal wall down (atticotomy)	2677.00	3	688.20
02263	Trans-tympanic polyneurectomy	1452.00	3	339.19
02254	Myringotomy with insertion of aerating tube (operation only) - unilateral - operation only	359.00	2	93.22
02274	– bilateral - operation only	562.00	2	142.08
	Myringotomy with insertion of aerating tube, under GA			
P02228	– unilateral (operation only)	348.00	2	138.99
P02229	– bilateral (operation only)	532.00	2	212.74
02255	Exploratory tympanotomy	1037.00	2	241.36
02261	– with chemical control, tac procedure, cryosurgical control, ultrasound	1703.00	3	397.90
02266	Myringoplasty - paper patch or synthetic - operation only	195.00	2	45.66
02256	Endolymphatic shunt (any procedure)	3793.00	6	887.10
02259	Excision of glomus - by tympanotomy approach	2961.00	3	691.43
02260	– where extensive dissection is required	3835.00	4	1275.70
02267	Conchal cartilage graft	1396.00	3	326.13
02268	Intra-cochlear implant (unilateral)	4438.00	4	1414.59
22268	Intra-cochlear implant (bilateral)	7341.00	4	2475.53
02269	Implantable bone conductor	2061.00	4	480.31
02242	Microsurgical repair and reconstruction soft tissue atresia, external ear canal - complete	3478.00	3	814.07
	NOTE: Includes skin grafting or flap.			
C02225	Middle Fossa Approach for Repair of Superior Canal Dehiscence	3199.00	5	1176.99
	NOTE: To include approach and plugging or repair of canal.			
02270	Transmastoid - posterior semi-circular canal occlusion or repair of superior canal dehiscence	4438.00	4	1554.65

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	8706.00	5	2236.66
	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	5223.00	5	1476.20
	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	4933.00	5	1292.84
	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	275.00	3	65.21
	Cauterization of septum:			
Item	– chemical	Per Visit		
02303	– electric - operation only	169.00	3	42.99
	Cryosurgical treatment of turbinates:			
02298	– unilateral	674.00	3	156.55
02299	– bilateral	834.00	3	195.68
	Turbinectomy:			
02304	– unilateral - operation only	422.00	3	97.84
02305	– bilateral	615.00	3	143.48
02306	Submucous resection of septum	725.00	3	169.58
	Naso-antral window:			
02307	– single - operation only	504.00	3	117.41
02308	– double	786.00	3	182.65
02309	Radical antrostomy	1396.00	3	326.13
02310	– with closure of alveolar fistula	2010.00	4	469.66

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Intranasal ethmoidotomy to include polypectomy, posterior:			
02360	– unilateral	1562.00	3	365.27
02361	– bilateral	2404.00	3	560.97
02362	Intranasal ethmoidotomy, anterior - unilateral	834.00	3	195.68
02363	– bilateral	1396.00	3	326.13
02315	External radical fronto - ethmoidotomy	2569.00	4	600.14
	Electrocoagulation of turbinates:			
02317	– one side - operation only	227.00	3	52.19
02318	– both sides - operation only	333.00	3	78.26
02319	Trephining frontal sinus	1123.00	3	260.92
02321	Sinus sphenoidotomy/sphenoid sinusotomy (intranasal)	1175.00	3	273.96
	Removal of nasal polyp:			
S02322	– unilateral - operation only	448.00	3	104.37
S02323	– bilateral	725.00	3	169.58
	Lavage or debridement of sino-nasal tract or cavity:			
02324	– unilateral (operation only)	147.00	3	34.34
02325	– bilateral (operation only)	224.00	3	51.49
	Choanal atresia; definitive repair of:			
02326	– unilateral	2119.00	3	495.75
02327	– bilateral	2961.00	4	691.43
	Choanal atresia; perforation of:			
02328	– unilateral	725.00	3	169.58
02329	– bilateral	1004.00	4	234.81
	Submucous turbinectomy:			
02330	– unilateral	725.00	3	169.58
02331	– bilateral	1123.00	3	260.92
	Lateral rhinotomy and excision of tumour:			
02332	– benign	2569.00	3	600.14
02333	– Lateral rhinotomy and/or medial maxillectomy for excision of nasal tumour	2736.00	3	639.25
	NOTES: i) To include open or endoscopic techniques ii) Not payable for polyps			
02334	Transantral ethmoidectomy	2119.00	3	495.75
02335	Transantral ligation, internal maxillary artery	2235.00	6	521.85
02337	Ligation of anterior and posterior ethmoid arteries	1396.00	6	326.13
02338	Removal of angiofibroma - nasal pharynx	3242.00	6	756.66
02342	Maxillectomy with exenteration of ethmoid	3523.00	5	821.90
02339	Palatal fenestration	1130.00	3	263.65
02343	Septal reconstruction	1674.00	3	391.38
02341	Posterior nasal packing (operation only) to include balloon control of epistaxis - operation only	275.00	3	121.73

		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)	437.00	3	194.81
02345	Drainage of abscess or hematoma of septum (operation only)	504.00	3	117.41
02347	External osteoplastic frontal flap operation	4074.00	4	952.37
02364	Nasal fracture, simple reduction - operation only	275.00	3	101.81
S02365	Nasal fracture, reduction and splinting - operation only	562.00	3	178.36
06123	Comminuted nasal fractures - transosseous wire plate fixation	1472.00	3	314.00
02348	Operative closure of oral nasal fistula	1562.00	3	837.75
02349	Operative closure of nasal septal perforation	2235.00	3	521.85
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	584.00	4	135.68
02359	Revision endoscopic intranasal spheno-ethmoidotomy (anterior, middle and posterior cells including sphenoid)	2325.00	3	542.69
25300	Endoscopic stereotactic resection of intranasal or sinus tumour – up to 7 hours operating time NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	4336.00	6	2129.47
25301	– additional payment after 7 hours operating time 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.	1069.00	6	532.35

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Includes all surgery necessary to access tumour. iv) Payable only when rendered in acute-care facility. v) Time over seven hours is payable under fee item 25301. vi) Minimum of 3 hours surgery duration required to bill fee item 25300. vii) Start and end times must be entered in both the billing claims and the patient's chart. viii) A written report must be submitted with claims billed under these items.			
25305	Endoscopic ligation – sphenopalatine artery ..... 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.	1720.00	6	428.02
25310	Endoscopic trans-nasal repair of CSF leak from anterior skull base ..... NOTES: i) Includes harvest of any tissue needed for the repair, including closure of any donor site. ii) Includes complete sphenoethmoidectomy or frontal sinusotomy or sinus trephine if required iii) Iatrogenic injuries payable at 50%.	3981.00	8	998.15
25315	Primary frontal sinusotomy ..... NOTES: i) Requires direct visualization of frontal sinus recess/ostium. ii) Not to be billed in uncomplicated anterior ethmoidotomy. iii) Frontal sinus disease must be present to bill this item. iv) Payable at 100% with fee items 02360, 02361, 02362 or 02363. v) Not payable with 25318. vi) Not payable with 25316 or 25317 on same side. vii) Payable at 50% if done within six months of 25318. viii) Payable at 50% if done within six months of 25316 or 25317 on same side.	972.00	3	237.54

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
T25316	Comprehensive aeration of a complex frontal sinus-without drilling (unilateral) ..... Includes comprehensive removal of all septations within the frontal recess – resulting in a maximally expanded frontal sinus outflow tract bounded by the orbit, frontal beak, posterior table of the frontal sinus (including identification of the anterior ethmoid artery) and middle turbinate (or septum, if the middle turbinate is removed). NOTES: i) Either a) or b) must apply: a) Frontal sinus with complex frontal recess cellularity as defined by the IFAC classification. b) For revision surgery, frontal sinus with complicated frontal recess anatomy (such as scarring following previous frontal sinus surgery). ii) Requires direct visualization of the top of the frontal sinus with an angled endoscope. iii) Frontal sinus disease must be present to bill this item. iv) Not to be billed in uncomplicated anterior ethmoidotomy. v) Payable at 100% with one of 02359, 02360, 02361, 02362, 0r 02363. vi) Payable at 150% if done bilaterally. vii) Not payable with 25318. viii) Not payable with 25315 or 25317 on same side. ix) Payable at 50% if repeated on same side within six months. x) Payable at 50% if done within six months of 25318. xi) Payable at 50% if done within six months of 25315 or 25317 on same side.	1322.00		366.00
T25317	Comprehensive aeration of a complex frontal sinus-with drilling (unilateral)	1699.00		470.18

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Frontal recess must have chronic inflammation, scarring or narrow anatomy (usually because of a prominent bony frontal beak resulting in a poor AP diameter to the frontal recess) and where the bone/scar tissue in the frontal recess is firm enough to necessitate use of a drill. Includes comprehensive removal of all septations within the frontal recess – resulting in a maximally expanded frontal sinus outflow tract bounded by the orbit, frontal beak posterior table of the frontal sinus (including identification of the anterior ethmoid artery) and middle turbinate (or septum, if the middle turbinate is removed). *(see notes on next page)* NOTES: i) Requires direct visualization of the top of the frontal sinus with an angled endoscope. ii) Frontal sinus disease must be present to bill this item. iii) Not to be billed in uncomplicated anterior ethmoidotomy. iv) Payable at 100% with one of 02359, 02360, 02361, 02362, 0r 02363. v) Payable at 150% if done bilaterally. vi) Not payable with 25318. vii) Not payable with 25315 or 25316 on same side. viii) Payable at 50% if repeated on same side within six months. ix) Payable at 50% if done within six months of 25318.			
T25318	Modified endoscopic Lothrop procedure (Draf III) Requires the drilling of the entire floor of both frontal sinuses, the frontal intersinus septum and an anterior/superior nasal septectomy (unilateral or bilateral)	2891.00		800.00

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

NOTES:
i) Restricted to Otolaryngologists.
ii) Requires direct visualization of frontal sinus recess/ostium.
iii) Frontal sinus disease must be present to bill this item.
iv) Not to be billed in uncomplicated anterior ethmoidotomy.
v) Payable at 100% with one of 02359, 02360, 02361, 02362, 0r 02363.
vi) Includes fee items 25315, 25316 or 25317.
vii) Payable at 50% if repeated within six months.
viii) Payable at 100% within six months of 25315, 25316 or 25317.

25100	Laser photocoagulation or electrosurgical plasmacoagulation (coblation) of hereditary hemorrhagic telangiectasia lesions for nasal cavities (HHT)	1885.00	6	456.19

(see notes on next page)

NOTES:
i) Not payable with fee items SY00907, SY00908, 00909, 00235, 00236, 00237, 02303, 02317, 02318, 02341, and 02346.
ii) Includes payment for any and all HHT sites treated by laser. Not for use on external non-symptomatic lesions.
iii) Payable for treatment of one or both nasal cavities at the same sitting regardless of the number of lesions treated.
iv) Maximum of five subsequent procedures in a six (6) month period, otherwise support with a written letter.

RHINOPLASTY

02351	Nasal refracture requiring lateral osteotomies	1562.00	3	401.44
02352	Reconstruction of nasal tip, ala and columella	1842.00	3	473.12
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma)	2468.00	3	633.73

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02354	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and/or reconstruction of nasal tip, without skin grafting via closed approach	2677.00	3	688.20
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and/or reconstruction of nasal tip without skin grafting via open (or external) approach. NOTE: To include a columellar incision with marginal incisions.	3393.00	3	927.33

THROAT

	Incision of peritonsillar abscess:			
02447	– under local anesthetic - operation only	305.00	4	106.87
02444	– under general anesthetic - operation only	563.00	6	144.89
	Tonsillectomy:			
02403	– under local anesthetic	1130.00	4	263.53
02445	– adult or child, over the age of 14 years	834.00	4	282.24
02446	– child, age 14 years and under (to include neonate)	786.00	4	300.13
02413	Operative control of post-tonsillectomy or post-adenoidectomy hemorrhage requiring local or general anesthetic	844.00	6	325.62
02399	Cryotherapy of tonsils and oral lesions - operation only	504.00	3	117.41
02442	Adenoidectomy - adult or child, over 14 years	563.00	4	144.89
02443	– child 14 years and under (to include neonate)	692.00	4	213.33
02448	Retropharyngeal abscess or hematoma - drainage under local anesthetic- operation only	562.00	4	173.29
02406	Retropharyngeal abscess or hematoma - drainage under local anesthetic requiring lateral pharyngotomy	1062.00	6	338.86
02409	Uvulo-palato-pharyngoplasty for obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy	1842.00	5	430.50

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: The following two indications are requirements: i) Patient is unable to use Continuous Positive Airway Pressure (CPAP). This may be due to: a) Failure to adapt to the wearing of a mask of any kind after a trial of at least 30 days supervised by a qualified sleep therapist. b) Failure of CPAP to improve symptoms directly related to OSA after CPAP delivery has been optimized by a titration Polysomnogram (PSG). ii) Patient has, on level 1 Polysomnography in a certified sleep lab, an Apnea Hyponea Index (AHI) of 15 or greater. (Home sleep studies (level 2 or 3 PSG) may be substituted for level 1 PSG only if they are done through a certified sleep lab).			
02408	Removal of tumour from larynx or trachea	834.00	5	195.68
02410	Thyrotomy (including cordectomy)	2235.00	5	521.85
02431	Hemilaryngectomy	6334.00	6	1480.34
02432	Supraglottic laryngectomy	6897.00	6	1610.94
02433	Vocal cord implant - injection	1396.00	5	326.13
02434	– external approach	2793.00	5	652.31
02414	Repair laryngo tracheal stenosis (to include skin grafting, stenting and associated endoscopy)	6314.00	8	1474.19
02418	Repair of fractured larynx - external approach	3627.00	8	847.99
02449	Rigid esophagoscopy for removal of foreign body	834.00	4	259.93
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	1123.00	6	312.59
02422	– in a child under the age of 3 years - operation only	1670.00	6	389.18
02420	Dilation of trachea - operation only	489.00	5	156.10
02421	– repeat within one month - operation only	647.00	5	155.88
02425	Arytenoidectomy	2793.00	5	652.31
02436	Arytenoid adduction	2606.00	5	830.43
	NOTES: i) Payable only to certified Otolaryngologists. ii) Includes fee item 02434.			
02437	Transphenoidal removal of pituitary tumour or hypophysectomy, two surgeons - Otolaryngologists	3958.00	8	1261.67
02438	Trans-oral cricopharyngeal myotomy	1842.00	5	430.50
02424	Tracheo-oesophageal puncture and insertion of voice prosthesis following laryngectomy	1562.00	5	365.27

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02440	Bilateral micro-transposition of submandibular salivary ducts when done with or without a microscope	1482.00	4	346.01
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) NOTE: 02441 is not billable when tracheostomy is performed by the same surgeon at the same time. Bill under 02407.	1308.00	11	305.28
02451	Excision of congenital cyst or fistula from neck	1842.00	4	447.55
02452	Sialolithotomy - simple - in duct - operation only	275.00	3	65.21
02453	– complicated - in gland	834.00	3	195.68
02455	Submandibular gland, excision	1396.00	4	390.71
02456	Salivary fistula, plastic to Stenson's duct	1842.00	4	430.50
02454	Alveolectomy	834.00	3	195.68
02457	Tongue tie - under general anesthetic - operation only	359.00	3	93.22
02458	Tongue; local excision - under general anesthetic	725.00	3	169.58
02459	Cystic hygroma, excision	2404.00	4	560.97

LARYNGEAL ENDOSCOPY AND SURGERY

02412	Biopsy of larynx and/or cauterization (including laryngoscopy) - operation only	562.00	5	173.28
02419	Direct or indirect laryngoscopy with foreign body removal	674.00	5	224.80
02428	Micro-laryngoscopy - with biopsy of larynx and/or cauterization	786.00	5	242.62
02423	Micro-laryngoscopy with removal of non-pedunculated malignancy or extensive submucosal lesion	1949.00	5	500.53
02429	Micro-laryngoscopy and removal of tumour from larynx or trachea	896.00	5	277.27
	Micro-surgery with use of CO_2 laser for removal of tumour(s) of larynx or trachea:			
02430	– first procedure	1949.00	6	501.50
02435	– subsequent procedure, each	1931.00	6	501.50

NOTES:

i) Maximum of 5 subsequent procedures in six (6) month period, otherwise support with written letter.

ii) Microsurgery treatment with CO_2 laser other than removal of tumour(s) of larynx or trachea, bill under 02599 with operative report.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
SKULL BASE PROCEDURES				
02262	Translabyrinthine approach for neurosurgical access exposure, closure with microscope	7795.00	8	2732.90
02622	Infra-temporal fossa approach to skull base - Otolaryngology fee.	8446.00	8	2502.20
02623	Infra-temporal fossa approach to skull base - Otolaryngology fee for procedure lasting longer than 8 hours	10556.00	8	2640.56
	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	8446.00	8	1973.42
02613	Middle cranial fossa approach, petrosectomy - procedure lasting longer than 8 hours	10556.00	8	2466.65
	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.			
02610	Middle cranial fossa approach without petrosectomy - for trauma, neoplasm resection, nerve section/decompression	5270.00	8	1620.19
	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	7078.00	8	2255.92
02618	Repair of CSF leak following skull base approach with mastoid obliteration (to include exposure, dissection and closure with microscope)	4491.00	8	1574.84

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
DIAGNOSTIC PROCEDURES				
S00701	Direct laryngoscopy - procedural fee NOTE: i) 00701 is not billable with 00907, 00908 and 00909. ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.	169.00	5	73.82
S00717	Micro-laryngoscopy - procedural fee NOTE: S00717 to be charged at 50% if performed with a surgical procedure (not payable in addition to 02423, 02428, or 02429).	333.00	5	147.62
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	210.00	2	56.20
SY00907	Endoscopic flexible or rigid examination of the nose and nasopharynx - procedure only	147.00	3	33.81
SY00908	– procedure and biopsy	238.00	3	54.09
SY00909	Flexible fiberoptic nasopharyngolaryngoscopy NOTES: i) 00909 is not payable with 00700, 00701, 00702, 00907 and 00908. ii) Payable only to certified Otolaryngologists.	186.00	3	45.30
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	397.00	3	120.07

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	8433.00	6	1969.95

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02281	Conservative radical neck dissection NOTE: Includes radical neck dissection with full dissection and sparing of entire accessory nerve and generally sternomastoid muscle and internal jugular vein.	5495.00	6	1283.62
02470	Radical neck dissection	4627.00	6	1080.17
02471	Parotidectomy; subtotal with complete facial nerve dissection	3690.00	4	861.07
02472	Total parotidectomy with nerve dissection for malignancy or deep lobe tumour	4244.00	4	991.49
02407	Tracheostomy NOTE: Not applicable to cricothyrotomy puncture.	1287.00	5	398.83
02411	Laryngectomy, total	5774.00	6	1697.50
02431	Hemilaryngectomy	6334.00	6	1480.34
02432	Supraglottic laryngectomy	6897.00	6	1610.94
C02473	Laryngo-pharyngo-esophagectomy (primary excision only)	6934.00	6	1942.99
C02474	Transoral maxillectomy with skin graft	4627.00	5	1080.14
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon	2793.00	5	652.31
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy	8433.00	7	1969.95
02477	Contralateral suprahyoid dissection	2119.00	5	495.75
02600	Complete temporal bone resection, ENT fee	10556.00	8	2955.38
02601	Temporal bone resection for neoplasm; subtotal and lateral, to include mastoidectomy and excision of external auditory canal	5281.00	8	1845.20
02275	Glossectomy subtotal with either division of mandible or transcervical resection	4627.00	6	1080.11
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) NOTE: 02280 includes rhinotomy, ethmoidectomy, cibriform plate, and orbital exenteration.	10556.00	8	3688.11
02478	Glossectomy - partial for carcinoma	1620.00	6	378.33
C02479	Transpalatal ethmoidectomy, maxillectomy, sphenoidectomy	5774.00	6	1350.10
C02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy	5774.00	7	1350.10

GENERAL INTERNAL MEDICINE

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

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

REFERRED CASES

There are now referred cases fee items for both Internal Medicine and General Internal Medicine. Where there is no specific fee item listed under General Internal Medicine, use applicable Internal Medicine fee.

GENERAL INTERNAL MEDICINE CONSULTATIONS AND VISITS

Note: Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

32210	**Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	909.67		250.60
32212	**Repeat or limited consultation:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	500.00		137.76
PG32312	**Complex Consultation – 2 medical conditions .....**	996.39		274.49

NOTES:

i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

ii) For hospital in-patients, paid once per patient per hospital admission.

iii) Written consultation report includes advice or recommendations for treatment regarding 2 of the conditions listed in note iv) below.

iv) Payable for patients that have 2 of the following listed chronic diseases (if patient has more than 2 diagnoses from the list, use 00311).

(notes continued on next page)

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

(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)

00311	**Complex Consultation – 3 medical conditions.....**	1083.00		298.37

NOTES:
i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

(notes continued on next page)

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

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.

(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)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Continuing care by consultant:			
32206	Directive care	409.57		112.83
32207	Subsequent office visit	360.56		99.33
32208	Subsequent hospital visit	294.00		80.99
PG32317	Subsequent follow-up office visit, complex patient – 2 medical conditions	397.67		109.55
	NOTES: i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training. ii) Payable for patients where the physician is actively managing 2 of the conditions listed in note iv) under fee item 32312. The condition must be noted at the time of each visit and documented in the patient's chart.			
PG32318	Subsequent hospital visit, complex patient – 2 medical conditions	312.00		85.94
	NOTES: i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training. ii) Payable for patients where the physician is actively managing 2 of the conditions listed in note iv) under fee item 32312. The condition must be noted at the time of each visit and documented in the patient's chart. iii) Payable only for an admitted patient.			
PG32307	Subsequent follow-up office visit, complex patient – 3 medical conditions.....	434.80		119.78
	NOTES: i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training. ii) Payable for patients where the physician is actively managing 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
PG32308	Subsequent hospital visit, complex patient – 3 medical conditions	344.34		94.86
	NOTES: i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training. ii) Payable for patients where the physician is actively managing 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart. iii) Payable only for an admitted patient.			
	Telehealth Service with Direct Interactive Video Link with the Patient:			
32370	**Telehealth Consultation**: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	909.67		250.60
32372	**Telehealth repeat or limited consultation**: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	500.00		137.76
P32373	**Telehealth Complex Consultation – 2 medical conditions**	996.39		274.49
	NOTES: i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training. ii) For hospital in-patients, paid once per patient per hospital admission. iii) Written consultation report includes advice or recommendations for treatment regarding 2 of the conditions listed in note iv) below. iv) Payable for patients that have 2 of the following listed chronic diseases (if patient has more than 2 diagnoses from the list, use 32271).			

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

(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)

(notes continued on next page)

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)

32271	**Telehealth Complex Consultation – 3 medical conditions .....**	1083.00		298.37

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

NOTES:

i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training.

ii) For hospital in-patients, paid once per patient per hospital admission.

iii) Written consultation report includes advice or recommendations for treatment regarding 3 or more of the conditions listed in note iv), below.

iv) Payable for patients that have 3 or more of the following listed chronic diseases. Exceptions to this rule could be made if the patient has two diagnoses from this list and one alternative diagnosis not on the list can be submitted with correspondence/note record, outlining the medical necessity. Each case will be reviewed on an independent consideration basis.
(Diagnostic codes in brackets):
Septicemia (038)
Other HIV infection (044)
DM including complications (250)
Disorders of Lipid Metabolism (272)
Thyroid disorders (246)
Purpura, thrombocytopenia and hemorrhagic conditions (287)

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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)			
32376	Telehealth directive care	409.57		112.83
32377	Telehealth subsequent office visit	360.56		99.33
32378	Telehealth subsequent hospital visit	294.00		80.99
P32366	Telehealth subsequent follow-up office visit, complex patient – 2 medical conditions	397.67		109.55
	NOTES: i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training. ii) Payable for patient where the physician is actively managing 2 of the conditions listed in note iv) under fee item 32312. The condition must be noted at the time of each visit and document in the patient’s chart.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
PG32367	Telehealth subsequent follow-up office visit, complex patient - 3 medical conditions	434.80		119.78
	NOTES: i) Payable only for General Internal Medicine specialists who have completed 3 years of core Internal Medicine training plus at least 1 year of General Internal Medicine training. ii) Payable for patients where the physician is actively managing 3 or more of the conditions listed in note iv) under fee item 00311. The condition must be noted at the time of each visit and documented in the patient's chart.			

INTERNAL MEDICINE CONSULTATIONS AND VISITS

00310	Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	757.00		192.59
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	382.00		90.73
00314	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only)	382.00		61.77
	NOTES: v) See Preamble D. 3. 3. vi) Start and end times must be entered in both the billing claims and the patient's chart.			
	Group counseling for groups of two or more patients			
00313	- first full hour	769.00		126.50
00315	- second hour, per 1/2 hour or major portion thereof ...	394.00		63.22
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
	<u>Continuing Care by Consultant:</u>			
00306	Directive care	188.00		80.51
00307	Subsequent office visit	147.00		59.92
00308	Subsequent hospital visit	107.00		52.82
00309	Subsequent home visit	213.00		57.87

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
00305	Emergency visit when specially called (not paid in addition to out-of-office hour premiums)..... NOTE: Claim must state time service rendered.	436.00		128.24
	Telehealth Service with Direct Interactive Video Link with the Patient:			
32270	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report. .	757.00		192.60
32272	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee.	382.00		90.73
32276	Telehealth directive care	188.00		80.51
32277	Telehealth subsequent office visit	147.00		58.80
32278	Telehealth subsequent hospital visit	107.00		51.83

EXAMINATIONS BY CERTIFIED INTERNIST

00322	Internists' part in cardioangiogram, per hour or fraction thereof ..... NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	263.00		51.17
33037	Replacement transfusion - hepatic failure to include two weeks care after transfusion..... NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra.	1552.00		294.36
00343	Cardiac screening (maximum 3 per month within manufacturer's guarantee and one per week beyond manufacturer's guarantee)	31.45		5.11
00344	– professional fee	18.05		2.56
00345	– technical fee.....	18.05		2.56
33032	Pacemaker standby and/or placement of the endocardial catheter - operation only	444.00		82.49
33033	Generator placement and venous cut-down.....	1437.00	4	82.49

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	1023.00	347.74
01421	2nd to 7th day (inclusive) per diem	506.00	174.38
01431	8th day to 30th day	307.00	133.01
01441	31st day onward	354.00	138.53

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 $C0_2$; transcutaneous blood gas application and assessment; and maximum inspiratory pressure monitoring and non-invasive metabolic measurements. There is an expectation of at least 1 hour of bedside care on Day 1. This is the fee to use when one physician is providing the ventilatory care and another physician, the critical care. This service may also be billed by a physician other than the operating surgeon or associate, for critical care required in addition to post-operative care by the surgeon.

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
01412	1st day	889.00	326.60
01422	2nd to 7th day (inclusive) per diem	448.00	174.65
01432	8th day to 30th day	323.00	134.95
01442	31st day onward	291.00	130.11

3. COMPREHENSIVE CARE - These fees apply to intensive care physicians who provide complete care, both critical care and ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment; 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
01413	1st day	1671.00	519.02
01423	2nd to 7th day (inclusive) per diem	763.00	262.42
01433	8th day to 30th day	383.00	145.33
01443	31st day onward	386.00	151.15

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
INJECTIONS				
00017	Insertion of central venous pressure catheter	116.00		26.63
00018	Autologous ascitic infusion	238.00		52.61
BLOOD TRANSFUSIONS				
00021	Administered in hospital	174.00		40.79
DIALYSIS FEES				
	Acute Renal Failure:			
	Peritoneal Dialysis:			
33756	Re-insertion of peritoneal catheter after 10 days from initial insertion	250.00		53.40

(see note on next page)

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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	709.00		207.87
	NOTE: This service is not payable more frequently than once every 28 days. The following treatments fall into this category: i) Chemotherapy for acute leukemia; ii) Chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment;			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;			
	iv) Chemotherapy using DTIC in a dose exceeding 100 mg/m2;			
	v) Chemotherapy utilizing methotrexate in a dose exceeding 1 g/m2 (and combined with the folic acid rescue regimen); and			
	vi) Chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).			
33582	Major cancer chemotherapy: To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counseling of patient and/or family, venesection and institution of an intravenous line, and administration of multiple parenteral chemotherapeutic agents..... NOTE: This service is not payable more than once every seven (7) days.	444.00		121.91
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..... 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.	226.00		74.17

DIAGNOSTIC PROCEDURES

	Cardio-Vascular Procedures – procedural fee			
S00839	Direct intracoronary streptokinase thrombolysis..... NOTE: When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).	1746.00	4	395.89

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Pulmonary Investigative and Function Studies			
S00930	Peak expiratory flow rate NOTE: Fee item S00930 payable when performed in physician's office (not restricted to an accredited facility).	31.45		6.22
	Diagnostic Procedures:			
S00928	Simple screening spirometry with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus - without bronchodilators	66.70		13.79
S00929	– before and after bronchodilators	100.00		20.78
	Exercise Studies: NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation.			
S00958	Testing for exercise-induced asthma by serial flow measurements - professional fee	116.00		22.86
S00959	– technical fee	174.00		33.69
	Miscellaneous Pulmonary Tests:			
S00970	Precipitin tests - one or more antigens - professional fee	59.30		12.44
S00971	- technical fee	144.00		30.17
	Puncture Procedures for Obtaining Body Fluids (when performed for diagnostic purposes)			
S00753	Marrow aspiration - procedural fee	174.00	2	44.76
S00755	Artery puncture - procedural fee	36.05	2	7.15
S00759	Paracentesis (thoracic) or transtracheal aspiration - procedural fee	220.00	2	103.74

MISCELLANEOUS

00319	Insertion of central catheter for total parenteral nutrition - operation only	270.00	2	63.36
S32031	Closed drainage of chest (operation only)	516.00	4	144.53

CARDIOLOGY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
33010	**Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, and a written report	687.00		186.14
33012	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee	347.00		93.08
33014	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only)	347.00		66.47
	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.			
	Group counseling for groups of two or more patients:			
33013	– first full hour	701.00		95.67
33015	– second hour, per 1/2 hour or major portion thereof.....	356.00		47.80
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
	<u>Continuing Care by Consultant:</u>			
33006	Directive care.....	205.00		82.42
33007	Subsequent office visit.....	200.00		82.51
33008	Subsequent hospital visit	173.00		63.95
33009	Subsequent home visit	195.00		88.71
33005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	395.00		97.15
	NOTE: Claim must state service rendered.			
Telehealth Service with Direct Interactive Video Link with the Patient				
33110	Telehealth consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report. ...	687.00		186.14

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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.	347.00		93.08
33114	Telehealth prolonged visit for counseling (maximum four per year).	347.00		66.47
	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.	205.00		82.42
33107	Telehealth subsequent office visit.	200.00		82.51
33108	Telehealth subsequent hospital visit.	173.00		63.95
	Telehealth Single Chamber permanent programmable pacemaker testing			
33126	– professional fee	248.00		47.29
33153	– technical fee	109.00		23.64
	Telehealth Dual chamber permanent programmable pacemaker testing			
33128	– professional fee	379.00		70.93
33154	– technical fee	218.00		47.29
	NOTES: i) 33126, 33153, 33128, 33154 include telehealth office visit or an office visit and necessary ECG. ii) May be billed by any qualified physician who performs this service from a location in BC. iii) Paid only on outpatients.			

MISCELLANEOUS

33020	Supervision of patient in a Cardiac Rehabilitation Program.....	199.00		63.82
	NOTES: i) Payable only for patients enrolled at a Health Authority approved Cardiac Rehabilitation Program. ii) Payable only to cardiologists with fellowship training in cardiac rehabilitation working at Health Authority approved Cardiac Rehabilitation programs.			

(notes continued on next page)

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

iii) Payable once per week and includes all services and multiple encounters, necessary for management and supervision of patient while patient is actively enrolled in a comprehensive cardiac rehabilitation program.
iv) Visits by primary cardiologist may be billed for reasons unrelated to cardiac rehabilitation.

REMOTE MONITORING CARDIAC DEVICES

	Remote Monitoring of Single chamber implantable cardiac devices			
33174	– professional fee	248.00		47.29
33175	– technical fee	109.00		23.64

NOTES:
i) For the virtual or telephone assessment of single chamber implantable cardiac devices with virtual or telephone connection with patient.
ii) Includes a telehealth, virtual or telephone assessment, necessary ECG and/or heart rhythm assessment including device interrogation.
iii) May be billed by any qualified physician who performs this service from a location in BC.
iv) Paid only on outpatients.

	Remote Monitoring of Dual chamber implantable cardiac devices			
33176	– professional fee	379.00		70.93
33177	– technical fee	218.00		47.29

NOTES:
i) For the virtual or telephone assessment of dual chamber implantable cardiac devices with virtual or telephone connection with patient.
ii) Includes a telehealth, virtual or telephone assessment, necessary ECG and/or heart rhythm assessment including device interrogation.
iii) May be billed by any qualified physician who performs this service from a location in BC.
iv) Paid only on outpatients.

EXAMINATIONS BY CERTIFIED CARDIOLOGIST

33016	Electrocardiogram and interpretation - office, each	118.00		25.08
33017	– home, each	187.00		34.88
33018	Electrocardiogram - professional fee	48.40		9.01

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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)	49.10		17.38
Y33025	Cardioversion - operation only.....	440.00	2	105.70
	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	251.00		52.32
33053	– technical fee.....	111.00		23.64
33028	Dual chamber permanent programmable pacemaker testing - professional fee	386.00		70.93
33054	– technical fee.....	226.00		47.29
	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	875.00	4	180.05
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)	1571.00	4	467.13
	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	444.00	4	82.49
33033	Generator placement and venous cut-down.....	1437.00	4	269.28
33034	Graded exercise test (performance and interpretation).	407.00		79.42
33035	– professional fee.....	243.00		47.11
33036	– technical fee.....	166.00		32.29

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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%.			
33037	Replacement transfusion - hepatic failure to include two weeks care after transfusion ..... NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra.	1552.00		294.36
	Scanning of 24-hour Electrocardiogram:			
33047	– professional fee	364.00		67.63
33048	– technical fee	135.00		25.37
33049	Technical fee for scanning: **Level I:** 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.....	293.00		55.39

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Patient Activated Cardiac Event Recorders:			
33062	Event/unmonitored loop recorder (first strip) - professional fee	162.00		37.03
33069	– each additional strip (per strip)	84.50		18.51
	NOTE: Additional strips are limited to two extra strips per patient, per two-week period.			
33092	Event/unmonitored loop recorder - technical fee	194.00		44.49
	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	4151.00	4	793.76
33068	Oesophageal or intra-atrial electrophysiological study	647.00	4	118.65
	Electrophysiological Mapping and Ablation:			
33084	Catheter ablation for atrial fibrillation	7214.00	6	1757.48
	NOTE: Includes percutaneous right heart catheterization, transseptal left heart catheterization, all diagnostic imaging, ECG's (electrophysiological mapping/ablation fee items 33066, 33085, 33086 and 33087).			
33085	Catheter ablation-AV node	4467.00	4	970.04
	NOTE: To include diagnostic study (33066).			
33086	Catheter ablation of SVT	6833.00	4	1483.58
	NOTE: To include diagnostic study (33066).			
33087	Catheter ablation of VT	7359.00	4	1757.48
	NOTE: To include diagnostic study (33066).			
33088	Repeat diagnostic EP study	1578.00	4	342.35
	NOTE: Not normally to be billed for recheck on the same day.			
33089	Catheter ablation - assistant's fee (per hour)	653.00		142.65
	NOTES:			

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

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.

PULMONARY INVESTIGATIVE AND FUNCTION STUDIES

Diagnostic Procedures:

	Overnight home oximetry (continuous recording of oxygen and pulse):			
S00910	– professional fee	139.00		29.48
S00911	– technical fee	72.90		16.64
S00944	Tilt table testing with continuous ECG monitoring and automatic BP recording - total fee	1528.00		296.72
S00947	– professional fee	830.00		182.61
S00948	– technical fee	629.00		114.11

NOTES:
i) Applicable only for investigation for diagnosis of neurally mediated syncope.
ii) Physician must be present throughout duration of procedure.

(notes continued on next page)

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.

Diagnostic Ultrasound:

S33057	Trans-esophageal echocardiography - procedural fee	525.00	3	169.20

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.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	869.00		
32091	Intra-operative transesophageal echocardiographic imaging – subsequent 30 minutes or portion thereof.....	347.00		

DIAGNOSTIC PROCEDURES

S33131	Diagnostic cardiac catheterization.....	1098.00	4	494.19
	NOTES:			
	i) Restricted to Cardiologists and Pediatric Cardiologists.			
	ii) Not payable with 33132, 33133, 33134 and/or 00842.			
	iii) Include arterial access, arterial pressure measurements and interpretations, direct coronary artery cannulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, and interpretation of aortic valve pullback gradient hemodynamics.			
S33132	Diagnostic cardiac catheterization with advanced arterial assessment	1589.00	4	494.19
	NOTES:			
	i) Restricted to Cardiologists and Pediatric Cardiologists.			
	ii) Not payable with 33131, 33133, 33134 and/or 00842.			
	iii) Applies to per patient, not per vessel or lesion when advanced arterial assessment is performed.			
	iv) Include arterial access, arterial pressure measurements and interpretations, direct coronary artery cannulation and injection with contrast, left heart catheterization with direct LV pressure measurement and assessment, interpretation of aortic valve pullback gradient hemodynamics, and advanced assessment of the coronary artery with Fractional Flow Reserve (FFR), intravascular			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	ultrasound (IVUS), and/or optical coherence tomography (OCT).			
	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.			
33091	Echocardiography - combined with two-dimensional real time and M-mode	691.00		148.61
	NOTE: The professional/technical split is as follows: Professional fee - $69.85, Technical fee - $78.76			
33093	Level III Echocardiographer Complex Assessment of Previous Echocardiogram (clinical assessment and review, interpretation and written report of submitted echocardiograms) - per patient	801.00		258.10
	NOTES: i) Payable following a written request from a cardiologist or cardiac surgeon for a clinical assessment, review and interpretation of submitted echocardiograms done on an out-patient basis only, performed in another institution by a different Echocardiographer.			
	(notes continued on next page) ii) A written report and management recommendation must be provided to the referring physician. iii) Not payable when echocardiograms above are used for comparison purposes with echocardiograms made in the Level III Echocardiographer's facility. iv) Not payable with a consult, visit or 33091 done on the same day. v) Payable once per year per patient, unless substantiated in note record. vi) Payable only on echocardiograms done in publicly-funded hospitals in BC. vii) Not payable in addition to a consultation rendered within 2 months on the same patient on referral by the same physician for the same diagnosis.			
33094	Contrast echocardiography (extra) – technical fee, per vial of contrast	404.00		130.33

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	59.30		11.36
	Puncture Procedures for Obtaining Body Fluids (When performed for diagnostic purposes)			
S00751	Pericardial puncture - procedural fee	1118.00	3	258.25
	Cardio-Vascular Procedures			
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee	116.00		22.60
S00810	Right heart catheterization - by duly qualified specialist	873.00	4	169.19
S00812	Selective angiocardiogram (extra) - by duly qualified specialist	293.00	4	56.77
S00813	Ergonovine provocative testing for coronary artery spasm	423.00	4	80.93
S00814	Dye dilution studies (extra) - by duly qualified specialist	293.00	4	56.77
S00816	Hydrogen ion study	144.00	2	29.61
	Pulse tracing, including interpretation:			
S00871	– intravascular, including both arterial and venous	293.00		56.77
	Cardiology Assistant Fees			
00845	First hour or fraction thereof	760.00		175.08
00846	After one hour, for each 15 minutes or fraction thereof NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	190.00		43.78

INTERVENTIONAL CARDIOLOGY PROCEDURES

33071	Percutaneous endovascular aortic or pulmonary heart valve replacement	5086.00	9	1173.05
	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			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	pacemaker, and percutaneous balloon valvuloplasty are included. ii) 30 days pre and 48 hour post-operative visits in hospital are included.			
33072	Percutaneous left atrial appendage closure..... NOTES: i) Includes all necessary catheterizations, angiography (00801, 00810, 00812, 00871, 00888, 00889, 33030), angiocardiography, intra-arterial cannulation, right heart catheterization, retrograde left heart catheterization, pulse tracing (intravascular), temporary pacemaker, any medically necessary diagnostic imaging (e.g.: Intra-cardiac ultrasound), CVP, arterial lines, blood pressure measurements, and any pharmacological infusion and studies, blood sampling, blood analysis and interpretations done in association with procedure. ii) 30 days pre and 48 hour post-operative visits in hospital included. iii) Fee item 33057 is payable when performed by another practitioner. iv) Cardiologist (specialty 26) paid under 00845/6 when assisting 33072.	3314.00	7	920.36
S33073	Percutaneous transcatheter cardiac occluder device closure of ASD for patients over 18 years of age - (composite fee)..... NOTES: i) Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary angiograms, angiocardiograms, atrial septostomy. HIS bundle recordings, CVP, venous cannulation, infusion of pharmacologic agents, pressure measurement, pressure gradient calculations. ii) 30 days pre and 48 hour post-operative visits in hospital included.	3166.00	7	729.89
S33074	Percutaneous transcatheter cardiac occluder device closure of PFO - for patients over 18 years of age - composite fee ..... NOTES: i) Includes all necessary diagnostic imaging, right and left heart catheterization, all necessary	2488.00	7	573.49

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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).....	4070.00	9	938.43
	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).....	2714.00	9	625.62
	(see notes on next page) 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			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	fraction thereof) and 00846 (after one hour, each 15 minutes or fraction thereof) at 50%.			
33077	Transcatheter edge to edge repair (TEER) – atrioventricular valve.....	3429.00	9	1789.60
	NOTES: i) Restricted to Interventional Cardiologists and Cardiac Surgeons. ii) All diagnostic imaging except echocardiography and CT scan, all necessary left and right heart catheterizations, arterial or venous cannulation, blood sampling, CVP, pressure or gradient measurement, infusion of pharmacological agents, temporary pacing and pacemaker, and percutaneous balloon valvuloplasty are included. iii) 30 days pre and 48 hours post-operative in hospital visits included. iv) Cardiac Surgeon (specialty 12) paid under 07917/07920 when assisting. v) Cardiologist (specialty 26) paid under 00845/00846 when assisting.			
	Percutaneous coronary interventions:			
S33133	Percutaneous coronary intervention with diagnostic cardiac catheterization.....	1851.00	4	583.44
	(see notes on next page) NOTES: i) Restricted to Cardiologists and Pediatric Cardiologists. ii) Includes balloon inflation (angioplasty), stent insertion, and/or diagnostic cardiac catheterization. iii) Not payable with 33131, 33132 and/or 33134. iv) Name of vessel must be provided in the note record. v) When temporary pacemaker insertion is performed in addition, 33030 to be paid at 50%.			
S33134	Percutaneous coronary intervention alone	1234.00	4	384.02
	NOTES: i) Restricted to Cardiologists and Pediatric Cardiologists. ii) Includes balloon inflation (angioplasty), stent insertion.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Payable when 33131 or 33132 had been performed by a different practitioner as part of the same procedure. iv) Not payable with 33131, 33132, 33133 when is performed by the same practitioner. v) Name of vessel must be provided in the note record. vi) When temporary pacemaker insertion is performed in addition, 33030 to be paid at 50%.			
S00842	Percutaneous coronary intervention – for additional vessel(s), per vessel.....	987.00		193.28
	NOTES: i) Only payable in addition to 33133 or 33134. ii) When temporary pacemaker insertion is performed in addition, it will be payable at 50% of listed fee(s). iii) Maximum of 5 named vessels per patient. iv) Name of vessel(s) must be provided in the note record.			
	Percutaneous coronary intervention anatomical named vessels (Including Coronary artery bypass graft to vessels below): Right Coronary: • Right coronary artery • Right posterior descending artery • Right posterior atrioventricular artery • First right posterolateral artery • Second right posterolateral artery • Acute marginal artery • Inferior septal artery Left Coronary: • Left main coronary artery • Left anterior descending artery • First diagonal artery • Second diagonal artery • Ramus artery • Circumflex artery • First obtuse marginal artery • Second obtuse marginal artery • Third obtuse marginal artery • Left atrioventricular artery • First left posterolateral artery			

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

- 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.....	325.00	61.25	42.91	104.16
08662	Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis.....	789.00	136.90	102.86	239.76

(see notes on next page)

		Non-MSP-Insured Total Fee ($)	A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)

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.....	148.00	29.10	18.68	47.78

ALLERGY AND IMMUNOLOGY

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

		Non-MSP - Insured Fee ($)	MSP & WSBC Fee ($)
REFERRED CASES			
	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	**Allergy and Immunology 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	207.10
30011	**Pediatric Allergy and Immunology 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..... NOTE: This code is intended for internal medicine-trained allergists and immunologists when consulting on pediatric patients.	829.00	215.23
30012	**Repeat or Limited Allergy and Immunology Consultation:** 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.....	347.00	97.15
	<u>Continuing Care by Consultant:</u>		
30006	Directive care	127.00	96.13
30007	Subsequent office visit	135.00	40.94
30008	Subsequent hospital visit.....	97.60	94.08
30005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums).....	395.00	89.55

	Non-MSP - Insured Fee ($)	MSP & WSBC Fee ($)
NOTE: Claim must state time service rendered.		
Telehealth Service with Direct Interactive Video Link with the Patient		
30070 Telehealth Clinical Immunology and Allergy Consultation: To include a detailed history and physical examination with review of laboratory investigations, plus appropriate allergy and immunology management and additional visits necessary to render a written report	687.00	207.10
30071 Telehealth Pediatric Clinical Immunology and Allergy Consultation: To include a detailed history and physical examination with review of laboratory investigations, plus appropriate allergy and immunology management and additional visits necessary to render a written report.	829.00	215.23
30072 Telehealth repeat or limited Clinical Immunology and Allergy Consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgement of the consultant, the consultative service does not warrant a full consultative fee	347.00	97.15
30076 Telehealth directive care	127.00	96.13
30077 Telehealth subsequent office visit	135.00	40.94
30078 Telehealth subsequent hospital visit	97.60	94.08

ALLERGY SKIN TESTING

S00762 Scratch test, per antigen ..... Note: Minor tray fee may be paid in addition if a minimum of 16 antigens are used.	8.40	1.08
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.	9.00	2.37
S00764 Intracutaneous test (per test)	12.05	2.20
S00765 Annual maximum (to include scratch or intracutaneous tests) for each physician - per patient	191.00	35.18
S00767 Patch testing (extra) - annual maximum is 80 tests (per test).....	7.75	2.00

PULMONARY INVESTIGATIVE AND FUNCTION STUDIES

Exercise Studies:

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

		Non-MSP - Insured Fee ($)	MSP & WSBC Fee ($)
S00958	Testing for exercise-induced asthma by serial flow measurements - professional fee	116.00	22.86
S00959	– technical fee	174.00	33.69

TESTS PERFORMED IN A PHYSICIAN'S OFFICE

30015	Secretion smear for eosinophils	34.55	7.45

MISCELLANEOUS

30020	Allergy Provocation Testing (delegated)	216.00	50.00

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

30021	Allergy Provocation Testing (non-delegated)	433.00	100.00

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

ENDOCRINOLOGY AND METABOLISM

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
33210	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	770.00		236.25
33212	**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 judgment of the consultant, the consultative service does not warrant a full consultative fee.....	388.00		113.41
33214	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only)	388.00		77.25
	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.....	786.00		158.16
33215	– second hour, per 1/2 hour or major portion thereof.....	399.00		79.01
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
	<u>Continuing Care by Consultant:</u>			
33206	Directive care	202.00		65.85
33207	Subsequent office visit	211.00		78.15
33208	Subsequent hospital visit	125.00		40.55
33209	Subsequent home visit.....	222.00		72.35
33205	Emergency visit when specially called (not paid in addition to out-of-office hour premiums).....	493.00		160.31
	NOTE: Claim must state time service rendered.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
P33280	Transfer of care from Pediatrics – Extended Consultation: To consist of an examination, review of history, previous laboratory & X-ray findings, and written report on a patient with a complex and chronic endocrine condition requiring active endocrinologist support transferring from pediatric to adult care In addition, specific and special documentation as outlined below must be included in the patient's chart and copies sent with the patient and/or family as appropriate	1060.00		365.50

NOTES:

i) Restricted to Endocrinology and Metabolism specialists.

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

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

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

v) Limited to one service per patient per lifetime.

Telehealth Service with Direct Interactive Video Link with the Patient

33270	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.....	770.00		236.25
33272	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee.	388.00		113.41
33276	Telehealth directive care.....	202.00		65.85
33277	Telehealth subsequent office visit.....	211.00		78.15
33278	Telehealth subsequent hospital visit	125.00		40.55

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
G33260	Initial virtual assessment, with patient or representative/ family	409.00		132.76
	NOTES: i) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received. ii) Restricted to Endocrinology and Metabolism specialists. iii) Not paid within 6 months of a 33210, 33270, or 33280, for the same diagnosis. iv) Not payable in addition to another service on the same day for the same patient by the same practitioner with the exception of 33255, 33256 or 33257.			
G33262	Repeat virtual assessment for same illness within six months of the last visit by the consultant, or where in the judgment of the consultant the services do not warrant an initial assessment fee.	205.00		66.39
	NOTES: i) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report and care plan to the referring physician within 14 days of referral being received. ii) Restricted to Endocrinology and Metabolism specialists. iii) Not payable in addition to another service on the same day for the same patient by the same practitioner, with the exception of 33255, 33256 or 33257.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33267	Subsequent virtual office visit, requiring a written individualized report to the Family Physician	132.00		43.24
	NOTES: i) Restricted to Endocrinology and Metabolism specialists. ii) Maximum 12 per calendar year, per patient. iii) Not payable in addition to another service on the same day for the same patient by the same practitioner, with the exception of 33255, 33256 or 33257.			
PG33250	Virtual communication with patient, or representative/family, for medically pertinent matters.....	34.55		11.24
	NOTES: i) Restricted to Endocrinology and Metabolism specialists. ii) Payable for communication with patient or representative/family through telephone or email. iii) Maximum 12 per calendar year, per patient. iv) Not payable in addition to another service on the same day for the same patient by the same practitioner.			

MISCELLANEOUS

GY33255	Diabetes injection medication start (insulin or glucagon-like-peptide receptor agonist).....	139.00		45.00
	NOTES: i) Payable in addition to endocrinology consultations or visits (33210, 33212, 33280, 33206, 33207, 33208, 33209, 33260, 33262, 33267, 33270, 33272, 33276, 33277, or 33278). ii) Restricted to Endocrinology and Metabolism specialists. iii) Maximum of one per day, per patient. Repeats on a different date of service are payable if the patient starts on a new medication/injection device. iv) Not paid same day as 33256 or 33257. v) Payable for insulin or glucagon-like-peptide receptor agonist.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
GY33256	Insulin pump start..... NOTES: i) Payable in addition to endocrinology consultations or visits (33210, 33212, 33280, 33206, 33207, 33208, 33209, 33260, 33262, 33267, 33270, 33272, 33276, 33277, or 33278). ii) Restricted to Endocrinology and Metabolism specialists. iii) Maximum one per patient, per day. Repeats on a different date of service are payable if the patient starts on a new medication/ injection device. iv) Not payable on the same day as 33255 or 33257.	276.00		89.97
P33257	Interpretation of insulin pump reports with Continuous Glucose Monitoring (CGM) ..... NOTES: i) This fee is restricted to the Section of Endocrinology and Metabolism. ii) Applicable for patients utilizing insulin pumps with CGM for management of type 1 or type 2 diabetes. iii) Not payable in addition to 33255 or 33256. iv) Payable for physician interpretation in addition to endocrinology consultations or visits fees (33210, 33212, 33280, 33206, 33207, 33208, 33209, 33260, 33262, 33267, 332790, 33272, 33276, 33277 and 33278). v) Payable twice per patient in a consecutive 12 month period.	87.00		30.00
G33240	Premium for patients 75 years and over, billed in addition to 33210, G33212, G33270, G33272, G33260, or G33262 ..... NOTES: i) Restricted to Endocrinology and Metabolism specialists. ii) Maximum one premium, per patient, per day.	183.00		59.25

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
G33241	Premium for patients 75 years and over, billed in addition to 33207, 33209, 33277, 33267, G33250, GY33255, or GY33256	48.85		15.91
	NOTES: i) Restricted to Endocrinology and Metabolism specialists. ii) Maximum one premium, per patient, per day.			

DIAGNOSTIC - MISCELLANEOUS

S00744	Thyroid biopsy - procedural fee	269.00	2	79.32

GASTROENTEROLOGY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
33310	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	801.00		182.82
33312	**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	456.00		101.07
33314	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only)	347.00		56.07
	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.			
33313	Group counseling for groups of two or more patients - first full hour	701.00		107.43
33315	– second hour, per 1/2 hour or major portion thereof	356.00		53.97
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
	<u>Continuing Care by Consultant:</u>			
33306	Directive care	269.00		81.57
33307	Subsequent office visit	303.00		95.32
33308	Subsequent hospital visit	186.00		51.81
33309	Subsequent home visit	222.00		50.34
33305	Emergency visit when specially called (not paid in addition to out-of-office hour premiums)	504.00		114.18
	NOTE: Claim must state time service rendered.			
Telehealth Service with Direct Interactive Video Link with the Patient				
33360	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.	801.00		182.82

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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.	456.00		101.07
33366	Telehealth directive care	269.00		81.57
33367	Telehealth subsequent office visit	303.00		95.32
33368	Telehealth subsequent hospital visit.....	186.00		51.81

DIAGNOSTIC PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION

Upper Gastrointestinal System

S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	476.00	3	119.27
	NOTE: Not payable with 33341.			
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	397.00	3	120.07
	NOTE: Not payable with 33341.			
S10763	Initial esophageal, gastric or duodenal biopsy.....	61.30	3	15.15
	NOTES: i) Paid only in addition to 10761, 10762 and 10750 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	237.00	3	44.56
	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	476.00		119.27
	NOTE: Restricted to Gastroenterology, General Internal Medicine and General Surgery specialists trained in this procedure.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Transient Elastography (TE)			
T33395	– Professional fee	95.00		25.00
T33396	– Technical fee	95.00		25.00
	NOTES: i) Payable only to physicians with completion of additional recognized training in Transient Elastography interpretation and performance. ii) Requires an elevated pre-test probability of hepatic fibrosis, based on identifiable risk factors or clinical indicators. iii) Interpretation of clinical findings and their application to the patient's care plan must be clearly documented in the patient's chart. iv) Payable once per patient in a consecutive 12-month period. Additional claims within this period will be given independent consideration when submitted with an explanatory note record.			
	Lower Gastrointestinal System			
SY00715	Sigmoidoscopy with biopsy - procedural fee.....	174.00	2	38.83
SY00718	Sigmoidoscopy, flexible – with biopsy.....	404.00	2	79.09
10708	Video capsule endoscopy using M2A capsule – professional fee	1159.00		262.44
	NOTE: Payable for gastrointestinal bleeding suspected to originate in the small intestine, and only after other investigations have ruled out other causes.			

UPPER GASTROINTESTINAL SYSTEM - ENDOSCOPY (SURGICAL)

S33321	Removal of foreign material causing obstruction, operation only	547.00	4	151.03
	NOTES: i) Paid only in addition to S10761 or S10762. 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	628.00	3	151.18

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Paid only once per endoscopy. ii) Paid only in addition to: a) 10761 or 10762; or b) 33341, at 50%.			
S33323	Transendoscopic tube, stent or catheter – operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	547.00	3	151.03
S33324	Thermal coagulation – heater probe and laser, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	326.00	3	150.81
S33325	Gastric Polypectomy, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	245.00	5	61.36
S33326	Percutaneous endoscopically placed feeding tube – operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	489.00	3	176.22
S33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	204.00	3	100.51
S33328	Esophageal dilation, blind bouginage, operation only NOTE: Repeats within one month paid at 100%.	310.00	3	100.58
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only NOTE: Repeats within one month paid at 100%.	586.00	3	151.10

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V33330	Per Oral Endoscopic Myotomy (POEM) under general anesthesia NOTES: i) Payable with 07001. ii) Not payable with 07003 or 10761.	1666.00	6	900.00
S33335	SBE or DBE (balloon assisted) enteroscopy NOTES: i) Not paid with 10761, 33373 or 33374. ii) Examination of the terminal ileum using a SBE/DBE is not billable under this fee item. iii) Billable only by specialist who are credentialed to bill fee item 10708.	1459.00	3	309.09
	The following fees are only paid in addition to S33335:			
S33336	– with biopsy (single or multiple) – extra	140.00		29.36
S33337	– removal of polyp – extra	244.00		51.52
S33338	– each additional polyp (maximum of 10) – extra	58.40		12.36
S33339	– with fulguration or coagulation, by any means of one or more lesions – extra	195.00		41.21

ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)

PV33341	Endoscopic Retrograde Cholanglopancreatography (ERCP), inclusive of sphincterotomy and biopsies or brushings NOTES: i) Includes 10761 and 10762. ii) 33322 payable at 50%.	1552.00	3	400.00
P33342	– with stone extraction (extra) NOTE: 00994 is not payable.	427.00	3	110.00
P33343	with balloon dilatation of ampullary/biliary/pancreatic stricture, biliary/pancreatic stenting or nasobiliary drainage tube (extra)	427.00	3	110.00
P33345	with intraductal lithotripsy (extra) NOTE: 00994 is not payable.	427.00	3	110.00
T33348	– with cholangioscopy or pancreatoscopy, inclusive of guided biopsies (extra)	794.00	3	200.00
P33347	Replacement of duodenal biliary stent (extra)	427.00	3	110.00

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

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.	694.00		157.47
10740	Upper GI endoscopy utilizing radial ultrasound	1159.00		262.44
10741	Upper GI endoscopy utilizing linear ultrasound NOTES: i) 10740 and 10741 are payable only when done in publicly funded acute care facilities. ii) 10741 payable at 50% when done subsequent to 10740 (same patient/same day).	1159.00		262.44
10742	Upper GI endoscopy utilizing radial/linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 – per lesion NOTES: i) Payable with P10740 or P10741 only. ii) First biopsy paid at 100%. Second and third biopsies payable at 50%.	232.00		52.49
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.	694.00		157.47
10744	Upper GI endoscopy utilizing radial/linear ultrasound – with drainage of pseudocyst (including stent insertion if performed) – extra Note: Payable with P10740 or P10741 only.	927.00		209.97

DIAGNOSTIC - MISCELLANEOUS

S00809	Retrograde pancreatography	1130.00	3	221.44

MISCELLANEOUS

S33373	Colonoscopy with flexible colonoscope - biopsy	1128.00		240.47

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33374	– removal of polyp	1681.00		287.87
07375	Complex polypectomy (extra)	800.00		178.96
	NOTES: i) Restricted to General Surgeons and Gastroenterologists. ii) Only for resection of a polyp with one or more of the followings: - large (≥ 20mm) non-pedunculated colorectal polyp/lesion - involving the appendiceal orifice, ileocecal valve, or dentate line - recurrent or previously attempted resection - complex polyp/lesion as determined by multidisciplinary committee iii) Requires 60 minutes or more of slated endoscopy time. iv) Not to be performed at index/diagnostic colonoscopy unless specifically referred for complex polypectomy. v) Complete removal after submucosal injection and piecemeal resection or endoscopic mucosal resection. vi) May not be claimed for pedunculated polyps. vii) Payable only in addition to 10730, 10731, 10761, 00716, 00718, or 33373. viii) Not payable in conjunction with 33374, 07464, 07465, 10714, 00715. ix) Second complex polypectomy on the same day for the same patient will be paid at 50%.			
33394	Assistant fee for PEG procedure	522.00		176.14
	NOTE: 33326, 33394 may be billed by any qualified physician.			

GERIATRIC MEDICINE

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
33410	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	687.00		214.73
33412	**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	347.00		124.21
33401	Comprehensive geriatric consultation - limited to patients aged 65 years and over: To consist of examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report which reflects the necessary components and complexity of care.....	1083.00		323.19

NOTES:

i) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to the following:

- Assessment and management of medical condition(s)/syndrome(s) in patients 65 yrs. and over.
- Assessment of failure to thrive and frailty.
- Mobility decline and falls.
- Polypharmacy, review of medication tolerability/response and compliance issues.
- Incontinence.
- Co-management with geriatric psychiatry, particularly where there is significant medical instability.
- Elder abuse/neglect, caregiver stress.
- Assessment/monitoring of functional status including issues of competency and “living at risk”.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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 ..... 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.	265.00		130.27
33403	Comprehensive cognitive consultation – for dementia or cognitive problems: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care ..... 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.	790.00		323.19

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	• Management of common psychiatric syndrome in the elderly, including depression, anxiety, insomnia, psychosis, bipolar disorder. • Substance abuse disorders. • Assessment/monitoring of functional status including issues of competency and “living at risk”. • Issues identified in 33401 may enter into the picture. ii) Minimum time requirement for 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.			
33404	Geriatric reassessment subsequent to comprehensive consultation - for dementia or cognitive problems	274.00		130.27
	NOTES: i) See 33403 note i) for billing criteria. ii) Minimum time requirement for service is 20 minutes. iii) Start and end times must be entered in both the billing claims and the patient’s chart. iv) payable once per hospital admission unless note record provided to indicate medical necessity for additional reassessments. v) payable up to twice per month per patient only when service rendered in out-patient setting unless note record provided to indicate medical necessity for additional reassessments.			
33440	Complex consultation – for 2 or more conditions: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care.....	541.00		295.89
	NOTES: i) Payable only for Geriatric Medicine Specialists.			

(notes continued on next page)

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

ii) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to, the following:

- Septicemia
- Other HIV infection
- DM including complications
- Disorders of Lipid Metabolism
- Thyroid disorders
- Purpura, thrombocytopenia and hemorrhagic conditions
- Anemia, unspecified
- Senile dementia, presenile dementia
- Acute confusional state
- Congestive Heart Failure
- Diseases of the aortic and mitral valve
- Essential hypertension
- Coronary atherosclerosis
- Neoplasm of uncertain behaviour of other and unspecified sites. “Not for minor or superficial skin malignancies”
- Cardiac dysarrhythmias
- Cerebral atherosclerosis
- Asthma allergic bronchitis
- Emphysema
- Other bacterial pneumonia
- Non infective enteritis and colitis
- GI hemorrhage
- Chronic liver diseases and cirrhosis of the liver
- CRF
- ARF
- Disorders of fluid, electrolyte and acid base balance
- Syncope
- Venous thrombosis and embolism
- Pulmonary fibrosis
- Rheumatoid Arthritis
- Systemic Lupus Erythematosus

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33442	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.....	326.00		158.32
	NOTES: i) Payable only for Geriatric Medicine specialists. ii) See 33440 note ii) for billing criteria.			
33414	Prolonged visit for counseling (maximum four (4) per year).....	347.00		54.42
	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.			
	Group counseling for groups of two or more patients			
33413	– first full hour	701.00		101.71
33415	– second hour, per 1/2 hour or major portion thereof	356.00		50.80
	Continuing Care by Consultant:			
33406	Directive care	127.00		61.61
33446	Comprehensive or complex directive care	196.00		76.85
	NOTES: i) Payable only for Geriatric Medicine specialists. ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months. iii) See 33401 note i) or 33403 note i) for billing criteria.			
33407	Subsequent office visit	144.00		76.76
33447	Comprehensive or complex subsequent office visit ...	190.00		92.20
	NOTES: i) Payable only for Geriatric Medicine specialists.			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or complex repeat or limited (33442, 33424) consultations or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months. iii) See 33401 note i) or 33403 note i) for billing criteria.			
33408	Subsequent hospital visit	103.00		47.49
33448	Comprehensive or complex subsequent hospital visit ..... 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 or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months. iii) See 34401 note i) or 33403 note i) for billing criteria.	116.00		47.49
33409	Subsequent home visit.....	367.00		207.02
33405	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) ..... NOTE: Claim must state time service rendered.	395.00		158.57
Telehealth Service with Direct Interactive Video Link with the Patient				
33470	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.	687.00		214.73
33472	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee.	347.00		124.21

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33421	Telehealth Comprehensive geriatric consultation - limited to patients aged **65** years and over: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care.	1083.00		323.19

NOTES:

i) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to the following:
   - Assessment and management of medical condition(s)/syndrome(s) in patients 65 yrs. and over.
   - Assessment of failure to thrive and frailty.
   - Mobility decline and falls.
   - Polypharmacy, review of medication tolerability/response and compliance issues.
   - Incontinence.
   - Co-management with geriatric psychiatry, particularly where there is significant medical instability.
   - Elder abuse/neglect, caregiver stress.
   - Assessment/monitoring of functional status including issues of competency and “living at risk”.

ii) Minimum time requirement for service is 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.

33422	Telehealth Geriatric reassessment - subsequent to comprehensive consultation - limited to patients aged 65 years and over.	265.00		130.27

NOTES:

i) See 33421 note i) for billing criteria.

ii) Minimum time requirement for service is 20 minutes.

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

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iv) Payable once per hospital admission unless note record provided to indicate medical necessity for additional reassessments. v) Payable up to twice per month per patient only when service rendered in out-patient setting unless note record provided to indicate medical necessity for additional reassessments.			
33473	Telehealth Comprehensive cognitive consultation – for dementia or cognitive problems: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care	790.00		323.19
	NOTES: i) Applicable only when written report includes at least two aspects of complexity. The focus here is the cognitive impairment and how it is affecting the patient's ability to function. Common clinical syndromes include, but are not limited to the following: • Assessment of dementia, using some form of formal cognitive measurement, as well as integrating reports from family/homemakers/Home Health. • Behavioural/affective issues in dementia management. • Management of common psychiatric syndrome in the elderly, including depression, anxiety, insomnia, psychosis, bipolar disorder. • Substance abuse disorders. • Assessment/monitoring of functional status including issues of competency and "living at risk". • Issues identified in 33401 may enter into the picture. ii) Minimum time requirement for service is 65 minutes clinical assessment time. iii) Start and end times must be entered in both the billing claims and the patient's chart.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33474	Telehealth Geriatric reassessment subsequent to comprehensive consultation - for dementia or cognitive problems	274.00		130.27

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.

33423	Telehealth Complex consultation – for 2 or more conditions: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care	541.00		295.89

NOTES:

i) Payable only for Geriatric Medicine Specialists.
ii) Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to, the following:
    - Septicemia
    - Other HIV infection
    - DM including complications
    - Disorders of Lipid Metabolism
    - Thyroid disorders
    - Purpura, thrombocytopenia and hemorrhagic conditions
    - Anemia, unspecified
    - Senile dementia, presenile dementia
    - Acute confusional state

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	• Congestive Heart Failure • Diseases of the aortic and mitral valve • Essential hypertension • Coronary atherosclerosis • Neoplasm of uncertain behaviour of other and unspecified sites. “Not for minor or superficial skin malignancies.” • Cardiac dysarrhythmias • Cerebral atherosclerosis • Asthma allergic bronchitis • Emphysema • Other bacterial pneumonia • Non infective enteritis and colitis • GI hemorrhage • Chronic liver diseases and cirrhosis of the liver • CRF • ARF • Disorders of fluid, electrolyte and acid base balance • Syncope • Venous thrombosis and embolism • Pulmonary fibrosis • Rheumatoid Arthritis • Systemic Lupus Erythematosus			
33424	Telehealth 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 ..... NOTES: i) Payable only for Geriatric Medicine Specialists. ii) See 33423 note ii) for billing criteria.	326.00		158.32
33476	Telehealth directive care.....	127.00		61.61
33426	Telehealth Comprehensive or complex directive care.....	196.00		76.85

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Payable only for Geriatric Medicine specialists. ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations, or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months. iii) See 33401 note i) or 33403 note i) for billing criteria.			
33477	Telehealth subsequent office visit	144.00		76.76
33427	Telehealth Comprehensive or complex subsequent office visit ..... NOTES: i) Payable only for Geriatric Medicine specialists. ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations, or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months. iii) See 33401 note i) or 33403 note i) for billing criteria.	190.00		92.20
33478	Telehealth subsequent hospital visit	103.00		47.49
33428	Telehealth Comprehensive or complex subsequent hospital visit ..... NOTES: i) Payable only for Geriatric Medicine specialists. ii) Payable only following comprehensive (33401, 33421), comprehensive cognitive (33403, 33473), complex (33440, 33423) or repeat or limited complex (33442, 33424) consultations, or complex/comprehensive cognitive reassessment (33402, 33422, 33404, 33474) within the prior 6 months. iii) See 33401 note i) or 33403 note i) for billing criteria.	116.00		47.48

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

MISCELLANEOUS

G33445	Geriatric Care Conference (planning for patient), - per 15 minutes, or greater portion thereof.....	145.00		53.65

NOTES:

i) Restricted to Geriatric Medicine.
ii) Requires interdisciplinary team meeting of at least one allied health professional, and may or may not include family members and/or representatives.
iii) Billable after any comprehensive 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 roles/relationships of those who participated in the meeting must be documented in patient's chart, and result communicated to the Family Physician, Specialist and/or appropriate Health care practitioner involved in the care of the patient.
vii) Claim must state start and end times of this service.
viii) Not payable to physicians for services provided within time periods when working under salary, service contract, or sessional arrangements.
ix) Visit paid in addition, if medically required and does not take place concurrently with the conference. Medically required visits performed consecutive to this fee will be paid.

PG33450	Family Conference (planning for patient) - per 15 minutes or greater portion thereof.....	132.00		47.01

NOTES:

i) Restricted to Geriatric Medicine.
ii) One or more family members/representatives must be present.

(notes continued on next page)

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

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 six per patient, per sitting.
v) Annual maximum of eighteen per patient.
vi) The results of the conference, as well as the names and roles/relationships of those who participated in the meeting must be documented in the patient's chart, and result communicated to Family Physician.
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.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
33510	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	687.00		199.86
33512	**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	347.00		90.67
33520	**Complex Consultation:** To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report for complex patient.....	1189.00		307.09

NOTES:

i) Restricted to Hematology and Oncology.

ii) Paid to a maximum of one per patient within six months of the last visit.

iii) Payable only for patients who are being directly managed for one of the following hematologic diseases:

- Multiple myeloma, **excludes** monoclonal paraproteinemia/monoclonal gammopathy of undetermined significance
- Acute leukemia **excludes** chronic lymphocytic leukemia
- Hereditary hemolytic anemia
- Acquired hemolytic anemia
- Aplastic anemia and red cell aplasia

Or one of the following diseases <u>with qualifying features:</u>

- Myelodysplastic syndrome or Myelofibrosis requiring chemotherapy, transfusion or growth factor therapy

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	• Coagulation defects requiring factor concentrate, transfusion or other hemostatic therapy • Thrombocytopenia requiring immunosuppressive, transfusion or growth factor therapy • Venous thromboembolism (VTE) / Phlebitis and thrombophlebitis that is: ○ unprovoked, ○ in a patient with cancer, ○ in a pregnant patient ○ in a patient with a contraindication to anticoagulation			
33522	**Repeat or Limited Consultation, Complex Patient:** Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee NOTES: i) Restricted to Hematology and Oncology. ii) Payable for complex patients (see notes for Complex Consultation – 33520).	459.00		155.44
33514	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) 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.	347.00		80.67
	Group counseling for groups of two or more patients			
33513	– first full hour	701.00		116.33
33515	– second hour, per 1/2 hour or major portion thereof	356.00		58.13
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
	<u>Continuing Care by Consultant:</u>			
33506	Directive care	209.00		94.05
33526	Directive care, Complex patient	400.00		133.26

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Hematology and Oncology. ii) Limited to 2 visits per patient per week (Sunday to Saturday). iii) Not paid in addition to 33506. iv) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iii of fee item 33520.			
33507	Subsequent office visit	145.00		76.95
33527	Subsequent Office Visit, Complex Patient NOTES: i) Restricted to Hematology and Oncology. ii) Payable for complex patients (see notes for Complex Consultation 33520). iii) Payment not contingent on whether or not a complex consultation was billed in the preceding 6 months.	264.00		135.92
33508	Subsequent hospital visit	146.00		69.66
33509	Subsequent home visit	195.00		53.22
33505	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) NOTE: Claim must state time service rendered.	395.00		161.40
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	687.00		199.86
33572	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	347.00		90.67
33577	Telehealth subsequent office visit	145.00		76.95
33540	Telehealth Complex Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report for complex patient	1170.00		307.09

(see notes on next page)

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

NOTES:

i) Restricted to Hematology and Oncology.

ii) Paid to a maximum of one per patient within six months of the last visit.

iii) Payable only for patients who are being directly managed for one of the following hematologic diseases:

- Multiple myeloma, **excludes** monoclonal paraproteinemia/monoclonal gammopathy of undetermined significance
- Acute leukemia **excludes** chronic lymphocytic leukemia
- Hereditary hemolytic anemia
- Acquired hemolytic anemia
- Aplastic anemia and red cell aplasia

Or one of the following diseases <u>with qualifying features:</u>

- Myelodysplastic syndrome or Myelofibrosis requiring chemotherapy, transfusion or growth factor therapy
- Coagulation defects requiring factor concentrate, transfusion or other hemostatic therapy
- Thrombocytopenia requiring immunosuppressive, transfusion or growth factor therapy
- Venous thromboembolism (VTE) / Phlebitis and thrombophlebitis that is:
  - unprovoked,
  - in a patient with cancer,
  - in a pregnant patient
  - in a patient with a contraindication to anticoagulation

33542	Telehealth Repeat or Limited Consultation, Complex Patient: Where a consultation for same illness is repeated within six months of the last visit by the consultant or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	453.00		155.44

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Hematology and Oncology. ii) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iv of fee item 33520.			
33546	Telehealth Directive care, Complex Patient	400.00		133.26
	NOTES: i) Restricted to Hematology and Oncology. ii) Limited to 2 visits per patient per week (Sunday to Saturday). iii) Not paid in addition to 33506. iv) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iii of fee item 33520.			
33547	Telehealth Subsequent Office Visit, Complex Patient.....	256.00		135.92
	NOTES: i) Restricted to Hematology and Oncology. ii) Payable for complex patients who are being directly managed for one of the hematologic diseases listed in note iv of fee item 33520. iii) Payment not contingent on whether or not a Complex Consultation or Telehealth Complex Consultation was billed in the preceding 6 months.			

EXAMINATION BY CERTIFIED HEMATOLOGIST AND ONCOLOGIST

33538	Plasmapheresis - therapeutic.....	643.00		204.17

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

S00753	Marrow aspiration - procedural fee.....	174.00	2	44.76

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.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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.....	709.00		207.87
	NOTE: This service is not payable more frequently than once every 28 days. The following treatments fall into this category: i) Chemotherapy for acute leukemia; ii) Chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment; iii) Chemotherapy utilizing isophosphamide in combination with bladder protector Mesna; iv) Chemotherapy using DTIC in a dose exceeding 100 mg/m2; v) Chemotherapy utilizing methotrexate in a dose exceeding 1 g/m2 (and combined with the folic acid rescue regimen); and vi) Chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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 ..... NOTE: This service is not payable more than once every seven (7) days.	444.00		121.91
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 ..... 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.	226.00		74.17
S00748	Bone biopsy under local/regional anesthetic.....	172.00		73.17

INFECTIOUS DISEASES

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
33610	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	738.00		236.39
33612	**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 judgment of the consultant, the consultative service does not warrant a full consultative fee	362.00		125.46
33620	Infectious Disease Extended Consultation for complex infectious diseases issues (antibiotic resistant organisms, outbreak management/infection control, tropical disease management), when requested by another Infectious Diseases Specialist, Internist, Internal Medicine Sub-Specialist, Pediatricians and Anesthesiologists. Includes history, physical examination, review of x-rays and additional visits necessary to render a written report.	1237.00		342.87

NOTES:

i) Minimum time requirement for service is 75 minutes (actual time spent with patient). Please submit start and stop times in the claim submission and log time in patient's chart.

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

iii) If an Infectious Diseases specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation service are met, a claim may be submitted under 33620 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33614	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) ..... NOTES: i) See Preamble D. 3. 3. Start and end times must be entered in both the billing claims and the patient's chart.	207.00		57.22
	Group counseling for groups of two or more patients			
33613	first full hour	422.00		117.23
33615	second hour, per 1/2 hour or major portion thereof.... NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	210.00		58.58
	Continuing Care by Consultant:			
33606	Directive care.....	207.00		85.72
33607	Subsequent office visit.....	191.00		79.35
33608	Subsequent hospital visit	138.00		42.62
33609	Subsequent home visit.....	195.00		53.60
33605	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) ..... NOTE: Claim must state time service rendered.	428.00		118.79
33645	Infectious Disease Care Management of HIV/AIDS – per half hour or major portion thereof..... NOTES: i) Payable to Infectious Diseases specialists only. ii) When performed in conjunction with visit, counselling or consultations, only the larger fee is paid. iii) Only applicable to services submitted under diagnostic codes 042, 043 and 044. iv) Start and end times must be included on claim, and in patient’s chart. v) Services that are less than 15 minutes should be billed under the appropriate visit fee item.	347.00		104.68

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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 ..... NOTE: Restricted to FRCP Infectious Disease Physicians.	738.00		236.39
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.....	362.00		125.46
33640	Telehealth Infectious Disease Extended Consultation for complex infectious diseases issues (antibiotic resistant organisms, outbreak management/infection control, tropical disease management), when requested by another Infectious Diseases Specialist, Internist, Internal Medicine Sub-Specialist, Pediatricians and Anesthesiologists. Includes history, physical examination, review of X-rays and additional visits necessary to render a written report..... NOTES: i) Minimum time requirement for service is 75 minutes (actual time spent with patient). Please submit start and stop times in the claim submission and log time in patient's chart. ii) Start and end times must be entered in both the billing claims and the patient's chart. iii) If an Infectious Diseases specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation service are met, a claim may be submitted under 33640 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.	1237.00		342.87

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
33636	Telehealth directive care	207.00		85.72
33637	Telehealth subsequent office visit	191.00		79.35
33638	Telehealth subsequent hospital visit	138.00		42.62
33635	Telehealth Infectious Disease Care management of HIV/AIDS – per half hour or major portion thereof	347.00		104.68

NOTES:

vi) Payable to Infectious Diseases specialists only.

vii) When performed in conjunction with visit, counselling or consultations, only the larger fee is paid.

viii) Only applicable to services submitted under diagnostic codes 042, 043 and 044.

ix) Start and end times must be included on claim, and in patient's chart.

x) Services that are less than 15 minutes should be billed under the appropriate visit fee item.

MISCELLANEOUS

G33655	Home Parenteral Antibiotic Management Fee, for active antibiotic treatment only	63.20		19.20

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 7 services per calendar week per physician per patient.

v) This fee may not be billed in addition to visits, out-of-office premiums, or other services provided on the same day, by the same physician, for the same patient.

A note record must be included for payment past 42 days.

MINOR PROCEDURES

13600	Biopsy of skin or mucosa - operation only	144.00	2	59.26

NOTE: Punch or shave biopsies not to be charged under fee items 13600 or 13601.

