# INSURED SERVICES TARIFF

**APPROVED BY THE MINISTER OF HEALTH AND SOCIAL SERVICES**

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# Preamble to the Insured Services Tariff for Physicians

## Index

## A Purpose and Structure of the Preamble

A.1 The preamble to the Insured Services Tariff for Physician Services (the "Schedule") assists medical practitioners in the Northwest Territories in submitting appropriate claims for the provision of insured medical services. The preamble provides the billing rules under which the services are claimed; these rules are a roadmap designed to clarify the use of the Schedule.

A.2 In some instances, a specialty-specific preamble is also provided (see Section G); if there is an inadvertent conflict between a specialty-specific preamble and any other section of the Schedule, the interpretation of the specialty-specific preamble shall prevail.

A.3 The preamble is divided into six interdependent sections:

- B Introduction to the Preamble
- C Administrative Items
- D Definitions
- E Types of Services
- F Premiums
- G Specialty-Specific Preambles

A.4 Two appendices further support the Schedule:

- H New Service Item Committee
- I Updating and Maintenance of the Schedule

## B Introduction to the Preamble

**B.1** 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:

a. Direct face-to-face encounter with the patient by the medical practitioner, appropriate physical examination when pertinent to the service and ongoing monitoring of the patient's condition during the encounter, where indicated. (For exceptions to this rule, refer to Section E.2, Telehealth Services).

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

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

d. Arranging for any related assessments, procedures, and therapy as may be appropriate, and interpreting the results, except where separate listings are applicable to these services.

e. Arranging for any follow-up care that may be appropriate.

f. 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 for such advice and discussion, or for the provision of prescriptions and/or 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.

g. Making and maintaining an adequate medical record of the encounter that supports appropriately 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.

**B.2** Where a benefit in the Schedule is stated to be payable by **assessment**, the value of that benefit will be assessed by the Director of Medical Care Services with consideration of what is fair and equitable in the clinical circumstances.

**B.3** It is not possible to interpret accurately the fee service codes or to submit appropriate claims using those codes without an understanding of the Preamble.

## C Administrative Items

### Index to Administrative Items



### C.1 Fees Payable by the Schedule

a. A payment schedule for insured medical services provided by medical practitioners is established under the *Act* and is referenced in master agreements between the Government of the Northwest Territories (GNWT) and the Northwest Territories Medical Association (NWTMA). Benefits payable 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 if compliant with the policies of the Department of Health and Social Services (DHSS) on delegated services.

b. Services requested or required by a third party for other than medical requirements are not insured or payable under the Act. Services, such as consultations, laboratory investigations, anaesthesia, and surgical assistance, rendered solely in association with other services which are not benefits also are not considered benefits of the Schedule, except in special circumstances as approved by the Minister of Health and Social Services.

## C.2 Setting and Modification of Fees

a. Additions, deletions, fee changes, or other modifications to the Schedule are the responsibility of the DHSS, with due consideration of consultation with the NWTMA and the recommendation(s) of the New Service Item Committee (NSIC).

b. The structure, mandate, and processes of the NSIC are provided as an appendix, namely Section G, to this preamble.

c. The processes of the updating and maintenance of the Schedule are provided as an appendix, namely Section H, to this preamble.

## C.3 Services Not Listed in the Schedule

Services not listed in the Schedule must not be billed to the DHSS under other listings. Medical practitioners who wish to have modifications to the Schedule should submit their proposals to the NWTMA for subsequent consideration by the NSIC and the DHSS. Interim listings may be designated by the DHSS for new procedures or other services for a limited period of time to allow definitive listings to be established, if appropriate.

## C.4 Exceptional Circumstances

When a medical practitioner satisfies the Director by means of supporting evidence, that a procedure has involved unusual complications or has required the exercise of an unusual degree of skill, care, responsibility, or an unusual amount of time, the Director may allow a benefit greater than the benefit approved in the Schedule.

## C.5 Insured Services Rendered Outside of Canada

Subject to the provisions of *Exceptional Circumstances*, the benefits payable in respect of insured services shall not exceed the benefits listed in the Schedule

for services rendered within the Northwest Territories. The Director may pay benefits in respect of insured services rendered outside of Canada, where:

a. The insured and required medical treatment is not available within Canada and the patient has been referred to a medical practitioner outside of Canada with the prior approval of the Director, or

b. In the opinion of the Director, circumstances exist which warrant medical treatment outside of Canada. This may include personal reimbursement for insured services received while on vacation; such personal reimbursement is limited to the value indicated in the Schedule. That notwithstanding, the benefits payable under these circumstances, as authorized by the Director, may exceed the benefits prescribed in the Schedule.

## C.6 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. 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 are, as follows:

a. Surgery for alteration of appearance (cosmetic surgery)
b. Gender-reassignment surgery
c. Surgery for reversal of sterilization
d. Therapeutic abortions
e. Routine periodic health examinations including routine eye examinations
f. In-vitro fertilization, artificial insemination
g. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy

h. Services to persons covered by other agencies: Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries)
i. Services requested by a "Third Party"
j. Team conference(s)
k. Genetic screening and other genetic investigation, including DNA probes
l. Procedures still in the experimental/developmental phase
m. Anaesthetic services and surgical assistant services associated with all of the foregoing.

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

## C.7 Medical Travel for Insured Services Outside of Northwest Territories

a. The Director may pay benefits for medical travel in respect of insured services rendered in Canada but outside of Northwest Territories, where the insured and required medical treatment is not available within Northwest Territories and the patient has been referred to a medical practitioner outside of Northwest Territories with the prior approval of the Director or, in the opinion of the Director, circumstances exist which warrant medical treatment outside of Northwest Territories.

b. For clarity, benefits for medical travel will be paid according to the GNWT policy on medical travel and with the explicit authorization of the Director.

## C.8 Adequate Medical Records of an Insured Benefit

A medical record of a benefit in the Schedule is considered adequate when it contains all information which may be designated or implied in the Schedule for the service, and when 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 and/or the patient's medical records from previous encounters:

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

## C.9 Uninsured Medical Services

Benefits shall not be paid for:

a. Medical-legal services, including:

    i. Examinations performed at the request of third parties in connection with legal proceedings
    ii. The giving of evidence by a medical practitioner in legal proceedings, or
    iii. The preparation of reports or other documents relating to the results of a medical practitioner's examination for use in legal proceedings or otherwise and whether requested by the medical practitioner's patient or by a third party

b. Examinations required for the use of third parties including examinations required for:

    i. Drivers' licenses

ii. Pre-school or university
iii. Attendance at a camp
iv. Employment requirements

c. Services not medically required including, but not limited to, the completion of sick leave forms
d. Group immunization
e. In vitro-fertilization
f. Services provided by a medical practitioner to his or her own family
g. Telephone advice or prescriptions given over the telephone
h. Surgery for cosmetic purposes except where medically required
i. Dental services other than oral surgery as set out in the approved tariff
j. Dressings, drugs, vaccines, biologicals and related materials, eyeglasses and special appliances, plaster, surgical appliances or special bandages
k. Treatments rendered in the course of chiropractics, physiotherapy, podiatry or any other practice ordinarily carried on by persons who are not medical practitioners
l. Optometry services
m. Mileage charges
n. Laboratory or x-ray services performed in a facility not approved by the Director
o. Services that a person is eligible to receive under
    i. A statute of any other province or territory
    ii. Any law of a jurisdiction outside the Territories relating to workers' compensation, and
    iii. Any statute of the Parliament of Canada
p. Routine annual check-up where there is no definable diagnosis, except where a patient has attained 65 years of age or is less than 10 years of age
q. Services not provided by or under the supervision of a medical practitioner

**C.10 Specialist Benefits**

a. Only those medical practitioners who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada may claim specialist benefits for assessments.

b. Specialist benefits for procedures may be claimed by those medical practitioners who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada; also by other medical practitioners who perform specialist procedures as General Practitioners granted credentials by a health authority or hospital to perform such procedures.

c. Specialists who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada may claim for procedures other than those generally accepted as within the scope of their specialty training, when granted credentials by a health authority or hospital to perform such procedures.

## C.11 Inclusive Services and Fees

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

## C.12 Medical Research

Costs of medical services (such as examinations by medical practitioners, laboratory procedures, other diagnostic procedures) that are provided solely for the purposes of research or experimentation are not the responsibility of the patient or DHSS. 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 an insured service. 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 will be considered insurable; additional services carried out specifically for the purposes of the research are not the responsibility of DHSS.

## C.13 Experimental Medicine

a. Costs of medical services that are provided for the purpose of what is considered to be experimental medicine are not the responsibility of the patient or DHSS.

b. 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 DHSS.

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

d. Where such a new therapy or procedure is being introduced into Northwest Territories and the medical practitioners performing the new therapy or procedure wish to have a new fee item inserted in to the fee schedule to cover the new therapy or procedure, the process describing the New Service Item Committee (See Appendix G) must be followed.

e. When a new therapy or procedure is being performed outside Northwest Territories, a patient or patient advocate may request that the services associated with this new therapy or procedure be considered insured services by DHSS. The Director of Medical Insurance, utilizing information obtained from various sources, such as medical practitioners, the NWTMA, or evidence-based research, will review the situation. 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 DHSS. If it is considered that the therapy or procedure is not experimental, the cost of medical services associated with this treatment will be evaluated by the DHSS to determine if it is an insured service in the Northwest Territories.

f. If procedures are accepted as no longer being experimental, they may be considered as an insured benefit in the Schedule on an interim basis and will be reviewed again within five years.

## C.14 Services to Family and Household Members

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

    i. Spouse,
    ii. Son or daughter,
    iii. Step-son or stepdaughter,
    iv. Parent or stepparent,
    v. Mother-in-law or a father-in-law,
    vi. Grandparent,
    vii. Grandchild, or
    viii. Brother or sister

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

## D Definitions

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

**Act**

Medical Care Act

**age categories**

Premature baby – neonate born before 37 weeks gestation
Newborn or Neonate – from birth up to, and including, 28 days of age
Infant – from 29 days up to the first birthday
Child – from 1 year up to the sixteenth birthday

**antenatal care**

Pregnancy-related visits from the time of confirmation of pregnancy to delivery
(same as prenatal)

**dental surgeon**

A person lawfully entitled to practise operative dentistry

**DHSS**

Department of Health and Social Services of the Government of the Northwest Territories

**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

For purposes of providing consultation services upon referral from a physician not providing services in the same Emergency Department, the

emergency department physician is recognized as FRCP (EM), CCFP (EM), or ABEM

**holiday**

The list of dates designated as statutory holidays will be issued annually by the DHSS and will reflect those dates identified in the Human Resource Manual under section 813.5

**home**

Patient's place of residence, including a multiple resident dwelling or single location that shares a common external building entrance, other than a hospital or long-term care institution

**independent consideration**

A process for assessing the value of services where a value is not listed in the *Insured Service Tariff*

**intensive care unit**

Special areas recognized and funded by the DHSS to provide high intensity care

**medical advisor**

A licensed physician designated as the medical advisor by the DHSS

**office**

The location where a physician is practising his or her profession, whether in a physician's home, in a hospital, in an institution, or in other facilities or buildings