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

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES

	Puncture procedures for obtaining body fluids (when performed for diagnostic purposes)			
SY00750	Lumbar puncture - procedural fee	251.00	2	61.83
S00753	Marrow aspiration - procedural fee	174.00	2	44.76
SY00757	Joint aspiration - procedural fee (not in addition to 00014 or 00015) - other joints	51.20	2	16.54
S00759	Paracentesis (thoracic) or transtracheal aspiration - procedural fee	220.00	2	103.74
S00760	Paracentesis (abdominal) - procedural fee	83.90	2	27.29
	Needle biopsy procedures			
S00749	Parietal pleural, including thoracentesis-procedural fee	341.00	2	136.23
	Allergy, patch and Photopatch tests			
S00764	Intracutaneous test - per test	12.05		12.05

ORTHOPAEDIC DIAGNOSTIC PROCEDURES

	Elbow, Proximal Radius and Ulna			
	Incision: Diagnostic, Percutaneous:			
S11302	Aspiration - bursa, tendon sheath.	108.00	2	23.76
	Hand and Wrist			
	Incision: Diagnostic, Percutaneous:			
S11402	Aspiration - bursa, synovial sheath, etc	108.00	2	23.76
	Pelvis, Hip and Femur			
	Incision: Diagnostic, Percutaneous:			
S11501	Aspiration hip joint	108.00	2	23.76
S11502	Aspiration - bursa, tendon sheath.	54.00	2	11.90
	Femur, Knee Joint, Tibia and Fibula			
	Incision: Diagnostic, Percutaneous:			
S11602	Aspiration - bursa, tendon sheath or other peri-articular structures	108.00	2	23.76

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
TESTS PERFORMED IN A PHYSICIAN'S OFFICE				
15136	Fungus, direct microscopic examination, KOH preparation	32.60		8.57

INTERNAL MEDICINE

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
00310	Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	757.00		192.59
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	382.00		90.73
00314	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only)	382.00		61.77
	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.			
	Group counseling for groups of two or more patients			
00313	- first full hour	769.00		126.50
00315	- second hour, per 1/2 hour or major portion thereof..	394.00		63.22
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			
	<u>Continuing Care by Consultant:</u>			
00306	Directive care	188.00		80.51
00307	Subsequent office visit	147.00		59.92
00308	Subsequent hospital visit	107.00		52.82
00309	Subsequent home visit.....	213.00		57.87
00305	Emergency visit when specially called (not paid in addition to out-of-office hour premiums)	436.00		128.24
	NOTE: Claim must state time service rendered.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Telehealth Service with Direct Interactive Video Link with the Patient:			
32270	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.	757.00		192.60
32272	Telehealth repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee.	382.00		90.73
32276	Telehealth directive care	188.00		80.51
32277	Telehealth subsequent office visit.....	147.00		58.80
32278	Telehealth subsequent hospital visit	107.00		51.83

EXAMINATIONS BY CERTIFIED INTERNIST

00322	Internists' part in cardioangiogram, per hour or fraction thereof..... NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	263.00		51.17
33037	Replacement transfusion - hepatic failure to include two weeks care after transfusion ..... NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra.	1552.00		294.36
00343	Cardiac screening (maximum 3 per month within manufacturer's guarantee and one per week beyond manufacturer's guarantee).....	31.45		5.11
00344	– professional fee.....	18.05		2.56
00345	– technical fee	18.05		2.56
33032	Pacemaker standby and/or placement of the endocardial catheter - operation only	444.00		82.49
33033	Generator placement and venous cut-down	1437.00	4	82.49

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 ICUs, 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	1023.00	347.74
01421	2nd to 7th day (inclusive) per diem	506.00	174.38
01431	8th day to 30th day	307.00	133.01
01441	31st day onward	354.00	138.53

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 $C0_2$; transcutaneous blood gas application and assessment; and maximum inspiratory pressure monitoring and non-invasive metabolic measurements. There is an expectation of at least 1 hour of bedside care on Day 1. This is the fee to use when one physician is providing the ventilatory care and another physician, the critical care. This service may also be billed by a physician other than the operating surgeon or associate, for critical care required in addition to post-operative care by the surgeon.

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
01412	1st day	889.00	326.60
01422	2nd to 7th day (inclusive) per diem	448.00	174.65
01432	8th day to 30th day	323.00	134.95
01442	31st day onward	291.00	130.11

3. COMPREHENSIVE CARE - These fees apply to intensive care physicians who provide complete care, both critical care and ventilatory support (as defined above), to Intensive Care patients. These fees include the initial consultation and assessment; 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
01413	1st day	1671.00	519.02
01423	2nd to 7th day (inclusive) per diem	763.00	262.42
01433	8th day to 30th day	383.00	145.33
01443	31st day onward	386.00	151.15

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
INJECTIONS				
00017	Insertion of central venous pressure catheter	116.00		26.63
00018	Autologous ascitic infusion	238.00		52.61
BLOOD TRANSFUSIONS				
00021	Administered in hospital	174.00		40.79
DIALYSIS FEES				
	Acute Renal Failure:			
	Peritoneal Dialysis:			
33756	Re-insertion of peritoneal catheter after 10 days from initial insertion	250.00		53.40

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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.....	709.00		207.87
	NOTE: This service is not payable more frequently than once every 28 days. The following treatments fall into this category: i) Chemotherapy for acute leukemia; ii) Chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment;			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;			
	iv) Chemotherapy using DTIC in a dose exceeding 100 mg/m2;			
	v) Chemotherapy utilizing methotrexate in a dose exceeding 1 g/m2 (and combined with the folic acid rescue regimen); and			
	vi) Chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol).			
33582	Major cancer chemotherapy: To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counseling of patient and/or family, venesection and institution of an intravenous line, and administration of multiple parenteral chemotherapeutic agents ..... NOTE: This service is not payable more than once every seven (7) days.	444.00		121.91
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 ..... 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.	226.00		74.17

DIAGNOSTIC PROCEDURES

Cardio-Vascular Procedures – procedural fee:

S00839	Direct intracoronary streptokinase thrombolysis ..... NOTE: When coronary angiography and/or angioplasty performed in addition, the lesser procedure(s) to be charged at 50% of listed fee(s).	1746.00	4	395.89

Pulmonary investigative and function studies:

S00930	Peak expiratory flow rate..... NOTE: Fee item S00930 payable when performed in physician's office (not restricted to an accredited facility).	31.45		6.22

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Diagnostic Procedures:			
S00928	Simple screening spirometry with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus - without bronchodilators	66.70		13.79
S00929	– before and after bronchodilators	100.00		20.78
	Exercise Studies: NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation.			
S00958	Testing for exercise-induced asthma by serial flow measurements - professional fee	116.00		22.86
S00959	– technical fee	174.00		33.69
	Miscellaneous Pulmonary Tests:			
S00970	Precipitin tests - one or more antigens - professional fee	59.30		12.44
S00971	- technical fee	144.00		30.17
	Puncture Procedures for Obtaining Body Fluids (when performed for diagnostic purposes)			
S00753	Marrow aspiration - procedural fee	174.00	2	44.76
S00755	Artery puncture - procedural fee	36.05	2	7.15
S00759	Paracentesis (thoracic) or transtracheal aspiration - procedural fee	220.00	2	103.74

MISCELLANEOUS

00319	Insertion of central catheter for total parenteral nutrition - operation only	270.00	2	63.36
S32031	Closed drainage of chest (operation only)	516.00	4	144.53

NEPHROLOGY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
33710	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	687.00		198.18
33712	**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	347.00		87.54
33714	Prolonged visit for counseling (maximum four (4) per year applies to MSP and WSBC only) 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.	347.00		53.33
	Group counseling for groups of two or more patients			
33713	– first full hour	701.00		109.19
33715	– second hour, per 1/2 hour or major portion thereof NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	356.00		54.57
	<u>Continuing Care by Consultant:</u>			
33706	Directive care	157.00		61.53
33707	Subsequent office visit	135.00		87.54
33708	Subsequent hospital visit	126.00		49.41
33709	Subsequent home visit	195.00		49.95
33705	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) NOTE: Claim must state time service rendered.	395.00		110.71

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
Telehealth Service with Direct Interactive Video Link with the Patient				
33730	**Telehealth Consultation**: Shall include a detailed history and physical examination, review of previous medical records, discussion with family, friends or witnesses, evaluation of appropriate laboratory, X-ray and ECG findings and report of opinions and recommendations in writing to the referring physician NOTE: Restricted to FRCP Nephrology Physicians.	687.00		198.18
33732	**Telehealth Repeat or Limited Consultation**: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	347.00		87.54
33736	Telehealth directive care	157.00		61.53
33737	Telehealth subsequent office visit	135.00		87.54
33738	Telehealth subsequent hospital visit	126.00		49.41

DIALYSIS FEES

(A) Acute Renal Failure

a) Hemodialysis:

33750	Blood dialysis - physician in charge	2470.00		543.29
33751	Repeat blood dialysis - physician in charge 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.	940.00		204.17
33752	Blood dialysis - fee for cutdown by surgeon to be charged in addition to item 33750 or 33751	624.00		137.35

b) Peritoneal Dialysis:

33756	Re-insertion of peritoneal catheter after 10 days from initial insertion 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.	250.00		53.40

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	(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	250.00		53.40
	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	1845.00		406.46
33759	Performance of each peritoneal dialysis thereafter - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions and any other problem that may arise during dialysis	250.00		53.40
	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.			
	Home Dialysis			
33761	Supervision of home dialysis - per week	307.00		64.56
	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.			
	EXAMINATIONS BY CERTIFIED INTERNIST			
33538	Plasmapheresis - therapeutic	643.00		204.17
	MISCELLANEOUS			
33790	Care of renal transplant patient, including immediate preparation and fourteen (14) days post-operative care	4825.00		1208.89
77380	Insertion permanent peritoneal catheter (procedure fee only)	646.00	3	194.99

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
77385	Removal by dissection of chronic peritoneal catheter (operation only).....	450.00	3	135.25
	NOTE: For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.			

OCCUPATIONAL MEDICINE

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
REFERRED CASES			
33910	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	502.00	182.51
33912	**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 judgment of the consultant, the consultative service does not warrant a full consultative fee	251.00	91.81
	Continuing care by consultant:		
33907	Subsequent office visit	137.00	56.86

RESPIROLOGY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
32010	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	687.00		243.29
32012	**Repeat or Limited Consultation:** Where a consultation for same illness is repeated within six (6) months of the last visit by the consultant, or where in the judgement of the consultant the consultative services do not warrant a full consultative fee	347.00		131.73
32014	Prolonged visit for counselling (maximum four (4) per year applies to MSP and WSBC only) 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.	347.00		101.81
	Continuing Care by Consultant:			
32006	Directive care	174.00		98.14
32007	Subsequent office visit	190.00		96.32
32008	Subsequent hospital visit	150.00		107.44
32005	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) NOTE: Claim must state time service rendered.	395.00		131.62
PG32011	Complex Respiratory Medicine Assessment, for patients with advanced multi-system disease, per 15 minutes or greater portion thereof	181.00		75.17

(see notes on next page)

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

NOTES:

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

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

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

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

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

vi) When consult, repeat or limited consult or visit is charged in addition to G32011, for billing purposes, the consultation fee shall constitute the first ½ hour and the repeat or limited consult or visit will constitute the first 15 minutes of the time spent with the patient.

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

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

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

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

Telehealth Service with Direct Interactive Video Link with the Patient

32110	**Telehealth Consultation**: To consist of examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report..	687.00		243.29

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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.	347.00		131.73
32114	Telehealth prolonged visit for counselling (maximum four per year) ..... 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.	347.00		101.81
32106	Telehealth directive care	174.00		98.14
32107	Telehealth subsequent office visit	190.00		96.32
32108	Telehealth subsequent hospital visit	150.00		107.44

DIAGNOSTIC THERAPEUTIC PROCEDURES

S32031	Closed drainage of chest (operation only)	516.00	4	144.53
10320	Insertion of permanent pleural drainage catheter NOTES: i) Not to be billed for simple thoracocentesis or placement of a temporary pigtail drainage catheter. ii) Not paid with S32031, 00749, 00759, 07924 and 08646.	655.00	5	242.68
10321	Removal permanent pleural drainage catheter ..... NOTE: Not paid with S32031, 00749, 07924 and 08646.	347.00	2	86.51

DIAGNOSTIC PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION

S00700	Bronchoscopy or bronchofibroscopy – procedural fee	348.00	4	138.87
S00702	Bronchoscopy with biopsy – procedural fee.....	641.00	4	218.67
10700	Endobronchial cautery - extra ..... NOTES: i) To a maximum of 3 lesions. ii) Second and third lesion payable at 50% iii) Payable only with 00700 or 00702 and 10702, 10703, 00736 iv) Not payable with 10739 or 02450	233.00	6	80.08

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10702	Endobronchial cryotherapy - extra NOTES: i) To a maximum of 3 lesions ii) Second and third lesion payable at 50% iii) Payable only with 00700 or 00702 and 10700, 10703, 00736 iv) Not paid with 10739, 02450 and 02422	233.00	6	80.08
10703	Transbronchial Needle Aspiration (TBNA) NOTES: i) To a maximum of 3 separate stations or lesions ii) Second and third station or lesion payable at 100% iii) Payable with 00700, 00702 or 10739 and 10700, 10702, 00736 iv) Paid at 100% with other diagnostic procedures.	183.00	6	72.47

DIAGNOSTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) – procedural fee (extra)	348.00	4	69.68
10739	Endobronchial Ultrasound (EBUS) NOTES: i) Not payable with 00700, 00702, 02450, 10700 or 10702. ii) Fee item 10703 and 00736 payable in addition.	1157.00	6	399.81

DIAGNOSTIC PROCEDURES OR ENDOSCOPY

S00818	Oesophageal pH study for reflux, extra – professional fee	213.00		42.72
S00817	Oesophageal pH study for reflux, extra – technical fee	65.70		15.59
	Polysomnogram Overnight home oximetry (continuous recording of oxygen and pulse):			
S00910	– professional fee	139.00		29.48
S00911	– technical fee 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.	72.90		16.64

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S11915	Standard polysomnography – professional fee	540.00		174.28
S11916	Standard polysomnography – technical fee	1251.00		402.47
S11919	Multiple sleep latency test (MSLT) – professional fee	269.00		87.04
S11920	Multiple sleep latency test (MSLT) – technical fee	625.00		201.24
S11925	Four channel home polysomnography – professional fee	253.00		86.94
S11926	Four channel home polysomnography – technical fee	253.00		87.21

PULMONARY INVESTIGATIVE AND FUNCTION STUDIES

Diagnostic Procedures

S00928	Peak expiratory flow rate with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus - without bronchodilators	66.70		13.79
S00929	Peak expiratory flow rate before and after bronchodilators	100.00		20.78
	Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume			
S00931	– professional fee	76.60		17.28
S00932	– technical fee	76.60		14.75
	Spirometry - forced expiratory spirogram to include FVC, FEV(i), FEV/FVC ratio MMEFR, etc. - without bronchodilators			
S00933	– professional fee	59.30		13.21
S00934	– technical fee	59.30		12.48
S00935	– before and after bronchodilators - professional fee	66.70		15.24
S00936	– technical fee	76.60		14.86
	Spirometry - flow volume loops - without bronchodilators			
S00937	– professional fee	59.30		13.21
S00938	– technical fee	100.00		18.93
S00940	– before and after bronchodilators – professional fee	76.60		15.76
S00941	– technical fee	144.00		28.00

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Diffusion studies with carbon monoxide - at rest or exercise			
S00942	– professional fee	81.00		17.04
S00943	– technical fee	48.10		13.38
	Detailed Pulmonary Function Studies			
S00945	– professional fee (includes S00931, S00935 and S00942)	224.00		44.29
S00946	– technical fee (includes S00932, S00936 and S00943)	212.00		41.90
	NOTE: Fee Items S00931 - S00936, S00942, S00943 will be paid at 100%.			
	Exercise Studies			
	NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation.			
	Progressive exercise test with at least three workloads, measuring ventilation and electro-cardiographic monitoring			
S00950	– professional fee	116.00		27.03
S00951	– technical fee	174.00		33.89
	Exercise in a steady state at two or more workloads with measurements of ventilation, O_2 and CO_2 exchange, and electro-cardiographic monitoring			
S00954	– professional fee	428.00		98.64
S00955	– technical fee	274.00		61.41
	Exercise in a steady state at two or more workloads with measurements of ventilation, O_2 and CO_2 exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space			
S00956	– professional fee	512.00		114.33
S00957	– technical fee	361.00		73.13
	Miscellaneous Pulmonary Tests			
	Oximetry at rest, with or without oxygen			
S11960	– professional fee	21.95		6.22
S11961	– technical fee	23.75		5.30

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Oximetry at rest and exercise, with or without oxygen			
S11962	– professional fee	47.55		12.54
S11963	– technical fee	74.30		16.59
	Sputum induction for the assessment of inflammatory cells, preparation & staining of sputum, for patients 12+ years:			
SY11964	– professional fee	53.70		21.40
SY11965	– technical fee	192.00		46.13
	NOTES: i) Restricted to Respirologists. ii) Maximum of one assessment per patient per day. iii) Annual maximum four per year. Two additional tests will be considered if accompanied by a note record. iv) Not payable in addition to bronchoscopy 00700, 00702.			
	Plethysmography and airway resistance			
S00964	– professional fee	69.20		14.74
S00965	– technical fee	144.00		28.00
	Inhalation challenge - assessed by serial flow measurements, per day			
S00968	– professional fee	191.00		42.20
S00969	– technical fee	191.00		37.85
	NOTE: For fee items 00968 and 00969, serial spirometric measurement before and after inhalation of pharmacologic agents or agents encountered in working environment or antigen exposure for the diagnosis of Asthma. The protocols/agents used as described for but not limited to the standardized agents of Methacholine, Histamine, Mannitol. For Occupational / Asthma antigen challenge to include peak expiratory flow rate recording hourly x 8 hours following exposure.			
	CO_2/O_2 responsiveness of respiratory centres by steady state test or rebreathing test			
S00972	– professional fee	100.00		21.30
S00973	– technical fee	59.30		11.54

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Inspiratory and expiratory muscle strength			
S00974	– professional fee	57.60		16.77
S00975	– technical fee	57.60		13.23

RHEUMATOLOGY

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
REFERRED CASES			
31010	**Consultation**: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	556.00	262.86
31012	**Repeat or Limited Consultation**: Where a consultation for same illness is repeated within six (6) months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee	335.00	154.32
31014	Prolonged visit for counseling (maximum, four (4) per year)	251.00	50.17
	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.		
31050	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.	776.00	345.61
	NOTES: i) Restricted to Rheumatology. ii) Applicable to patients with chronic and complex medical needs. Paid with the following diagnostic codes: a. Diffuse Diseases of Connective Tissue (710), Systemic Lupus Erythematosus (710.0), Systemic Sclerosis (710.1), Sicca Syndrome (710.2), Dermatomyositis (710.3), Polymyositis (710.4), Other (710.8), Unspecified (710.9);		

(notes continued on next page)

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

b. Rheumatoid Arthritis and other Inflammatory Polyarthropathies (714), Rheumatoid Arthritis (714.0), Felty's Syndrome (714.1), Other Rheumatoid Arthritis with Visceral or Systemic Involvement (714.2), Juvenile Chronic Polyarthritis (714.3), Chronic Postrheumatic Arthropathy (714.4), other (714.8), Unspecified (714.9);
c. Polyarteritis Nodosa and Allied Conditions (446), Polyarteritis Nodosa (446.0), Acute Febrile Mucocutaneous Lymphnode Syndrome (MCLS) (446.1), Hypersensitivity Angiitis (446.2), Lethal Midline Granuloma (446.3), Wegener's Granulomatosis (446.4), Giant Cell Arteritis (446.5), Thrombotic Microangiopathy (446.6), Takayasu Disease (446.7);
d. Ankylosing Spondylitis and Other Inflammatory Spondylopathies (720), Ankylosing Spondylitis (720.0), Spinal Enthesopathy (720.1), Sacroiliitis, not Elsewhere Classified (720.2), Other Inflammatory Spondylopathies (720.8), Unspecified Inflammatory Spondylopathy (720.9);
e. Psoriasis and Similar Disorders (696), Psoriatric Arthropathy (696.0), other Psoriasis (696.1), Parapsoriasis (696.2), Pityriasis rosea (696.3), Pityriasis Rubra Pilaris (696.4), Other Unspecified Pityriasis (696.5), Other (696.8).
f. Arthropathy associated with infections (711)
g. Polymalgia rheumatic (725)

iii) One of either 31050 or 31150 is payable per patient within six months of the last visit.
iv) Not paid when there is no change in condition from previous assessment.
v) Start and end times must be recorded on claim and in the patient's chart.

31015 Rheumatology Management of Complex Joint(s) requiring Aspiration and/or Injection 68.50 30.50

NOTES:
i) Restricted to Rheumatologists.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	ii) For patients with severe degenerative diseases or inflammatory diseases, rheumatoid or psoriatic arthritis. It is not intended for disorders such as bursitis/tendonitis or soft tissue injections. iii) Maximum of one service per patient, per day. iv) Maximum of four services per patient, per calendar year. v) Payable in addition to an in person visit, except for 31027.		
	Continuing Care by Consultant:		
31006	Directive care	274.00	107.27
31007	Subsequent office visit	232.00	101.00
31008	Subsequent hospital visit	135.00	52.73
31005	Emergency visit when specially called (not paid in addition to out-of-office hours premium) Note: Claim must state time service rendered.	285.00	99.41
P31027	Extended subsequent office visit - exceeding 30 minutes (at least 25 minutes spent with patient) NOTES: i) Applicable to patients with chronic and complex medical needs. ii) Includes review of extensive documentation regarding the patient. iii) Payment not contingent on whether or not 31050 or 31150 was billed within the preceding six months. iv) For time spent with the patient, start and end times must be submitted with claim and recorded in the patient's chart. v) 31015 and 31055 not payable in addition.	292.00	130.00
P31037	Complex multi-system/multi-organ subsequent office visit NOTES: i) Applicable for patients with complex inflammatory or autoimmune diseases involving active management by the rheumatologist of at least two or more systems or organs in order to minimize potential adverse effects while treating them simultaneously.	270.00	120.00

(notes continued on next page)

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

ii) Includes review of extensive documentation regarding the patient.
iii) Payment not contingent on whether or not 31050 or 31150 was billed within the preceding six months.
iv) 31037 and 31137 are limited to a maximum of two per patient within a 12-month period.
v) Not to be billed for additional unrelated joint pain, osteoarthritis, or chronic pain.

Telehealth Service with Direct Interactive Video Link with the Patient

31110	Telehealth Consultation: To consist of an examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report.....	556.00	262.86
31112	Telehealth Repeat or Limited Consultation: Where a consultation for same illness is repeated within six (6) months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee	335.00	154.32
31150	Telehealth extended consultation – exceeding 53 minutes (actual physician time spent with patient). To consist of examination, review of history, laboratory, x-ray findings, necessary to initiate care.....	776.00	345.61

NOTES:
i) Restricted to Rheumatology.
ii) Applicable to patients with chronic and complex medical needs. Paid with the following diagnostic codes:
a. Diffuse Diseases of Connective Tissue (710), Systemic Lupus Erythematosus (710.0), Systemic Sclerosis (710.1), Sicca Syndrome (710.2), Dermatomyositis (710.3), Polymyositis (710.4), Other (710.8), Unspecified (710.9);

(notes continued on next page)

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

b. Rheumatoid Arthritis and other Inflammatory Polyarthropathies (714), Rheumatoid Arthritis (714.0), Felty's Syndrome (714.1), Other Rheumatoid Arthritis with Visceral or Systemic Involvement (714.2), Juvenile Chronic Polyarthritis (714.3), Chronic Postrheumatic Arthropathy (714.4), other (714.8), Unspecified (714.9);
c. Polyarteritis Nodosa and Allied Conditions (446), Polyarteritis Nodosa (446.0), Acute Febrile Mucocutaneous Lymphnode Syndrome (MCLS) (446.1), Hypersensitivity Angiitis (446.2), Lethal Midline Granuloma (446.3), Wegener's Granulomatosis (446.4), Giant Cell Arteritis (446.5), Thrombotic Microangiopathy (446.6), Takayasu Disease (446.7);
d. Ankylosing Spondylitis and Other Inflammatory Spondylopathies (720), Ankylosing Spondylitis (720.0), Spinal Enthesopathy (720.1), Sacroiliitis, not Elsewhere Classified (720.2), Other Inflammatory Spondylopathies (720.8), Unspecified Inflammatory Spondylopathy (720.9);
e. Psoriasis and Similar Disorders (696), Psoriatric Arthropathy (696.0), other Psoriasis (696.1), Parapsoriasis (696.2), Pityriasis rosea (696.3), Pityriasis Rubra Pilaris (696.4), Other Unspecified Pityriasis (696.5), Other (696.8).
f. Arthropathy associated with infections (711)
g. Polymalgia rheumatic (725)

iii) One of either 31050 or 31150 is payable per patient within six months of the last visit.
iv) Not paid when there is no change in condition from previous assessment.
v) Start and end times must be recorded on claim and in the patient's chart.

31106	Telehealth directive care	274.00	107.27
31107	Telehealth subsequent office visit	232.00	101.00
31108	Telehealth subsequent hospital visit	135.00	52.73
P31127	Telehealth extended subsequent office visit - exceeding 30 minutes (at least 25 minutes spent with patient)	292.00	130.00

(see notes on next page)

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

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

P31137 Telehealth complex multi-system/multi-organ subsequent office visit 270.00 120.00

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

MISCELLANEOUS

G31055 Rheumatology Immunosuppressant Review 71.90 32.00

NOTES:
i) Restricted to Rheumatology.
ii) Applicable only to patients with chronic systemic inflammatory diseases requiring aggressive immunosuppression.
iii) Applicable only to patients prescribed immunosuppressant medication.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	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. vii) Payable in addition to a visit, except for 31027 or 31127.		
31060	Multidisciplinary Care Assessment for community-based patients. To consist of assessment, written treatment plan and any other counselling the patient needs for management of their particular diagnosis.	676.00	232.79
	NOTES: i) Restricted to Rheumatology. ii) For the ongoing management of complex disorders of the musculoskeletal system, where the complexity of the condition requires the continuing management by a rheumatologist. It is not intended for the evaluation and/or management of uncomplicated rheumatologic disorders (e.g.: routine osteoarthritis, bursitis/tendonitis). iii) Only paid when a Registered Nurse or Licensed Practical Nurse is present. iv) Applicable to patients with rheumatoid arthritis diagnoses or similar inflammatory disease. v) Maximum one per patient in a 6 month period. vi) Not payable in addition to a consultation or visit fee. vii) Service may be provided in person or using telephone or video technology.		

NEUROLOGY

PREAMBLE

Acute Cerebral Vascular Syndrome (Stroke & TIA) Listings:
Acute cerebrovascular syndrome (ACVS) includes acute stroke and TIA. Both are indistinguishable clinically at onset and are acute emergencies. The ACVS fee items have been developed in conjunction with the BCSS and the Section of Neurology and are intended for services provided by neurologists in the acute management of stroke/TIA. When submitting claims, the appropriate 3-digit ICD-9 stroke code (431, 433, 434 and 435) must be used, and the patient's initial NIHSS 2-digit code for the billed visit must be appended in the ICD-9 field (i.e. 43412 or 43405). The TIA code (435) may also have an appended score if the billed visit includes the symptomatic phase.

Face-to-Face Services:
These fee items are intended for services rendered at public facilities with adequate diagnostic capabilities (i.e. laboratory services, diagnostic imaging ability including CT scan, ultrasound) to ensure timely patient care.

Telestroke Services:
"Telestroke Service" is defined as a Neurologist-delivered health service provided via videoconferencing for a patient referred by a physician at a different site for diagnosis related to acute cerebral vascular syndrome (ACVS).

- 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 Heath 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 family physician at the patient's site to assist with the essential physical assessment, without which the neurologist's service would be ineffective, the neurologist must indicate in the "Referred by" field that a request was made for a family physician assisted assessment.

Where a receiving neurologist, after having provided a Telestroke consultation service to a patient, decides s/he must examine the patient in person, the neurologist should claim the

subsequent visit as a limited consultation, unless more than 6 months has passed since the Telestroke consultation.

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

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

In exceptional circumstances, for facilities targeted in the BCSS phased implementation in the process of implementing Telestroke services, a telephone consultation may be payable in an emergent (i.e. life or death) situation. Telemetry review of diagnostic images is required as an integral aspect of the consultation. A note record is required in these instances.

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

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
REFERRED CASES			
00410	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	562.00	204.82
00411	**Repeat or Limited Consultation:** 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	278.00	144.85
G00450	Complex Care – Extended Consultation – per 15 minutes or major portion thereof 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.	175.00	70.64
00452	Neurology in-hospital consultation – extra NOTES: i) Not for patients seen within the last 6 months by the same physician for the same or related condition. ii) Payable in addition to 00410, 00441, 00485, and 40441. iii) Not payable for hospital outpatients, or for patients located in transient ischemic attack (TIA) or rapid access neurology clinics. iv) Daily maximum of 5 claims per day per Neurologist.	71.70	75.00

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
P00493	Pediatric neurology development assessment	112.40	40.00
	NOTES: i) Restricted to Pediatric Neurologists. ii) Must include completion of standardized developmental assessment scales including motor, fine motor, communication, cognitive and behavioural development. iii) Payable once per patient in a 12-month period. iv) Limited to 24 assessments per practitioner per month. v) Payable only in addition to a consult or visit.		
G00460	Transfer of Care from Pediatrics – Extended Consultation: To consist of an examination, review of history, previous laboratory & x-ray findings, and written report on a patient with a complex and chronic neurologic condition requiring active neurologist support transferring from pediatric to adult care. In addition, specific and special documentation as outlined below must be included in the patient's chart and copies sent with the patient and/or family as appropriate.	1159.00	416.61
	NOTES: i) For patients 16 years to 21 years of age. ii) This fee is payable to a neurologist who accepts the primary responsibility for the neurologic management of a patient transferring from pediatric to adult care, and includes review of ALL necessary data, including birth and developmental assessments. iii) Paid once per patient in that patient's lifetime. iv) Not paid with 00410, 00411, 00441, 40441, 00470, 00471, G00450 or 00457.		
	Continuing Care by Consultant:		
00406	Directive care.....	281.00	151.45
00407	Subsequent office visit.....	275.00	112.44
00408	Subsequent hospital visit.....	278.00	146.43
00409	Subsequent home visit	158.00	97.16
00405	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	315.00	130.18
	NOTE: Claim must state time service rendered.		

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
00457	Complex Care – Extended Visit – per 15 minutes or major portion thereof..... NOTES: i) Paid in addition to 00406, 00407, 00408, 00409, 00476, 00477 or 00478 after 15 minutes. ii) Paid to a maximum of 2 units per patient, during same sitting. iii) Start and end times must be entered on patient's chart and claim.	109.00	68.65
P00440	Neurological review and written care plan ..... NOTES: i) Restricted to Neurology specialists. ii) Includes review of referral materials, acquisition of additional necessary data, communication with the patient (through telephone or email) as necessary, and delivery of comprehensive written individualized report & care plan to the referring physician within 14 days of referral being received. iii) If billed within 6 months of a 00410, 00470, 00441, 00485, or 40441 for the same diagnosis, the medical necessity must be provided in the note record. iv) Not payable in addition to a consult or visit. v) Not payable with 00487, 00488, 00492, 00900, 00901, or 00902 by the same practitioner on the same date of service. vi) Limited to 20 virtual assessments per practitioner per month.	385.00	122.66
00441	Face to face ACVS Consultation ..... To consist of examination, review of history, laboratory, diagnostic imaging, and the rendering of a written report, including required BCSS registry data. NOTES: i) Applicable for patients seen within 4.5 hours of onset of symptoms for diagnosis of acute cerebral vascular syndrome. ii) Also applicable for patients seen within 72 hours of onset of symptoms for relapse prevention (00444). iii) Refer to Neurology ACVS Preamble for further information. iv) Restricted to Neurologists. v) Not billable in conjunction with 00410, 00081, 00082 or 40441 by the same neurologist.	721.00	240.24

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
00442	Face to Face follow-up neurological clinical monitoring and treatment for persisting ACVS: without administration of tPA, per ½ hour or major portion thereof.	323.00	116.59

NOTES:

i) To be used for the ongoing evaluation, clinical monitoring and treatment of a patient referred for acute cerebral vascular syndrome requiring ongoing 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.

00443	Face to face follow-up neurological clinical monitoring and treatment for persisting ACVS: with administration of tPA, per ½ hour or major portion thereof.	323.00	116.59

NOTES:

i) To be used for the ongoing evaluation, clinical monitoring and treatment of a patient referred for suspected acute cerebral vascular syndrome requiring ongoing care by the neurologist.
ii) Includes ongoing review/discussion of any and all diagnostic imaging and/or interventional imaging.
iii) Includes the time required for use and monitoring of TPA by the neurologist.
iv) Includes sequential scales, e.g.: NIHSS, as necessary.

(notes continued on next page)

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

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.	258.00	116.59

NOTES:
i) To be used for the ongoing evaluation, neurological clinical monitoring and treatment of a patient seen within 72 hours of onset of symptoms with referral diagnosis of ACVS with remission (partial or complete) of original symptoms who requires ongoing care by the neurologist.
ii) Includes ongoing review of any and all diagnostic imaging.
iii) Not payable with 00410 or 00081, 00082 by same physician.
iv) Includes sequential scales, e.g.: NIHSS, as necessary.
v) Not intended for standby time such as waiting for laboratory results.
vi) For payment purposes, when immediately subsequent to 00441, the consultation fee constitutes the first half hour of the time spent with the patient 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
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.....	644.00	233.17
	NOTES: i) Restricted to Neurologists. ii) Applicable only for patients seen within 14 days of onset of symptoms. Date of onset of symptoms must be recorded in the medical record. iii) Payable only for patients with established diagnosis of MS (ICD-9 code 340 billed previously by any neurologist). iv) Repeat services payable after 42 days of a previous P00485. v) Maximum two per patient per calendar year. vi) Includes lumbar puncture (00750) if required. vii) Fee item 00486 payable in addition if assessment exceeds 30 minutes. viii) Not payable same day with critical care fee items (01411, 01412, 01413, 00081, 00082 or fee item G00450 or 00410). Only highest priced item will be paid. ix) Start and end times must be submitted with the claim.		
00486	Face to face assessment for acute deterioration in status of an MS patient - each additional half hour or major portion thereof.	323.00	123.78
	NOTES: i) Paid only with 00485. ii) Maximum of 4 units per face to face assessment. iii) Payable for the ongoing assessment, clinical monitoring and treatment of an MS patient with acute deterioration. iv) Start and end times must be submitted with the claim.		
00487	Detailed cognitive assessment by Behavioral Neurologist – extra	159.00	97.96

(see notes on next page)

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

NOTES:
i) Restricted to practitioners with a subspecialty in Behavioral Neurology.
ii) Payable for documented MMSE or MOCA or similar standardized cognitive assessment.
iii) Limited to 2 assessments per patient per calendar year.
iv) Limited to 40 assessments per practitioner per month.
v) Minimum time between assessments is 4 months.
vi) Payable only in addition to a consult or visit.

00488 Detailed cognitive assessment – extra 159.00 97.96

NOTES:
i) Restricted to Neurologists.
ii) Practitioners with a subspecialty in Behavioral Neurology must bill 00487.
iii) Payable for documented MMSE or MOCA or similar standardized cognitive assessment.
iv) Limited to 2 assessments per patient per calendar year.
v) Limited to 24 assessments per practitioner per month.
vi) Minimum time between assessments is 4 months.
vii) Payable only in addition to a consult or visit.
viii) Not payable in addition to 00440.

00491 Detailed Parkinson's disease quantitative review for neurologists with a Movement Disorder (MD) fellowship – extra..... 181.00 97.97

NOTES:
i) Restricted to Neurologists with a fellowship in movement disorder.
ii) Must be submitted with ICD-9 for Parkinson's disease (332) and include completion of a Parkinson's Assessment Scale on a complex Parkinson's patient.
iii) Paid only in addition to a consult or visit.
iv) Not payable on the same day with fee items 00487, 00488, 00900, 00901, 00902, 00440, 00441 and 40441 by the same practitioner.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	v) Limited to 2 assessments per patient per calendar year. vi) Limited to 24 assessments per practitioner per month. vii) Minimum time between assessments is 6 months.		
00492	Detailed Parkinson's disease quantitative review – extra. NOTES: i) Restricted to Neurologists. ii) Must be submitted with ICD-9 for Parkinson's disease (332) and include completion of a Parkinson's Assessment Scale on a complex Parkinson's patient. iii) Paid only in addition to a consult or visit. iv) Not payable on the same day with fee items 00487, 00488, 00900, 00901, 00902, 00440, 00441 and 40441 by the same practitioner. v) Limited to 2 assessments per patient per calendar year. vi) Limited to 4 assessments per practitioner per month. vii) Minimum time between assessments is 6 months.	81.00	97.97

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.....	479.00	204.82
00471	Telehealth Repeat or limited consultation: Where a consultation for the same illness is repeated within six months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	278.00	144.85
00476	Telehealth directive care	281.00	151.45
00477	Telehealth subsequent office visit.....	275.00	112.44
00478	Telehealth subsequent hospital visit.....	278.00	146.43

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

TELESTROKE SERVICES

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. 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.	721.00	240.24
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..... 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.	323.00	116.59

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	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.	323.00	116.59
	NOTES: i) To be used for the ongoing evaluation, clinical monitoring and treatment of a patient referred for suspected acute cerebral vascular syndrome requiring ongoing videoconference care by the neurologist. ii) Includes ongoing review of any and all diagnostic imaging. iii) Includes the time required for monitoring of TPA by the neurologist. iv) Includes sequential scales e.g.: NIHSS, as necessary. v) Not payable with 00410, 00081, 00082 or 40442 by same physician. vi) Not intended for standby time such as waiting for laboratory results. vii) For payment purposes, when immediately subsequent to 40441, the consultation fee constitutes the first half hour of the time spent with the patient during the videoconference. viii) Start and end times must be submitted with claim. ix) Restricted to Neurologists. x) If billed in addition to 40441, paid at 100% 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	258.00	116.59
	NOTES: i) To be used for the ongoing evaluation, neurological clinical monitoring and treatment of a patient seen within 72 hours of onset of symptoms with referral diagnosis of ACVS with remission (partial or complete) of original symptoms who requires ongoing care by the neurologist.		

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	ii) Includes ongoing review of any and all diagnostic imaging. iii) Not payable with 00410, 00081, or 00082 by same physician. iv) Includes sequential scales e.g.: NIHSS, as necessary. v) Not intended for standby time such as waiting for laboratory results. vi) For payment purposes, when immediately subsequent to 40441, the consultation fee constitutes the first half hour of the time spent with the patient during the videoconference. vii) Start and end times must be submitted with claim. viii) Restricted to Neurologists. ix) If billed in addition to 40441, paid at 100%. x) Daily maximum per patient is four (4), unless note record indicates medical necessity for extended service.		

SPECIAL EXAMINATIONS

P00416	Electroencephalogram under 2-hour study - professional fee	128.00	82.65
P00413	Electroencephalogram - technical fee NOTE: Payable only in addition to 00416, 00433, 00436, 00438 and 00439.	327.00	80.41
00417	Electrocorticography	1021.00	246.29
00419	Electroclinical detailed interpretation of a set of seizures	1774.00	434.71
00420	Short study of electroclinical interpretation of seizures - professional fee	904.00	223.84
00421	Electrocorticography with functional mapping in awake craniotomy	2053.00	530.75
P00433	Electroencephalogram with video monitoring, 2-12 hour study - professional fee NOTE: 00416 not payable in addition.	562.00	200.00
P00436	Ambulatory electroencephalogram, two days (minimum 44-hour study) - professional fee	772.75	275.00

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
P00438	Ambulatory electroencephalogram, two days (minimum 44-hour study) - professional fee	1081.85	385.00
P00439	Ambulatory electroencephalogram, three days (minimum 68-hour study) - professional fee	1390.95	495.00

MISCELLANEOUS

00424	Botulinum toxin injections	505.00	127.53
	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.		
00480	DMT (Disease Modifying Treatment) management for active inflammatory disease of the Central Nervous System (CNS).....	476.00	173.85
	NOTES: i) Payable every 6 months to prescribing Neurologists responsible for continuing care of patients with active CNS inflammatory disease, who are on DMT's. ii) Under this code the prescribing Neurologist is responsible for all associated drug monitoring, drug related complication management and communication to the patient and care providers with respect to the particular drug. iii) Payable alone or if billed in addition to face-to-face services, telehealth services, and physician-to-physician phone calls. iv) Includes organization of all treatment plans, drug initiation algorithms, medication review, MRI assessment and lab review (including CSF) if required. v) Includes monitoring of all investigations for subsequent 6 months, including imaging and lab work, and conversations with allied health professionals as required. vi) Maximum number of services payable per neurologist per month is 40.		

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
P00481	DMT (Disease Modifying Treatment) management for active inflammatory disease of the Peripheral Nervous System (PNS)	174.00	99.76
	NOTES: i) Payable every 6 months to prescribing Neurologists responsible for continuing care of patients with active PNS inflammatory disease who are on DMT's. ii) Under this code, the prescribing Neurologist is responsible for all associated drug monitoring, drug related complication management and communication to the patient and care providers with respect to the particular drug. iii) Payable alone or if billed in addition to face-to-face services, telehealth services, and physician-to-physician phone calls. iv) Includes organization of all treatment plans, drug initiation algorithms, medication review and lab review (including CSF) if required. v) Includes monitoring of all investigations for subsequent 6 months, including imaging and lab work, and conversations with allied health professionals as required. vi) Payable to a maximum of 50 services per physician per calendar year.		
G00462	Neurological Interpretation and written report of submitted x-ray films (including CT scan, TCD, MRI) – per case	155.00	56.33
	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 10001, 10002, or 10003 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.		

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

DOPPLER ULTRASOUND

G00468	Neurology Outpatient Transcranial Doppler Ultrasound: To consist of static and dynamic insonation and definition of intracranial circulation, within 72 hours of stroke onset. This study is designed to assist with a CVA NOTES: i) Restricted to Neurologists. ii) Paid for outpatients at provincial stroke prevention clinics. iii) Billable only in addition to 00441, 00442, 00443, 00444 and with 00410, 00411, 00407, 00409, 00470, 00471, or 00477, for patients with sickle cell disease or subarachnoid hemorrhage. iv) The physician must be present throughout the study. v) Start and end times must be entered on the patient's chart and on the claim. vi) Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation, as indicated by the clinical setting.	355.00	127.57
G00469	Neurology Outpatient Transcranial Doppler Ultrasound – Prolonged Study – per 15 minutes or greater portion thereof: To consist of prolonged study, which includes fitting of halo-type head brace or other device, and review of study..... NOTES: i) Restricted to Neurologists. ii) Paid for outpatients at provincial stroke prevention clinics. iii) Paid after 45 minutes of G00468. iv) The physician must be present throughout the study. v) Start and end times must be entered on patient's chart and on the claim. vi) Paid to a maximum of 8 units per patient, per study. vii) Includes insonation (both ipsilateral and contralateral to suspected pathology), and both anterior and posterior circulation as indicated by the clinical setting.	88.90	31.88

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

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)	562.00	130.77
S00901	Schedule B - limited examination (4 to 7 items)	391.00	87.47
S00902	Schedule C - short examination (1 to 3 items)	191.00	43.59
S00922	Electrodiagnostic component of the decamethoniumedrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests	204.00	61.58
S00923	Technical fee for electrodiagnostic testing	95.00	20.85
S00905	Daily measurements of nerve conduction thresholds in facial palsy	29.30	6.81
S00906	– maximum per course	194.00	47.39
S00915	Intra-carotid injection of sodium amytal - speech localization test	430.00	105.19
S00927	Decamethonium test - for attendance at and follow-up observation if necessary	184.00	36.24

EVOKED RESPONSE PROCEDUREDS

S00985	Brainstem auditory evoked response, supra threshold testing for integrity of brainstem function	255.00	52.22
S00986	Somatosensory evoked response - upper extremity	174.00	43.55
S00987	upper and lower extremity	345.00	75.29

NEUROSURGERY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
03010	**Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, and a written report	522.00		185.26
03011	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee	249.00		81.91
	Continuing Care by Consultant:			
03007	Subsequent office visit	147.00		69.63
03008	Subsequent hospital visit	92.60		32.27
03009	Subsequent home visit	189.00		56.07
03005	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) NOTE: Claim must state time service rendered.	387.00		115.49
03315	Pre-Operative Assessment NOTES: i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances. ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent. iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition. iv) Maximum of one pre-operative assessment per patient per procedure. v) Only paid to the surgeon who performs the procedure.	482.00		185.26

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
Telehealth Service with Direct Interactive Video Link with the Patient				
03310	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	454.00		185.26
03312	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	228.00		81.91
03317	Telehealth subsequent office visit	147.00		69.63
03318	Telehealth subsequent hospital visit	92.60		32.27

DIAGNOSTIC PROCEDURES

	Puncture procedures for obtaining body fluids (when performed for diagnostic purposes):			
SY00750	Lumbar puncture in a patient 13 years of age and over…… Note: Procedure not payable with Critical Care sectional fee items or chemotherapy fee items.	251.00	2	61.83

MISCELLANEOUS

03211	Muscle biopsy	191.00	2	88.80
S03216	Puncture of ventricular shunt for CSF aspiration (operation only)	126.00	2	37.02
S03217	Percutaneous ventricular puncture (operation only)	444.00	2	132.29
03227	Neurosurgical interpretation and written report of submitted x-ray films (including CT scan, MRI) NOTE: Not payable in addition to a consultation rendered within 2 months (+/-) on the same patient on referral by the same physician.	165.00		64.21

TRAUMA

03110	Elevation or "attempted" elevation of depressed skull fracture in infant under the age of one year, by neurosurgeon, using vacuum extractor (operation only)	485.00	6	145.51
03111	Elevation of simple depressed skull fracture	2495.00	5	746.49
03112	Elevation of compound depressed skull fracture	3248.00	6	1204.31

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03113	with repair of dura, debridement of cerebral laceration and sinuses	5105.00	8	1909.97
03115	Exploration of subdural space for chronic subdural hematoma - unilateral or bilateral	2819.00	6	934.80
03116	Craniotomy for evacuation of intracranial hematoma (cerebral, subdural, extradural or abscess)	5374.00	8	1828.48
03118	Craniotomy for repair of CSF leak	5512.00	8	1648.65
03126	Re-opening or removal of bone flap	2230.00	6	708.95
S03165	Insertion of intracranial pressure monitoring device, operation only	1019.00	6	302.81

CEREBROVASCULAR

03141	Cerebral re-vascularization procedure with extracranial-intracranial anastomosis	6403.00	9	2272.47
03142	Application of Silverstone clamps (operation only)	1921.00	5	574.37
03136	Craniotomy for intracranial aneurysm or angioma	7141.00	9	3096.71
03119	Craniotomy for microvascular decompression of cranial nerve	6316.00	8	2044.77

NEURO-ONCOLOGY

03129	Craniotomy for tumour	5312.00	8	1820.27
03114	Craniotomy and microsurgical removal of tumour of ventricle, brain stem, thalamus, hypothalamus, or basal ganglia	9950.00	8	2975.29
03130	Craniotomy for removal of extra-axial brain tumour using operating microscope when procedure is prolonged more than 8 hours (to include operative report) NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	13921.00	8	4591.91
03135	Craniotomy or laminectomy using operating microscope when procedure is prolonged more than 8 hours (to include operative report) NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	12085.00	9	4013.39
03222	Craniotomy lasting more than 12 hours and requiring operating microscope NOTES: i) 03222 is applicable to the principal neurosurgeon who is required to spend more than 12 hours performing this surgery.	18252.00	9	5458.58

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	Craniotomy for microsurgical resection of extra-axial tumour, extra to 03222, per hour or major portion thereof, after 12 hours NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	661.00		197.53
03133	Craniotomy for removal of extra-axial brain tumour using operating microscope NOTE: May be billed as the neurosurgical portion of a team procedure with fee item 02610 when done for extra-axial skull based procedures.	9950.00	8	2975.29
03128	Stereotactic biopsy for intracranial pathology via frame-based or frameless techniques NOTE: Fee item 03189 is not payable in addition.	3855.00	7	1508.01
03320	Removal of skull tumour without craniectomy	1433.00	6	428.25
03131	Transsphenoidal removal of pituitary tumour or hypophysectomy - one surgeon	6916.00	8	2272.76
03132	– two surgeons - Neurosurgeon	5281.00	8	2065.68
02437	– Otolaryngologist	3958.00	8	1261.67
03189	Stereotactic localization during neurosurgery in association with craniotomy and spinal fusion/stabilization procedures - extra NOTE: Applicable to procedures involving cranium or spine.	1508.00		524.01

SKULL BASE

02262	Translabyrinthine approach for neurosurgical access - exposure, closure with microscope	7795.00	8	2732.90
02610	Middle cranial fossa approach without petrosectomy for trauma, neoplasm resection, nerve section/decompression	5270.00	8	1620.19

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) To include exposure, removal and closure with microscope. ii) May include extra-dural resection of lesion by Otolaryngologist.			
02612	Middle cranial fossa approach, petrosectomy	8446.00	8	1973.42
02613	Middle cranial fossa approach, petrosectomy - procedure lasting longer than 8 hours	10556.00	8	2466.65
	NOTE: 02612 and 02613 to include exposure, extra-dural removal and closure with microscope.			
02614	Retrolabyrinthine approach for neurosurgical access - exposure, closure with microscope	7078.00	8	2255.92
02618	Repair of CSF leak following skull base approach with mastoid obliteration - to include exposure, dissection and closure with microscope	4491.00	8	1574.84
02622	Infra-temporal fossa approach to skull base, Otolaryngology fee	8446.00	8	2502.20
02623	Infra-temporal fossa approach to skull base, Otolaryngology fee for procedure lasting longer than 8 hours.	10556.00	8	2640.56
	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.			
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) NOTE: Not billable for exposure only.	5607.00	7	1676.55
03224	Neurosurgical component of microsurgical removal of cerebellar pontine angle tumour NOTE: Not billable for exposure only.	6447.00	8	1927.72

PEDIATRIC NEUROSURGERY

03183	Microsurgical repair of meningomyelocele	6003.00	6	1794.21
03175	Repair of meningocele or encephalocele	3422.00	6	1024.05
	Posterior decompression of Chiari malformation or foramen magnum:			
03095	– no dural repair	4724.00	8	1787.39
03096	– with dural repair	5613.00	8	2119.33

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03097	– with fourth ventricular exploration	6500.00	8	2374.67
03121	Cranioplasty	3248.00	7	971.62
03145	Cranioplasty using autologous bone graft	3902.00	7	1493.58
03122	Craniectomy for osteomyelitis or skull tumour	3629.00	7	1085.42
03123	– with cranioplasty	5105.00	7	1527.02
03124	Linear craniectomy or craniotomy for cranial stenosis - 1st suture	3533.00	7	1056.23
03127	– additional sutures to a maximum of 3 - each extra	870.00	7	259.24
	Lateral canthal advancement or similar procedure for coronal synostosis:			
03137	unilateral	4088.00	8	1222.75
03143	bilateral	4379.00	8	1309.31
03125	Bilateral craniectomies for cranial expansion or delayed treatment of synostosis (patient must be older than one year)	6537.00	8	1956.60
03146	Morcellation of skull for craniosynostosis	5969.00	8	1785.02
03147	Cranial reconstruction for complex deformity in a child. 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.	6484.00	8	2536.48
03148	Forehead reconstruction, extra to linear craniectomies for craniosynostosis	976.00		292.31
03053	Craniotomy for combined plastic surgical/neuro-surgical cranioplasty (neurosurgical component)	2347.00	8	701.10
03120	Neurosurgical fee for facial craniotomy reconstruction	4609.00	9	1377.82
	Bilateral orbital advancement -intracranial approach for correction of hypertelorism when done as a team procedure with a Neurosurgeon and Plastic Surgeon			
03080	Neurosurgery Portion	6549.00	8	2285.82
61380	Plastic Surgery Portion	9563.00	8	2285.82

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Unilateral orbital advancement - intracranial approach when done as a team procedure with a Neurosurgeon and Plastic Surgeon			
03081	Neurosurgery Portion	6078.00	8	2120.57
61381	Plastic Surgery Portion	8871.00	8	2120.57
	Bilateral orbital advancement – intracranial approach - when done as a team procedure with a Neurosurgeon and Plastic Surgeon			
03082	Neurosurgery Portion	8130.00	8	2836.39
61382	Plastic Surgery Portion	11865.00	8	2836.39

ENDOSCOPY/HYDROCEPHALUS

03181	Shunt for ventricular obstruction	3457.00	6	1034.19
03182	revision	3457.00	6	1034.19
03184	Lumbar peritoneal shunt for hydrocephalus	3457.00	5	1034.19
S03188	Ventriculostomy or insertion of external ventricular drain (operation only)	989.00	6	347.12
S03240	Implantation of totally implantable ventricular access device (e.g.: Ommaya reservoir), (operation only) NOTE: S03240 not to be used for external ventricular drain.	1605.00	6	478.40
03036	Ventricular shunt with ventriculoscopic guidance	3679.00	6	1099.19
S03037	Removal of ventricular shunt (operation only) NOTES: i) Restricted to Neurosurgeons. ii) Not paid with fee item 03182. If fee item 03188 is performed under the same anesthetic, pay in accordance with preamble D.5.3.	937.00	6	294.67
03038	Stereotactic localization during intracranial shunt procedures – extra NOTES: i) Restricted to Neurosurgeons. ii) Paid only in addition to 03181, 03188, 03240, 03030, 03031, 03032, 03033, 03034, 03035 or 03036. Daily maximum of 1 per patient – if a second procedure is required on the same day, provide note record.	994.00	6	421.85

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
VENTRICULOSCOPIC PROCEDURES				
	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	2876.00	6	859.75
03031	Ventriculoscopy, third ventriculostomy	4414.00	6	1354.69
03032	Ventriculoscopy/endoscopy biopsy of intraventricular or intracranial lesion	4992.00	6	1952.87
03033	Ventriculoscopic retrieval of foreign body	4414.00	6	1675.93
03034	Ventriculoscopy and fenestration of cyst or septum pellucidum, or lysis of adhesions	4414.00	6	1508.83
03035	Ventriculoscopic resection of intraventricular tumour	8810.00	6	2635.25
EPILEPSY				
03055	Craniotomy with microsurgical cortical resection for epilepsy, under general anesthesia	7766.00	6	2530.40
03056	Craniotomy with microsurgical cortical resection for epilepsy, in awake patient	9597.00	6	3322.75
03057	Craniotomy with cortical resection for epilepsy	5620.00	8	2198.12
03058	Hemispherectomy	7646.00	8	2490.75
03059	Craniotomy and microsurgical hemispherotomy for epilepsy	8864.00	8	2651.59
	NOTES: i) Includes corpus callosum section, disconnection of the cerebral hemisphere. ii) Requires loupe magnification and/or operating microscope. iii) Not paid with fee item 03058.			
03144	Section of corpus callosum	5896.00	8	2306.18
03221	Implantation of vagal nerve stimulator - to include electrodes and stimulator	1667.00	4	639.86
03223	Replacement of stimulator component of vagal nerve stimulator	1107.00	3	270.20
03225	Removal of vagal nerve stimulator and electrodes	1248.00	4	476.59

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03235	Intraoperative cortical localization SSEP or stimulation, under general anesthesia (extra to craniotomy)	808.00		284.02
03236	Insertion of subdural strip electrodes - unilateral (epilepsy surgery, to include burrhole(s))	3760.00	8	1123.89
03237	Removal of subdural strip electrodes - unilateral	1612.00	6	481.67
03238	Cortical or deep brain localization with SSEP or stimulation in an awake patient (extra to craniotomy)	1612.00		481.67
03239	Craniotomy and insertion of subdural grid electrodes with or without additional strip electrodes - unilateral	5011.00	7	1498.38
	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	2702.00	6	807.04
	NOTE: Isolated procedure - not payable in addition to other epilepsy surgical listings.			

SPINE

Miscellaneous

NOTE: Asterisk items (*) - operation only. Refer to Orthopaedic Preamble 1.

	Incision – Therapeutic, Percutaneous:			
*58205	Injection/aspiration facet joint	437.00	2	95.07
	Excision – Diagnostic, Percutnaeous:			
S11830	Needle biopsy - soft tissue/bone thoracic spine, under GA	1001.00	2	219.58
S11831	Needle biopsy - soft tissue/bone lumbar spine, under GA	869.00	2	190.94
	Excision – Diagnostic, Open:			
11845	Biopsy, with general anesthesia	1131.00	3	248.23
	NOTE: Not payable with definitive spinal surgery.			
	Fracture and/or Dislocation (Cervical Spine):			
	Cervical			
*58710	Application of halo	869.00	4	190.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03094	Anterior decompressing craniovertebral junction, using operating microscope	10076.00	8	3014.17
03155	Laminectomy for hematoma, tumour or vascular malformation	3144.00	6	1331.92
03368	Discogram (operation only)	437.00	2	95.07
03369	Abscess or hematoma, extraspinal, under GA (operation only)	869.00	4	190.94
03361	Percutaneous discectomy	1265.00	3	276.87
03367	Removal of spinal instrumentation	2392.00	5	1035.38
03160	Laminectomy for congenital spinal malformation or tethered spinal cord	5301.00	5	2073.75
03168	Laminectomy for intradural spinal cord or extra-medullary tumour or vascular malformation by microsurgical technique	6224.00	7	2458.37
S03167	Insertion of skull tongs (operation only)	436.00	4	129.15
03169	Fracture of spine without cord injury, open reduction and fusion	2349.00	7	702.27
03170	in conjunction with Orthopaedic Surgeon (operation only)	2224.00		663.92
03172	Fracture of spine with cord injury, open reduction and fusion	3205.00	7	958.27
03173	in conjunction with Orthopaedic Surgeon (operation only)	2224.00		663.92
03215	Insertion of spinal subarachnoid catheter (operation only)	161.00	2	47.67
03231	Repair of spinal CSF leak or pseudo-meningocele	2049.00	5	919.30

CERVICAL

Decompression Procedures

	<u>Laminectomy for cervical disc:</u>			
03156	one level	5239.00	6	2049.28
03157	multiple levels	5765.00	6	2254.72
03180	Multiple level laminectomy for cervical cord compression - three or more levels	4468.00	6	1463.12
	Anterior cervical discectomy and fusion:			
03163	– one level	3739.00	6	1462.23
03164	– multiple levels	5062.00	6	2166.60
03362	Cervical - single level	2915.00	6	639.68
03363	Cervical - two or more levels	3761.00	6	825.85

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Vertebral Body Resection			
03365	Cervical	7604.00	6	1670.80
	Instrumented Procedures			
	Stabilization - Anterior:			
03347	Cervical - stabilization alone (with Neurosurgeon)	2349.00	6	515.54
03348	Cervical - with plates and discectomy	4610.00	6	1812.93
03349	Cervical - with plates and vertebrectomy	8243.00	6	2066.41
	Stabilization - Posterior:			
03340	Cervical - simple, single or multiple level (includes Gallie fusion)	2520.00	6	553.74
03341	Cervical segmental (includes C1-2 transarticular screws)	5067.00	6	1112.28
	Posterior Osteotomy with Instrumentation:			
03354	Cervical	11397.00	6	2901.00
	Cervical			
03358	ORIF	4697.00	7	1031.13

THORACIC

	Decompression Procedures			
03166	Removal of thoracic disc	6143.00	8	2402.61
03185	Postero-lateral microsurgical thoracic discectomy	5008.00	8	1958.90
03174	Trans-thoracic or trans-abdominal removal of thoracic disc, team procedure, Neurosurgeon	4236.00	8	1267.84
03179	Chest Surgeon or General Surgeon	1609.00	8	481.13

THORACOLUMBAR

	Decompression Procedures			
	Laminectomy for lumbar disc:			
03158	one level	2096.00	5	802.24
03159	multiple levels	3487.00	5	1412.24
03161	Laminectomy for localized spinal stenosis - two levels or less	2434.00	5	906.31
03162	Laminectomy for generalized spinal stenosis - more than two levels	3791.00	5	1274.70

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Posterior lumbar interspinous/interlaminar stabilization/instrumentation (extra)			
03371	Single level (extra)	812.00		206.06
03372	Multiple level (extra)	1622.00		412.12
	NOTES: i) Paid only in addition to 03158, 03161 or 03162. ii) Restricted to Neurosurgery and Orthopaedic Surgeons.			
	Decompression - Anterior			
	Discectomy with or without fusion:			
03364	Thoracolumbar, includes decompression	6717.00	8	1475.06
	Vertebral body resection:			
03366	Thoracolumbar	8875.00	8	1947.67
	Instrumented Procedures			
	Anterior release/osteotomy:			
03352	Thoracolumbar	6717.00	8	1475.06
03353	Thoracolumbar - with anterior instrumentation and correction	7979.00	8	1751.95
03351	Thoracolumbar - instrumentation with anterior release or vertebrectomy	9504.00	8	2504.84
	NOTE: 03350 and 03351 are payable in full when done in conjunction with posterior instrumentation and fusion.			
	Posterior Instrumentation and Fusion			
03356	Adult	8243.00	7	2083.23
03357	Pediatric	6717.00	7	1728.95
	Thoracolumbar			
03359	ORIF with segmental fixation alone	6086.00	7	1336.64
03360	ORIF with segmental fixation and decompression	7347.00	7	1613.52
03342	Thoracolumbar - without instrumentation	2286.00	5	501.24
03343	Thoracolumbar - simple instrumentation (Harrington, wires or screw, etc.)	3606.00	7	792.44
03350	Thoracolumbar - approach and stabilization alone (with Neurosurgeon)	4431.00	8	973.84
03344	Thoracolumbar - segmental instrumentation and spinal fusion	5829.00	7	1432.75

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03345	Thoracolumbar - segmental instrumentation and fusion with decompression - single level	7347.00	7	2104.70
03346	Thoracolumbar - segmental instrumentation and fusion with decompression - multiple levels	8606.00	7	2465.86
C03355	Thoracolumbar Spinal Fusion – including posterior osteotomy via Smith-Peterson, pedicle subtraction or vertebral column resection with fusion of greater than four (4) vertebral segments NOTE: Restricted to Neurosurgery and Orthopaedic Surgeons.	11397.00	7	3606.03
03370	Thoracolumbar Spinal Fusion (lasting longer than 6 hours) – per 15 minutes or greater portion thereof (maximum of 16 units per patient) NOTES: i) Paid only in addition to 03355. ii) Surgical start time begins and ends with positioning. iii) Start and end times must be entered in both the billing claims and the patient's chart. iv) Restricted to Neurosurgery and Orthopaedic Surgeons.	206.00		51.93
	Posterior lumbar interbody fusion (PLIF) or transforaminal lumbar interbody fusion (TLIF) (extra):			
03373	Single level (extra)	1622.00		412.12
03374	Multiple level (extra) NOTES: i) Paid only in addition to 03345, 03346, 03355, 03356 or 03357. ii) Restricted to Neurosurgery and Orthopaedic Surgeons.	2433.00		618.18

FUNCTIONAL NEUROSURGERY/PAIN

03301	Laminotomy for insertion of spinal stimulator electrode for chronic pain (operation only)	1237.00	5	575.08
03302	Percutaneous fluoroscopically controlled insertion of spinal stimulator electrode for chronic pain (operation only) NOTES: Restricted to Neurosurgeons and certified specialists in Anesthesiology.	924.00	2	422.69

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03303	Implantation of pulse generator or receiver for chronic pain stimulation (operation only) ..... NOTES: Restricted to Neurosurgeons and certified specialists in Anesthesiology.	1583.00	3	720.94
03304	Implantation of spinal stimulator (complete system), to include implantation pulse generator/receiver, using percutaneous electrode (operation only)..... NOTES: Restricted to Neurosurgeons and certified specialists in Anesthesiology.	2227.00	3	1023.33
03305	Implantation of spinal stimulator (complete system), to include implantation of pulse/generator receiver - using laminotomy electrode (operation only).....	2489.00	5	1125.69
03306	Revision of spinal/cranial stimulator pulse generator....	1583.00	3	720.94
03307	Removal of spinal/brain stimulator system..... NOTE: Restricted to Neurosurgeons and certified specialists in Anesthesiology.	1048.00	3	460.52
03218	Replacement of spinal subarachnoid catheter access device with infusion pump for spinal subarachnoid infusion (operation only).....	1582.00	3	472.46
03219	Insertion of spinal subarachnoid device-reservoir in paraspinal region (operation only)..... NOTE: 03219 to include insertion of spinal subarachnoid catheter.	1339.00	3	400.39
03220	Insertion of spinal subarachnoid catheter access device-reservoir/pump in anterior chest wall or abdominal wall (operation only) ..... NOTE: 03220 to include insertion of spinal subarachnoid catheter.	2142.00	3	640.63
03152	Bischoff's or longitudinal myelotomy	3203.00	5	957.28
03176	Cordotomy, percutaneous.....	3367.00	4	1006.30
03177	Cordotomy	2707.00	5	809.07
03178	Operative microsurgical rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic..... NOTE: Restricted to Neurosurgery and Orthopaedic Surgery.	3188.00	5	953.53
03108	Operative facet rhizotomy utilizing fluoroscopy or CT in an operating room environment under general anesthetic ..... NOTE: Restricted to Neurosurgery and Orthopaedic Surgery.	2495.00	4	460.19
03150	Laminectomy for selective posterior rhizotomy	4296.00	5	1284.43
03153	Laminectomy, with DREZ lesion for pain	4821.00	6	1440.56

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03101	Supra or infra orbital nerve avulsion	775.00	3	231.04
03102	Decompression of Gasserian ganglion	4090.00	8	1222.85
03103	Pre-ganglionic rhizotomy, 5th nerve	3547.00	3	1061.44
S03104	Percutaneous rhizotomy, 5th nerve	3507.00	3	1250.75
03106	Posterior fossa exploration with rhizotomy, 5th nerve	5888.00	8	2065.71
03232	Microsurgical anastomosis of intracranial portion of cranial nerve in conjunction with other craniotomy - with graft (extra to craniotomy) NOTE: 03232 includes harvesting of graft.	2508.00		749.81
03233	Microsurgical anastomosis of intracranial portion of cranial nerve in conjunction with other craniotomy without graft (extra to craniotomy)	1537.00		459.34
03138	Unilateral stereotaxic intracranial procedures	4088.00	7	1222.75
03139	Implantation of stimulator	2575.00	3	1200.35
03140	Insertion of intracranial stimulating electrodes	6406.00	7	2809.35
03250	Microelectrode recording (MER) - electrophysiological (EP) mapping of the basal ganglia and thalamus, intra-operatively (extra)	10691.00		3197.98
	Single Channel Neural Stimulator Implant Testing			
03274	Professional fee	129.00		47.13
03275	Technical fee	63.10		23.56
	Dual Channel Neural Stimulator Implant Testing			
03276	Professional fee	192.00		70.67
03277	Technical fee	129.00		47.13
	NOTES: i) Restricted to Neurosurgeons and Neurologists. ii) 03274, 03275, 03276 and 03277 is included on the same day and for six weeks post-operative of fee item 03140 whether performed by the same or different physician and at any location.			

PERIPHERAL NERVE/MICROSURGERY

S03196	Exploration, mobilization and transposition	962.00	2	287.85
03198	Neurectomy of major nerve	757.00	2	227.46
03200	Secondary suture including transposition	1967.00	3	588.25
03201	Secondary suture of major nerve	1501.00	3	447.63
03204	Hypoglossal facial anastomosis	2333.00	4	697.20
03205	Nerve graft	1472.00	3	441.58

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03207	Microsurgical removal of neoplasm - major peripheral nerve	2790.00	3	833.63
	Brachial Plexus Surgery:			
03045	Brachial plexus exploration for neurolysis, primary repair or tumour removal	3922.00	3	1533.94
03046	Post traumatic delayed or repeat exploration in brachial plexus surgery (extra)	1438.00	3	562.45
03047	Intraoperative diagnostic monitoring in brachial plexus surgery (extra)	731.00		218.25
03048	Nerve graft done in addition to brachial plexus exploration - extra per graft NOTE: Includes harvesting of graft.	666.00		198.41
03049	Neurotization in brachial plexus surgery (extra)	1547.00		462.95
	Microneural Surgery:			
	Neurolysis:			
06210	– external	1383.00	2	347.38
06211	– intraneural	2106.00	2	448.87
	Microfascicular neurorrhaphy, primary:			
06212	– digital or palmar	1383.00	2	408.74
06213	– major nerve	2949.00	2	628.85
	Interfascicular nerve graft (to include harvest of graft):			
06214	– digital or palmar	2283.00	2	545.66
06215	– major nerve	6844.00	4	1636.20

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:

<u>Cranial:</u>

- Re-operation for residual or recurrent brain tumour.

(notes continued on next page)

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

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 myelomeningocoele, or lipomyelomeningocoele.

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.

OBSTETRICS AND GYNECOLOGY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
04010	**Consultation:** To include complete history and gynecological examination, review of x-ray and laboratory findings, if required, and a written report or consultation during labour	585.00		171.95
04012	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where, in the judgement of the consultant the consultative services do not warrant a full consultative fee	321.00		90.04
	Continuing Care by Consultant:			
04007	Subsequent office visit (for gynecology visits only, all pregnant patients and routine pre-natal patients billed under fee item 04191)	201.00		58.68
04008	Subsequent hospital visit	201.00		60.74
04009	Subsequent home visit	482.00		123.11
04005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) NOTE: Claim must state time service rendered.	531.00		159.30
Telehealth Service with Direct Interactive Video Link with the Patient				
04070	Telehealth Consultation: To include complete history and gynecological examination, review of X-ray and laboratory findings, if required, and a written report or consultation during labour	585.00		171.95
04072	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	321.00		90.04
04077	Telehealth subsequent office visit (for gynecology visits only.)	201.00		58.68
04078	Telehealth subsequent hospital visit	201.00		60.74

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

MINOR PROCEDURES

P04681 Vaginal Speculum Examination Procedure (extra) 30.30 10.10

NOTES:

i) Restricted to Obstetrics and Gynecology.

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

iii) Payable only when:

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

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

T04682 Initial Pessary Fitting 379.00 101.00

NOTES:

i) Restricted to Obstetrics and Gynecology specialists and Urologists.

ii) Not payable with a visit.

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

iv) Not payable with 04683.

T04683 Pessary Maintenance 227.00 75.75

NOTES:

i) Restricted to Obstetrics and Gynecology specialists and Urologists.

ii) Not payable with a consult or visit.

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

iv) Not payable with 04682.

OBSTETRICAL PROCEDURES

04038 Repeat intrapartum assessment by consultant at request of primary care physician..... 924.00 286.48

(see notes on next page)

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

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..... 2774.00 707.55

NOTES:
i) Requires completion of written record
ii) Payable only after at least one hour of attendance at bedside
iii) Start and end times must be entered in both the billing claims and the patient's chart.
iv) Not payable with 04038, 04050, 04414, or 14199.
v) Payable x 1 only, regardless of multiple gestation
vi) Payable only for the following conditions:
Fetal conditions:
(a) Abnormal FH tracing requiring scalp pH monitoring, (or attendance at bedside by obstetrician for no less than 60 minutes)
(b) Prematurity <37 completed weeks gestation
(c) Severe IUGR (< 2500 g)
(d) Face or breech presentation
(e) Multiple gestation
(f) Congenital anomaly where neonatal morbidity/mortality is an issue and may be affected by labour/delivery process (e.g.: open neural tube defect, body wall defect such as omphalocele, or gastroschisis, congenital; fetal arrhythmia, hydrocephalus)
(g) Hydrops fetalis
(h) Iso-immunization
Placental or amniotic fluid conditions:
(a) Placental abruption
(b) Severe oligohydramnios (AFI<6)
(c) Severe polyhydramnios (AFI>25)

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Maternal Conditions: (a) Cardiovascular disease where the management of labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction, severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrythmia 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			
G04718	Care of complex antepartum patient prior to transfer to higher level of care facility for delivery.....	1166.00		358.10
	NOTES: Restricted to Obstetrics and Gynecology specialists. i) Not paid with 04038, 04039, 04025, 04050, 04052, 04414, 14105. ii) Start and end times required in claim submission and patient's chart. iii) Paid only when time spent stabilizing patient by obstetrician exceeds 60 minutes, and patient is transferred to a higher level of care. iv) Payable on the same date as a Family Physician is paid for 14105 v) Payable for pre-eclampsia, preterm labour, and for serious maternal condition(s) that requires stabilization prior to transfer.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
T04721	Management of stillbirth fee > 20 weeks gestation or ≥ 500g (extra)	620.00		169.93
	NOTES: i) Includes all initial supportive care performed by the physician responsible for the delivery of the stillbirth, such as counselling of the patient, completing the necessary paperwork, liaising with social workers, arranging for serology and other bloodwork to identify the cause of the stillbirth, discussing the value of an autopsy with parents, arranging for pathology examination, and assisting with mortuary arrangements. ii) Payable only in addition to fee items 04025, 04050, 04052, 04414, or 14104. iii) Not payable with any in office or out of office individual counselling fee to same physician on same date of service.			
04014	Complicated delivery - midcavity surgical delivery (operation only).....	1875.00	4	648.58
04017	Midcavity rotation from OP or OT to OA, surgical delivery (operation only)	2292.00	4	798.29
04018	Breech vaginal birth (operation only).....	2436.00	4	798.05
	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%.			
04000	Complicated vaginal delivery - includes shoulder dystocia, premature delivery less than 37 weeks or less than 2500 grams (operation only).....	1563.00	4	562.73
	NOTES: i) Complicated delivery fees will be paid at 50% when 14104 or 04414 is payable to the same physician. ii) Only one of fee items 04014, 04017, 04018 or 04000 is payable at any one time (for single births).			
04022	Repair of complete separation of external sphincter (operation only).....	1001.00	3	317.78
	NOTE: Not paid in addition to 04024.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
04023	Repair of extensive cervical and/or vaginal lacerations (operation only)..... NOTE: Not paid in addition to 04022 and 04024.	1001.00	3	317.78
04024	Repair of 4th degree laceration (operation only).....	1209.00	3	397.17
04026	Manual removal of retained placenta (operation only)...	1001.00	3	275.09
04190	Prenatal visit – complete examination	341.00		148.71
04191	Prenatal visit – subsequent examination	128.00		56.69

NOTES:

i) Restricted to Obstetrics and Gynecology specialists.

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

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

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

v) Other than procedures, services for the care of unrelated conditions during a prenatal or postnatal visit are included in the prenatal (04191) or postnatal visit fee (04194), and are not to be billed under fee item 04007. Procedures rendered for unrelated conditions are chargeable as set out in Preamble D. 8. d.

G04717	Prenatal office visit for complex obstetrical patient.....	195.00		68.52

(see notes on next page)

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

NOTES:

i) Paid only for the following diagnoses:

(a) Fetal Conditions:

- Congenital anomaly where neonatal morbidity/mortality is an issue and may be affected by labour/delivery process (e.g.: open neural tube defect, body wall defect such as omphalocele, or gastroschisis, congenital; fetal arrhythmia, hydrocephalus).
- Hydrops fetalis
- Iso-immunization

(b) Maternal conditions:

- Cardiovascular disease where the management of labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction, severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrhythmia requiring pharmacological treatment, any lesion with pulmonary hypertension or ventricular dilatation).
- Renal disease (e.g.: renal failure, renal transplant)
- Pulmonary disease (e.g.: pulmonary fibrosis, severe asthma, cystic fibrosis)
- Endocrine disease (e.g.: Addison's disease, clinical hyperthyroidism, Type 1 Diabetes Mellitus)
- Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia)
- Infectious disease (HIV, severe pneumonia, systemic sepsis)

(c) Pregnancy qualifying conditions: hypertension on medication, IUGR with growth less than 10%, oligohydramnios AFI less than 8, hydramnios AF1 greater than 23, Type 1 Diabetes Mellitus.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	(d) Current pregnancy conditions: preterm labour, cervical incompetence, or abruption occurring in this pregnancy; (the high risk antenatal visit fee reverts to 04191 after 36 weeks gestation). (e) Previous pregnancy conditions: 2 preterm births, or 1 previous preterm birth less than 30 weeks (reverts to 04191 after 36 weeks gestation). ii) Restricted to Obstetrics and Gynecology specialists.			
04194	Postnatal office visit..... NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) 04194 may be billed in the six weeks following delivery (vaginal delivery or caesarean section). iii) Not payable to the physician performing the caesarean section.	128.00		56.69
14199	Management of prolonged second stage of labour, per 30 minutes or major portions thereof..... 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.	266.00		98.72
04106	Caesarean hysterectomy.....	3089.00	8	1666.92
04418	Postnatal care after caesarean section (1-14 days in-hospital)..... NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Postnatal office visits are payable under fee item 04194. ii) Not payable in addition to 04419.	500.00		139.85

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
04419	Primary management of labour, attendance at delivery, and postnatal care associated with emergency caesarean section (1-14 days in-hospital).. NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Postnatal office visits are payable under fee item 04194. iii) Not payable in addition to 04418.	2024.00		566.16
04085	Trial of Forceps/Vacuum Delivery..... NOTES: i) Payable for a forceps/vacuum assisted vaginal delivery that was unsuccessful. ii) Applicable only to mid-pelvis procedures. iii) Payable only if followed by an immediate caesarean section. iv) Not payable with complicated delivery fees 04000, 04017 or 04018 (for single births). v) Maximum of one payable per pregnancy.	882.00	4	224.78
04116	Curettage for post-partum hemorrhage (>20 weeks)....	833.00	3	306.94
04092	Multiple live or stillbirths, each additional child - vaginal birth	672.00		211.87
04093	Multiple live or stillbirths, each additional child - Caesarean section..... NOTE: Fee item 04093 is to be billed in full in addition to fee items 04025, 04050, 04052 or 04106.	344.00		87.11
04107	Supervision of labour and vaginal delivery in a case of previous Caesarean section - operation only..... NOTE: Fee item 04107 is a standby fee only and is not payable in addition to delivery fees (14104, 04414, 04000, 04014, 04017, 04018, 04050, 04052, 04025) when done by the same physician.	833.00		212.39
04049	External cephalic version..... NOTE: Administration of IV tocolytic agent and fetal heart monitoring included.	529.00		221.20
04414	Delivery and post-natal care (1-14 days in-hospital).....	2429.00		679.70

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Additional post-partum office visit(s) are payable under fee item 04194.			
	Caesarean section:			
04050	– elective	2083.00	5	542.27
04052	– emergency	2334.00	6	653.43
04025	– high risk, fetus less than 1500 grams	2708.00	6	690.73
	Therapeutic abortion (surgical or medical):			
04111	– less than 14 weeks gestation (operation only)	624.00	2	255.38
04110	– 14 -18 weeks, including non-viable pregnancy or pregnancy with congenital malformations requiring termination. Ultrasound confirmed gestational age (operation only)	1040.00	2	292.76
G04716	Obstetrical surcharge therapeutic abortion (D&E) at 14 to 18 weeks (extra) NOTE: Paid only with 04110.	255.00		65.21
04114	Therapeutic abortion by D & E or medical means above 18 weeks gestation, including non-viable pregnancy or pregnancy with congenital abnormality requiring termination. Ultrasound confirmed gestation age (operation only)	1250.00	3	413.92
G04715	Obstetrical surcharge therapeutic abortion (D&E) at 18 weeks and over (extra) NOTES: i) Paid only with 04114. ii) Restricted to Obstetrics and Gynecology specialists.	341.00		86.92
S04080	Insertion of Multiple Osmotic Dilators with Paracervical Block, prior to second trimester pregnancy termination NOTES: i) Paid for gestations over 14 weeks. ii) Not paid with 04111 or 01022.	588.00		161.74

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Paid when performed within 48 hours prior to 04110 or 04114.			
	iv) Maximum of two per patient, within 48 hours prior to 04110 and 04114.			
	v) When performed within 24 hours prior to 04114, transabdominal amniocentesis (00787) is paid at 100%.			
	vi) Amniocentesis (00787) is not paid with 04110.			
04118	Induction or stimulation of labour by oxytocin intravenous drip, where attendance by the physician is readily available - first hour	174.00		44.52
04119	– subsequent hours	119.00		30.68
	NOTES:			
	i) Physician must be readily available – response time by telephone is immediate and response time on the unit is within minutes.			
	ii) Maximum charge for above service to be 10 hours per pregnancy.			
	iii) Start and end times must be entered in both the billing claims and the patient's chart.			

SURGICAL FEE MODIFIERS

G04708	Prolonged laparoscopic surgery, per 15 minutes or major portion thereof (extra)	298.00		102.31
	NOTES:			
	i) Restricted to Obstetrics and Gynecology.			
	ii) Payable for significant uterine enlargement due to fibroids, significant adnexal enlargement, presence of significant endometriosis, or significant adhesions.			
	iii) Fee item 00815 is considered included in 04708.			
	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.			
G04714	Prolonged surgery – Open procedure per 15 minutes or major portion thereof (extra)	298.00		102.31

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Payable for significant uterine enlargement due to fibroids, significant adnexal enlargement, presence of significant endometriosis, or significant adhesions. iii) Paid as an extra to an open surgical procedure, when surgical time exceeds 2 hours. iv) Not payable if multiple surgical procedures are billed (except for 04001 for when a laparoscopic procedure is converted to open). v) When an open case results from conversion of a laparoscopic procedure, G04714 is paid after 2 hours total surgical time. vi) Start and end times (for total time of surgery) must be entered on the claim and patient's chart.			
G04719	Gynecology surgical surcharge for patients 75 years and older	266.00		102.31
	NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Fee item 04719 will only be paid once whether single or multiple procedures are performed under the same anesthetic. iii) Paid with the following surgical procedures: 04701, 04702, 04703, 04704, 04705, 04706, 04707, 04709, 00704, 00705, 00770, 00807, 00808, 00878, 04001, 04003, 04011, 04029, 04032, 04033, 04041, 04042, 04048, 04202, 04203, 04212, 04217, 04218, 04219, 04220, 04223, 04227, 04228, 04229, 04232, 04233, 04250, 04301, 04303, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 04330, 04331, 04401, 04402, 04405, 04406, 04408, 04410, 04411, 04421, 04422, 04424, 04427, 04429, 04500, 04508, 04510, 04512, 04530, 04531, 04551, 04605, 04621, 04622, 04623, 04624, 04628, 04662, 04722, 04723, 04728, 04729, 07027, 07597, 07634, 08178, 08205, 08232, 08250, 08255, 08257, 08263, 08278, 08282, 08283 or 70120. iv) Applies to procedures performed in hospital operating room, ambulatory care or office setting.			