**palliative care**

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

**participating province**

A province or territory in which there is a health care insurance plan in respect of which a contribution is payable under the *Canada Health Act*

**postnatal care**

A single visit performed approximately 6 weeks following delivery for the purpose of assessment and advice to the mother

**postpartum care**

Inpatient hospital visits to the mother following delivery

**premium**

A fee that may be claimed by a physician in addition to the fee for an insured medical service, outlined in the tariff, and in situations described in Section F of the preamble

**prenatal care**

See antenatal care

**professional fee**

A fee able to be claimed by a registered medical practitioner for providing an insured medical service, other than an identified and insured technical fee that supports the equipment used for that service

**referral**

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

**specialist**

A medical practitioner who is a certificant or a fellow of the Royal College of Physicians and Surgeons of Canada, and is licensed to practice in the Northwest Territories as a specialist

**technical fee**

A fee able to be claimed in support of equipment used to provide an insured medical service for which a professional fee can be billed

**third party**

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

**transferal**

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 normally does not provide the basis for billing a consultation; the exception is that, when the complexity or severity of illness necessitates that accepting the transferal 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

**uninsured service**

A service that is not prescribed as insured by the DHSS

**visit**

A service rendered by a medical practitioner to a patient for diagnosis or treatment or both in the office, home, hospital, or elsewhere

# E Types of Services

## Index to Types of Services



## E.1 Introduction

a. Where services are provided to the same patient by the same medical practitioner, or by another medical practitioner within the same clinic, major first visit benefits, including consultation benefits, shall not be paid more frequently than once in each six months.

b. The 6-month limitation does not apply to a major consultation by a specialist if that consultation is for a referred service that differs from the previous consultation.

c. A consultation for a referred medical service may be claimed on the same day as a procedure in an office, clinic, or hospital, performed subsequent to that consultation.

d. When a medical practitioner sees a patient for the sole purpose of receiving an injection or undergoing a procedure for which the benefit is less than that approved for a visit, the visit benefit shall not be paid.

e. Claims for special visits to an Emergency or Outpatient Department must indicate the actual time the patient was seen by the medical practitioner in the outpatient department.

## E.2 Telehealth and Teleconference Services

a. “Telehealth Services” are defined as a medical practitioner delivering a health service provided to a patient at a Health Authority approved, publicly funded telehealth program, and live image transmission of those images to a receiving medical practitioner at another approved site, through the use of video technology.

b. “Video technology” means the recording, reproducing, and broadcasting of live visual images utilizing a direct interactive video link with a patient. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those services that are designated as telehealth services may be claimed; other services/procedures require face-to-face encounters.

c. Telehealth services are payable only when patients are informed and are provided opportunity to agree to services rendered using this modality.

d. ”Telehealth examination” means an examination of a patient by the consultant at the receiving site using “telehealth services” as defined above.

e. In those cases where a specialist service requires a general practitioner at the patient’s site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate the requirement in the medical record.

f. Where a receiving medical practitioner, after having provided a telehealth consultation service to a patient, decides s/he must examine the patient in person, the medical practitioner should claim the subsequent visit as a limited consultation, unless more than 6 months has passed since the telehealth consultation.

g. 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.

h. Video technology services are generally payable once per patient/per day/per medical practitioner. Information regarding the medical necessity and times of additional services should accompany related claims.

i. Teleconference services may originate from a nurse practitioner, home care nurse, public health nurse, or midwife in a community health centre with no resident physician and directed to a medical practitioner, or from a physician in a community health centre outside of Yellowknife and directed to a specialist.

## E.3 Electrocardiography

Only medical practitioners who have been accredited by a College of Physicians and Surgeons in Canada to provide such services may claim for the interpretation of an electrocardiogram.

## E.4 Consultation

a. A consultation applies when a medical practitioner, or a health care practitioner (midwife, for obstetrical or neonatal related consultations; nurse practitioner; optometrist, for ophthalmology consultations; oral/dental surgeon, for diseases of mastication; community nurse), 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.

b. The referring physician 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.

c. The service includes the initial services of a consultant necessary to enable the consultant 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.

d. When a consultation is followed by a procedure performed by the consultant, a benefit shall be paid for both the consultation and the procedure.

e. A benefit for continuing care shall be paid to a consultant following a consultation where the continuing care is provided by the consultant at the request of the referring medical practitioner.

f. Where the benefits for continuing care by a consultant are applicable, a benefit for insured services provided by the referring medical practitioner after the consultation shall only be paid to the referring medical practitioner after the full responsibility for the care of the patient has been returned to the referring medical practitioner, unless the complexity of the clinical needs of the patient require the services of the referring medical practitioner in addition to those of the consultant.

g. 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 any visit for the patient; a **limited consultation** may be payable within the six month interval, if medically necessary.

h. A **minor** or **repeat 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.

i. It is expected that a minor or repeat consultation, when medically necessary, will be billed as part of continuing care, and that a full consultation is not billed simply because of the passage of time.

j. 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 for the patient.

k. 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 Schedule pertaining to the specialty.

l. 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.

m. Continuing care by a specialist, following consultation, normally is paid at the 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 referring practitioner.

## E.5 Counseling

a. Counseling 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. Counseling, to be claimed as such, must not be delegated and must last at least 20 minutes.

b. Counseling 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 counseling 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 counseling 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 counseling codes generally applicable to the explanation of the results of diagnostic tests. A counseling service cannot be claimed for a time in excess of 90 minutes.

c. Group counseling fee items apply only when two or more patients are provided counseling in a group session lasting 60 minutes or more, but not greater than 90 minutes. The group counseling 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 counseling fee item could be billed, using that patient's personal health number.

d. Group counseling fee items are not billable for each person in the group. Claims should be submitted under the name of only one of the beneficiaries, with the names of the other patients attending the session listed in the note record. Times should be included with billings for group counseling fee items.

e. A claim for greater than 90 minutes counseling in any single session or day requires assessment by the medical advisor.