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

04720 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery or procedure performed for patients with a BMI of 35 or greater .....

NOTES:

i) Payable only to Obstetricians and Gynecologists.

ii) Patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.

iii) Maximum of one surcharge per operation unless two obstetricians or gynecologists perform two synchronous surgeries that are both eligible for the surcharge.

iv) When multiple procedures are performed during the same operation, the surcharge applies to all eligible procedures based on the prorated value according to the applicable preamble(s).

v) The surcharge does not apply to surgical fee modifiers 04715, 04716 or 04719, but may be paid in addition.

vi) Not payable if 04708 or 04714 is billed with the surgery or procedure.

vii) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the BMI surcharge.

viii) The surcharge is excluded from the calculation of total operative fee(s) for which surgical assist fees are based.

ix) Payable when the following Obstetrics and Gynecology fee items are performed for patients with a BMI of 35 or greater: 00770, 00775, 00776, 00787, 00794, 00807, 00808, 00815, 00819, 04000, 04001, 04003, 04011, 04014, 04017, 04018, 04022, 04023, 04024, 04025, 04026, 04029, 04032, 04033, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04049, 04050, 04052, 04080, 04085, 04106, 04110, 04111, 04114, 04116, 04141, 04142, 04201, 04202, 04203, 04204, 04206, 04208, 04212, 04216, 04217,

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	04218, 04219, 04220, 04221, 04222, 04223, 04224, 04225, 04227, 04228, 04229, 04232, 04233, 04250, 04300, 04301, 04303, 04304, 04305, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 04330, 04331, 04401, 04405, 04406, 04408, 04410, 04411, 04421, 04422, 04424, 04427, 04429, 04500, 04502, 04503, 04508, 04510, 04512, 04515, 04516, 04517, 04530, 04531, 04536, 04551, 04602, 04605, 04616, 04617, 04620, 04621, 04622, 04623, 04624, 04628, 04630, 04631, 04632, 04633, 04640, 04641, 04662, 04664, 04680, 04701, 04702, 04703, 04704, 04705, 04706, 04707, 04709, 04722, 04723, 04728, 04729.			

ABDOMINAL OPERATIONS

04228	Hysterectomy - total NOTE: Includes salpingectomy/oophorectomy (04003), ovarian cystectomy (04201) and abdominal enterocele repair.	3065.00	5	1110.85
04229	Removal of complicated pelvic disease	2725.00	6	1110.85
04204	Abdominal hysterotomy, with or without sterilization	1493.00	5	530.44
04203	Myomectomy	2083.00	5	741.12
04208	Ectopic pregnancy removal by salpingotomy or salpingectomy (open procedure)	2083.00	5	531.25
04206	Suspension of uterus	1000.00	4	254.73
04216	Presacral neurectomy	1739.00	5	443.40
04217	Post-operative hemorrhage - intra-abdominal management	1493.00	6	526.63
04003	Oophorectomy and/or salpingectomy (unilateral or bilateral), including for sterilization	1493.00	5	380.49
04201	Ovarian cystectomy (to include ovary repair)	1863.00	5	474.83
04605	Abdominal sacrocolpopexy - open (includes oophorectomy when applicable)	2725.00	5	1040.20
TC04722	Laparoscopic excision of rectovaginal endometriosis	3970.00	6	1110.85

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Obstetrics and Gynecology specialists for management of advanced endometriosis. ii) For histologically confirmed rectovaginal endometriosis only. iii) Inclusive of unilateral and/or bilateral ureterolysis, enterolysis, adhesiolysis, cystoscopy/cystectomy, ureteral stenting, para-rectal spaces, restoration of recto-vaginal anatomy. iv) In cases where conversion to open surgery is necessary, pay as open procedure 04229 plus 04001 at 50%. v) 04708 will apply after 2 hours. vi) Not payable with laparoscopic fees 04001, 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04723, 72658, 72659. vii) Not payable with hysterectomy fees 04709, 04228, 04729, 04202. viii) Not payable with 08159, 00704, 00815, 08155, 04003, 04201, 04216, 04208, 08201, 00724.			
TC04723	Laparoscopic excision of rectovaginal endometriosis with laparoscopic hysterectomy	6951.00	6	1512.84
	NOTES: i) Restricted to Obstetrics and Gynecology specialists for management of advanced endometriosis. ii) For histologically confirmed rectovaginal endometriosis only. iii) Inclusive of unilateral and/or bilateral ureterolysis, enterolysis, adhesiolysis, cystoscopy/cystectomy, ureteral stenting, para-rectal spaces, restoration of recto-vaginal anatomy. iv) In cases where conversion to open surgery is necessary, pay as open procedure 04229 plus 04001 at 50%. v) 04708 will apply after 2 hours. vi) Not payable with laparoscopic fees 04001, 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04723, 72658, 72659. vii) Not payable with hysterectomy fees 04709, 04228, 04729, 04202. viii) Not payable with 08159, 00704, 00815, 08155, 04003, 04201, 04216, 04208, 08201, 00724.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
ABDOMINAL OPERATIONS FOR CANCER				
04011	Debulking operation for cancer of ovary or fallopian tubes	4209.00	6	1330.08
	NOTES: ix) Excluding stage one disease. x) Includes omentectomy and hysterectomy if done.			
04218	Radical abdominal hysterectomy for carcinoma, including partial vaginectomy	4583.00	6	1464.66
04212	Pelvic lymphadenectomy	2479.00	6	631.99
	Para-aortic lymphadenectomy:			
04219	– total	2479.00	6	767.36
04220	– partial	1099.00	5	332.52
04029	Omentectomy	1493.00	5	460.42
	NOTES: i) Not to be billed in addition to 0401. ii) Only payable for: a) High-risk endometrial cancer (grade ≥ 2, and/or p-53 abnormal, and/or MMR-deficient [MSH2/6, MLH1, PMS2], or stage 1 ovarian cancers, or b) Elevated CA125 or ER negative or enlarged nodes on imaging. iii) Exceptional circumstances will be given independent consideration upon receipt of an explanatory note record.			
04628	Removal of extra pelvic soft tissue mass, greater than 10 cm	1986.00	5	665.05
P04630	Sentinel lymph node biopsy vulva (SLN-V) – unilateral	1972.00	3	613.89
P04631	Sentinel lymph node biopsy vulva (SLN-V) – bilateral	2958.00	3	920.82
	NOTES: i) Payable only for the staging of vulvar malignancies and malignant melanoma. ii) SLN component of the combined procedure not payable to surgeons during the training phase.			
C04640	Laparoscopic Sentinel lymph node biopsy (SLN-L) – unilateral	1972.00	3	613.57
C04641	Laparoscopic Sentinel lymph node biopsy (SLN-L) – bilateral	2958.00	3	920.45

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Payable only for the staging of malignant cervical cancer and endometrial cancer. ii) 04640 paid at 50% with 04212 if ICG dye fails to localize a lymph node. 04641 is not payable with 04212. iii) SLN component of the combined procedure not payable to surgeons during the training phase.			
04728	Laparoscopic assisted radical vaginal trachelectomy (LARVT) and sentinel node procedure	5376.00	6	1718.88
	(see notes on next page)			
	NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Includes laparoscopy and sentinel node procedures required for patient screening and selection. iii) Includes pelvic lymphadenectomy. iv) Not payable with 04708 and 04714.			
C04729	Laparoscopic assisted radical hysterectomy (LARH) (includes oophorectomy and/or salpingectomy).....	6383.00	7	2041.17
	NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Includes sentinel lymph node biopsy. iii) Includes pelvic lymphadenectomy. iv) Not payable with 04708 and 04714.			
04141	Insertion of intra-peritoneal catheter for chemotherapy under general anesthetic	1331.00	4	474.07
	NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Includes fee item 04001.			
04142	Removal of intra-peritoneal catheter for chemotherapy	583.00	3	205.48
	NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) For removal of catheter not requiring surgical dissection, use visit fees.			

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

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	819.00	2	255.79

NOTE: Intended for procedures performed under direct vision, but less than 1/2 of uterine cavity involved with IUA.

04222	– complicated	1366.00	2	434.83

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.

04223	Resection of myoma - includes diagnostic hysteroscopy	1893.00	2	482.76

NOTES:

i) Payable only when done under direct vision.

ii) Not payable with a surgical assist except in exceptional circumstances (for example, needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). The medical necessity for the surgical assist must be provided in the note record.

04224	Endometrial ablation - includes diagnostic hysteroscopy	1893.00	2	482.76

NOTE: Not payable with a surgical assist except in exceptional circumstances (for example, needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). The medical necessity for the surgical assist must be provided in the note record.

04225	Hysteroscopic division of uterine septum	1366.00	2	434.83
04226	Hysteroscopic tubal occlusion (bilateral)	813.00		207.14
T04250	Hysteroscopic removal of endometrial polyp(s), retained placental or other intrauterine tissue(s), and/or fragmented intrauterine device	1184.00	2	325.00

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTE: i) Restricted to Obstetrics and Gynecology specialists. ii) Not payable with a surgical assist except in exceptional circumstances (for example, needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). The medical necessity for the surgical assist must be provided in the note record.			

LAPAROSCOPIC OPERATIONS

04001	Laparoscopy (operation only) ..... NOTE: Not paid with 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048.	875.00	4	306.88
C04707	Laparoscopic sacrocolpopexy, includes oophorectomy and/or salpingectomy..... NOTES: i) Fee items 00704, 00705, 00815, 04001, 04003, 04041, 04042, 04408, 04605, 04232, 04233 or G04706 not paid in addition. ii) Fee items 04040 and 04047 payable in addition but the maximum payable under these items shall not exceed the value of fee item 04229. iii) Other items listed under laparoscopic operations are not payable in addition to this item. iv) In cases where conversion to open surgery is necessary, 04001 paid at 50%, plus the open procedure. v) 04708 will apply after 2 hours. vi) Restricted to Obstetrics and Gynecology specialists.	4079.00	5	1040.20
C04709	Laparoscopic total or supracervical hysterectomy, and/or laparoscopic assisted vaginal hysterectomy (LAVH) (includes oophorectomy and/or salpingectomy)	4079.00	5	1110.85

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

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, 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) 04708 will apply after 2 hours.
vi) Restricted to Obstetrics and Gynecology specialists.

P04662	Laparoscopic removal of intraperitoneal foreign body (operation only)	1509.00	4	422.37
P04664	Laparoscopic management of ectopic pregnancy	2155.00	4	603.15
P04034	Laparoscopic salpingolysis - unilateral (operation only)	1393.00	4	389.75
P04035	Laparoscopic salpingolysis - bilateral (operation only)	1807.00	4	505.77
P04036	Laparoscopic salpingostomy - unilateral (operation only)	1799.00	4	503.40
P04037	Laparoscopic salpingostomy - bilateral	1246.00	4	699.78
P04040	Laparoscopic cautery of endometriosis (operation only)	1279.00	4	357.94
P04041	Laparoscopic oophorectomy and/or salpingectomy, including for sterilization - unilateral (operation only)	1614.00	5	451.53
P04042	Laparoscopic oophorectomy and/or salpingectomy, including for sterilization - bilateral	2227.00	5	623.26
P04043	Laparoscopic ovarian cystectomy - unilateral	1982.00	5	554.61
P04044	Laparoscopic ovarian cystectomy - bilateral	2841.00	5	795.12
P04045	Laparoscopic ventral suspension of uterus (operation only)	1503.00	4	420.60
P04047	Laparoscopic excision of extensive peritoneal endometriosis including pelvic sidewall dissection and unilateral ureterolysis	2437.00	6	682.07
P04048	Laparoscopic removal of complicated pelvic disease	2976.00	6	832.76

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

MICRO-SURGICAL OPERATIONS

04602	Salpingolysis and removal of adhesions - loupes or microscope (unilateral or bilateral)	1863.00	5	474.83
	Micro salpingostomy:			
04616	unilateral	2564.00	5	654.02
04617	bilateral	3331.00	5	849.26
	Tubo-cornual anastomosis:			
04626	unilateral (micro-surgical)	3711.00	5	946.38
04627	bilateral (micro-surgical)	4821.00	5	1229.31

NOTES:

i) Tuboplasty listings are not payable following a previous surgical sterilization and should not be billed to the Plan when a previous sterilization has been performed.

ii) Operative report may be required.

OPERATIONS ON THE VULVA

NOTE: Surgical assists are not billable in conjunction with fee items 04300, 04301, 04305, 04306, 04312, 04317, or 04330 except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). In such cases, the medical necessity for the surgical assist must be provided in the note record.

04300	Incision of hymen (operation only)	624.00	2	255.79
04301	Marsupialization of a Bartholin's cyst – under general anesthesia or procedural sedation (operation only) NOTE: When performed under local anesthesia, operative/procedural report must be submitted.	1050.00	2	300.00
P04330	I&D of Bartholin's cyst with insertion of Word catheter (operation only) NOTE: 07027 to be charged if Bartholin's Cyst/Abscess is treated by Incision and Drainage (I&D) without insertion of a Word catheter.	799.00	2	275.00
P04331	Removal of Bartholin's Gland – under general anesthesia or procedural sedation (operation only)	1166.00	2	400.00

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
04303	Excision of hydrocele or canal of Nuck	751.00	2	315.17
04304	Urethral caruncle - cautery or excision in hospital - operation only	259.00	2	66.09
04305	Venereal warts - cautery or excision (operation only)	160.00		53.64
04306	Excision of venereal warts under general or local anesthesia in hospital - operation only NOTE: Must be performed in an Operating Room (location code G, I, or P).	624.00	2	255.79
04309	Labium Varicocele - operation only	556.00	2	210.04
04311	Operation of atresia of vulva or enlargement of vaginal introitus for stenosis - operation only	624.00	2	255.79
04312	Labia minora resection - operation only	624.00	2	266.86
04316	Vulvovaginoplasty NOTE: This item is payable for genetic females only.	1000.00	2	269.69
	Biopsy of vulva:			
04317	– excisional lesion less than 2 cm	125.00	2	54.79
04032	– excisional lesion greater than or equal to 2 cm.	382.00	2	126.54
	Vulvectomy:			
04307	– simple	1615.00	3	411.95
04318	– radical	3751.00	3	956.33
	Inguinal and femoral lymphadenectomy:			
04320	– unilateral	1667.00	4	425.02
04322	– bilateral	2916.00	4	743.73
04632	Vulvar wide local excision 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.	1176.00	3	460.42
04633	Radical partial/hemi Vulvectomy (RPV)	1384.00	3	511.57

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

OPERATIONS (VAGINA)

04202	Hysterectomy - vaginal	3065.00	4	1110.85
04232	Oophorectomy/ovarian cystectomy and/or salpingectomy (vaginal route), extra to vaginal hysterectomy – unilateral	371.00	5	119.72
04233	Oophorectomy/ovarian cystectomy and/or salpingectomy (vaginal route), extra to vaginal hysterectomy - bilateral	730.00	5	235.42
04033	Vaginectomy for VAIN (partial)	1493.00	4	483.14
04411	Vaginectomy - total	2231.00	4	646.00
04401	Fistula recto-vaginal repair	2480.00	3	700.31
04402	Colpotomy with drainage pelvic abscess - operation only	629.00	2	255.79
04405	Removal of a vaginal cyst situated above the introitus - operation only	653.00	2	255.79
04406	Septum vaginal removal - operation only	624.00	2	255.79
04408	Vault prolapse following hysterectomy	2231.00	4	569.12
04410	Post-operative hemorrhage, vaginal management (operation only) NOTE: Must be performed in an Operating Room (location code G, I or P).	653.00	5	255.79

PLASTIC OPERATIONS FOR GENITAL PROLAPSE AND INCONTINENCE

04227	Cystocele and/or urethrocele repair	1575.00	2	431.33
04421	Rectocele repair	1575.00	2	431.33
04422	Enterocele repair 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.	1919.00	2	489.46
04424	Complete repair of prolapse (Manchester or Fothergill types)	2458.00	3	626.54
04427	Le Fort's operation	1374.00	2	482.25
04429	Repair of old 3rd degree perineal laceration	1641.00	2	484.25

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
04432	Repeat vaginal plastic procedure (extra)	554.00	2	161.47
04701	Repeat urinary incontinence procedure for cases of a previously failed retropubic or vaginal procedure NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Fee items 00704, 00705, 08202, 08282, or 08283 not paid in addition.	1749.00	4	445.70
G04702	Transection or removal of suburethral mesh sling NOTES: i) Restricted to Obstetrics and Gynecology specialists. ii) Fee items 00704, 00705 or 08232 not paid in addition.	1734.00	4	525.41
G04703	Augmented anterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to Arcus Tendinous NOTES: i) Fee items 00704, 00705 or 04227 not paid in addition. ii) Restricted to Obstetrics and Gynecology specialists.	1730.00	2	441.19
G04704	Augmented posterior compartment vaginal prolapse with insertion of synthetic mesh or biologic graft with attachment to sacrospinous ligament NOTES: i) Fee items 04421 or 04422 not paid in addition. ii) Restricted to Obstetrics and Gynecology specialists.	1730.00	2	441.19
G04705	Removal of trans-vaginal placed synthetic mesh where indicated, form anterior or posterior compartment, due to pain or complications 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.	2077.00	2	644.84
G04706	Vaginal vault suspension – Apical support procedure	1687.00	2	568.67

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

NOTES:
i) Paid for sacrospinous, pre-spinous, iliococcygeal suspension or high, uterosacral ligament plication performed for vault suspension (synthetic or biologic).
ii) Paid for Stage 3 and Stage 4 prolapse with or without hysterectomy.
iii) Fee items 00704, 00705, 04408, 04424, 04605 not paid in addition.
iv) 04227, 04421, 04422, G04703, G04704, paid in addition, as per Preamble D. 5. 3.).
v) Restricted to Obstetrics and Gynecology specialists.

VAGINAL OPERATIONS ON THE CERVIX AND UTERUS

NOTE: Surgical assists are not billable in conjunction with fee items 04503, 04508, 04509, 04510, 04515, 04530, 04533, 04536, or 04545 except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). In such cases, the medical necessity for the surgical assist must be provided in the note record.

S04500	Cervix dilation and curettage (pelvic examination not billable in addition when done as an isolated procedure) - operation only	624.00	2	255.79
04502	Cervix - repair of - operation only	624.00	2	255.79
	Cervical incompetence:			
04517	– elective repair	1000.00	2	306.94
04516	– emergency repair	1246.00	2	460.42
04515	Removal of buried cervical ligature under anesthesia - operation only	624.00	2	255.79
04509	Cervical polypectomy - operation only	88.40	2	32.13
04508	Biopsy cervix, under general anesthetic	624.00	2	255.79
04510	Biopsy of cervix with dilation and curettage (operation only)	624.00	2	255.79
04536	Cone biopsy of cervix with endocervical curettage (dilation and curettage included in the fee)	1099.00	2	279.88

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Cauterization cervix:			
04533	– electric, in office - operation only	160.00		51.17
04530	– under general anesthesia - operation only	624.00	2	255.79
S04531	– with dilation and curettage, if done - operation only	624.00	2	255.79
04503	Cryosurgery of cervix - operation only	308.00	2	153.48
04551	Cervical stump removal	1099.00	3	409.26
04512	Myomectomy, vaginal - operation only	629.00	4	255.79
04545	Artificial insemination (operation only)	137.00		34.68
14540	Insertion intrauterine contraceptive device (operation only) Note: Includes Pap smear if required.	153.00	2	55.77
S00770	Pelvic examination under anesthesia – when done as an independent procedure - procedural fee	624.00	2	255.79

LASER VAPORIZATION

NOTE: Surgical assists are not billable in conjunction with fee items listed under Laser Vaporization except in exceptional circumstances (e.g., needing concurrent bedside ultrasound assistance or patient's BMI is >40, etc.). In such cases, the medical necessity for the surgical assist must be provided in the note record.

04620	Cervical neoplasia - operation only	645.00	2	255.79
04621	Vaginal neoplasia, with or without GA - operation only	645.00	2	255.79
04622	Vulvar condylomata - operation only	645.00	2	255.79
04623	Extensive vulvar or vaginal condylomata, under general anesthesia	959.00	2	306.94
04624	Vulvar intraepithelial diffuse, multifocal and/or perianal lesions	1594.00	2	431.46

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

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, procedures within the same body cavity or procedures on the same limb.

Total Operative Fee(s) for Procedure(s):

00195	Less than $317.00 inclusive	680.00		147.95
00196	$317.01 - $529.00 inclusive	964.00		209.92
00197	Over $529.00	1421.00		309.31
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	157.00		34.10

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.

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

Certified Surgical Assistant:

		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	1265.00		282.60
	NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020	Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof	148.00		32.96
	(see notes on next page)			
	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.			
04795	Certified Gynecologic Surgeon Assist (extra). Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	57.00		18.12
	NOTES:			
	i) Restricted to Gynecologists.			
	ii) Paid only in addition to fee item 70020.			
	iii) Maximum payable is 8 units per surgery.			
	iv) Any additional assistants, if required, are paid under fee items 00197, 00198, and 13197 only.			
	v) Start and end times must be entered in both the billing claims and the patient's chart.			

TESTS PERFORMED IN A PHYSICIAN'S OFFICE

15136	Fungus, direct microscopic examination, KOH preparation	32.60		8.57
04699	Fern Test	39.55		16.03
15137	Hemoglobin - cyanmethemoglobin method and/or hematocrit	9.95		3.19
	NOTE: See the Laboratory Services Payment Schedule for additional hematology information.			
15000	– other methods	5.30		1.66

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
15139	Seminal examination for presence or absence of sperm	57.00		15.11
15141	Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination	26.55		6.55
15142	Urinalysis, complete diagnostic, semi-quantitative and microscopic	20.55		5.78
15120	Pregnancy test, immunologic - urine	34.60		14.09

DIAGNOSTIC ULTRASOUND

Preamble: Real-time ultrasound fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.

Obstetrical B-scan:

08651	– 14 weeks gestation or over (for singles)	309.00		116.03
08655	– under 14 weeks gestation	250.00		87.05

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)	264.00		86.34
08652	B-scan I.U.D. localization	165.00		58.03
08653	Pelvic B-scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal Doppler	323.00		115.50

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	323.00		116.14
04680	Ultrasonic guidance for amniocenteses	545.00		204.63

NOTE: The professional/technical split is as follows: Professional fee - $72.85, Technical Fee - $131.78.

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 (e.g.: bilateral leg casts) are paid at 100%

9. **Re-operation**
The treatment of a fracture and/or dislocation or a reconstructive procedure where remanipulation or (re)operation is required is chargeable in full. It is chargeable by the physician providing the initial service only if it is carried out more than 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 listings cannot be correctly interpreted without reference to the Preamble.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
51010	**Consultation:** (in office or hospital) To include a history and physical examination, review of x-ray and laboratory findings and a written report.....	414.00		116.15
51012	**Repeat or limited consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where, in the judgement of the consultant, the consultative service does not warrant a full consultative fee	224.00		61.05
51015	**Orthopaedics special consultation:** Extended consult for complex problems (i.e. oncology, complex trauma, adult cerebral palsy etc.), when requested by another Orthopaedic Surgeon, Neurosurgeon, Plastic Surgeon or Rehabilitation Physician. Includes history, physical examination, review of x-rays and written report ..... NOTE: If an orthopaedic specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation service are met, a claim may be submitted under *51015 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.	746.00		167.43
	Continuing care by consultant:			
51007	Orthopaedics office visit.....	192.00		53.53
51008	Orthopaedics hospital visit.....	117.00		31.39
51005	Pre-Operative Assessment..... NOTES: i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances. ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.	430.00		116.15

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition. iv) Maximum of one pre-operative assessment per patient per procedure. v) Only paid to the surgeon who performs the procedure.			
51009	Pavlic Harness – case management; meeting by specific appointment to discuss/plan patient management with parents and/or caregivers – per 15 minutes, or major portion thereof..... 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.	178.00		56.14
	Telehealth Service with Direct Interactive Video Link with the Patient:			
51110	Telehealth Consultation: To include a history and physical examination, review of X-ray and laboratory findings, and a written report	481.00		116.15
51112	Telehealth Repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where, in the judgment of the consultant, the consultative service does not warrant a full consultative fee	261.00		61.05

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
51115	Telehealth Orthopaedic Special Consultation: Extended consult for complex problems (i.e. oncology, complex trauma, adult cerebral palsy, etc.), when requested by another Orthopaedic Surgeon, Neurosurgeon, Plastic Surgeon or Rehabilitation Physician. Includes history, physical examination, review of X-rays and written report ..... NOTE: If an orthopaedic specialist receives a referral by a physician other than the specialty types noted above and the conditions defined within the consultation services are met, a claim may be submitted under 51115 with correspondence/note record outlining medical necessity. Each case will be reviewed independently.	715.00		169.53
51107	Telehealth Orthopaedic office visit.....	225.00		53.53

SURGICAL FEE MODIFIERS

P51003 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery performed when the patient has a Body Mass Index (BMI) of 35 or greater .....

NOTES:

i) Payable only to Orthopaedic Surgeons.

ii) Patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.

iii) Maximum of one surcharge per operation unless two Orthopaedic Surgeons perform two synchronous surgeries that are both eligible for the surcharge.

iv) When multiple procedures are performed during the same operation, the surcharge applies to all eligible procedures based on the prorated value according to the surgical preamble for multiple procedures.

v) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the BMI surcharge.

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

(notes continued on next page)

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

vii) Payable when the following Orthopaedic fee items are performed for patients with a BMI of 35 or greater: 51051, 51052, 51053, 51054, 51055, 51056, 51057, 52365, 52370, 52415, 52505, 52506, 52515, 52516, 52519, 52526, 52545, 52601, 52602, 52603, 52604, 52605, 52606, 52607, 52705, 52710, 52715, 52725, 52735, 52736, 52745, 52982, 53250, 53255, 53365, 53370, 53505, 53510, 53515, 53521, 53601, 53602, 53603, 53604, 53605, 53642, 53643, 53644, 53705, 53715, 53725, 53726, 53735, 53745, 53755, 53765, 53775, 54310, 54315, 54387, 54505, 54510, 54515, 54601, 54602, 54603, 54632, 54705, 54715, 54725, 54810, 55370, 55371, 55385, 55515, 55603, 55605, 55632, 55633, 55634, 55635, 55661, 55662, 55663, 55671, 55672, 55673, 55674, 55675, 55705, 55706, 55707, 55715, 55735, 55736, 55745, 55746, 55751, 55755, 55761, 55771, 55783, 55785, 55983, 55984, 55985, 56285, 56360, 56365, 56370, 56385, 56510, 56515, 56520, 56525, 56530, 56540, 56541, 56542, 56601, 56602, 56603, 56604, 56661, 56662, 56663, 56664, 56665, 56704, 56705, 56715, 56716, 56735, 56745, 56746, 56754, 56755, 56980, 57280, 57290, 57385, 57505, 57510, 57515, 57516, 57535, 57550, 57601, 57602, 57603, 57631, 57632, 57661, 57662, 57705, 57715, 57716, 57735, 57745, 57810, 57811, 57812 and 57813.

SURGICAL ASSISTANCE

51194	First Surgical Assist of the Day - Orthopaedics	340.00		78.45

NOTES:
i) Restricted to Orthopaedic Surgeons.
ii) Maximum of one per day per physician, payable in addition to 00195, 00196, 00197 and 13197.

Total operative fee(s) for procedure(s):

00195	Less than $317.00 inclusive	680.00		147.95
00196	$317.01 - $529.00 inclusive.....	964.00		209.92
00197	Over $529.00.....	1421.00		309.31

		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	157.00		34.10
	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. iv) Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s) for which surgical assist fees are based.			
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	1265.00		282.60
	NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020	Time after one hour of continuous certified surgical assistance, for one patient, up to and including 3 hours of continuous surgical assistance, each 15 minutes or fraction thereof	148.00		32.96
	NOTES: i) After 3 hours of continual surgical assistance for one patient, bill under fee item 00198 (time after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof). ii) Please indicate start and end time of service on claim.			

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

CERTIFICATES AND FORMS

A00060	Written certificate, including time loss benefit form (extra to examination) and death certificates	55.10		
A00061	Medical advice by letter	188.00		
A00069	Insurance company form to include review of records – short report	188.00		
A00059	– extensive report	246.00		
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.			

APPLICATION OF CAST (INCLUDES EXTERNAL STIMULATOR)

*51016	Short arm (elbow to hand)	108.00	2	23.76
*51017	Long arm (axilla to hand)	108.00	2	23.76
*51018	Shoulder spica	409.00	2	88.92
*51019	Below knee	108.00	2	23.76
*51020	Long leg cylinder	108.00	2	23.76
*51021	Long leg	108.00	2	23.76
*51022	Hip spica - child	409.00	2	299.01
*51023	Hip spica - adult	409.00	2	88.92
*51024	Body (shoulder to hips)	409.00	2	88.92
*S51025	Cast brace	215.00	5	47.54

MISCELLANEOUS - ORTHO

*51030	Orthopaedic interpretation and written report of submitted x-ray films including CT scan and MRI	151.00		42.46
	NOTE: Not payable in addition to consultation rendered within 2 months on the same patient on referral by the same physician.			
*51035	Application of skeletal traction	437.00	2	95.49
*51036	Compartment pressure monitoring (extra)	437.00	2	95.07
*51037	Harvesting of iliac crest autograft (extra)	437.00	2	149.51
*51038	Harvesting of skin graft (extra) - for orthopaedic procedures only	482.00	2	105.00

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Ilizarov instrumentation (Any Bone/Joint) to Include Corticotomy:			
51065	Simple construction - lengthening/angular correction, with or without lengthening/non-union stabilization/fracture stabilization	5085.00	3	1134.71
51066	Complex construction - multiplanar corrections/ multiple level lengthening/ elevator technique.	6981.00	4	1541.97
*51067	Extension/revision of frame	1001.00	3	219.58

SHOULDER GIRDLE, CLAVICLE AND HUMERUS

	Incision - Diagnostic, Percutaneous:			
S11200	Arthroscopy shoulder joint	1396.00	2	305.53
SY00757	Aspiration, other joints	51.20	2	16.54
	Incision - Diagnostic, Open:			
11215	Arthrotomy shoulder joint or bursa	869.00	2	190.94
	Incision - Therapeutic, Drainage:			
51039	Bursa aspiration - operation only	108.00		23.76
51040	Joint aspiration - operation only	108.00		23.76
*52210	Bursa, I and D, under GA	869.00	2	316.89
*52215	Abscess, I and D, under GA	869.00	2	316.89
52220	Hematoma, drainage, under GA, when sole procedure	1131.00	2	248.23
	NOTE: Payable at 50% in post-op period.			
*52225	Shoulder joint arthrotomy, I and D	869.00	2	316.89
	Incision - Therapeutic, Release:			
52255	Major release (shoulder contracture)	2520.00	2	593.00
52250	Soft tissue release (muscle, tendon)	1776.00	2	389.05
	Excision - Diagnostic, Percutaneous:			
S11230	Needle biopsy, under GA	869.00	2	190.94
S11232	Arthroscopy - biopsy, shoulder	1131.00	2	248.23
	Excision - Diagnostic, Open:			
11245	Biopsy, open	1133.00	2	248.23
	Excision - Therapeutic, Endoscopic:			
52305	Removal loose body	1131.00	2	294.13

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
52306	Drilling osteochondral defect, with or without loose body	1131.00	2	294.13
52307	Pinning osteochondral fragment	1628.00	2	358.05
52310	Debridement, synovectomy - total or subtotal NOTE: Includes debridement of articular surface and/or synovium, and/or debridement of partial tears of the rotator cuff.	1637.00	2	453.46
52315	Shoulder, abrasion	1628.00	2	358.05
52320	Excision labrum tear	1131.00	2	248.23
52325	Stabilization procedure	2653.00	2	582.39
52330	Endoscopic acromioplasty	1628.00	2	453.46
52335	Arthroscopic clavicle excision-medial/lateral (extra) NOTES: i) Paid only with 52330. ii) Not paid with 52505, 52506, 52515, 52516, 52525, 52526, 52535, 52540, 52541, 52545, 52602.	459.00		108.98
	Excision - Therapeutic, Open:			
52355	Bursa, excision, subacromial.	1001.00	2	219.58
52356	Acromionectomy, acromioplasty, with or without resection of coraco-acromial ligament	1628.00	2	358.05
52357	Clavicle, excision lateral/medial	1001.00	2	302.00
52360	Arthrotomy, shoulder: synovectomy, capsulectomy	1892.00	2	438.34
52365	Benign soft tissue Tumour (sub-fascial)	1892.00	2	449.83
52370	Bone Tumour, benign	1892.00	2	449.83
*52380	Osteomyelitis, acute, decompression	869.00	2	305.35
*52385	Osteomyelitis, debridement with or without reconstruction NOTE: *52380 and *52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.	1504.00	3	408.07
	Introduction and/or Removal, Therapeutic:			
*52405	Injection joint	54.00		11.90
*52410	Injection bursa, tendon sheath, other peri articular structures	54.00		11.90
52415	Removal of internal fixation device(s), when performed in the operating room	1131.00	2	316.89
*52420	Removal of internal fixation device(s), (operation only)	326.00	2	71.61

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Repair, Revision, Reconstruction (Soft Tissue):			
	When fee items 52505, 52506, 52310, 52517, 52518, 52519, 52520, 52521, 52525, 52526, 52535, 52540, 52541, 52545 are performed arthroscopically, the following services are not paid in addition: removal of symptomatic loose body(ies) (52305), drilling of defect and/or micro fracture (52306), pinning of osteochondral fragment (52307), debridement and/or synovectomy (52310), synovial biopsy, shoulder abrasion (52315), excision labral tear (52320), stabilization procedure (52325), endoscopic acromioplasty (52330), and 52555 (tendon transplant).			
	SLAP/Biceps tenodesis: (Superior Labrum Anterior Posterior) repair (reattachment of the biceps anchor utilizing an anchoring device).			
	Bankart repair: (reattachment of labrum to the rim of the glenoid).			
52505	Rotator cuff repair, simple (to include acromioplasty)..	2025.00	3	524.07
52506	Rotator cuff reconstruction, complex (rotation flap or muscle transfer to include acromioplasty)	3351.00	4	796.68
52515	Acromioclavicular joint stabilization, acute (within six weeks post injury).....	1265.00	2	508.05
52516	Acromioclavicular joint stabilization, chronic (beyond six weeks post injury)	1892.00	2	617.56
52517	Open or arthroscopic SLAP/Biceps tenodesis repair (reattachment of the biceps anchor utilizing an anchoring device) (isolated procedure)	2753.00	3	686.73
	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).....	3997.00	3	977.64

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	4516.00	3	1099.13
	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	5893.00	3	1436.19
	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	6900.00	3	1656.40
	NOTE: Includes 52505, 52506, 52525, 52526, 52535, 52541, 52545, 52550, 52555, 52517, 52518, 52519 and 52520.			
52525	Shoulder instability: inferior capsular shift	2653.00	3	603.22
52526	Shoulder instability: Bankart	2932.00	3	702.10
52535	Shoulder instability: other anterior repairs	2144.00	3	470.21
52540	Shoulder instability, posterior: glenoid osteotomy	3351.00	3	776.68
52541	Shoulder instability, posterior: soft tissue…	2789.00	3	695.24
52545	Shoulder instability, revision, stabilization (post previous stabilization)	3351.00	3	831.60
52550	Tendon repair, proximal, biceps, pectoralis major	2025.00	3	453.46
52555	Tendon transfer, transplant	2392.00	3	727.32

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Repair, Revision, Reconstruction (Bone, Joint):			
	Osteotomy, Malunion/Non-union With or Without Internal Fixation:			
52601	Proximal humerus	3351.00	3	856.32
52602	Clavicle	1972.00	2	604.52
	Glenohumeral Joint Arthroplasty:			
52603	Hemi-arthroplasty shoulder	2895.00	4	664.34
52604	Total shoulder prosthesis	3805.00	5	1078.34
52605	Removal prosthesis shoulder	2150.00	3	472.60
	NOTE: Includes repair of rotator cuff and/or soft tissues.			
52606	Revision total shoulder arthroplasty to hemi-arthroplasty	3742.00	5	956.61
52607	Revision total shoulder arthroplasty	5457.00	5	1510.98
	Bone Grafting (i.e. onlay grafting):			
52651	Proximal humerus	1131.00	2	248.23
52652	Clavicle	694.00	2	152.76
	Fracture and/or Dislocation:			
	Clavicle, Acromion, Coracoid:			
52705	ORIF	1675.00	2	542.04
*52708	Open injury, primary wound care	437.00	2	152.79
*52709	Open injury, secondary wound management	869.00	2	214.45
52710	Sterno-clavicular joint stabilization	1972.00	2	680.27
	NOTES: i) Restricted to Orthopaedic Surgeons. ii) Not paid with 52357, 52602, 52652, 52705, 52708 or 52709.			
	Scapula:			
52715	ORIF	4309.00	3	1015.74
*52718	Open injury, primary wound care	437.00	2	152.79
*52719	Open injury, secondary wound management	869.00	2	214.45
	Glenohumeral Dislocation - Acute:			
*52721	Closed reduction, without GA	437.00	2	95.49
52722	Closed reduction, with GA	1131.00	2	255.56
52725	Open reduction	1892.00	2	468.59

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Proximal Humerus:			
*52731	Closed reduction, with GA	869.00	2	190.94
*52732	Closed reduction, with GA, traction/pin	869.00	2	251.60
52735	ORIF - two part	2520.00	2	687.49
52736	ORIF - three or more parts	2789.00	2	806.68
	NOTE: 52735 and 52736 include repair of rotator cuff if required.			
52737	Hemiprosthesis and wiring for fracture	3742.00	3	828.24
*52738	Open injury, primary wound care	437.00	2	152.79
*52739	Open injury, secondary wound management	869.00	2	214.45
	Humerus - Shaft:			
52741	Closed reduction, with GA	1131.00	2	248.23
52742	Closed reduction, external fixation	1651.00	2	409.05
52745	ORIF/intramedullary nailing	2653.00	2	722.12
*52748	Open injury, primary wound care	437.00	2	152.79
*52749	Open injury, secondary wound management	869.00	2	224.55
	Manipulation: Shoulder Joint:			
*S52800	Manipulation under GA	437.00	2	95.49
	Arthrodesis:			
52810	Shoulder joint	4431.00	4	973.84
52811	Scapulo-thoracic joint	3475.00	4	763.81
	Amputation:			
52980	Shoulder disarticulation	3606.00	4	792.44
52981	Forequarter	4309.00	5	945.21
52982	Humeral shaft	2520.00	3	654.71
*52998	Open injury, primary wound care	437.00	3	152.79
*52999	Open injury, secondary wound management	869.00	3	214.45

ELBOW, PROXIMAL RADIUS AND ULNA

	Incision - Diagnostic, Percutaneous:			
S11300	Arthroscopy elbow joint	1251.00	2	274.51
S11302	Aspiration, bursa, tendon sheath.	108.00	2	23.76
SY00757	Aspiration, other joints	51.20	2	16.54
	Incision - Diagnostic, Open:			
11315	Arthrotomy elbow joint	869.00	2	190.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Incision - Therapeutic, Drainage:			
51039	Bursa aspiration - operation only	108.00		23.76
51040	Joint aspiration - operation only	108.00		23.76
*53210	Bursa, I and D (olecranon, etc.), under GA	869.00	2	316.89
*53215	Abscess, I and D, under GA	869.00	2	316.89
53220	Hematoma, drainage, under GA, when sole procedure	1131.00	2	248.23
	NOTE: Payable at 50% in post-op period.			
*53225	Elbow joint arthrotomy, I and D	869.00	2	316.89
	Incision - Therapeutic, Release:			
53250	Decompression, neurolysis, nerve	1131.00	2	368.81
53255	Decompression, neurolysis, submuscular transposition of nerve	1892.00	2	473.09
*53260	Fasciotomy, compartment syndrome	1001.00	2	353.75
*53269	Fasciotomy, secondary wound management	869.00	2	318.02
	Excision - Diagnostic, Percutaneous:			
S11332	Arthroscopy and biopsy	1383.00	2	303.15
S11330	Needle biopsy under GA	869.00	2	190.94
	Excision - Diagnostic, Open:			
11345	Biopsy, open	1133.00	2	248.23
	NOTE: Not billable with other procedures on the same joint.			
	Excision - Therapeutic, Endoscopic:			
53305	Removal loose body	1383.00	2	341.40
53310	Debridement, synovectomy - total	2653.00	2	685.03
	Excision - Therapeutic, Open:			
53355	Bursa/ganglion, excision	1001.00	2	252.17
53360	Arthrotomy, elbow; open synovectomy with or without radial head resection	1892.00	2	415.31
53365	Benign soft tissue Tumour, subfascial	1265.00	2	302.11
53370	Bone Tumour, benign	1265.00	2	302.11
*53380	Osteomyelitis - acute, decompression	869.00	2	305.35
*53385	Osteomyelitis - debridement, with or without reconstruction	1504.00	2	408.07
53386	Radial head resection with or without replacement	1131.00	2	418.34

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Introduction and/or Removal, Therapeutic:			
*53405	Injection joint	54.00		11.90
*53410	Injection bursa, tendon sheath, other peri articular structures	54.00		11.90
53415	Removal of internal fixation device(s), when performed in the operating room	1001.00	2	316.89
*53420	Removal of internal fixation device(s), loperation only)	326.00	2	71.61
	Repair, Revision, Reconstruction (Soft Tissue):			
53505	Elbow instability, chronic	3153.00	2	766.82
53510	Recurrent dislocating radial head	2653.00	2	632.49
53515	Triceps tendon, acute	1641.00	2	428.46
53516	Triceps tendon, fascial reconstruction	1892.00	2	501.95
53520	Biceps tendon, longhead, tenodesis	1265.00	2	302.11
53521	Biceps tendon, distal insertion	2653.00	2	639.37
53530	Tendon transfer, major NOTE: Includes latissimus/pectoralis to biceps transfer.	3351.00	2	765.90
53531	Tendon transfer, minor (Steindler or triceps)	2025.00	2	454.40
53540	Epicondylitis, fascial stripping	1001.00	2	281.94
	Repair, Revision, Reconstruction (Bone, Joint):			
	<u>Osteotomy, Malunion/Non-union; With or Without Internal Fixation:</u>			
53601	Humeral shaft	2732.00	2	815.74
53602	Distal humerus	3351.00	2	841.79
53603	Radius shaft	2770.00	2	642.41
53604	Ulnar shaft	2025.00	2	564.30
53605	Radius and ulnar shafts	3351.00	2	775.98
53606	Epiphysiodesis	1265.00	2	276.87
53607	Physeal Bar excision NOTE: Includes harvest, with or without insertion of fat graft, cement, or other material.	2087.00	2	458.28
	<u>Arthroplasty:</u>			
53641	Interposition/distraction arthroplasty	4309.00	3	981.60

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTE: Includes harvest and insertion of local fascial graft, application of distraction device and neurolysis, if applicable.			
53642	Total elbow arthroplasty	3805.00	3	1135.36
53643	Total elbow arthroplasty revision	5326.00	3	1528.74
	NOTE: 53642 and 53643 include ligament balancing, neurolysis and nerve transposition.			
53644	Osteocapsular arthroplasty (elbow, open or arthroscopic)	4201.00	4	1000.82
	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.			
	Bone Grafting (i.e. onlay grafting):			
53651	Humerus	1131.00	2	248.23
53652	Radius and/or ulna	1131.00	2	248.23
53653	Olecranon	694.00	2	152.76
	Fracture and/or Dislocation:			
	Humeral Epicondyle:			
53701	Closed reduction, with GA, cast	1131.00	2	248.23
53702	Closed reduction, percutaneous fixation	1265.00	2	276.87
53705	ORIF	1265.00	2	393.42
*53708	Open injury, primary wound care	437.00	2	152.79
*53709	Open injury, secondary wound management	869.00	2	214.45
	Distal Humerus: Supracondylar:			
*53711	Closed reduction, with GA, cast/traction	869.00	2	190.94
53712	Closed reduction, external fixation/percutaneous fixation	1646.00	2	493.74
53715	ORIF	1904.00	2	637.90
*53718	Open injury, primary wound care	437.00	2	152.79
*53719	Open injury, secondary wound management	869.00	2	214.45
	Distal Humerus: Intra-articular:			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
*53721	Closed reduction, with GA, cast/traction and/or percutaneous fixation	869.00	2	190.94
53722	Closed reduction, external fixation	1651.00	2	409.05
53725	ORIF - unicondylar/ osteochondral	1892.00	2	637.50
53726	ORIF - bicondylar with or without olecranon osteotomy NOTE: Includes ulnar nerve transposition, if required.	4043.00	2	1004.87
*53727	Open injury, primary wound care	437.00	2	152.79
*53728	Open injury, secondary wound management	869.00	2	214.45
	Olecranon:			
53735	ORIF	1600.00	2	548.87
*53738	Open injury, primary wound care	437.00	2	152.79
*53739	Open injury, secondary wound management	869.00	2	214.45
	Radial Head/Neck:			
53741	Closed reduction, with GA, cast	1131.00	2	248.23
53742	Closed reduction, percutaneous fixation	1265.00	2	374.36
53745	ORIF	1892.00	2	608.57
*53748	Open injury, primary wound care	437.00	2	152.79
*53749	Open injury, secondary wound management	869.00	2	214.45
	Elbow Joint Dislocation:			
53751	Closed reduction, without GA	694.00	2	183.69
53752	Closed reduction, with GA	1131.00	2	248.23
53755	Open reduction	1389.00	2	357.27
	Radius and Ulna Shaft:			
*53761	Closed reduction, without GA, cast	437.00	2	102.18
53762	Closed reduction, with GA, cast	1389.00	2	316.87
53765	ORIF	2520.00	2	667.39
*53768	Open injury, primary wound care	437.00	2	152.79
*53769	Open injury, secondary wound management	869.00	2	214.45
	Radius or Ulna Shaft/Monteggia:			
53771	Closed reduction, with GA, cast	1265.00	2	276.87
53772	Closed reduction, external fixation	1265.00	2	276.87
53775	ORIF	1776.00	2	533.09

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	437.00	2	152.79
*53779	Open injury, secondary wound management	869.00	2	214.45
	Manipulation: Elbow Joint:			
*S53800	Manipulation, under GA	437.00	2	95.49
	Arthrodesis:			
53810	Elbow joint	3351.00	3	766.58
	Amputation:			
53980	Elbow	1892.00	3	611.13
53981	Forearm	1892.00	3	611.13
*53998	Open injury, primary wound care	437.00	3	152.79
*53999	Open injury, secondary wound management	869.00	3	214.45

HAND AND WRIST

	Incision - Diagnostic, Percutaneous:			
S11400	Arthroscopy wrist joint	1104.00	2	294.13
S11402	Aspiration bursa, synovial sheath, etc.	108.00	2	23.76
SY00757	Aspiration, other joints	51.20	2	16.54
	Incision - Diagnostic, Open:			
11415	Arthrotomy wrist joint - (isolated procedure)	869.00	2	190.94
11416	Arthrotomy MP, PIP, DIP joints - (isolated procedure)	869.00	2	190.94
	Incision - Therapeutic, Drainage:			
51039	Bursa aspiration - operation only	108.00		23.76
51040	Joint aspiration - operation only	108.00		23.76
	Excision - Diagnostic, Percutaneous:			
S11430	Needle biopsy, under GA	869.00	2	190.94
S11432	Arthroscopy and biopsy, wrist /hand joint(s)	869.00	2	190.94
	Excision - Diagnostic, Open:			
11445	Open biopsy, hand or wrist	1133.00	2	265.66

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Excision - Therapeutic, Endoscopic:			
54305	Removal loose body	1131.00	2	248.23
54310	Debridement synovectomy, total	1511.00	2	383.70
54315	Excision triangular fibro cartilage complex (TFCC)	1511.00	2	448.35
	Excision - Therapeutic, Open:			
54350	Foreign body from wound, under GA	1001.00	2	301.90
54351	Meniscus, radiocarpal	1511.00	2	352.56
V07055	Ganglia, of wrist	933.00	2	255.66
	Bone Tumour, Benign:			
54372	Carpals, distal radius	1511.00	2	376.76
*54380	Osteomyelitis, acute, decompression	869.00	2	352.29
*54385	Osteomyelitis, debridement with or without reconstruction	1504.00	2	423.16
54386	Excision of radial or ulnar styloid NOTE: Not payable with other wrist procedures.	1001.00	2	252.17
54387	Proximal row carpectomy NOTE: Not payable with wrist arthrodesis.	2520.00	2	624.47
	Introduction and/or Removal, Therapeutic:			
*54405	Injection joint	108.00		25.54
*54410	Injection bursa, tendon sheath, other peri-articular structures	108.00		25.54
54415	Removal of internal fixation device(s), when performed in the operating room	1001.00	2	316.89
*54420	Removal of internal fixation device(s), (operation only)	215.00	2	47.73
	Repair, Revision, Reconstruction (Soft Tissue):			
	Ligament:			
54505	Carpal instability: acute	2789.00	2	654.48
54510	Carpal instability: chronic	3066.00	2	728.00
54515	Distal radio-ulnar instability: chronic	2274.00	2	582.83
	Repair, Revision, Reconstruction (Bone, Joint):			
	Osteotomy, Malunion or Non-union:			
54601	Distal radius	3066.00	2	761.94
54602	Distal ulna	1518.00	2	413.41

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTE: A Darrach resection or limited resection/hemiresection arthroplasty are not payable under this item.			
54603	Carpal bone (scaphoid)	2520.00	2	590.45
54604	Epiphysiodesis, epiphysioplasty, radius and/or ulna, or hand	1892.00	2	488.65
	Arthroplasty Joint:			
54631	Ulna, distal excision, with or without silastic	1131.00	2	271.90
54632	Total wrist joint replacement, includes tenosynovectomy and distal ulnar reconstruction	3351.00	2	796.81
54633	Silastic wrist arthroplasty, includes tenosynovectomy and distal ulnar reconstruction	2520.00	2	586.05
54634	Removal prosthesis	1265.00	2	302.11
54635	Revision total wrist arthroplasty	4431.00	3	1046.07
	Bone Grafting (i.e. onlay grafting):			
54651	Distal radius and/or ulna	1131.00	2	272.63
54652	Metacarpal or phalanx - operation only	564.00	2	124.11
	Fracture and/or Dislocation:			
	Radius With or Without Ulna - Distal, Fracture:			
54701	Closed reduction, without GA	1180.00	2	270.86
54702	Closed reduction, with GA	1389.00	2	327.12
54703	Closed reduction, external or percutaneous fixation	1518.00	2	453.11
54705	ORIF	2425.00	2	598.70
*54708	Open injury, primary wound care	215.00	2	86.50
*54709	Open injury, secondary wound management	437.00	2	127.43
	Carpal Bone Fracture (Scaphoid):			
54715	Open reduction, internal fixation	2025.00	2	522.88
	Carpus: Dislocations: With or Without Fracture:			
54721	Closed reduction, without GA	1180.00	2	285.63
54722	Closed reduction, percutaneous fixation	1389.00	2	393.66
54725	Open reduction, internal and/or external fixation	2789.00	2	663.64
*54728	Open injury, primary wound care	215.00	2	86.50
*54729	Open injury, secondary wound management	437.00	2	127.43
	Manipulation: Hand/Wrist Joint:			
S54800	Manipulation, under GA	437.00	2	95.49

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Arthrodesis/Tenodesis:			
54810	Wrist arthrodesis, limited or total	3066.00	2	736.98
	Amputation:			
06218	Transmetacarpal	1221.00	2	306.79
06219	Finger, any joint or phalanx - operation only	1221.00	2	306.79

PELVIS, HIP AND FEMUR

	Incision - Diagnostic, Percutaneous:			
S11500	Arthroscopy hip joint	2425.00	3	529.91
S11501	Aspiration hip joint	108.00	2	23.76
S11502	Aspiration bursa, tendon sheath.	54.00	2	11.90
	Incision - Diagnostic, Open:			
11515	Arthrotomy hip joint	1389.00	3	305.53
	Incision - Therapeutic, Drainage:			
51039	Bursa aspiration - operation only	108.00		23.76
51040	Joint aspiration - operation only	108.00		23.76
*55210	Bursa, I and D (trochanteric, etc.) under GA	869.00	2	316.89
*55215	Abscess, I and D, under GA	869.00	2	316.89
55220	Hematoma, drainage under GA (when sole procedure) NOTE: Payable at 50% in post-op period.	1389.00	2	305.53
*55225	Hip Joint - Arthrotomy, I and D	1504.00	3	443.38
	Incision - Therapeutic, Release:			
55255	Soft tissue release, percutaneous	1265.00	2	276.87
55270	Minor release hip, one tendon	1389.00	2	305.53
55275	Major release hip, two or more	1892.00	3	453.17
	Excision - Diagnostic, Percutaneous:			
S11530	Needle biopsy, under GA	869.00	2	190.94
S11532	Arthroscopy and biopsy, hip	2425.00	3	529.91
	Excision - Diagnostic, Open:			
11545	Arthrotomy and biopsy, hip	1133.00	3	248.23
11546	Biopsy, open, soft tissue or bone	1133.00	2	248.23
	Excision - Therapeutic, Endoscopic:			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
55305	Removal loose body	1759.00	3	386.67
55310	Debridement or synovectomy, total	2789.00	3	654.69
	Excision – Therapeutic, Open:			
55355	Bursa, excision, trochanteric, etc.	1001.00	2	219.58
55360	Arthrotomy, hip: open synovectomy, total	2653.00	3	582.39
55365	Benign soft tissue Tumour, subfascial	1892.00	3	504.65
55370	Bone Tumour, benign	2025.00	3	504.65
S55371	Heterotopic bone resection NOTE: Paid only for heterotopic bone resection which meets the criteria for Brooker Classification III or IV.	2413.00	3	572.55
*55380	Osteomyelitis, acute, decompression	869.00	3	305.35
*55385	Osteomyelitis, debridement with or without reconstruction	1504.00	3	503.49
	Introduction and/or Removal, Therapeutic:			
*55405	Injection joint	54.00		15.30
*55410	Injection bursa, tendon sheath, other peri articular structures	54.00		15.30
55415	Removal of internal fixation device(s), when performed in the operating room	1131.00	3	316.89
*55420	Removal of internal fixation device(s), (operation only)	326.00	3	71.61
	Repair, Revision, Reconstruction (Soft Tissue):			
55505	Hip instability, soft tissue repair	3044.00	3	668.33
55510	Tendon-muscle transfer, hip	3066.00	3	812.91
55515	Tendon avulsion repair	1518.00	3	610.12
	Repair, Revision, Reconstruction (Bone, Joint):			
	<u>Osteotomy:</u>			
55601	Pelvis, adult	3475.00	6	936.20
55602	Pelvis, pediatric	2789.00	6	936.20
55603	Proximal femur, adult	3475.00	4	911.34
55604	Proximal femur, pediatric	2868.00	4	926.32
55605	Femoral shaft, adult	3606.00	4	926.32
55606	Femoral shaft, pediatric	2974.00	4	926.32
55607	Multiple for osteogenesis imperfecta	4168.00	6	1036.97
	<u>Malunion or Non-union:</u>			
C55631	Pelvis (including Sacroiliac joint arthrodesis)	6349.00	4	1511.03

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Orthopaedic Surgeons. ii) Removal of previously placed hardware to be paid at 50% if removed from a separate incision. iii) Harvesting of bone graft is paid in addition when performed at the same time.			
55632	Acetabulum	8606.00	4	2008.56
55633	Proximal femur (i.e. subtrochanteric)	4175.00	4	1017.85
55634	Shaft, femur (includes closed femoral lengthening and open femoral shortening)	3606.00	4	911.39
55635	Femoral lengthening, open	4175.00	4	957.32
55636	Femoral shortening, closed	4175.00	4	957.32
	<u>Bone Grafting (i.e. onlay grafting):</u>			
55651	Femur – intertrochanteric, shaft	1265.00	4	276.87
55652	Epiphysiodesis, greater trochanter	1518.00	4	453.10
	<u>Arthroplasty:</u>			
55661	Hip resection arthroplasty	2286.00	5	567.73
55662	Hemi-arthroplasty - hip	2414.00	5	695.34
55663	Total hip prosthesis	3742.00	5	849.66
	<u>Revision, Total Hip Arthroplasty:</u>			
55671	Components, removal only (isolated procedure)	3742.00	5	847.62
55672	Exchange of modular component	2025.00	5	703.70
55673	Revision femur or acetabulum NOTE: 55673 and 55674 include trochanteric osteotomies if required.	4627.00	6	1095.31
55674	Revision femur and acetabulum, includes PROSTALAC	6109.00	6	1461.04
55675	Proximal femoral replacement, allograft or custom prosthesis and/or acetabular reconstruction with internal fixation	7640.00	6	1702.27

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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 <u>during</u> a revision total hip, the procedure will be paid at the rate for revision total hip only.			
	Hip Arthroscopy:			
55520	Hip arthroscopy with labral debridement +/- microfracture/chondroplasty +/- iliopsoas release	3235.00	3	782.43
55521	Hip arthroscopy with labral repair and/or abductor repair, and/or hamstring repair, +/- capsule closure	4528.00	3	1095.40
55522	Hip arthroscopy with femoral and/or acetabular osteoplasty +/- capsule closure	4528.00	3	1095.40
55523	Hip arthroscopy with labral repair and femoral and/or acetabular osteoplasty	5607.00	4	1356.21
C55524	Hip arthroscopy with labral reconstruction and/or ligamentum teres reconstruction	6254.00	3	1512.69
	NOTES: The following applies to fee items 55520, 55521, 55522, 55523 and 55524 i) Restricted to Orthopaedic Surgeons. ii) Maximum of one hip arthroscopy payable per patient per day. iii) Hip arthroscopies are composite fees and include all necessary procedures. No other procedures involving the hip are payable during the same operation.			
	Fracture With or Without Dislocation:			
	<u>Pelvis: Operative Rx Unstable:</u>			
*55701	Closed reduction, skeletal traction.....	437.00	3	95.49
55702	Closed reduction, external fixation	2305.00	4	506.03
55705	External fixation and open reduction internal fixation ..	5085.00	5	1244.67
55706	Open reduction internal fixation, anterior or posterior..	3559.00	5	1196.68
55707	Open reduction internal fixation, anterior and posterior	5457.00	5	1396.46
	<u>Hip: Dislocation, Traumatic (Includes Total Hip Arthroplasty):</u>			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
*55711	Reduction hip, without anesthetic	437.00	2	95.49
*55712	Reduction hip, with GA	869.00	2	352.21
55715	Open reduction	2286.00	4	603.57
	Hip: Dislocation, Congenital: Conservative Management:			
55721	Closed reduction under GA, with or without tenotomy	1265.00	2	448.32
	Hip: Dislocation, Congenital: Operative Management:			
55725	Open reduction	3328.00	2	846.54
55726	Open reduction, femoral or pelvic osteotomy	4877.00	4	1181.08
55727	Open reduction, femoral and pelvic osteotomy	6144.00	4	1540.73
	Hip: Fracture, Dislocation (Includes Lip and/or Head Fractures):			
*55731	Reduction hip, without anesthetic	437.00	2	95.49
*55732	Reduction hip, with GA	869.00	2	252.32
55735	Open reduction	2286.00	4	590.45
55736	ORIF	4431.00	5	1070.00
*55738	Open injury, primary wound care	437.00	2	152.79
*55739	Open injury, secondary wound management	869.00	2	214.45
	Hip: Acetabulum Fracture (One or Two Column Fractures):			
*55741	Closed reduction	869.00	2	190.94
55745	ORIF - one approach	6086.00	5	1455.82
55746	ORIF - two approach/ extensile approach	8606.00	6	2055.30
	Hip: Fracture Femoral Neck or Subcapital:			
55751	Closed reduction, internal fixation	2425.00	5	588.89
55755	ORIF (with supporting documentation)	3869.00	5	949.21
*55758	Open injury, primary wound care	437.00	2	152.79
*55759	Open injury, secondary wound management	869.00	2	214.45
55760	SCFE in situ fixation	2274.00	5	592.67
	Hip: Fracture, Intertrochanteric With or Without Subtrochanteric Extension:			
55761	Reduction internal fixation	3044.00	5	754.98
*55768	Open injury, primary wound care	437.00	2	152.79
*55769	Open injury, secondary wound management	869.00	2	214.45
	Hip: Fracture, Subtrochanteric:			
55771	Internal fixation	4152.00	5	971.96

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
*55778	Open injury, primary wound care	437.00	2	152.79
*55779	Open injury, secondary wound management	869.00	2	214.45
	Femur: Shaft:			
*55780	Closed reduction, without GA, cast/traction	566.00	2	124.11
	NOTE: If *55780 or *55781 is followed by an ORIF/IM nailing after 48 hours, both are paid in full.			
*55781	Closed reduction, with GA, cast/traction	1006.00	2	219.58
55782	Closed reduction, external skeletal fixation	1651.00	4	409.05
55783	Closed reduction, IM nail	3606.00	5	856.52
55785	ORIF	3606.00	5	856.52
*55788	Open injury, primary wound care	437.00	2	152.79
*55789	Open injury, secondary wound management	869.00	2	214.45
	Manipulation: Hip Joint:			
*S55800	Manipulation, under GA	437.00	2	95.49
	Arthrodesis:			
55810	Hip joint	5718.00	6	1312.55
	Amputation:			
55980	Hemicorporectomy	11397.00	6	2535.69
55981	Hemipelvectomy	6349.00	6	1441.31
55982	Hip disarticulation	4829.00	6	1225.08
55983	Above knee	3044.00	4	684.95
55984	Knee disarticulation	3044.00	4	684.95
55985	Revision, amputation, below knee, after 14 days	2153.00	3	705.49
	NOTE: Restricted to Orthopaedic Surgeons.			
*55998	Open injury, primary wound care	437.00	4	152.79
*55999	Open injury, secondary wound management	869.00	4	214.45

FEMUR, KNEE JOINT, TIBIA AND FIBULA

	Incision - Diagnostic, Percutaneous:			
S11600	Arthroscopy knee joint	1001.00	2	219.58
SY00757	Aspiration, other joints	51.20	2	16.54
S11602	Aspiration bursa, tendon sheath or other peri-articular structures	108.00	2	23.76
	Incision - Diagnostic, Open:			
11615	Arthrotomy knee joint	1131.00	3	248.23
	Incision - Therapeutic, Drainage:			
51039	Bursa aspiration - operation only	108.00		23.76

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
51040	Joint aspiration - operation only	108.00		23.76
*56210	Bursa, I and D (prepatellar, etc.), under GA	869.00	2	316.89
*56215	Abscess, I and D, under GA	869.00	2	316.89
56220	Hematoma, drainage under GA, (when sole procedure)	1389.00	2	316.89
	NOTE: Payable at 50% in post-op period.			
*56225	Knee joint, arthrotomy, I and D	869.00	3	316.89
	Incision - Therapeutic, Release:			
56250	Decompression, neurolysis, nerve	1001.00	2	219.58
*56260	Fasciotomy, compartment syndrome	1001.00	3	419.25
*56269	Fasciotomy, secondary closure wound, with or without graft	869.00	2	214.45
	Soft Tissue Release:			
56270	Minor release knee - tendons only, unilateral or bilateral	1609.00	2	392.68
56275	Major release knee - includes posterior capsulotomy, unilateral or bilateral	2274.00	3	498.85
56280	Knee liberation/major release (post ligament reconstruction)	3592.00	3	807.88
56285	Quadriceps plasty	2915.00	3	693.24
56290	Open lateral/medial retinacular release	1131.00	2	261.92
	Excision - Diagnostic, Percutaneous:			
S11630	Needle biopsy, under GA	869.00	2	190.94
S11632	Arthroscopy, biopsy	1001.00	2	219.58
	Excision - Diagnostic, Open:			
11645	Biopsy, open	1133.00	2	248.23
	Excision - Therapeutic, Endoscopic:			
56315	Resection 'plica' (isolated procedure)	1104.00	2	354.79
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.	553.00	2	169.31

		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.....	275.00		78.76
	NOTES: i) Paid only with 56322. ii) Paid to a maximum of two additional units. iii) Start and end times of debridement must be recorded in the patient's chart and claim submission.			
56325	Meniscal repair	1641.00	2	507.90
	NOTES: i) Includes 56320, debridement of attachment site. ii) Not paid for trimming of the meniscus.			
56330	Abrasion/debridement (isolated procedure)	1131.00	2	354.94
56335	Lateral or medial release, endoscopic (isolated procedure).....	1131.00	2	352.63
	Excision – Therapeutic, Knee Arthroscopic: Synovial biopsy is included in 56305, 56306, 56310, 56315, 56320, 56325, 56330 and 56322.			
56305	Removal symptomatic loose body.....	1131.00	2	352.54
	NOTE: Not paid for removal of iatrogenic loose body(ies).			
56306	Pinning/drilling osteochondral fragment(s) for osteoarthritic cartilage deficiency	1576.00	2	483.40
	NOTE: Includes removal of loose body(ies).			
56310	Synovectomy, knee, for diseased synovium, anterior, posterior or complete total.....	2150.00	2	521.47
56320	Menisectomy, knee, partial or total for symptomatic meniscal tear.	1131.00	2	354.61
56321	Drilling of defect or Microfracture and/or abrasion arthroplasty.	1104.00	2	354.61

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Excision - Therapeutic, Open:			
56353	Ganglion or cyst	1001.00	2	304.60
56354	Popliteal cyst	1389.00	2	305.53
56355	Bursa, prepatellar	1001.00	2	377.75
	Arthrotomy Knee:			
56356	Removal loose body	1131.00	3	405.69
56356	Removal loose body	1131.00	3	405.69
56357	Pinning/drilling osteochondral fragment(s)	1641.00	3	360.42
56360	Synovectomy, knee, total	2169.00	3	514.84
56361	Menisectomy, knee	1133.00	3	271.90
56362	Meniscal repair	1641.00	3	403.11
56365	Benign soft tissue Tumour, subfascial	1518.00	3	402.81
56370	Bone Tumour, benign	1265.00	3	402.81
*56380	Osteomyelitis, acute, decompression	869.00	3	352.29
*56385	Osteomyelitis, debridement, with or without reconstruction	1001.00	3	406.71
56390	Patellectomy	1518.00	3	521.52
	Introduction (With or Without Removal, Therapeutic):			
*56405	Injection joint	108.00		24.53
*56410	Injection bursa, tendon sheath, other peri-articular structures	108.00		24.53
56415	Removal of internal fixation device(s), when performed in the operating room	1131.00	2	316.89
*56420	Removal of internal fixation device(s), (operation only)	326.00	2	71.61
	Repair, Revision, Reconstruction (Soft Tissue):			
	Knee Ligament, Instability (With or Without Arthroscopy):			
56505	One ligament repair/reconstruction, acute or chronic	2520.00	3	736.91
56510	Posterior cruciate repair/reconstruction, acute or chronic	3475.00	3	891.30
56515	Two ligament repair/reconstruction, acute or chronic	2907.00	3	1015.94
56520	Three ligament repair/reconstruction, acute or chronic (includes PCL)	3891.00	3	1241.17
56525	Revision knee ligament reconstruction (post previous ligament reconstruction)	3351.00	3	886.55
	NOTE: 56505 to 56525 include meniscectomy, graft harvest plus use of synthetic device. Meniscus repair is payable in addition at 50%.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
*56528	Open injury, primary wound care	437.00	2	152.79
*56529	Open injury, secondary wound care	869.00	2	214.45
	Recurrent Subluxation/Dislocation Patella:			
56530	Extensor re-alignment procedures, soft tissue/bone	2025.00	3	557.76
56531	Lateral release, open or endoscopic	1131.00	2	376.86
56540	Quadriceps tendon rupture, acute (within 6 weeks post injury)	1609.00	2	570.38
56541	Quadriceps tendon rupture, chronic (beyond 6 weeks post injury)	2286.00	2	633.65
56542	Patellar tendon repair	2070.00	2	570.38
	NOTES: i) Restricted to Orthopaedic Surgeons. ii) Not paid with 56540, 56541 or 56545.			
56545	Tendon transfer, transplant	1518.00	2	383.31
	Repair, Reconstruction (Bone/Joint):			
	<u>Osteotomy and/or Internal Fixation: Arthritis, Malunion or Non-union:</u>			
56601	Distal femur	3742.00	3	948.24
56602	Proximal tibia	2653.00	3	821.57
56603	Tibia, shaft, includes fibula	3475.00	3	821.57
56604	Fibula	1265.00	3	302.11
	<u>Bone Grafting (i.e. onlay grafting):</u>			
56651	Femur	1265.00	3	276.87
56652	Tibia, with or without fibular osteotomy	1265.00	3	276.87
56653	Epiphysiodesis	1389.00	3	407.77
56654	Physeal Bar excision	2368.00	3	562.45
	<u>Arthroplasty: Knee Joint:</u>			
56661	Knee replacement, unicompartmental	3178.00	4	846.63
56662	Total knee replacement	3742.00	4	849.66
56663	Total knee, removal prosthesis knee, includes PROSTALAC	2286.00	4	519.88
56664	Revision, total knee	5143.00	4	1234.01
56665	Revision, patellar component	1904.00	3	544.03
C56666	Meniscal Allograft Transplant	5342.00	5	1359.73

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

NOTES:
i) Restricted to Orthopaedic Surgeons.
ii) If the procedure is abandoned after initial diagnostic arthroscopy due to advanced articular chondromalacia or the state of the remnant meniscus, only fee item 11600 would be payable.
iii) Includes 11600, 11615, 56320 and 56321.

Fracture and/or Dislocation:

	Metaphysis Femur: Supracondylar:			
*56701	Closed reduction, without GA, cast/traction	566.00	2	124.11
*56702	Closed reduction, with GA, cast/traction	1006.00	2	219.58
56703	Closed reduction, external fixation/percutaneous fixation	1651.00	2	409.05
56704	Closed reduction, IM nail	3606.00	5	856.44
56705	ORIF	3606.00	4	856.44
*56708	Open injury, primary wound care	437.00	2	152.79
*56709	Open injury, secondary wound management	869.00	2	214.45
	Metaphysis Femur: Condyle or Intracondylar:			
*56711	Closed reduction, without GA, cast/traction	437.00	2	95.49
*56712	Closed reduction, with GA, cast/traction	869.00	2	190.94
56713	Closed reduction, external fixation/ percutaneous fixation	1651.00	2	409.05
56715	ORIF - unicondylar	3606.00	4	856.44
56716	ORIF - bicondylar	5198.00	4	1289.64
*56718	Open injury, primary wound care	437.00	2	152.79
*56719	Open injury, secondary wound management	869.00	2	214.45
	Patellar Dislocation:			
56725	Open reduction and repair	1131.00	2	248.23
*56728	Open injury, primary wound care	437.00	2	152.79
*56729	Open injury, secondary wound management	869.00	2	214.45
	Patellar Fractures:			
56734	Patellectomy	1518.00	2	408.12
56735	ORIF	2150.00	2	558.81
*56738	Open injury, primary wound care	437.00	2	152.79
*56739	Open injury, secondary wound management	869.00	2	214.45
	Tibial Plateau Fractures:			
*56741	Closed reduction, with GA, cast/traction	869.00	2	190.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
56742	Closed reduction, external fixation, with or without minimal internal fixation	1784.00	2	409.05
56745	ORIF - unicondylar	3044.00	3	793.82
56746	ORIF - bicondylar	4318.00	3	1037.76
*56748	Open injury, primary wound care	437.00	2	152.79
*56749	Open injury, secondary wound management	869.00	2	214.45
	Tibial Shaft Fractures:			
*56751	Closed reduction, without GA, cast/traction	437.00	2	95.49
*56752	Closed reduction, with GA, cast/traction	1006.00	2	219.58
56753	Closed reduction, external fixation, with or without minimal internal fixation	1651.00	2	409.05
56754	Closed reduction, IM nail	3195.00	3	771.87
56755	ORIF	2653.00	3	771.87
*56758	Open injury, primary wound care	437.00	2	152.79
*56759	Open injury, secondary wound management	869.00	2	214.45
	Fibular Shaft Fractures:			
*56769	Open injury, primary/secondary wound care	869.00	2	190.94
	Manipulation: Knee Joint:			
*S56800	Manipulation, with GA	437.00	2	112.42
	Arthrodesis:			
56810	Knee joint	3742.00	3	848.68
	Amputation:			
56980	Below knee	2414.00	3	674.81
*56998	Open injury, primary wound care	437.00	3	152.79
*56999	Open injury, secondary wound management	869.00	3	214.45

TIBIAL METAPHYSIS (DISTAL), ANKLE AND FOOT

	Incision - Diagnostic, Percutaneous:			
S11700	Arthroscopy, ankle joint/subtalar joint	869.00	2	190.94
S11702	Aspiration bursa, tendon sheath	108.00	2	23.76
SY00757	Aspiration, other joints	51.20	2	16.54
	Incision - Diagnostic, Open:			
11715	Ankle joint	869.00	2	190.94
11716	Subtalar joint	869.00	2	190.94
11717	Midtarsal joint	869.00	2	190.94
11718	Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint	869.00	2	190.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Incision - Therapeutic, Drainage:			
51039	Bursa aspiration - operation only	108.00		23.76
51040	Joint aspiration - operation only	108.00		23.76
*57210	Bursa, I and D (tendo-achilles, etc.), under GA	869.00	2	316.89
*57215	Abscess, I and D, under GA	869.00	2	316.89
57220	Hematoma, drainage under GA, (when sole procedure)	1389.00	2	305.53
	NOTE: Payable at 50% in post-op period.			
*57225	Ankle/foot joint, I and D, under GA	869.00	2	316.89
	Incision - Therapeutic, Release:			
57250	Decompression, neurolysis, nerve (isolated procedure)	1389.00	2	305.53
*57260	Fasciotomy, compartment syndrome	1001.00	2	272.17
*57269	Fasciotomy, secondary wound closure	869.00	2	201.89
	<u>Soft Tissue Release: Musculo-tendonous:</u>			
57270	Plantar fascia: open release or partial excision, unilateral or bilateral	1265.00	2	276.87
57275	Plantar fasciectomy - total	1892.00	2	434.21
57280	Achilles tendon lengthening, percutaneous, unilateral or bilateral	1001.00	2	288.96
57285	Posterior hindfoot release	2025.00	2	487.99
57286	Posteromedial release (club foot /vertical talus)	3351.00	2	806.67
57290	Tendon lengthening, open	1265.00	2	309.77
57295	Tenosynovectomy	1265.00	2	309.77
	Excision - Diagnostic:			
S11730	Needle biopsy, under GA	869.00	2	190.94
11745	Open biopsy, under GA	1133.00	2	248.23
	Excision - Therapeutic, Endoscopic:			
57305	Removal loose body	1131.00	2	311.84
57306	Pinning/drilling osteochondral fragments	1641.00	2	448.47
57310	Synovectomy ankle, total	2025.00	2	508.90
57330	Abrasion or debridement	1131.00	2	331.68
	Excision - Therapeutic, Open:			
57354	Ganglion, tendon sheath or joint	1001.00	2	261.94
57355	Bursa, excision, Achilles	1001.00	2	228.70
57356	Neuroma (i.e. sensory, digital, etc.)	1001.00	2	236.79
57360	Total synovectomy/debridement	1651.00	2	373.12
57365	Benign soft tissue Tumour	1001.00	2	246.78
57370	Bone Tumour, benign	1641.00	2	398.35

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
57371	Tarsal coalition NOTE: Includes harvesting of interposition material, if required.	1641.00	2	418.29
57372	Sesamoidectomy	1131.00	2	271.16
57373	Excision, accessory navicular	1131.00	2	319.35
57374	Talectomy	2520.00	2	576.05
57375	Excision, nail bed, under GA, single or multiple	1001.00	2	226.70
*57380	Osteomyelitis, acute, decompression	869.00	2	323.02
*57385	Osteomyelitis, debridement with or without reconstruction	1504.00	2	407.46
	Introduction and/or Removal, Therapeutic:			
*57405	Injection joint	54.00		11.90
*57410	Injection bursa, tendon sheath, other peri articular structures	54.00		11.90
57415	Removal of internal fixation device(s), when performed in the operating room	1001.00	2	306.79
*57420	Removal of internal fixation device(s), (operation only)	215.00	2	47.73
	Repair, Revision, Reconstruction (Soft Tissue):			
	<u>Ankle Instability: Capsule or Ligament Repair:</u>			
57505	Acute ligament repair, medial and/or lateral	1131.00	2	287.03
57510	Reconstruction for ankle instability	1776.00	2	553.90
	<u>Tendon-muscle Repair:</u>			
57515	Tendo Achilles repair, acute (within 6 weeks post injury)	1641.00	2	442.37
57516	Tendo Achilles repair, chronic (beyond 6 weeks post injury)	2520.00	2	622.46
57520	Flexor tendon repair, ankle or foot, single or multiple	1641.00	2	392.45
57525	Extensor tendon(s), without GA - operation only	564.00	2	133.23
57526	Extensor tendon(s), single, under GA	1131.00	2	313.76
57527	Extensor tendon(s), multiple, under GA	1566.00	2	403.42
57535	Repair/reconstruction of tendon sheath	1776.00	2	453.25
	<u>Tendon Muscle Transfer, Transplant, Tenoplasty:</u>			
57550	Tendon transfer	2025.00	2	502.99
57555	Jones' procedure	1518.00	2	357.44

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Repair, Revision, Reconstruction (Bone, Joint):			
	Osteotomy/Malunion:			
57601	Distal tibial	3026.00	2	746.89
57602	Malleolus, lateral and/or medial	2025.00	2	567.76
57603	Calcaneal Osteotomy (not to include Hagelund's)	2025.00	2	592.61
57604	Midtarsal Osteotomy	2789.00	2	642.32
57605	Metatarsals, base, shaft, neck	1641.00	2	408.36
57606	Phalanges, open osteotomy	1131.00	2	252.46
	Osteotomy/Nonunion:			
57631	Distal tibial	2520.00	2	664.45
57632	Malleolus, lateral and/or medial	1518.00	2	499.02
57633	Tarsals	1776.00	2	417.81
57634	Metatarsals, base, shaft, neck	1001.00	2	264.28
57635	Phalanges	1001.00	2	219.58
57636	Epiphysiodesis	1389.00	2	314.38
57637	Physeal Bar excision	1892.00	2	483.09
	Bone Grafting (i.e. onlay grafting):			
57651	Distal tibia	1131.00	2	248.23
57652	Malleolus, medial and/or lateral - tarsals, metatarsals, phalanges	694.00	2	152.76
	Arthroplasty: Ankle Joint:			
57661	Total ankle prosthesis	3805.00	3	1102.55
57662	Revision total ankle	5125.00	3	1421.20
*57663	Removal of total ankle arthroplasty	869.00	3	190.94
	Metatarsal Phalangeal Joint: Arthroplasty:			
57671	Excision arthroplasty great toe (Keller's cheilectomy)	1265.00	2	302.74
57672	Resection, soft tissue reconstruction	1389.00	2	326.88
57673	Distal metatarsal osteotomy	1389.00	2	326.88
57674	Proximal metatarsal osteotomy with distal realignment	2025.00	2	460.88
57675	Implant arthroplasty	1389.00	2	326.88
57676	Interphalangeal joint arthroplasty, single or multiple	1265.00	2	276.87
57677	Minor forefoot reconstruction (lesser toes)	1776.00	2	418.26
57678	Major forefoot reconstruction (includes excision arthroplasty, stabilization with or without implant, and great toe)	2770.00	2	654.30
	Fracture and/or Dislocation:			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Ankle Fracture: Intra-articular Tibial Metaphysical (PILON)			
*57701	Closed reduction, with GA, cast/traction	869.00	2	190.94
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	2286.00	2	501.24
57705	Open reduction internal fixation (include fibular fracture)	4175.00	2	985.74
*57708	Open injury, primary wound care	437.00	2	152.79
*57709	Open injury, secondary wound management	869.00	2	214.45
	Ankle (Malleolar) Fracture:			
*57711	Closed reduction, without GA, application of cast	437.00	2	102.18
*57712	Closed reduction, with GA, application of cast	1265.00	2	276.87
57713	Closed reduction, external fixation/percutaneous fixation	1265.00	2	356.91
57715	ORIF - one malleolus	1641.00	2	443.34
	NOTE: Injuries requiring opposite side soft tissue repairs (i.e. deltoid ligament repair with lateral malleolar fracture ORIF) are payable under 57716.			
57716	ORIF - two or more	1892.00	2	518.11
*57718	Open injury, primary wound care	437.00	2	152.79
*57719	Open injury, secondary wound management	869.00	2	214.45
	Hindfoot/Midfoot/Lisfranc Dislocation With or Without Fracture:			
*57721	Closed reduction, without GA, cast	437.00	2	95.49
*57722	Closed reduction, with GA, cast	869.00	2	190.94
57723	Closed reduction, fixation	1389.00	2	362.84
57725	Open reduction, with or without internal fixation	2025.00	2	617.52
*57728	Open injury, primary wound care	437.00	2	152.79
*57729	Open injury, secondary wound management	869.00	2	214.45
	Os Calcis: Fracture:			
*57732	Closed reduction, with GA, cast	869.00	2	190.94
57733	Closed reduction, fixation	1389.00	2	305.53
57735	ORIF	2915.00	2	746.91
*57738	Open injury, primary wound care	437.00	2	152.79
*57739	Open injury, secondary wound management	869.00	2	214.45
*57749	Open injury, secondary wound management	869.00	2	214.45
	Talus Fracture:			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
*57741	Closed reduction, without GA, cast	437.00	2	95.49
*57742	Closed reduction, with GA, cast	869.00	2	190.94
57743	Closed reduction, fixation	1518.00	2	353.31
57745	ORIF	2274.00	2	662.37
*57748	Open injury, primary wound care	437.00	2	152.79
	Tarsal Fracture:			
*57751	Closed reduction, without GA, cast	437.00	2	95.49
*57752	Closed reduction, with GA, cast	869.00	2	190.94
57753	Closed reduction, fixation	1389.00	2	305.53
57755	ORIF	1518.00	2	443.26
*57758	Open injury, primary wound care	437.00	2	152.79
*57759	Open injury, secondary wound management	869.00	2	214.45
	NOTE: Multiple tarsal fractures are payable under hind/midfoot Lisfranc dislocation with or without fracture items *57721 to *57729.			
	Metatarsal Fractures:			
57761	Closed reduction, fixation	1265.00	2	276.87
57765	ORIF, one	1389.00	2	373.64
57766	ORIF, two or more	1641.00	2	429.15
*57768	Open injury, primary wound care	437.00	2	152.79
*57769	Open injury, secondary wound management	869.00	2	214.45
	Metatarso-phalangeal Dislocation:			
*57771	Closed reduction, without GA, cast, single or multiple	437.00	2	95.49
*57772	Closed reduction, with GA, cast, single or multiple	869.00	2	190.94
57773	Closed reduction, fixation, single or multiple	1006.00	2	219.58
57775	ORIF	1389.00	2	373.64
*57778	Open injury, primary wound care	437.00	2	152.79
*57779	Open injury, secondary wound management	869.00	2	214.45
	Phalangeal Fracture:			
57781	Closed reduction, fixation, single or multiple	1265.00	2	302.74
57785	ORIF	1389.00	2	305.53
*57788	Open injury, primary wound care	215.00	2	81.45
*57789	Open injury, secondary wound management	437.00	2	112.28
	Interphalangeal Dislocations with or without Fracture:			
*57791	Closed reduction, without GA, cast, single or multiple	215.00	2	47.73
*57792	Closed reduction, with GA, cast, single or multiple	869.00	2	190.94
57793	Closed reduction, fixation, single or multiple	1265.00	2	276.87
57795	Open reduction, with or without fixation	1389.00	2	305.53

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
*57798	Open injury, primary wound care	215.00	2	81.45
*57799	Open injury, secondary wound management	437.00	2	112.28
	Manipulation: Ankle/Foot:			
*S57800	Manipulation, with GA	437.00	2	95.49
	Arthrodesis:			
57810	Tibiocalcaneal	2789.00	2	664.71
57811	Pantalar	3911.00	2	896.24
57812	Ankle joint	3351.00	3	801.68
57813	Subtalar joint/triple	2789.00	2	856.52
57814	Midtarsal joint	2520.00	2	652.29
57815	Tarso-metatarsal joints	3066.00	2	714.02
57816	Metatarsophalangeal	1641.00	2	443.14
57817	Interphalangeal, single or multiple	1265.00	2	308.75
	Amputation:			
57980	SYME	2482.00	2	544.18
57981	Midtarsal	2286.00	2	521.41
57982	Transmetatarsal	1904.00	2	521.41
57983	Single metatarsal/Ray resection	1651.00	2	382.34
57984	Toe	877.00	2	190.94
*57998	Open injury, primary wound care	215.00	2	81.45
*57999	Open injury, secondary wound management	437.00	2	112.28

VERTEBRA, FACET AND SPINE

	Incision - Diagnostic, Percutaneous:			
SY00757	Aspiration, other joints	51.20	2	16.54
	Incision - Therapeutic, Percutaneous:			
*58205	Injection/aspiration, facet joint	437.00	2	95.07
	Incision - Therapeutic, Drainage:			
51039	Bursa aspiration - operation only	108.00		23.76
	Excision - Diagnostic, Percutaneous:			
S11830	Needle biopsy, soft tissue/bone - thoracic spine, under GA	1001.00	2	219.58
S11831	Needle biopsy, soft tissue/bone - lumbar spine, under GA	869.00	2	190.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Excision - Diagnostic, Open:			
11845	Biopsy, with GA	1131.00	3	248.23
	NOTE: Not payable with definitive spinal surgery.			
	Excision - Therapeutic, Open:			
	Decompression - Posterior:			
	Laminectomy:			
03155	– for hematoma, tumour or vascular malformation	3144.00	6	1331.92
03161	– for localized spinal stenosis (two levels or less)	2434.00	5	906.31
03162	– for generalized spinal stenosis (more than two levels)	3791.00	5	1274.70
03160	– for congenital spinal malformation or tethered spinal cord	5301.00	5	2073.75
03180	Multiple level laminectomy for cervical cord compression, three or more levels	4468.00	6	1463.12
	Introduction and/or Removal, Therapeutic:			
S03167	Insertion of skull tongs (operation only)	436.00	4	129.15
	Fracture and/or Dislocation (Cervical Spine):			
	Cervical:			
S03167	Application of skull tongs	436.00	4	129.15
*58710	Application of halo	869.00	4	190.94

MUSCULOSKELETAL ONCOLOGY

51051	Resection of subfascial malignant soft tissue Tumour, simple	2789.00	5	644.13
51052	Resection of subfascial malignant soft tissue Tumour, complex (involvement of neuro/vascular structures)	5954.00	6	1367.13
	NOTE: Fee items 51053 to 51058. Reconstruction items are payable in full with the resection, if applicable.			
*51053	Resection of malignant bone Tumour limb, limb sparing	5048.00	6	1157.93
51054	Reconstruction of skeletal defect following excision	5085.00	6	1178.25
51055	Resection of malignant girdle Tumour, scapula	5048.00	6	1107.52
*51056	Resection of malignant girdle Tumour, pelvis and/or sacrum	7566.00	6	1676.97
51057	Reconstruction of shoulder/pelvis or sacrum	5085.00	6	1360.32

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
51058	Resection of malignant Tumour, rotation plasty	10130.00	6	2249.46

MINOR PROCEDURES

13610	Minor laceration or foreign body - not requiring anesthesia (operation only)	99.60		40.64
	NOTES: i) Intended for primary treatment of injury. ii) Not applicable to dressing changes or removal of sutures. iii) Applicable for steri-strips or glue to repair a primary laceration.			
13611	requiring anesthesia (operation only)	188.00	2	75.71
13630	Paronychia (operation only)	99.30		40.50
13631	Removal of nail, simple (operation only)	99.30		40.50
13632	with destruction of nail bed - operation only	199.00		81.96
13633	Wedge excision or Vandenbos procedure of one nail – (operation only)	178.00		72.32

PERIPHERAL NERVE

S03196	Exploration, mobilization and transposition	962.00	2	287.85
03198	Neurectomy of major nerve	757.00	2	227.46
S06258	Exploration of peripheral nerve and neurolysis	1229.00		262.46
	NOTE: Multiple neurolyses are paid in accordance with Preamble Clause D.5.3. to a maximum of four neurolyses per sitting.			