**f.** Claims for counseling to non-psychiatric patients and in excess of 5 sessions annually require assessment by the medical advisor.

## E.6 Referral and Transferral

a. 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 or medical treatment.

b. 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.

c. 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.

d. 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.

## E.7 House Visits

a. A house visit is considered necessary and may be billed only when the patient cannot practically attend a medical practitioner 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.

b. If a house visit is determined to be necessary and is initiated by the patient during the medical practitioner's regular office hours, the house visit should be billed as a home visit irrespective of when the service is rendered. Service charges do not apply to pre-booked house visits rendered after regular office hours.

**c.** The necessity and detail and the time of the visit should be documented in the patient's clinical record

## E.8 Hospital Care

a. Where an outpatient visit results in the admission of a patient to a hospital the maximum benefit paid is that of a first visit when not seen in house or office.

b. An in-hospital admission examination may be claimed when a patient is admitted to an acute care hospital for medical care rendered by a general practitioner. The service also may be applicable when a medical practitioner is required to perform an admission examination prior to a hospital service being delivered by a health care practitioner (e.g., a dental surgeon). The hospital admission examination listing is not applicable when a patient has been admitted for surgery or when a patient is admitted for care 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 service includes all of the components of a complete examination.

c. 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.

d. 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, an explanation should be submitted with the claim and consideration will be given.

e. If a surgeon who is not resident in the Northwest Territories provides surgical services in the Northwest Territories and is unable to render the usual post-operative care, the medical practitioner who performs the post-operative services for the patient may claim for necessary hospital visits.

f. 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 as **concurrent care** by each medical practitioner, as required for that care.

g. 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.

h. **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.

i. When visits are required to patients in long-term-care institutions, such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities, whether or not any of these facilities are situated on the campus of an acute care facility, claims may be made to a maximum of one visit every two

weeks. It is not sufficient, however, for the medical practitioner simply to review the patient's chart. A face-to-face patient/medical practitioner encounter must be made. For acute concurrent illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation.

### E.9 Designated Procedures

a. When a patient enters a hospital and undergoes a procedure for which no booking was made in advance, and where the procedure is indicated in the Insured Services Tariff with the notation "+", benefits shall be paid for:

    i. Visits before and after the day on which the procedure is performed,
    ii. Visits on the day on which the procedure is performed, and
    iii. The procedure

b. When a patient attends at a medical practitioner's office or clinic and undergoes a procedure for which no booking was made in advance, and where the procedure is indicated in the Insured Services Tariff with the notation "+", benefits shall be paid for the procedure and either:

    i. The visit on the day on which the procedure is performed, or
    ii. Consultation on the day on which the procedure is performed

### E.10 Emergency Detention Time

a. Benefits for emergency detention time shall be paid to a medical practitioner for the time s/he is medically required to personally and continuously attend and treat an illness or injury of an emergency nature.

b. Illness of an emergency nature includes mental or emotional disorders.

c. No medical detention time benefit shall be paid to a medical practitioner unless the medical practitioner submits, in writing, a simple explanation of the activity

and the time spent in performing the activity.

d. Medical detention time shall not apply to:

    i. Counseling or psychotherapy;
    ii. Waiting for results of laboratory or x-ray examinations;
    iii. Giving advice to family members of the patient or to the patient;
    iv. Waiting for a family medical practitioner or consultant;
    v. Service provided in the office in conjunction with routine visits, except when it is documented that an emergency existed; or
    vi. Medivac detention time described in section E.11.

e. Where a visit benefit is claimed, the medical detention time benefit does not apply until 2 hours after the start of the visit.

f. The maximum time for which benefits are payable as medical detention is seven hours.

**E.11 Medivac Detention Time**

a. Medivac detention time shall be paid to a medical practitioner for the time s/he is medically required to personally and continuously attend a patient being transported by surface or air ambulance.

b. No medivac detention time benefit shall be paid to a medical practitioner unless the medical practitioner submits, in writing, a simple explanation of the activity and the time spent in performing the activity.

c. Where a patient is being transported from a medical facility to another medical facility, medivac detention time begins when the patient is discharged from the medical facility and ends when the patient is admitted to the receiving medical facility.

d. Where a patient who has not been admitted to a medical facility is being transported to a medical facility, medivac detention time begins when the medical

practitioner begins to prepare the patient for transportation to a medical facility and ends when the patient is admitted to the facility.

e. Where a medical practitioner has to travel outside his or her community to reach a patient, medivac detention time includes the time the medical practitioner spends in reaching the patient.

f. The maximum time for which medivac detention time benefits are payable is 12 hours.

g. Return travel time, or time stranded, shall be paid to a medical practitioner who is out of his or her community as a direct result of an emergency medivac for the time the medical practitioner spends in returning home, or is stranded outside his or her community after the completion of the medivac.

h. No benefit for return travel or time stranded shall be paid to a medical practitioner unless the medical practitioner submits, in writing, the times for the beginning and end of the period the medical practitioner claims under this benefit.

i. The maximum time for which return travel or time stranded benefits are payable is five hours per day.

### E.12 Cosmetic Procedures

a. Surgery to alleviate significant physical symptoms or to restore or to improve function to any area altered by disease, trauma, or congenital deformity normally is a benefit of the Schedule.

b. Surgery solely to alter or restore appearance is not considered medically necessary and is not a benefit of the Schedule.