SPINE

03152	Bischoff's or longitudinal myelotomy	3203.00	5	957.28
03153	Laminectomy, with DREZ lesion for pain.....	4821.00	6	1440.56
03155	Laminectomy for hematoma, tumour or vascular malformation	3144.00	6	1331.92
	<u>Laminectomy for cervical disc:</u>			
03156	one level.....	5239.00	6	2049.28
03157	multiple levels.....	5765.00	6	2254.72
	<u>Laminectomy for lumbar disc:</u>			
03158	one level.....	2096.00	5	802.24
03159	multiple levels.....	3487.00	5	1412.24

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
03160	Laminectomy for congenital spinal malformation or tethered spinal cord	5301.00	5	2073.75
03161	Laminectomy for localized spinal stenosis (two levels or less)	2434.00	5	906.31
03162	Laminectomy for generalized spinal stenosis (more than two levels)	3791.00	5	1274.70
03168	Laminectomy for intradural spinal cord or extra-medullary Tumour or vascular malformation by microsurgical technique	6224.00	7	2458.37
03180	Multiple level laminectomy for cervical cord compression, three or more levels	4468.00	6	1463.12
03163	Anterior cervical discectomy and fusion – one level	3739.00	6	1462.23
03164	multiple levels	5062.00	6	2166.60
03166	Removal of thoracic disc	6143.00	8	2402.61
03185	Postero-lateral microsurgical thoracic discectomy	5008.00	8	1958.90
S03167	Insertion of skull tongs (operation only)	436.00	4	129.15
03169	Fracture of spine without cord injury, open reduction and fusion	2349.00	7	702.27
03231	Repair of spinal CSF leak or pseudomeningocoele	2049.00	5	919.30

SKIN GRAFTS

NOTE: Additional procedures, other than skin grafts, are extra; e.g.: bone or tendon grafts, inlay grafts, etc.

Local tissue shifts: Advancements, rotations, transpositions, “Z” plasty, etc.

Hand and Wrist, Incision; Open:

06051	Finger tip - operation only	1326.00	2	317.02
06050	Regions of major joints and hands - early	1883.00	2	449.96

Hand and Wrist, Excision; Therapeutic, Open:

V07055	Ganglia, of the wrist	933.00	2	255.66

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

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)	2116.00	5	562.45
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	1194.00	3	301.31
70159	Debridement of skin and subcutaneous tissue; for each additional 5% of body surface area or major portion thereof – extra	599.00		132.78
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	1339.00	4	306.30
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each additional 5% of body surface area or major portion thereof – extra	674.00	3	133.93
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	1480.00	4	316.74
70166	Debridement of skin, fascia, muscle and bone; for each additional 5% of body surface area or major portion thereof – extra	666.00		147.32
70168	Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area 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.	399.00		80.35
70169	Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area - operation only Notes: i) Payable only when performed by a medical practitioner in the operating room under general anesthesia or conscious sedation. ii) Requires wound assessment and dressing change and may include VAC application. iii) Debridement not payable in addition.	581.00	4	128.56

PEDIATRICS

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

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

REFERRED CASES

00510 **Consultation**: To consist of an examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report 1020.00 271.26

00550 **Extended Consultation – exceeding 53 minutes** (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report 1409.00 392.49

NOTES:

i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00510, 00511, 00512, 00551, 50510, 50511, 50512, 50515 or 50516.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

00551 **Extended Consultation – exceeding 68 minutes** (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report 1720.00 470.54

NOTES:

i) Applicable to patients with chronic and complex medical needs.
ii) Not payable in addition to 00510, 00511, 00512, 00550, 50510, 50511, 50512, 50515 or 50516.
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.

00511 **Consultation for Complex Behavioural Development or Psychiatric Condition in a Child:** To consist of a physical and neurological examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report. 2043.00 523.23

(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 NOTE: Payable in cases of prematurity or fetal anomaly.	642.00	175.65
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	469.00	115.63
00585	Diabetic Ketoacidosis (DKA) – 1st day management – in hospital 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.	2093.00	522.12
00514	Prolonged visit for counseling 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.	410.00	150.85

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	Group Counseling:		
00513	Group counseling for groups of two or more patients - first full hour	569.00	230.08
00515	– second hour, per 1/2 hour or major portion thereof	287.00	115.02
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		
	Continuing Care by Consultant:		
00506	Directive care	448.00	135.72
00507	Subsequent office visit	358.00	102.86
00552	Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient).	428.00	119.10
	NOTES: i) Applicable to patients with chronic and complex medical needs. ii) Includes review of extensive documentation regarding the patient. iii) Not payable in addition to 00507, 00553, 00554, 50507, 50517, 50518, 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)	687.00	181.33
	Notes: i) Applicable to patients with chronic and complex medical needs. ii) Includes review of extensive documentation regarding the patient. iii) Not payable in addition to 00507, 00552 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)	978.00	265.63

(see notes on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	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	**Antenatal follow-up visit** ..... NOTE: Payable in cases of prematurity or fetal anomaly.	169.00	52.03
00508	Subsequent hospital visit	448.00	135.72
00509	Subsequent home visits	699.00	196.03
00505	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) ..... NOTES: i) Claim must state time service rendered. ii) For premature care or intensive care of a newborn, see Clauses D. 4. 5., D. 4. 6., D. 4. 7., and D. 4. 8. of the Preamble.	577.00	153.06
Telehealth Service with Direct Interactive Video Link with The Patient			
50510	**Telehealth Consultation:** To consist of an examination, review of history, laboratory, X-ray findings and additional visits necessary to render a written report.	1020.00	271.26
50515	Telehealth Extended Consultation – exceeding 53 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report ..... NOTES: i) Applicable to patients with chronic and complex medical needs. ii) Not payable in addition to 00510, 00511, 00512, 00550, 00551, 50510, 50511, 50512 or 50516. iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.	1409.00	392.49

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
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	1720.00	470.54
	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.		
50511	**Telehealth consultation for complex behavioural, developmental or psychiatric condition in a child:** To consist of a physical and neurological examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.	2043.00	523.23
	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	**Telehealth repeat or limited consultation:** Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	469.00	115.63
50514	Telehealth prolonged visit for counselling	410.00	101.02
	NOTES: i) The Plan will pay up to four such visits per year (See Clause D. 3. 3. of the Preamble). ii) Start and end times must be entered in both the billing claims and the patient's chart.		

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
50506	Telehealth directive care	448.00	135.72
50507	Telehealth subsequent office visit.....	358.00	102.86
50508	Telehealth subsequent hospital visit.....	448.00	135.72
50517	Telehealth Complex subsequent office visit – exceeding 12 minutes (at least 10 min. spent with patient)	428.00	119.10

NOTES:
- i) Applicable to patients with chronic and complex medical needs.
- ii) Includes a review of extensive documentation regarding the patient.
- iii) Not payable in addition to 00507, 00552, 00553, 00554, 50507, 50518 or 50519.
- iv) For time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.

50518	Telehealth Complex subsequent office visit – exceeding 23 minutes (at least 20 min. spent with patient)	659.00	181.33

NOTES:
- i) Applicable to patients with chronic and complex medical needs.
- ii) Includes a review of extensive documentation regarding the patient.
- iii) Not payable in addition to 00507, 00552, 00553, 00554, 50507, 50517 or 50519.
- iv) For time spent with the patient, start and end times must be submitted with claim and must be recorded in the patient's chart.

50519	Telehealth Complex subsequent office visit – exceeding 38 minutes (at least 20 min. spent with patient)	935.00	265.63

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.

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

SPECIAL SERVICES

A00516	Newborn care in hospital, without complications	340.00	
A00517	Periodic health examinations - infants	179.00	
A00519	children and adolescents	198.00	
A00520	Assessment and examination prior to adoption	708.00	

MISCELLANEOUS

50571	Pediatric evening surcharge (service rendered between 1800 hours and 2300 hours).....	141.00	38.26
50572	Pediatric Saturday, Sunday and Statutory Holiday surcharge (service rendered between 0800 hours and 2300 hours).....	141.00	38.26
50573	Pediatric night surcharge (service rendered between 2300 hours and 0800 hours).....	432.00	117.99

NOTES:

i) Restricted to Pediatrics and Pediatric Cardiology.
ii) Payable only in addition to fee items 00510, 00550, 00551, 00585, 01511, 01512 and 01513.
iii) Payable only in addition to out-of-office premiums (01200, 01201, 01202, 01205, 01206, 01207).
iv) Not applicable to full or part-time onsite practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.

00545	Pediatric Case Conference - a formal, scheduled session/meeting to discuss/plan medical management of patients with serious and complex pediatric problems. Payable only when coordination of care and two-way collaborative conference with community agency representative and/or health care provider is required e.g.: psychologists, counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry - per 1/4 hour or major portion thereof..	324.00	89.64

(see notes on next page)

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

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, by phone, or by videoconference.

ix) A visit or consult may be payable for the same patient on the same day as a case conference, provided the two items are consecutive, not concurrent, and start and end times are provided for both. A note record must be submitted for consults and patient management conferences occurring on the same day.

x) It may not be claimed unless the pediatrician has a pre-existing relationship with the patient.

xi) 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
P00546	Pediatric to Adult Transition Care and Communication. For patients 15-19 years of age transitioning from community pediatric care to adult services	819.00	381.78

NOTES:
- i) Limited to one service per patient per year per physician.
- ii) Limited to two services per patient per lifetime per physician.
- iii) Limited to pediatricians in community practice.
- iv) Limited to patients with chronic and complex medical needs.
- v) Not payable unless the patient has been seen by the physician in the preceding 12 months.
- vi) A visit is payable for the same patient on the same day provided the services are not concurrent and start and end times are provided for both.
- vii) A written transition summary, for example the BC Pediatric Society Medical Transfer Summary form, must be recorded in the patient's chart.
- viii) Transition documentation must be communicated to accepting adult service(s).

00547	Adolescent (12-19 years of age) care surcharge	95.50	24.50

NOTES:
- i) Restricted to Pediatricians.
- ii) Payable only in addition to 00510, 00550, 00551, 50510, 50515 or 50516 on the same date of service.
- iii) Limited to one claim per patient per physician per day.

SPECIAL PROCEDURES

00525	Insertion of intra-arterial infusion line in infants - extra to consultation.....	435.00	107.03
00523	Exchange transfusion - procedural fee	2079.00	512.88

NOTES:
- i) Charge full fee for all repeat transfusions.
- ii) Normally an assistant for exchange transfusion is not required. However, in those exceptional cases when an assistant is required, an explanation of need must accompany the account to the payment agency.
- iii) Paid at 50% when billed in conjunction with critical care codes.
- iv) Not applicable to replacement of blood with saline for hyperviscosity syndrome.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	261.00	64.01
	Electrocardiogram and interpretation:		
00527	– (office) - each	159.00	39.08
00528	– (home) - each	221.00	54.32
00529	Electrocardiogram - professional fee	55.10	13.68
	The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:		
93120	E.C.G. tracing, without interpretation, (technical fee)	49.10	17.38
	Graded exercise test:		
00530	– technical fee	196.00	48.23
00535	– professional fee	288.00	70.36
00531	– total fee	481.00	118.61
	NOTE: The note following fee items 33034, 33035 and 33036 in the Cardiology section of this Guide apply to items 00530, 00531 and 00535.		
00532	Electrocardiogram and interpretation for children under 2 years of age	261.00	64.01
00533	– interpretation	61.70	15.01
00534	– technical fee	199.00	48.99
00539	Rectal suction biopsy in children	482.00	118.93
00540	24 hour intraesophageal pH study in children (to include probe and monitoring)	1113.00	274.59
SY00541	Pediatric urethral catheterization in child under 5 years – isolated procedure	89.50	22.26

Notes:

i) Procedure not payable if delegated to a non-physician.
ii) Not payable with critical care listings or diagnostic urological procedures (e.g.: voiding cystourethrogram.)
iii) Restricted to Pediatricians.

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

CHEMOTHERAPY

a. Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.
b. Hospital visits are not payable on the same day.
c. Visit fees are payable on subsequent days, when rendered.
d. A consultation, when rendered, is payable in addition to fee item 00578, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.
e. The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.

00578	**High Intensity Cancer Chemotherapy for patients 16 years of age and under:** To include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis.....	1103.00	272.05

Notes: This service is not payable more frequently than once every 28 days. The following treatments fall into this category:

a) chemotherapy for acute leukemia;
b) chemotherapy utilizing cisplatinum given in a dose exceeding 50 mg/m2 per treatment;
c) chemotherapy utilizing isophosphamide in combination with bladder protector Mesna;
d) chemotherapy using DTIC in a dose exceeding 100 mg/m2;
e) chemotherapy utilizing methotrexate in dose exceeding 1 g/m2 (and combined with the folinic acid rescue regimen);
f) chemotherapy using continuous infusion technique exceeding a period of 8 hours per session (except for the infusional 5-FU treatment protocol.)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
00579	**Major Intensity Cancer Chemotherapy for patients 16 years of age and under:** To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents. Note: This service is not payable more frequently than once every 7 days.	852.00	210.19
00580	**Limited Intensity Cancer Chemotherapy for patients 16 years of age and under:** To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line..... 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.	502.00	123.63

DIAGNOSTIC PROCEDURES

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.	251.00	2	61.83
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.	378.00	2	92.73

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00755	Artery puncture - procedural fee	36.05	2	7.15
S00571	Pediatric esophagogastroduodenoscopy in a patient 16 years of age and under Note: Restricted to pediatricians and pediatric general surgeons.	901.00	3	222.55
S00572	Pediatric colonoscopy with flexible colonoscope – patients 16 years of age and under Notes: i) Includes biopsies, removal of polyps, collection of specimens by brushing or washing, control of bleeding, removal of foreign body, if required. ii) Restricted to pediatricians and pediatric general surgeons.	1655.00	2	408.03
	Cardiology Procedures			
S50520	Pediatric right heart catheterization – patients 0-6 years of age Note: Restricted to BC Children's Hospital	1625.00	4	401.27
S50521	Pediatric right heart catheterization – patients 7-16 years of age Note: Restricted to BC Children's Hospital	1219.00	4	300.95
S50522	Pediatric myocardial biopsy for ages 0-16 years of age, extra Notes: i) Payable once per session, regardless of number of biopsies performed. ii) Payable only to Pediatric Cardiologists at BC Children's Hospital. iii) Only paid in addition to fee item S50520 or S50521.	467.00		115.29
S50527	Pediatric retrograde left heart catheterization, extra – patients 0-6 years of age Note: Restricted to BC Children's Hospital	1302.00	4	320.95
S50528	Pediatric retrograde left heart catheterization, extra – patients 7-16 years of age Note: Restricted to BC Children's Hospital	976.00	4	240.68
S50530	Pediatric trans-septal left heart catheterization – patients 0-6 years of age	1753.00	4	432.50

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Note: Restricted to BC Children's Hospital			
S50531	Pediatric trans-septal left heart catheterization – patients 7-16 years of age Note: Restricted to BC Children's Hospital	1315.00	4	324.37
S50539	Pediatric percutaneous transluminal coronary angioplasty – patients 0-6 years of age Note: Restricted to BC Children's Hospital	3703.00	4	913.53
S50540	Pediatric percutaneous transluminal coronary angioplasty – patients 7-16 years of age Note: Restricted to BC Children's Hospital	2777.00	4	685.14
S50541	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 0-6 years of age Note: Restricted to BC Children's Hospital	1953.00	4	481.58
S50542	Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 7-16 years of age Note: Restricted to BC Children's Hospital	1462.00	4	361.19
S50545	Pediatric therapeutic radiological embolization – patients 0-6 years of age Note: Restricted to BC Children's Hospital	3394.00	3	837.65
S50546	Pediatric therapeutic radiological embolization – patients 7-16 years of age Note: Restricted to BC Children's Hospital	2548.00	3	628.26
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.	4760.00	7	1174.66

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Not payable with fee items 00898 and 00871. This composite also includes the taking of blood pressure (intra-arterial or intravenous), calculation of pressure gradients during the procedure and any pharmacological study or infusion of therapeutic substance. iv) Payable to Pediatricians only. v) Medically necessary assistance payable under cardiac assist fee items 00845 and 00846.			
50551	Additional stents – extra	1003.00		247.30
	Notes: i) Must be inserted into a differently named, non-contiguous vessel (provide information in note record). ii) Maximum payable is 2 additional stents.			
50555	Percutaneous transcatheter cardiac occluder device closure of ASD in pediatric patients (0-18 years of age) – composite fee (operation only)	4760.00	7	1174.66
	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.			
T50556	Fetal Echocardiogram (per 15 minutes or greater portion thereof).....	235.00		60.60
	NOTES: i) Restricted Pediatric Cardiologists.			

(notes continued on next page)

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

ii) When antenatal consultation (00590) or antenatal follow-up visit (00597) is charged in addition, for billing purposes the antenatal consultation fee shall constitute the first ½ hour or the antenatal follow-up visit will constitute the first 15 minutes of the time spent with the patient.
iii) Start and end times of the pediatric cardiologist must be entered in both the billing claims and the patient's chart.
iv) Not payable with any services performed concurrently.
v) Limited to maximum of 6 units per patient per sitting.

Neonatal Intensive Care

Please refer to the Critical Care Section of the Payment Schedule/Fee Guide 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/Fee Guide" 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/Fee Guide and personally attends the patient.

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

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included are: family 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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	LEVEL A - Infants in a Neonatal Intensive Care Unit requiring artificial ventilation and full intensive monitoring and parenteral alimentation if necessary. These fees include all procedures.		
01511	Day 1	2885.00	716.38
01521	Day 2 - 10	1155.00	288.18
01531	Day 11 onward	770.00	193.65
	LEVEL B - Infants in a Neonatal Intensive Care Unit requiring full monitoring both invasive and non-invasive and requiring IV therapy or parenteral alimentation but without ventilator support.		
01512	Day 1	2117.00	550.09
01522	Day 2 - 10	770.00	202.59
01532	Day 11 onward	573.00	146.48
	LEVEL C - Infants in a Neonatal Intensive Care Unit requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.		
01513	Day 1	1830.00	474.76
01523	Day 2 - 10	566.00	149.74
01533	Day 11 onward	448.00	132.05

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. **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 ($)	MSP & WSBC Fee ($)
REFERRED CASES			
	Full Consultations		
	Individual: Diagnostic interview or examination, including history, mental status exam and treatment recommendation and written report.		
00610	Private office or hospital out-patient	640.00	303.31
00611	Extended Adult Psychiatry Consultation > 68 minutes 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.	850.00	410.62
00615	Hospital/institution in-patient or home	642.00	303.31
00613	Geriatric consultation (patients 75 years or older)	968.00	454.98
00622	Emotionally disturbed child: Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	1140.00	530.80
00623	Multiple disturbed family: (3 or more members) - Simultaneous diagnostic interviews or examination, including mental status of the members, their interactions and written report	1219.00	530.80
	Repeat or Limited Consultations 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)	337.00	154.58
00614	Geriatric (see 00613)	496.00	227.48
00626	Emotionally disturbed child (see 00622)	570.00	265.40
00627	Multiple disturbed family (see 00623)	612.00	265.40

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	Continuing care by consultant:		
	Psychiatric Treatment		
00607	Office visit to include services such as chemotherapy management and/or minimal psychotherapy	143.00	65.14
00608	Hospital visit	154.00	65.14
00609	Home visit	192.00	87.26
00605	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	388.00	170.45
	NOTE: Claim must state time service rendered.		
	Individual: (office or hospital out-patient)		
00630	– per 1/2 hour	281.00	132.44
00631	– per 3/4 hour	407.00	198.67
00632	– per 1 hour	523.00	264.89
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		
	Individual: (hospital or institution in-patient or home)		
00650	– per 1/2 hour	313.00	132.44
00651	– per 3/4 hour	430.00	198.67
00652	– per 1 hour	554.00	264.89
	NOTE: The start time of the first patient seen and the end time of the last patient seen each day must be entered in the billing claims and the patient's chart should have sufficient documentation around the timing of the patient interaction (see Psychiatry Preamble 1.).		
	Family/conjoint therapy: (2 or more family members)		
00633	– per 1/2 hour	281.00	132.44
00635	– per 3/4 hour	407.00	198.67
00636	– per 1 hour	523.00	264.89
00638	– per 1 ¼ hour	665.00	331.04
00639	– per 1 ½ hour	795.00	397.32
	NOTES: i) Start and end times must be entered in both the billing claims and the patient's chart. ii) A note record is required for sessions longer than one hour.		
	Group Psychotherapy: (fee per patient), per 1/2 hour		
00663	– three patients	126.00	64.52
00664	– four patients	101.00	50.48
00665	– five patients	87.50	42.05
00666	– six patients	77.80	36.44

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
00667	– seven patients	71.10	32.43
00668	– eight patients	66.00	29.40
00669	– nine patients	62.00	27.07
00670	– ten patients	58.60	25.19
00671	– eleven patients	51.40	23.67
00672	– twelve patients	48.25	22.39
00673	– thirteen patients	44.65	21.32
00674	– fourteen patients	43.85	20.39
00675	– fifteen patients	42.00	19.59
00676	– sixteen patients	40.80	18.88
00677	– seventeen patients	39.15	18.26
00678	– eighteen patients	38.55	17.71
00679	– nineteen patients	36.90	17.22
00680	– twenty patients	36.00	16.78
00681	– Greater than 20 patients (per patient)	34.70	16.38

NOTES:

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

ii) Where two co-therapists are involved in a group of eight (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.

Telehealth Service with Direct Interactive Video Link with the Patient:

Full Telehealth Consultations:

60610	**Telehealth Individual Consultation:** Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report	640.00	303.31
60613	Telehealth Geriatric consultation (patients 75 years or older).	968.00	454.98
60622	Telehealth consultation: Emotionally disturbed child: Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	1140.00	530.80

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	Repeat or Limited Telehealth Consultations: 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	337.00	154.58
60614	Telehealth–Geriatric consultation	496.00	227.48
60626	Telehealth–Emotionally disturbed child	570.00	265.40
	Telehealth Psychiatric Treatment		
60607	Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy	143.00	65.14
60608	Telehealth hospital in-patient visit	143.00	65.14
	Individual Telehealth Psychiatric Treatment		
60630	per 1/2 hour	281.00	132.44
60631	per 3/4 hour	407.00	198.67
60632	per 1 hour	523.00	264.89
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.		
	Family/conjoint Telehealth Therapy: (two or more family members):		
60633	per 1/2 hour	281.00	132.44
60635	per 3/4 hour	407.00	198.67
60636	per 1 hour	523.00	264.89
60638	per 1 ¼ hour	665.00	331.04
60639	per 1 ½ hour	795.00	397.32
	NOTES: i) Start and end times must be entered in both the billing claims and the patient's chart. ii) A note record is required for sessions longer than one hour.		
	Telehealth—Miscellaneous		
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	141.00	66.22

(see notes on next page)

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

NOTES:
i) When not the direct interactive focus of the interview, the patient may be present (e.g.: child or geriatric patient).
ii) Payable in addition to other services when performed consecutively, not concurrently.
iii) Maximum of one hour (4 units) may be claimed per patient per day.
iv) This fee is payable when the interview occurs in person or by telephone.
v) Start and end times must be included in the time fields.

60645	Telehealth Patient Management Conference - meeting by specific appointment to discuss/plan patient management with third parties, including referring physicians or allied hospital staff (if an 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	141.00	66.22

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.

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	141.00	66.22

(see notes on next page)

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	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	236.00	107.05
00645	Patient Management Conference - meeting by specific appointment to discuss/plan patient management with third parties, including referring physicians or allied hospital staff (if an 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.....	141.00	66.22
	NOTES: i) Not to exceed a maximum of four hours per patient, per psychiatrist, per calendar year. ii) A written record of the meeting must be maintained and/or a report generated by the psychiatrist. iii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods. iv) Not payable unless the patient has been seen by the Psychiatrist in the preceding 180 days. v) Names and positions of other participants in the Patient Management Conference must be recorded in the patient's chart. vi) This fee is payable when the case conference occurs in person or by phone. vii) Start and end times must be entered in both the billing claims and the patient's chart.		
A00643	Environmental intervention by the physician on a psychiatric patient's behalf with agencies, employers or institutions - per 1/2 hour.....	192.00	
A00644	Environmental intervention by the psychiatrist on a disturbed child's behalf with agencies, schools or institutions - per 1/2 hour.....	192.00	

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
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.....	192.00	
96301	*Mental Health Act* second opinion, performed by specialist - first assessment.....	178.00	
96302	*Mental Health Act* second opinion, performed by specialist - follow-up	81.40	
96201	*Mental Health Act* second opinion, performed by general practitioner - first assessment or follow-up..... NOTE: Submit claims for 96301, 96302 and 96201 to MSP. Do not bill privately.	59.00	

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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
REFERRED CASES			
01710	**Consultation:** To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report.....	585.00	235.72
01712	**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 judgment of the consultant, the consultative service does not warrant a full consultative fee.....	296.00	134.58
01714	Prolonged visit for counseling (up to four annually)..... 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.	296.00	87.01
	Group Counseling:		
01713	Group counseling for groups of two or more patients - first full hour.....	427.00	155.06
01715	– second hour, per 1/2 hour or major portion thereof..... NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	211.00	77.49
	<u>Continuing Care by Consultant:</u>		
01706	Directive care	200.00	118.47
01707	Office.....	278.00	118.56
01708	Hospital	187.00	76.92
01709	Home	392.00	161.32
01705	Emergency visit when specially called (not paid in addition to out-of-office hour premiums)..... NOTE: Claim must state time service rendered.	331.00	116.05
Telehealth Service with Direct Interactive Video Link with the Patient			
01770	Telehealth Formal Consultation: To consist of examination, review of history, laboratory, X-ray findings, functional, social, and vocational appraisal, and additional visits necessary to render a written report .	585.00	235.72

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
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.	296.00	134.58
01776	Telehealth directive care	200.00	118.47
01777	Telehealth subsequent office visit	278.00	118.56
01778	Telehealth subsequent hospital visit	187.00	76.92

MISCELLANEOUS

01728	Biofeedback for neurological and/or muscular retraining ..	69.70	22.93

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	119.00	36.64
01731	– Professional fee	174.00	53.48
01732	– Total fee	293.00	90.12

NOTE: The notes following fee items 33034, 33035 and 33036 in the Cardiology Section of this schedule also apply to fee items 01730, 01731 and 01732.

01721	Family rehabilitation conference where a certified specialist in Physical Medicine and Rehabilitation is involved with two (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	249.00	97.49

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

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	200.00	

NOTE: Where more than one certified specialist in physical medicine and rehabilitation required, each to submit separate accounts.

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

v) dysplastic nevi
vi) lentigo maligna
vii) congenital nevi
viii) actinic (solar) keratosis
ix) atypical pigmented nevi
x) painful neurofibromata

The following are not a benefit of MSP, unless there is medically significant pathophysiological dysfunction:

i) excisions for the listed benign skin lesions
ii) benign nevi
iii) seborrheic keratosis
iv) common warts (verrucae)
v) lipomata
vi) uncomplicated benign dermal and/or epidermal cysts
vii) telangiectasias and angiomata of the skin
viii) skin tags
ix) acrochordons
x) fibroepithelial polyps
xi) papillomata
xii) neurofibromata
xiii) dermatofibromata

Premalignant Lesions:

i) dysplastic nevus (nevus with dysplastic features, atypical melanocytic hyperplasia, atypical melanocytic proliferation, atypical lentinginous melanocytic proliferation or premalignant melanosis).
ii) actinic/solar keratosis
iii) chemical and other premalignant 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.

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.

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

REFERRED CASES

06010	**Major Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	422.00		111.03
06012	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgement of the consultant the consultative service does not warrant a full consultative fee	237.00		54.56
	Continuing Care by Consultant:			
06007	Subsequent office visit	124.00		31.22
06008	Subsequent hospital visit	179.00		38.86
06009	Subsequent home visit	344.00		129.50
06005	Emergency visit when specially called (not paid in addition to out-of-office hour premiums) NOTE: Claim must state time service rendered.	459.00		127.56
66015	Pre-Operative Assessment NOTES: i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances. ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent. iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition. iv) Maximum of one pre-operative assessment per patient per procedure. v) Only paid to the surgeon who performs the procedure.	422.00		111.03

Telehealth Service with Direct Interactive Video Link with the Patient

66010	**Telehealth Major Consultation:** To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	422.00		111.03

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
66012	**Telehealth repeat or limited consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where, in the judgment of the consultant, the consultative service does not warrant a full consultative fee	237.00		54.56
66007	Telehealth subsequent office visit	124.00		31.22
66008	Telehealth subsequent hospital visit	179.00		38.86

SURGICAL FEE MODIFIERS

P06003 Body Mass Index Surcharge payable at 25% of listed fee for surgery performed when:

- The patient has a Body Mass Index (BMI) of 35 or greater for major surgery

NOTES:

i) Payable only to Plastic Surgeons.

ii) Patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.

iii) Maximum of one surcharge per operation unless two plastic surgeons perform two synchronous surgeries that are both eligible for the surcharge.

iv) When multiple procedures are performed during the same operation, the surcharge applies to all eligible procedures based on the prorated value according to the surgical preamble for multiple procedures.

v) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the BMI surcharge.

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

vii) Payable when the following Plastic Surgery fee items are performed for patients with a BMI of 35 or greater: 06031, 06032, 06085, 06086, 06127, 06128, 06150, 06151, 06156, 06159, 06164, 06165, 06166, 06167, 06168, 06169, 06170, 06177, 06178, 06179, 06215, 06220, 61050, 61053, 61054, 61152, 61156, 61157, 61158, 61166 and 61167.

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

SKIN AND SUBCUTANEOUS TISSUES

	Biopsy			
61291	Biopsy, not sutured	381.00		91.11
61292	Biopsy, not sutured, multiples same sitting, maximum of four (extra)	107.00		25.58
	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)	649.00	2	203.96
07028	Biopsy of sural nerve – operation only	819.00	2	181.28
	Excision – Diagnostic, Open:			
11445	Open biopsy, hand or wrist	1133.00	2	265.66
	Incisional or excisional biopsy, includes suture closure			
13600	Biopsy of skin or mucosa (operation only)	144.00	2	59.26
13601	Biopsy of facial area (operation only)	144.00	2	59.26
	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)	352.00	2	77.73
	Hand and Wrist			
	Incision – Diagnostic, Percutaneous:			
S11402	Aspiration bursa, synovial sheath, etc.	108.00	2	23.76
	Abscess – incision and drainage			
	Abscess:			
07059	– deep (complex, subfascial, and/or multilocular) with local or regional anesthesia (operation only)	377.00	2	83.30
07027	– under general anesthesia or procedural sedation (operation only)	941.00	2	255.34
07061	– deep, post-operative wound infection under general anesthesia (operation only)	940.00	2	230.09
07045	Anterior closed space abscess – operation only	470.00	2	103.74

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
13605	Opening superficial abscess, including furuncle operation only	126.00	2	50.75
	Pilonidal cyst or Sinus			
70084	– incision and drainage abscess (operation only)	469.00	2	103.66
07685	– excision or marsupialization – operation only	1356.00	2	306.79
	Hand and Wrist Abscess			
06028	Web space abscess – (operation only)	1091.00	2	306.47
06029	– under general anesthetic (operation only)	1242.00	2	352.43
06042	Mid palmar, thenar, and dorsal: subaponeurotic space abscess – (operation only)	1221.00	2	306.47
06197	Acute tenosynovitis – finger – (operation only)	1242.00	2	367.70
06198	– ulnar or radial bursa – (operation only)	1242.00	2	367.70
13630	Paronychia – operation only	99.30	2	40.50

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)	2116.00	5	562.45
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	1194.00	3	301.31
70159	Debridement of skin and subcutaneous tissue; for each subsequent 5% of body surface area or major portion thereof	599.00		132.78
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	1339.00	4	306.30
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each subsequent 5% of body surface area or major portion thereof	674.00		133.93
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	1480.00	4	316.74
70166	Debridement of skin, fascia, muscle and bone; for each subsequent 5% of body surface area or major portion thereof	666.00		147.32

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
70168	Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area – operation only NOTES: i) Payable when rendered at the bedside but only when performed by a medical practitioner. ii) Requires wound assessment and dressing change and may include VAC application. iii) Applicable with or without anesthesia.	399.00		80.35
70169	Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area (operation only) NOTES: i) Payable only when performed by a medical practitioner in the operating room under general anesthesia or conscious sedation. ii) Requires wound assessment and dressing change and may include VAC application. iii) Debridement not payable in addition.	581.00	4	128.56
	Foreign Body and Minor Laceration In cases where a foreign body was simply extracted but the wound was not closed bill (13610 without anesthetic) or (13611 with anesthetic)			
06063	Extraction of foreign body from a wound requiring general anesthesia or procedural sedation – operation only NOTES: i) Also payable when performed under local anesthetic if the extraction requires at least 30 min and is complicated due to: a) The need for increased surgical exposure, or b) A delicate or deeper dissection, or c) Difficulty localizing the foreign body ii) If performed under local anesthetic, a note record must be provided with the length of the procedure and explaining why the extraction was complex in nature.	1074.00	2	306.47

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
13610	Minor laceration or foreign body – not requiring anesthesia – operation only 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.	99.60		40.64
13611	Minor laceration or foreign body – requiring anesthesia – operation only	188.00	2	75.71

ABLATION

Abrasive Surgery

06112	Abrasive surgery – less than quarter face (operation only)	606.00	3	129.56
S06113	– between quarter and half-face	1182.00	3	251.75
S06114	– full face	2512.00	3	535.64

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) 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.”	101.00		35.87
00218	Curettage and electrosurgery of skin carcinoma proven histopathologically (operation only)	303.00		80.00
00219	For each additional lesion – to a maximum of two additional lesions per day (operation only) *These items are subject to the general regulations covering surgical procedures.	227.00		40.00

Laser Therapy

00235	Pulsed laser surgery of the face and/or neck, treatment area less than 50 cm^2 (operation only)	564.00	3	70.65

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
00236	Pulsed laser surgery of the face and/or neck, treatment area greater than or equal to 50 cm^2, or treatment of the eyelids with eye shield insertion (operation only)	1219.00	3	105.84
00237	Additional surgical professional fee billable when either of the above two procedures are performed under general anesthesia	236.00		57.35

NOTES:
(a) Only the following conditions qualify for payment under 00235, 00236, 00237:
- i) Port wine stains involving the face and/or neck;
- ii) Complicated superficial haemangiomas:
  - lesions interfering with function (vision, breathing or feeding).
  - lesions which are ulcerated, bleeding, or prone to infections
  Where standard wound care has failed.
- iii) Facial naevus of Ota
- iv) Disfiguring facial pigmentary anomalies (eg: segmental or systematized).

(b) Only the following types of lasers qualify for payment under 00235, 00236, 00237:
- i) Pulsed dye laser
- ii) Q-Switched Ruby laser
- iii) Q-Switched YAG laser

(c) Restricted to Dermatology and Plastic Surgery.

Special case – Skin and Soft Tissue

06166	Excision of axillary sweat glands for hyperhidrosis – unilateral	1559.00	4	332.49

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	679.00	2	141.11

Excision of skin and subcutaneous tissue of hidradenitis suppurativa:
Note: Direct closure included.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Foreign Body:			
	Excision of skin and subcutaneous tissue of hidradenitis suppurativa:			
07072	– axillary (operation only)	1156.00	2	255.66
07075	– inguinal (operation only)	1156.00	2	255.66
07076	– perianal (operation only)	1156.00	2	255.66
07082	– perineal (operation only)	1156.00	2	255.66
	Nail Surgery			
13631	Removal of nail – simple operation only	99.30	2	40.50
13632	– with destruction of nail bed (operation only)	199.00	2	81.96
13633	Wedge excision or Vandenbos procedure of one nail – (operation only)	178.00	2	72.32
	Ganglia			
06182	Ganglia of tendon sheath or joint	875.00	2	186.40
	Torn ear Lobe			
06027	Repair of torn (split) earlobe (simple) (operation only)... NOTES: i) Single flap only, under 2 cm. ii) Paid only for complete tear of lobe through margin.	569.00	3	120.99

SUTURE OF LACERATIONS AND MINOR TRAUMATIC WOUNDS

Wounds – Simple, <u>or</u> involving minor debridement of traumatic wounds

These fees apply to closure using tissue glue (included), direct closure with sutures (included) but <u>not</u> 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)	588.00	2	140.65
S61301	– up to 5 cm – on face and/or requiring tying of bleeders and/or closure in layers (operation only)	872.00	2	208.38

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S61302 –	5.1 to 10 cm – other than face, simple closure (operation only)	1046.00	2	250.06
S61303 –	5.1 to 10 cm – on face and/or requiring tying of bleeders and/or closure in layers (operation only)	1089.00	2	260.48
S61304 –	10.1 to 15 cm – other than face, simple closure (operation only)	1220.00	2	291.75
S61305 –	10.1 to 15 cm – on face and/or requiring tying of bleeders and/or closure in layers (operation only)	1524.00	2	364.67
S61306 –	15.1 cm or more – other than face, simple closure (operation only)	1307.00	2	312.57
S61307 –	15.1 cm or more – on face and/or closure in layers (operation only)	1743.00	2	416.77

NOTES:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Multiples paid at 50%, to a maximum of 5 lacerations at the same sitting.
iii) Removal of sutures included in any visit fee.
iv) Not paid with skin flap or graft fees. (Per wound. Cannot bill flap and wound closure on same wound, but if one wound requires a flap/graft and second/third wounds require simple layered closure then existing 100%/50% billing applies as per Note ii above).
v) Direct closure paid when the procedure includes at least one deep layer of sutures and cyanoacrylate.
vi) Minor undermining (to help evert wound edges) is considered included.

61308	Laceration(s) under GA – if general anesthetic is used, and when suture of laceration(s) is the sole procedure – extra	872.00	2	208.38

NOTES:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Paid in addition to 61300-61307 and 61310-61322.

Wounds – avulsed and complicated (in special areas)

V70150	Complicated lacerations of tongue, floor of mouth	1328.00	3	276.62

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
06238	Repair of complicated fingertip injury under digital block or anesthetic (regional/general)..... Note: Requires nail bed repair (includes removal of nail plate, suturing of nail bed laceration and replacement of nail plate) including associated management of distal phalangeal fracture.	964.00	2	280.78
06075	Lips and eyelids.....	1626.00	3	347.09
06076	Nose and ear.....	2045.00	3	436.01
06077	Complicated lacerations of the scalp, cheek and neck..	1598.00	3	340.66

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
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.

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

LESIONS AND SCARS

For medically necessary excision and/or repair of benign, pre-malignant and malignant lesions and scars, by direct closure, and resulting in linear closure:

NOTES:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) First paid at 100%, 2nd to 5th – 50%. The maximum payable for benign and pre-malignant lesions is 5 per sitting. If additional (>5) malignant lesions are removed at the same sitting payment will be made at 25% of the listed fee. If more than 10 malignant lesions are removed at the same sitting a copy of the operative and pathology reports is required.
iii) Not paid with excision fees 61320, 61321, 61322.

	Trunk, Arms and Legs			
S61310	Resulting in repair less than 5 cm (operation only).....	523.00		125.04
S61311	Resulting in repair 5-10 cm (operation only).....	677.00		161.49
S61312	Resulting in repair greater than 10 cm (operation only).	1003.00		239.65
	Face, scalp, neck, genitalia, hands, feet, axilla			
S61313	Resulting in repair less than 5 cm (operation only).....	724.00		172.95
S61314	Resulting in repair 5-10 cm (operation only).....	958.00		229.22
S61315	Resulting in repair greater than 10 cm (operation only)	1177.00		281.33
	Eyelids, ears, lips, nose, mucous membrane, eyebrow			
S61316	Resulting in repair less than 2 cm (operation only).....	764.00		189.18
S61317	Resulting in repair 2-4 cm (operation only).....	916.00		224.98
S61318	Resulting in repair greater than 4 cm (operation only)	1243.00		296.95
61319	For excision of lesion (in hospital), to achieve tumour-free margin with frozen section, (extra)	436.00		132.82

NOTES:
i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Paid once per sitting
iii) Paid with 61310-61318, 61320-61322 and 61325-61341.

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

SKIN FLAPS AND GRAFTS

Excision of Malignant and Pre-malignant Lesions

NOTE: For excision of malignant and pre-malignant lesions, when the recipient area requires skin flaps, full thickness grafts or split thickness grafts for closure, use the following fee items for excision in addition to the fees for skin flaps or grafts. For defects less than 10 cm^2 (3cm x 3cm), payment is made for closure only.

61320	Area 10-50 cm^2 (minimum 10 cm^2) – extra (operation only).....	262.00	2	62.51
61321	Area 51-100 cm^2 (minimum 51 cm^2) – extra (operation only).....	567.00	2	143.17
61322	Area over 100 cm^2 (minimum 101 cm^2) – extra (operation only).....	784.00	2	204.53

NOTES:

i) Restricted to Plastic Surgery, Orthopaedics and Otolaryngology.
ii) Not paid with direct linear closure fees (61310-61318).
iii) For areas ≥10 cm^2.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)

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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)	793.00	2	189.64
61325	– 2.1 to 5 cm (operation only)	1003.00	2	239.65
61327	– face, neck or scalp	1519.00	2	363.31
	Other areas:			
61326	– 2.1 to 5 cm (operation only)	781.00	2	186.51
61328	– 5.1 to 10 cm (operation only)	999.00	2	238.75
61329	Defects more than 10 cm (such as a thoracic abdominal flap)	1893.00	2	402.76
	Rotations, transpositions, Z-plasty, Limberg or V-Y type flaps			
	NOTES: i) These flaps differ from advancement flaps in that they require skin incisions specifically to create the shape of the flap. ii) Fee items 61330 to 61344 are restricted to Plastic Surgery, Orthopaedics and Otolaryngology.			
	Trunk			
61330	Defect up to 40 cm^2	1175.00	2	312.82
61331	Defect 40 cm^2 to 100 cm^2	1558.00	2	332.17
61332	Defect greater than 100 cm^2	2033.00	2	433.25
	Arms, legs and scalp			
61333	Defect up to 6 cm^2	1308.00	2	312.68
61334	Defect 6 cm^2 to 19 cm^2	1480.00	2	353.83
61335	Defect greater than 19 cm^2	2199.00	2	469.23
	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck			
61336	Defect up to 6 cm^2	1466.00	2	312.68
61337	Defect 6 cm^2 to 19 cm^2	1661.00	2	354.62
61338	Defect greater than 19 cm^2	2249.00	2	479.62

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Ears, eyelids, lips and nose			
61339	Defect up to 6 cm^2	1667.00	2	354.88
61340	Defect 6 cm^2 to 19 cm^2	2196.00	2	468.28
61341	Defect greater than 19 cm^2	2442.00	2	520.79
	Revision of Graft			
61342	Revision, less than 2 cm	869.00	2	207.61
61343	Revision, between 2 and 5 cm	1706.00	2	249.13
61344	Revision, greater than 5 cm	1770.00	2	290.65
	Specialized Flaps			
06026	Arterial island flap	1700.00	2	361.91
06177	Neurovascular pedicle flap	3572.00	3	761.28
	Flaps from a distance for defects under 10 cm^2, requiring two stages (e.g.: groin flap, deltopectoral flap or cross leg flap):			
06030	Upper extremity – initial stage (with free skin graft) – over 10 cm^2	2836.00	2	604.85
06031	– second stage – over 10 cm^2	2262.00	2	482.16
06032	Lower extremity (plaster cast included) – initial stage - over 10 cm^2	3406.00	2	726.33
	NOTE: Second stage for lower extremity paid at 50% (of 06032).			
	Flaps from a distance for defects under 10 cm^2, requiring two stages (e.g.: cross finger flap, thenar flap for digital defects):			
06033	First stage – per operation (skin graft to secondary defect included) – under 10 cm^2	1700.00	4	361.91
06034	Minor Second stage - per operation - under 10 cm^2	1130.00	3	240.71
06035	Delaying a flap (operation only) – under 10 cm^2	785.00	3	167.18
	Specific areas:			
	Eyebrow			
06148	Hair bearing scalp vascular island flap to eyebrow	2323.00	3	494.93
	Hand			
06171	Syndactyly, local flaps – first cleft	1221.00	2	306.47
06172	– with skin grafts – first cleft	2176.00	2	511.31

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Free Skin Grafts (including mucosa)			
	Full-thickness grafts:			
	NOTES:			
	i) Full thickness fees, 2 to 19 cm^2, include direct closure of donor site.			
	ii) Each additional 19 cm^2 or major portion thereof, will be paid at 50%, depending on the anatomic location of the defect.			
	iii) Paid to a maximum of 2 additional units.			
	iv) Fee items 61350 to 61354 are restricted to Plastic Surgery, Orthopaedics and Otolaryngology.			
61350	Trunk (2 to 19 cm^2) (operation only)	977.00	2	233.55
61351	Arms, legs, scalp (2 to 19 cm^2)	1238.00	2	347.38
61352	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck (2 to 19 cm^2)	1519.00	2	363.31
61353	Ears, eyelids, lips and nose (2 to 19 cm^2)	1695.00	2	404.85
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)	1086.00	2	317.02
	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)	1074.00	2	306.79
06047	– 65 sq.cm. (operation only)	1849.00	2	441.77
06048	– 650 sq.cm	2771.00	2	662.66
06049	For each 6.5 sq. cm. over 650 sq. cm. (operation only)	35.55	3	8.18
	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)	1326.00	2	317.02

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
06050	Regions of major joints and hands – early	1883.00	2	449.96
06058	– late – with scar excision graft	2512.00	2	535.64
06052	Head and neck – 65 sq.cm. or less	1883.00	3	449.96
06053	– in excess of 65 sq.cm.	2771.00	3	662.66
06054	– in excess of 195 sq.cm.	4959.00	3	1057.36
	Major Flap Procedures			
06151	Decubitus ulcers – excision and treatment of bone, rotation flaps, and skin grafts to secondary defect	4158.00	4	886.31
61152	Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment. NOTE: To include umbilicoplasty where medically indicated.	3893.00	4	930.59
C61156	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving small muscles 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 interosserous 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	2127.00	5	454.85
C61157	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving medium muscles	3012.00	5	645.19

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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) stemocleidomastoid 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	4086.00	5	976.61
	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)	3121.00	3	665.26
06110	– dynamic slings with local functional muscle transfer (unilateral)	3769.00	3	803.47
06120	Complete repair for facial paralysis, plication of paralyzed muscles, meloplasty, and resection of overactive muscles – bilateral	4019.00	3	857.04

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
06129	Combined complete repair as above and rhytidectomy- unilateral	4533.00	3	997.06
	Cell-assisted Lipotransfer for soft defects (Aspiration and Injections)			
	Cell-assisted Lipotransfer – Aspiration			
S61250	– Volume less than 20 ml	392.00	3	97.09
S61251	– Volume between 21-60 ml	487.00	3	122.59
61252	– Volume greater than 60 ml	685.00	3	163.50
	NOTES: i) Lipoaspiration and lipo injection components are paid together at 100%. Subsequent lipo injection procedures to anatomically discrete sites, completed during the same session, are paid at 50% ii) When performed with another procedure (e.g.: breast reduction, mastopexy) during the same date of service, the surgical preamble rules will apply. iii) As with other medically necessary procedures for alteration of appearance, pre-approval is required. iv) These fees are not intended to accompany any liposuction procedures. Lipoaspiration is only to be followed by lipo injection. v) Restricted to Plastic Surgery. vi) Aspirate from multiple sites is pooled for a total amount; only one aspirate fee is paid per session, for the aggregate amount. vii) Volume harvested is the total usable fat cells after processing and does not include the oil or aqueous layers.			
	Cell-assisted Lipotransfer – Injection			
	Functional area:			
S61260	– Volume less than 20 ml	587.00	3	157.25
S61261	– Volume greater than 20 ml	881.00	3	224.73
	Non-Functional area:			
S61270	– less than 20 ml	487.00	3	127.64
S61271	– 21 to 60 ml	685.00	3	173.66
61272	– greater than 60 ml	881.00	3	214.56

(see notes on next page)

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

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	2428.00	3	664.71
06086	Tissue expansion – minor areas	1688.00	2	359.94

BLEPHAROPLASTY

06125	Blepharoplasty, simple, non-cosmetic (unilateral)	1258.00	3	306.47

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)	1884.00	3	414.81

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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). 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.	1884.00	3	434.61
61026	Blepharoplasty, complicated, non-cosmetic (bilateral)... 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.	2825.00	3	602.61
	Eyebrow ptosis			
61360	Eyebrow ptosis repair – simple skin excision – non-cosmetic – unilateral	1257.00		267.82
61361	Eyebrow ptosis repair – simple skin excision – non-cosmetic – bilateral	1884.00		401.71

(see notes on next page)

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

NOTES:
i) Significant eyebrow ptosis is defined as present when the visual field is restricted to within 20 degrees of fixation above the horizontal meridian.
ii) Includes resection of any amount of forehead skin and upward brow advancement required to correct the functional deficit.
iii) For upper lid skin excess secondary to severe brow ptosis as opposed to primary upper lid skin excess.
iv) Not paid with 06125 or 61025 on the same patient, same date of service.

TENOTOMY

NOTES:
i) Tenotomy fees paid once per tendon only. Two repairs on the same tendon will be paid as one repair.
ii) Restricted to Plastic Surgery, Family Medicine, Orthopaedics, General Surgery and Emergency Medicine.

	Flexor – primary or secondary repair			
61363	– first tendon	1810.00	2	409.05
61364	– second to sixth tendon repair (extra)	904.00	2	204.53
61365	– seventh to eleventh tendon repair (extra)	453.00	2	102.26
61366	– twelfth and over tendon repair (extra)	227.00	2	51.14
	Extensor – primary or secondary repair			
61368	– first tendon	1137.00	2	304.45
61369	– second to sixth tendon repair (extra)	570.00	2	143.17
61370	– seventh to eleventh tendon repair (extra)	285.00	2	71.59
61371	– twelfth and over tendon repair (extra)	143.00	2	35.79
	Tenoplasty – tenodesis, tenovaginitis, shortening or lengthening, stenosing tenosynovitis:			
06186	– one tendon, any location	1112.00	2	276.24
06187	– two or more tendons	1810.00	2	393.88
06188	Tenolysis	1881.00	2	401.01
06189	– each additional, to a maximum of three (extra) (operation only)	699.00	2	148.73
06185	Tendon graft	3386.00	2	721.59
06203	Tendon transfer in hand and wrist	2151.00	2	511.54

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
06204	– each additional, to a maximum of three (extra)	785.00	2	184.15
06175	Pollicization	5520.00	4	1176.62
06176	Digital transplant	4076.00	5	974.27
S61230	Needle Aponeurectomy - Dupuytren's Disease	692.00		194.11
	NOTES: i) Restricted to Plastic Surgery and Orthopaedics. ii) Not paid in addition to fee items 06193 and 06194. iii) Bilateral services paid at 150%.			
57270	Plantar Fascia: open release or partial excision, uni- or bilateral	1265.00	2	276.87
06193	Extensive palmar – fasciectomy involving one or more digits	2081.00	2	511.31
06194	– with skin grafting	2692.00	2	613.58
	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	2220.00	3	472.63

CAVITY GRAFTING

06055	Eye socket	2116.00	3	451.00
06056	– with mucosa	3243.00	3	690.97
06057	Nose	1891.00	3	402.81
06060	Mouth	2512.00	3	535.64
06061	Lining pedicle flaps	1445.00	3	307.47
06062	Bone cavity over 7.5 cm in diameter in large bone, e.g.: femur	2116.00	4	451.00
06065	Bone cavity up to 7.5 cm in diameter in large bone	1494.00	3	318.17
06064	Bone cavity in small bone, e.g.: hand or foot	1221.00	2	260.69
06066	Operation for congenital absence of vagina (McIndoe) plastic surgery and care	2795.00	4	595.63

BURNS (WITH OR WITHOUT GENERAL ANESTHESIA – PER OPERATION)

	General care, severe only:			
06083	– first hour	1221.00		260.69
06084	– subsequent hour (per hour)	978.00		208.54
Item	– subsequent visits	Per Visit		
	NOTE: Start and end times must be entered in both the billing claims and the patient's chart.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Local care:			
	Minor burns – per visit:			
06078	– dressing (in-hospital care only)	274.00	4	58.92
06079	– surgical debridement – for each 5% of body surface (operation only)	587.00	5	125.12
06080	– subsequent debridement – for each 5% of body surface (operation only)	145.00	5	31.06
06081	Surgical excision of burnt tissue prior to immediate skin grafting – for first 5 percent of body surface, extra (operation only)	1608.00	5	384.59
06082	– for each subsequent 5 percent of body surface, extra (operation only)	978.00	5	208.54

OSTEOMYELITIS

06087	Incision subperiosteal abscess (operation only)	1221.00	2	260.69

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).

	Fracture - mandible:			
06240	Interdental and intermaxillary wiring	1907.00	6	456.05
06241	Wiring with Gunning splints or dentures	2196.00	6	468.23

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Open reduction:			
06242	– unilateral	2832.00	6	766.97
06243	– bilateral	3706.00	6	920.36
	Open reduction and intermaxillary wiring:			
06244	– unilateral	3269.00	6	818.10
06245	– bilateral	4158.00	6	1022.63
06246	Removal of sutures, intra-oral splints, etc. (under general anesthetic) - operation only	1290.00	4	308.29
	Fracture-maxilla (central mid-third):			
06250	Le Fort I - horizontal fractures	4158.00	6	1073.76
06251	Le Fort II - pyramidal fractures	4647.00	6	1176.02
06252	Le Fort III - cranio-facial dysjunction	5332.00	6	1329.41
06253	Open reduction and internal or external craniomaxillary wire suspension with or without intermaxillary fixation	5332.00	6	1227.15
	Fracture-Zygomatic (Lateral Mid-Third)			
	Zygomatico-Maxillary (including Orbital Floor):			
06260	Temporal elevation - operation only	1405.00	3	357.92
06261	Open reduction and interosseous wiring (to include antral packing where necessary)	3028.00	4	690.27
06262	Reduction via transantral approach and antral packing - operation only	1959.00	4	468.29
	Zygomatic Arch:			
06265	Temporal elevation - operation only	1523.00	3	383.49
06266	Open reduction and interosseous wiring	1910.00	4	456.35
	Orbital Floor Fractures (Blow-out Fractures):			
06270	Open reduction (to include antral packing where necessary)	3182.00	4	818.10
	Fracture - Alveolus:			
06271	Alveolar fracture with one tooth extraction - operation only	617.00	3	131.10
06272	– each additional tooth - operation only	383.00	3	81.52
06273	Arch bar fixation of teeth	1753.00	3	418.89
	Temporo-mandibular Joint:			
06280	Meniscectomy	1910.00	3	456.35
06281	Condylectomy	2448.00	3	522.20

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
06282	Arthroplasty	3482.00	3	818.10
	Mandibular Resection:			
06291	Tumours - enucleation, partial or complete resection	2909.00	4	620.26
06292	– with bone graft	4130.00	4	880.26
	Bone graft to jaw or face:			
06293	– autologous	2598.00	4	588.01
06294	– non-autologous	2397.00	4	536.88

MAXILLO-FACIAL

	Osteotomies:			
C06300	Le Fort I - horizontal	5419.00	6	1155.68
C06301	Le Fort II - pyramidal	6713.00	6	1431.11
C06302	Le Fort III - intracranial	13944.00	8	2973.49
C06303	Le Fort III - extracranial	11880.00	7	2532.81
	Bilateral orbital advancement – intracranial approach for correction of hypertelorism when done as a team procedure with a Neurosurgeon and Plastic Surgeon			
61380	Plastic Surgery portion	9563.00	8	2285.82
03080	Neurosurgery portion	6549.00	8	2285.82
	Unilateral orbital advancement – intracranial approach when done as a team procedure with a Neurosurgeon and Plastic Surgeon			
61381	Plastic Surgery portion	8871.00	8	2120.57
03081	Neurosurgery portion	6078.00	8	2120.57
	Bilateral orbital advancement – intracranial approach - when done as a team procedure with a Neurosurgeon and Plastic Surgeon			
61382	Plastic Surgery portion	11865.00	8	2836.39
03082	Neurosurgery portion	8130.00	8	2836.39
C06310	Unilateral orbital advancement, intracranial approach	13430.00	8	2863.31
C06311	Intracranial orbital advancement and correction of hypertelorism	14979.00	8	3193.82
C06312	Intracranial correction of hypertelorism	18079.00	8	3854.85
C06313	Unilateral orbital expansion by osteotomy for macrophthalmia	14462.00	8	3083.65
06314	Canthopexy	2707.00	3	593.12
C06304	Malar maxillary	6196.00	6	1320.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Mandibular - for prognathism, micrognathism, malocclusion, etc.:			
C06305	– unilateral with intermaxillary fixation	3869.00	6	825.17
C06306	– bilateral with intermaxillary fixation	4646.00	6	990.43
C06307	Premaxillary set back	3869.00	6	825.17
	Mandibular osteotomy with rigid internal fixation:			
C06308	– unilateral	3948.00	6	841.69
C06309	– bilateral	5680.00	6	1210.76

NOSE AND SINUSES

	Cryosurgical treatment of turbinates:			
02298	– unilateral	674.00	3	156.55
02299	– bilateral	834.00	3	195.68
02306	Submucous resection of septum	725.00	3	169.58
	Rhinoplasty			
06109	Removal of hump	1142.00	3	281.03
06118	Bone graft to nose -autologous	2881.00	3	614.75
06119	– non-autologous	2367.00	3	504.58
06115	Forehead rhinoplasty - 2 operations NOTE: Partial forehead rhinoplasties, charge under item 61339, 61340 or 61341.	4403.00	3	938.44
02351	Nasal refracture requiring lateral osteotomies	1562.00	3	401.44
02352	Reconstruction of nasal tip, ala and columella	1842.00	3	473.12
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma)	2468.00	3	633.73
02354	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and reconstruction of nasal tip without skin grafting	2677.00	3	688.20
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and external reconstruction of nasal tip without skin grafting	3393.00	3	927.33
06116	Composite graft	1587.00	3	357.68
06117	Rhinophyma	1608.00	3	342.63
	Fractures:			
06123	Comminuted nasal fractures - transosseous wire plate fixation	1472.00	3	314.00
06124	Naso-orbital fractures - open reduction and interosseous wiring or transosseous wire plate fixation	2558.00	3	545.34

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Nasal Fracture:			
02364	– simple reduction - operation only	275.00	3	101.81
S02365	– reduction and splinting - operation only	562.00	3	178.36

EARS

06131	Outstanding ears - unilateral otoplasty	1522.00	3	352.80
61031	Outstanding ears - bilateral otoplasty	2286.00	3	562.45
06132	Microtia or loss of ear - partial - per stage	1810.00	3	434.30
06133	– total - major stage	4502.00	3	959.59
06134	– total - minor stage	1472.00	3	314.00
06130	Accessory auricle (operation only)	1221.00	3	286.34
06135	Preauricular sinus - simple	1221.00	3	301.76
06180	– complicated	1303.00	3	311.21

MOUTH

06181	Lip adhesion procedure for cleft palate	1885.00	3	402.12
06146	Lip shave - vermilionectomy	1915.00	3	408.16
06136	Plastic repair - e.g.: Abbe operation - 2 stages	3074.00	4	766.97
06137	Full lip thickness transfer by rotation flap	2634.00	4	664.71
06139	Unilateral cleft lip	2676.00	4	740.58
06138	Bilateral cleft lip - complete	5090.00	4	1227.15
06144	– incomplete	3600.00	4	767.89
06140	Wedge resection of lip - vermilion (operation only)	858.00	3	205.11
06141	– to sulcus	1129.00	3	256.39
06142	Pharyngoplasty or pharyngeal flap	2605.00	6	715.21
06143	Push-back of palate with pharyngeal flap or similar procedure	3600.00	6	919.74
06145	Cleft palate	2657.00	6	715.21
06147	Bone graft to palatal cleft	2940.00	4	626.86

ORBIT

06153	Bone graft to orbit - autologous	2940.00	4	626.86
06154	– non-autologous implant	2220.00	4	472.63

BREAST

NOTE: See Preamble regarding cosmetic surgery.

06150	Reduction mammoplasty - for hypermastia - unilateral NOTE: For ptosis - cosmetic only.	2534.00	4	664.71
61050	Reduction mammoplasty for hypermastia - bilateral NOTE: For Ptosis, cosmetic only.	3522.00	4	955.20

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
61045	Immediate Breast Reconstruction – extra NOTES: i) Payable only to Plastic Surgeons. ii) Must be performed under the same anesthesia as a mastectomy (07471, 07498, 07472, 07473) done by a different surgeon. iii) Paid only in addition to breast reconstruction surgery done by same surgeon. iv) Maximum of one whether unilateral or bilateral.	866.00		206.89
P61046	Biologic tissue for breast reconstruction – extra NOTES: i) Payable only in addition to fee items 06164, 06165 or 06085. ii) Payable only for cases that require major functional repair. iii) Not payable for secondary revision cases requiring pocket modifications for cosmetic corrections. iv) Paid at 100% for unilateral and 150% for bilateral reconstruction. v) Payable only to Plastic Surgeons.	1298.00		310.32
61047	Filling of tissue expander NOTES: i) Not payable on same day as fee items 06085 and 06086. ii) Maximum of 1 per patient per day regardless of number of fills or unilateral/bilateral. iii) Not paid with a visit fee.	198.00		55.51
T61048	Drainage of post-operative hematoma of the breast under general anesthesia or procedural sedation, when sole procedure	1111.00	3	298.77
06085	Tissue expansion – major areas – breast scalp and tibial areas, regions of major joints	2428.00	3	664.71
C61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	4086.00	5	976.61

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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			
61053	Bilateral breast construction in the context of gender affirming surgery, male to female (MtF)..... 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.	3492.00	3	1124.89
C06159	TRAM Flap reconstruction of mastectomy defect..... 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%.	4902.00	5	1227.15
C06220	Free flap, including closure of defect at donor site	14908.00	5	3476.93

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

CELL-ASSISTED LIPOTRANSFER FOR SOFT DEFECTS (ASPIRATION AND INJECTIONS)

Cell-assisted Lipotransfer – Aspiration

S61250	– Volume less than 20 ml	392.00	3	97.09
S61251	– Volume between 21-60 ml	487.00	3	122.59
61252	– Volume greater than 60 ml	685.00	3	163.50

NOTES:

i) Lipoaspiration and lipo injection components are paid together at 100%. Subsequent lipo injection procedures to anatomically discrete sites, completed during the same session, are paid at 50%

ii) When performed with another procedure (e.g.: breast reduction, mastopexy) during the same date of service, the surgical preamble rules will apply.

iii) As with other medically necessary procedures for alteration of appearance, pre-approval is required.

iv) These fees are not intended to accompany any liposuction procedures. Lipoaspiration is only to be followed by lipo injection.

v) Restricted to Plastic Surgery.

vi) Aspirate from multiple sites is pooled for a total amount; only one aspirate fee is paid per session, for the aggregate amount.

vii) Volume harvested is the total usable fat cells after processing and does not include the oil or aqueous layers.

Cell-assisted Lipotransfer – Injection

Non-Functional area:

S61270	– less than 20 ml	487.00	3	127.64
S61271	– 21 to 60 ml	685.00	3	173.66
61272	– greater than 60 ml	881.00	3	214.56

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.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	1414.00	3	409.05
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)	7080.00	3	1124.89
	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	1734.00	3	613.58
06165	– bilateral	2605.00	3	818.10
61166	Mastopexy, balancing unilateral (isolated procedure)	1959.00	3	664.71
61167	Mastopexy, balancing — when performed at same time as contralateral breast surgery	1307.00	3	460.19
06178	Excision of breast implant and associated pathologic capsule	1754.00	2	419.28
06179	Excision of breast implant only (operation only)	1052.00	2	251.26
06157	Nipple-areolar reconstruction	1627.00	2	378.38
	NOTE: This procedure is to result in a pigmented areolar complex using pigmented epithelium.			
61057	Nipple areolar reconstruction and tattooing	2195.00	2	468.20

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	3356.00	3	715.88
06128	– entire lower extremity	5018.00	3	1070.26
06167	Treatment of lymphoedema using the Thompson procedure - upper extremity forearm	1700.00	4	361.91
06168	– arm	1130.00	4	240.71
	(Total of $577.96 whether one or two stages)			
06169	– lower extremity leg	2836.00	4	604.86
06170	– thigh	2836.00	4	604.86
	(Total of $1,160.18 whether one or two stages)			

MICROSURGERY

06259	Microsurgical removal of neoplasm - digital or palmar	1613.00	2	343.64
	Microneural Surgery:			
	Neurolysis:			
06210	– external	1383.00	2	347.38
06211	– intraneural	2106.00	2	448.87
	Microfascicular neurorrhaphy, primary:			
06212	– digital or palmar	1383.00	2	408.74
06213	– major nerve	2949.00	2	628.85
	Interfascicular nerve graft (to include harvest of graft):			
06214	– digital or palmar	2283.00	2	545.66
06215	– major nerve	6844.00	4	1636.20
03207	Microsurgical removal of neoplasm - major peripheral nerve	2790.00	3	833.63
	Microvascular Surgery:			
06216	Artery or vein - primary repair (to include operative report) NOTE: If a major artery in trunk, anesthetic IC level 9.	3242.00	6	690.76
C06220	Free flap, including closure of defect at donor site	14908.00	5	3476.93

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Microreimplantation:			
C06217	Digit or extremity (to include operative report)	13950.00	4	3476.93
61210	Certified Plastic Surgeon Assist - Complex Case (extra). Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	215.00		71.46
	NOTES: i) Restricted to Plastic Surgery. ii) Paid only for assisting microsurgical surgeries; fee items 06217 or 06220. iii) Paid in addition to fee items 70020 and 00198. iv) Maximum payable is 20 units per surgery. v) Any additional assistants, if required, are paid under fee items 00198 and 13197 only. vi) This fee is intended for plastic surgeons in active practice to compensate for lost office or operating room time in taking the day to assist a colleague on complex procedures. Fellowship trainees and short term locums (<6 months) are not eligible. vii) Start and end times must be entered in both the billing claims and the patient's chart.			

AMPUTATIONS

06218	Transmetacarpal	1221.00	2	306.79
06219	Finger, any joint or phalanx - operation only	1221.00	2	306.79

BONE GRAFTING

06221	Inlay bone grafting of metacarpal, or phalanx	1518.00	2	362.95

FRACTURES

06222	Finger phalanx, requiring reduction (operation only)	606.00	2	129.56
06223	Metacarpal, requiring reduction (operation only)	606.00	2	129.56
61222	CRIF of phalangeal (middle or proximal) or metacarpal fracture	975.00	2	306.78
61223	ORIF of phalangeal (middle or proximal) or metacarpal fracture	1455.00	2	409.05
	Note: Multiple fractures paid in accordance with Preamble D. 6.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
61224	Open (compound) hand fractures—Primary wound management (operation only) NOTES: i) Includes management of soft tissue component of open fracture, including wound excision, debridement, irrigation and implementation of antibiotic beads. ii) Payable in addition to 06224, 06225, 61223 iii) Payable at same percent as applies to fracture fee iv) Payable only when procedure performed in operating room	198.00	2	46.02
61225	Open (compound) hand fractures—Secondary Wound Management - operation only NOTES: i) Repeat primary management of soft tissue component of open fracture, including wound excision, debridement, irrigation, implementation of antibiotic beads at a second sitting, or return to the O.R. for delayed primary closure. Not payable in addition to closure with skin grafts and/or local skin 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	394.00	2	92.04
	Distal phalanges open reduction and wiring:			
06224	– first	724.00	2	426.62
06225	– each additional (extra) - operation only	606.00	2	292.48

JOINTS – INTERPHALANGEAL OR METACARPOPHALANGEAL

06228	Arthroplasty of metacarpophalangeal or interphalangeal (hand) joint	1654.00	2	352.55
06229	Arthrodesis of metacarpophalangeal or interphalangeal (hand) joint	1474.00	2	352.55
06231	Reconstruction of rheumatoid hand joints, multiple, e.g.: synovectomy, intrinsic release, repositioning of extensor tendons, each hand, fee for service, at any one operative session—up to Note: Only applicable when performed on more than 2 joints	4758.00	3	1014.66

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
06232	Finger joint prosthesis - first joint	1246.00	2	265.52
06233	– subsequent joints same sitting - each (operation only)	709.00	2	150.92
06234	Synovectomy - of flexor or extensor tendons in wrist and hand for rheumatoid disease	1685.00	2	359.15
06235	Intrinsic release	1221.00	2	281.22
	Dislocations:			
06236	Metacarpophalangeal or interphalangeal joint – closed reduction (operation only)	536.00	2	128.19
06237	– open reduction - operation only	1221.00	2	260.69

NERVES

	Peripheral nerve:			
06255	Minor, digital, primary suture or secondary	1221.00	2	260.69
06256	Repair of palmar nerve	1221.00	2	260.69
06257	Major, primary suture	1934.00	3	412.43
S06258	Exploration of peripheral nerve and neurolysis NOTE: Multiple neurolyses are paid in accordance with Preamble, Clause D. 5. 3. to a maximum of 4 neurolyses per sitting.	1229.00	2	262.46
S03196	Exploration, mobilization and transposition	962.00	2	287.85
03198	Neurectomy of major nerve	757.00	2	227.46
03200	Secondary suture including transposition	1967.00	3	588.25
03201	Secondary suture of major nerve	1501.00	3	447.63
03205	Nerve graft	1472.00	3	441.58
06156	Transplant of neuroma	1221.00	2	260.69

TATTOOING SURGERY (FOR HAEMANGIOMATA, VITILIGO, LENTIGINES, ETC.)