### E.13 Surgical Assisting

a. Where the surgical assistant is also the attending physician requesting the surgical consultation that leads to provision of a procedure, he or she shall be entitled to claim either the emergency benefit or the admission benefit in addition to the assisting benefit.
b. Claims for surgical assisting must indicate the lesser of the actual operating time from induction of anaesthesia to skin closure, or the total time of attendance by the medical practitioner; assisting time shall not exceed the anaesthetic time.

c. Premiums payable for a surgical procedure apply equally to the payment for surgical assisting.

d. Procedures for which surgical assisting benefits are not payable are:
    i. Minor cutaneous and subcutaneous tumors and biopsies
    ii. D and C, minor gynecological procedures
    iii. Anal fissure, ischiorectal abscess, anal and rectal polypi
    iv. Abscesses, except for major abscesses
    v. Endoscopic procedures and examinations
    vi. Transfusions
    vii. Closed reductions of fractures, except femur, tibia, radius and ulna
    viii. Application of plaster casts, orthopaedic appliances and manipulations
    ix. Ingrown toenails
    x. Minor plastic surgery, such as stamp graft, dermabrasion
    xi. Thoracentesis and closed drainage
    xii. Arteriography
    xiii. Tympanoplasty, fenestration
    xiv. Tonsillectomy and adenoidectomy
    xv. Vasectomy
    xvi. Submucous resection, rhinoplasty
    xvii. A-V shunt
    xviii. Release carpal tunnel

e. Procedures for which surgical assisting benefits may be required sometimes and are payable by assessment are:
    i. Phalangeal and digital amputations

ii. Ganglion wrist
iii. Excisional breast biopsy
iv. Simple fistula
v. Hemorrhoidectomy
vi. Bunionectomy
vii. Mastoidectomy
viii. Open reduction of fractured finger
ix. Hammer toe repair
x. Morton's neuroma

A claim for discretionary surgical assisting benefits, as listed herein, requires an explanatory letter from the surgeon, applicable to that claim.

## E.14 Unlisted Services

Provision of a medically necessary service for which there is no service code or value in the Insured Services Tariff may be claimed using the code K-500.

A claim of K-500 will lead to an assessment by the Medical Advisor and decision whether the service, as provided, should be funded and at what value.

It is anticipated that the physician submitting a claim of K-500 will also give consideration to request consideration by the New Service Item Committee using the processes outlined in Appendix H of this Preamble.

# F Modifiers

## Index to Modifiers



## F.1 Eligibility for Special Visit Premiums

Special visit premiums are based on the time of a request for a service and the performance of service. The special visit premium can apply to the provision of a consultation or a procedure, but not to both when the consultation leads to the procedure within the designated times.

## F.2 General Practice Special Visit Premiums

For General Practice, special visit premiums are available for hospital visits to Emergency and Outpatient Departments, as follows:

1. When specially called from home or office from 08:00 to 17:00:
   **SV-001 $95.00**

2. Repeat visit when patient previously seen same day in Emergency or Outpatient Department or office:
   **SV-002 $35.00**

3. When specially called from home or office from 17:00 to 08:00 or Saturdays, Sundays, or statutory holidays:
   **SV-003 $95.00**

## F.3 Consultations and Procedures Special Visit Premiums

For consultations and procedures rendered by medical and surgical specialists and General Practice Anaesthetists, special visit premiums may be claimed, as follows:

a. Special visit premium when the service request is placed between 17:00 and 00:00 and the service is rendered between 17:00 and 08:00, for the first service only:
**SV-004 $95.00**

b. Special visit premium when the service request is placed between 00:00 and 08:00 and the service is rendered between 00:00 and 08:00, for the first service only:
**SV-005 $125.00**

c. Special visit premium on a weekend and statutory holiday when the service request is placed between 08:00 and 17:00 and the service is rendered between 08:00 and 17:00, for the first service only:
**SV-006 $95.00**

## F.4 Consultations and Procedures After Hours Premiums

a. After hours premiums may be claimed for the provision of non-elective consultations, surgical and anaesthetic procedures in the operating room, and obstetrical deliveries.

b. The after hours premiums are based on the time of day that an eligible non-elective service is initiated, applying the following codes and percentage increases to the submitted claim:

i. 17:00 to 00:00
**AH-001 50%**

ii. 00:00 to 08:00

**AH-002 75%**

**iii. 08:00 to 17:00 on Saturday, Sunday, and a statutory holiday**

**AH-003 50%**

## F.5 Body Mass Index Premium

For surgical and anaesthetic services that are performed in the operating room, a body mass index (BMI) modifier may be claimed if the BMI exceeds 40. The premium is an additional 20% applied to the surgical, anaesthetic, and surgical assistant fees, using the code **BP-001 for surgical and surgical assisting claims**. **For anaesthetic BMI modifiers, refer to codes AN-025 and AN-026 in the Insured Services Tariff.**

# G Specialty-Specific Preambles

## Index to Specialty-Specific Preambles

## G.1 Surgical Specialties

### a. Payment for Pre-operative and Post-operative Care

i. Benefits for surgical procedures, other than an obstetrical procedure, listed in the Insured Services Tariff and valued at greater than $175.00 include compensation for post-operative care for a period of 14 days following the procedure.

ii. Notwithstanding subsection G.1.a.i, additional benefit may be claimed for services required to deal with a complication to the procedure or, when unusual clinical circumstances require that additional medical services are provided, the additional services are not part of the inclusive fee and may be claimed separately.

iii. When a surgeon does not provide the major portion of the post-operative care during the period of 14 days following the procedure, the benefit for the procedure shall be assessed by the medical advisor and paid at a lesser rate than the procedural rate listed in the Insured Services Tariff.

iv. When a medical practitioner other than the surgeon provides the major portion of the post-operative care during the period of 14 days following the procedure, the benefit paid to that medical practitioner shall be based on the number of hospital, home, or office visits provided to that patient.

v. Hospital care provided prior to a procedure may be claimed on the basis of first and subsequent visits by the medical practitioner who performed the surgery or by a different medical practitioner providing such care.