	Facial area:			
S06200	Less than 1/4 of face - operation only	551.00	3	117.28
S06201	1/4 to 1/2 of face	1130.00	3	240.71
S06202	Full face	1700.00	4	361.91
	Nonfacial area:			
06205	Less than 6.5 sq. cm - operation only	288.00	2	61.11
S06206	Less than 65 sq. cm - operation only	569.00	2	120.99
S06207	Less than 650 sq. cm	1130.00	2	240.71

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	941.00	3	208.23

ARTERIES

Trauma:

Repair of injury of major vessel in extremity:

77330	– suture	1982.00	6	596.96
77335	– graft	2549.00	6	767.87

ELBOW, PROXIMAL RADIUS AND ULNA

Incision – Therapeutic, Release:

53250	Decompression, neurolysis, nerve	1131.00	2	368.81
53255	Decompression, neurolysis, submuscular; transposition of nerve	1892.00	2	473.09

Repair, Revision, Reconstruction (Soft Tissue):

53520	Biceps tendon, longhead, tenodesis	1265.00	2	302.11

SHOULDER GIRDLE, CLAVICLE AND HUMERUS

Repair, Revision, Reconstruction (Soft Tissue):

52555	Tendon transfer, transplant	2392.00	3	727.32

GENERAL SURGERY

General Surgeons billing surgical 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 ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
07010	**Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report.	624.00		121.20
07012	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	276.00		60.61
	Continuing Care by Consultant:			
07007	Subsequent office visit	123.00		36.38
07008	Subsequent hospital visit	117.00		31.70
07009	Subsequent home visit	241.00		51.14
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) NOTE: Claim must state time service rendered.	533.00		121.20
07006	Directive care in emergent surgical conditions, per visit 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.	140.00		31.70

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
71008	Post operative visit, in-hospital (1-14 days post-operatively)	119.00		31.70
	NOTES: i) Restricted to General Surgeons whose most recent specialty is General Surgery. ii) Restricted to surgical fee items with a “V” prefix. iii) Do not bill this item for “operation only” procedures, bill 07008 (subsequent hospital visit) or other appropriate fee item. iv) For visits outside 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	533.00		121.20
	NOTES: i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances. ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent. iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition. iv) Maximum of one pre-operative assessment per patient per procedure. v) Only paid to the surgeon who performs the procedure.			
71010	Complex consultation for management of malignancy.....	673.00		202.02
71017	Special office visit for new diagnosis or recurrent malignancy.....	279.00		85.91
	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 18 months prior.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
Telehealth Service with Direct Interactive Video Link with the Patient				
70070	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and written report.	624.00		120.19
70072	Telehealth repeat or limited consultation: To apply where a consultation is repeated for the same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	276.00		60.61
70077	Telehealth subsequent office visit	123.00		33.50
70078	Telehealth subsequent hospital visit	117.00		31.70
70076	Telehealth directive care in emergent surgical conditions – per visit 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.	140.00		31.70
70080	Telehealth Complex consultation for management of malignancy	655.00		202.02
70087	Telehealth Special office visit for new diagnosis or recurrent malignancy 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.	279.00		85.91

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

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 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:

(continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.			
	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	379.00		119.97
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof	188.00		71.88

	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 ≤ 90 at any time in adults.
ii) Airway Compromise including intubations.
iii) Transfer patients from other Emergency Departments receiving blood to maintain vital signs.
iv) Unresponsiveness – Glasgow Coma Score ≤ 8 with a mechanism suggestive of injury.
v) Gunshot or other penetrating wounds to head, neck, chest, abdomen or proximal extremity (at or above knee or elbow).
vi) Autolaunched Trauma Patient.
vii) Pediatric Trauma Patient under 16 years of age.
viii) Special consideration will be given for patients with significant 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
vii) - Partial thickness (2º) burn ≥ 10% and full thickness (3º) burn
- Electrical or lightning burn
- Chemical burn or Inhalation injury
- Burn injury in patients with significant co-morbidities
- Burn injury with concomitant trauma

(continued on next page)

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

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
- 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

(continued on next page)

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

- 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	1659.00		308.71

NOTES:

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10088	Trauma Team Leader – Tertiary Assessment (after 24 hrs. and before 72 hrs.)	573.00		106.35

NOTES:
- i) Restricted to General Surgeons.
- ii) Not paid on same date of service as 10087 or 10089.
- iii) Not paid unless 10087 or 01871 has been previously claimed (on same PHN).
- iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
- v) Not paid with any consult, visit or emergency care fees, by the same practitioner on the same date of service.
- vi) Payable to only one physician for one patient, per facility, per day.

10089	Trauma Team Leader Subsequent Hospital Visit (Days 3-15 inclusive)	435.00		80.50

NOTES:
- i) Restricted to General Surgeons
- ii) Not paid on same date of service as 10087 or 10088.
- iii) Not paid unless 10087 or 01871 has been previously claimed (on same PHN).
- iv) Not paid in addition to the adult and pediatric critical care fees by the same practitioner.
- v) Not paid with any consult, visit or emergency care fees, by the same practitioner, on the same date of service.
- vi) Payable to only one physician for one patient, per facility, per day.

SURGICAL FEE MODIFIERS

NOTES:
- i) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the modifier
- ii) Surgical fee modifiers are excluded from the calculation for total operative fee(s) for which surgical assist fees are based.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
07001	Surgical Surcharge (Age 75+).....	394.00		92.04

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 surgical fee Items are performed for patients who are age 75 or older:
07027, 07061, 07072, 07075, 07076, 07082, 07108, 07109, 07110, 07111, 07112, 07143, 07147, 07150, 07360, 07363, 07366, 07368, 07402, 07403, 07404, 07405, 07406, 07407, 07408, 07409, 07410, 07411, 07412, 07413, 07414, 07431, 07432, 07433, 07434, 07435, 07436, 07437, 07438, 07440, 07441, 07442, 07443, 07444, 07445, 07446, 07447, 07448, 07449, 07452, 07455, 07460, 07470, 07471, 07472, 07473, 07474, 07475, 07479, 07481, 07482, 07483, 07497, 07498, 07516, 07522, 07528, 07536, 07561, 07565, 07567, 07569, 07570, 07578, 07580, 07588, 07589, 07597, 07600, 07601, 07603, 07610, 07623, 07624, 07626, 07627, 07628, 07630, 07632, 07634, 07635, 07636, 07640, 07641, 07643, 07645, 07646, 07647, 07648, 07649, 07650, 07651, 07654, 07658, 07660, 07662, 07663, 07665, 07666, 07672, 07675, 07676, 07677, 07678, 07679, 07683, 07685, 07687, 07689, 07698, 07699, 07703, 07705, 07706, 07707, 07711, 07714, 07725, 07732, 07733, 07740, 07741, 07743, 07744, 07745, 07749, 07756, 07758, 07769, 07771, 07776, 07782, 07789, 07790, 07796, 33321, 33322, 33323, 33324, 33321, 33325, 33326, 33329, 33330, 33347, 70084, 70155, 70158, 70159, 70162, 70163, 70165, 70166, 70168, 70169, 70470, 70471, 70473, 70477, 70478, 70479, 70500, 70530, 70531, 70532, 70533, 70534, 70535, 70536, 70538, 70539, 70540, 70541, 70542, 70544, 70545, 70601, 70603, 70605, 70607, 70620, 70621, 70622, 70625, 70626, 70627, 70628, 70629, 70630, 70631, 70632, 70633, 70635, 70637, 70639, 70640, 70641, 70642, 70643, 70644, 70645, 70646, 70648, 70649, 70650, 70660, 70661, 70665, 70666, 70668, 70671, 70672, 70674, 70676, 70680, 70683, 70694, 70695, 70698, 70700, 70701, 70702, 70703, 70704, 70705, 70712, 70713, 70714,

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

70715, 70716, 70718, 70720, 70721, 70722, 70725, 70726, 70727, 70728, 70731, 70740, 70742, 70743, 70745, 70747, 70748, 71282, 71290, 71292, 71293, 71380, 71530, 71535, 71536, 71537, 71538, 71539, 71540, 71541, 71542, 71543, 71546, 71548, 71549, 71551, 71606, 71607, 71608, 71609, 71610, 71611, 71612, 71613, 71614, 71615, 71616, 71617, 71618, 71619, 71620, 71621, 71622, 71623, 71624, 71625, 71634, 71635, 71650, 71651, 71681, 71682, 71684, 71686, 71700, 71703, 71704, 71705, 71706, 71708, 71709, 71710, 71712, 71713, 71714, 71716, 71717, 71718, 71719, 71720, 71721, 71722, 71725, 71746, 72572, 72600, 72601, 72602, 72603, 72604, 72605, 72606, 72607, 72608, 72609, 72610, 72620, 72622, 72623, 72624, 72625, 72626, 72631, 72632, 72633, 72634, 72635, 72636, 72640, 72641, 72644, 72647, 72648, 72650, 72651, 72652, 72653, 72656, 72657, 72658, 72659, 72660, 72665, 72666, 72669, 72670, 72671, 72672, 72673, 72683, 72703, 72704, 72705, 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.

07003 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery performed .....

- The patient has a Body Mass Index (BMI) greater than 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.

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NOTES:

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

i) Payable only to General Surgeons.
ii) Patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.
iii) Maximum of one surcharge per operation unless two general surgeons perform two synchronous surgeries that are both eligible for the surcharge.
iv) When multiple procedures are performed during the same operation, the surcharge applies to all eligible procedures based on the prorated value according to the surgical preamble for multiple procedures.
v) The surcharge does not apply to surgical fee modifier 07001 (Surgical Surcharge Age 75+) but may be paid in addition.
vi) Payable when the following General Surgery fee items are performed for patients with a BMI greater than or equal to 35: 07134, 07360, 07363, 07366, 07368, 07402, 07403, 07404, 07405, 07406, 07407, 07408, 07409, 07410, 07411, 07412, 07413, 07414, 07431, 07432, 07433, 07434, 07435, 07436, 07437, 07438, 07440, 07441, 07442, 07443, 07444, 07445, 07446, 07447, 07448, 07449, 07450, 07451, 07452, 07455, 07474, 07475, 07479, 07565, 07566, 07567, 07569, 07570, 07578, 07580, 07588, 07589, 07596, 07597, 07600, 07601, 07603, 07610, 07623, 07624, 07626, 07627, 07628, 07630, 07632, 07633, 07634, 07635, 07636, 07640, 07641, 07643, 07645, 07646, 07647, 07648, 07649, 07650, 07651, 07654, 07655, 07658, 07660, 07662, 07663, 07664, 07672, 07698, 07699, 07703, 07705, 07706, 07707, 07711, 07714, 07732, 07733, 07756, 07758, 07764, 07769, 07776, 70024, 70025, 70501, 70503, 70504, 70505, 70506, 70509, 70511, 70531, 70532, 70533, 70534, 70535, 70536, 70538, 70539, 70540, 70541, 70542, 70544, 70601, 70603, 70604, 70605, 70607, 70620, 70621, 70622, 70624, 70625, 70626, 70627, 70628, 70629, 70630, 70631, 70632, 70633, 70635, 70639, 70640, 70641, 70646, 70648, 70649,

(notes continued next page)

70650, 70651, 70660, 70661, 70665, 70666, 70668,

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

70670, 70671, 70672, 70694, 70695, 70696, 70698, 70700, 70701, 70702, 70703, 70704, 70705, 70710, 70711, 70712, 70713, 70714, 70715, 70716, 70717, 70718, 70720, 70721, 70722, 70725, 70726, 70727, 70728, 70730, 70731, 70748, 71290, 71291, 71292, 71293, 71380, 71535, 71536, 71537, 71538, 71539, 71540, 71541, 71542, 71543, 71544, 71546, 71547, 71549, 71551, 71606, 71607, 71608, 71609, 71610, 71611, 71612, 71613, 71614, 71615, 71616, 71617, 71618, 71619, 71620, 71621, 71622, 71623, 71624, 71625, 71634, 71635, 71650, 71651, 71698, 71700, 71703, 71704, 71705, 71708, 71709, 71710, 71712, 71713, 71714, 71715, 71716, 71717, 71718, 71719, 71720, 71721, 71722, 71725, 71747, 72572, 72600, 72601, 72602, 72603, 72604, 72605, 72606, 72607, 72608, 72609, 72610, 72620, 72621, 72622, 72623, 72624, 72625, 72626, 72631, 72632, 72633, 72634, 72635, 72636, 72640, 72641, 72644, 72645, 72646, 72647, 72648, 72650, 72651, 72652, 72653, 72654, 72656, 72657, 72658, 72659, 72660, 72662, 72664, 72665, 72666, 72667, 72669, 72670, 72671, 72672, 72673, 72683, 72684, 72703, 72704, 72705, 72713, 72714, 72715, 72720, 72721, 72723, 72725, 72726, 72727, 72728, 72729, 72730, 72731, 72732, 72733, 72734, 72735, 72736, 72737, 72740, 72741, 72745, 72751, 72755, 72760, 72762, 72763, 72765, 72767, 72769, 72770, 72775, 72788, 72789, 72794, 72795, 72796, 72797, and 72798

vii) Payable when the following General Surgery Fee items are performed for patients with a BMI greater than or equal to 40: 07361, 07740, 07741, 07743, 07744, 07745, 07771, 07796, 70023, 70500, 70502, 70530, 70545, 70740, 70742, 70743, 70745, 70747, 71530, 71548, 71550, 71706, 71707, 71746, and 71748

SURGICAL ASSISTANT OR SECOND OPERATOR

	Total Operative Fee(s) for Procedures:			
00195	Less than $317.00 inclusive	680.00		147.95
00196	$317.01 - $529.00 inclusive	964.00		209.92
00197	Over $529.00	1421.00		309.31

		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.....	157.00		34.10
	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. iv) Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s) for which surgical assist fees are based.			
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.....	1265.00		282.60
	NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020	Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof	148.00		32.96
	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)	75.70		40.58

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof			
	NOTES: i) Restricted to General Surgery. ii) Paid only in addition to fee item 70020 iii) Maximum payable is 8 units per surgery. iv) Any additional assistants, if required, are paid under fee items 00197, 00198, and 13197 only. v) Start and end times must be entered in both the billing claims and the patient's chart.			

SECOND SURGEON

	Total or near total esophagectomy, without thoracotomy (Transhiatal): with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty:			
70503	– secondary surgeon	3005.00		664.71
	with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
70504	– secondary surgeon	3005.00		664.71
	Total or near total esophagectomy; with thoracotomy, with or without pyloroplasty (3 -hole):			
70505	– secondary surgeon	3005.00		664.71
	with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
70506	– secondary surgeon	3005.00		664.71
	Partial esophagectomy, distal 2/3, with thoracotomy and separate abdominal incision and thoracic esophagogastrostomy: (Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.) with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
70509	– secondary surgeon	3005.00		664.71
	Partial esophagectomy, thoracoabdominal or			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	abdominal approach, with esophagogastrostomy: (Includes vagotomy, proximal gastrectomy, pyloroplasty and splenectomy, if required.) with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
70511	– secondary surgeon	3005.00		664.71
07702	Fee for second surgeon participating in total correction of cloacal anomalies	2346.00		519.02
	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	1670.00		346.80
	NOTE: When 07571 and 07593 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.			
	Second operator:			
77025	Synchronous combined bypass graft - extremities	1023.00		609.98
77030	– trunk	1023.00		609.98
	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)	126.00	2	50.75
07041	Aspiration: abdomen or chest (operation only)	352.00	2	77.73
	Abscess:			
07059	– deep (complex, subfascial, and/or multi-locular) with local or regional anesthesia - operation only	377.00	2	83.30
07027	– under general anesthesia or procedural sedation - operation only	941.00	2	255.34
07061	– deep post-operative wound infection, under GA - operation only	940.00	2	230.09
07045	Anterior closed space abscess (operation only)	470.00	2	103.74
06028	Web space abscess (operation only)	1091.00	2	306.47
06029	– under general anesthetic - operation only	1242.00	2	352.43
	Pilonidal cyst or sinus:			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
70084	– incision and drainage, abscess - operation only	469.00	2	103.66
07685	– excision or marsupialization (operation only)	1356.00	2	306.79
	Wounds - Simple:			
13610	Minor laceration or foreign body - not requiring anesthesia (operation only)	99.60	2	40.64
	NOTES: i) Intended for primary treatment of injury. ii) Not applicable to dressing changes or removal of sutures. iii) Applicable for steri-strips or glue to repair a primary laceration.			
13611	Minor laceration or foreign body - requiring anesthesia (operation only)	188.00	2	75.71
06063	Extraction of foreign body from a wound requiring general anesthesia or procedural sedation – operation only	1074.00	2	306.47
	NOTES: i) Also payable when performed under local anesthetic if the extraction requires at least 30 min and is complicated due to: a) The need for increased surgical exposure, or b) A delicate or deeper dissection, or c) Difficulty localizing the foreign body ii) If performed under local anesthetic, a note record must be provided with the length of the procedure and explaining why the extraction was complex in nature.			
13620	Excision of tumour of skin or subcutaneous tissue or small scar, under local anesthetic - up to 5 cm - operation only	188.00		75.70
13621	– additional lesions removed at the same sitting (maximum per sitting - five), each - operation only	92.20		37.87
	NOTES: i) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for 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	144.00		59.26

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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 ..	204.00		87.72

REMOVAL OF TUMOURS OR SCARS

V70116	Removal of tumour (including intraoral) or scar revision – 2 to 5 cm (operation only) ..... NOTE: For tumours or scars under 2 cm, bill under fee item 13620.	629.00	2	141.42
V70117	Removal of tumour (including intraoral) - 5.1 cm to 10 cm	1290.00	2	267.82
V70118	Removal of tumour (including intraoral) – greater than 10 cm ..... NOTE: 70116, 70117 and 70118 are not billable by Plastic Surgery, Orthopaedics or Otolaryngology.	2229.00	2	462.80
V70125	Radical resection of malignant skin or soft tissue tumour measuring 5-10 cm	1290.00	2	306.79
V70126	Radical resection of malignant skin or soft tissue tumour measuring 10 cm or greater	2229.00	2	462.80
70127	Closure or radical resection requiring a free split thickness (extra)..... – greater than 65cm^2 on trunk – greater than 25cm^2 on extremities or head/neck 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.	499.00		183.88

LOCAL TISSUE SHIFTS: ADVANCEMENTS, ROTATIONS, TRANSPOSITIONS,

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

"Z" PLASTY, ETC.

NOTES:

i) Advancement flaps are defined as adjacent tissue transfers based on undermining and layered closure. The medical necessity for a flap or graft occurs when direct closure alone would not suffice due to unacceptable wound tension or local distortion. The distances required to be undermined are measured from each edge, not the combined distance:
   a) 1 cm – nose, ear, eyelid, lip or eyebrow
   b) 1.5 cm – other face and neck
   c) 3 cm – rest of body

ii) Direct closure means approximation of wound/skin edges with less undermining that defined by an advancement flap.

iii) A Limberg flap for pilonidal sinus repair is considered a single flap.

iv) 70119, 70120, 70121, 70122, 70123, 70124 are not billable by Plastic Surgery, 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)	780.00	2	161.96
V70120	Single flap for lesion greater than 2 cm	1599.00	2	332.09
V70121	Single flap for lesion greater than 2 cm with free skin graft to secondary defect	2011.00	2	417.81
V70122	Multiple flap for lesion greater than 2 cm	2817.00	2	584.91
V70123	Multiple flap for lesion greater than 2 cm with free skin graft to secondary defect	3203.00	2	665.26
V70124	Eyebrow, eyelid, lip, ear, nose – single	1454.00	3	301.82
	NOTE: Repair of torn earlobe to be claimed under 06027.			
	Foreign Body: Excision of skin and subcutaneous tissue of hidradenitis suppurativa:			
07072	– axillary - operation only	1156.00	2	255.66
07075	– inguinal - operation only	1156.00	2	255.66
07076	– perianal - operation only	1156.00	2	255.66
07082	– perineal - operation only	1156.00	2	255.66
06166	Excision of axillary sweat glands for hyperhidrosis -	1559.00	4	332.49

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	unilateral			
	NOTES: i) Direct closure included when open procedure used. ii) Aggressive removal of apocrine sweat glands by any means.			
	Tenotomy:			
07073	– congenital torticollis - operation only.....	1406.00	3	311.04
V07074	– resection	1269.00	3	263.82
	NOTES: i) Payable only when performed in an Operating Room (Service Location Code G, I, or P). ii) Not payable for percutaneous procedures. iii) For operative section of transverse carpal ligament - bill under 06258.			
	Excisional biopsy of lymph glands for suspected malignancy:			
70023	– neck - operation only	941.00	3	245.43
V70024	– axilla	1163.00	2	245.43
70025	– groin - operation only.....	940.00	2	245.43
13630	Paronychia (operation only)	99.30		40.50
13631	Removal of nail - simple (operation only).....	99.30		40.50
13632	– with destruction of nail bed - operation only.....	199.00		81.96
13633	Wedge excision or Vandenbos procedure of one nail – (operation only).....	178.00		72.32
V07053	Excision of nail bed, complete, with shortening of phalanx	679.00	2	141.11
07025	Temporal artery biopsy - operation only.....	649.00	2	203.96
07028	Biopsy of sural nerve - operation only.....	819.00	2	181.28
V07055	Ganglia, of the wrist	933.00	2	255.66

WOUNDS

13612	Extensive lacerations over 5 cm (maximum charge 35 cm) - (operation only), per cm.....	36.80		15.19
	NOTE: Not billable by Plastic Surgery, Orthopaedics or Otolaryngology.			
	Wounds - avulsed and complicated:			
06075	Lips and eyelids	1626.00	3	347.09
06076	Nose and ear	2045.00	3	436.01
06077	Complicated lacerations of the scalp, cheek and neck	1598.00	3	340.66

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

(see notes on next page)

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 and key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or
ix) Lacerations into the subcutaneous tissue requiring alignment and repair of cartilage and 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	1328.00	3	276.62

DEBRIDEMENT OF SOFT TISSUES FOR NECROTIZING INFECTION OR SEVERE TRAUMA

V70155	Debridement of skin and subcutaneous tissue restricted to genitalia and perineum for necrotizing infection (Fournier's Gangrene) (stand-alone procedure).....	2116.00	5	562.45

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	1194.00	3	301.31
70159	Debridement of skin and subcutaneous tissue; for each additional 5% of body surface area or major portion thereof – extra	599.00		132.78
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	1339.00	4	306.30
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each additional 5% of body surface area or major portion thereof – extra	674.00	3	133.93
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	1480.00	4	316.74
70166	Debridement of skin, fascia, muscle and bone; for each additional 5% of body surface area or major portion thereof – extra	666.00		147.32
70168	Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area - operation only …… Notes: i) Payable when rendered at the bedside but only when performed by a medical practitioner. ii) Requires wound assessment and dressing change and may include VAC application. iii) Applicable with or without anesthesia.	399.00		80.35
70169	Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area - operation only …… Notes: i) Payable only when performed by a medical practitioner in the operating room under general anesthesia or conscious sedation. ii) Requires wound assessment and dressing change and may include VAC application. iii) Debridement not payable in addition.	581.00	4	128.56

VASCULAR ACCESS

00319	Insertion of central catheter for total parenteral nutrition	270.00	2	63.36

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	- operation only			
	Broviac type catheter:			
07139	– insertion of	677.00	2	166.23
V07140	– insertion of - less than 3 months of age or less than 3 kg.	1321.00	4	275.11
07141	– removal of - operation only	586.00	2	129.65
	Totally implantable venous access port with subcutaneous reservoir (port-a-cath type device):			
07142	– insertion of	1239.00	2	261.77
V07143	– revision (removal and reinsertion)	1617.00	2	357.92
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	261.00		64.01
07145	Intra osseous - access - operation only	469.00	2	103.59
V07134	Peritoneal venous shunt for ascites	1921.00	6	399.20
V07146	Insertion of inferior vena cava filter, percutaneous placement or cutdown (e.g.: Kimray Greenfield filter)	1800.00	2	376.16
V07147	Insertion of a peritoneal catheter under general anesthetic or procedural sedation NOTE: Includes fee items 77380, 07600 and 04001 (laparoscopy).	1528.00	4	312.81
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee	116.00		22.60

HEAD AND NECK

	Lips:			
06140	Wedge resection of lip - vermilion - operation only	858.00	3	205.11
06141	– to sulcus	1129.00	3	256.39

MOUTH - EXCISION

	Excision of lesion of tongue with closure anterior 2/3:			
V07789	– with local tongue flap	1562.00	3	326.52
	Excision, lesion of floor of mouth:			
07790	– benign (operation only)	707.00	3	156.27

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02457	Tongue tie, under general anesthesia - operation only.	359.00	3	93.22
02458	Tongue - local excision, under general anesthesia	725.00	3	169.58
02275	Glossectomy subtotal with either division of mandible or transcervical resection	4627.00	6	1080.11
02279	Resection base of tongue and/or tonsil and soft palate	8433.00	6	1969.95
02478	Glossectomy - partial for carcinoma	1620.00	6	378.33
C02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy	5774.00	7	1350.10

PHARYNX AND TONSILS

S00701	Direct laryngoscopy - procedural fee	169.00	5	73.82
	NOTES: i) 00701 is not payable with 00907, 00908 and 00909. ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.			
	Incision of peritonsillar abscess:			
02447	– under local anesthesia - operation only	305.00	4	106.87
02444	– under general anesthesia - operation only	563.00	6	144.89
	Tonsillectomy:			
02403	– under local anesthesia	1130.00	4	263.53
02445	– adult or child over the age of 14 years	834.00	4	282.24
02446	– child age 14 years and under (to include neonate)	786.00	4	300.13
02413	Operative control of post-tonsillectomy or post-adenoidectomy hemorrhage requiring local or general anesthetic	844.00	6	325.62
02399	Cryotherapy of tonsils and oral lesions - operation only	504.00	3	117.41
	Adenoidectomy:			
02442	– adult or child over 14 years - operation only	563.00	4	144.89
02443	– child 14 years and under (neonate included)	692.00	4	213.33
02449	Rigid esophagoscopy for removal of foreign body	834.00	4	259.93
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	1123.00	6	312.59
02422	– in a child under the age of 3 years	1670.00	6	389.18

SALIVARY GLANDS AND DUCTS

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
07515	Drainage of abscess - parotid, submaxillary or sublingual (see abscess - deep) - operation only	937.00	3	207.17
07526	Dilation of salivary duct - operation only	725.00	3	155.82
02452	Sialolithotomy, simple - in duct - operation only	275.00	3	65.21
02453	Sialolithotomy, complicated - in gland	834.00	3	195.68
02456	Salivary fistula, plastic to Stenson's duct	1842.00	4	430.50
	Excision:			
S00844	Biopsy of salivary gland - fine needle or core needle	265.00	3	55.25
07516	Excision or marsupialization of sublingual salivary cyst (ranula) - operation only	941.00	3	208.16
02455	Submandibular gland, excision	1396.00	4	390.71
07522	Local excision of parotid tumour, without nerve dissection - operation only	941.00	3	208.23
02471	Parotidectomy, subtotal with complete facial nerve dissection	3690.00	4	861.07
02472	Total parotidectomy with nerve dissection for malignancy or deep lobe tumour	4244.00	4	991.49

NECK DISSECTION

02281	Conservative radical neck dissection NOTE: Includes radical neck dissection with full dissection and sparing of entire accessory nerve and generally sternomastoid muscle and internal jugular vein.	5495.00	6	1283.62
02470	Radical neck dissection	4627.00	6	1080.17
C02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy	8433.00	7	1969.95
02477	Contralateral suprahyoid dissection	2119.00	5	495.75

HEAD AND NECK - MISCELLANEOUS

02459	Cystic hygroma, excision	2404.00	4	560.97
V07500	Resection of mandible	1977.00	5	411.33
V07749	Partial maxillectomy for malignancy - fenestration	3751.00	5	829.82
CV07725	Maxillectomy	4688.00	5	1037.32
V07796	Excision, neurogenic neoplasm - neck	5156.00	5	1140.95
	Diverticulectomy of hypopharynx or esophagus, with or without myotomy:			
V70545	– cervical approach	2637.00	6	548.90
02407	Tracheostomy	1287.00	5	398.83

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTE: Not applicable to cricothyrotomy puncture.			
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon	2793.00	5	652.31

BREAST

Incision:

70041	Fine needle aspiration of solid or cystic lesion - operation only	213.00	2	50.81
70042	– each additional cyst or lesion (maximum of 3) - operation only	54.10	2	12.73
70043	Mastotomy with exploration or drainage of abscess or hematoma; deep (operation only)	399.00	2	153.40
V70044	– under general anesthesia or procedural sedation	941.00	2	255.66

Excision:

Biopsy of breast:

70469	– needle core - operation only	278.00	2	102.26
70470	– incisional - operation only	704.00	2	204.53
70471	– excisional - operation only	941.00	2	255.66

Stereotactic or ultrasound-guided core needle biopsy:

70472	– 1 to 5 core samples - operation only	399.00	2	95.81
70473	– 6 or more core samples - operation only	566.00	2	135.28
V07470	Nipple exploration, with excision of lactiferous duct(s) or papilloma of lactiferous duct (microdochectomy)	1284.00	2	306.79
V07497	Biopsy or segmental resection of non-palpable breast lesion following radiological fine wire localization	1086.00	2	306.79
70477	– each additional lesion identified by a radiologic marker	541.00	2	112.92

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

MASTECTOMY

For malignant breast disease or invasive melanoma the following procedures when performed by the same surgeon will be paid at 100% for the greater procedure, lesser procedures will be paid at 100% for the second, 75% for the third, and 50% for the remaining.
(NOTE: This does not apply to procedures that are inclusive of others (e.g., oncoplastic breast-conserving procedures - see notes under 07481, 07482, 07483).

Mastectomy: 07472, 07473, 07498, 07481, 07482, 07483
Axillary dissection: 07474, 07475
Sentinel lymph node biopsy: 07479
Tumours or scars: 70116, 70125, 70126

V70478	– for gynecomastia	1414.00	3	409.05
V07471	– simple for benign disease (female only)	1674.00	3	409.05
V07498	– skin sparing, when performed for reconstruction - unilateral (female only)	3005.00	3	715.84
V07473	– partial for malignancy	1522.00	3	383.49
V07472	– total for malignancy	2325.00	3	511.31
V70479	– radical	3815.00	4	795.18
	NOTE: Includes pectoral muscles and complete axillary node dissection.			
V07475	Partial axillary dissection	1163.00	3	242.72
V07474	Complete axillary dissection (level 2)	2345.00	3	562.45
79135	Chest wall tumour with rib resection	2646.00	6	1078.49
V07479	Sentinel lymph node biopsy (SLN)	2191.00	3	484.86

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

Oncoplastic breast surgery:
Lumpectomy for malignancy with immediate reconstruction of the defect using mammoplasty techniques. Excision of the tumour with planned margins to achieve locoregional control.

V07481	Oncoplastic breast conserving surgery – Level 1	2155.00	4	460.19

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to General Surgeons with appropriate training and/or mentoring. ii) Includes mobilization of breast parenchyma, creation of skin flaps, and layered closure and mammoplasty. iii) Not payable when additional ipsilateral breast reconstructive procedure(s) are performed on the same day by a second surgeon, or when part of a pre-planned staged breast reconstruction. iv) Not payable in addition to the Mastectomy fee items 07472, 07473, 07498, 07482, and 07483 as well as fee items 06150, 06164, 61045, 61050, 61157, and 61158.			
CV07482	Oncoplastic breast conserving surgery – Level 2.....	2633.00	4	562.45
	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. iii) Not payable when additional ipsilateral breast reconstructive procedure(s) are performed on the same day by a second surgeon, or when part of a pre-planned staged breast reconstruction. iv) Not payable in addition to the Mastectomy fee items 07472, 07473, 07498, 07481, and 07483 as well as fee items 06150, 06164, 61045, 61050, 61157, and 61158.			
TCV07483	Oncoplastic breast conserving surgery - Level 3	2859.00	4	725.00
	NOTES: i) Restricted to General Surgeons with appropriate post-graduate or post-fellowship training. ii) Includes glandular pedicles coupled with large mobilizations, transpositions, and rotations of residual breast tissue.			

(notes continued on next page

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

iii) Only payable when resected breast volume exceeds 25% of ipsilateral breast parenchyma, and the operative report documents the use of reduction mammoplasty techniques sufficient to achieve cosmesis.
iv) Not payable when additional ipsilateral breast reconstructive procedure(s) are performed on the same day by a second surgeon, or when part of a pre-planned staged breast reconstruction.
v) Not payable in addition to the Mastectomy fee items 07472, 07473, 07498, 07481, and 07482, as well as fee items 06150, 06164, 61045, 61050, 61157, and 61158.

ESOPHAGUS

Incision

Esophagotomy:

V70500	– cervical approach with removal of foreign body	2637.00	5	548.90
V70501	– thoracic approach with removal of foreign body	3129.00	8	652.01
V70502	Cricopharyngeal myotomy - cervical approach	2303.00	4	479.96

Excision

Excision of lesion, esophagus with primary repair:

CV70530	– cervical approach	2637.00	6	548.90
CV70531	– thoracic or abdominal approach - open	3815.00	8	795.18
CV70532	– thoracic or abdominal approach - laparoscopic or thoracoscopic	3815.00	8	795.18

Total or near total esophagectomy, without thoracotomy (transhiatal):

With pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty:

V70533	– primary surgeon	9383.00	8	2076.08
70503	– secondary surgeon	3005.00		664.71

With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):

V70534	– primary surgeon	9383.00	8	2076.08
70504	– secondary surgeon	3005.00		664.71

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Total or near total esophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):			
V70535	– primary surgeon	10555.00	8	2335.58
70505	– secondary surgeon	3005.00		664.71
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70536	– primary surgeon	10555.00	8	2335.58
70506	– secondary surgeon	3005.00		664.71
V70538	Partial esophagectomy, distal 2/3 - with thoracotomy and separate abdominal incision and thoracic esophagogastrostomy NOTE: Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.	8021.00	8	1671.88
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70539	– primary surgeon	9150.00	8	1906.97
70509	– secondary surgeon	3005.00		664.71
CV70540	Partial esophagectomy, thoracoabdominal or abdominal approach, with esophagogastrostomy NOTES: i) Includes vagotomy. ii) Includes proximal gastrectomy, pyloroplasty and splenectomy, if required.	7021.00	8	1462.86
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70541	– primary surgeon	8211.00	8	1711.06
70511	– secondary surgeon	3005.00		664.71
CV70542	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy (includes gastrostomy)	5269.00	6	1097.79
	Diverticulectomy of hypopharynx or esophagus, with or without myotomy:			
V70545	– cervical approach	2637.00	6	548.90
V70544	– thoracic approach	3208.00	8	668.74

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Esophagus - Endoscopy:			
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee NOTE: Not payable with 33341.	476.00	3	119.27
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing - procedural fee NOTE: Not payable with 33341.	397.00	3	120.07
S10763	Initial esophageal, gastric or duodenal biopsy NOTES: i) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs. ii) First biopsy paid at 100%, second and third at 50%.	61.30	3	15.15
S10764	Multiple biopsies for differential diagnoses of Barrett's Esophagus, H pylori, Eosinophiic Esophagitis, infection of stomach, surveillance for high or low grade dysplasia, or carcinoma NOTES: i) Paid only once per endoscopy. ii) Paid only in addition to S10763 at 100%. iii) Only applicable to services submitted under diagnostic codes 530, 041, 235, and 234.9.	237.00	3	44.56
	Upper Gastrointestinal System – Endoscopy (Surgical)			
S33321	Removal of foreign material causing obstruction, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	547.00	4	151.03
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions - operation only NOTES: i) Paid only once per endoscopy. ii) Paid only in addition to: a) 10761 or 10762; or b) 33341, at 50%.	628.00	3	151.18
S33323	Transendoscopic tube, stent or catheter – operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	547.00	3	151.03

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S33324	Thermal coagulation – heater probe and laser, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	326.00	3	150.81
S33325	Gastric Polypectomy, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	245.00	5	61.36
S33326	Percutaneous endoscopically placed feeding tube – operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	489.00	3	176.22
S33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	204.00	3	100.51
S33328	Esophageal dilation, blind bouginage, operation only NOTE: Repeats within one month paid at 100%.	310.00	3	100.58
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only NOTE: Repeats within one month paid at 100%.	586.00	3	151.10
TV33330	Per Oral Endoscopic Myotomy (POEM) under general anesthesia NOTES: i) Payable with 07001. ii) Not payable with 07003 or 10761.	1666.00	6	900.00
	Esophagus - Repair:			
V71530	Cervical esophagostomy	2608.00	5	543.38
V71531	Repair tracheo-esophageal fistula - cervical approach NOTE: 71530 and 71531 include gastrostomy.	9243.00	6	2045.25

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Esophagoplasty (plastic repair or reconstruction) thoracic approach			
CV71532	– without repair of tracheoesophageal fistula	9243.00	8	2045.25
CV71533	– with repair of tracheoesophageal fistula	10399.00	8	2300.91
V71534	Division of tracheoesophageal fistula without esophageal anastomosis (thoracic approach)	3952.00	8	868.66
	NOTE: C71533 and 71534 include gastrostomy.			
	Esophagogastric Fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:			
CV71535	– laparoscopic	5063.00	6	1022.63
V71536	– open	3619.00	6	843.66
CV71537	Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure), abdominal and/or thoracic approach	3889.00	8	920.36
V71538	– with gastroplasty - Collis	5629.00	8	1245.65
	Plastic operation for cardiospasm, Heller:			
CV71539	– thoracic approach - open	3304.00	8	766.97
CV71540	– laparoscopic or thorascopic (endoscopy to be billed separately)	4624.00	6	945.93
CV71541	– with fundoplication - open	4618.00	6	1073.76
CV71542	– with fundoplication - laparoscopic	6461.00	6	1227.15
	Gastrointestinal reconstruction for previous esophagectomy, for obstructing esophageal lesion or fistula or for previous esophageal exclusion:			
CV71543	– with stomach, with or without pyloroplasty	7021.00	6	1462.86
CV71544	– with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	8211.00	6	1711.06
CV07536	Direct ligation of esophageal varices	3619.00	7	753.19
CV71546	Transection of esophagus with repair, for esophageal varices	4074.00	6	920.36
CV71547	Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation	5547.00	6	1227.15
	Suture of esophageal wound or injury:			
V71548	– cervical approach	5865.00	6	1297.56
CV71549	– transthoracic or transabdominal approach	7037.00	8	1557.05
	Closure of esophagostomy or fistula:			
CV71550	– cervical approach	5865.00	6	1297.56
CV71551	– transthoracic or transabdominal approach	7037.00	8	1557.05

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
07528	Placement of gastroesophageal venous compression balloon (e.g.: Minnesota or Blakemore) operation only....	933.00	5	206.68
	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	5605.00	6	1328.31
	Repair of diaphragmatic hernia of any type, with or without fundoplication, vagotomy, or drainage procedure:			
CV70603	– laparoscopic	5605.00	6	1378.81
CV70604	– congenital diaphragmatic hernia.....	7037.00	9	1557.05
CV70605	– open.....	5614.00	8	1328.34
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	3697.00	8	818.10
	NOTE: For anti-reflux procedures, such as fundoplications, etc., please see Oesophageal section.			

STOMACH

	Incision:			
	Gastrotomy:			
V70620	Gastrotomy or enterotomy - with exploration or foreign body removal only.....	2335.00	5	516.79
V70621	– with suture repair of bleeding ulcer (including duodenal).....	3314.00	6	689.65
CV70622	Gastrotomy - with suture repair of pre-existing oesophagogastric laceration (e.g.: Mallory-Weiss)	3451.00	6	718.36
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation).....	2335.00	5	516.79
	Excision			
	Limited or wedge excision:			
V70625	– ulcer or benign tumour of stomach - open	2811.00	6	585.15
CV72725	– ulcer or benign tumour of stomach – laparoscopic	3932.00	6	731.45
V70626	– malignant tumour of stomach - open	3208.00	6	816.25
CV72726	– malignant tumour of stomach – laparoscopic	4495.00	6	835.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Gastrectomy, total			
CV70627	– - with esophagoenterostomy - open	7856.00	6	1738.46
CV72727	– with esophagoenterostomy – laparoscopic	9243.00	6	2045.25
CV70628	– with Roux-en-Y reconstruction - open	7856.00	6	1738.46
CV72728	– with Roux-en-Y reconstruction – laparoscopic	9243.00	6	2045.25
CV70629	– with formation of intestinal pouch, any type - open	7856.00	6	1738.46
CV72729	– with formation of intestinal pouch, any type – laparoscopic	9243.00	6	2045.25
	Gastrectomy, partial, distal:			
V70630	– with gastroduodenostomy (Billroth I) - open	5085.00	6	1124.89
CV72730	– with gastroduodenostomy (Billroth I) – laparoscopic	6740.00	6	1253.92
V70631	– with gastrojejunostomy (Billroth II) - open	5085.00	6	1124.89
CV72731	– with gastrojejunostomy (Billroth II) – laparoscopic	6740.00	6	1253.92
V70632	– with Roux-en-Y reconstruction - open	5547.00	6	1227.15
CV72732	– with Roux-en-Y reconstruction – laparoscopic	7021.00	6	1306.13
V70633	– with formation of intestinal pouch - open	6008.00	6	1329.41
CV72733	– with formation of intestinal pouch – laparoscopic	7585.00	6	1410.66
70634	Vagotomy (extra)	318.00		65.31
V70635	Proximal gastrectomy, thoracic or abdominal approach including esophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy, with or without splenectomy - open	5899.00	6	1229.88
CV72735	Proximal gastrectomy, thoracic or abdominal approach including esophagogastrostomy, with vagotomy and includes pyloroplasty or pyloromyotomy, with or without splenectomy –laparoscopic	8266.00	6	1537.33
CV70639	Radical gastrectomy including D2 Extended Lymphadenectomy – open or laparoscopic – first 60 minutes	2534.00	6	677.76
CV70640	Radical gastrectomy including D2 Extended Lymphadenectomy – open or laparoscopic – each additional 15 minutes or greater portion thereof	310.00	6	78.20

NOTES:

i) Restricted to General Surgeons and Thoracic Surgeons.

ii) For curative-intent gastric resection for adenocarcinoma of the stomach.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Payable only for complete dissection of periportal, common hepatic artery, celiac and splenic artery nodal basins as detailed in operative note. iv) Not billable for D1 lymphadenectomy or palliative intent resections. v) Not paid with portal lymphadenectomy (70718), total and/or partial gastrectomy. vi) Start and end times are required in the claim and the patient's chart for the radical gastrectomy and cannot be billed for time performing concurrent procedures.			
CV07624	Emergency gastrectomy for continued hemorrhage (with operative report)	5547.00	7	1227.15
V07628	Gastrojejunostomy or pyloroplasty with vagotomy, with or without gastrostomy	3124.00	5	651.05
CV07578	Highly selective vagotomy	3124.00	5	651.05
	Stomach - Introduction:			
V07630	Gastrostomy - open	2111.00	5	467.13
33394	Assistant fee for PEG procedure NOTE: S33326, 33394 may be billed by any qualified physician.	522.00		176.14
70637	Change of gastrostomy tube - operation only	210.00	2	51.08
	Stomach - Other Procedures:			
V07626	Pyloroplasty	1977.00	5	411.33
V07627	Gastrojejunostomy - open	2580.00	5	570.93
CV72737	Gastrojejunostomy – laparoscopic	2986.00	5	816.01
	Patch or suture of perforated duodenal or gastric ulcer, wound or injury:			
V07632	– open	3467.00	6	766.97
V70641	– laparoscopic	3467.00	6	766.97
V70642	Gastric restrictive procedure, without gastric bypass, for morbid obesity (includes vertical banded and other gastroplasties)	4691.00	7	1038.04
CV72739	Laparoscopic Vertical Sleeve Gastrectomy	6073.00	7	1130.07
V70643	Gastric restrictive procedure, with bypass, for morbid obesity;, gastroenterostomy - open	7394.00	7	1636.20
CV72743	Gastric restrictive procedure, with bypass, for morbid obesity; gastroenterostomy – laparoscopic	6544.00	7	1447.78

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V70644	– with small bowel reconstruction to limit absorption - ileojejunal bypass	5512.00	7	950.83
V70645	Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity - open	7475.00	7	1653.84
CV72775	Revision or reversal of gastric restrictive procedure for morbid obesity with takedown gastroenterostomy and reconstitution of small bowel integrity – laparoscopic	7856.00	7	1738.46
CV07623	Revision gastrectomy after previous gastrectomy, with or without vagotomy - open	5626.00	7	1244.92
CV72723	Revision gastrectomy after previous gastrectomy, with or without vagotomy – laparoscopic	7034.00	7	1556.11
V70646	Closure of gastrostomy, surgical	1977.00	4	411.33
CV07633	Closure of gastrojejunocolic fistula	5595.00	5	1165.85
CV70649	Closure of gastrocolic fistula - operation only	3857.00	5	804.58

INTESTINES

V70650	Lysis of intra-abdominal adhesions - first 30 minutes (extra)	806.00	7	163.62
70651	– each additional 15 minutes or greater portion thereof (extra)	353.00		81.81

NOTES:
i) Restricted to General Surgeons only.
ii) Payable for open procedures only.
iii) Not payable with fee item 07650.
iv) Not payable to same general surgeon doing the surgical assist.
v) Start and stop times for Lysis must be provided in patient chart and claim time field.

V70660	Lysis of intra-abdominal adhesions, laparoscopic – first 30 minutes (extra)	806.00	7	163.62
70661	- each additional 15 minutes or greater portion thereof (extra)	353.00		81.81

NOTES:
i) Restricted to General Surgeons only.
ii) Not payable with fee item V07650, V70650, or S04001.
iii) Not payable to same general surgeon doing the surgical assist.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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 NOTE: Not payable with fee items 70650, 70651, 70660, 70661.	2542.00	5	562.45
CV72650	Intestinal obstruction; resection of bands, enterolysis – laparoscopic NOTES: i) Restricted to General Surgeons. ii) Not payable with fee items 70650, 70651, 70660, 70661.	3252.00	5	641.82
V70648	Tube or needle catheter jejunostomy for enteral alimentation, intraoperative any method	2344.00	4	518.47
V07634	Full thickness repair of iatrogenic intestinal perforation (single) - open	2677.00	5	498.40
CV71634	Full thickness repair of iatrogenic intestinal perforation (single) – laparoscopic	2742.00	5	623.02
V07635	Full thickness repair of iatrogenic intestinal perforation (multiple) - open	3523.00	5	654.34
CV71635	Full thickness repair of iatrogenic intestinal perforation (multiple) – laparoscopic	3589.00	5	817.93
V07654	Intestinal obstruction - plication or insertion of intraluminal tube	2797.00	5	582.94
V07651	Reduction of volvulus, intussusception, internal hernia, by laparotomy	2901.00	5	538.14
V71650	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) - open	2336.00	5	517.05
V71651	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic NOTES: i) Restricted to General Surgeons. ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100% plus fee item 04001 at 50%.	3123.00	5	599.28

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Excision			
	Resection of small intestine:			
V07636	– with anastomosis - open	2961.00	5	696.58
CV72736	– with anastomosis – laparoscopic	4148.00	5	763.09
CV72620	– with enterostomy; without anastomosis (does not include separate enterostomies or resections) - open	3990.00	5	832.19
CV72720	– with enterostomy; without anastomosis (does not include separate enterostomies or resections) – laparoscopic	5592.00	5	1040.24
CV71725	Resection of duodenum NOTES: i) Requires appropriate training or experience in proximal pancreatic surgery. ii) Requires complete mobilization of the entire duodenum, including taking down the ligament of Treitz and separating the duodenum from the superior mesenteric vessels. iii) For limited resection of the duodenum requiring only Kocherisation bill fee item 07636. iv) Includes lymph node biopsies (00745).	7122.00	8	1503.19
V07643	Enteroenterostomy	2802.00	5	620.16
V07570	Colo-colostomy or entero-colostomy - open NOTE: 07570 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.	4420.00	6	820.99
CV72770	Colo-colostomy or entero-colostomy – laparoscopic NOTE: CV72770 applies to unprepared, non-resectable bowel obstructions. In all other instances, 07643 is applicable instead.	5519.00	6	1026.23
72621	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (extra) (not applicable to right or left hemicolectomy) - operation only - open	470.00	6	97.96

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
C72721	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy – laparoscopic - extra (not applicable to right or left hemicolectomy) – (operation only)	623.00	6	122.45
	NOTES: i) Restricted to General Surgeons. ii) If conversion to open procedure is required, bill under the appropriate open procedures at 100%.			
	Limited resection of colon:			
V72622	– open	4339.00	6	970.35
CV72623	– laparoscopic	4551.00	6	1010.12
	Hemicolectomy; right (see also 72640):			
V72624	– open	4558.00	6	1022.63
CV72625	– laparoscopic	5684.00	6	1085.88
	Hemicolectomy; left:			
V72626	– open	4824.00	6	1110.12
CV72631	– laparoscopic	6031.00	6	1124.85
	Sigmoid resection:			
V72632	– open	5021.00	6	1111.14
CV72633	– laparoscopic	6278.00	6	1262.64
V72634	– with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) - open	4762.00	6	1010.12
CV72734	– with end colostomy and closure of distal segment or mucous fistula (Hartmann type procedure) – laparoscopic	5934.00	6	1103.28
CV72635	Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) - with or without protective stoma - open	7006.00	6	1566.19
CV72755	Anterior resection of rectosigmoid for carcinoma (low pelvic anastomosis; coloproctostomy) - with or without protective stoma – laparoscopic	7478.00	6	1686.92
	Proctectomy, abdominal and transanal approach; coloanal anastomosis (with or without protective colostomy):			
V72636	– synchronous - abdominal portion	6201.00	7	2034.21
CV07662	Abdomino-perineal resection (single surgeon) - open	7942.00	7	1868.73

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV72762	Abdomino-perineal resection (single surgeon) – laparoscopic	9267.00	7	1941.98
V07663	– synchronous - abdominal portion - open	6201.00	7	1431.68
CV72763	– synchronous - abdominal portion – laparoscopic	7736.00	7	1532.77
V07664	Proctectomy, in combination with any abdominal resection - synchronous - perineal portion	2336.00	7	517.01
CV07569	Colectomy and hemiproctectomy - open	5996.00	6	1124.89
CV72769	Colectomy and hemiproctectomy – laparoscopic	7481.00	6	1391.30
CV07640	Colectomy - total, abdominal (without proctectomy) - open NOTE: Includes ileostomy or ileoproctostomy.	6206.00	6	1327.55
CV72760	Colectomy - total, abdominal (without proctectomy) – laparoscopic NOTE: Includes ileostomy or ileoproctostomy.	7746.00	6	1440.93
V07567	Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy - open	8527.00	6	1789.60
CV72767	Proctectomy with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J) with or without loop ileostomy – laparoscopic	10644.00	6	1979.83
V07566	Rectal mucosectomy and ileaoanal anastomosis	4114.00	6	856.38
CV07641	Total proctocolectomy with perineal excision of rectum and ileostomy (single surgeon) - open	9064.00	7	2249.78
CV72741	Total proctocolectomy with perineal excision of rectum and ileostomy (single surgeon) – laparoscopic	11313.00	7	2449.98
V07589	– synchronous - abdominal portion - open	7251.00	7	1346.90
CV72789	– synchronous - abdominal portion – laparoscopic	9052.00	7	1737.79
V07565	Takedown of pelvic pouch, to include ileostomy - open	5629.00	5	1245.65
CV72765	Takedown of pelvic pouch, to include ileostomy – laparoscopic	7030.00	5	1555.30
V72640	Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy - open	4343.00	6	970.67
CV72740	Partial right colectomy (caecum) with removal of terminal ileum and ileocolostomy – laparoscopic	5418.00	6	1010.12

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
72641	Caecostomy, tube for decompression (extra) - open	1868.00	5	413.34
72601	Caecostomy, tube for decompression – laparoscopic (extra)	1956.00	5	460.19
	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%.			
	Transanal Minimally Invasive Total Mesorectal Excision (TaTME)			
CV72602	TaTME second surgeon – synchronous perineal portion NOTE: for second surgeon when performed with synchronous abdominal fees 72604, 72606, 72608, or 72610.	6508.00	7	1636.20
CV72603	Rectosigmoid resection in combination with a TaTME – single surgeon – open	9560.00	7	2403.17
CV72604	Rectosigmoid resection in combination with a TaTME – synchronous abdominal portion – open	4068.00	7	1022.63
CV72605	Rectosigmoid resection in combination with a TaTME – single surgeon – laparoscopic	10319.00	7	2594.40
CV72606	Rectosigmoid resection in combination with a TaTME – synchronous abdominal portion – laparoscopic	5086.00	7	1278.29
CV72607	Proctocolectomy in combination with a TaTME – single surgeon – open	10780.00	7	2709.96
CV72608	Proctocolectomy in combination with a TaTME – synchronous abdominal portion – open	5694.00	7	1431.68
CV72609	Proctocolectomy in combination with a TaTME – single surgeon – laparoscopic	11849.00	7	2978.40
CV72610	Proctocolectomy in combination with a TaTME – synchronous abdominal portion – laparoscopic	7119.00	7	1789.60
	Revision of colostomy, ileostomy:			
V07648	– simple incision of scar, etc.	2080.00	4	562.45
V07649	– radical; reconstruction with bowel resection	2336.00	5	766.97
V72644	– with repair of paracolostomy hernia requiring laparotomy	3113.00	5	715.29
V72645	Continent ileostomy (Koch procedure) - open	4930.00	6	1026.94
CV72745	Continent ileostomy (Koch procedure) – laparoscopic	6903.00	6	1283.67
V07645	Colostomy or ileostomy – loop - open	2335.00	5	516.82
CV72715	Colostomy or ileostomy – loop – laparoscopic	2814.00	5	561.96

			Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V07588	–	end - open	2596.00	5	517.07
CV72788	–	end – laparoscopic	3243.00	5	602.94
72646	–	multiple biopsies (e.g.: for Hirschsprung disease) - extra - operation only	657.00	5	137.53
		Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation, for intestinal obstruction:			
V72647	–	single	2804.00	5	620.26
V72648	–	multiple (two or more)	4202.00	5	930.13
		Closure of loop enterostomy, large or small intestine:			
V07646	–	without resection	2352.00	4	562.45
V07647	–	with resection and anastomosis	3113.00	5	715.84
		Reconstruction Hartman procedure with or without protective colostomy:			
V72651	–	open	4672.00	5	1111.13
CV72652	–	laparoscopic	5684.00	5	1245.25
		Closure of fistula; enterovesical, colovesical or colovaginal:			
V72653	–	without intestinal and/or bladder resection - open	4343.00	5	930.47
72654	–	with bowel resection (extra to 72653) - open	1869.00	5	413.49
		NOTE: For bladder resection, see Urology Guide.			
CV72683	–	without intestinal and/or bladder resection – laparoscopic	4756.00	5	1003.95
72684	–	with bowel resection (extra to 72683) – laparoscopic	2041.00	5	430.79
		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	5528.00	6	1227.15
V07658		Exteriorization of large bowel lesion (carcinoma, perforation, etc.)	3320.00	5	616.15

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
MECKEL'S DIVERTICULUM AND THE MESENTERY				
	Excision			
V07655	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	2335.00	4	516.66
	Suture and Repairs			
V07447	Repair of mesenteric injury	2811.00	6	869.24
APPENDIX				
	Incision			
V72660	Incision and drainage of appendiceal abscess, transabdominal NOTE: Not payable in addition to appendectomy listings.	2128.00	4	444.02
	Excision			
V72656	Appendectomy - open	2221.00	4	511.06
V72658	– laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee)	2221.00	4	511.31
V72657	Appendectomy - perforated with abscess or generalized peritonitis - open	2335.00	5	536.63
V72659	– laparoscopic (if conversion to open procedure is necessary bill open procedure plus 50% of laparoscopy fee)	2335.00	5	536.88
RECTUM				
	Incision			
V07660	Transrectal drainage of pelvic abscess	1401.00	2	310.01
	Excision			
07665	Biopsy of anorectal wall, anal approach (e.g.: congenital megacolon) - operation only	828.00	2	154.40
CV07662	Abdomino-perineal resection (single surgeon)	7942.00	7	1868.73
PCV72762	Abdomino-perineal resection (single surgeon) – laparoscopic	9267.00	7	1941.98
V07663	– synchronous - abdominal portion - open	6201.00	7	1431.68

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
PCV72763	– synchronous - abdominal portion – laparoscopic	7736.00	7	1532.77
V07664	Proctectomy, in combination with any abdominal resection - synchronous - perineal portion	2336.00	7	517.01
	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull through procedure and anastomosis (e.g.: Swenson, Duhamel, or Soave type operation):			
V72662	– synchronous - abdominal	7112.00	7	1344.65
CV72664	– with subtotal or total colectomy, with multiple biopsies	9064.00	7	2343.78
V72665	Proctectomy, partial, without anastomosis, perineal approach	2758.00	5	570.93
V72666	Altemeier transperineal excision of rectal procidentia with anastomosis	3731.00	3	766.97
	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	1166.00	2	306.19
V07580	Excision of rectal tumour by posterior parasacral, transacral or transcoccygeal approach (Kraske)	3697.00	5	818.10
	Excision of rectal tumour, transanal approach to include operative sigmoidoscopy:			
72669	– 0 to 2.5 cm - operation only	1170.00	2	306.20
72670	– 2.6 to 5 cm (operation only)	1407.00	2	357.35
72671	– greater than 5 cm (operation only)	2363.00	2	465.39
72672	Electrodesiccation or fulguration of malignant tumour of rectum, transanal (includes endoscopy) - operation only	1167.00	2	258.40
CV72673	Transanal Endoscopic Microsurgical Resection of rectal tumour	4922.00	6	938.43
	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)

		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.			
	Repair			
V07672	Complete rectal prolapse - transabdominal rectopexy - open	3777.00	5	714.50
	NOTE: Paid as a stand-alone procedure with the exception when performed in conjunction with sigmoid resection (72632, 72633) payment will be at 25%.			
CV72572	Complete rectal prolapse - transabdominal rectopexy – laparoscopic	4241.00	5	893.14
	NOTE: Paid as a stand-alone procedure with the exception when performed in conjunction with sigmoid resection (72632, 72633) payment will be at 25%.			
	Rectum - Endoscopy			
	NOTES:			
	i) **Proctosigmoidoscopy** is the examination of the rectum and sigmoid colon.			
	ii) **Sigmoidoscopy** is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.			
	iii) **Colonoscopy** is the examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum.			
SY10714	Proctosigmoidoscopy, rigid; diagnostic	169.00	2	36.20
SY00715	Sigmoidoscopy (with biopsy) - procedural fee	174.00	2	38.83
S07460	– with decompression of volvulus - operation only	1201.00	2	234.01
SY00716	Sigmoidoscopy; flexible - diagnostic	352.00	2	77.81
SY00718	– with biopsy	404.00	2	79.09
S07461	– with removal of foreign body - operation only	836.00	2	185.09
S07462	– with control of bleeding, any method - operation only	836.00	2	185.09
S07463	– with decompression of volvulus, any method - operation only	1058.00	2	234.01
S07464	– with removal of polyp(s) (operation only)	1385.00	2	256.70

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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)	937.00	2	173.59
S10730	Colonoscopy, flexible, via colostomy - single or multiple	1181.00	4	234.43
S10731	Colonoscopy, flexible, proximal to splenic flexure; diagnostic with or without collection of specimen(s) by brushing or washing	1181.00	2	234.35
S10732	– with removal of foreign body	1336.00	2	278.22
S10733	– with control of bleeding, any method	1497.00	2	310.87
07375	Complex polypectomy (extra)	800.00		178.96

NOTES:

i) Restricted to General Surgeons and Gastroenterologists.

ii) Only for resection of a polyp with one or more of the followings:
- large (≥ 20mm) non-pedunculated colorectal polyp/lesion
- involving the appendiceal orifice, ileocecal valve, or dentate line
- recurrent or previously attempted resection
- complex polyp/lesion as determined by multidisciplinary committee

iii) Requires 60 minutes or more of slated endoscopy time.

iv) Not to be performed at index/diagnostic colonoscopy unless specifically referred for complex polypectomy.

v) Complete removal after submucosal injection and piecemeal resection or endoscopic mucosal resection.

vi) May not be claimed for pedunculated polyps.
Payable only in addition to 10730, 10731, 10761, 00716, 00718, or 33373.
Not payable in conjunction with 33374, 07464, 07465, 10714, 00715.

vii) Second complex polypectomy on the same day for the same patient will be paid at 50%.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
ANUS				
	Repair			
V70665	Anoplasty; plastic procedure for stricture - adult	2086.00	2	461.71
V70666	Sphincteroplasty; for incontinence or prolapse (posterior anal repair) – adult	2086.00	2	461.71
V07690	Anoplasty for imperforate anus	3320.00	4	714.61
70668	Graft (Thiersch operation) for rectal incontinence or prolapse - operation only	942.00	2	208.54
V70670	Sphincteroplasty; anal, for incontinence - Gracillis muscle implant	3246.00	3	718.41
V70671	Levator muscle imbrication; Park posterior - anal repair	2086.00	2	461.71
V70672	Implantation of artificial sphincter	4665.00	4	1032.16
	NOTE: 70670, 70671 & 70672 are not payable together.			
V07452	Repair extra-peritoneal rectum, with or without colostomy	5305.00	7	1227.15
	Destruction of anal lesion, any method including fulguration anal condylomata:			
70674	– simple; less than 10% perianal skin involvement - operation only	349.00	2	152.45
70680	– complicated; greater than 10% of perianal skin involvement (with operative report) - operation only	1167.00	2	306.19
S70683	EUA with or without sigmoidoscopy, with or without biopsy - operation only	708.00	2	178.68
CV72673	Transanal Endoscopic Microsurgical Resection of rectal tumour	4922.00	6	938.43
	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)

		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 or procedural sedation (operation only)	707.00	2	156.13
04401	Fistula, recto-vaginal repair	2480.00	3	700.31
	Incision			
70675	Removal of anal seton, other marker - operation only	133.00	2	29.32
V70676	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	1804.00	2	398.77
07691	Anus imperforate, simple incision - operation only	1401.00	2	309.92
07679	Incision and drainage of ischiorectal, intramural, intramuscular or submucosal abscess - under anesthesia or procedural sedation - operation only	939.00	2	306.79
07678	Incision and drainage, perianal abscess - superficial - operation only	506.00	2	153.40
	Excision			
07687	Anal fissure, excision under local anesthetic - operation only	532.00	2	117.60
V71681	Sphincterotomy with or without fissurectomy	1401.00	2	309.93
SV71682	Botox injection for anal fissure. NOTES: i) Payment restricted to General Surgeons. ii) Tray fee is not paid when the procedure is performed in hospital or publicly-funded facilities (D&T Centres, psychiatric facilities). iii) Paid to a maximum of four injections per patient per year.	1165.00	2	280.93

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Papillectomy or excision of anal tag or polyp:			
71684	– single (extra) - operation only	314.00	2	102.26
71686	– multiple (extra) - operation only	570.00	2	143.17
71689	Hemorrhoid(s); (e.g.: band ligation) - to include proctoscopy - operation only	445.00	2	82.41
71690	Hemorrhoid(s); - infrared photocoagulation to include proctoscopy - operation only	445.00	2	82.41
71691	Hemorrhoid(s) add on fee	146.00		17.20
	NOTES: i) Restricted to General Surgeons. ii) Paid only when service performed in an office (location code Q or T), not payable in a public facility. iii) Paid only with fee item 71689 or 71690.			
V07683	Hemorrhoidectomy, with or without sigmoidoscopy	1476.00	2	306.79
	Fistula-in-ano (fistulectomy or fistulotomy)			
07675	– subcutaneous or submucous - operation only	1156.00	2	306.79
V07676	– submuscular	1861.00	2	345.36
V07677	– multiple or horseshoe, with or without placement of seton	2488.00	2	461.71
V07666	Fistula-in-ano; second stage; division of sphincter after placement of seton	1156.00	2	306.16
V71700	Closure of congenital or acquired anal fistula with rectal advancement flap	3555.00	2	659.75

LIVER

Incision

	Hepatotomy for drainage of abscess or cyst; laparoscopic or open:			
V07402	– single	2128.00	6	511.31
V07403	– multiple, including marsupialization	3208.00	6	668.74
CV71380	Open or Laparoscopic operative liver tumour non-resectional ablation by any means.	3501.00	7	1021.36

(see notes on next page)

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

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.

Excision

CV07404	Non-anatomic, subsegmental excision of liver mass	4622.00	7	1124.89
CV72794	Laparoscopic non-anatomic sub-segmental excision of liver mass	5278.00	7	1226.41

NOTES:
i) Restricted to General Surgery.
ii) If laparoscopic procedure is converted to open, bill under open procedure (07404) at 100% and 04001 at 50%.
iii) Not for incomplete resection or incision/core biopsy of liver masses.
iv) Only for therapeutic liver resection and not diagnostic excisional biopsy.

HEPATECTOMY; SEGMENTAL RESECTION:

Liver resections for metastasis, billed in conjunction with colorectal resections or sarcoma resections, will be paid at 100% of the listed fees, for each item, when done as a team by two general surgeons. Only payable when ICD-9 code is 153, 154, 158 or 171.
The following lists of procedures are eligible for payment as team fees:

Liver resections: 07405, 72795, 07406, 72796, 07407, 72797, 07408, 72798, 07409, 07410, 07411.

Colorectal resections: 72622, 72623, 72624, 72625, 72626, 72631, 72632, 72633, 72634, 72734, 72635, 72755, 72636, 07664, 07662, 72762, 07663, 72763, 07569, 72769, 07640, 72760, 07641, 72646, 72740, 07662, 07580.

Sarcoma resections: 71290, 71291.

Hepatectomy, segmental resection:

CV07405	– one or more, same side - open	5547.00	8	1329.41

NOTE: Cholecystectomy is not paid in addition.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV72795	Laparoscopic hepatectomy, segmental resection – one or more, same side	6771.00	8	1328.93
	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	7394.00	8	1738.46
	NOTES: i) Surgeon must operate on right and left lobes. ii) Cholecystectomy is not paid in addition.			
CV72796	Laparoscopic segmental resection of liver: two or more segments, bilateral lobes	8318.00	8	2247.25
	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	9243.00	8	2147.51
	NOTE: Cholecystectomy is not paid in addition.			
CV72797	Laparoscopic total left lobectomy	11555.00	8	2758.56
	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	9243.00	8	2147.51
	NOTE: Cholecystectomy is not paid in addition.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV72798	Laparoscopic total right lobectomy	11555.00	8	2758.56
	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)	10166.00	8	2352.04
CV07410	– caudate lobectomy (isolated procedure)	9705.00	8	2249.78
CV07411	– extended right lobectomy; 5 or more segments (includes caudate)	10631.00	8	2454.30
	NOTE: Cholecystectomy is not paid in addition.			
	Liver - Repair (Trauma)			
	Hepatorrhaphy; suture of liver wound or injury:			
V07412	– simple	2816.00	8	622.82
V07413	– with packing	3173.00	8	920.36
CV07440	Resectional debridement of liver	5865.00	8	1585.07
CV07441	Hepatic artery ligation to include resectional debridement where indicated	4691.00	8	1038.04
CV07442	Hepatic lobectomy for trauma to include resectional debridement where indicated	11555.00	9	2812.22

BILIARY TRACT

	Incision: **Choledochotomy or choledochostomy and exploration, drainage or removal of calculus:**			
V70694	– open	3928.00	5	869.24
V70695	– laparoscopic	4160.00	5	920.36
V70696	– with transduodenal sphincteroplasty	4541.00	5	971.50
V07769	Duodenotomy and sphincteroplasty	4687.00	5	1036.97
	Cholecystostomy:			
V07698	- open	2336.00	5	526.65
V70698	– laparoscopic	2103.00	5	526.65
71698	– percutaneous (operation only)	811.00	2	168.58
	Biliary Tract - Endoscopy:			
07780	Biliary endoscopy; intraoperative, choledochoscopy (extra)	938.00		207.35

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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	937.00	2	207.17
07782	– with removal of stone - operation only	1054.00	2	233.22
07783	– with dilation of duct stricture with or without stent - operation only	1054.00	2	233.22
PV33341	Endoscopic Retrograde Cholanglopancreatography (ERCP), inclusive of sphincterotomy and biopsies or brushings	1552.00	3	400.00
	NOTES: i) Includes 10761 and 10762. ii) 33322 payable at 50%.			
P33342	with stone extraction (extra) NOTE: 00994 is not payable.	427.00	3	110.00
P33343	– with balloon dilatation of ampullary/biliary/pancreatic stricture, biliary/pancreatic stenting or nasobiliary drainage tube (extra)	427.00	3	110.00
P33345	– with intraductal lithotripsy (extra) – NOTE: 00994 is not payable.	427.00	3	110.00
T33348	with cholangioscopy or pancreatoscopy, inclusive of guided biopsies (extra)	794.00	3	200.00
P33347	Replacement of duodenal biliary stent (extra)	427.00	3	110.00
	Biliary Tract - Excision			
	Cholecystectomy:			
V07707	– laparoscopic	2603.00	5	562.45
V07699	– open	2804.00	5	674.93
V70700	– open cholecystectomy immediately preceded by attempted laparoscopic cholecystectomy	3271.00	5	723.86
V70701	– with exploration of CBD (laparoscopic)	5605.00	5	1240.10
V70702	– with exploration of CBD (open)	5605.00	5	1240.10
V70703	– with choledochoduodenostomy (includes CBD exploration)	6071.00	5	1343.54
V70704	– with choledochojejunostomy (includes CBD exploration)	6072.00	5	1343.64
V70705	– with transduodenal sphincterotomy or sphincteroplasty (includes CBD exploration)	6071.00	5	1343.54

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV70710	Exploration for congenital atresia of bile ducts without repair NOTE: Includes liver biopsy and/or cholangiography, if required.	7037.00	5	2443.22
CV70711	Portoenterostomy (Kasai procedure)	7779.00	6	1620.75
	Excision of bile duct tumour or stricture:			
CV70712	– lower (below bifurcation), any repair	8782.00	6	2245.99
CV70713	– upper (at or above bifurcation) - one anastomosis	10166.00	6	2451.78
CV70714	– upper (at or above bifurcation) - multiple anastomoses	11555.00	6	2758.56
	Excision of choledochal cyst (to include cholecystectomy):			
CV70715	– below bifurcation	6537.00	5	1446.54
CV70716	– above bifurcation requiring one ductoplasty	7222.00	5	1504.66
CV70717	– above bifurcation - multiple anastomoses	7820.00	5	1630.07
CV70718	Portal lymphadenectomy NOTES: i) Paid as stand-alone procedure or in conjunction with liver resection, bile duct resection, or pancreatectomy for cancer of the liver, pancreas, gallbladder and bile ducts. ii) Paid only with skeletonization of the hepatic artery and portal vein from the superior duodenum to the liver hilum. iii) Restricted to General Surgery.	4076.00	4	782.03
	Biliary Tract - Repair			
	Cholecystoenterostomy:			
V07706	– direct (loop)	4691.00	6	1123.82
V70720	– with gastroenterostomy	5629.00	5	1328.38
V70721	– Roux-en-Y	5160.00	5	1226.10
V70722	– Roux-en-Y with gastroenterostomy	6098.00	5	1430.65
CV07703	Choledochoduodenostomy	5160.00	6	1327.10
V07705	Choledochojejunostomy (anastomosis of extra-hepatic biliary ducts and GI tract)	5629.00	6	1429.38
V70725	– with gastrojejunostomy	7856.00	6	1839.46
V70726	– Roux-en-Y	7856.00	6	1839.46
V70727	– Roux-en-Y with gastrojejunostomy	7856.00	6	1839.46

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV70728	Anastomosis of intra-hepatic ducts and GI tract (Longmyer); Roux-en-Y	8176.00	6	1941.33
07561	Placement of choledochal stent (operation only)	845.00	5	176.36
CV70730	U-tube hepatico enterostomy	8176.00	5	1941.33
CV70731	Primary repair of extra-hepatic biliary duct for injury (including intraoperative), any method	6568.00	5	1532.94
V07776	Repair of cholecystenteric fistula	4622.00	5	1022.63

ENDOCRINE SYSTEM

Thyroid - Incision

70740	Incision and drainage of thyroglossal cyst, infected - operation only	942.00	3	208.54
S00744	Thyroid biopsy - procedural fee	269.00	2	79.32

Thyroid - Excision

V07740	Biopsy of thyroid - open	1641.00	4	362.86

Total thyroid lobectomy:

V70742	– unilateral with or without isthmusectomy	2886.00	4	601.14
V70743	– unilateral with contralateral subtotal lobectomy including isthmus	3577.00	4	744.51

Thyroidectomy:

V07743	– total or complete	4688.00	4	1111.13
V07741	– subtotal unilateral (local excision of thyroid lesion)	1884.00	4	460.19
V70745	– subtotal bilateral	3468.00	4	722.81
V70747	– removal of all remaining thyroid tissue following previous removal of portion of thyroid (completion thyroidectomy)	3409.00	4	710.57
C70748	Sternal split for substernal thyroid (extra)	806.00		167.18
V07771	Central neck dissection for confirmed and/or potential extrathyroidal metastatic thyroid cancer (with operative report) NOTE: Payable for comprehensive removal of all resectable pathologic tissue between trachea and carotid from the innominate artery (inferiorly) to the hyoid bone superiorly with dissection of recurrent laryngeal nerve.	5085.00	5	1124.89

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Endocrine System - Parathyroid			
	Parathyroidectomy or exploration of parathyroids:			
V07745	– removal of single adenoma	4160.00	4	1010.11
V07744	– subtotal parathyroidectomy	4688.00	4	1212.13
V71746	– re-exploration	5625.00	4	1430.41
CV71747	– with mediastinal exploration and sternal split	5626.00	6	1328.36
	NOTE: Re-exploration is not payable in addition to C71747.			
71748	Parathyroid autotransplantation, extra to thyroidectomy and parathyroidectomy procedures - operation only	472.00		104.26
	Endocrine System - Adrenal			
VC71703	Adrenalectomy for Pheochromocytoma - open	4834.00	8	1042.24
	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	7255.00	8	1531.08
	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.			
	Adrenalectomy; any approach:			
CV71704	– Unilateral - open	3952.00	8	1020.16
CV72704	– Unilateral – laparoscopic	5528.00	8	1224.70
CV71705	– Bilateral - open	7394.00	8	1636.20
CV72705	– Bilateral - laparoscopic	8318.00	8	2042.73

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Endocrine System - Carotid Body			
	Excision of carotid body tumour:			
CV71706	– without excision of carotid artery	4688.00	6	1325.81
CV71707	– with excision of carotid artery	5626.00	8	1378.87
	Endocrine System – Pancreas - Incision			
V71708	Placement of drains, peripancreatic for acute pancreatitis	4622.00	2	1224.63
V71709	Resectional debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis; to include gastrostomy, jejunostomy and cholecystostomy any approach	6008.00	8	1329.41
	Endocrine System - Pancreas - Excision			
71710	Open biopsy of pancreas, any method (fine needle, core, wedge) intraoperative (extra) - operation only	463.00	6	102.26
S00826	Biopsy of pancreas - percutaneous	470.00	2	103.74
CV71712	Limited excision of pancreatic lesion (e.g.: cyst or adenoma)	4622.00	6	1325.63
	Pancreatectomy, distal subtotal:			
CV71713	– with splenectomy and without pancreaticojejunostomy - open	6008.00	7	1329.41
CV72713	– with splenectomy and without pancreaticojejunostomy – laparoscopic	7030.00	7	1555.26
	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	7394.00	7	1636.20
CV72714	– with splenic preservation – laparoscopic	6718.00	7	1834.13
	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.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV71715	– with pancreaticojejunostomy and with splenectomy	6933.00	7	1533.94
CV71716	– with splenic preservation and pancreatico-jejunostomy	7856.00	7	1738.46
CV71717	Pancreatectomy, distal, near total with preservation of duodenum	11092.00	7	2454.30
CV71718	Excision ampulla of vater	5213.00	6	1124.89
CV71719	Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochojejunostomy and gastroenterostomy, with or without pancreaticojejunostomy (Whipple procedure)	14073.00	8	3476.93
CV71720	– pyloric sparing (Whipple procedure)	14073.00	8	3476.93
CV71721	Regional pancreatectomy to include above Whipple procedures with portal vein reconstruction, with portosystemic shunt and with celiac lymphadenectomy	15943.00	9	3681.45
CV71722	Total pancreatectomy with Whipple procedure	11555.00	8	3067.88
CV07714	Pancreaticojejunostomy; side-to-side anastomosis (Peustow type procedure) NOTE: Includes removal of calculi.	6470.00	6	1431.68
	Endocrine System - Pancreas - Repair **External drainage, pseudocyst of pancreas:**			
V07756	– open	4622.00	5	1022.63
V07758	– laparoscopic	4622.00	5	1022.63
CV07711	Internal drainage or anastomosis of pancreatic pseudocyst to gastrointestinal tract - cyst-gastrostomy open (endoscopy payable separately)	4458.00	5	986.13
CV72711	Internal drainage or anastomosis of pancreatic pseudocyst of GI tract-laparoscopic NOTES: i) Restricted to General Surgery. ii) If conversion to open procedure is necessary, bill open procedure (07711) at 100% plus 50% of laparoscopy fee, 04001.	5575.00	5	1139.69
CV07732	– transduodenal	4691.00	5	1038.04
CV07733	– Roux-en-Y	4691.00	5	1038.04

HERNIA - REPAIR

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V71600	Repair inguinal or femoral hernia; under 6 months age, with or without hydrocelectomy	1877.00	2	427.46
V71601	– bilateral	3270.00	2	745.49
V71602	– incarcerated or strangulated	2346.00	3	534.84
V71603	Repair inguinal or femoral hernia; age 6 months to 12 years, with or without hydrocelectomy	1753.00	2	398.83
V71604	– bilateral	2804.00	2	639.14
V71605	– incarcerated or strangulated	2001.00	3	456.10
	Repair inguinal or femoral hernia; greater than age 12:			
V71606	– reducible - open	2083.00	2	393.71
V71607	– reducible - laparoscopic	2083.00	4	423.37
V71608	– incarcerated or strangulated	2135.00	3	439.73
	Repair recurrent inguinal or femoral hernia; any age:			
V71609	– reducible - open	2306.00	2	479.61
V71610	– reducible - laparoscopic	2336.00	4	532.79
V71611	– incarcerated or strangulated	2668.00	3	542.00
	Bilateral primary inguinal or femoral hernias greater than age 12, not incarcerated or recurrent:			
V71612	– open	2804.00	2	639.14
V71613	– laparoscopic	3082.00	4	702.55
	Repair initial incisional hernia: NOTE: Lysis of adhesions not payable in addition.			
V71614	– reducible	2758.00	2	610.15
V71615	– incarcerated or strangulated	2758.00	3	610.15
V71616	– using prosthetic mesh	2758.00	3	610.15
V71623	Laparoscopic initial ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis.	3222.00	5	713.22
	Repair recurrent incisional hernia:			
V71617	– reducible	2879.00	2	622.63
V71618	– incarcerated or strangulated	3329.00	3	622.94

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V71624	Laparoscopic recurrent ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis. NOTE: Lysis of adhesions not payable in addition.	3722.00	6	778.44
CV71625	Myofascial abdominal wall advancement flaps (component separation procedure) for massive initial or recurrent incisional hernia repair NOTES: i) For complex and recurrent abdominal wall hernias, with or without mesh. ii) To include removal of previous mesh, if required. iii) If lysis of adhesions (70650 and 70651) is performed and takes longer than 30 minutes to complete, it is payable in addition after 30 minutes of time.	4618.00	7	920.36
	Repair umbilical hernia:			
V71619	– reducible	1589.00	2	363.03
V71620	– incarcerated or strangulated	1625.00	3	363.03
V71621	Repair of hernia with resection of bowel; all performed through same incision	3503.00	5	869.24
V71622	Repair of hernia with resection of bowel requiring a separate incision	3765.00	5	945.93
07596	Hernia, incisional; repair following laparotomy (with operative report) (extra) - operation only	577.00	2	127.83
V07610	Epigastric	1589.00	4	363.03
CV70604	Congenital diaphragmatic hernia	7037.00	9	1557.05

PEDIATRIC PROCEDURES

	Broviac type catheter:			
07139	– insertion of	677.00	2	166.23
V07140	– insertion of - less than 3 months of age or less than 3 kg.	1321.00	4	275.11
07141	– removal of - operation only	586.00	2	129.65
V07571	Pena posterior sagittal anal proctoplasty; primary surgeon	5647.00	6	1176.17
07593	Fee for second surgeon participating in Pena posterior sagittal anal proctoplasty NOTE: When 07571 and 07593 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.	1670.00		346.80

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V07700	Total correction cloacal anomalies; primary surgeon	11841.00	6	2199.19
07702	Fee for second surgeon participating in total correction cloacal anomalies	2346.00		519.02
	NOTE: When 07700 and 07702 are claimed, assistants' fees are not applicable to either surgeon for assisting the other.			
V07690	Anoplasty; for imperforate anus	3320.00	4	714.61
V07466	Anal stricture; plastic repair, child	2484.00	2	460.68
	Proctectomy; complete (for congenital megacolon) abdominal and perineal approach with pull through procedure and anastomosis (e.g.: Swenson, Duhamel or Soave type operation):			
V72662	– synchronous - abdominal portion	7112.00	7	1344.65
CV07697	Excision of sacroccygeal teratoma	7037.00	6	1557.05
	Intestinal stricturoplasty (enterotomy and enterorrhaphy) with or without dilation for intestinal obstruction:			
V72647	– single	2804.00	5	620.26
V72648	– multiple (two or more)	4202.00	5	930.13
	Omphalocele or gastroschesis:			
V07615	– permanent repair	3006.00	7	626.94
V07614	– temporary repair	1977.00	7	411.33
CV70604	Congenital diaphragmatic hernia	7037.00	9	1557.05
V07651	Reduction of volvulus, intussusception; internal hernia by laparotomy	2901.00	5	538.14
CV72751	Reduction of volvulus, intussusception, internal hernia – laparoscopic	3407.00	5	672.68
	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%.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	2335.00	5	516.79
V07552	Aortopexy for tracheomalacia	4691.00	9	1038.04
V07653	Atresia; small bowel	7037.00	6	1557.05
V07655	Excision of Meckel's diverticulum (diverticulectomy) or omphalomesenteric duct	2335.00	4	516.66
CV07692	Repair major anorectal anomalies with concurrent urogenital malformations via sacral approach	7037.00	7	1557.05
V71531	Repair tracheoesophageal fistula-cervical approach NOTE: To include gastrostomy.	9243.00	6	2045.25
V07630	Gastrostomy - open	2111.00	5	467.13
33394	Assistant fee for PEG procedure NOTE: S33326, 33394 may be billed by any qualified physician.	522.00		176.14
CV71532	Esophagoplasty (plastic repair or reconstruction); thoracic approach - without repair of tracheoesophageal fistula	9243.00	8	2045.25
CV71533	– with repair of tracheoesophageal fistula NOTE: Includes gastrostomy.	10399.00	8	2300.91
V71534	Division of tracheoesophageal fistula without esophageal anastomosis (thoracic approach) NOTE: Includes gastrostomy.	3952.00	8	868.66
	Esophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:			
CV71535	– laparoscopic	5063.00	6	1022.63
V71536	– open	3619.00	6	843.66
V71650	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure)	2336.00	5	517.05
V71651	Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (e.g.: Ladd procedure) – laparoscopic NOTES: i) Restricted to General Surgeons. ii) If conversion to open procedure is required, bill under the appropriate open procedure at 100% plus fee item 04001 at 50%.	3123.00	5	599.28

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

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	939.00	4	255.66
	NOTES: i) Restricted to General Surgeons and Respirologists. ii) Must be a French 20 or greater thoracostomy tube. iii) Payable once for each chest cavity per day, if performed bilaterally billable at 150%. iv) Not payable with 10087, 10088, 10089, 01088, 32031, 00081 and critical care fees.			
S32031	Closed drainage of chest (operation only)	516.00	4	144.53
07430	Diagnostic peritoneal lavage (catheter) - operation only	505.00	3	105.16
V07432	Laparotomy in the trauma patient	2232.00	5	511.31
V07431	Repair diaphragmatic injury	3952.00	8	1073.76
	Hepatorrhaphy; suture of liver wound or injury:			
V07412	– simple	2816.00	8	622.82
V07413	– with packing	3173.00	8	920.36
V07440	– resectional debridement of liver	5865.00	8	1585.07
V07441	Hepatic artery ligation, to include resectional debridement where indicated	4691.00	8	1038.04
V07442	Hepatic lobectomy for trauma, to include resectional debridement where indicated	11555.00	9	2812.22
V07434	Laparotomy and splenic repair, any method	3663.00	7	971.50
V07433	Laparotomy to include removal of injured spleen	3928.00	7	1073.76
V07435	Repair of lacerations to stomach	3467.00	7	1022.63
V07436	Exploration and mobilization of duodenum and pancreas	3173.00	7	920.36
V07437	Repair of laceration to duodenum	4210.00	7	1124.89
V07438	Resection and debridement of duodenal injury; to include duodenal diverticulisation where indicated	7037.00	7	1840.73
V07445	Repair of lacerations to small bowel	2811.00	7	869.24
V07446	Resection of injured small bowel	3173.00	7	920.36
V07450	Exteriorization of colonic injury	3320.00	7	818.10

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V07448	Repair of colonic injury with or without colostomy	5305.00	7	1227.15
V07449	Resection of colonic injury	5305.00	7	1227.15
V07452	Repair of extra-peritoneal rectum with or without colostomy	5305.00	7	1227.15
V07447	Repair of mesenteric injury	07447bmc	6	869.24
V07443	Resection of distal pancreas for trauma	5865.00	8	1585.07
V07444	Pancreaticoduodenectomy (Whipple procedure) for trauma	14073.00	9	3374.66
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 NOTE: Treatment for cosmetic purposes is not a benefit under MSP.	45.65		13.77
77046	Ultrasound directed (with image capture) foam sclerotherapy – initial	519.00		175.84
77047	Ultrasound directed (with image capture) foam sclerotherapy –repeat	519.00		175.84

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) 77046 and 77047 may each be charged only once per patient per leg per lifetime. ii) One additional repeat per leg may be billed under fee item 77060 in the same 12 month period. iii) Services in subsequent 12 month periods should be billed in accordance with the notes following fee item 77050 and 77060.			
	Compression sclerotherapy:			
77050	– initial	273.00	2	82.65
77060	– repeat	131.00	2	38.72
	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	635.00	2	228.08
V07108	Stripping long saphenous	1262.00	2	269.85
V07109	Stripping short saphenous	726.00	2	233.46
	Multiple ligations and stripping tributaries:			
07110	– 3 to 5 incisions - operation only	794.00	2	285.22
V07111	– 6 or more incisions	946.00	2	311.16
V07112	Ligation of 2 or more perforators	978.00	2	285.22
77070	Complete fasciotomy with or without multiple ligations	1083.00	2	326.47
	NOTE: For decompression fasciotomy, see 77360.			
77075	Re-exploration, groin and/or popliteal fossa	1023.00	2	306.98
V07116	Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy)	2561.00	3	535.25
77077	Excision of ulcer and grafting - add full fee to venous procedures - operation only	409.00	3	123.00
77079	Venous crossover graft for iliac obstruction	2067.00	7	623.66
	Acute Venous:			
77082	Ligation of femoral vein	506.00	2	152.21
77084	Ligation or fenestration of inferior vena cava (requires laparotomy)	1681.00	5	506.47
77086	Thrombectomy for acute ilio-femoral thrombophlebitis	2107.00	5	634.64

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Portosystemic Shunting:			
C77090	Spleno-renal shunt	3205.00	8	966.43
C77092	Porto-caval shunt	3205.00	8	966.43
	Mesocaval graft:			
C77094	– Synthetic	3205.00	8	966.43
C77096	– autogenous	3409.00	8	1028.98

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	1889.00	5	569.33
C77120	Embolectomy - trunk or extremities (subclassified by location and incision)	2107.00	5	882.70
C77125	– one side	1516.00	5	456.20

Removal of Synthetic Graft:

77104 – with replacement at a different site (payable at 75% of current fee listed for the initial insertion), extra to the replacement 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.