### b. Multiple Surgical Procedures

i. When two or more similar surgical procedures, including bilateral procedures, are performed at one time, the procedure with the greater

listed fee may be claimed in full and the fees for the additional procedures are reduced to 75%, unless otherwise indicated in the Schedule.

ii. When two or more different procedures are performed through separate incisions under the same anaesthetic, and repositioning or re-draping of the patient or more than one separately draped surgical operating field is medically or surgically required (because of the nature of the procedure and/or the safety of the patient), both procedures may be claimed in full, unless otherwise indicated in the Schedule.

iii. Secondary surgical procedures, including those performed for post-operative complications, by the same surgeon for the same or related condition, shall be paid at 75% pf the listed benefit for the secondary procedure. That notwithstanding, when an emergency procedure is followed by a procedure intended conclusively to stabilize the condition of the patient, then each procedure may be claimed in full.

iv. When two procedures are performed under the same anaesthetic by two surgeons and both procedures are within the competence of either one of the surgeons, the total surgical fee claimed should be no greater than that which would be payable if both procedures had been performed by one surgeon plus one fee for surgical assisting.

**c. Abandoned Surgical Procedures**

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

**d. Diagnostic Surgical Procedures**

Payment rules for diagnostic surgical procedures vary according to the site of service and the listed benefit value for the procedure. These are summarized in the following table:

| Site of Service | Benefit of $175.00 or less | Benefit Exceeding $175.00 |
|---|---|---|
| **Hospital** | **Benefit shall be paid for**<br>the procedure<br>**and**<br>visits before and after the day on which the procedure is performed | **Benefit shall be paid for**<br>the procedure<br>**and**<br>visits before the day on which the procedure is performed |
| **Office or Clinic** | **Benefit shall be paid for**<br>the procedure<br>**or**<br>the visit on the day of the procedure | **Benefit shall be paid for**<br>visits before the day on which the procedure is performed<br>**and**<br>**either** the procedure **or** the visit on the day of the procedure |

## G.2 Obstetrics

a. The obstetrical benefit includes services provided for minor prenatal and minor coincidental medical conditions occurring during the pregnancy.

b. The obstetrical benefit does not include claims made for visits for unrelated major medical conditions, which may be claimed separately.

c. The obstetrical benefit includes minor postnatal conditions and contraceptive advice.

## G.3 Paediatrics

### a. When a Paediatrician Provides Care for a Premature or Newborn Infant

i. Newborn care on the date of birth and the date of discharge may be claimed when a medical practitioner has referred a healthy newborn to a Paediatrician; a consultation may not be claimed in this circumstance.

ii. If it becomes apparent that, while in the care of the Paediatrician, the newborn is ill, then the appropriate consultation benefit shall be paid and benefits shall be paid for the appropriate number of hospital days involved.

iii. When the Paediatrician requests consultation with another specialist, a consultation benefit shall be paid to the specialist.

iv. Claims for routine care and care for minor complications of a premature infant shall be paid as a minor or repeat consultation for the initial visit and in accordance with the approved tariff for subsequent daily care benefits.

### b. When a Medical Practitioner other than a Paediatrician Provides Care for a Premature or Newborn Infant

i. Where a consultation is required, the referring physician may claim the benefit for newborn assessment on the day of birth and the consultant shall be paid a consultation benefit.

ii. When the ongoing care of the newborn is transferred to a consultant, the attending medical practitioner shall be paid by assessment, based on medical necessity.

iii. The routine care of, or the care for minor complications of, a healthy premature infant shall be paid in accordance with the approved tariff for daily hospital care.

**c. Subsequent Office Visit of a Newborn Infant**

i. When a medical practitioner has already claimed benefits for each of the delivery and postnatal care, newborn care on the day of birth, and newborn care on the day of discharge:

- No benefit shall be paid for a subsequent office visit if the newborn is well.

- A subsequent visit benefit shall be paid if the newborn is sick.

- Subsequent to the initial post-partum visit, claims may be made for whatever benefit items are appropriate for the care provided.

ii. When a medical practitioner has received a benefit only for newborn care on the day of birth, and newborn care on the day of discharge, an office benefit may be claimed for a first visit not requiring a general assessment and subsequent visits, whether the newborn is ill or well.

## G.4 Orthopaedic Surgery – Fractures

a. When a medical practitioner attempts a closed reduction of fracture unsuccessfully and finds it necessary to transfer the patient into the care of another medical practitioner, the initial benefit may be claimed at 50% of the listed benefit.

b. A medical practitioner receiving a transferred patient after an initial unsuccessful closed reduction of a fracture may claim the full benefit for the final reduction.

c. A medical practitioner performing an open reduction after his/her initial unsuccessful closed reduction of a fracture shall claim only the benefit for the open reduction.

d. Rigid immobilization of a fracture that does not require a closed reduction may be claimed at 50% of the listed benefit for the closed reduction.

e. Closed reduction of a compound fracture may be claimed at 150% of the listed benefit.

## G.5 Psychiatry

a. Individual psychotherapy or counseling may be claimed when the intent of the encounter is the therapy of one individual.

b. Group psychotherapy may be claimed when all members of the group, present at the encounter, are receiving therapy in the session.

c. Individual counseling by a general practitioner may be claimed only where an appointment is specifically for the purpose of psychotherapy.