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).

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Neck or Thoracic:			
	Bypass graft (synthetic) and/or thrombo-endarterectomy:			
C77130	– carotid arteries	2799.00	8	1205.45
C77135	– inominate	2644.00	5	796.76
C77140	– subclavian	2519.00	5	1067.65
C77145	Ligation of carotid artery	869.00	5	261.16
	Groin Dissection:			
C77180	Resection of abdominal aneurysm with associated femoral dissection - one or both sides (extra fee to be added to procedure) - operation only.	422.00	9	126.92
	NOTE: Peripheral aneurysm - charge associated bypass graft procedure.			
C77110	Re-exploration of groin for bleeding or hematoma - operation only	428.00	4	128.31
77112	Re-dissection of groin (after 21 days) - extra	450.00	4	135.47
	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.	2083.47		795.22
	NOTES: i) Payable once per side only. ii) Not payable with fee items 77100, 77102, 77104, or 77112.			
	Aortoiliac:			
	Bypass graft (synthetic or autologous vein) and/or thromboendarterectomy including extension onto femoral artery by either retroperitoneal or trans peritoneal approach			
	Note: Harvest of autologous vein (77280, 77285, 77290 or 77295) paid at 100%.			
C77150	– aorta and/or iliac (unilateral)	2544.00	9	912.42
C77155	– aorta and/or iliac (bilateral)	3995.00	9	1943.81
C77160	– aorto-femoral and/or ilio-femoral (unilateral)	2938.00	9	885.99
C77165	– aorta-femoral and/or ilio-femoral (bilateral)	3995.00	9	1943.81

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Aneurysm:			
	NOTE: Peripheral aneurysm - charge associated bypass graft procedure.			
77170	Arteriovenous aneurysm	1681.00	9	506.47
C77175	Abdominal aneurysm, with grafting	3985.00	9	2042.33
C77185	Ruptured aneurysm, with grafting	4558.00	10	1941.21
	Mesenteric:			
C77190	Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy	2728.00	7	1417.41
C77195	Superior mesenteric bypass graft (autogenous vein)	2728.00	7	1417.41
	Renal:			
C77200	Renal bypass graft (synthetic) and/or thromboendarterectomy	2933.00	7	1417.41
C77205	Renal bypass graft (autogenous vein)	2933.00	7	1417.41
	Axillo - Femoral:			
	Axillo-femoral bypass graft and/or thromboendarterectomy:			
C77210	– unilateral	2792.00	7	1001.38
C77215	– bilateral	3621.00	7	1298.11
	Femoral Crossover:			
C77230	Femoro-femoral crossover bypass graft (synthetic) and/or thromboendarterectomy	2655.00	5	951.74
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	2655.00	5	951.74
	Infrainguinal:			
C77240	Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	2447.00	5	877.77
C77245	– popliteal (endarterectomy)	2303.00	5	694.96
C77250	– popliteal (synthetic)	2105.00	5	634.57
C77255	– anterior, posterior tibial or peroneal	2519.00	5	759.09

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Bypass graft (autogenous Vein):			
C77260	– femoral	2449.00	5	878.67
C77265	– popliteal	3058.00	5	1601.42
C77270	– anterior, posterior tibial or peroneal	3182.00	5	1645.88
77275	– in situ vein graft (extra)	746.00	7	363.83
77280	– non-ipsilateral long saphenous graft (extra)	867.00	7	361.42
77285	– short saphenous graft (extra)	867.00	7	361.42
77290	– superficial femoral vein graft (extra)	867.00	7	361.42
77295	– arm vein graft (extra)	867.00	7	361.42
77300	– A-V fistula with bypass graft in limb salvage (extra)	629.00	7	189.76
	Profunda thromboendarterectomy:			
77310	Profunda thromboendarterectomy without patch repair	1873.00	5	565.53
77315	Profunda thromboendarterectomy with patch repair (synthetic or autologous) NOTES: i) If performed with inflow procedure (77175, 77160, 77165, 77210, 77215, 77230, or 77235), payment will be made at 50% for unilateral or 2 x 50% for bilateral. ii) If performed with outflow procedure (77240, 77260, 77265, or 77270) payment will be made at 50%.	2549.00	5	767.87
	Trauma:			
	Repair of injury of major vessel in extremity:			
C77330	– suture	1982.00	6	596.96
C77335	– graft	2549.00	6	767.87
	Repair of injury of major vessel in trunk:			
C77340	– suture	2973.00	9	896.03
C77345	– graft	3968.00	9	1195.15
77350	Supra-renal aortic cross-clamp - extra to abdominal vascular or major trauma cases - operation only NOTE: Operative report required.	388.00		423.58
	Fasciotomy:			
77360	Decompression fasciotomy - subcutaneous NOTE: 77360 includes secondary closure.	954.00	3	342.14
	Miscellaneous:			
77370	Release of popliteal entrapment syndrome NOTE: Not to be paid if full femoral popliteal bypass is performed.	979.00	3	342.14

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
00722	Arteriography, operative - procedural fee	373.00		127.71
	Second Operator:			
77025	Synchronous combined bypass graft – extremities	1023.00		609.98
77030	– trunk	1023.00		609.98
	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)	646.00	3	194.99
77385	Removal by dissection of chronic peritoneal catheter (operation only)	450.00	3	135.25
	NOTE: For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.			
77395	Creation of internal arterio-venous fistula	1261.00	4	424.32
77396	Revision of AV fistula	1519.00	5	517.02
	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	1940.00	4	723.49
	NOTE: Not paid with 77295, 77395, 77396 and 77402.			
77402	Creation of brachiobasilic arteriovenous fistula with vein transposition	2274.00	5	723.76
	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)	2127.00	5	723.75
	NOTE: Not paid with C77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77300, 77395, and 77396.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
77405	Thrombectomy of arterio-venous fistula	1187.00	3	356.90

SYMPATHECTOMY

77420	Lumbar sympathectomy - unilateral	1261.00	4	379.55
77422	Cervical sympathectomy - unilateral	1552.00	5	513.22
77424	Preganglionic sympathectomy; upper dorsal region - unilateral	1552.00	7	468.75
77426	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	1552.00	7	468.75
	Lumbar sympathectomy with abdominal procedure:			
77428	– unilateral (extra)	422.00		126.93
77430	– bilateral (extra)	839.00		253.87

LYMPHATIC SYSTEM

V07360	Splenectomy	3738.00	6	826.87
CV07368	Laparoscopic splenectomy NOTES: i) Fee items 07360 or 07434 not payable in addition. ii) If laparoscopic procedure is converted to open, bill under 07360 at 100% and 04001 at 50%.	3952.00	6	869.24
V07361	TB glands - radical removal	1321.00	4	357.92
V07363	Radical femoral, inguinal and/or iliac dissection	2637.00	5	715.84
CV07365	Isolated limb perfusion to include groin dissection and laparotomy	4610.00	5	960.22
CV07366	Laparotomy and staging of lymphoma (to include splenectomy)	4204.00	6	930.44

LYMPHOEDEMA – LEG

	Lymphoedema of limbs - excision and grafting:			
06127	– entire leg	3356.00	3	715.88
06128	– entire lower extremity	5018.00	3	1070.26

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
ABDOMINAL SURGERY - MISCELLANOUS				
V07603	Resuture abdominal wound evisceration	1876.00	5	415.22
07451	Thoracic extension of abdominal incision (extra)	1400.00	8	511.31
V07600	Exploratory laparotomy (to include biopsy)	1875.00	5	460.19
V07597	Post-operative hemorrhage; intra-abdominal management	1864.00	6	483.84
V07601	Intra-abdominal abscess excluding intrahepatic (stand-alone procedure) NOTE: Not paid for post operative hemorrhage (by any approach) which should be billed as fee item 07597.	2128.00	5	485.75
V72600	Temporary or delayed abdominal closure for complex abdominal sepsis or abdominal compartment syndrome – with Vacuum Assisted Closure (VAC) system Bogota bag or other temporary abdominal closure system (with or without abdominal exploration and washout) NOTES: i) Payable only in the operating room or ICU under general anesthesia. ii) Repeat services billed at 100%. iii) If required over 10 times in a single hospital stay, provide explanation in a note record. iv) Not billable in addition to 07600 or 07601.	1792.00	5	408.75
S04001	Laparoscopy (operation only)	875.00	4	306.88
V07414	Exploratory laparoscopy with incisional, excisional or core liver biopsy and/or peritoneal washings NOTES: i) Restricted to General Surgery. ii) For excisional biopsy of very small superficial liver lesion(s) for stating/diagnostic purposes or iii) For incisional or core biopsy of a large liver lesion for staging/diagnostic purposes. iv) Not for laparoscopy without biopsy (see fie item 04001).	2242.00	6	516.04

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
07415	Liver biopsy in conjunction with other open or laparoscopic abdominal procedure – extra	572.00		130.66
	NOTES: i) Restricted to General Surgery. ii) For excisional biopsy of very small superficial liver lesion(s) for staging/diagnostic purposes, or iii) For incisional or core biopsy of large liver lesion for staging/diagnostic purposes.			
	Removal of indwelling Enteral tubes with or without exploration of tube insertion site:			
S71280	– not requiring anesthesia (operation only)	159.00		50.88
S71281	– requiring local or regional anesthesia (operation only)	313.00		101.80
S71282	– requiring general anesthesia (operation only)	942.00	2	208.54

DIAGNOSTIC PROCEDURES OR ENDOSCOPY

S71283	– replacement of tube - extra	159.00		50.88
	NOTES: i) Tray fee is not paid when the procedure is performed in hospital or publicly-funded facilities (D&T Centres, psychiatric facilities). ii) Not paid with Fee Items 07781, 07782, 07783, 70637, 33326, 33341, 33342, 33342 and 33347. 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.	3063.00	8	677.76
C71291	Resection of retroperitoneal or intra-abdominal soft tissue tumour measuring 10 cm or greater - each additional 15 minutes or greater portion thereof.	353.00		78.20
	NOTES: i) Payment restricted to General Surgeons. ii) Not paid with fee items 51051, 51052, 04029 or 04628. iii) Start and end times are required in the claim and the patient's chart for the resection of the tumour and cannot be billed for time performing concurrent procedures.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV71292	Peritonectomy, with or without intraperitoneal chemotherapy – each hour (up to 8 hours) NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	3415.00	7	677.76
CV71293	Peritonectomy, with or without intraperitoneal chemotherapy – each additional 15 minutes or greater portion thereof (maximum of 16 units per patient) 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.	350.00	7	77.32
07764	Cholangiography; operative (extra)	374.00		102.02
07710	Pancreatogram with or without sphincterotomy done in conjunction with any of the biliary or pancreatic surgical procedures (extra)	328.00		68.71
T00879	EMG pudendal nerve testing for fecal incontinence	649.00		151.50
S00869	Manometry, adult - anal	469.00	2	103.67
S00797	Esophageal, motility test	814.00		180.13
S00788	– technical fee	361.00		76.03
S00798	– professional fee	471.00		104.09
	Esophageal pH study for reflux (extra):			
S00817	– technical fee	65.70		15.59
S00818	– professional fee	213.00		42.72
S00826	Biopsy of pancreas - percutaneous	470.00	2	103.74
S00809	Retrograde pancreatography	1130.00	3	221.44
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee NOTE: Not payable with 33341.	476.00	3	119.27
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing - procedural fee NOTE: Not payable with 33341.	397.00	3	120.07

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S10763	Initial esophageal, gastric or duodenal biopsy.....	61.30	3	15.15
	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	237.00	3	44.56
	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	512.00	4	208.31
SY00716	Sigmoidoscopy; flexible; diagnostic - procedural fee....	352.00	2	77.81
SY00718	Sigmoidoscopy; flexible; diagnostic - with biopsy.....	404.00	2	79.09
33373	Colonoscopy with flexible colonoscope, biopsy.....	1128.00	2	240.47
33374	– removal of polyp.....	1681.00	2	287.87
S00780	Schirmer's test (included in fee item 02015).....	69.70		13.89
SY00789	Peritoneal lavage	337.00	2	87.68

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.

Open vascular surgery with angioplasty and stent

Open surgical procedures are considered separate billable procedures from endovascular procedures in the context of hybrid revascularization. The surgical procedures are paid in accordance with Section D. 5. 3. Multiple Surgical Procedures. Angioplasties (77113, 77114) are billed at 50% of the listed fee for the first and 25% of the listed fee for the second to a maximum of two angioplasties. Simultaneous stenting (10919) on differing anatomical named vessels is to be paid: the first at 100% and the second at 50% to a maximum of two stents.

Endovascular surgery with angioplasty and stent

When angioplasty procedures (e.g., 77177) are performed in combination with open or percutaneous angioplasties, a maximum of one angioplasty (77114) is payable at 50%. One tibial artery angioplasty (77113) may also be payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels to be paid: the first at 100% and the second at 50% to a maximum of two stents.

Isolated angioplasties and stents

When angioplasty 77113 or 77114 is performed as isolated endovascular procedure (not in combination with open surgery or another endovascular surgery), multiple angioplasties done during the same procedure on different anatomical named vessels are paid as follows: the first is paid at 100%, the second at 50%, the third at 25% to a maximum of 3 endovascular interventions. Simultaneous stenting 10919 on differing anatomical named vessels is to be paid: the first at 100%, the second at 50%, and the third at 25% to a maximum of 3 stents.

In cases of combined endovascular procedures involving 77113 and 77114, the higher 77113 fee may be claimed in full and the lower 77114 fee is reduced to 50%.

Anatomical Named Vessels

One or more angioplasty 77113 or 77114 or stent 10919 per anatomical named vessel will be considered as one angioplasty and stent of that anatomical named vessel despite vessel continuity in series or in parallel with other vessels requiring intervention.

The fee codes include any and all imaging required to complete the procedure.

Intraoperative open or percutaneous tibial artery angioplasty 77113 anatomical named vessels

Refers to the following four anatomical named vessels:
Anterior tibial artery
Posterior tibial artery
Peroneal artery
Tibioperoneal trunk

Intraoperative open or percutaneous angioplasty 77114 anatomical named vessels

Refers to angioplasty of the following anatomical named vessels with the exception of the 77113 named vessels as defined above.

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

Lower extremity vessels
Right common femoral artery
Right superficial femoral artery
Right profunda femoral artery
Right popliteal artery
Left common femoral artery
Left superficial femoral artery
Left profunda femoral artery
Left popliteal artery

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

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

Left vertebral artery

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
77010	**Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report.	409.00		181.59
77012	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	202.00		91.57
	Continuing Care by Consultant:			
77007	Subsequent office visit	80.80		43.84
77008	Subsequent hospital visit	69.10		31.60
77009	Subsequent home visit	142.00		45.64
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) NOTE: Claim must state time service rendered.	285.00		91.08
77006	Directive care in emergent surgical conditions, per visit NOTE: Fee item 77006 charged only where no other consultant is involved in directive care of this emergent condition. Use only where further resuscitation and assessment is medically required in preparation for surgery.	79.50		31.60
77015	Pre-Operative Assessment NOTES: i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances. ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent.	411.00		139.73

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.			
	i) Only paid to the surgeon who performs the procedure.			
	Telehealth Service with Direct Interactive Video Link with the Patient:			
77710	**Telehealth Consultation**: to include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report.....	409.00		181.59
77712	**Telehealth Repeat or Limited Consultation:** to apply where a consultation is repeated for same condition within 6 months of the last visit by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee.....	209.00		91.57
77707	Telehealth subsequent office visit.....	80.80		43.84
77708	Telehealth subsequent hospital visit	69.10		31.60

EMERGENCY CARE

1. 00081 is to be used for the evaluation, diagnosis and treatment of a critically ill patient who requires constant bedside care by the physician.
2. A critically ill patient may be defined as a patient with an immediately life threatening illness/injury associated with any of the following conditions (which are given as examples):
   (a) Cardiac Arrest;
   (b) Multiple Trauma;
   (c) Acute Respiratory Failure;
   (d) Coma;
   (e) Shock ;
   (f) Cardiac Arrhythmia with hemodynamic compromise;
   (g) Hypothermia; and
   (h) Other immediate life threatening situations.

	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.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
00081	Emergency care, per half hour or major portion thereof..	379.00		119.97
00082	Monitoring of critically ill patients (when modification of the care and active intervention is not necessary), per half hour or major portion thereof.....	188.00		71.88

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)	362.00		79.08
01201	Night (call placed and service rendered between 2300 hours and 0800 hours).....	508.00		111.05
01202	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 2300 hours).	362.00		79.08

NOTE: Claims must state time service rendered.

CONTINUING CARE SURCHARGES

a) NON-OPERATIVE

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

Applicable also, without the 30 minute time lapse and with timing continuing, to immediately subsequent patients seen on the same callout 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.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
01205	Evening (service rendered between 1800 hours and 2300 hours) - per half hour or major part thereof	327.00		72.69
01206	Night (service rendered between 2300 hours and 0800 hours) - per half hour or major part thereof	447.00		99.40
01207	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - per half hour or major part thereof	327.00		72.69

NOTES:

i) Claim must state start and end times.

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

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

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) – 44.68% of surgical (or assistant) fee:			
	– minimum charge	152.36		66.32
	– maximum charge for surgeries under two hours	2058.57		457.46
	– maximum charge for surgeries of two hours or longer	2,865.80		1,246.00
01211	Night (2300 hours to 0800 hours) – 71.73% of surgical (or assistant) fee:			
	– minimum charge	214.17		93.12
	– maximum charge for surgeries under two hours	3305.00		734.42
	– maximum charge for surgeries of two hours or longer	4,600.00		2,000.00
01212	Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) – 44.68% of surgical (or assistant) fee:			
	– minimum charge	152.36		66.32
	– maximum charge for surgeries under two hours	2058.57		457.46

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	– maximum charge for surgeries of two hours or longer	2,865.80		1,246.00

NOTES:

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

ii) When emergency surgery commences prior to 1800 hrs, surgical surcharges are payable provided the major portion of surgical time is after 1800 hrs.

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

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

SURGICAL ASSISTANT OR SECOND OPERATOR

	Total Operative Fee(s) for Procedures:			
00195	Less than $317.00 inclusive	680.00		147.95
00196	$317.01 - $529.00 inclusive	964.00		209.92
00197	Over $529.00	1421.00		309.31
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof	157.00		34.10

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.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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. iv) Surgical fee modifiers such as BMI modifiers or age modifiers are excluded from the calculation for total operative fee(s) for which surgical assist fees are based.			
70019	Certified surgical assistant (where it is necessary for one certified surgeon to assist another certified surgeon, an explanation of the need is required except for procedures prefixed by the letter "C") - for up to one hour NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.	1265.00		282.60
70020	Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof NOTES: i) After 3 hours of continual surgical assistance for one patient, bill under fee item 00198 (time after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof). ii) Please indicate start and end time of service on claim.	148.00		32.96

SECOND OPERATOR

77025	Second operator, synchronous combined bypass graft - extremities - operation only	1023.00		609.98
77030	– trunk	1023.00		609.98
	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)	126.00	2	50.75
07041	Aspiration - abdomen or chest - operation only	352.00	2	77.73

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Abscess:			
07059	– deep (complex, subfascial, and/or multi-locular) with local or regional anesthesia - operation only	377.00	2	83.30
07027	– under general anesthesia or procedural sedation - operation only	941.00	2	255.34
07061	– deep post-operative wound infection, under GA - operation only	940.00	2	230.09
07045	Anterior closed space abscess (operation only)	470.00	2	103.74
06028	Web space abscess (operation only)	1091.00	2	306.47
06029	– under general anesthetic - operation only	1242.00	2	352.43
	Pilonidal cyst or sinus:			
07685	– excision or marsupialization (operation only)	1356.00	2	306.79
	Osteomyelitis:			
*52380	Osteomyelitis, acute, decompression	869.00	2	305.35
*52385	Osteomyelitis, debridement with or without reconstruction	1504.00	3	408.07
	NOTE: *52380 and *52385 include insertion of antibiotic beads or antibiotic loaded temporary prosthesis, if necessary.			
	Wounds - Simple:			
13610	Minor laceration or foreign body - not requiring anesthesia (operation only)	99.60		40.64
13611	Minor laceration or foreign body - requiring anesthesia (operation only)	188.00	2	75.71
06063	Removal of foreign body - requiring general anesthesia (operation only)	1074.00	2	306.47
13612	Extensive lacerations over 5 cm (maximum charge 35 cm) (operation only), per cm	36.80		15.19

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)	2116.00	5	562.45
V70158	Debridement of skin and subcutaneous tissue; up to the first 5% of body surface area	1194.00	3	301.31
70159	Debridement of skin and subcutaneous tissue; for each additional 5% of body surface area or major portion thereof – extra	599.00		132.78

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V70162	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; up to the first 5% of body surface area	1339.00	4	306.30
70163	Debridement of skin, subcutaneous tissue and necrotic fascia OR muscle; for each additional 5% of body surface area or major portion thereof – extra	674.00	3	133.93
V70165	Debridement of skin, fascia, muscle and bone; up to the first 5% of body surface area	1480.00	4	316.74
70166	Debridement of skin, fascia, muscle and bone; for each additional 5% of body surface area or major portion thereof – extra	666.00		147.32
70168	Active wound management during acute phase after debridement of soft tissues for necrotizing infection or severe trauma – per 5% of body surface area 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.	399.00		80.35
70169	Active wound management during acute phase after debridement of soft tissue for necrotizing infection or severe trauma – per 5% of body surface area - operation only NOTES: i) Payable only when performed by a medical practitioner in the operating room under general anesthesia or conscious sedation. ii) Requires wound assessment and dressing change and may include VAC application. iii) Debridement not payable in addition.	581.00	4	128.56
	Wounds - Avulsed and Complicated:			
06075	Lips and eyelids	1626.00	3	347.09
06076	Nose and ear	2045.00	3	436.01
06077	Complicated lacerations of the scalp, cheek and neck	1598.00	3	340.66

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: The following conditions are necessary for 06075, 06076 or 06077 to apply: i) A layered closure* is required and at least one of: a) Injuries involving necrotic tissue requiring debridement such that simple suture closure is precluded; or b) injuries involving tissue loss such that simple suture is precluded; or c) Wounds requiring tissue shifts for closure aside from minor undermining or advancement flaps; or d) Skived, ragged or stellate wounds where excision of tissue margins is necessary to obtain 90 degree closure; or e) Contaminated wounds that require excision of foreign material, or ii) Lacerations requiring layered closure and key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or iii) Lacerations into the subcutaneous tissue requiring alignment and repair of cartilage and layered closure. iv) A note record indicating how the service meets the above criteria must accompany claims billed under these fee items. * A layered closure is required when the defect would require too much tension for an acceptable primary closure. It involves at least two layers of deep dissolving sutures to close off dead space and take tension off the wound. A deep cartilage closure is also considered a layered closure.			
V70150	Complicated lacerations of tongue, floor of mouth	1328.00	3	276.62
	Excisional biopsy of lymph glands for suspected malignancy:			
70023	– neck - operation only	941.00	3	245.43
V70024	– axilla	1163.00	2	245.43
70025	– groin	940.00	2	245.43

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Foreign Body:			
	Excision of skin and subcutaneous tissue of hidradenitis suppurativa:			
07072	– axillary - operation only	1156.00	2	255.66
07075	– inguinal - operation only	1156.00	2	255.66
07076	– perianal - operation only	1156.00	2	255.66
07082	– perineal - operation only	1156.00	2	255.66
06166	Excision of axillary sweat glands for hyperhidrosis - unilateral	1559.00	4	332.49
	NOTES: i) Direct closure included when open procedure used. ii) Aggressive removal of apocrine sweat glands by any means.			
	Tenotomy:			
07073	– congenital torticollis	1406.00	3	311.04
V07074	– resection	1269.00	3	263.82
	NOTES: i) Payable only when performed in an Operating Room (Service Location Code G, I, or P). ii) Not payable for percutaneous procedures. iii) For operative section of transverse carpal ligament - bill under 06258.			
13630	Paronychia (operation only)	99.30	2	40.50
13631	Removal of nail - simple (operation only)	99.30	2	40.50
13632	– with destruction of nail bed - operation only	199.00	2	81.96
13633	Wedge excision or Vandenbos procedure of one nail – (operation only)	178.00	2	72.32
V07053	Excision of nail bed, complete, with shortening of phalanx	679.00	2	141.11
	Biopsy of Nerve or Artery:			
07025	Temporal artery biopsy - operation only	649.00	2	203.96
07028	Biopsy of sural nerve	819.00	2	181.28

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

FREE SKIN GRAFTS AND MYELOPLASTY

Split Thickness Grafts:

NOTE:
Non-functional areas include posterior or trunk, anterior trunk, arm (above elbow), forearm (below elbow), thigh, leg (below knee).
Functional areas include head, face, neck, shoulder, axilla, elbow, wrist, hand, groin, perineum, knee, ankle and foot. Also includes coverage of exposed vital structures (bone, tendon, major vessel, nerve).

Non-functional areas: (total area treated, whether at one operation or at staged intervals):

06046	– less than 6.5 sq. cm - operation only	1074.00	2	306.79
06047	– 65 sq. cm - operation only	1849.00	2	441.77
06048	– 650 sq. cm	2771.00	2	662.66
06049	For each 6.5 sq. cm over 650 sq. cm - operation only	35.55	3	8.18

NOTE: Refrigerated graft - 50% of appropriate fee.

VASCULAR ACCESS

Broviac type catheter:

07139	– insertion of	677.00	2	166.23
V07140	– insertion of - less than 3 months of age or less than 3 kg	1321.00	4	275.11
07141	– removal of- operation only	586.00	2	129.65

Totally implantable venous access port with subcutaneous reservoir (port-a-cath type device):

07142	– insertion of	1239.00	2	261.77
77142	Removal of totally implantable access device (e.g.: portacath), operation only.	411.00	2	130.85

NOTES:
i) Not paid with 07143.
ii) Tray fees are not applicable when the service is performed at a funded facility (e.g.: hospital, D&T Center, Psychiatric Institution, etc.)

V07143	– revision (removal and reinsertion)	1617.00	2	357.92
00526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	261.00		64.01

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
07145	Intra osseous - access- operation only	469.00	2	103.59
V07134	Peritoneal venous shunt for ascites	1921.00	6	399.20
S00801	Intra-arterial cannulation (with multiple aspirations) - procedural fee	116.00		22.60
00319	Insertion of central catheter for total parenteral Nutrition - operation only	270.00	2	63.36

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.	45.65		13.77
77046	Ultrasound directed (with image capture) foam sclerotherapy – initial	519.00		175.84
77047	Ultrasound directed (with image capture) foam sclerotherapy –repeat	519.00		175.84

NOTES:

i) 77046 and 77047 may each be charged only once per patient per leg per lifetime.
ii) One additional repeat per leg may be billed under fee item 77060 in the same 12 month period.
iii) Services in subsequent 12 month periods should be billed in accordance with the notes following fee item 77050 and 77060.

Compression sclerotherapy:

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
77050	– initial	273.00	2	82.65
77060	– repeat	131.00	2	38.72
	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	635.00	2	228.08
V07108	Stripping long saphenous	1262.00	2	269.85
V07109	Stripping short saphenous	726.00	2	233.46
	Multiple ligations and stripping tributaries:			
07110	– 3 to 5 incisions - operation only	794.00	2	285.22
V07111	– 6 or more incisions	946.00	2	311.16
V07112	Ligation of 2 or more perforators	978.00	2	285.22
77070	Complete fasciotomy with or without multiple ligations	1083.00	2	326.47
	NOTE: For decompression fasciotomy, see 77360.			
77075	Re-exploration, groin and/or popliteal fossa	1023.00	2	306.98
V07116	Multiple ligations, strippings and perforators; re-exploration of groin and/or popliteal fossa (to include complete fasciotomy)	2561.00	3	535.25
77077	Excision of ulcer and grafting - add full fee to venous procedures - operation only	409.00	3	123.00
77079	Venous crossover graft for iliac obstruction	2067.00	7	623.66
	Acute Venous:			
77082	Ligation of femoral vein	506.00	2	152.21
77084	Ligation or fenestration of inferior vena cava (requires laparotomy)	1681.00	5	506.47
77086	Thrombectomy for acute ilio-femoral thrombophlebitis	2107.00	5	634.64
V07146	Insertion of inferior vena cava filter; percutaneous placement or cutdown (e.g.: Kimray Greenfield filter)	1800.00	2	376.16
	Portosystemic Shunting:			
C77090	Spleno-renal shunt	3205.00	8	966.43
C77092	Porto-caval shunt	3205.00	8	966.43
	Mesocaval graft :			
C77094	– synthetic	3205.00	8	966.43

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
C77096	– autogenous	3409.00	8	1028.98

ARTERIAL SYSTEM

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	428.00	4	128.31
77112	Re-dissection of groin (after 21 days) - extra	450.00	4	135.47

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.	2083.47		795.22
	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	29.20		7.05
S00920	– technical fee	144.00		35.33

ARTERIAL PROCEDURES

	Therapeutic procedures utilizing radiological equipment			
10900	Abdominal aortic aneurysm repair using endovascular stent graft - second operator	2871.00		521.36
	NOTES: i) Intraoperative renal artery angioplasty payable in addition at 50% of fee item 00982 when done. ii) Intravascular stent placement – extra (10919) paid in addition under 10919 at 100%. iii) This fee will not be paid to the primary operator.			

ANGIOPLASTY

S77113	Intraoperative open or percutaneous tibial artery angioplasty	1995.00	2	713.20

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

NOTES:
i) Restricted to Vascular Surgeons.
ii) When 77113 is combined with another open vascular surgery, multiple angioplasties will be paid as follows: 50% for the first and 25% for the second payable to a maximum of two angioplasties.
iii) When angioplasty is performed as an isolated procedure, multiple angioplasties done during the same procedure are paid as follows: the first is paid at 100%, second at 50% and third at 25%. Payable to a maximum of 3 angioplasties.
iv) Any and all diagnostic imaging required to complete the procedure is considered included.

S77114	Intraoperative open or percutaneous angioplasty	1856.00	3	602.74

(see notes on next page)

NOTES:
i) Restricted to Vascular Surgeons.
ii) When 77114 is combined with another open vascular surgery, multiple angioplasties will be paid as follows: 50% for the first and 25% for the second. Payable to a maximum of two angioplasties.
iii) When angioplasty is performed as an isolated procedure, multiple angioplasties done during the same procedure are paid as follows: the first is paid at 100%, second at 50% and third at 25%. Payable to a maximum of three angioplasties.
iv) Any and all diagnostic imaging required to complete the procedure is considered included.
v) When done with 77177, payable once, to either the primary or second operator.

SURGICAL PROCEDURES

Thrombectomy, Embolectomy:

C77115	Thrombectomy with or without angioplasty	1889.00	5	569.33
C77120	Embolectomy - trunk or extremities (subclassified by location and incision).....	2107.00	5	882.70
C77125	– one side	1516.00	5	456.20

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Neck or Thoracic:			
	Bypass graft (synthetic) and/or thrombo-endarterectomy:			
C77130	– carotid arteries	2799.00	8	1205.45
C77135	– inominate	2644.00	5	796.76
C77140	– subclavian	2519.00	5	1067.65
C77145	Ligation of carotid artery	869.00	5	261.16
	Aortoiliac:			
	Bypass graft (synthetic or autologous vein) and/or thromboendarterectomy including extension onto femoral artery by either retroperitoneal or trans peritoneal approach			
	Note: Harvest of autologous vein (77280, 77285, 77290 or 77295) paid at 100%.			
C77150	– aorta and/or iliac (unilateral)	2544.00	9	912.42
C77155	– aorta and/or iliac (bilateral)	3995.00	9	1943.81
C77160	– aorto-femoral and/or ilio-femoral (unilateral)	2938.00	9	885.99
C77165	– aorta-femoral and/or ilio-femoral (bilateral)	3995.00	9	1943.81
	Aneurysm:			
	NOTE: Peripheral aneurysm - charge associated bypass graft procedure.			
77170	Arteriovenous aneurysm	1681.00	9	506.47
C77175	Abdominal aneurysm, with grafting	3985.00	9	2042.33
77177	Abdominal aortic aneurysm repair using endovascular stent graft – vascular surgery component	3985.00	9	1428.76

NOTES:

i) In order to bill 77177, vascular surgeon must be present throughout the entire procedure.

iv) Includes iliac endarterectomy/iliac artery repair.

ii) Fem-fem crossover payable in addition at 50% of 77230 or 77235 when done.

v) When done with 77177, if second operator present, 77114 and 10919 payable to either the primary or second operator.

vi) When Coll-plug embolization occlusion of the internal iliac artery is required, S00981 is payable in addition to 77177 at 50% for the first and 25% for the second, to a maximum of 2.

iii) 00981 is not payable when iliac branch graft (77178 or 77179) is done with 77177.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Iliac Branch Graft (IBG): Endovascular abdominal aneurysm repair involving the left or right common iliac and internal iliac arteries			
T77178	Unilateral – extra	4332.00		707.00
T77179	Bilateral – extra	6481.00		1060.50
	NOTES: i) Restricted to Vascular Surgeons. ii) Payable only with 77177. iii) Includes all necessary procedures such as construction of iliac conduit, iliac or femoral endarterectomy/artery repair as well as open revascularization of femoral artery, coil embolization of internal iliac arteries, in situ fenestration and drain placements.			
T77176	Surgical repair unilateral or bilateral iliac artery aneurysms during open repair of infra-renal abdominal aortic aneurysm – extra	2708.00		429.69
	(see notes on next page)			
	NOTES: i) Extra fee to be billed in addition to 77175 when one or both common and/or internal iliac aneurysms are repaired by grafting. ii) Maximum one per surgery.			
C77180	Resection of abdominal aneurysm with associated femoral dissection - one or both sides (extra fee to be added to procedure) - operation only. NOTE: Peripheral aneurysm - charge associated bypass graft procedure.	422.00	9	126.92
C77185	Ruptured aneurysm, with grafting	4558.00	10	1941.21
	Complex endovascular aneurysm repair			
77485	Ruptured endovascular abdominal aneurysm repair (REVAR)	5981.00	10	2043.03

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Vascular Surgeons. ii) In order to bill 77485, Vascular Surgeons must be present throughout the entire procedure. iii) Limited to repair of the abdominal aorta. iv) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker. v) A maximum of one angioplasty (77114) is payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents. vi) When done with 77485, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator. vii) Certified surgical assistants (70019 and 70020) are not payable with 77485.			
77487	Emergency endovascular thoracic aorta repair (EEVTAR)	6833.00	10	2334.10
	NOTES: i) Restricted to Vascular Surgeons and Cardiac Surgeons. *(notes continued on next page)* ii) In order to bill 77487, Vascular Surgeon or Cardiac Surgeon must be present throughout the entire procedure. iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iv) A maximum of one angioplasty (77114) is payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents. v) When done with 77487, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator. vi) Certified surgical assistants (70019 and 70020) are not payable with 77487.			
77490	Fenestrated endovascular graft for repair of juxta renal abdominal aortic aneurysm (FEVAR).....	5090.00	10	1785.95
	NOTES: i) Restricted to Vascular Surgeons. ii) In order to bill 77490, Vascular Surgeon must be present throughout the entire procedure. iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker. iv) A maximum of two angioplasties (77114) are payable in addition: the first at 50% and the second at 25%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents. v) When done with 77490, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator. vi) Certified surgical assistants (70019 and 70020) are not payable with 77490.			
77495	Thoracic endovascular aneurysm repair (TEVAR).....	5981.00	10	2043.03
	(see notes on next page) NOTES: i) Restricted to Vascular Surgeons and Cardiac Surgeons. ii) In order to bill 77495, Vascular Surgeon or Cardiac Surgeon must be present throughout the entire procedure.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker. iv) A maximum of one angioplasty (77114) is payable in addition at 50%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents. v) When done with 77495, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator. vi) Certified surgical assistants (70019 and 70020) are not payable with 77495.			
77497	Complex thoraco-abdominal endovascular aneurysm repair (CTAEVAR)	6275.00	10	2143.15
	NOTES: i) Restricted to Vascular Surgeons. ii) In order to bill 77497, Vascular Surgeon must be present throughout the entire procedure. iii) Includes all necessary procedures such as construction of an iliac conduit, iliac or femoral endarterectomy/artery repair, in situ fenestration, carotid access, drain placement, and temporary pacemaker. iv) A maximum of two angioplasties (77114) are payable in addition: the first at 50% and the second at 25%. Simultaneous stenting (10919) on differing anatomical vessels is payable: the first at 100% and the second at 50%, to a maximum of two stents. v) When done with 77497, if a second operator is present, 77114 and 10919 are payable to either the primary or the second operator. vi) Certified surgical assistants (70019 and 70020) are not payable with 77497.			
77500	Second Operator – complex endovascular aneurysm repair.....	1908.00	10	651.71

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Vascular Surgeons, Cardiac Surgeons, and Interventional Radiologists. ii) Intraoperative angioplasties (77114) and stent placements (10919) are payable in addition to the extent allowed under the primary procedure. iii) The fee will not be paid to the primary operator. iv) Paid to the second operator only when the primary operator performs procedures payable under 77485, 77487, 77490, 77495, or 77497. v) Certified surgical assistants (70019 and 70020) are not payable to the second operator.			
	Mesenteric:			
C77190	Superior mesenteric bypass graft (synthetic) and/or thromboendarterectomy	2728.00	7	1417.41
C77195	Superior mesenteric bypass graft (autogenous vein)	2728.00	7	1417.41
	Renal:			
C77200	Renal bypass graft (synthetic) and/or thromboendarterectomy	2933.00	7	1417.41
C77205	Renal bypass graft (autogenous vein)	2933.00	7	1417.41
	Axillo - Femoral:			
	Axillo-femoral bypass graft and/or thromboendarterectomy:			
C77210	– unilateral	2792.00	7	1001.38
C77215	– bilateral	3621.00	7	1298.11
	Femoral Crossover:			
C77230	Femoro-femoral crossover bypass graft (synthetic) and/or thromboendarterectomy	2655.00	5	951.74
C77235	Femoro-femoral crossover bypass graft (autogenous vein)	2655.00	5	951.74
	Infrainguinal:			
C77240	Femoral bypass graft (synthetic) and/or thromboendarterectomy (common or superficial endarterectomy)	2447.00	5	877.77
C77245	– popliteal (endarterectomy)	2303.00	5	694.96
C77250	– popliteal (synthetic)	2105.00	5	634.57
C77255	– anterior, posterior tibial or peroneal	2519.00	5	759.09
	Bypass Graft (Autogenous Vein):			
C77260	– femoral	2449.00	5	878.67

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
C77265	– popliteal	3058.00	5	1601.42
C77270	– anterior, posterior tibial or peroneal	3182.00	5	1645.88
C77275	– in situ vein graft (extra)	746.00	7	363.83
77280	– non-ipsilateral long saphenous graft (extra)	867.00	7	361.42
77285	– short saphenous graft (extra)	867.00	7	361.42
77290	– superficial femoral vein graft (extra)	867.00	7	361.42
77295	– arm vein graft (extra)	867.00	7	361.42
77300	– A-V fistula with bypass graft in limb salvage (extra)	629.00	7	189.76
	Profunda thromboendarterectomy:			
77310	Profunda thromboendarterectomy without patch repair	1873.00	5	565.53
77315	Profunda thromboendarterectomy with patch repair (synthetic or autologous)	2549.00	5	767.87
	NOTES: i) If performed with inflow procedure (77175, 77160, 77165, 77210, 77215, 77230, or 77235), payment will be made at 50% for unilateral or 2 x 50% for bilateral. ii) If performed with outflow procedure (77240, 77260, 77265, or 77270) payment will be made at 50%.			
	Trauma:			
	Repair of injury of major vessel in extremity:			
C77330	– suture	1982.00	6	596.96
C77335	– graft	2549.00	6	767.87
	Repair of injury of major vessel in trunk:			
C77340	– suture	2973.00	9	896.03
C77345	– graft	3968.00	9	1195.15
77350	Supra-renal aortic cross-clamp - extra to abdominal vascular or major trauma cases - operation only NOTE: Operative report required.	388.00		423.58
V07447	Repair of mesenteric injury NOTE: Trauma fee item 07447 is to be charged in cases of blunt and/or penetrating abdominal injury. It does not apply to incidental intraoperative injury to abdominal structures.	2811.00	6	869.24
	Operative repair – arteriography – for iatrogenic injury during percutaneous endovascular aortic valve implantation:			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
77352	Repair of major vessel in extremity – suture	1931.00	6	576.33
77353	Repair of major vessel in extremity – graft	2487.00	6	741.33
77354	Repair of major vessel in trunk – suture	2901.00	9	865.09
77355	Repair of major vessel in trunk – graft	3868.00	9	1153.83
	Fasciotomy:			
77360	Decompression fasciotomy - subcutaneous NOTE: 77360 includes secondary closure.	954.00	3	342.14
	Tibial Metaphysis (Distal), Ankle and Foot:			
	Incision - Therapeutic, Release (Fasciotomy & Nerve Release):			
57250	Decompression, neurolysis, nerve (isolated procedure)	1389.00	2	305.53
*57260	Fasciotomy, compartment syndrome	1001.00	2	272.17
*57269	Fasciotomy, secondary wound closure	869.00	2	201.89
	Miscellaneous:			
77370	Release of popliteal entrapment syndrome NOTE: Not to be paid if full femoral popliteal bypass is performed.	979.00	3	342.14
S00722	Arteriography, operative - procedural fee	373.00		127.71

RENAL ACCESS

77380	Insertion permanent peritoneal catheter (procedure fee only)	646.00	3	194.99
77385	Removal by dissection of chronic peritoneal catheter (operation only) NOTE: For removal of Tenckhoff type chronic peritoneal catheter not requiring surgical dissection, use visit fees.	450.00	3	135.25
77395	Creation of internal arterio-venous fistula	1261.00	4	424.32
77396	Revision of AV fistula 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.	1519.00	5	517.02
77400	Synthetic AV graft for hemodialysis NOTE: Not paid with 77295, 77395, 77396 and 77402.	1940.00	4	723.49

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
77402	Creation of brachiobasilic arteriovenous fistula with vein transposition Note: Not paid with 77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77330, 77395 and 77400.	2274.00	5	723.76
77403	Arm revascularization with distal revascularization and interval ligation (DRIL) Note: Not paid with C77260, 77265, 77270, 77275, 77280, 77285, 77290, 77295, 77300, 77395, and 77396.	2127.00	5	723.75
77405	Thrombectomy of arterio-venous fistula	1187.00	3	356.90
	Sympathectomy:			
77420	Lumbar sympathectomy - unilateral	1261.00	4	379.55
77422	Cervical sympathectomy - unilateral	1552.00	5	513.22
77424	Preganglionic sympathectomy; upper dorsal region - unilateral	1552.00	7	468.75
77426	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	1552.00	7	468.75
	Lumbar sympathectomy with abdominal procedure:			
77428	– unilateral (extra)	422.00		126.93
77430	– bilateral (extra)	839.00		253.87
	Lymphatic System:			
V07361	TB glands - radical removal	1321.00	4	357.92
V07363	Radical femoral, inguinal and/or iliac dissection	2637.00	5	715.84
V07360	Splenectomy	3738.00	6	826.87
VC07366	Laparotomy and staging of lymphoma to include splenectomy	4204.00	6	930.44
VC07365	Isolated limb perfusion to include groin dissection and laparotomy	4610.00	5	960.22
	Lymphoedema - Leg			
	Lymphoedema of Limbs - Excision and Grafting:			
06127	– entire leg	3356.00	3	715.88
06128	– entire lower extremity	5018.00	3	1070.26

ABDOMINAL SURGERY

	Miscellaneous:			
V07603	Resuture abdominal wound evisceration	1876.00	5	415.22
07451	Thoracic extension of abdominal incision (extra)	1400.00	8	511.31

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V07600	Exploratory laparotomy to include biopsy	1875.00	5	460.19

TRANSPLANTATION

Implantation of Kidney Graft:

77440	Vascular surgeon	2841.00	7	855.39

AMPUTATION

Hand and Wrist:

06218	Transmetacarpal	1221.00	2	306.79
06219	Finger, any joint or phalanx - operation only	1221.00	2	306.79

Pelvis, Hip, and Femur:

55983	Above knee	3044.00	4	684.95
55980	Hemicorporectomy	11397.00	6	2535.69
55981	Hemipelvectomy	6349.00	6	1441.31
55982	Hip disarticulation	4829.00	6	1225.08
55984	Knee disarticulation	3044.00	4	684.95
*55998	Open injury, primary wound care	437.00	4	152.79
*55999	Open injury, secondary wound management	869.00	4	214.45

Femur, Knee Joint, Tibia and Fibula:

56980	Below knee	2414.00	3	674.81
*56998	Open injury, primary wound care	437.00	3	152.79
*56999	Open injury, secondary wound management	869.00	3	214.45

Tibial Metaphysis (Distal), Ankle and Foot:

57981	Midtarsal	2286.00	2	521.41
57982	Transmetatarsal	1904.00	2	521.41
57983	Single metatarsal/Ray resection	1651.00	2	382.34
57980	SYME	2482.00	2	544.18
57984	Toe	877.00	2	190.94
*57998	Open injury, primary wound care	215.00	2	81.45
*57999	Open injury, secondary wound management	437.00	2	112.28

CHEST WALL SURGERY

Ribs and Chest Wall:

79125	Cervical rib resection	972.00	5	382.77
79130	Trans-axillary resection of first rib	2263.00	5	921.87

		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	359.00	92.80	35.78	128.58
	Peripheral Arterial:				
08664	Resting arterial assessment - To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index	183.00	49.87	11.68	61.55
	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	319.00	62.34	46.78	109.12
08666	– without monitoring physician present	211.00	62.15	11.67	73.82
08668	Vasospastic assessment - To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis	211.00	62.15	11.67	73.82
08669	Sympathetic tone response - To include resting arterial assessment plus plethysmography and/or impedance monitoring and/or digital wave forms, response to Valsalva maneuvres or other stimuli	132.00	33.29	11.67	44.96
	NOTE: 08669 not chargeable when done in conjunction with 08668.				

CARDIAC SURGERY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
07810	**Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, and a written report	506.00		199.28
07812	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee	191.00		66.99
	Continuing Care by Consultant:			
07807	Subsequent office visit.....	80.80		29.69
07808	Subsequent hospital visit.....	69.10		25.35
07809	Subsequent home visit	142.00		51.06
07805	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) ..... NOTE: Claim must state time service rendered.	285.00		101.91
07815	Pre-Operative Assessment..... NOTES: i) To be billed when a patient is transferred from one surgeon to another for surgery due to external circumstances. ii) Service to include a review of the medical records, performance of an appropriate physical exam, provide a written opinion, and obtain an informed consent. iii) Not payable to any physician who has billed a consult within 6 months prior for the same condition. iv) Maximum of one pre-operative assessment per patient per procedure. v) Only paid to the surgeon who performs the procedure.	506.00		199.28

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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.	506.00		199.28
78012	Telehealth repeat or limited Consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	191.00		66.99
78007	Telehealth subsequent office visit	80.80		29.69
78008	Telehealth subsequent hospital visit	69.10		25.35
ARTERIAL SYSTEM				
07820	Coarctation of aorta	2598.00	9	969.02
07818	Resection of ascending aortic aneurysm	4708.00	10	1740.08
07819	Resection of descending aortic aneurysm	4708.00	10	3254.76
07826	Resection or repair of total aortic arch, semiarch, or hemiarch NOTE: Restricted to Cardiac Surgery.	4085.00	10	1730.62
07829	Repair of traumatic injury of major intrathoracic vessels	2598.00	10	969.02
HEART				
	Heart:			
07830	Banding of pulmonary artery	2268.00	9	846.86
07831	Pericardiotomy with poudrage	2268.00	9	846.86
07832	Pericardectomy	2268.00	9	846.86
07833	Left atrial appendage ligation	1657.00	9	682.31
07834	Patent ductus arteriosus	2268.00	9	846.86
07835	Tetralogy of Fallot - Blalock or Pott's	2268.00	9	846.86
07836	Blalock-Hanlon procedure	2268.00	9	846.86
07837	Mitral commissurotomy (closed)	2268.00	9	846.86
07838	Pulmonary valvulotomy (closed)	2268.00	9	846.86
07839	Aortic valvulotomy	2268.00	9	846.86
S07843	Endocardial pacemaker (ventricular)	1187.00	4	426.30
S07953	Double lead endocardial pacemaker	1522.00	4	557.53
S78030	AICD and single ventricular lead	1513.00	8	595.38

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.	601.00		216.51
S78032	Subcutaneous Implantable Cardiac Defibrillator Implantation ..... NOTES: i) Fee for implantation, testing and programming of S-ICD. ii) Restricted to Cardiac Surgery and Cardiology. iii) Includes 33025.	1300.00	8	876.51
S07952	Electronic monitoring of pacing and pacemaker function.....	273.00		99.01
S07844	Implantation or replacement of pulse generator for cardiac pacing	710.00	4	257.56
07845	Repair, replacement, adjustment of electrode ..... . NOTE: For implantation of temporary pacemaker, see 33030.	710.00	4	260.51
07851	Phrenic nerve stimulator.....	1316.00	8	487.32
07846	Surgical treatment of cardiac arrest by cardiac massage (operation only)..... NOTE: To be supported by a written letter. Clause D. 5. 3. of the General Preamble will apply.	1155.00	11	431.14
07852	Gore-Tex modified aorto-pulmonary shunt.....	2598.00	9	969.02
78041	Laser Lead Extraction after 30 days, first lead ……. 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 13197.	3686.00	9	1450.90
78042	Laser Lead Extraction after 30 days, additional leads, to a maximum of two – extra	2366.00	9	544.66
78043	Debridement of chest wall during laser lead extraction – extra (payable only with P78041)	228.00	9	54.46
78044	Wide debridement of chest wall during laser lead extraction – extra (payable only with P78041).....	504.00	9	108.94
78045	Thoracotomy post cardiac surgery for hemorrhage..... NOTE: Must be performed by a Cardiac Surgeon in the Operating Room, under general anesthetic.	2281.00	8	772.92

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

OPEN HEART SURGERY

07824	Resecting aneurysm of the ventricle as an isolated procedure	4370.00	10	1633.32
07825	Resecting left ventricular aneurysms in conjunction with another procedure	757.00	10	281.02
78051	Minimal Access Mitral or Aortic valve replacement or Mid-Cavity CABG (extra) NOTES: i) Paid at 100% and only paid with 07853, 07854, 07855, 07856, 07857, 07858, 07859, 07860 and 07908. ii) Restricted to Cardiac Surgery.	1134.00		514.71
T78052	Explant Transcatheter Heart Valve Repair Device - extra NOTES: i) Restricted to Cardiac Surgery. ii) Paid only in addition to 07855, 07859, 07860, 07862, 07864, 07865, 07866, 78060. Paid up to a maximum of 2 per patient per day.	1994.00	10	801.51
	Mitral Valve:			
07853	Commissurotomy	3909.00	9	1463.40
07854	Plication	3909.00	9	1463.40
07855	Replacement	4370.00	9	2036.63
07856	Simple repair NOTES: Restricted to Cardiac Surgery.	4370.00	9	1633.32
78056	Mitral Valve Complex repair – including remodeling Annuloplasty and repair of anterior or posterior leaflet, with or without transposition and/or implantation of chordae/neochordae NOTE: Restricted to Cardiac Surgery.	6020.00	9	2041.68
	Aortic Valve:			
07857	Commissurotomy	3909.00	9	1463.40
07858	Plication	3909.00	9	1463.40
07859	Replacement	4370.00	9	1633.32
07860	Aortic root reconstruction with mechanical valved conduit, Homograft, or Xenograft room	7061.00	10	3258.77
T78059	Valve-Sparing Root Replacement (David Procedure) NOTES: i) Restricted to Cardiac Surgery. ii) Not payable with 07860 or 78060.	11935.00	10	4797.46

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
T78060	Pulmonary Autograft (Ross Procedure) NOTES: i) Restricted to Cardiac Surgery. ii) Includes 07860 and 78059.	12554.00	10	5046.21
	Tricuspid Valve:			
07861	Commissurotomy	3909.00	9	1463.40
07862	Replacement	4370.00	9	1633.32
07863	Annuloplasty	3909.00	9	1463.40
	Multiple Valve Replacement:			
07864	Two valves	6589.00	10	2844.77
07865	Three valves	7611.00	10	3253.71
07866	Valved external conduit	6062.00	10	2268.11
	Atrial Septum Defect:			
07867	Secundum - suture	3909.00	9	1463.40
07868	– patch	3909.00	9	1463.40
07869	Primum	4370.00	9	1633.32
07870	Multiple	3909.00	9	1463.40
07871	– plus pulmonary stenosis	3909.00	10	1463.40
07872	– plus partial anomalous pulmonary drainage	4370.00	10	1633.32
	Ventricular Septal Defect:			
07874	Simple	4209.00	9	1571.55
07875	Multiple	4209.00	9	1571.55
T78057	Apical Myectomy, Transapical Approach NOTES: i) Restricted to Cardiac Surgery. ii) Start and end times must be entered in both the billing claim and the patient's chart.	3909.00	9	2003.76
T78058	Extended Septal Myectomy NOTES: i) Restricted to Cardiac Surgery. ii) Start and end times must be entered in both the billing claim and the patient's chart.	3909.00	9	2137.35
07876	– plus patent ductus	4209.00	9	1571.55
07877	– plus pulmonary hypertension	4209.00	10	1571.55
07878	– plus corrected transposition	4209.00	10	1571.55
07879	– plus aortic regurgitation	4209.00	10	1571.55

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Subaortic Stenosis:			
07881	Fibrous ring	3909.00	9	1463.40
07882	Muscular hypertrophy	4370.00	9	1633.32
	Pulmonary Valve:			
07884	Valvulotomy	3909.00	9	1463.40
07885	Infundibulectomy	4370.00	9	1633.32
07886	Patch	4370.00	9	1633.32
07889	Tetralogy of Fallot	4370.00	10	1633.32
07890	– plus outflow patch	5020.00	10	1879.09
07893	– with previous anastomosis shunt	5020.00	10	1879.09
07898	Transposition	5434.00	10	2032.18
07887	Pulmonary arterioplasty with bypass	4372.00	9	1633.32
07899	Anomalous pulmonary drainage - total	5434.00	10	2032.18
07900	Aorticopulmonary window	4370.00	10	1633.32
07901	Repair aortic root, sinus of Valsalva, or aortic annulus, including with patch repair; root enlargement (Nicks or Manougian); or aortic annuloplasty NOTES: i) Restricted to Cardiac Surgery. ii) Not payable with 07860 or with 78059.	4370.00	10	1633.32
07902	Atrioventricular communis	6589.00	10	2464.73
07905	Intracardiac tumours	4370.00	9	1633.32
07906	Pulmonary embolectomy with bypass	3909.00	11	1463.40
07908	Coronary artery by-pass graft (end-to-side or side-to-side) - one artery	3909.00	9	1481.95
07909	– each additional artery NOTE: When 7 or more arteries are by-passed, a written explanation must be submitted along with the account.	760.00		281.60
07990	Harvest of arterial conduit for the purpose of coronary revascularization – per conduit (extra) NOTES: i) Paid with fee items 07908 and 07909 only. ii) Paid to a maximum of two per patient. iii) Restricted to Cardiac Surgery.	586.00		282.87
07910	Complete Cox-Maze procedure to include all right and left atrial lesion sets and pulmonary vein isolation Note: Not paid with 33084.	5113.00	9	1872.65
07962	Left atrial lesion sets only, with or without pulmonary vein isolation Note: Not paid with 33084.	6120.00	9	1397.23
07963	Pulmonary vein isolation only Note: Not paid with 33084.	2684.00	9	629.58

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
07911	Ventricular arrhythmia surgery - must include mapping and ablation, and includes aneurysmectomy if necessary	6206.00	9	2273.95
07912	Endocardial mapping	1080.00		393.24
07913	Pericardectomy with bypass	3909.00	9	1463.40
07914	Recurrent surgery after 21 days (add to 07824, 07855, 07859, 07860, 07862, 07864, 07865, 07908 and congenital heart operations), extra	2023.00		1537.62
07991	Repair of acute thoracic aortic dissection or intramural hematoma (extra) NOTES: i) Restricted to Cardiac Surgery. ii) Paid at 100% with fees listed under the headings "Open Heart Surgery" and "Arterial System".	2043.00		845.44
07992	Hypothermic circulatory arrest (extra) NOTES: i) Restricted to Cardiac Surgery. ii) Paid at 100% with fees listed under the headings "Open Heart Surgery" and "Arterial System". iii) Includes cannulation of one of the following vessels for purposes of cerebral perfusion: axillary, subclavian, carotid, and/or innominate arteries and/or superior vena cava for purposes of cerebral perfusion. iv) If a second site of cannulation for cerebral perfusion is required, fee item 07992 will be paid at 25%.	1701.00		704.17
	Specially Qualified Assistant Fees:			
07915	1st Assistant for operations of $1,033 or less	761.00		283.85
07916	2nd and 3rd Assistant for operations of $1,033 or less	463.00		166.01
07917	1st Assistant for operations over $1,033	1098.00		407.27
07918	2nd and 3rd Assistant for operations over $1,033	691.00		254.73
07920	Time, after 4 hours of continuous surgical assistance for one patient, each 15 minute period or fraction thereof NOTE: Start and end times must be entered in both the billing claims and the patient's chart.	60.00		22.29

RESPIRATORY SYSTEM

	Pleura and Lung:			
S07924	Decompression of traumatic pneumothorax - (operation only)	106.00	4	39.32
S07925	Artificial pneumothorax - operation only	76.10	4	27.37

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Ribs and Chest Wall:			
07949	Laser therapy for intra-tracheal or intra-bronchial tumour - to include endoscopy	1274.00	7	468.17

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	1549.00	10	524.66
78062	Removal of Abiomed Impella 5.0 (includes artery repair)	1082.00	10	367.26
78063	Uni-ventricular – temporary device (i.e. Levitronix) – thoracotomy (includes blood vessel repair)	5259.00	10	1783.81
78064	Removal of Levitronix device	2168.00	10	734.51
78065	Uni-ventricular – fully implantable (i.e. Heartmate II or Heartware) includes blood vessel repair	8972.00	10	3042.98
78066	Removal of fully implantable device includes blood vessel repair	4640.00	10	1573.96
07960	Intra-aortic balloon insertion, removal and care	1856.00	8	692.37

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	1858.00	10	629.58
78072	Veno-Arterial (V-A) ECMO insertion – central	2475.00	10	839.45
78073	Veno-Veno (V-V) ECMO insertion – peripheral	1239.00	10	419.73

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

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	1265.00		282.60
	NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020	Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof	148.00		32.96
	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	2637.00	5	548.90
V70501	– thoracic approach with removal of foreign body	3129.00	8	652.01
V70502	Cricopharyngeal myotomy - cervical approach	2303.00	4	479.96

Esophagus - Excision:

	Excision of lesion, esophagus, with primary repair:			
CV70530	– cervical approach	2637.00	6	548.90
CV70531	– thoracic or abdominal approach, open	3815.00	8	795.18
CV70532	– thoracic or abdominal approach, laparoscopic or thoracoscopic	3815.00	8	795.18

Total or Near Total Esophagectomy; without Thoracotomy (Transhiatal):

	with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty:			
V70533	– primary surgeon	9383.00	8	2076.08
70503	– secondary surgeon	3005.00		664.71

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70534	– primary surgeon	9383.00	8	2076.08
70504	– secondary surgeon	3005.00		664.71
	Total or Near Total Esophagectomy; with thoracotomy; with or without pyloroplasty (3 hole):			
V70535	– primary surgeon	10555.00	8	2335.58
70505	– secondary surgeon	3005.00		664.71
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70536	– primary surgeon	10555.00	8	2335.58
70506	– secondary surgeon	3005.00		664.71
V70538	Partial esophagectomy, distal 2/3 - with thoracotomy and separate abdominal incision and thoracic esophagogastrostomy NOTE: Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.	8021.00	8	1671.88
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70539	– primary surgeon	9150.00	8	1906.97
70509	– secondary surgeon	3005.00		664.71
CV70540	Partial esophagectomy, thoraco-abdominal or abdominal approach-with esophagogastrostomy NOTES: i) Includes vagotomy. ii) Includes proximal gastrectomy, pyloroplasty and splenectomy, if required.	7021.00	8	1462.86
	with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
CV70541	– primary surgeon	8211.00	8	1711.06
70511	– secondary surgeon	3005.00		664.71
CV70542	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy (includes gastrostomy)	5269.00	6	1097.79

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Diverticulectomy of hypopharynx or esophagus, with or without myotomy:			
V70545	– cervical approach	2637.00	6	548.90
V70544	– thoracic approach	3208.00	8	668.74
	Upper Gastrointestinal System – Endoscopy (Surgical)			
S33321	Removal of foreign material causing obstruction, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	547.00	4	151.03
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only NOTES: i) Paid only once per endoscopy. ii) Paid only in addition to S10761 or S10762..	628.00	3	151.18
S33323	Transendoscopic tube, stent or catheter – operation only NOTES: i) Paid only in addition to S10761 or S10762.. ii) Paid only once per endoscopy.	547.00	3	151.03
S33324	Thermal coagulation – heater probe and laser, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	326.00	3	150.81
S33325	Gastric polypectomy, operation only NOTES: i) Paid only in addition to S10761 or S10762.. ii) Paid only once per endoscopy.	245.00	5	61.36
S33326	Percutaneous endoscopically placed feeding tube – operation only NOTES: i) Paid only in addition to S10761 or S10762.. ii) Paid only once per endoscopy.	489.00	3	176.22
33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only	204.00	3	100.51

(see notes on next page)

		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.			
S33328	Esophageal dilation, blind bouginage, operation only .. NOTE: Repeats within one month paid at 100%.	310.00	3	100.58
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only ..... NOTE: Repeats within one month paid at 100%.	586.00	3	151.10
	Esophagus Repair:			
V71530	Cervical esophagostomy	2608.00	5	543.38
V71531	Cervical approach - repair TE fistula ..... NOTE: 71530 and 71531 include gastrostomy.	9243.00	6	2045.25
	Esophagoplasty (plastic repair or reconstruction) thoracic approach:			
CV71532	– without repair of tracheo-esophageal fistula	9243.00	8	2045.25
CV71533	– with repair of tracheo-esophageal fistula	10399.00	8	2300.91
V71534	Division of tracheo-esophageal fistula without esophageal anastomosis (thoracic approach)..... NOTE: C71533 and 71534 include gastrostomy.	3952.00	8	868.66
	Esophagogastric fundoplasty (e.g.: Nissen, Belsey IV, Hill procedures); antireflux:			
CV71535	– laparoscopic.....	5063.00	6	1022.63
V71536	– open.....	3619.00	6	843.66
CV71537	Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	3889.00	8	920.36
V71538	– with gastroplasty - Collis	5629.00	8	1245.65
	Plastic Operation for Cardiospasm; Heller:			
CV71539	– thoracic approach - open	3304.00	8	766.97
V71540	– laparoscopic or thorascopic (endoscopy to be billed separately).....	4624.00	6	945.93
CV71541	– with fundoplication - open	4618.00	6	1073.76
CV71542	– with fundoplication - laparoscopic	6461.00	6	1227.15

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Gastrointestinal Reconstruction for Previous Esophagectomy; for Obstructing Esophageal Lesion or Fistula or for Previous Esophageal Exclusion:			
CV71543	– with stomach, with or without pyloroplasty	7021.00	6	1462.86
CV71544	– with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	8211.00	6	1711.06
	Suture of Esophageal Wound or Injury:			
V71548	– cervical approach	5865.00	6	1297.56
CV71549	– transthoracic or transabdominal approach	7037.00	8	1557.05
	Closure of Esophagostomy or Fistula:			
CV71550	– cervical approach	5865.00	6	1297.56
CV71551	– transthoracic or transabdominal approach	7037.00	8	1557.05
02449	Rigid esophagoscopy for removal of foreign body	834.00	4	259.93

DIAPHRAGM - REPAIR

V70601	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplication	5605.00	6	1328.31
	Repair of diaphragmatic hernia of any type, with or without fundoplication, vagotomy, or drainage procedure:			
CV70603	– laparoscopic	5605.00	6	1378.81
CV70604	– congenital diaphragmatic hernia	7037.00	9	1557.05
CV70605	– open	5614.00	8	1328.34
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	3697.00	8	818.10
	NOTE: For anti-reflux procedures, such as fundoplications, etc., please see Oesophageal section.			

TRAUMA

NOTE: Trauma fee items are to be charged in cases of blunt and/or penetrating abdominal injury. They do not apply to incidental intra-operative injury to abdominal structures.

V07431	Full thickness repair diaphragmatic injury (traumatic) with or without mesh	3952.00	8	1073.76

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

MISCELLANEOUS

70023	Excisional biopsy of lymph glands for malignancy - neck - operation only	941.00	3	245.43
V70624	Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	2335.00	5	516.79
V07630	Gastrostomy - open	2111.00	5	467.13
V07648	Revision of ileostomy or colostomy - simple - incision of scar, etc.	2080.00	4	562.45
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	1123.00	6	312.59
02422	– in a child under the age of 3 years	1670.00	6	389.18
02420	Dilation of trachea - operation only	489.00	5	156.10
02421	– repeat within one month - operation only	647.00	5	155.88
	Microsurgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:			
02430	– first procedure	1949.00	6	501.50
02435	– subsequent procedure, each	1931.00	6	501.50
	NOTES: i) Maximum of 5 subsequent procedures in six (6) month period, otherwise support with written letter. ii) Microsurgery treatment with CO_2 laser other than removal of tumour(s) of larynx or trachea, bill under 07999 with operative report.			
02407	Tracheostomy puncture NOTE: Not applicable to cricothyrotomy.	1287.00	5	398.83
C02473	Laryngo-pharyngo-esophagectomy - primary excision only	6934.00	6	1942.99

THORACIC PROCEDURES

S00700	Bronchoscopy or bronchofibroscopy - procedural fee	348.00	5	138.87
00702	Bronchoscopy with biopsy - procedural fee	641.00	5	218.67
S00719	Thoracoscopy	862.00	7	351.12
S00701	Direct laryngoscopy - procedural fee NOTES: i) 00701 is not payable with 00907, 00908 and 00909. ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.	169.00	5	73.82

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral - procedural fee	476.00	3	119.27
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	397.00	3	120.07
S10763	Initial esophageal, gastric or duodenal biopsy	61.30	3	15.15
	NOTES: iii) Paid only in addition to S10761, S10762 and SY10750 to a maximum of three biopsies per endoscopy, in one organ or multiple organs. iv) 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	237.00	3	44.56
	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	512.00	4	208.31
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee (extra)	348.00	4	69.68
S00868	Percutaneous gastrostomy / gastrojejunostomy - procedural fee	1258.00	2	291.74
S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	210.00	2	56.20
S00749	Parietal pleural, including thoracentesis - procedural fee	341.00	2	136.23
S00751	Pericardial puncture - procedural fee	1118.00	3	258.25
S00755	Artery puncture - procedural fee	36.05	2	7.15
S00759	Paracentesis (thoracic) or transtracheal aspiration - procedural fee	220.00	2	103.74
S00797	Esophageal motility test	814.00		180.13
S00788	– technical fee	361.00		76.03
S00798	– professional fee	471.00		104.09
S00818	Esophageal pH study for reflux (extra) - professional fee	213.00		42.72
S00817	– technical fee	65.70		15.59

CHEST SURGERY

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
REFERRED CASES				
79010	**Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, and a written report	379.00		154.25
79012	**Repeat or Limited Consultation:** To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgement of the consultant the consultative service does not warrant a full consultative fee	188.00		69.42
	Continuing Care by Consultant:			
79007	Subsequent office visit	79.00		30.78
79008	Subsequent hospital visit	67.10		26.26
79009	Subsequent home visit	139.00		52.91
79005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums) NOTE: Claim must state time service rendered.	274.00		105.60
Telehealth Service with Direct Interactive Video Link with the Patient				
79210	**Telehealth Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, and a written report	379.00		154.25
79212	**Telehealth repeat or limited consultation:** 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	188.00		69.42
79207	Telehealth subsequent office visit	79.00		30.78
79208	Telehealth subsequent hospital visit	67.10		26.26

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

LUNG SURGERY

	Lobe:			
79015	Lobectomy	3553.00	8	1447.66
79020	Bronchoplasty (extra to lobectomy)	681.00	9	262.48
	Entire Lung:			
79025	Pneumonectomy	3861.00	9	1572.97
	Other Lung Operations:			
79030	Segmental resection of lung (operative report required)	3553.00	8	1447.66
79035	Thoracotomy, including wedge resection	1994.00	8	812.23
79036	– each additional wedge resection of lung when done thorascopically, to a maximum of two extra	264.00		83.08
79040	Drainage of lung abscess (operation only)	1376.00	8	542.85
	Thoracotomy (Miscellaneous):			
S07924	Decompression of traumatic pneumothorax (operation only)	106.00	4	39.32
79045	Exploratory thoracotomy with or without biopsy or removal of foreign body	2016.00	8	821.47
79050	Decortication of lung	3110.00	8	1266.46
79055	Pleurectomy	1994.00	8	812.23
79060	Intrathoracic tumour - without lung involvement	2677.00	8	1090.78

AIRWAY SURGERY

	Trachea:			
79065	Tracheal resection	2582.00	10	1023.17
79070	– with laryngeal release (extra)	1281.00	10	505.04
79075	– with hilar release (extra)	1281.00	10	505.04
02420	Dilation of trachea - operation only	489.00	5	156.10
02421	– repeat within one month - operation only	647.00	5	155.88
02407	Tracheostomy	1287.00	5	398.83
	NOTE: Not applicable to cricothyrotomy puncture.			
	Bronchus:			
79080	Closure of bronchopleural fistula	2582.00	10	1011.65
79085	Repair of ruptured bronchus	2582.00	9	1023.17
07949	Laser therapy for intra-tracheal or intra-bronchial tumour - to include endoscopy	1274.00	7	468.17

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	1123.00	6	312.59
02422	– in a child under the age of 3 years	1670.00	6	389.18
	Micro-surgery with Use of CO_2 Laser for Removal of Tumour(s) of Larynx or Trachea:			
02430	– first procedure	1949.00	6	501.50
02435	– subsequent procedure, each	1931.00	6	501.50
	NOTES: i) Maximum of 5 subsequent procedures in six (6) month period, otherwise support with written letter. ii) Microsurgery treatment with CO_2 laser other than removal of tumour(s) of larynx or trachea, bill under 02599 with operative report.			

MEDIASTINAL SURGERY

79095	Mediastinal cyst or tumour	2772.00	8	1129.89
79100	Thymectomy	2073.00	8	844.08

CHEST WALL SURGERY

79105	Rib resection for empyema	1336.00	6	528.33
79110	Closure of pleurostomy following long term management of empyema with rib section	1336.00	6	528.33
79115	Pectus excavatum and carinatum	2079.00	8	823.73
79120	Thoracoplasty	2079.00	6	823.73
79125	Cervical rib resection	972.00	5	382.77
79130	Trans-axillary resection of first rib	2263.00	5	921.87
79135	Chest wall tumour with rib resection	2646.00	6	1078.49

DIAPHRAGM SURGERY

V70601	Repair paraoesophageal hiatus hernia, transabdominal, with or without fundoplication	5605.00	6	1328.31
	Repair of diaphragmatic hernia of any type, with or without fundoplication, vagotomy, or drainage procedure:			
CV70603	– laparoscopic	5605.00	6	1378.81
CV70604	– congenital diaphragmatic hernia	7037.00	9	1557.05
CV70605	– open	5614.00	8	1328.34
V70607	Imbrication of diaphragm for eventration, transthoracic or transabdominal	3697.00	8	818.10

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
V07431	Repair diaphragmatic injury	3952.00	8	1073.76
	NOTE: For anti-reflux procedures, such as fundoplications, etc., please see Oesophageal section.			

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	1265.00		282.60
	NOTE: Time is calculated at the earliest, from the time of physician/patient contact in the operating suite.			
70020	Time after one hour of continuous certified surgical assistance for one patient, up to and including 3 hours of continuous surgical assistance for one patient - each 15 minutes or fraction thereof	148.00		32.96
	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.....	2637.00	5	548.90
V70501	– thoracic approach with removal of foreign body.....	3129.00	8	652.01
V70502	Cricopharyngeal myotomy - cervical approach.....	2303.00	4	479.96
	Esophagus - Excision:			
	Excision of lesion, oesophagus, with primary repair:			
CV70530	– cervical approach.....	2637.00	6	548.90
CV70531	– thoracic or abdominal approach - open.....	3815.00	8	795.18
CV70532	– thoracic or abdominal approach - laparoscopic or thoracoscopic.....	3815.00	8	795.18
	Total or Near Total Esophagectomy, without Thoracotomy (Transhiatal):			
	With pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty:			
V70533	– primary surgeon	9383.00	8	2076.08

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
70503	– secondary surgeon	3005.00		664.71
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70534	– primary surgeon	9383.00	8	2076.08
70504	– secondary surgeon	3005.00		664.71
	Total or Near Total Esophagectomy; with thoracotomy, with or without pyloroplasty (3-hole):			
V70535	– primary surgeon	10555.00	8	2335.58
70505	– secondary surgeon	3005.00		664.71
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70536	– primary surgeon	10555.00	8	2335.58
70506	– secondary surgeon	3005.00		664.71
V70538	Partial esophagectomy, distal 2/3 - with thoracotomy and separate abdominal incision and thoracic esophagogastrostomy NOTE: Includes proximal gastrectomy and pyloroplasty (Ivor Lewis), if required.	8021.00	8	1671.88
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
V70539	– primary surgeon	9150.00	8	1906.97
70509	– secondary surgeon	3005.00		664.71
CV70540	Partial esophagectomy, thoraco-abdominal or abdominal approach - with esophagogastrostomy NOTES: i) Includes vagotomy. ii) Includes proximal gastrectomy, pyloroplasty and splenectomy, if required.	7021.00	8	1462.86
	With colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es):			
CV70541	– primary surgeon	8211.00	8	1711.06
70511	– secondary surgeon	3005.00		664.71
CV70542	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy (includes gastrostomy)	5269.00	6	1097.79

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Diverticulectomy of Hypopharynx or Esophagus, with or without Myotomy:			
V70545	– cervical approach	2637.00	6	548.90
V70544	– thoracic approach	3208.00	8	668.74
	Upper Gastrointestinal System – Endoscopy (Surgical)			
S33321	Removal of foreign material causing obstruction, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	547.00	4	151.03
S33322	Therapeutic injection(s), sclerosis, band ligation, and/or clipping for GI hemorrhage, bleeding esophageal varices or other pathologic conditions – operation only NOTES: i) Paid only once per endoscopy. ii) Paid only in addition to S10761 or S10762.	628.00	3	151.18
S33323	Transendoscopic tube, stent or catheter – operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	547.00	3	151.03
S33324	Thermal coagulation – heater probe and laser, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	326.00	3	150.81
S33325	Gastric polypectomy, operation only NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.	245.00	5	61.36
S33326	Percutaneous endoscopically placed feeding tube – operation only	489.00	3	176.22

(see notes on next page)

		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.			
33327	Endoscopic repositioning of the gastric feeding tube through the duodenum for enteric nutrition, operation only	204.00	3	100.51
	NOTES: i) Paid only in addition to S10761 or S10762. ii) Paid only once per endoscopy.			
S33328	Esophageal dilation, blind bouginage, operation only NOTE: Repeats within one month paid at 100%.	310.00	3	100.58
S33329	Esophageal dilation or dilation of pathological stricture, by any method, except blind bouginage, under direct vision or radiologic guidance, operation only NOTE: Repeats within one month paid at 100%.	586.00	3	151.10

ESOPHAGUS REPAIR:

V71530	Cervical oesophagostomy	2608.00	5	543.38
V71531	Cervical approach - repair TE fistula NOTE: 71530 and 71531 include gastrostomy.	9243.00	6	2045.25
	Esophagoplasty (Plastic Repair or Reconstruction); thoracic Approach:			
CV71532	– without repair of tracheo-esophageal fistula	9243.00	8	2045.25
CV71533	– with repair of tracheo-esophageal fistula	10399.00	8	2300.91
V71534	Division of tracheo-esophageal fistula without oesophageal anastomosis (thoracic approach) NOTE: C71533 and 71534 include gastrostomy.	3952.00	8	868.66
	Esophagogastric Fundoplasty (e.g.: Nissen, Belsey IV, Hill Procedures); Antireflux:			
V71535	– laparoscopic	5063.00	6	1022.63
V71536	– open	3619.00	6	843.66
V71537	Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure) - abdominal and/or thoracic approach	3889.00	8	920.36
V71538	– with gastroplasty - Collis	5629.00	8	1245.65
	Plastic Operation for Cardiospasm; Heller:			
CV71539	– thoracic approach - open	3304.00	8	766.97

			Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
CV71540	–	laparoscopic or thorascopic (endoscopy to be billed separately)	4624.00	6	945.93
CV71541	–	with fundoplication - open	4618.00	6	1073.76
CV71542	–	with fundoplication - laparoscopic	6461.00	6	1227.15
		Gastrointestinal Reconstruction for Previous Esophagectomy; for Obstructing Esophageal Lesion or Fistula or for Previous Esophageal Exclusion:			
CV71543	–	with stomach, with or without pyloroplasty	7021.00	6	1462.86
CV71544	–	with colon interposition or small bowel reconstruction, including bowel mobilization, preparation and anastomosis(es)	8211.00	6	1711.06
		Suture of Esophageal Wound or Injury:			
V71548	–	cervical approach	5865.00	6	1297.56
CV71549	–	transthoracic or transabdominal approach	7037.00	8	1557.05
		Closure of Esophagostomy or Fistula:			
CV71550	–	cervical approach	5865.00	6	1297.56
CV71551	–	transthoracic or transabdominal approach	7037.00	8	1557.05
02449		Rigid esophagoscopy for removal of foreign body	834.00	4	259.93
C02473		Laryngo-pharyngo-esophagectomy - primary excision only	6934.00	6	1942.99

MISCELLANEOUS SURGERY

70023		Excisional biopsy of lymph glands for suspected malignancy - neck - operation only	941.00	3	245.43
V70624		Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)	2335.00	5	516.79
V07630		Gastrostomy - open	2111.00	5	467.13
S32031		Closed drainage of chest (operation only)	516.00	4	144.53
79140		Anterior scalenotomy	535.00	3	213.06

DIAGNOSTIC PROCEDURES

		THORACIC PROCEDURES: **Procedures Involving Visualization by Instrumentation:**			
S00700		Bronchoscopy or bronchofibroscopy - procedural fee	348.00	4	138.87
S00702		Bronchoscopy with biopsy - procedural fee	641.00	4	218.67

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00719	Thoracoscopy	862.00	7	351.12
S00701	Direct laryngoscopy - procedural fee	169.00	5	73.82
	NOTES: i) 00701 is not payable with 00907, 00908 and 00909. ii) 00701 is payable with 00700 and 00702 only when done under general anesthesia.			
	Upper Gastrointestinal System:			
S10761	Esophagogastroduodenoscopy (EGD), including collection of specimens by brushing or washing, per oral – procedural fee	476.00	3	119.27
S10762	Rigid esophagoscopy, including collection of specimens by brushing or washing, - procedural fee	397.00	3	120.07
S10763	Initial esophageal, gastric or duodenal biopsy	61.30	3	15.15
	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	237.00	3	44.56
	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	512.00	4	208.31

Diagnostic procedures utilizing radiological equipment:

The following fees are separate from the fees for the radiological part of this examination and should be charged by the attending physician or by the radiologist who performs the procedure, e.g.: instrumentation or injection of contrast material.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee (extra)	348.00	4	69.68
S00868	Percutaneous gastrostomy / gastrojejunostomy - procedural fee	1258.00	2	291.74

NEEDLE BIOPSY PROCEDURES

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

S00745	Peripheral or subcutaneous lymph node biopsy - procedural fee	210.00	2	56.20
S00749	Parietal pleural, including thoracentesis - procedural fee	341.00	2	136.23
	Puncture Procedures for Obtaining Body Fluids (When performed for diagnostic purposes):			
S00751	Pericardial puncture - procedural fee	1118.00	3	258.25
S00755	Artery puncture - procedural fee	36.05	2	7.15
S00759	Paracentesis (thoracic) or transtracheal aspiration - procedural fee	220.00	2	103.74
	Miscellaneous:			
S00797	Esophageal, motility test	814.00		180.13
S00788	– technical fee	361.00		76.03
S00798	– professional fee	471.00		104.09
S00818	Esophageal pH study for reflux (extra) - professional fee	213.00		42.72
S00817	– technical fee	65.70		15.59

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	**Consultation:** To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	424.00		99.99
08012	**Repeat or limited consultation:** 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	254.00		55.67
	Continuing Care by Consultant:			
08007	Subsequent office visit	184.00		45.44
08008	Subsequent hospital visit	200.00		43.83
08009	Subsequent home visit	279.00		61.35
08005	Emergency visit when specially called (not paid in addition to out-of-office hours premiums)	576.00		125.68
	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.	424.00		99.99

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
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	254.00		55.67
08077	Telehealth subsequent office visit	184.00		45.44
08078	Telehealth subsequent hospital visit	200.00		43.83

SURGICAL ASSISTANCE

81194	First Surgical Assist of the Day - Urology NOTES: i) Restricted to Urology Surgeons ii) Maximum of one per day per physician, payable in addition to 00195, 00196, 00197, and 13197.	358.00		78.20
P81195	Certified urologic surgeon assist (extra) Time after 1 hour of continuous surgical assistance for one patient, each 15 minutes or fraction thereof. NOTES: i) Restricted to Urology. ii) Paid only in addition to fee item 70020. iii) Maximum payable is 8 units per surgery. iv) Any additional assistants, if required, are paid under fee items 00195, 00196, 00197, 00198 and 13197 only. v) Start and end times must be entered in both the billing claims and the patient's chart.	76.10		17.94

KIDNEY AND PERINEPHRIUM

08100	Drainage of perinephric abscess	2270.00	5	495.29
08117	Nephrolithotomy and/or pyelolithotomy	3647.00	5	796.03
08118	Nephrolithotomy or pyelolithotomy with x-ray control with or without nephroscopy	3692.00	5	864.61
08119	Nephrolithotomy or pyelolithotomy with renal cooling, with or without x-ray control, with or without nephroscopy	3326.00	6	755.95
S08123	Extra-corporeal shock wave lithotripsy (ESWL) (operation only)	1043.00	4	227.58
08104	Partial nephrectomy	6329.00	5	1381.48
08105	Nephrectomy	5850.00	5	1277.21
08106	ectopic kidney	4104.00	5	1277.36
08108	thoraco-abdominal	6209.00	8	1355.41

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
08109	radical with gland dissection	5972.00	6	1303.26
C81104	Laparoscopic partial nephrectomy for suspected renal malignancy, with or without ipsilateral adrenalectomy, includes excision of perinephric fat. NOTE: Restricted to Urologists.	9135.00	5	1994.18
C81105	Laparoscopic radical nephrectomy for suspected renal malignancy, with or without ipsilateral adrenalectomy, includes excision of perinephric fat. NOTES: i) Restricted to Urologists. ii) Not paid with open nephrectomy fee items (08105, 08106, 08108, 08109).	7166.00	7	1564.07
08110	Nephro-ureterectomy to include bladder cuff	7045.00	6	1538.01
C81110	Laparoscopic nephroureterectomy (including excision of bladder cuff) NOTE: Not paid with 08105, 08106, 08109, 08110, C81104, C81105.	8807.00	6	1922.48
08112	Open renal biopsy (as independent procedure)	1481.00	5	323.37
08113	Symphysiotomy and nephropexy or nephrectomy in horseshoe kidney	2037.00	5	1277.36
08114	Pyeloplasty including management of aberrant vessels and nephropexy	4687.00	5	1024.11
C81114	Laparoscopic pyeloplasty, with or without insertion of ureteral stent, includes management of aberrant vessels and nephropexy, cystoscopy or retrograde pyelogram. NOTES: Includes nephrolithotomy (08117) if done at same time. i) Fee item 08155 paid at 75% when retrograde approach is required. ii) Not paid with open pyeloplasty (08114). iii) Repeat pyeloplasty within three months is included in the original fee.	6334.00	7	1382.63
08116	Ruptured or lacerated kidney - repair or removal	5924.00	6	1292.85
C08120	Renal Autotransplant to include nephrectomy, ex-vivo kidney preparation, autologous renal transplant (stand alone)	27651.00	6	6524.30

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Urologists with subspecialty training/credentials in renal transplantation. ii) This is an all-inclusive fee, for the day of surgery, under the same anesthetic. iii) Same day emergent postoperative complication under different anesthetic may be billed, a note record is required.			
TC81115	Complex Radical Nephrectomy for Renal Tumours stage IIB or higher with or without ipsilateral adrenalectomy, includes excision of perinephric fat & thrombectomy if required	9180.00	8	2150.00
	NOTES: i) Restricted to Urologists. ii) Not paid with 08105, 08106, 08108, 08109, 08110, 81104, and 81105.			

ENDOUROLOGY

S08146	Ureteroscopy and basket manipulation of ureteral calculus with or without lithopaxy (operation only)	2900.00	3	562.38
S08155	Insertion of internal ureteral stent to include C&P and ureteroscopy (operation only)	602.00	3	153.20
	NOTE: Additional stents to be paid at 50%.			
08168	Nephroscopy and stone removal - to include lithopaxy (operation only)	2900.00	4	632.93
	NOTE: Not payable in addition to 00800.			
S08185	Endoscopic Treatment of upper Tract Transitional Cell Carcinoma	4217.00	6	920.36
	NOTES: i) Restricted to Urologists. ii) Includes fee items 00704, 00800, 08146 and 08155. iii) Not payable with 08168, 08117 or 08118. iv) Bilateral procedures which involve both kidneys/ureters are payable at 150%. v) Antegrade percutaneous access (00978, 00979) payable at 100% in addition.			

URETER

08144	Ureterocele incision	1364.00	2	357.46
	NOTE: Restricted to Urologists.			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
S08145	Subureteric endoscopic injection for vesicoureteral reflux (VUR) NOTES: i) Includes cystoscopy. ii) Includes injection of one or both ureters, whether done at the same time or on two separate days. iii) Maximum of 3 injections per lifetime.	1208.00	2	314.88
08147	Ureterotomy - ureteral lithotomy - upper and lower	1919.00	5	418.88
08151	Ureterotomy or removal of stump	3542.00	5	772.97
08152	Uretero-vesical reanastomosis - unilateral	4059.00	5	886.07
08148	– bilateral	4738.00	5	1034.22
08153	Unilateral ureteral tailoring - extra to 08152 or 08148	1089.00	5	237.84
08154	Bilateral ureteral tailoring - extra to 08148	1541.00	5	336.10
08156	Uretero - ureterostomy	3106.00	5	911.05
08157	Uretero-cutaneous-anastomosis - unilateral	3130.00	5	842.32
08158	Ureteral sigmoid anastomosis - bilateral	2961.00	5	646.35
08159	Ureterolysis	2814.00	5	614.20
08160	Reconstruction lower segment ureter by bladder flap	4299.00	5	938.43
08161	Transurethral manipulation of ureteral calculus with recovery of calculus	1019.00	3	222.32
08163	Ureterovesical anastomosis in the presence of ureterocele or ureteral duplication	3673.00	5	801.46
T81151	Distal Ureterectomy and Ureteric Reimplant NOTES: i) Restricted to Urologists. ii) Fee items 08160 paid at 50% when billed with 81151, if a tubularized Baori bladder flap is utilized to obtain ureteric anastomosis. iii) 04212 paid at 25% when billed with 81151. iv) Not paid with 08151, 08152, 08153, 08154, 08155 and 08159.	7401.00	6	1733.39

URINARY DIVERSION AND CYSTECTOMY

08170	Preparation of intestinal segment and reanastomosis	2416.00	5	527.43
08174	– and ureteral transplantation (same surgeon)	4273.00	6	932.57
08184	Cystectomy (isolated procedure), with or without urethrectomy	5799.00	6	1266.08
08173	Radical cystectomy with pelvic lymphadenectomy (isolated procedure)	9079.00	7	1981.91
08177	Cystectomy and ileal loop diversion (includes preparation of intestinal segment and ureteral transplantation - same surgeon)	10072.00	6	2198.65

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
08178	Radical cystectomy and ileal loop urinary diversion (to include preparation of intestinal segment and ureteral transplantation - same surgeon)	13362.00	7	2916.73
08181	Bladder augmentation with bowel segment	5685.00	5	1240.95
08182	Continent urinary diversion NOTE: When a second urologist with expertise in continent diversion performs the continent urinary diversion, both surgeons shall be paid in full.	5678.00	6	1239.36
08183	Radical cystectomy and continent urinary diversion (includes preparation of intestinal segment and ureteral transplantation - same surgeon)	14757.00	7	3221.27

BLADDER

S08200	Bladder fulguration with cystoscopy	740.00	2	237.46
08201	Cystostomy (isolated procedure)	1032.00	2	225.22
S08202	– by trochar (isolated procedure) - operation only	478.00	2	207.28
08203	Cystolithotomy	1479.00	2	323.04
08204	Cystectomy - partial for tumour or diverticulum	3333.00	5	727.43
S08205	Intravesical botulinum toxin injection(s) NOTES: i) Restricted to Urologists and approved Urogynecologists. ii) To a maximum of 3 services per patient per year. iii) Includes fee items 00704, 00705, 08232 and 08200.	1335.00	2	291.45
08207	Ruptured bladder repair	3343.00	5	772.92
08255	Closure of fistula - suprapubic, vesico-vaginal, vesico-rectal or vesico-sigmoid	3343.00	5	729.89
PC08355	Tensor fascia lata or abdominal rectus fascia harvest To include peration for urinary incontinence or urinary tract reconstruction and harvest of tensor fascia lata or abdominal rectus fascia for use as a bladder neck sling. NOTES: i) Restricted to Urologists and approved Urogynecologists. ii) Not payable with fee item 08283, 08255, 08259, 08317, 08268, 04227, 81153 or. iii) Includes cystoscopy.	4399.00	2	1072.76
T08356	Manual Bladder Irrigation and Clot Evacuation (operation only)	1174.00	3	275.00

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Restricted to Urologists. ii) To be utilized when 3-way irrigation catheters have failed to clear clot or otherwise contraindicated. iii) Maximum of 2 per patient per day.			
	Endoscopy:			
S08250	Transurethral resection of bladder or urethral tumour and adjacent muscle and electro-coagulation as necessary	1508.00	3	355.54
S08251	Transurethral resection bladder neck, female	1411.00	3	308.12
S08257	Transurethral removal of foreign body (excluding ureteric stents) NOTE: Removal of ureteric stents is paid under fee item S00704.	1184.00	3	258.47
08253	Y-V vesical neck plasty	3016.00	4	786.30
S08254	Litholapaxy and removal of fragments	1314.00	2	354.02
S08256	Transurethral resection of external urinary sphincter	1419.00	3	312.48

URETHRA

S08232	Periurethral collagen injections NOTES: i) Includes cystoscopy. ii) Applicable for females only. iii) Additional training at recognized centre required.	1111.00	2	242.67
S08260	Urethrotomy, external or internal	1007.00	2	255.22
S08261	Urethrostomy	1413.00	2	308.52
S08262	Meatotomy and plastic repair - operation only	639.00	2	235.67
08263	Urethrectomy - total	1658.00	3	361.96
S08264	Stricture of urethra - office dilation - operation only	92.60		20.22
S08265	Stricture of urethra - dilation in hospital (isolated procedure) - with or without anesthesia - operation only	232.00	2	50.50
08266	– first stage plastic repair (excluding urethrostomy)	5015.00	3	1094.84
08259	– first stage plastic repair requiring pedicle graft	4776.00	3	1042.71
81159	Buccal mucosa graft harvest, extra NOTES: i) Restricted to Urologists. ii) Paid only with fee item 08259 (stricture of urethra first stage plastic repair).	1075.00		234.61

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
08267	Stricture of urethra - second stage plastic repair (excluding urethrostomy)	4776.00	3	1042.71
08268	Urethral diverticulectomy, male or female	2811.00	2	664.80
S08269	TUR posterior urethral valves	1658.00	2	362.05
08283	Retropubic or transvaginal tape (TVT) or transobturator tape (TOT) operation for urinary incontinence	1555.00	4	339.54
C81153	Male suburethral sling, including cystoscopy	3343.00	4	729.89
	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	2625.00	4	573.15
	NOTES: i) Restricted to Urology specialists. ii) Fee items 00704, 00705 or 08232 not paid in addition.			
08272	Urethral fistula (penile excision)	1878.00	2	461.15
08274	Hypospadias (excluding urethrostomy) - 1st stage chordee	2572.00	2	561.56
08275	– 2nd stage (penile)	2579.00	2	562.80
08276	– penoscrotal	4738.00	2	1034.34
08277	– epispadias plastic repair	3079.00	2	672.19
08278	Suprapubic cystostomy and primary repair of urethra	1892.00	3	415.41
S08282	Excision prolapse of urethra or caruncle (includes cystoscopy) - operation only	1138.00	2	248.57
S08271	Catheterization, complex-male patient (operation only)	955.00		208.54
	NOTES: i) Restricted to Urologists and General Surgeons. ii) Procedure must involve the use of Filiforms and Followers, or introducers (stylet or catheter guide). iii) Not paid in addition to the critical care fees, or diagnostic urological procedures (e.g.: voiding cystourethrogram).			

PENIS

08296	Insertion of semi-rigid or self-contained inflatable prosthesis	2866.00	3	625.62

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
08363	Revision of penile prosthesis (includes removal, correction of any mechanical failure, and replacement)	4041.00	3	882.15
08364	Repair of penile fracture or traumatic laceration of cavernous tissue NOTES: i) Restricted to Urologists. Diagnostic cystoscopy prior to surgery is payable at 100%.	3733.00	2	814.63
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) NOTE: Must be preceded by colour flow Doppler or duplex sonogram.	1895.00	2	413.73
08300	Priapism - sapheno-cavernous shunt	2666.00	2	582.03
08366	Emergency Management of Priapism, includes aspiration and irrigation of the corporal bodies and injections in the corporal body (includes distal shunt if necessary) NOTES: i) Restricted to Urologists. ii) Cystoscopy to rule out urethral injury may be paid in addition at 100%. iii) May be paid at 100% if entire procedure is repeated on the same day.	2153.00		508.24
S08301	Dorsal slit (isolated procedure) - operation only	523.00	2	167.09
S08312	Circumcision (excluding clamp or bell technique) - operation only NOTE: Routine circumcision of the newborn for non-medical reasons is not a benefit under MSP.	959.00	2	302.02
08305	Simple amputation of penis	2166.00	2	472.49
08299	Radical amputation of penis	2843.00	2	620.57
08306	Clitoral recession	1185.00	2	258.54
08309	Excision of femoral and inguinal glands, with or without iliac glands - bilateral	6210.00	4	1355.52
08308	– unilateral	4299.00	4	938.43

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
08307	Excision of Peyronie's plaque, with replacement graft (tissue or synthetic)	3733.00	2	814.63
08365	Penile plication for correction of penile curvature for Peyronie's disease	3733.00	2	814.63

NOTES:
i) Restricted to Urologists.
ii) Circumcision if required is payable in addition at 50%.

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	2225.00	5	511.00
08314	– radical perineal retropubic prostate seminal vesiculectomy	6469.00	7	1412.08

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.

TC81312	Open Simple Retropubic Prostatectomy – Operation only	4270.00	7	1000.00

NOTES:
i) Restricted to Urologists.
ii) Not billable with 08311 or 81311.
iii) Visits billable in addition for post operative are under 08008.

T81322	Cryosurgical ablation of recurrent prostate cancer, unilateral or bilateral	4186.00	7	1000.00

NOTES:
i) Restricted to Urologists.
ii) Reserved for salvage cases following the local recurrence of prostate cancer. Not applicable for primary treatment of prostate cancer.
iii) Includes all necessary biopsy mapping and ultrasound required to complete the procedure.
iv) 00704, 00705, 08684 not paid in addition.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
08318	– radical to include lymphadenectomy	6607.00	7	1442.14
C81305	Laparoscopic radical prostatectomy NOTES: i) Restricted to Urologists. ii) Not paid for repeat prostatectomies done within a period of three months by the same operator, except where radical prostatectomy is subsequently required for cancer.	9744.00	7	2127.12
C81310	Laparoscopic radical prostatectomy, with pelvic lymph node dissection (PLND) NOTE: Restricted to Urologists	11227.00	7	2450.37
S81311	Holmium laser enucleation of prostate (HoLEP) 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.	4443.00	5	970.14
T81313	Green Light Laser Photo Vaporization of the Prostate NOTES: i) Restricted to Urologists. ii) Not paid with 08311 or cystoscopy (00704 or 00705).	2668.00	5	625.00
08317	Anti-incontinence procedure (artificial urinary sphincter)	3612.00	4	788.73
S08319	Balloon dilation of prostate (includes cystoscopy)	1064.00	2	232.40

TESTIS

S08329	Simple orchidectomy - operation only	1136.00	2	306.06
08330	Orchidectomy via inguinal approach	1600.00	2	349.31

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTE: Includes excision of spermatic cord to level of internal inguinal ring.			
T08331	Bilateral orchidectomy in the context of gender-affirming surgery via transcrotal, bilateral inguinal/subinguinal approach	2501.00	2	597.47
	NOTES: i) For MSP approved gender-affirming surgery under Preamble D. 9. 4. Gender Affirming Surgery. ii) Scrotal surgeries (i.e. scrotal skin removal, implants, structures adjacent to the spermatic cord, hydroceles) are payable in addition only if note record is submitted to explain medical rationale. iii) Not billable in addition to 08329, 08330, 08345, 08346, 08323, 08324.			
08322	Orchidopexy - one or two stages	1825.00	2	398.31
S08323	Exploration of scrotal contents - unilateral - operation only	1139.00	2	273.50
08324	Exploration of undescended testicle, without orchidopexy	1228.00	2	307.00
08328	Recurrent undescended testis	2386.00	2	520.76
S08325	Reduction of torsion of testis and spermatic cord, repair - bilateral	1911.00	2	475.23
08326	Ruptured testicle - repair	1906.00	2	511.40
S08327	Biopsy of testis	710.00	2	154.92
08349	Retroperitoneal lymphadenectomy for carcinoma of testis	9553.00	4	2085.41
08354	Retroperitoneal lymphadenectomy for carcinoma of testis, post chemotherapy node dissection only	10868.00	4	2372.17

EPIDIDYMIS

S08340	Abscess, incision, complete care - operation only	916.00	2	199.78
S08341	Spermatocele or hydrocele - excision	1182.00	2	351.89
08342	Epididymectomy - unilateral	1307.00	2	285.39
SA08343	Epididymovasostomy or re-anastomosis of vas - unilateral	3645.00	2	795.64
	NOTE: This item is an insured benefit under the Plan only when a previous vasectomy has not been performed.			
S08344	Vas cannulation - unilateral or bilateral	592.00	2	129.27
S08345	Vasectomy - bilateral - operation only	476.00	2	103.81

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
08346	Varicocele - resection	1837.00	2	400.93
08370	Sub-inguinal Microsurgical Varicocelectomy NOTE: Restricted to Urologists.	4885.00	7	1066.60
08347	Avulsion of penile skin and scrotum - repair	1897.00	2	414.27
08350	Urethro-vesical neck plasty for congenital incontinence	4839.00	4	1056.13
08353	Plastic repair of exstrophy and plastic repair of bladder with skin	6231.00	5	1360.04

DIAGNOSTIC PROCEDURES

S00866	Dynamic cavernosometry and cavernosography NOTE: Includes interpretation of x-ray is included in technical portion and is not billable in addition to procedure.	371.00	2	80.84

DIAGNOSTIC ULTRASOUND

Preamble: Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.

08399	Doppler evaluation of penile blood flow wave from evaluation of dorsal and cavernosal arteries. (Blood pressure recordings and calculation of penile brachial index.) NOTE: The Doppler Vascular listings are applicable to hospital-based, accredited and approved ultrasound vascular studies laboratories only.	222.00		48.50

MINOR PROCEDURES

T04682	Initial Pessary Fitting NOTES: i) Restricted to Obstetrics and Gynecology specialists and Urologists. ii) Not payable with a visit. iii) Not payable if delegated to an allied care provider in a publicly-funded facility. iv) Not payable with 04683.	379.00		101.00

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
T04683	Pessary Maintenance.....	227.00		75.75
	NOTES: i) Restricted to Obstetrics and Gynecology specialists and Urologists. ii) Not payable with a consult or visit. iii) Not payable if delegated to an allied care provider in a publicly-funded facility. iv) Not payable with 04682.			

MISCELLANEOUS

YT08206	Intravesical treatment instillation	135.00	2	32.36
	NOTES: i) Restricted to Urologists. ii) For instillation of intravesical medication treatment (non-chemotherapy). iii) Does not apply to instillation of xylocaine jelly for routine cystoscopy or catheterization. iv) Not billable in addition or 00704, 00705, or 08205. v) This fee is payable once per 7 days per patient.			
YT08339	Intracavernosal penile injection for test dosing	283.00		67.50
	NOTES: i) Restricted to Urologists. ii) Maximum one per day, per patient. iii) Not payable in addition to penile Duplex ultrasound or peripheral nerve block. iv) Injections are only for evaluation/testing of erectile dysfunction response by intracavernosal injection or assessment of Peyronie's disease to determine severity for potential surgical treatment.			

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

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.

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
HEAD AND NECK					
08500	Skull - routine	153.00	42.15	13.89	56.04
08501	Skull - special studies additional	103.00	27.97	9.09	37.06
08503	Paranasal sinuses	103.00	27.97	9.09	37.06
08504	Facial bones - orbit	103.00	27.97	9.09	37.06
08505	Nasal bones	103.00	27.97	9.09	37.06
08506	Mastoids	153.00	42.15	13.89	56.04
08507	Mandible	103.00	27.97	9.09	37.06
08508	Temporo-mandibular joints	103.00	27.97	9.09	37.06
08509	Salivary gland region	103.00	27.97	9.09	37.06
08510	Sialogram	153.00	43.48	14.35	57.83
08511	Eye - for foreign body	103.00	27.97	9.09	37.06
08512	– for foreign body localization - additional	153.00	37.04	18.45	55.49
08513	Dacryocystogram	103.00	27.66	9.00	36.66
08514	Nasopharynx and/or soft tissue, neck - single lateral view	59.70	17.91	6.14	24.05
08515	Laryngogram (excluding procedural fee)	153.00	37.03	18.47	55.50
08518	Pre-MRI view(s) of orbits to rule out metallic foreign body	70.40	19.23	6.25	25.48
UPPER EXTREMITY					
08520	Shoulder girdle	103.00	27.97	9.09	37.06
08521	Humerus	103.00	27.97	9.09	37.06
08522	Elbow	103.00	27.97	9.09	37.06
08523	Forearm	103.00	27.97	9.09	37.06
08524	Wrist	103.00	27.97	9.09	37.06
08525	Hand (any part)	103.00	27.97	9.09	37.06
08526	Special requested views in upper extremity	51.70	13.92	4.77	18.69
LOWER EXTREMITY					
08530	Hip	103.00	27.97	9.09	37.06
08531	Femur	103.00	27.97	9.09	37.06
08532	Knee	103.00	27.97	9.09	37.06
08533	Tibia and fibula	103.00	27.97	9.09	37.06
08534	Ankle	103.00	27.97	9.09	37.06
08535	Foot (any part)	103.00	27.97	9.09	37.06

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
08536	Leg length films - whatever method	118.00	28.18	15.46	43.64
08537	Special requested additional views for lower extremity	51.70	13.92	4.77	18.69

SPINE AND PELVIS

08540	Cervical spine	127.00	33.09	11.27	44.36
08541	Thoracic spine	103.00	27.97	9.09	37.06
08542	Lumbar spine	153.00	42.15	13.89	56.04
08543	Sacrum and coccyx	103.00	27.97	9.09	37.06
08549	Spine - requested additional views (flexion, bending views, etc.) NOTE: Fee item 08549 is not intended to cover normal oblique projections.	96.20	25.81	9.09	34.90
08544	Pelvis	103.00	27.97	9.09	37.06
08545	Sacro-iliac joints	103.00	27.97	9.09	37.06
08546	Scoliosis films - single AP or lateral - 14 x 36 film taken at 6 feet	135.00	33.59	14.91	48.50
08547	Pelvis and additional requested views, i.e. sacroiliac joints, hip, etc.	126.00	33.09	11.27	44.36
08548	Myelogram and/or posterior fossa positive contrast (excluding procedural fee)	307.00	67.56	42.21	109.77

CHEST

08550	Thoracic viscera	105.00	27.77	9.00	36.77
08551	Thoracic inlet	105.00	27.77	9.00	36.77
08552	– additional requested views	51.70	13.92	4.77	18.69
08553	Fluoroscopy, when requested	51.70	12.72	6.10	18.82
08554	Ribs - one side	103.00	27.97	9.09	37.06
08555	– both sides	153.00	42.15	13.89	56.04
08556	Sternum or sterno - clavicular joints	103.00	27.97	9.09	37.06
08557	Sternum and sterno - clavicular joints	153.00	42.15	13.89	56.04

ABDOMEN

08570	Abdomen	103.00	27.97	9.09	37.06
08571	Abdomen, multiple views	153.00	42.15	13.89	56.04

GASTRO-INTESTINAL TRACTS

08572	Esophagus, only	183.00	45.48	17.72	63.20

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
08573	Esophagus, stomach and duodenum	253.00	61.64	28.63	90.27
08574	Small bowel	259.00	70.67	19.60	90.27
08576	Colon or double contrast air studies	265.00	63.03	38.72	101.75
08577	Hypotonic duodenography	259.00	67.66	22.61	90.27
08578	Pancreatography (excluding procedural fee)	153.00	41.91	13.33	55.24
08579	Glucagon assisted contrast study (in addition to routine fee)	111.00	32.29	7.42	39.71

GALL BLADDER

08581	Intravenous cholangiogram	237.00	56.83	23.30	80.13
08582	Operative cholangiogram (transhepatic also)	173.00	42.37	17.88	60.25
08583	Direct post-operative cholangiogram or pyelogram	183.00	38.79	26.18	64.97
08584	Removal of biliary calculi by Burhenne technique or equivalent including necessary cholangiogram and fluoroscopy (excluding procedural fee)	191.00	50.73	17.12	67.85

GENITO-URINARY SYSTEM

08590	K.U.B	103.00	27.97	9.09	37.06
08591	Pyelogram - intravenous	259.00	62.56	20.92	83.48
08593	Pyelogram - retrograde or antegrade	153.00	41.74	13.75	55.49
08594	Intravenous pyelogram with voiding cystourethrogram	313.00	79.93	29.84	109.77
08595	Cystogram or retrogradeurethrogram (not including catheterization)	153.00	41.74	13.75	55.49
08596	Hysterosalpingogram (excluding injection)	259.00	67.66	22.61	90.27
08597	Pelvimetry	208.00	55.56	21.02	76.58
08599	Voiding cystourethrogram	259.00	62.27	29.44	91.71

		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				45.15
	NOTES:				
	i) Applicable to the following indications only: complicated oesophageal motility, aspiration, abnormal swallowing, dysphagia or webs.				
	ii) A note record of the indication is required.				
08601	Radiographic study of sinus, fistula, etc. with contrast media, including injection and fluoroscopy, if necessary	192.00	38.58	31.18	69.76
08602	Body section radiography - Applies to all tomographic procedures (including polytomography when done in one plane-per plane series, including orthopantogram)	147.00	38.26	14.60	52.86
08603	Bone age - whatever method.....	106.00	27.96	10.88	38.84
08604	Bone survey - first anatomical area.....	103.00	27.97	9.09	37.06
08605	– each subsequent anatomical area.....	51.70	13.92	4.77	18.69
08606	Arthrogram - shoulder (excluding injection of contrast).....	111.00	28.16	11.89	40.05
08607	hip (excluding injection of contrast).....	103.00	27.84	9.00	36.84
08608	knee (excluding injection of contrast).....	231.00	59.64	19.40	79.04
08609	ankle (excluding injection of contrast)....	103.00	27.84	9.00	36.84
08631	wrist (excluding injection of contrast).....	95.70	27.84	9.00	36.84
08637	elbow (excluding injection of contrast)...	95.70	27.84	9.00	36.84
08610	Mammography - unilateral	270.00	81.07	28.67	109.74
08611	– bilateral.....	378.00	115.75	38.07	153.82
	NOTES:				
	i) Indications for Unilateral Mammograms				
	a) New symptoms within one year of a previous bilateral mammogram.				
	b) Work-up of an abnormal screening mammography.				

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
	c) Short-term follow-up of an abnormality, within one year of a previous bilateral mammogram. d) Follow-up of surgery/radiotherapy, within one year of a previous bilateral mammogram. e) Absence of other breast. f) Visualization for fine wire localization or stereotactic biopsy. ii) All other requests for mammograms should be bilateral. However, there may be instances where a bilateral mammogram is requested inappropriately and is converted to a unilateral mammogram.				
08615	Cerebral angiography - unilateral	398.00	100.28	42.62	142.90
08616	– bilateral	687.00	160.41	84.80	245.21
08617	Peripheral angiography (arteriography and venography) - unilateral.....	206.00	55.82	18.15	73.97
08618	– bilateral	313.00	83.29	26.99	110.28
08620	Aortography (aortography plus peripheral angiography)	536.00	142.23	47.77	190.00

The entry "Thoracic or abdominal angiogram" is intended to include the following:

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

		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	425.00	106.42	38.78	145.20
08627	– using multiple sequential views - selective	398.00	100.28	42.62	142.90
*08628	Interpretation of submitted films - per examination 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.	144.00	0.54	53.58	54.12
*08629	Radiologist performing fluoroscopy for various clinical procedures 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.	106.00	18.92	23.94	42.86
*08630	Percutaneous transluminal angioplasty	913.00	316.98	18.73	335.71

RADIOLOGY ASSISTANT FEE

*08632	Radiology assistant fee - first hour or fraction thereof	313.00	1.17	117.31	118.48

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
*08633	– each 15 minutes or fraction thereof after one hour.....	88.80	0.29	29.36	29.65

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	198.00	53.75	18.91	72.66
08689	Bone density - second area.....	139.00	30.80	18.90	49.70
08696	Bone density - whole body	357.00	90.59	40.24	130.83

NOTES:

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

ii) Altering patient care requires one of the following:
a) prescribing bisphosphonates (i.e. Fosamax)
b) weaning patient off glucocortico-steroids (i.e. prednisone)
c) adequate ongoing monitoring (in cases of primary hyperpara-thyroidism)

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)

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

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	153.00	0.48	47.74	48.22
*08691	– with contrast	224.00	0.67	66.57	67.24
*08692	– double scan or 2 planes	285.00	0.86	85.97	86.83

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
*08693	Body scan - one region without contrast	319.00	0.95	95.26	96.21
*08694	– one region with contrast	348.00	1.05	105.30	106.35
*08695	– double scan or 2 regions	470.00	1.44	143.94	145.38
P83095	– additional body region	12.65			5.00

NOTES:

i) Payable in addition to 08695 up to a maximum of seven claims, for each additional body region beyond those body regions counted in the associated 08695 claim.

ii) Eligible body regions include:
   a) neck
   b) chest
   c) abdomen
   d) pelvis
   e) cervical spine
   f) thoracic spine
   g) lumbar spine
   h) upper extremity (maximum of 1)
   i) lower extremity (maximum of 1)

83090	Cardiac CT/CT Coronary Angiography, professional fee	443.00	1.77	176.84	178.61

NOTES:

i) Paid once daily per patient.

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

(notes continued on next page)

	Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)

iii) Includes supervision of oral beta blockers and/or IV injection.
iv) Paid only for a minimum of a 64-detector CT scanner.
v) Restricted to Radiologists with a minimum of Level 2 CCTA; or other duly qualified Specialists with a minimum of Level 2 CCTA who also meet the American College of Radiology standards of competency in Performing and Interpreting Diagnostic Computed Tomography, and Performance of (Adult) Thoracic Computed Tomography.
vi) Paid only for the following indications:
    a) Diagnosis of obstructive CAD in symptomatic patients with an intermediate pre-test likelihood of CAD; or symptomatic patients with equivocal/inclusive stress test results.
    b) Assessment of patency or course of coronary bypass grafts.
    c) Exclusion of obstructive CAD in low risk patients who require invasive coronary angiography.
    d) Identification or definition of the course of anomalous coronary arteries.
    e) Assessment of LV or RV size, volume, and function when alternative imaging modalities are unavailable or inconclusive.

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
	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) ..... 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.	161.00	0.65	64.62	65.27

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
	iv) Rural FP's (in RSA communities) can refer patients for this procedure in communities where a specialist referral is not available. v) Paid on out-patients only. vi) Paid in addition to 08695, same patient, same day. vii) Maximum one per patient per day.				

INTERVENTIONAL RADIOLOGY

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

83000	Interventional Radiology Consultation – to include pertinent patient history, regional physical examination, review of laboratory and radiological findings and generation of a written report	249.00			108.94
	NOTES: i) Payable only to physicians with appropriate training in interventional radiology. ii) Must be initiated by written request by another physician. iii) Payable only when patient is referred for an interventional radiological procedure which requires extensive discussion and review of all available data. iv) Includes all patient visits necessary. v) Repeat consultation not applicable for same condition same patient within 6 months.				

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
	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.				
T10923	Adrenal Vein Sampling NOTES: i) Ultrasound guided vessel puncture, vessel catheterization, angiography, and interpretation are included in the fee. ii) Payable once per day, per patient, regardless of the number of catheterizations performed.	1645.00			650.00

		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.....	249.00		108.94
	NOTES: i) Payable only to physicians with appropriate training in interventional radiology. ii) Must be initiated by written request by another physician.			

(notes continued on next page)

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

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.

THERAPEUTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

10901	Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery.....	1741.00	2	621.60

NOTES:
i) Includes any medically necessary angiographies, any necessary imaging, all necessary catheter repositioning and ongoing assessment and care throughout the patient's active treatment phase.
ii) Payable at 100% for the first 12 hours of care and 50% for each additional 12 hours of care, up to 36 hours.
iii) Start and end times must be entered in both the billing claims and the patient's chart.

10902	Complex peripherally inserted image-guided central venous catheter line (PICC)	340.00	2	136.07

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

10323	Simple peripherally inserted image-guided central venous catheter line (PICC)	213.00		84.36

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	NOTES: i) Not applicable if performed via other than peripheral access. ii) Includes placement and medically required ultrasound image guidance. iii) May not be delegated.			
10903	Percutaneous hemodialysis graft thrombolysis.....	1741.00	2	621.60
	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).....	1741.00	3	621.60
	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.....	3965.00	5	1383.23
	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	1157.00	4	384.81
10907	each additional level (to a maximum of 3)	271.00	4	88.82
	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.			

	Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10908 Percutaneous image-guided tumour ablation – first lesion	1741.00	3	558.91

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	1157.00	3	414.41

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)	1157.00	2	414.41

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	1157.00	2	414.41

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%.

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10913	Cerebral arterial balloon occlusion tolerance test	2082.00	5	842.15
	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;			
10914	Percutaneous balloon angioplasty for cerebral vasospasm.....	2675.00	9	1082.41
	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.			
10915	Endovascular obliteration of aneurysms using Guglielmi detachable coil (GDC) technique	5203.00	7	2105.39

(see notes on next page)

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

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.

10916	Complex diagnostic neuroangiography for the assessment of complex vascular tumours or vascular malformations - up to 4 hours procedural time	3747.00	5	1238.45
10917	– after 4 hours (extra to 10916)	769.00		309.63

NOTES:

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

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
10918	Percutaneous sclerotherapy of head and neck vascular lesions under fluoroscopic guidance.....	1224.00	6	495.40

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

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

10919	Intravascular stent placement - extra.....	373.00		136.59

NOTES:
i) Includes all diagnostic imaging associated with stent placement.
ii) Payable when follows angioplasty procedure (S00982) where stent is not initially deployed.
iii) For non-Vascular surgery, placement of second stent in 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

	Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
Lower extremity vessels			
Anterior tibial artery			
Posterior tibial artery			
Peroneal artery			
Tibioperoneal trunk			
Right common femoral artery			
Right superficial femoral artery			
Right profunda femoral artery			
Right popliteal artery			
Left common femoral artery			
Left superficial femoral artery			
Left profunda femoral artery			
Left popliteal artery			
Intra-abdominal vessels			
Abdominal aorta			
Celiac axis			
Hepatic artery			
Splenic artery			
Superior mesenteric artery			
Inferior mesenteric artery			
Right common iliac artery			
Right external iliac artery			
Right internal iliac artery			
Left common iliac artery			
Left external iliac artery			
Left internal iliac artery			
Right renal artery			
Left renal artery			
Thoracic vessels			
Ascending thoracic aorta			
Transverse thoracic aorta			
Descending thoracic aorta			
Brachiocephalic artery			
Right common carotid artery			
Right subclavian artery			
Right vertebral artery			
Left common carotid artery			
Left subclavian artery			
Left vertebral artery			

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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 NOTES: Includes all diagnostic imaging associated with stent placement. i) Includes all associated tract dilation(s). ii) Second procedure same day payable at 50% iii) Removal of stent within 6 months of insertion payable at 50%. iv) 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. v) Placement of second stent in non-contiguous site payable at 50%.	373.00		136.59
10921	Transjugular Intrahepatic Porto-systemic shunt (TIPS) 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.	3650.00	8	1173.73
10922	Embolization in the management of Epistaxis without vascular lesion or tumour	1721.00	3	662.11

(see notes on next page)

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

NOTES:

i) Includes the procedure performed, preparation of the embolic agent(s), catheter(s), catheterization(s), and follow-up care of the patient by the radiologist.

ii) Billable only by physicians with appropriate training in interventional radiology.

iii) Payable once per day regardless of the number of embolizations or catheterizations performed, or balloons inserted.

iv) 10922 include:

a) Diagnostic angiograms done during the procedure.

b) Angiograms performed as a separate procedure before or after the embolization are billable.

c) Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted embolization procedure. each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of $1,700. Claims must be accompanied by written details of vessels injected.

d) Repeat procedures performed by the same physician and done within 30 days of the original procedure will be paid at 75% of the original fee.

v) Includes 10913 if performed on same day.

S00978	Percutaneous nephrostomy - procedural fee.....	784.00	2	317.46
S00979	Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation - procedural fee	1046.00	2	423.19
S00980	Transhepatic biliary drainage procedure (includes fee item S00857)	1108.00	3	448.48
S00981	Therapeutic radiological embolization	1108.00	3	448.48
S00982	Percutaneous transluminal angioplasty	1057.00	2	427.50

(see notes on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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	722.00	2	292.00
00995	Embolization of brain and spinal cord AVM's.....	6144.00	3	2212.12
	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	4224.00	3	1383.23
	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	5211.00	3	1705.91
	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.			

(notes continued on next page)

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	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.			
10900	Abdominal aortic aneurysm repair using endovascular stent graft – second operator	2871.00		521.36
	NOTES:			
	i) Intraoperative renal artery angioplasty payable in addition at 50% of fee item 00982 when done.			
	ii) Intravascular stent placement – extra (10919) paid in addition under 10919 at 100%.			
	iii) This fee will not be paid to the primary operator.			

CARDIO-VASCULAR PROCEDURES

S00880	Portal pressures - hepatic vein wedge pressure - by duly qualified specialist.....	293.00		69.46
S00881	– percutaneous splenic portal pressure	242.00	2	55.60

BREAST

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

Incision

70041	Fine needle aspiration of solid or cystic lesion – operation only.....	213.00	2	50.81
70042	– each additional cyst or lesion (maximum of 3) – operation only.....	54.10	2	12.73

		Non-MSP-Insured Fee ($)	Anes. Lev.	MSP & WSBC Fee ($)
	Stereotactic or ultrasound-guided core needle biopsy:			
70472	– 1 to 5 core samples – operation only	399.00	2	95.81
70473	– 6 to 10 core samples – operation only	566.00	2	135.28
	Post biopsy marker			
83045	Post biopsy radiological marker (clip) placement	407.00		158.14
	NOTES: i) Restricted to Radiologists who work at approved Community Imaging Clinics only. ii) Paid only in addition to 86047; or 86048 when combined with 86047. iii) Maximum two clips per patient per day, either unilateral or bilateral.			
	Digital Breast Tomosynthesis Includes detailed diagnostic workup of an abnormality requiring follow-up (from previous breast imaging studies).			
T83046	– Unilateral	108.00		50.50
T83047	– Bilateral	159.00		74.30
	NOTES: i) Restricted to Radiologists. ii) 83046 payable only in addition to 08610 or 08611 on the same date of service. iii) 83047 payable only in addition to 08611 on the same date of service. iv) Limited to one claim of either 83046 or 83047 per patient per day.			

DIAGNOSTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

S00868	Percutaneous gastrostomy/gastrojejunostomy - procedural fee	1258.00	2	291.74

MAGNETIC RESONANCE IMAGING

08697	Standard 2-sequence or 2-plane study	1014.00		
08698	– additional sequences or planes	421.00		

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.

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.

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
HEAD AND NECK					
A08480	Transcranial Doppler…….	158.00			
08641	Ophthalmic B-scan (immersion and contact)…	298.00	59.97	46.20	106.17
	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……..	198.00	39.33	32.82	72.15
	NOTE: To include thyroid, parathyroid, parotid and submandibular glands.				
08659	B-scan of brain	309.00	64.28	46.16	110.44
HEART					
08638	Echocardiography – real time……..	325.00	61.25	42.91	104.16
08644	Ultrasonic guidance for pericardio-centesis…..	323.00	73.41	42.62	116.03
THORAX					
08645	B-scan	253.00	58.09	32.86	90.95
08646	Ultrasonic guidance for thoracentesis.....	292.00	72.58	32.88	105.46
	Breast Sonogram:				
86047	– unilateral	184.00	45.46	28.99	74.45
86048	– additional side	92.20	22.93	14.62	37.55
	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.				

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
	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	323.00	69.36	46.16	115.52
08649	Renal B-scan NOTE: 08649 not chargeable when done in conjunction with 08648 and/or 08653.	298.00	58.09	32.86	90.95
08650	Ultrasonic guidance for biopsy or cyst puncture	319.00	87.43	46.10	133.53
08684	Prostate scan using rectal probe	323.00	69.34	46.16	115.50
OBSTETRICS AND GYNECOLOGY					
08655	Obstetrical B-scan under 14 weeks gestation	250.00	54.18	32.87	87.05
08651	Obstetrical B-scan - 14 weeks gestation or over 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.	309.00	69.87	46.16	116.03
86051	Obstetrical B scan (14 weeks gestation or over) (for multiples – each additional fetus)	264.00	47.08	39.26	86.34
86055	Obstetrical B scan less than 14 weeks with Nuchal Translucency measurement (for singles)	404.00	78.46	55.37	133.83

(see notes on next page)

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
	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. v) Women pregnant following invitro fertilization with intracytoplasmatic sperm injection.				
86056	Obstetrical B scan less than 14 weeks with Nuchal Translucency measurement (for multiples – each additional fetus)	356.00	56.83	43.54	100.37
08652	B-scan I.U.D. localization	165.00	34.99	23.04	58.03
08653	Pelvic B-scan (male or female) to include uterus, ovaries, testes and ovarian/scrotal Doppler.....	323.00	69.34	46.16	115.50
	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	323.00	72.31	43.83	116.14

EXTREMITIES

08658	Extremity B-scan	174.00	39.35	23.20	62.55

(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	359.00	92.80	35.78	128.58
	Peripheral Arterial:				
08664	Resting arterial assessment - To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index NOTE: Not chargeable when done in conjunction with 08665 or 08666.	183.00	49.87	11.68	61.55
08665	Treadmill stress examination with or without ECG monitoring - To include sequential post stress measurement and calculations - with monitoring physician present	319.00	62.34	46.78	109.12
08666	– without monitoring physician present	211.00	62.15	11.67	73.82
08668	Vasospastic assessment - To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis	211.00	62.15	11.67	73.82

		Non-MSP-Insured Fee ($)	MSP and WSBC A Tech Fee ($)	B Prof Fee ($)	C Total Fee ($)
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 ..... NOTE: 08669 not chargeable when done in conjunction with 08668.	132.00	33.29	11.67	44.96
	Peripheral Venous:				
08670	Diagnostic facility assessment for deep venous system	132.00	34.83	12.22	47.05
	Heart:				
08662	Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis ..... 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.	789.00	136.90	102.86	239.76
08679	Doppler echocardiography	148.00	29.10	18.68	47.78
	Extracranial:				
	Carotid imaging: To include delineation of extra cranial vessels on both sides of the neck:				
08676	– Duplex scanning of neck vessels to include Doppler flow assessment	325.00	92.64	35.77	128.41
08677	Periorbital assessments, either oculoplethysmography (OPG) or photoplethysmography (PPG) and/or Doppler directional determination with extracranial artery compression manoeuvres	132.00	34.83	12.22	47.05
08678	Subclavian or vertebral assessment, including assessment of subclavian steal - To include directional Doppler determination of flow direction in vertebral arteries with or without arm compression and other manoeuvres	184.00	51.72	12.73	64.45

PALLIATIVE MEDICINE

Complete understanding of the following paragraphs is essential to appropriate billing of the palliative medicine fees. Not payable to physicians for services when working under salary, service contract, or sessional arrangement.

PREAMBLE

These listings are applicable for referred services to a palliative medicine physician.

Palliative medicine fees do not apply when unexpected death occurs after prolonged Hospitalization for another diagnosis unrelated to the cause of death.

The palliative medicine fees are comprehensive time-based fees.

- Applicable only for palliative care patients and diagnostic code V66.7 must be submitted on the claim.
- Start and end times are for direct face-to-face time with the patient and include all services provided within those times.
- Travel time is not billable in addition.
- Documentation which occurs outside of the direct face-to-face times is not billable in addition and is compensated through the rate set for the palliative medicine fees.

When a referral from a physician is not available, referrals from a registered nurse for specialist palliative care can be accepted by indicating the practitioner number of the requesting nurse in the "referred by" field when submitting claims. For registered nurses not registered with MSP, use practitioner number 99987. The name of the referring registered nurse should be documented in the note field of the claim and in the patient's clinical record.

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

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
REFERRED CASES			
P43000	**Consultation:** To consist of examination, review of history, laboratory and imaging findings, and written report – per 15 minutes, or greater portion thereof.....	195.00	75.75
	NOTES: i) Paid to a maximum of 6 units. ii) Start and end times must be included with the claim and documented in the patient chart. iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.		

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	Consultation in patient's home: To consist of examination, review of history, laboratory and imaging findings, and written report		
P43100	– First 15 minutes or greater portion thereof	421.80	175.75
P43101	– Each additional 15 minutes or greater portion thereof (extra).....	195.00	75.75
	NOTE: i) Paid to a maximum of 6 units (43100 and 43101 combined). ii) Start and end times must be included with the claim and documented in the patient chart. iii) Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement. See Palliative Medicine preamble. iv) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.		
	Continuing care by consultant:		
P43001	Subsequent office visit – per 15 minutes, or greater portion thereof.....	131.00	50.50
	NOTES: i) Paid to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum. ii) Start and end times must be included with the claim and documented in the patient chart. iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.		
P43002	Subsequent hospital or facility visit – per 15 minutes, or greater portion thereof.....	131.00	50.50
	NOTES: i) Paid to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum. ii) Start and end times must be included with the claim and documented in the patient chart. iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.		

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
	Subsequent visit in patient's home		
P43200	– First 15 minutes or greater portion thereof.....	361.20	150.50
P43201	– Each additional 15 minutes or greater portion thereof (extra)	195.00	50.50

NOTES:

i) Paid to a maximum of 4 units (43200 and 43201 combined).
Submit an explanatory note record for additional units claimed beyond the maximum.

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

iii) Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement.
See Palliative Medicine preamble.

iv) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Complex End-of-life Visits

	Complex end-of-life visit in hospital or facility (extra)		
P43006	– Per 15 minutes, or greater portion thereof	195.00	75.74

NOTES:

i) Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient's family, notifying other healthcare providers or services.

ii) Payable only in addition to 43002.

iii) Paid once per patient to a maximum of 2 units.
Submit an explanatory note record for additional units claimed beyond the maximum.

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

v) Not payable in addition to out-of-office-hours premiums.

vi) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

	Complex end-of-life visit in patient's home (extra)		
P43007	– Per 15 minutes, or greater portion thereof	195.00	75.75

NOTES:

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

i) Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient's family, notifying other healthcare providers or services.
ii) Payable only in addition to 43200 and 43201.
iii) Paid once per patient to a maximum of 4 units. Submit an explanatory note record for additional units claimed beyond the maximum.
iv) Start and end times must be included with the claim and documented in the patient chart.
v) Not payable in addition to out-of-office-hours premiums.
vi) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

Telehealth Service:

P43010	Telehealth Consultation: To consist of examination, review of history, laboratory and imaging findings, and written report – per 15 minutes, or greater portion thereof.....	195.00	75.75

NOTES:
i) Paid to a maximum of 6 units.
ii) Start and end times must be included with the claim and documented in the patient chart.
iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

P43011	Telehealth subsequent office or home visit – per 15 minutes, or greater portion thereof.....	131.00	50.50

NOTES:
i) Paid to a maximum of 2 units.
ii) Start and end times must be included with the claim and documented in the patient chart. Submit an explanatory note record for additional units claimed beyond the maximum.
iii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

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

MISCELLANEOUS

P43008	First palliative hospital or facility visit of the day bonus (extra) ..... NOTES: i) Paid only if 43002 paid the same day. ii) Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended. iii) Not payable same day for same physician as 13338 or 13339.	240.00	100.00
P43009	First palliative home visit of the day bonus (extra) .... NOTES: i) Paid only if 43200 paid the same day. ii) Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended. iii) Not payable same day for same physician as 13338 or 13339.	480.00	200.00
P43003	Palliative hospital or facility admission examination – per 15 minutes, or greater portion thereof..... NOTES: i) Paid to a maximum of 6 units. Submit an explanatory note record for additional units claimed beyond the maximum. ii) Start and end times must be included with the claim and documented in the patient chart. Start and end times must not be concurrent with another service. iii) Not payable with consultation or visit (43000, 43001, 43002, 43010, 43011, 43100, 43200 or 43201). iv) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.	195.00	80.00
P43004	Palliative Family Conference (planning for patient) – per 15 minutes, or greater portion thereof..... NOTES: i) Restricted to Palliative Medicine.	195.00	75.75

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

ii) Paid to a maximum of 4 units per patient, per sitting. Submit an explanatory note record for additional units claimed beyond the maximum.
iii) Annual maximum of 12 units per patient.
iv) Start and end times must be included with the claim and documented in the patient chart. Start and end times must not be concurrent with another service.
v) One of more family members/representatives must be present.
vi) Service may be provided face-to-face, telephone, or video technology.
vii) The results of the conference, as well as the names and roles of those who participated in the meeting must be documented in the patients chart, and result communicated to the Family Physician, Specialist and/or appropriate Allied Care Provider involved in the care of the patient.
viii) Visit paid in addition, if medically required and does not take place concurrently with the conference.
ix) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

P43005 Palliative Interdisciplinary Conference with Allied Care Provider and/or Physician – per 15 minutes, or greater portion thereof..... 195.00 75.75

NOTES:
i) Restricted to Palliative Medicine.
ii) Paid to a maximum of 2 units per sitting. Submit an explanatory note record for additional units claimed beyond the maximum.
iii) Start and end times must be included with the claim and documented in the patient chart. Start and end times must not be concurrent with another service.
iv) Service may be provided face-to-face, telephone or video technology.
v) Payable for two-way collaborative conferencing with another physician and/or an allied care provider.
vi) Details of care conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and

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

information on clinical discussion and decisions made.

vii) Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.

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.

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
CONSULTATIONS AND VISITS			
94010	**Consultation:** To consist of examination, review of history and laboratory findings with a written report	340.00	170.17
94012	**Repeat or Limited Consultation:** 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	190.00	94.56
	Continuing Care by Consultant:		
94006	Directive care.....	75.10	35.96
94007	Subsequent office visit.....	75.10	36.76
94008	Subsequent hospital visit.....	75.10	36.64
94009	Subsequent home visit	150.00	73.05
94005	Emergency visit when specially called (not paid in addition to out-of-office hour charges) ..... NOTE**:** Claim must state time service rendered.	303.00	145.93
Telehealth Service with Direct Interactive Video Link with the Patient			
94070	**Telehealth Consultation:** To consist of examination, review of history and laboratory findings with a written report.....	340.00	170.17
94072	**Telehealth repeat or Limited Consultation:** Where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where, in the judgment of the consultant, the consultative service does not warrant a full consultative fee	190.00	94.56
94076	Telehealth directive care	75.10	35.96

		Non-MSP-Insured Fee ($)	MSP & WSBC Fee ($)
94077	Telehealth subsequent office visit	75.10	36.76
94078	Telehealth subsequent hospital visit	75.10	36.64
	The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:		
93120	E.C.G. tracing, without interpretation, (technical fee)	49.10	17.38

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 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* ($)
CONSULTATIONS		
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	188.00
– Multiple or complex specimens (Category VI specimens)	A94505	379.00
Intra-operative Consultation:		
Operative consult with or without frozen section - first	A94500	236.00
– each additional (no limit)	A94502	74.10

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).

	Code	Non-MSP-Insured Fee* ($)
AUTOPSY		
Autopsy - complete	A94506	1442.00
Autopsy - partial	A94508	436.00
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	18.45
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	56.00
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	71.60
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;		

(notes continued on next page)

	Code	Non-MSP-Insured Fee* ($)
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; fissure/fistula in ano; foreskin - other than newborn; gall bladder; ganglion cyst; heart valve; hematoma; hemorrhoids; hydatid of Morgagni; material passed per vaginum or other orifice; mucocele - salivary; neuroma - Mortons/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.).		
Category IV - Small specimens for diagnosis ..... 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).	A94516	135.00
Category V - Complex biopsies or small whole organs....	A94518	188.00

(see notes on next page)

	Code	Non-MSP-Insured Fee* ($)
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; 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.		
Category VI - Large complex organ requiring extensive gross dissection and microscopic assessment	A94520	379.00
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.		

	Code	Non-MSP-Insured Prof. Fee ($)	Non-MSP-Insured Total Fee ($)
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	65.30
Screening by immunoassay for drug class without identification/quantitation	A94572	15.06	65.30
Screening by gas chromatography (GC) for drug class (acidic drugs) with identification but not quantitation	A94574	15.06	88.20
Screening by gas chromatography (GC) for drug class (basic drugs) with identification but not quantitation	A94576	15.06	88.20
Screening by thin layer chromatography for drug class(es) with identification but not quantitation	A94578	15.06	198.00
Drug identification and/or quantitation by Gas Chromatography Mass Spectrometry (GCMS) (applies primarily to basic drugs)	A94580	15.06	153.00
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	305.00
Comprehensive drug screen (includes screening by GC and radioimmunoassay and drug identification/quantitation by GCMS (applies primarily to basic drugs)	A94584	15.06	337.00
Ethanol	A94586	15.06	90.10
Carbon monoxide	A94588	15.06	189.00

NUCLEAR MEDICINE PROCEDURES

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.

NUCLEAR MEDICINE PREAMBLE

1. A separate fee item for SPECT is not required, since SPECT is included in the scan fee when performed. Fee item 09877 (repeat of major scan) should not be billed for SPECT.

2. When medically necessary, the following items are billable with Nuclear Medicine Listings. A note record is required:

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:

a) 09824 - Testicular imaging - isolated procedure.

b) 09834 - Bone scan (only for indications listed under this fee item).

c) 95045 - RBC (Red Blood Cell) liver scan.

6. When it is medically necessary to perform an aspiration in addition to a Nuclear Medicine scan, it is appropriate to bill the applicable joint aspiration fee (e.g.: 00757). A note record is required.

7. Fee item 09877 (Repeat of major scan - 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:

a) 09806 Parathyroid imaging
b) 09807 MIBG imaging (I131 - metaiodobenzyl-guanidine)
c) 09817 Receptor imaging
d) 09826 Tumour imaging
e) 09829 Adrenal imaging
f) 09844 Red cell survival study
g) 09854 Thallium myocardial scan
h) 09867 Brain scan, static
i) 09869 Pancreas scan, static
j) 09886 Cisternography
k) 95015 Iodine 131 - whole body scan
l) 95053 Thallium Body Imaging
m) 95055 Renal imaging with pharmaceuticals (isolated procedure)
n) 95060 Renal imaging without pharmaceuticals (isolated procedure)
o) 95065 White blood cell labeled with radioisotope (if views are performed on separate days or 24 hours apart)
p) 09834 Bone scan (only if 24 hour views are performed)
q) 09878 Liver clearance of HIDA (biliary scan) (if 24 hour views are performed)
r) 95025 Liver clearance of HIDA with pharmaceutical (if 24 hour views are performed).

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

	Code	Non-MSP-Insured Fee ($)	MSP and WSBC Prof. Fee ($)	MSP and WSBC Total Fee ($)
SCANNING AND LOCALIZATION PROCEDURES				
Adrenal imaging (isolated procedure)	09829	1227.00	66.97	456.02
Blood pool joint scan	09832	434.00	36.19	169.89
NOTE: Not payable with joint scan.				
Bone marrow scan	09833	448.00	41.58	174.93
Bone scan	09834	641.00	67.59	240.42
NOTES: i) Includes SPECT. ii) Fee item 09866 is the only Nuclear Medicine listing payable in addition to a bone scan and is payable only in cases of suspected infection or trauma, possible osteomyelitis, evaluation of reflex sympathetic dystrophy, heterotopic ossification, arthropathy, avascular necrosis, metabolic bone disease, primary bone tumours and insufficiency and stress fractures. Note record indicating reason required when billing 09866 in addition to bone scan.				
Brain scan - regional cerebral blood flow (isolated procedure)	09871	938.00	135.91	367.91
Brain scan, static	09867	538.00	55.10	210.46
Carbon-14 glycinecholate breath analysis	09805	323.00	29.40	119.94
Cardiac first pass	95000	250.00	27.39	93.15
NOTE: Not paid with 95005.				
Cardiac scan, static	09864	419.00	41.79	190.80
Cardiac shunt	95005	270.00	27.55	105.40
NOTE: Not paid with 95000.				
Cisternography	09886	893.00	86.73	349.33
CNS shunt	09813	458.00	39.20	179.63
Coronary perfusion with radio particles, per radionuclide	09898	535.00	72.02	202.39
Coronary administration of radio particles, transcatheter	09897	80.50	0.00	29.40

	Code	Non-MSP-Insured Fee ($)	MSP and WSBC Prof. Fee ($)	MSP and WSBC Total Fee ($)
Esophageal motility - utilizing an orally administered radioisotope	09802	538.00	46.24	210.74
Gallium scan	09838	785.00	69.52	289.31
– each repeat with no additional radionuclide	09839	269.00	20.13	104.91
NOTE: 09877 not payable same day.				
Gastric emptying (liquid)	09879	747.00	37.89	292.59
Gastric emptying (solid)	09808	694.00	36.99	271.53
NOTE: If both liquid and solid phases are performed on the same day, charge 09877 for the second test.				
Gastro-esophageal reflux	09895	694.00	36.99	255.09
NOTE: Not payable with fee items 09808 or 09879.				
Gastro-intestinal blood loss study	09859	326.00	28.87	122.33
Gastro-intestinal protein loss study	09858	419.00	41.79	156.35
GFR (In-Vitro)	09848	332.00	29.26	130.23
GI bleeding - red cell label	09804	879.00	74.55	343.84
NOTE: 09859 and 95045 are not payable with 09804.				
Iodine - 131 whole body scan	95015	666.00	68.72	247.49
Joint scan	95020	666.00	68.72	247.49
NOTE: Not payable with blood pool joint scan.				
Lacrimal duct scan	09814	386.00	30.51	151.28
Liver clearance of HIDA (biliary scan)	09878	743.00	71.19	276.47
NOTE: Included in 95025 when performed same day.				
Liver clearance of HIDA with pharmaceutical	95025	1098.00	106.67	406.70
Liver scan, static	09850	450.00	41.28	168.34
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	624.00	68.50	232.39
Lumbar administration of radionuclide	09896	86.60	0.00	33.86
Lung quantification	95030	672.00	68.89	262.67
NOTES: i) Fee item 95030 not payable with 09868. ii) 09855 payable in addition only if both ventilation and perfusion are quantified. iii) Provide details in note record if billing associated procedures on same day.				

	Code	Non-MSP-Insured Fee ($)	MSP and WSBC Prof. Fee ($)	MSP and WSBC Total Fee ($)
Lung scan, static	09868	624.00	68.48	232.16
NOTE: Fee item 09866 not to be billed in addition to this item.				
Lymphoscintigraphy (isolated procedure)	09816	780.00	40.87	311.44
Meckel's localization (ectopic gastric mucosa)	09853	891.00	83.16	348.84
MIBG imaging (I131-metaiodobenzyl-guanidine)	09807	2529.00	129.63	989.34
Ocular tumour localization	09870	504.00	68.77	189.92
Pancreas scan, static	09869	809.00	81.37	303.58
Parathyroid imaging	09806	1081.00	92.87	423.02
Perfusion study (dynamic scan), regional or organ - when done alone	09865	333.00	27.76	122.77
Perfusion study (dynamic scan), regional or organ - in addition to major scan	09866	127.00	13.73	46.66
Plasma volume (with plasma label), total blood volume, and red-cell mass by calculation	09835	99.30	5.81	36.97
Platelet survival	09849	828.00	88.64	312.47
Radioiron:				
– clearance	09840	419.00	43.61	156.57
– turnover	09841	402.00	42.49	152.46
– red cell utilization	09842	419.00	41.79	156.35
– combined study at one time of above three	09843	810.00	84.98	304.05
Radionuclide cardiac ventriculography	09863	724.00	76.82	269.21
– with stress	95040	1063.00	115.21	396.39
NOTES: i) Only one of the following items is payable when requested and rendered with a radionuclide cardiac ventriculography (gated study MUGA) – (fee items 09863, 95040): a) Cardiac first pass (fee item 95000), or b) Cardiac shunt (fee item 95005), or c) Cardiac function studies, dynamic (fee item 09862) ii) 95040 includes 09863.				
Radionuclide venogram alone	09809	517.00	44.39	202.10
Receptor imaging (isolated procedure)	09817	720.00	90.30	271.55
RBC (red blood cell) liver scan	95045	805.00	73.96	296.83
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	623.00	39.94	243.73

	Code	Non-MSP-Insured Fee ($)	MSP and WSBC Prof. Fee ($)	MSP and WSBC Total Fee ($)
Red cell mass (with RBC label) and plasma volume (with plasma label) combined study	09837	417.00	26.95	163.03
Red cell survival study	09844	708.00	44.74	238.71
Renal imaging - with pharmaceuticals (isolated procedure)	95055	942.00	83.50	348.37
– without pharmaceuticals (isolated procedure)	95060	854.00	73.97	315.56
NOTES: i) Fee items 95055 and 95060 may only be billed together on the same day when renography is performed for the assessment of renovascular hypertension using a one-day protocol. For these instances, a note record stating "renovascular hypertension one day protocol" must be submitted when both items are billed. Payment for other renal imaging studies with pharmaceuticals (e.g.: lasix renogram) will be made under 95055 only. ii) 95055 and 95060 include camera GFR. iii) Blood GFR (09848) may be billed on the same day, when required.				
Repeat of major scan, no additional radionuclide - charge 50% of scheduled fee for primary procedures	09877			
Rest myocardial perfusion	95062	740.00	58.22	281.33
Stress myocardial perfusion	95063	740.00	60.16	290.66
NOTE: 95062 and 95063 (as well as stress test) are billable same day, if performed.				
Salivary gland study	09818	476.00	36.69	185.79
SeCHAT	09819	683.00	32.29	267.32
Spleen scan, static	09873	419.00	41.79	156.35
NOTE: When performed in conjunction with liver scan, static (09850), bill as 09851 only (liver and spleen scan, static).				
Testicular imaging (isolated procedure)	09824	470.00	54.34	177.27
Thallium myocardial scan	09854	1088.00	71.17	425.86
Thallium body imaging	95053	1001.00	75.79	484.11
NOTES: i) Not payable with 09806, 09817, 09854 or 09826. ii) 09877 payable in addition if the patient is brought back for additional imaging the same or next day.				
Thyroid uptake:				
– single determination	09820	126.00	13.72	46.50
– double determination	09821	180.00	20.62	70.33

	Code	Non-MSP-Insured Fee ($)	MSP and WSBC Prof. Fee ($)	MSP and WSBC Total Fee ($)
Thyroid scan (Iodine - 123)	09823	533.00	23.57	191.60
Thyroid scan (pertechnetate)	09825	211.00	17.36	76.63
Transfer of radionuclide from CSF to blood	09876	206.00	14.26	77.24
Tumour Imaging with metabolic or biological imaging agent (excluding Thallium-201 or Gallium-67)	09826	3795.00	108.99	1440.09
NOTE: Includes imaging of the entire torso with tomographic and planar images as indicated.				
Ventilation lung scan	09855	647.00	51.35	240.10
NOTES:				
i) 09868 payable in addition, if applicable.				
ii) Ventilation-perfusion scan to rule out pulmonary embolism is billable under 09855 and 09868.				
iii) 09866 not paid in addition.				
Vitamin B12 absorption study (e.g.: Schilling test):				
– without intrinsic factor	09856	374.00	14.87	136.87
– with intrinsic factor	09857	450.00	21.76	164.40
– with blood radioactive determination	09852	199.00	14.48	75.30
– with two radionuclides	09860	250.00	27.71	94.22
Voiding cystography	09828	487.00	48.20	190.99
White blood cell labeled with radioisotope	95065	2229.00	189.74	797.78

THERAPEUTIC PROCEDURES

Joint injection with isotope - therapeutic	09890	1985.00	96.94	776.35
Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (iodine therapy)	09880	1024.00	140.03	400.89
Treatment for polycythemia vera with P32 - per course of treatment	09881	624.00	82.65	236.58
Treatment for thyroid cancer - per course of treatment	09882	1332.00	111.52	521.02
Treatment for prostate cancer - per course of treatment	09883	1251.00	208.04	477.85
Treatment for metastatic carcinoma of bone - per course of treatment	09884	814.00	133.52	307.04

CONSULTANT SPECIALIST OF BC FEE LISTINGS

1. Preamble

The following Consultant Specialist of BC (CSBC) Fee items are billable only by Specialists certified by the Royal College of Physicians and Surgeons of Canada.

The objectives of CSBC fees are to reduce unnecessary face-to-face encounters, to reduce care gaps, and to provide more timely care from the most appropriate physician, thereby improving patient care.

1. For the purposes of this section, face-to-face services include consultation; office, home or hospital visit; and any diagnostic, therapeutic, anesthetic or surgical procedure with both physician and patient in the same room.

2. CSBC fees are not payable for situations where the sole purpose of the communication is to:
    a) book an appointment
    b) arrange for routine admission or transfer of care that occurs within 24 hours, except for coordination for patients under the Patient Transfer Network (PTN)
    c) arrange for an expedited consultation or procedure within 24 hours
    d) arrange for laboratory or diagnostic investigations
    e) inform the referring physician of results of diagnostic investigations
    f) arrange a hospital bed for the patient
    g) renew prescriptions with a pharmacist.

3. For fee items G10001, G10002, G10003, G10004, and 78711, refer to section D.1. Telehealth Services of the General Preamble.

4. G10002, G10004, G10005, 78710, and 78711: All registered and regulated health care providers can serve as referral sources. When advice is requested by an Allied Care Provider who does not have an MSP practitioner number, or conferencing is initiated with one, use the generic practitioner number 99987: Allied Care Provider not registered with MSP.

5. At minimum, the following is required, and the practitioner is responsible for keeping their practice consistent with any new guidelines which may be published by the Canadian Medical Protective Association (CMPA) and/or the College of Physicians and Surgeons of British Columbia (CPSBC).

    Electronic communication as part of patient care must ensure that security and patient confidentiality are maintained and guarded in the same way that paper records are protected.

- The CMPA and 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 or text message record should be included in the patient record.
- Develop clear, written policies around use of email and/or text messaging.
- Communication between providers should clearly identify the most responsible physician (MRP).
- Information should be encrypted as an attachment, or, at a minimum, password protected. Send password or cryptographic key separately.
- Use secure communication modalities (i.e. Health Authority email addresses) if possible.
- Email addresses, and phone numbers for text messaging, need to be double-checked.

6. CSBC fees are payable for face-to-face, telephone, video conference and email and text messaging communication. Review the individual fee notes which identify their respective eligible communication modality.

7. CSBC fees are not payable to physicians for services provided within time periods when working on salary, service contract or sessional arrangement.

8. No claim may be made where communication or service is with a proxy for the billing physician.

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

10. G10001, G10002, G10004, G10005, 78710, and 78711 are not payable for the same patient on the same date of service if adult or pediatric critical care team fees have been paid to the same practitioner or a practitioner who belongs to the same critical care team.

2. CSBC Fees

Note: These fees cannot be correctly interpreted without reference to the Preamble for CSBC Fees above, and the Eligibilities preceding each set of fee items below.

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

SPECIALIST ADVICE FEES T10000, G10001, G10002, G10005, T10009, 78710 AND 78711

Eligibility

The intent is to replace the need for the Specialist to see the patient in person. The consulting Specialist is responsible for ensuring that such communication meets the medical needs of the patient.

NOTES:

i) Payable to Specialists for communication regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iii) An adequate medical record/chart, including times as specified under each fee item, is required.

iv) The Specialist is responsible for the confidentiality and security of all records, and electronic transmissions. For video technology, see Section D. 1. of the Preamble.

v) G10001, G10002, G10005, 78710, 78711 may not be delegated to resident physicians.

T10000	Urgent Specialist Advice on patient with previous visit/service – Initiated by a Specialist, Family Physician or Health care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request	175.00	75.00

NOTES:

i) Payable for telephone, video technology or face to face communication only. Not payable for written communication (i.e. fax, letter, email).

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP Fee ($)
	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.		
G10001	Urgent Specialist Advice – Initiated by a Specialist, Family Physician or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request.....	175.00	75.00
	NOTES: i) Payable for telephone, video technology or face to face communication only. Not payable for written communication (i.e. fax, letter, email). ii) Document time of initiating request, time of response, as well as advice given and to whom. iii) Include the practitioner number of the physician or Health Care Practitioner requesting the advice in the "referred by" field when submitting claim. iv) Not payable in addition to another service on the same day for the same patient by 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.		
G10002	Specialist Advice for Patient Management – Initiated by a Specialist, Family Physician, Allied Care Provider, or coordinator of the patient's care. Verbal real-time response in 7 days of initiating request – per 15 minutes or portion thereof.....	133.00	57.00
	NOTES: i) Payable for telephone, video technology or face-to-face communication only. Not payable for written communication (i.e. fax, letter, email.)		

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP Fee ($)
	ii) Document date of initiating request, date of the response, as well as advice given and to whom. iii) Document start and end times in the medical record, and in time fields when submitting claim. iv) Include the practitioner number of the physician or Allied Care Provider requesting advice in the “referred by” field when submitting claim. (For Allied Care Providers not registered with MSP use practitioner number 99987.) v) Not payable in addition to another service on the same day for the same patient by the same practitioner. vi) Limited to two services per patient per physician per week. vii) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 30 days.		
G10005	Specialist Email Advice for Patient Management – Initiated by a Specialist, Family Physician or Allied Care Provider. Response within 7 days of request.....	29.50	11.07
	NOTES: i) Payable for email communication only. Maximum 3 services per patient per physician per day. ii) Document date of request, date of the response, as well as advice given and to whom. iii) Include the practitioner number of the physician or Allied Care Provider requesting advice in the “referred by” field when submitting claim. (For Allied care Providers not registered with MSP use practitioner number 99987). iv) Not payable in addition to another service on the same day, for the same patient by same practitioner. v) Limited to 3 services per patient per physician per day. vi) Limited to maximum of 12 services per patient per physician per year. vii) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 30 days.		

		Non-MSP-Insured Fee ($)	MSP Fee ($)
T10009	Specialist Advice for Patient Management on patient with previous visit/service – Initiated by a Specialist, Family Physician, Allied Care Provider, or coordinator of the patient's care. Verbal real-time response within 7 days of initiating request	133.00	57.00
	NOTES: i) Payable for telephone, video technology or face-to-face communication only. Not payable for written communication (i.e. fax, letter, email). ii) Document date of initiating request, date of the response, as well as advice given and to whom. iii) 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.		
78710	Specialist Text Message Advice – Initiated by a Specialist, Family Physician, or Allied Care Provider. Response within 7 days of initiating request	83.30	20.00
	NOTES: i) Payable for two-way text message communication in response to request for patient management advice from another physician or allied care provider. ii) Not payable for advice rendered to allied care providers located in the same facility or clinic at the time the service is rendered. iii) Document date of request, date of the response, as well as advice given and to whom. iv) Include the practitioner number of the physician or allied care provider requesting advice in the "referred by" field when submitting the claim. (For allied care providers not registered with MSP, use practitioner number 99987). v) Limited to one service per patient per physician per day. vi) Limited to two services per patient per physician per week. vii) Limited to 100 services per physician per calendar year.		

		Non-MSP-Insured Fee ($)	MSP Fee ($)
P78711	Specialist Initiation of Conference with a Physician and/or Allied Care Provider	250.00	60.00

NOTES:

i) Payable to the initiating specialist for two-way collaborative conferencing, care coordination or advice, either by telephone, videoconferencing or in-person, between the specialist and one or more physicians and/or Allied Care Providers.

ii) Conferencing initiation cannot be delegated. No claim may be made unless conference initiation is performed by the provider themselves. No claim may be made where communication is with a proxy for the receiving provider (with the sole exception of resident physicians).

iii) Details of care conference must be documented in the patient's chart, including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.

iv) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility, or communications which occur as part of regular workflow within a physician's community practice.

v) Include the practitioner number of the receiving physician or Allied Care Provider in the "referred to" field when submitting claim. (For Allied Care Providers not registered with MSP, use practitioner number 99987).

vi) Document start and end times in the medical record, and in time fields when submitting claim.

vii) Payable in addition to a visit fee on the same day.

viii) Not payable in addition to 10004, 00545, or 33445 for the same patient on the same day by the same physician.

ix) Payable to a maximum of 3 services per patient per physician per day. Repeat conferences with the same physician(s) and/or allied care providers for the same patient on the same date of service are included in the initial conference.

x) Payable to a maximum of 6 services per patient per week.