## G.6 Anaesthesia

a. An anaesthesia benefit is based on the time between the induction of anaesthesia and when the attendance of the anaesthetist is no longer required, and an additional benefit that reflects the nature of the procedure.

b. For the purpose of assessment of anaesthetic benefits, each anaesthestic procedure shall be considered as a separate and complete procedure.

c. The listed benefit is for professional services including pre-anaesthesia evaluation and **post-anaesthetic** follow-up and all immediate supportive measures.

d. In special cases where the Department, in the interests of the patient, considers more than one Anaesthetist necessary, the benefit payable to the second Anaesthetist may not exceed 75% of the benefit otherwise prescribed for the procedure.

e. If multiple surgical procedures are provided to a patient under a single anaesthetic, the principles, which apply to the payment of surgeons, are applicable to the payment of anaesthetic benefits.

f. For diagnostic and therapeutic anaesthetic procedures, the anaesthetic benefit is for professional services and excludes the cost of materials but includes examination, **post-treatment** observation, and **follow-up**; consultations, when requested, may be charged in addition to nerve block procedures.

g. Claims submitted for general anaesthesia must include the services provided, the duration of the anaesthesia, the fee code and its descriptor; as well, the letter "AX" must be placed after the fee code to indicate that it is an anaesthesia claim.

h. Where the anaesthetist is the medical practitioner in attendance of a patient, and consultation by a surgeon, the anaesthetist is entitled to claim either:

    i. The emergency benefit or the admission benefit, and
    ii. The anaesthetic benefit, if applicable

i. In addition to the entitlement to claim the anaesthetic benefit, the anaesthetist may claim

    i. The admission benefit, where the anaesthetist is the admitting medical practitioner, and
    ii. The daily care benefit, where the anaesthetist has been

providing daily care prior to surgery

## G.7 Critical Care

a. **Life threatening critical care** is care to a critically ill or injured patient, where the illness or injury acutely impairs one more vital organ systems and results in imminent life threatening deterioration in the patient's conditions, or makes such deterioration highly probable. This can include, but is not limited to central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

b. Life threatening critical care is time-based and includes the following services that are not eligible to be claimed when rendered to the same patient by the same physician on the same day:

    i. Assessment and ongoing monitoring of the patient's condition
    ii. Intravenous lines
    iii. Cutdowns
    iv. Arterial and/or venous catheters
    v. Central venous pressure lines
    vi. Endotracheal intubation
    vii. Tracheal toilet
    viii. Blood gases
    ix. Nasogastric intubation with/without anaesthesia with/without lavage
    x. Urinary catheterization
    xi. Pressure infusion sets and pharmacological agents
    xii. Defibrillation
    xiii. Cardioversion

c. The time claimed for life threatening critical care may be consecutive or non-consecutive, but must be spent fully devoted to the care of the patient. It cannot be claimed for the services of a physician on the same day for which the physician claims a per diem fee for critical

care in the intensive care unit, ventilatory support, or comprehensive care.

d. **Other critical care** is a service rendered for resuscitation, assessment, and related procedures, other than those described as life threatening critical care but where there is a potential threat to life and limb such that the medical care is necessary to prevent the loss of limb or the requirement for life threatening care.

e. Other critical care is time-based and includes the following services that are not eligible to be claimed when rendered to the same patient by the same physician on the same day:

    i. Assessment and ongoing monitoring of the patient's condition
    ii. Intravenous lines
    iii. Cutdowns
    iv. Arterial and/or venous catheters
    v. Central venous pressure lines
    vi. Endotracheal intubation
    vii. Tracheal toilet
    viii. Blood gases
    ix. Nasogastric intubation with/without anaesthesia with/without lavage
    x. Urinary catheterization
    xi. Pressure infusion sets and pharmacological agents

f. **Critical care per diem** claims apply per patient treated by the physician-in-charge of a patient in the intensive care unit and reflect the number of days the patient has received such care.

g. Critical care per diem charges can be any of Critical Care, Ventilatory Support, or Comprehensive Care (both Critical Care and Ventilatory Support); when claimed, no other critical care codes may be used by the same physician.

h. **Critical Care** is the provision by a physician of all aspects of the care of a critically ill patient in the intensive care unit, excluding Ventilatory Support.

i. **Ventilatory Support** is the provision of ventilatory care to a critically ill patient in the intensive care unit, including initial consultation and assessment, peripheral intravenous lines, endotracheal intubation with positive pressure ventilation, insertion of arterial and central venous lines, tracheal toilet, use of artificial ventilator, and the interpretation of all related laboratory testing.

j. **Comprehensive Care** is the provision of both Critical Care and Ventilatory Support to a critically ill patient in the intensive care unit.

k. Physicians other than those providing Critical Care or Comprehensive Care may claim consultation, visit, or procedural fees not listed as part of critical care. If Ventilatory Care is the only service provided by one physician, another may claim Critical Care fees or the appropriate consultation, visit, or procedural fees.

l. The critical care per diem fees should not be claimed for stabilized patients or for those patients who are in the intensive care unit for the purpose of monitoring.