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

SPECIALIST PATIENT FOLLOW-UP FEES G10003, G10006, T10007

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

G10003	Specialist Patient Management / Follow-up – per 15 minutes or portion thereof	50.20	26.35

NOTES:

i) For verbal, real-time telephone and video technology communication (including other forms of electronic verbal communication) only. Not payable for written communication (i.e. fax, letter, 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.

G10006	Specialist Email Patient Management / Follow-up	58.60	25.10

(see notes on next page)

		Non-MSP-Insured Fee ($)	MSP Fee ($)
	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.....	37.50	16.06
	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.		

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

MULTIDISCIPLINARY CONFERENCING FOR COMPLEX PATIENTS G10004

Eligibility

This fee is only billable for a scheduled meeting to discuss and plan medical management of patients with serious and complex problems under extraordinary circumstances that the Specialist cannot manage by him/herself. Payable only when coordination of care is required via a collaborative conference with at least two of the following in addition to the Specialist billing:
Specialists, Family Physicians, Allied Care Providers and/or coordinators of the patient's care.
NOTES:

i) Includes scheduled face-to-face, telephone or video technology communication regarding assessment, clinical coordination and management of a complex patient.
ii) All Specialists involved in the conference may each independently bill this fee.
iii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed under the PHN of each patient for the specific time period.
iv) Not payable to the same patient on the same date of service as 00545, 00645, 60645, G33445, G10001, G10002, G10003, G10005, G10006, G78717 when claimed by the same practitioner.
v) Not payable to the same patient on the same date of service if adult or pediatric critical care team fees have been paid to the same practitioner or a practitioner who belongs to the same critical care team.
vi) Patient must be complex, with multiple medical needs or complex co-morbidities (two or more distinct but potentially interacting problems), where care needs to be coordinated over a period of time between several health disciplines.

(notes continued on next page)

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

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

Document complexity in the medical record using the ICD-9 code for one of the major disorders when billing. If patient has non-medical co-morbidity use the ICD-9 code M04 when billing.

Specialist Multidisciplinary Conferencing for Complex Patients G10004

G10004	Multidisciplinary Conferencing for Complex Patients – per 15 minutes, maximum one hour	146.00	60.00

NOTES:

i) Each Specialist involved in the case conference must document their contribution to the discussion and its effects on the patient's overall care in the medical record/chart.
ii) Start and end times of the conference must be documented in both the medical record and in time fields when submitting the claim.
iii) The names and job titles of the other participants at the meeting must be documented in the medical record.
iv) Maximum 16 services per patient per physician per calendar year.

(notes continued on next page)

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

v) Maximum of 4 services may be claimed per patient per physician per day.
vi) Case must be complex, as defined in the Eligibility.
vii) Use the ICD-9 code for one of the major disorders when billing.
viii) If patient has non-medical co-morbidity (see Eligibility) use the ICD-9 code M04 when billing.

Group Medical Visits 78763 – 78781 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 intervals of the Group Medical Visit is not permitted. The physician must be physically present at the GMV for the majority of each time interval billed. While portions of the Group Medical Visit may be delegated to a non-physician staff member the specialist must be present for the majority of the GMV, and assumes clinical responsibility for the patients in attendance.

Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs.

Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction. Physicians can also benefit by reducing the need to repeat the same information many times and free up time for other patients. Appropriate patient privacy is always maintained and typically these benefits result in improved satisfaction for both patients and physicians.

This fee is not intended for provision of group psychotherapy (00663, 00664, 00665, 00666, 00667, 00668, 00669, 00670, 00671, 00672, 00673, 00674, 00675, 00676, 00677, 00678, 00679, 00680, 00681).

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP Fee ($)
	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 behavioural patterns, other than in the context of the individual medical condition.		
	Referred Cases Fee per patient, per ½ hour		
G78763	Three patients	126.00	51.68
G78764	Four patients	101.00	41.26
G78765	Five patients	87.50	35.87
G78766	Six patients	77.80	31.92
G78767	Seven patients	71.10	29.13
G78768	Eight patients	66.00	27.00
G78769	Nine patients	62.00	25.37
G78770	Ten patients	58.60	24.00
G78771	Eleven patients	51.40	21.04
G78772	Twelve patients	48.25	19.77
G78773	Thirteen patients	44.65	18.31
G78774	Fourteen patients	43.85	17.98
G78775	Fifteen patients	42.00	17.26
G78776	Sixteen patients	40.80	16.73
G78777	Seventeen patients	39.15	16.03
G78778	Eighteen patients	38.55	15.78
G78779	Nineteen patients	36.90	15.13
G78780	Twenty patients	36.00	14.76
G78781	Greater than 20 patients (per patient)	34.70	14.26

NOTES:

i) Submit a separate claim for each patient.
ii) Each patient must have an active referral.
iii) Start and end times required in both the medical record and time fields in the claim.
iv) Not payable with any other services, for the same patient, on the same day by the same physician.
v) If multiple physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate for only the patients in their own fraction of the group. The claim note and patient chart should specify:
    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.

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

SPECIALIST DISCHARGE CARE PLAN FOR COMPLEX PATIENTS G78717

Eligibility

This fee premium is intended to support clinical coordination leading to effective discharge and community-based management of complex patients. It is to be billed for provision of a care plan for patients who require community support upon discharge, and who are otherwise at risk of readmission.

NOTES:

i) Primary health care provider must be notified by phone, fax or electronic means within 24 hours of admission.

ii) Care Plan must:
   a. Be developed in consultation with the providers identified in the plan
   b. Include record of appropriate clinical information, interventions, co-morbidities and safety risks
   c. Include re-referral triggers and description of arranged follow-up care
   d. Include expectation of symptom progression/remission and patient progress

iii) Be included in the patient's medical record.

iv) 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).

(notes continued on next page)

		Non-MSP-Insured Fee ($)	MSP Fee ($)
	Or one morbidity plus a minimum of one of the following non-medical conditions: • poor socioeconomic status • unstable home environment • dependency on family/caregiver for daily living tasks • accessibility/mobility issues • under care of MCFD Protection Services • received Tertiary or Acute level of care related to psychiatric condition within the previous 6 months • frail elderly • >75 years old • BMI >35 • high readmission rate Document complexity in the medical record using the ICD-9 code for one of the major disorders when billing. If patient has non-medical co-morbidity use the ICD-9 code M04 when billing.		
G78717	Specialist Discharge Care Plan for Complex Patients – extra	189.00	82.19

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.

iv) Document the time the primary health care provider was notified of discharge in the medical record.

v) Payable once per patient per discharge from hospital.

vi) Claim on the day of discharge.

vii) Use the ICD-9 code for one of the major disorders when billing.

viii) If patient has non-medical co-morbidity (see Eligibility) use the ICD-9 code M04 when billing.

ADVANCE CARE PLANNING G78720

Eligibility

Advance Care Planning occurs when a capable adult forms his/her beliefs, values and wishes for health care, in the event of future incapacity. Advance care planning discussions may take place with family, trusted friends, and/or health care providers.

This fee premium is for a Specialist to discuss advance care planning based on the patient's beliefs, values and wishes for future health care.

NOTES:

i) The advance care planning discussion should include sharing information and resources on how a patient can create an advance care plan, including Advance Directives.

ii) An advanced care plan form is required to be completed and added to the patient's medical record, medical chart and the discussion should be summarized in the consultation report including any decisions about the patient's future health care wishes. (The care plan form template is available at: www.sscbc.ca).

iii) The care plan template form must be shared with:
   a) The patient; and
   b) The patient's primary health care provider.

iv) The message to the patient and the plan must be consistent with the Practice Support Program's End of Life Module resources.

v) Not payable in the same hospital admission during which adult or pediatric critical care (01400 series) or neonatal intensive care (01500 series) fees are claimed.

		Non-MSP-Insured Fee ($)	MSP Fee ($)
	Specialist Advance Care Planning		
G78720	Specialist Advance Care Planning Discussion – extra	93.20	43.82

NOTES:

i) Planning discussions and plan development for patients presenting with:
   a) a chronic medical illness or complex co-morbidities, and
   b) a deteriorating quality of life or end-stage disease state.

ii) Always payable at 100%.

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, 2025.

SESSIONAL RATES

	Sessional Rate	Per hour Rate
Family Physician	$615.02	$175.72
Specialist.....	$725.46	$207.27

FORENSIC PSYCHIATRIC SERVICES COMMISSION RATE

	Psychiatric Services Rate	Per Hour Rate
Family Physician	$667.06	$190.58
Specialist.....	$1,026.81	$293.37

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.

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 *(<u>NOT</u> CRIMINAL PROSECUTION OR CRIMINAL DEFENCE)*

		Non-MSP-Insured Fee ($)
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.....	213.00
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	452.00
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.....	1348.00
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 ***Required to meet specific criteria to qualify for court admission as an expert report***.....	2254.00
A00095	Review of paper or EMR records by physician *(for medical/legal purposes or transfer of patient records*) - per 15 minutes or portion thereof.....	127.00

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.

		Non-MSP-Insured Fee ($)
A00096	Photocopy/Print from digital or paper medical record - per page (first 10 pages)	2.30
	– 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.	

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.....	3600.00
A00075	Testimony per half-day or less	2254.00
A00091	Preparation to give testimony, per hour ..... NOTE: This fee does not include charges for extra record keeping necessary to provide expert testimony. These charges are in addition.	536.00
A00092	Failure of notification of hearing, scheduled consultation meeting, discovery, depositions, or trial adjournment or out-of-court settlement..... 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.	2704.00
A00009	Mileage per kilometer	0.68

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	– Family Physician	305.00
A94526	– Specialist	356.00
	Travel Time (Per Hour):	
A94527	– Family Physician	174.00
A94528	– Specialist	202.00

NOTES:

i) "Family Physician", 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.

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.

ICBC FEE GUIDE FOR ALL PHYSICIANS

This Guide has three sections:

1. For Family Physicians providing primary care services
    - Fee Information
    - FAQ

2. For Physicians providing consultation services
    - Fee Information
    - FAQ

3. For all Physicians
    - Consent
    - Invoicing
    - Vendor Number
    - Claim Numbers
    - Questions

SECTION 1: FOR FAMILY PHYSICIANS PROVIDING PRIMARY CARE SERVICES

The purpose of this Guide is to outline the fees and process for ICBC's Family Physician Reports. These services and fees are enshrined in Schedule 3.1 of the Insurance (Vehicle) Regulation.

		ICBC Fee ($)
TABLE 1: FAMILY PHYSICIAN FEES AS PER BC'S INSURANCE (VEHICLE) REGULATION		
A94564	Standard Physician Medical Report – CL489	198.00

NOTES:
i) Applicable to patients who are not off work and/or not significantly impacted in performing their typical activities of daily living (ADLs).
ii) Payment is for completion of the report after the initial assessment.
iii) Bill the assessment to the Medical Services Plan (MSP) using the appropriate MSP billing code(s).
iv) A report is required for each new claim. Complete either a Standard Physician Report or Extended Physician Report.

A94565	Extended Physician Medical Report – CL489A	398.00

NOTES:
i) Applicable to patients who are off work/school, on a modified work plan, or are experiencing significant functional impairment and unable to perform their typical ADLs.
ii) Payment is for completion of the report after the initial assessment.
iii) Bill the assessment to the Medical Services Plan (MSP) using the appropriate MSP billing code(s).
iv) A report is required for each new claim. Complete either a Standard Physician Report or Extended Physician Report.

A94566	Physician Reassessment Medical Report – CL489B.	256.00

NOTES:
i) Applicable to patients who are not recovering as expected from a motor vehicle accident and require an updated diagnosis and/or treatment plan.
ii) Payment is for completion of the report.
iii) Bill the assessment to the Medical Services Plan (MSP) using the appropriate MSP billing code(s).
iv) This report supports a referral to specialized services from the family physician.
v) This report is NOT required at regular intervals or with every follow-up visit.

		ICBC Fee ($)
A94569	Physician Conference Fee	64.14

NOTES:

i) Payable for verbal or written physician conferencing with ICBC or other treatment providers.
ii) Physician conferencing is defined as an interactive exchange of information for the purpose of addressing barriers and discussing care plan recommendations.
iii) Payable per 15 minutes or portion thereof with a daily maximum of 45 minutes per claim.
iv) The physician conference fee is not payable for administrative tasks, such as arranging expedited consults or diagnostic investigations.

Other ICBC Fee Items

Permanent Impairment Benefit (PIB) Documentation Rates

ICBC may require a Scarring and/or Loss of Range of Motion report to be completed by either a patient's physiotherapist, occupational therapist, or family physician to help determine a patient's entitlement to Permanent Impairment Benefit (PIB).

Important: ICBC should request that these forms be completed by the patient's physiotherapist or occupational therapist when available, their family physician should only be asked to complete these forms when the other two options are not feasible. These forms should be completed only when requested by ICBC.

		ICBC Fee ($)
A94575	Scarring Measurement Report billed by a Family Physician.....	64.14
A94577	Range of Motion Report billed by a Family Physician.....	128.28

For other non-insured services fees including medical-legal matters and copies of patient medical records, please refer to the Doctors of BC's Medical-Legal Matters fee guide.

FAQ

What is the purpose of the Family Physician ICBC reports?

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.

- **Standard Report (Code A94564 $198.00):** If your patient's injuries do not result in missed work or significantly affect their usual activities, a Standard Report would be applicable.
- **Extended Report (Code A94565 - $398** to participate in usual activities, an Extended Report would be applicable.
- **Reassessment Report (Code A94566 - $256.00):** If your patient is not recovering as expected from a motor vehicle accident and requires an updated diagnosis and/or treatment plan, a Reassessment Report would be applicable. This report supports a referral to specialized services from the family physician. This report is NOT required at regular intervals or with every follow-up visit.

These reports provide ICBC with early information to support patient recovery goals such as the return to activities of daily living (ADL) and work planning, as well as informing other benefit entitlements from 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 be found on:

- ICBC Physician Services
- The Forms Repository in Pathways

When do I fill out an ICBC Report?

- When you see a patient who has been in a motor vehicle accident for the first time, fill in either a Standard or Extended Report for each new motor vehicle accident claim.
- During follow-up visits, fill in reassessment report if a patient is not recovering as expected and an updated plan of care or change in diagnosis may be required.

How do I share the Family Physician Reports with ICBC?

There are two options to share the report with ICBC:

- With patient consent*, you can send it to ICBC; or

- Alternatively, you can 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).

*See Section on Consent for more details.
NOTE: Submission of the ICBC Report triggers payment of the report.

Is there a timeline for ICBC to receive the Family Physician Reports?

Yes, it is recommended that reports be delivered to ICBC no later than 30 business days from the date of assessment in order to provide information that is clinically relevant to the care of the patient.

When do I bill the ICBC Family Physician Reports?

Physicians should bill the ICBC Family Physician Reports when a patient is seeking medical services specific to an ICBC-related injury.

- MSP is responsible for payment of all medically required visits. Visits are billed as usual via Teleplan, with MSP as the insurer. Please note that ICBC does not prepay for reports.

SECTION 2: FOR PHYSICIANS PROVIDING CONSULTATION SERVICES

The purpose of this Section is to outline the service for Specialized Services Reports introduced April 1, 2023.

Fee Information

		ICBC Fee ($)
TABLE 2: SPECIALIZED SERVICES FOR ICBC		
A94573	Specialized Physician Services Report	275.00

NOTES:

i) Applicable to patients seeking specialized services through a written referral from any physician providing a consultation for injuries sustained in a motor vehicle accident.
ii) Payment is for completion of the report.
iii) Bill the consultation to the Medical Services Plan (MSP) using the appropriate MSP billing code(s).

A94569	Physician Conference Fee	64.14

NOTES:

i) Payable for verbal or written physician conferencing with ICBC or other treatment providers.
ii) Physician conferencing is defined as an interactive exchange of information for the purpose of addressing barriers and discussing care plan recommendations.
iii) Payable per 15 minutes or portion thereof with a daily maximum of 45 minutes per claim. The physician conference fee is not payable for administrative tasks, such as arranging expedited consults or diagnostic investigations.

For other non-insured services fees including medical-legal matters and copies of patient medical records, please refer to the Doctors of BC's Medical-Legal Matters fee guide.

FAQ

What is the purpose of the Specialized Physician Services Report?

- The intent of the Report is to provide assistance in maximizing recovery and progress towards functional restoration for patients who have an active claim under ICBC's new Enhanced Care Insurance System.
- The Report allows for additional information sharing between the physician and ICBC, specifically information that would not normally be included in a typical consultation letter completed by a physician providing specialized services.
- This information is important for ICBC to help determine care supports and other funding decisions to support patients.

Who can fill out the Specialized Services Report?

- Any physician providing a consultation to a patient involved in a motor vehicle accident.
- In order to provide a consultation, you require a written referral from a physician.

Where do I find the ICBC Specialized Services Report template?

- ICBC Physician Services
- The Forms Repository in Pathways

When do I fill out a Specialized Services Report?

- Complete the report following an initial consultation with the patient who has been in a motor vehicle accident,
- In circumstances where more information (e.g., labs/imaging) is required, you may choose to complete the report after the results are available.
- When a report has been requested by ICBC.

Does the Specialized Services Report include payment for the consultation?

The report does not include payment for the consultation itself. Please submit a billing claim for the consultation through the usual Teleplan process with MSP named as the insurer using the standard MSP consultation codes.

Can I complete a Specialized Services Report when I provide care for an ICBC-related injury in a facility setting?

- This Report can be completed for both community and facility-based patients.

How do I share the Specialized Services Report with ICBC?

There are two options to share the report with ICBC:

1. Pro-actively send the report to ICBC Health Care Inquiry Unit after the initial consultation with patient consent.

2. Complete the report after the initial consultation and notify ICBC that a report is ready. This will prompt ICBC to submit a formal request to collect this information. Formal requests do not require patient consent as ICBC has the legislative authority to collect this information.

*See Section on Consent for more details.
NOTE: Submission of the ICBC Report triggers payment of the report.

Is there a timeline for ICBC to receive the Specialized Services Report?

It is recommended that the report be delivered to ICBC no later than 30 business days from the date the consultation was completed in order to provide information that is clinically relevant to the care of the patient.

When does the Specialized Service Report apply?

The Specialized Service Report applies when:
- A patient has a motor vehicle accident date of **May 1, 2021, or later,** and
- A patient is seeking an initial consultation for a specialty service specific to an ICBC-related injury.

ICBC does not:
- remunerate for missed or cancelled appointments,
- pre-pay for reports, and
- pay for Specialized Services Reports for injuries occurring before May 1, 2021.

Do physicians have to provide a portion of the Specialized Services Report fee to clinic owners/operators for overhead?

There are no specific requirements for how physicians and clinics are expected to distribute the specialized services report fee amongst themselves.

Physicians and clinic owners are advised to develop formal cost sharing agreements to clearly define and document physician's financial obligations to their clinics. Physicians and clinic owners should discuss how their cost sharing agreements apply to all aspects of their billing, including services billed to ICBC.

Please see Doctors of BC Physician Business Services for more resources on the business elements of medical practice, including a Guide to Cost Sharing Agreements and a Cost Sharing Agreement template.

SECTION 3: FOR ALL PHYSICIANS

Consent

There are two options available when submitting an ICBC Report. These options are based on whether the patient provides consent during your visit.

Option 1: Submitting the ICBC Report with Patient Consent

- The physician obtains patient consent to share information with ICBC. This allows the physician to proactively send the Report to ICBC after the initial office visit.
- See here for the *Consent to Sharing of Information* template.

Option 2: Submitting the ICBC Report without Patient Consent

- If the patient does not provide consent, the physician may continue to complete the report, however, they must wait for a formal request from ICBC before sending the report.
- To alert ICBC that you have seen an ICBC patient, the physician's office must contact ICBC's Health Care Inquiry Unit (healthcareinquiry@icbc.com or 604-587-7150 in the lower mainland, 1-800-717-7150 elsewhere in BC) with the patient's name and claim number, indicating that consent was not obtained, and that an ICBC request letter is required.
- ICBC sends a formal request letter to the Physician's office.
- The ICBC Report is submitted upon receipt of ICBC's request letter.

Why do I need patient consent to proactively 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 proactively 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: Consent to Sharing of Information template.

Invoicing

For Reports:

- Physicians must submit their completed reports to ICBC via fax or regular mail to receive payment.
- A separate invoice is not required for the Reports. There is space on the report to include an invoice number for personal tracking purposes.
- Reports must include claim numbers (this should be provided by the patient).
- These reports service as both your medical record documentation and the invoice to ICBC.
- **The Standard, Extended, Re-assessment Reports do not include payment for the visit.**
- **The Physician Specialized Services Report does not include payment for the office consult.**
- All consultations must be billed as usual via Teleplan, with MSP named as the insurer, using appropriate MSP billing codes.

For non-Report services:

- **Physician Conference Fee (A94569)**

Prepare the invoice. The following must be included in the invoice:

  - ICBC Claim number
  - Date of accident
  - Patient name
  - Physician providing the service
  - Payee where this differs from the Physician providing the service
  - Date of service

Send the completed Reports and/or invoices (when appropriate) to ICBC by one of the following:

Submission Information	
Fax	1-877-686-4222
Mailing Address	PO Box 2121, STN Terminal Vancouver, BC V6B 0L6

- **Follow-up visits**
    - Patient follow-up visits with no medical reports and consultations for the Physician Specialized Services Report are billed as usual via Teleplan, with MSP named as the insurer, using the standard MSP codes.

How do I update payment information invoiced through MSP – Teleplan?

To update payment information for standard visits, which are invoiced to MSP-Teleplan, you must contact MSP-Teleplan directly.

Vendor Number

If you are a physician already providing services to ICBC patients and wish to be paid directly for reports and other uninsured services, your vendor number can be found on any recent cheque or EFT statement that you received from ICBC. The Health Care Inquiry Unit can confirm your ICBC vendor number.

If you are a physician not already providing services to ICBC patients or a clinic that only employs physicians and no other treatment providers (e.g.: physiotherapist, chiropractor, counsellor that see ICBC patients), you can apply for a vendor number. ICBC can issue payments directly to your account via electronic fund transfer (EFT).

Vendor number requests or updates to an existing vendor number can be made by using the "apply for a vendor number" link on the ICBC Physician page or by contacting the Health Care Inquiry Unit.

If you are a clinic that employs physicians and other treatment providers (e.g.: physiotherapist, chiropractor, counsellor that see ICBC patients), vendor number application requirements for other treatment providers can be found at the "apply for or update a direct billing vendor number".

Claim Number

Why do I need to add a claim number to Reports?

Claim numbers ensure a valid claim with ICBC. If a claim number is missing from the reports sent to ICBC, ICBC will initiate a search based on other identifying information from the report provided; if this fails, ICBC will send an automated template informing the physician's office the report could not be processed.

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 Unit (HICU)
604-587-7150
1-888-717-7150
healthcareinquiry@icbc.com

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

Please be sure to include claim number, patient name, payee name, and invoice number if applicable.

WORKSAFE BC

SCHEDULE A
DESCRIPTION OF SERVICES

1.0 INTRODUCTION

1.1 Almost all Workers in BC are covered under the WCA. 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 WCA 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 WCA 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 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 The 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 The Doctors of BC will encourage Physicians to assist Injured Workers in receiving benefits they are entitled to under the WCA.

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 Injured Workers, with assistance of the Injured 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,

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 section 8.0.

3.0 OCCUPATIONAL HEALTH EDUCATION

3.1 WorkSafeBC undertakes to liaise with the Doctors of BC regarding occupational health care issues.

3.2 Rehabilitation initiatives will be discussed with the Doctors of BC during development, providing the 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 the 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 may be completed and signed by the worker as a hardcopy form, completed Electronically through worksafebc.com or over the telephone through Teleclaim. If WorkSafeBC does not receive the Form 6, a claim may be suspended and may not be paid.
- **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 Payment for a Form 8 will only be made for the first Form 8 received by WorkSafeBC submitted by any Physician, and if a second Form 8 is subsequently submitted Electronically by the Injured Worker's regular Physician and it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC, it will be paid at the Form 8 rate, rather than the Form 11 rate.

5.2 In order to indicate that the Physician is the Injured Worker's regular Physician, and to be paid the Form 8 rate, the Physician must answer "yes" to the question on the Form 8 "Are you the injured worker's regular practitioner?"

5.3 A Physician may only submit one Form 8 per claim. Any subsequent Form 8 will be paid at a Form 11 rate.

5.4 Any submitted Forms 8 and 11 that are missing mandatory field(s) or are illegible will be rejected without any cost to WorkSafeBC.

5.5 Fees will be reimbursed based on submission Electronically 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 in Schedule A – section 5.0:

Form 8 - First Report of Injury

6.1.1 The Physician of first contact or the Injured Worker's regular 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, WorkSafeBC will pay fee code 19927. The time limit for the submission of this form and/or medical records is 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 Injured 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 Form 8 shall not be billed by a specialist submitting an expedited consultation.

6.1.5 There will be no payment for forms received after the time limits described in this Agreement in Schedule B.

Form 11 - Progress Report

6.1.6 Follow-up examination visits shall be conducted by the attending Physician as medically necessary, as a result of Injured Worker requirement or at the request of a Board Officer.

6.1.7 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 Injured Worker's medical condition, treatment plan, or return to work status is not payable unless an interval of at least 4 weeks has passed since the Physician last billed a Form 11.

6.1.8 Follow-up examination visits will be paid regardless of whether a Form 11 has been submitted.

6.1.9 There will be no payment for forms received after the time limits described in this Agreement as indicated in Schedule B.

6.1.10 The Parties agree that if WorkSafeBC requests a Form 11, when a Form 11 was not initially required, WorkSafeBC will pay fee code 19559. The time limit for the

submission of this form is 10 business days from the date the request is faxed or telephoned by WorkSafeBC.

7.0 EXPEDITED COMPREHENSIVE CONSULTATION

7.1 Referrals for Initial and Repeat Expedited Comprehensive Consultations can be made to a Specialist Physician or a Physician with Areas of Expertise by a referring Physician, a Nurse Practitioner or by WorkSafeBC on behalf of the referring Physician or Nurse Practitioner.

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 15 business days from the referral.

7.2.1.2 Referrals other than the Initial Expedited Comprehensive Consultation: The report must be received within 15 business days of the referral.

7.2.1.3 For any other consultations: The report must be received within 5 business days of the consultations.

7.2.1.4 Where following a consultation the Physician concludes the Injured Worker is fit to return to work, this information must be received within 3 business 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 fee when both of the following conditions occur:

7.3.1.1 more than 6 months lapsed since the physician last saw the Injured 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 1 repeat consultation when the repeat consultation occurs within 12 weeks of the Initial Expedited Comprehensive

Consultation for which fee code 19911 was billed. Any other repeat consultation is not entitled to Expedited fees.

7.4.1 In the case of a post-operative consultation, the follow up visit and report are to be invoiced as the post-operative consultation as described in Fee Schedule B, using fee code 19931 (Consultation after Surgery). 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 5 business days of receipt) identifying the area(s) of deficiency. The Physician shall supply the deficient information within 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 in 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, Medical Advisor, employer or treating Physician. The steps included in the return to work plan are as follows:

8.2.1 Discussion between treating Physician and employer, or employer representative including discussion of the return to work plan..

8.2.2 Follow up with Injured Worker to discuss return to work plan.

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 Board Officer. This further consultation will be invoiced as fee code 19950.

8.5 Fee code 19950 includes the related office visit and phone calls related to the return to work planning and reporting in order to complete the return to work plan. A Form 11 is billable in addition to fee code 19950 if a return to work consultation is completed on the same day as the office visit.

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 3 business 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, workers should be encouraged to report the injury to WorkSafeBC.

9.4 Interest will be paid in accordance with Article 8.8 on outstanding accounts pertaining to disallowed or suspended claims up to the time that the Physician is notified.

10.0 ACTIVITIES AND LIMITATIONS FORM (FEE CODE 19958)

10.1 When Required: An Activities and Limitation Form 83D405 is required where:

10.1.1 There is not enough medical evidence to decide if a referral for a permanent disability assessment is appropriate;

10.1.2 The Injured Worker is nearing full or maximum medical recovery, and the Injured Worker disagrees with one of the following: the return to work

plan/discharge recommendations; the expectation that the Injured Worker will recover from their injury; or the reported limitations or restrictions; or

10.1.3 The treating Physician and/or Injured Worker would like to provide further evidence regarding the existence of a permanent disability.

10.2 Completion of Form: An Activities and Limitations Form can be completed by:

10.2.1 A WorkSafeBC salaried Medical Advisor or Sessional Medical Advisor over the phone with the treating Physician, in which case the Physician will receive a copy to validate; or

10.2.2 Directly by the treating Physician.

In either case, the Physician may schedule an office visit with the Injured Worker if the Physician determines it is required in order to complete the Activities and Limitations Form.

WORKSAFE BC
FEE ITEMS

These fees cannot be correctly interpreted without reference to the WorkSafeBC Schedule A – Description of Services

WSBC Fee ($)

SCHEDULE B
WORKSAFEBC UNIQUE FEE FOR SERVICE ITEMS: FORM FEES, PHYSICIAN SERVICES FEES, AND EXPEDITED CONSULTATION FEES BY SPECIALISTS AND PHYSICIANS WITH AREAS OF EXPERTISE

1.0 FORM FEES

19937 Form 8 - Report of First Injury (Electronically) – within 1 business day..... 74.97

NOTES:

- Payable when a Form 8 is received Electronically by WorkSafeBC within 1 business day of the date of service, where the date of service is the date of the assessment and is considered day 0.
- Payment for a Form 8 will only be made as follows:
  - for the first Form 8 received by WorkSafeBC submitted by any Physician, and;
  - for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC.
- A Physician may only submit one Form 8 per claim.
- Any subsequent Form 8 will be paid at a Form 11 rate.
- Billable in addition to an office visit.

Form 8 - Report of First Injury (Electronically) – within 2 business days ... 70.28

NOTES:

- Payable when a Form 8 is received Electronically by WorkSafeBC within 2 business days of the date of service where the date of services is the date of the assessment and is considered day 0.
  -

(notes continued on next page)

	WSBC Fee ($)

- Payment for a Form 8 will only be made as follows:
  - for the first Form 8 received by WorkSafeBC submitted by any Physician, and;
  - for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC.
- A Physician may only submit one Form 8 per claim.
- Any subsequent Form 8 will be paid at a Form 11 rate.
- Billable in addition to an office visit.

Form 8 – First Report of Injury (Electronically) – within 3 business days .. 65.64

NOTES:

- Payable when a Form 8 is received Electronically by WorkSafeBC within 3 business days of the date of service, where the date of service is the date of the assessment and is considered day 0.
- Payment for a Form 8 will only be made as follows:
  - for the first Form 8 received by WorkSafeBC submitted by any Physician, and;
  - for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days on which the first Form 8 was received by WorkSafeBC.
- A Physician may only submit one Form 8 per claim.
- Any subsequent Form 8 will be paid at a Form 11 rate.
- Billable in addition to an office visit.

Form 8 – First Report of Injury (Electronically) – within 4-6 business days 46.33

NOTES:

- Payable when a Form 8 is received Electronically by WorkSafeBC within 4-6 business days of the date of service, where the date of service is the date of the assessment and is considered day 0.
- Payment for a Form 8 will only be made as follows:
  - for the first Form 8 received by WorkSafeBC submitted by any Physician, and;
  - for a Form 8 that is subsequently submitted Electronically by the Injured Worker's regular Physician if it is received by WorkSafeBC within 10 business days on which the first Form 8 was received by WorkSafeBC.

(notes continued on next page)

		WSBC Fee ($)

- A Physician may only submit one Form 8 per claim.
- Any subsequent Form 8 will be paid at a Form 11 rate.
- If a Form 8 is received 7 business days or later following the date of service, the fee paid is $0.
- Billable in addition to an office visit.

19900 Form 8 – First Report of Injury, received by WorkSafeBC (fax transmission) within 3 business days 43.33

NOTES:

- Payable when a Form 8 is received by fax by WorkSafeBC within 3 business days of the date of service, where the date of service is the date of the assessment and is considered day 0.
- A Physician may only submit one Form 8 per claim.
- Any subsequent Form 8 will be paid at a Form 11 rate.
- Billable in addition to an office visit.

Form 8 – First Report of Injury, received by WorkSafeBC (fax transmission) within 4-6 business days 28.89

NOTES:

- Payable when a Form 8 is received by fax by WorkSafeBC within 4-6 business days of the date of service, where the date of service is the date of the assessment and is considered day 0.
- A Physician may only submit one Form 8 per claim.
- Any subsequent Form 8 will be paid at a Form 11 rate.
- If Form 8 is received 7 business days or later following the date of service, the fee paid is $0.
- Billable in addition to an office visit.

19927 Form 8 - First Report of Injury requested by WorkSafeBC. 65.64

NOTES:

- Payable when a Form 8 is requested by WorkSafeBC where the form is not initially required (See Form 8 rules) and is received within 10 business days of the faxed or telephone request where the date of the request is considered day 0.
- Submissions received after 10 business days of the request will not be paid.
- Fee code 19904 may not be billed in addition to fee code 19927 as fee code 19904 includes copying of an existing report from an Injured Worker’s file.

		WSBC Fee ($)
19940	Form 11 - Progress Report (Electronically) within 3 business days	53.54

NOTES:

- Payable when a Form 11 is received Electronically by WorkSafeBC within 3 business days of the date of service where the date of service is the date of the assessment and is considered day 0.
- Billable in addition to an office visit.

	Form 11 – Progress Report (Electronically) within 4-6 business days …..	24.30

NOTES:

- Payable when a Form 11 is received by WorkSafeBC within 4-6 business days of the date of service, where the date of service is the date of the assessment and is considered day 0.
- If a Form 11 is received 7 business days or later following the date of service, the fee paid is $0.
- Billable in addition to an office visit.

19902	Form 11 - Progress Report (fax transmission) within 3 business days.	39.00

NOTES:

- Payable when a Form 11 is submitted by fax transmission and received by WorkSafeBC within 3 business days of the date of service, where the date of services is the date of the assessment and is considered day 0.
- Billable in addition to an office visit.

	Form 11 – Progress Report (fax transmission) within 4-6 business days.	19.49

NOTES:

- Payable when a Form 11 is submitted by fax transmission and received by WorkSafeBC within 4-6 business days of the date of service, where the date of service is the date of the assessment and is considered day 0.
- If Form 11 is received 7 business days or later following the date of service the fee paid is $0.
- Billable in addition to an office visit.

19559	Form 11 – Progress Report requested by WorkSafeBC	53.54

NOTES:

- Payable when a Form 11 is requested by WorkSafeBC where the form is not initially required (see Form 11 rules) and is received within 10 business days of the faxed or telephone request, where the date of the request is considered day 0.

(notes continued on next page)

		WSBC Fee ($)
	• Submissions received after 10 business days of the request will not be paid. • Fee code 19904 may not be billed in addition to fee code 19559 as fee code 19904 includes copying of an existing report from an Injured Worker's file.	
19977	Opioid Extension Form – within 15 business days NOTES: • To be completed by a Physician or a Surgeon only when requested by WorkSafeBC. • Service is to be provided for the completion of the Opioid Extension Form (68D80). • Form Fee includes the physical examination and completion of the form. • The Physician shall not complete a Form 11 for the examination when an Opioid Extension Form is requested. • Payable when the Opioid Extension Form is completed and received by WorkSafeBC within 15 business days of the request where the date of the request is considered day 0.	98.87
	Opioid Extension Form – after 15 business days NOTES: • To be completed by a Physician or a Surgeon only when requested by WorkSafeBC. • Service is to be provided for the completion of the Opioid Extension Form (68D80). • Form Fee includes the physical examination and completion of the form. • The Physician shall not complete a Form 11 for the examination when an Opioid Extension Form is requested. • Payable when the Opioid Extension Form is completed and received by WorkSafeBC after 15 business days of the request where the date of the request is considered day 0.	92.29
19978	Standardized Assessment or Pre-Operative Assessment Form – within 15 business days	247.18

(see notes on next page)

	WSBC Fee ($)

NOTES:

- To be completed by a Physician only when requested by WorkSafeBC or a surgeon.
- Service is to be provided for specific assessments upon request, for example for the completion of one of the following forms:
  - Pre-operative Assessment Form (83MI)
  - WorkSafeBC Standard Assessment of Patients with Cervical Pain (form 10D12)
  - WorkSafeBC Standardized Assessment of Patients with Low Back Pain (Form 10D13)
- Form Fee includes physical examination and completion of the report form.
- The Physician shall not complete a Form 11 for the examination when a Standard Assessment or Pre-Operative Assessment Form is requested.
- Payable when the Standard Assessment Form is completed and received by WorkSafeBC and/or the surgeon (if applicable) within 15 business days of the request where the date of the request is considered day 0.

Standardized Assessment or Pre-Operative Assessment Form – after 15 business days 230.72

NOTES:

- To be completed by a Physician only when requested by WorkSafeBC or a surgeon.
- Service is to be provided for specific assessments upon request, for example for the completion of one of the following forms:
  - Pre-operative Assessment Form (83MI)
  - WorkSafeBC Standard Assessment of Patients with Cervical Pain (form 10D12)
  - WorkSafeBC Standardized Assessment of Patients with Low Back Pain (Form 10D13)
- Form Fee includes physical examination and completion of the report form.
- The Physician shall not complete a Form 11 for the examination when a Standard Assessment or Pre-Operative Assessment Form is requested.
- Payable when the Standard Assessment Form is completed and received by WorkSafeBC and/or the surgeon (if applicable) after 15 business days of the request where the date of the request is considered day 0.

ADDITIONAL PROVISIONS TO FORM FEES:

1. Eligibility for Form 8 Fee (See Schedule A section 6.1.3): WorkSafeBC will reimburse the Physician for a Form 8 First Report of Injury and an office visit for the firs visit where the Physician suspects the Injured 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. Note; WorkSafeBC will pay the full cost of the office visit, if the injury is compensable and the injury is the primary reason for the office visit and where applicable, a form fee (See Agreement section 7.7).

2. Expedited Consultations Not Eligible (See Schedule A section 6.1.4): A Specialist billing for an Expedited consultation must not bill for a Form 8 First Report of Injury.

3. Electronic and Fax Submission Only (See section 7.6): WorkSafeBC will only compensate Physician for invoices and forms for Form 8 First Report of Injury and Form 11 Progress Report submitted Electronically (through MSP Teleplan) or by fax transmission. WorkSafeBC will not compensate Physicians that submit invoices or forms for Form 8 First Report of Injury and Form 11 Progress Report by mail.

4. Form 8 and Regular Physician (See Schedule A section 5.1): Payment for a Form 8 First Report of Injury will only be made (a) for the first Form 8 received by WorkSafeBC submitted by any Physician and (b) If a second Form 8 is subsequently submitted Electronically by the Injured Worker's regular Physician and it is received by WorkSafeBC within 10 business days from the date on which the first Form 8 was received by WorkSafeBC.

5. One Form 8 (See Schedule A section 5.3): A Physician may only submit one Form 8 per claim and any subsequent Form 8 First Report of Injury will be paid at a Form 11 Progress Report rate, unless submitted by the Injured Worker's regular Physician, in which case point 4 above applies.

6. Form 11 Requirements (See Schedule A section 6.1.7): A Form 11 Progress Report must only be submitted for a change of medical condition or as an accompaniment to fee codes 19509, 19510, 19511 and 19950. A Form 11 Progress Report where there is no change in the Injured Worker's medical condition, treatment plan, or return to work status is not payable unless an interval of at least four weeks has passed since the Physician last invoiced for a Form 11 Progress Report.

7. Missing Information (See Schedule A section 5.4): Any submitted Form 8 First Report of Injury and/or Form 11 Progress Report that is missing mandatory field(s) or is illegible will be rejected without any cost to WorkSafeBC.

8. Follow Up Visits (See Schedule A section 6.1.8): Follow-up examination visits will be paid regardless of whether a Form 11 has been submitted.

		WSBC Fee ($)
	2.0 PHYSICIAN SERVICES FEES	
19904	Copy of existing report requested by WorkSafeBC	52.73

NOTES:

- Payable when WorkSafeBC requests a copy of an existing report, received within 3 business days of request
- Where a Physician is required to review a chart or a report for the purpose of severing and separating confidential information not related to the claim, the Physician must bill fee code 19953.

19953	Copy of chart notes requested by WorkSafeBC that requires Physician to review notes for the purpose of **isolating specific information**.....	158.22

NOTES:

- Payable when WorkSafeBC requests a copy of chart notes and where complying with that request requires the Physician to review the chart or report prior to the submission of the copy for the purpose of:
  - severing identified personal information not relevant to the claim prior to submission of copy; or
  - identifying previous injury or illness relevant to the current claim; or
  - identifying an area of injury in question from prior records and separating that information from other clinical information
- An additional unit of this Fee Code may be invoiced on an exception basis as outlined in the Physicians and Surgeons' WorkSafeBC Services Reference Guide on worksafebc.com, provided that this exception has been pre-approved by the Health Care Program Manager in their sole discretion.
- Must be received by fax within 10 business days of request.
- Fee code 19953 includes all courier charges.
- Fee code 19904 cannot be billed in addition to 19953.

19907	Written Summary or Reasoned Medical Opinion Requested by WorkSafeBC.....	336.21

NOTES:

- Payable when a written summary or reasoned medical opinion is requested by WorkSafeBC.
- This is to pay for the generation of a new report and not to pay for a copy of an existing report.

19908 Non-Expedited Specialist Consultation Report - Initial or Repeat 53.11
NOTES:
- 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 10 business days of the date of service or the date of the request, where the date of service is the date of the assessment and is considered day 0 and the date of request by WorkSafeBC is day 0.

19930 Telephone or Office Consultation – per 15 minutes 93.61
NOTES:
- Payable for any telephone or office consultation between the treating Physician and:
  - A WorkSafeBC Medical Advisor. It is expected that such a call or consultation takes place within 24 hours if initiated by the Medical Advisor; or
  - A Board Officer or designate; or
  - A WorkSafeBC-sponsored treatment program Physician or other program staff, a community Physician and/or a community allied health provider. Community allied health care providers are providers involved in the care of an Injured Worker, such as a physiotherapist, occupational therapist, or psychologist.
- Can be billed for multidisciplinary team conferences.
- Billed in 15 minute increments up to a maximum of 45 minutes, or 3 units, per day per claim.
- Cannot be invoiced for administrative inquiries.

00129 Emergency Call-Out..... 88.59
NOTES:
- Payable for an emergency call-out when a Physician (Family Physician or Specialist) has to immediately leave the Physician’s home or office (outside of hospital) to attend an Injured Worker.
- This fee is billed over and above MSP Medical Services fees.
- This fee cannot be billed with MSP fee codes: 01200, 01201, 01202, 01205, 01206, 01207, 01210, 01211, 01212, 01215, 01216, 01217.

19942 WorkSafeBC Job-Site Meeting 388.94
NOTES:
- Payable when a Physician attends a job-site meeting.
- Flat fee that includes travel time and all other costs associated with a job-site meeting/visit.

19922 Cost of Materials..... Actual Cost

NOTES:

- Applies for materials used in conjunction with sterile tray fees.
- Bill the actual cost of materials.

19929 Prolonged or Complex Case Review and Report Requested by WorkSafeBC..... 212.12

NOTES:

- Payable at the request of WorkSafeBC for a Physician to review the file(s), examine the Injured Worker, and develop a report on an Injured Worker whose recovery is prolonged or complex.
- Unless it is not practical, such cases should be referred to WorkSafeBC Medical and Return to Work Planning (MARP) program for appropriate review, assessment and case planning.
- In situations where WorkSafeBC requires information about an Injured Worker who is not under active treatment but who continues to have an injury claim, WorkSafeBC may request a Physician who had treated the Injured Worker to review the file(s) and develop a report describing the details of the injury, diagnosis, and treatment.
- Report must be received within 20 business days of service.
- Submissions received after 20 business days will not be paid.

19931 Consultation after Surgery..... 110.80

NOTES:

- Payable to an office visit and a consultation report (for Surgeons) or a Form 11 (for Family Medicine physicians who are exclusively responsible for follow up post-operative care) within 42 calendar days following the surgery to:
  - assess an Injured Worker's potential to return to work; or
  - refer an Injured Worker to an appropriate treatment program; or
  - if neither of the foregoing are appropriate, to recommend a treatment plan with an estimate of recovery and return to work.
- Report (consultation or Form 11) must be received within 5 business days of service.

19950 Return to Work Consultation..... 373.33

(see notes on next page)

NOTES:

- Can be initiated by Board Officer or delegate, WorkSafeBC Medical Advisor, employer or by treating Physician to facilitate a safe, early return to work.
- Must include consultation by Physician with the employer and follow up to discuss return to work with the Injured Worker.
- One further consultation cycle may be billed if initial attempt at return to work is unsuccessful.
- Fee code 19950 includes the office visit and phone calls related to the return-to-work planning in order to complete the return-to-work plan.
- A Form 11 is billable in addition to fee code 19950 if the return-to-work consultation is completed on the same day as the office visit.

19976 Return to Work planning request. 54.48

NOTE:

- Payable on request by a Board Officer or designated rehabilitation provider to endorse a 1-page return to work planning request form.

19558 Activities and Limitation Form 170.86

NOTES:

- Payable when the Activities and Limitation Form is completed by a WorkSafeBC Board Officer or Medical Advisor over the phone with the treating Physician and the treating Physician receives a copy to validate or completed directly by the treating Physician.
- Billable in addition to an office visit with the Injured Worker if the visit is required in order to complete the Activities and Limitation Form.
- Billable in addition to fee code 19930 if completed over the phone.

19509 Complex Spinal Cord Injury - initial visit or **yearly assessment**..... 193.88

NOTES:

- Payable only for an Injured Worker with a spinal cord injury.
- Visit to include a complete physical exam and updated care plan documented and presented on a Form 11.
- Only payable once per Injured Worker per year to noted regular Physician.
- Form 11 is payable in addition to fee code 19509.

19510 Complex Spinal Cord Injury **office visit**..... 129.26

(see notes on next page)

NOTES:
- Payable only for an Injured Worker with a spinal cord injury.
- Cannot be billed in addition to a yearly assessment fee (fee code 19509) on the same day.
- Form 11 is payable in addition to fee code 19510 if there are changes in the Injured Worker's condition.

19511 Complex Spinal Cord injury **home visit**..... 258.51
NOTES:
- Payable only for a home visit with an Injured Worker with a spinal cord injury.
- Physician must also complete and bill for a Form 11.
- Cannot be billed with office visit fee code 19510.

19556 Image-guided diagnostic and therapeutic injection..... 286.66
NOTES:
- Payable only for an injection that requires imaging guidance (e.g.: CT, fluoro, ultrasound) regardless of the location where the injection is performed.
- Billable if the procedure is performed at a hospital, WorkSafeBC-contracted private surgical facility or in the Physician's office.

19557 Usage of Physician's own imaging equipment for image-guided diagnostic and therapeutic injection..... 167.87
NOTES:
- Payable for the usage of Physician's own imaging equipment in addition to fee code 19556 when an injection requires imaging guidance (e.g.: CT, fluoro, ultrasound).
- Cannot be billed if the procedure is performed at a hospital or a WorkSafeBC-contracted private surgical facility.

19932 Medical-Legal Report – **All Physicians** 1331.54
NOTES:
- Payable only with prior approval by a Board Officer, Review Officer or WCAT Vice Chair.
- Medical Legal Report fee code 19932 is applicable to all Physicians.
- Report must recite symptoms, history and records and give diagnosis, treatment, results and present condition, and be a factual summary of all information about when the Injured Worker will be able to return to work and may include whether there will be a permanent disability.
- Fee code includes examination, review of records, and other processes leading to completion of the written report.

19933 Medical-Legal Opinion **– Specialists** 2227.98
NOTES:
- Payable only with prior approval by a Board Officer, Review Officer or WCAT Vice Chair.
- Medical-legal Opinion fee code 19933 is applicable only to Specialists with relevant qualifications, or other Physicians with recognized expert knowledge.
- Medical-Legal 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, the long-term consequences and possible complications in the further development of the condition or other matter. There will be the extensive exercise of expert knowledge and judgment with respect to the known facts set out in the opinion with a detailed prognosis.
- Fee code includes examination, review of records, and other processes leading to completion of the written opinion.

19911 Initial Expedited Comprehensive Consultation from Specialists (except Anesthesiologists). 462.02
NOTES:
- Payable for an Initial Expedited Comprehensive Consultation from Specialists.
- Report must be received within 15 business days of the referral.
- Includes a physical examination and a written report.

19912 Repeat Expedited Comprehensive Consultation Specialists (except Anesthesiologists) 224.86
NOTES:
- Payable for 1 repeat Expedited Comprehensive Consultation when the repeat consultation takes place within 12 weeks of the Initial Expedited Comprehensive Consultation for which fee code 19911 was billed.
- Includes a physical examination and a written report.
- Report must be received within 5 business days of the consultation.

19934 Initial Expedited Comprehensive Consultation - Anesthesiologist 448.35
NOTES:
- Payable for an initial Expedited Comprehensive Consultation from an Anesthesiologist for diagnostic opinion and/or therapeutic management.

(notes continued on next page)

- Report must be received within 15 business days of the referral.
- Includes 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.

19935 Repeat Expedited Comprehensive Consultation – Anesthesiologist. .. 218.03
NOTES:
- Payable for one (1) repeat Expedited Comprehensive Consultation from an Anesthesiologist when the repeat consultation takes place within twelve (12) weeks of the Initial Expedited Comprehensive Consultation for which fee code 19934 was billed.
- Includes a physical examination and a written report.
- Report must be received within 5 business days of the consultation.

19945 Initial Expedited Comprehensive Consultation - Physician With Areas of Expertise 360.80
NOTES:
- Payable for an Initial Expedited Comprehensive Consultation by a Physician with Areas of Expertise.
- Report must be received within 15 business days of the referral.
- Includes a physical examination and a written report.

19946 Repeat Expedited Comprehensive Consultation – Physician With Areas of Expertise after fee code 19945..... 175.65
NOTES:
- Payable for 1 Repeat Expedited Comprehensive Consultation by Physician with Areas of Expertise when the repeat consultation takes place within 12 weeks of the Initial Expedited Comprehensive Consultation for which fee code 19945 was billed.
- Includes a physical examination and a written report.
- Report must be received within 5 business days of the consultation.

19936 Expedited Consultation Cancellation Fee 95.73
NOTE:
- May be invoiced if an Expedited Consultation is cancelled by the Injured Worker within 24 hours of the assessment, or in the case that the Injured Worker does not arrive for the consultation with no forewarning (i.e. a ‘no-show’).

ADDITIONAL PROVISIONS TO EXPEDITED SPECIALIST CONSULTATIONS

1. Return to Work Exception (See Schedule A section 7.2.1.4): Despite the timelines for reports set out in the table above, where following a consultation the Physician concludes the Injured Worker is fit to return to work, the report must be received within three business days of the consultation.

2. Initial Expedited Comprehensive Consultation (See Schedule A section 7.3): A Physician is entitled to the Initial Expedited Comprehensive Consultation fee as applicable for the first consultation on each claim and a subsequent Initial Expedited Comprehensive Consultation as applicable only when both of the following conditions occur:

    (a) more than six months lapsed since the Physician last saw the Injured Worker; and

    (b) the consultation is as a result of a new referral in accordance with Schedule A.

3. Emergency (See Schedule A section 7.3.2): A Physician is entitled to the Initial Expedited Comprehensive Consultation fee as applicable where the consultation occurs as a result of an emergency (e.g.: Trauma).

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; and

- 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 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 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 1.10 and 1.11 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 D – 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, anesthetic, 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 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, section 1.0, for the Expedited consultation sessional rate for VSC.

3.2.2 Refer to Schedule B – Fee Schedule for WorkSafeBC Unique Fee for service Items, 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 Sessional and Expedited Services, section 2.0 for the Expedited surgical procedural rate.

3.3.2 All Expedited surgical procedures, with the exception of Extensive Spine Surgery, and qualifying out of office hours emergency surgery shall be billed and compensated in accordance with Schedule D section 2.0 using the Expedited Surgical Premium rate.

3.3.2.1. Expedited Surgical Procedures:

Physicians who perform Expedited surgeries for WorkSafeBC shall be entitled to a unique fee of an Expedited Surgical Premium in addition to the applicable MSP surgical procedure fee(s). The Expedited Surgical Premium will be automatically applied to payments for surgeries that meet the Expedited timelines as described below in section 3.3.3. With this 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 Expedited Surgical Premium is as follows:

- Effective April 1, 2023: 224.47%
- Effective April 1, 2024: 232.39%

3.3.3 All surgical procedures that are performed on WorkSafeBC Injured Workers will be billable at the Expedited procedural rate set out in Schedule D provided that:

- The prescribed Authorization for Surgery Form (Form 83D6 – Authorization Request for Surgery) is submitted within five business days following WorkSafeBC's receipt of the comprehensive consultation report recommending expedited surgery. WorkSafeBC will provide written authorization confirming its approval of the surgery via the Form 83D6.

- A surgery is considered Expedited if performed within forty business days from the date on which the physician receives written authorization for surgery from WorkSafeBC Board Officer. The Expedited Surgical Premium will be applied automatically provided that the physician bills fee code 19326 (zero dollars) when the surgeon receives the written approval and records the authorization date as the date of service of fee code 19326 while electronically billing it to WorkSafeBC prior to surgery. If the physician does not bill fee code 19326, the Expedited Surgical Premium will only be applied automatically if the surgery is performed within forty business days from the date of the last consultation.

- In the case of emergency (trauma) surgery performed, the surgeon will submit the prescribed Authorization for Surgery Form (Form 83D6 – Authorization Request for Surgery) within five business days following the emergency (trauma) surgery to the Board Officer along with the comprehensive consultation report, the Expedited surgical procedure rates will be paid in recognition of the role of the emergency (trauma) surgery in injury outcome and of the episode of care following the surgery, including he Physician's role in facilitating return to work as set out in Schedule A.

3.3.4 Procedures performed outside the limitation period as specified in section 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 Program Manager for adjudication of the Expedited Fee.

3.3.6 Only the first three elective surgeries per Injured Worker will be considered for Expedited surgical procedure rates 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 Program Manager.

3.3.7 Expedited surgical procedure rates 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 Injured Worker details, volume and proposed procedures, and timeline to completion;

- A Surgical Authorization form is directed to the Board Officer for entitlement approval; and

- A letter is directed to the Health Care 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 section 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 business days of the date of surgery, and is a requirement for WorkSafeBC to process payment.

3.3.11 All appropriate out-of-office hours Service and surcharges (as per MSP Payment Schedule) 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 time limit constraint for Expedited rates. Any surgeon found violating this principle would be excluded from this Agreement.

3.4 **Anesthesia Expedited Fees**

3.4.1 Refer to Schedule D – Fee Schedule for Sessional and Expedited Services, section 3.0 for the procedural anesthesiology rate. These fees shall be billed through Teleplan, except for Extensive Spine Surgery anesthesia.

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 anesthesiologists 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;

(b) A time based fee code as described in Fee Schedule D, section 3.0.

(c) Where applicable, the fee code 01169 and the fee code for the Out-of-Office Hours Surcharge as described in Fee Schedule D, section 3.0.

3.4.3 WorkSafeBC shall pay Expedited rates when an Anesthesiologist provides anesthetic for an Injured Worker undergoing Expedited surgery and the surgical procedure meets the timeline requirements in section 3.3.3 of Schedule C. Otherwise, the anesthesiology Services must be billed at the MSP anesthesiology code rates only, unless the Health Care Program Manager determines otherwise.

3.4.4 Anesthesia consultations must be billed fee-for-service (fee code 19934). The consultative report shall be comprehensive.

3.4.5 The anesthesia time includes a pre-operative assessment, as well as the time from induction until the Anesthesiologist is no longer in attendance and the Injured Worker can be safely discharged for the post anesthetic recovery (PAR). If the pre-operative and PAR times are significantly longer than 15 minutes, respectively, or a total of 30 minutes then an explanatory note shall accompany the record of anesthesia.

3.4.6 The Anesthesiologist will provide the Record of Anesthesia, 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 Anesthesiologist. The Anesthesiologist must support the need with written statements to WorkSafeBC explaining why there was a medical requirement to have 2 in attendance.

3.4.8 The Anesthesiologist’s fee covers all Services rendered by the Anesthesiologist during the procedure.

3.4.9 Except for life or limb threatening circumstances, an Anesthesiologist may not bill for 2 Injured Workers during the same time period. The Anesthesiologist must support the need with a written statement to WorkSafeBC providing explanation as to the medical requirement for the circumstance.

3.5 Surgical Assist Fees

3.5.1 Refer to Schedule D – Fee Schedule for Sessional and Expedited Services, section 4.0, for the Expedited surgical assist rate. These fees shall be billed through Teleplan.

3.5.2 Surgical Assists are to be billed electronically through Teleplan at the rates outlined in Schedule D section 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 and where applicable, the MSP fee code 13003 and the fee code for the Out-of-Office Hours Surcharge as described in Fee Schedule D, section 4.0:

Level 1 Surgical Assist (surgery time up to 1.5 hours)

Level 2 Surgical Assist (surgery time 1.51 to 2.0 hours)

Level 3 Surgical Assist (surgery time 2.01 to 2.5 hours)

Level 4 Surgical Assist (surgery time 2.51 to 3.0 hours)

Level 5 Surgical Assist (surgery time 3.01 to 3.5 hours)

Level 6 Surgical Assist (surgery time 3.51 to 5.99 hours)

Level 7 Surgical Assist (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 Spine Surgery 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 in section 3.3.3 of Schedule C are waived for these Services.

3.6.4 Refer to Schedule D – Fee Schedule for Expedited Services, section 2.0, for the Expedited Extensive Spine Surgery rates.

Fee Code	Description	Fee ($) (Effective April 1, 2022)	Fee ($) (Effective April 1, 2023)	Fee ($) (Effective April 1, 2024)

SCHEDULE D
FEE SCHEDULE FOR SESSIONAL AND EXPEDITED SERVICES

1.0 EXPEDITED SESSIONAL SERVICES

1150464	Initial Expedited Consultation Service Fees / Sessional Rate (VSC ONLY)..... NOTE: Bill as per contract.	2,431.99	2,613.17	2,705.29
1150465	Repeat Expedited Consultation Service Fees / Sessional Rate (VSC ONLY)..... NOTE: Bill as per contract.	2,431.99	2,613.17	2,705.58

2.0 EXPEDITED SURGICAL PROCEDURE RATES AND OUT-OF-OFFICE HOURS SURCHARGE

MSP Fee Code	For Expedited surgical procedures excluding Extensive Spine Surgery, invoice MSP fee codes applicable to the procedure. If the surgery meets the requirements for Expedited surgical procedure rates as set out in Schedule C section 3.3.3, HIBC will apply the applicable Expedited Surgical Premium in addition to the paid MSP surgery procedure fees. ..... NOTE: Bill through Teleplan	208.91%	224.47%	232.39%
19516	Expedited Extensive Spine Surgery – Sessional fee (no MSP fee code applicable)..... NOTE: Bill through Teleplan	4,429.20	4,759.17	4,926.94
19320	Out-of-Office Hours Surcharge, Operative Evening (commencing on or after 6pm up to 11pm). Applicable to emergency surgery or to elective surgery that is rescheduled due to intervening emergency surgery in an Operative Evening..... NOTE: Bill through Teleplan.	The greater of $69.65 or 17.50% of the paid MSP surgery procedure fees	The greater of $74.84 or 17.50% of the paid MSP surgery procedure fees	The greater of $77.48 or 17.50% of the paid MSP surgery procedure fees

Fee Code	Description	Fee ($) (Effective April 1, 2022)	Fee ($) (Effective April 1, 2023)	Fee ($) (Effective April 1, 2024)
19321	Out-of-Office Hours Surcharge, Operative Night (commencing on or after 11pm to 8 am). Applicable to emergency surgery or to elective surgery that is rescheduled due to intervening emergency surgery in an Operative Night..... NOTE: Bill through Teleplan.	The greater of $112.53 or 28.00% of the paid MSP surgery procedure fees	The greater of $120.91 or 28.00% of the paid MSP surgery procedure fees	The greater of $125.17 or 28.00% of the paid MSP surgery procedure fees
19322	Out-of-Office Hours Surcharge, Operative Sat/Sun/Holidays (8am to 11pm). Applicable to emergency surgery or to elective surgery that is rescheduled due to intervening emergency surgery in an Operative Sat/Sun/Holidays..... NOTE: Bill through Teleplan.	The greater of $69.65 or 17.50% of the paid MSP surgery procedure fees	The greater of $74.84 or 17.50% of the paid MSP surgery procedure fees	The greater of $77.48 or 17.50% of the paid MSP surgery procedure fees

ADDITIONAL PROVISIONS

1. Invoice MSP fee codes applicable to the surgical procedure, and where applicable, fee codes 19320, 19321 or 19322 for an out-of-office hours surcharge. If an out-of-office hours surcharge is claimed under fee codes 19320, 19321 or 19322, the invoice must include the time that the surgery commenced in order to be paid. For qualifying out-of-office hours surgeries commencing during the operative evening and continuing in the operative night (both as defined in the table above), invoice for the period in which the major portion of the surgical time is spent (operative evening or operative night).

2. Fee codes 19320, 19321 and 19322 are applicable only to emergency or elective surgery that is:

   (a) rescheduled to an out-of-office time period due to intervening emergency surgery or is scheduled in an out-of-office time period at the request of the Injured Worker; and

   (b) at least 45 minutes of surgery time or requires general, spinal or epidural anesthesiology.

3. Where applicable, fee codes 19320, 19321 or 19322 may be billed even if the surgery does not meet the requirements for Expedited surgical procedure rates as set out in Schedule C section 3.3.3.

4. Where a surgery meets the requirements for an out of office hours surcharge and for Expedited surgical procedure rates in accordance with Schedule C section 3.3.3, fee codes 19320, 19321 or 19322, as applicable, are eligible for the applicable Expedited Surgical Premium.

5. “Emergency surgery” when used in this Schedule D section 2.0 means emergency surgery that is defined, deemed or adjudicated under MSP to be emergency surgery.

6. Where applicable, fee codes 19320, 19321 or 19322 are billable in addition to MSP out-of-office hours surcharge fee codes 01210, 01211 and 01212.

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
3.0	**EXPEDITED ANESTHESIA RATES FOR EXPEDITED SURGICAL PROCEDURES**			
MSP Fee Code	Expedited Anesthesia Services: Invoice 1 appropriate MSP fee code, plus the MSP fee code 01169 where applicable, plus the applicable number of units of block billing time-based fee code 19507. ..... NOTE: Bill through Teleplan.			
19507	Expedited Anesthesia Time. One unit equals 15 minutes ..... NOTE: Bill through Teleplan.	87.56	94.09	97.40
19518	Expedited Extensive Spine Surgery Anesthesia – Sessional fee (no MSP fee code applicable) ..... NOTE: Bill through Teleplan.	2,693.57	2,894.24	2,996.26
19405	Expedited Anesthesiology, Out-of-Office Hours Surcharge, Operative Evening (1800 to 2300 hours) – applied to 19507 ..... NOTE: Bill same number of units as is billed for fee code 19507	32.77%	32.77%	32.77%

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
19406	Expedited Anesthesiology, Out-of-Office Hours Surcharge, Operative Evening (2300 to 0800 hours) – applied to 19507 ..... NOTE: Bill same number of units as is billed for fee code 19507	52.54%	52.54%	52.54%
19407	Expedited Anesthesiology, Out-of-Office Hours 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%	32.77%

4.0 EXPEDITED SURGICAL ASSIST RATES FOR EXPEDITED SURGICAL PROCEDURES

MSP Fee Code	Invoice 1 appropriate MSP surgical assist fee code related to surgical procedure, plus the MSP fee code 13003 where applicable, plus applicable block billing time-based fee code below. NOTE: Bill through Teleplan.			
19545	Expedited Surgical Assist – Level 1 (Surgery time up to 1.5 hours) ..... NOTE: Bill through Teleplan.	263.77	283.42	293.41
19546	Expedited Surgical Assist – Level 2 (Surgery time 1.51 to 2.0 hours) ..... NOTE: Bill through Teleplan.	381.14	409.54	423.97
19547	Expedited Surgical Assist – Level 3 (Surgery time 2.01 to 2.5 hours) ..... NOTE: Bill through Teleplan.	522.89	561.84	581.64
19548	Expedited Surgical Assist – Level 4 (Surgery time 2.51 to 3.0 hours) ..... NOTE: Bill through Teleplan.	639.10	686.71	710.92
19549	Expedited Surgical Assist – Level 5 (Surgery time 3.01 to 3.5 hours) ..... NOTE: Bill through Teleplan.	761.11	817.81	846.64

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
19551	Expedited Surgical Assist – Level 6 (Surgery time 3.51 to 5.99 hours)..... NOTE: Bill through Teleplan.	1,121.32	1,204.86	1,247.33
19552	Expedited Surgical Assist – Level 7 (Surgery time 6.00 hours plus)..... NOTE: Bill through Teleplan.	1,719.76	1,847.88	1,913.02
19517	Expedited Extensive Spine Surgery Surgical Assist – Sessional fee (no MSP fee code applicable). ..... NOTE: Bill by fax to WorkSafeBC	1,727.38	1,856.06	1,921.49
19410	Expedited surgical assist, Out-of-Office Hours Surcharge, Operative evening (6 to 11pm)..... NOTE: Bill this percentage applied to applicable Level fee code billed.	32.77%	32.77%	32.77%
19411	Expedited surgical assist, Out-of-Office Hours Surcharge, Operative night (11pm to 8am)..... NOTE: Bill this percentage applied to applicable Level fee code billed.	52.54%	52.54%	52.54%
19412	Expedited surgical assist, Out-of-Office Hours Surcharge, Operative Sat/sun/Holidays ..... NOTE: Bill this percentage applied to applicable Level fee code billed.	32.77%	32.77%	32.77%

5.0 EXPEDITED PSYCHIATRY SERVICES – PERSONAL SERVICES AGREEMENT

Where WorkSafeBC enters into a Personal Services Agreement with a psychiatrist for Expedited psychiatry services, WorkSafeBC will pay the psychiatrist in accordance with the table below for the categories of Expedited services set out in the table.

	PSYCHIATRY ASSESSMENT			
19949	Psychiatric Opinion Assessment.....	1,577.46	1,694.98	1,754.73

(see notes on next page)

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
	NOTES: • Fee includes all services included in psychiatric opinion assessment including: o Injured Worker interview (medical history, drug/treatment history, psychosocial history, etc.); o DSM diagnosis; o Treatment recommendations; Management Plan • Report must be received within 10 business days of the assessment.			
19948	Psychiatric Opinion Assessment – Telehealth ..... NOTES: • Fee includes all services included in psychiatric opinion assessment including: o Injured Worker interview (medical history, drug/treatment history, psychosocial history, etc.); o DMS diagnosis; o Treatment recommendations; Management Plan • Report must be received within 10 business days of the assessment.	1,507.33	1,619.63	1,676.72
OUTPATIENT PSYCHIATRY TREATMENT				
19430	Outpatient Psychiatry Treatment Per ½ hour.....	187.32	201.27	208.37
19431	Outpatient Psychiatry Treatment Per ¾ hour	279.81	300.66	311.26
19432	Outpatient Psychiatry Treatment per 1 hour.....	374.64	402.55	416.74
19449	Outpatient Psychiatry Treatment per 1 ½ hours.....	561.96	603.82	625.11
19424	Outpatient Psychiatry Evaluation Interview with Family Member(s) Per ½ hour.....	187.32	201.27	208.37

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
19425	Outpatient Psychiatry Patient Management Conference Per ¼ hour.....	100.68	108.19	112.00
	NOTES: • Fee includes all services involved in outpatient psychiatry treatment including: o Individual, family or group psychotherapy; evaluation interview with family member(s); o Actual Injured Worker contact time; o Does not include psychiatric treatment or counselling by telephone; o Drafting of progress report; o Progress report must be submitted for each follow-up visit.			
INPATIENT PSYCHIATRIC TREATMENT				
19426	Inpatient Individual Treatment per ½ hour.....	187.32	201.27	208.37
19427	Inpatient Individual Treatment per ¾ hour.....	280.98	301.91	312.55
19429	Inpatient Individual Treatment per 1 hour.....	374.64	402.55	416.74
	NOTES: • Fee includes all services included in inpatient psychiatry treatment including: o Hospital or institution; o Actual Injured Worker contact time; o Drafting of progress report. • Progress report must be submitted every 10 business days and within 10 business days following Injured Worker discharge.			

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
TELEHEALTH PSYCHIATRY TREATMENT				
19310	WorkSafeBC Telehealth Psychiatry Treatment – ½ hour	187.32	201.27	208.37
19311	WorkSafeBC Telehealth Psychiatry Treatment – ¾ hour	279.81	300.66	311.26
19312	WorkSafeBC Telehealth Psychiatry Treatment – 1 hour	374.64	402.55	416.74
	NOTES: • Where direct interactive video link with the Injured Worker. • Telehealth office visit to include services such as chemotherapy management and/or psychotherapy.			
19444	Psychiatry Independent Medical Examination			
	– Including timely completion bonus	3,273.88	3,517.79	3,641.79
	– where no timely completion bonus	3,059.55	3,287.48	3,403.37
	NOTES: • Fee for an independent psychiatric evaluation by a non-treating psychiatrist to address referral questions that may include an opinion on the Injured Worker's medical needs or condition or further treatment. • Fee includes all services including: o Patient (Injured Worker) interview (medical history, drug/treatment history, psychosocial history, etc.); o DSM diagnosis; o Treatment recommendations; o Results of psychiatric opinion; and o Respond to referral questions.			

(notes continued on next page)

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
	• Report must be received within 10 business days of the assessment to receive timely completion bonus.			
19445	Complex Psychiatric Opinion			
	– including timely completion bonus	3,273.88	3,517.79	3,641.79
	– where no timely completion bonus	3,059.55	3,287.48	3,403.37
	NOTES: • Fee is payable for a psychiatric assessment for the following conditions: o Complex concurrent or co-morbid psychiatric disorders may include two or more of the following: severe mental health disorder (e.g.: bipolar, psychosis, TBI), active substance abuse disorder; o Significant pre-existing psychiatric disorders and/or significant co-morbid medical disorders requiring review of extensive psychiatric and medical documents; and o Acute risk assessment (suicidal/homicidal) • Fee includes all services including: o Patient (Injured Worker) interview (medical history, drug/treatment history, psychosocial history, etc.); o DSM diagnosis; o Treatment recommendations; and o Results of psychiatric opinion.			

(notes continued on next page)

Fee Code	Description	Fee ($) (Effective April 1, 2019)	Fee ($) (Effective April 1, 2020)	Fee ($) (Effective April 1, 2021)
	• Report must be received within 10 business days of the assessment to receive timely completion bonus.			
6.0	**MEDICAL ADVISORS**			
Not applicable	Medical Advisor, sessional rate – per session..... NOTE: Billing as instructed	616.39	658.00	677.87
Not applicable	Specialist Medical Advisor, sessional rate – per session ..... NOTE: Billing as instructed	774.71	827.00	851.98

REVISED FEES FOR NON-MSP-INSURED SERVICES EFFECTIVE APRIL 1, 2026*

**The April 1, 2025, Doctors of BC uninsured services rates reflect an increase of 2.1 % on each fee item with the following exceptions: A00009, 96201, 96301, 96302, 96400, 96501, 96502, 96503, 96504, 96505, (which are negotiated separately) The fees in this document are subject to the rounding rules of the Doctors of BC.*

This is not an all-inclusive or exhaustive list of services but represents the most commonly requested professional services.

These fees cannot be correctly interpreted without reference to Preamble Clause C. 2.

C. 2. Setting and Modification of Fees

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

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

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

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

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 Fee Guide. 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.

		Non-MSP-Insured Fee ($)
INDUSTRIAL AND INSURANCE		
A00001	General insurance examination, industrial examinations (to include MOT, marine personnel, pilots and air traffic controllers), pre-placement and periodic examinations, and CPP examinations	265.00
A00002	Limited examinations for special policies	188.00
A00003	Industrial pre-placement and periodic examination not requiring complete examination	110.00

		Non-MSP-Insured Fee ($)
	Part-time professional employment where fee-for-service is not applicable:	
A00004	Group examination of apparently healthy persons, including school examinations – per hour	449.00
A00005	– Half day session (3.5 hours), 5 or less sessions per week – per session	1198.00
A00006	– 6th or additional half day session the same week – per session	999.00
	NOTE: Medical Services Plan reimbursement agreement for sessional fees may be found in the Sessional Arrangements section of the Fee Guide.	
	Consultative or Advisory Committee work:	
A00007	– per half day (3.5 hours)	1460.00
A00008	– per day	2915.00

ROADSAFETYBC

	Examinations (other than the eyes) to obtain a driver's license	
A00055	– full exam	258.00
A00056	– partial exam	115.00

MEDICAL RECORDS

A00093	Transfer of patient records – basic fee	45.05
	NOTES: This fee is recommended for a simple transfer of records from a physician to another physician. Photocopying may be charged in addition. i) Other direct costs, such as courier services, may be charged in addition. ii) A fee for review of records may be charged in addition if the physician reviews the records for the purpose of selecting current an necessary medical information to be transferred. iii) Original records must be retained by the transferring physician as required by Law. iv) 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	127.00

(see notes on next page)

		Non-MSP-Insured Fee ($)
	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	Photocopy/Print from digital or paper medical record – per page (first 10 pages)	2.30
	– Subsequent pages	.30

PREVENTATIVE MEDICINE

A00052	Biofeedback rendered by a physician for other than neurological and/or muscular retraining – per half hour	188.00
A00053	Hypnosis for services not insured by the Medical Services Plan, e.g.: smoking withdrawal, weight loss or other lifestyle services – per half-hour	188.00
A00054	Preventative medicine counselling all forms, e.g.: health maintenance assessment and counselling 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 counselling – per half hour	188.00

CERTIFICATES AND FORMS

A94523	Completion of Drug Benefit Form for third party insurer	95.20
A94529	Completion of the Occupational Fitness Assessment (OFA) form (extra to examination)	222.00
A94533	Completion of the Public Trustee's form for opinion of incapacity (extra to examination)	452.00
A00060	Written certificate, including time loss benefit form (extra to examination), medical certification of death, etc.	55.10
A00061	Medical advice by letter	188.00
A00063	Initial screening examination for chronic or rehabilitation care	192.00

		Non-MSP-Insured Fee ($)
A00068	Physical fitness examination for school, summer camp, etc., including certificate	93.10
	Insurance company form to include review of records:	
A00059	– Extensive report	246.00
A00069	– Short report	188.00
A00097	Examination and completion of Canadian Blood Services form for report on Plasmapheresis Donors	135.00

CORRECTIONAL CENTRE

A00085	Correctional centre visit to examine one patient including certification – day time	264.00
A00086	Subsequent correctional centre visit to examine patient again including certification	264.00
A00087	Other patients examined at same correctional centre visit including certification – each	188.00
A00088	Correctional centre visit to examine one patient including certification – night (1700 hrs to 0830 hrs), Saturday, Sunday or Statutory holiday	344.00
A00089	Examination of patients in doctor's office including certification – each	188.00

BLOOD AND ALCOHOL SAMPLING

A00036	Taking sample	119.00
A00037	Additional charge for standby time, per half hour	205.00
	Note: Services charges and surcharges extra.	

OPHTHALMOLOGY: FITTING OF CONTACT LENSES

A02050	Hard Lenses	I.C.
A02051	Soft Lenses	I.C.
A02052	Unilateral cases – hard lenses	I.C.
A02053	Unilateral cases – soft lenses	I.C.

		Non-MSP-Insured Fee ($)
	Evaluation of Lenses Not Fitted by Practitioner:	
A02054	– First visit	I.C.
A02055	– Subsequent visit	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.	

PEDIATRICS: SPECIAL SERVICES

A00516	Newborn care in hospital without complications	340.00
	Periodic health examinations	
A00517	– Infants	179.00
A00519	– Children and adolescents	198.00
A00520	Assessment and examination prior to adoption	708.00

PHYSICAL MEDICINE AND REHABILITATION: SPECIAL SERVICES

A01720	Advice on the medical requirements of one or more patients at a formally scheduled multi-disciplinary rehabilitative conference of at least one hour duration, per half hour or major portion thereof .. NOTE: Where more than one certified specialist in physical medicine and rehabilitation required each to submit separate accounts.	200.00

PSYCHIATRY: SPECIAL SERVICES

A00643	Environmental intervention by the physician on a psychiatric patient's behalf with agencies, employers or institutions – per ½ hour	192.00
A00644	Environmental intervention by the psychiatrist on a disturbed child's behalf with agencies, schools or institutions – per ½ hour ..	192.00
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 ½ hour	192.00

		Non-MSP-Insured Fee ($)

UROLOGY: SPECIAL SERVICES

A08343	Epididymovasostomy or re-anastomosis of vas – unilateral NOTE: MSP will pay only when a previous vasectomy has not been performed.	3645.00

DIAGNOSTIC ULTRASOUND: SPECIAL SERVICES

A08480	Head and Neck: Transcranial Doppler	158.00

LABORATORY MEDICINE: SPECIAL SERVICES

A94600	Identification of micro-organisms	36.70
A94601	Immunologic techniques	36.70
	Autopsy	
A94506	– Complete	1442.00
A94508	– Partial	436.00
A94510	Category I – Identification by gross examination only	18.45
A94512	Category II – Confirmation of normality	56.00
A94514	Category III – Confirmation of common degenerative and inflammatory conditions and common benign tumours	71.60
A94516	Category IV – Small specimens for diagnosis	135.00
A94518	Category V – Complex biopsies or small whole organs	188.00
A94520	Category VI – Large complex organ requiring extensive gross dissection and microscopic assessment comprehensive	379.00
	Consultations	
	Operative consult with or without frozen section	
A94500	– First	236.00
A94502	– Each additional consult (no limit)	74.10
A94504	Referred histology slides for opinion and letter	188.00
A94505	– Multiple or complex specimens (Category VI specimens)	379.00
	Forensic Toxicology	
A94570	Screening by radioimmunoassay for drug class without identification/quantitation	65.30
A94572	Screening by immunoassay for drug class without identification/quantitation	65.30
A94574	Screening by gas chromatography (GC) for drug class (acidic drugs) with identification but not quantitation	88.20
A94576	Screening by gas chromatography (GC) for drug class (basic drugs) with identification but not quantitation	88.20

		Non-MSP-Insured Fee ($)
A94578	Screening by thin layer chromatography for drug class(es) with identification but not quantitation by liquid	198.00
A94580	Drug identification and/or quantitation by Gas Chromatography Mass Spectrometry (GCMS) (applies primarily to basic drugs)	153.00
A94582	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)	305.00
A94584	Comprehensive drug screen (includes screening by GC and radioimmunoassay & drug identification/quantitation by GCMS (applies primarily to basic drugs)	337.00
A94586	Ethanol	90.10
A94588	Carbon monoxide	189.00
	Hematology and Blood Bank	
A94540	ABO typing	56.50
A94541	Absorption	137.00
A94542	Antibody identification	228.00
A94543	Antibody screen	112.00
A94544	Consultation, written for unusual antibodies	213.00
A94545	Crossmatch – per unit	56.50
A94546	Direct antiglobulin test – polyspecific	67.60
A94547	Direct antiglobulin test, using anti-C3 or anti-IgG	67.60
A94548	Irradiation of blood products	56.50
A94549	Neutralization, per antigen	228.00
A94550	Phenotyping by DAT, per antigen	45.60
A94551	Phenotyping by indirect antiglobulin test, per antigen	64.60
A94552	Pooling blood products	137.00
A94553	Preparation of eluate	137.00
A94554	Preparation of leukocyte poor blood by filtration or manual wash	228.00
A94555	Preparation of leukocyte poor blood by microaggregate filtration	228.00
A94556	Preparation of lyophilized products, per pack	56.50
A94557	Preparation of packed cells per unit	56.50
A94558	Review of trans reaction data including preparation of a written report	213.00
A94559	RH (D) typing	47.20
A94560	Rosette test for RH + cells	112.00
A94561	Thawing of plasma	56.50
A94562	Washing red cells, first unit using cell washer	67.60
A94563	Washing red cells, each additional unit	228.00
	Chemistry - Miscellaneous	
A94522	Specimen submitted for examination in cases of suspected sexual assault – per specimen or article	179.00
A94524	– To maximum	361.00