## G.8 Emergency Medicine

a. The schedule of services for Emergency Medicine apply only to assessments and procedures rendered by the emergency physician(s) who are on duty and on-site in the emergency department.

b. The time designations for assessments and procedures in the emergency department are, as follows:

i. Day 08:00 – 18:00
ii. Evening 18:00 – 24:00
iii. Night 24:00 – 08:00
iv. Weekend and Holidayservices are defined as occurring from 08:00 to 24:00 on a Saturday, Sunday, or statutory holiday

c. When not specific to the emergency department, procedures shall be claimed using the appropriate service codes designated in other specialty sections of the Schedule, providing that the emergency physician has the appropriate credentials and privileges to provide these services.

d. **Level I** visits in the emergency department are defined as a level of service pertaining to the evaluation and treatment of a single condition requiring a short history, examination, and treatment; it shall include review of related laboratory tests and x-rays. This visit level shall pertain, as well, to patients not meeting the criteria for Level II or Level III care.

e. **Level II** visits in the emergency department pertain to the evaluation of a medical condition that necessitates a detailed medical history and physical examination of three or more regions; it shall include review of related laboratory tests and x-rays, and the initiation of appropriate treatment. This visit level shall pertain, as well, to those patients whose illness or injury requires prolonged observation, continuous therapy, and multiple reassessments.

f. **Level III** visits in the emergency department pertain to the evaluation of a patient with serious multiple or complex medical problem(s) which can be obscure and which require a detailed and comprehensive history and complete physical examination; it shall include review of related laboratory tests and x-rays, and the initiation of appropriate

treatment, in addition to discussions with the patient, family members, and other physicians.

g. **Critical care** visits in the emergency department are defined as **life threatening critical care** and **other critical care** in section G.7 of this preamble.

h. **Medivac preparation** of a patient includes those assessments and interventions required after the decision to transport a seriously ill patient is confirmed by the receiving hospital.

# H Appendix: New Service Item Committee

**H.1** The New Service Item Committee (NSIC) is a joint committee constituted by representatives of the Northwest Territories Medical Association (NWTMA) and the Department of Health and Social Services (DHSS) of the Government of the Northwest Territories (GNWT).

**H.2** The mandate of the NSIC is to recommend to the Minister of Health and Social Services (the ”Minister”) the inclusion of new insured medical services in the Insured Services Tariff (the “Schedule”), as published by the GNWT.

**H.3** Implementation of the recommendations of the NSIC requires the approval of the Deputy Minister of Health and Social Services (if the recommendation is not cost neutral) or the Director of Health Services Administration (if the recommendation is cost neutral).

**H.4** All recommendations of the NSIC will incorporate proposed billing rules around a new service item, including but not limited to site of service, eligible specialty(ies), anaesthesia units (where applicable), and associated eligible premiums.

**H.5** The NWTMA shall appointment two physicians to serve on the NSIC with the following responsibilities:

a. Chair the NSIC
b. Receive new service items requests from clinical specialty representatives of the NWTMA, or from the DHSS
c. Set the agenda and provide items for discussion at NSIC meetings, with input from the DHSS
d. Provide liaison between the NSIC and the originator of a proposal, clarifying related issues and reporting results of the committee deliberations
e. Work with DHSS staff in developing billing rules for a recommended new service item

**H.6** The Director, Health Services Administration of the DHSS shall appoint two GNWT representatives to serve on the NSIC with the following responsibilities:

a. Organize materials for the DHSS representatives
b. Document and collate NWTMA and DHSS proposals
c. Document and collate actions and correspondence on each new service item under consideration by the NSIC
d. Prepare relevant utilization data on each new service item under consideration by the NSIC
e. Prepare a cost impact analysis on each new service item under consideration by the NSIC
f. Where required, obtain an independent clinical perspective on a new service item that is under consideration, and provide that perspective for consideration by the NSIC
g. Provide liaison between the NSIC and Deputy, or the delegate of the Deputy, clarifying related issues and reporting results of the committee deliberations
h. Where required, undertake environmental scans across the country concerning the items being considered by the NSIC, including but not limited to codes for the specific services, insured benefits, service volumes, and associated descriptions of the service
i. Work with the NWTMA in developing billing rules for a recommended new service item

**H.7** The CEO of the Stanton Territorial Health Authority shall appoint two hospital representatives to serve on the NSIC with the following responsibilities:

a. Provide the perspective of hospital services
b. Provide the perspective of other health authorities, where applicable
c. Where required, provide technology expertise and advice to the NSIC

**H.8** Following is the process that guides the activities of the NSIC:

a. The NWTMA, DHSS, or the health authorities, using a standard New Service Item Request Form, can submit a request for a new service item to the Chair of the NSIC.
b. When a physician contacts the DHSS Medical Advisor and requests to be paid through Independent Consideration (IC) for a new service which does not have a specific code for it in the Insured Services Tariff, the Medical Advisor or Consultant may assign an interim value for the service and advise the physician to bill the service/procedure as an IC, using a manual payment form. It is then incumbent upon the physician to ensure there is a New Service Item Request Form completed and sent to the NWTMA within six months. If no formal request has been received by the NWTMA and the DHSS notified of the request, payment of the service through IC will be discontinued.
c. DHSS documents and collates proposals, actions, and correspondence that relate to potential new service items, under consideration by the NSIC
d. The Chair of the NSIC, after consultation with the Director, Health Services Administration, will call a meeting of the NSIC and provide all available documentation prior to that meeting; the documentation includes that provided by both the NWTMA and the DHSS
e. Requests for a new service item are duly considered by the NSIC with respect to merit, validity, completeness, cost, and perceived benefit. If the NSIC determines that there are necessary clarifications or extra information required, the Chair, on behalf of the NSIC, will undertake to contact the appropriate resource for such clarification or extra information
f. NSIC decisions are based on consensus, and could be any of the following: acceptance, as submitted; acceptance, with adjustments; rejection; or referral
g. NSIC decisions are communicated to the originator of the proposal for a response. If the decision is acceptance of the requested item and the originator is in agreement with the conditions on which the NSIC has based its decision, the matter can move forward to the next step; if however, the requestor does not accept the decision, the issue may be brought back to the NSIC for further discussion and possible adjustment.

h. Once both the NSIC and the originator of the proposal accept the documented decision, the NSIC will submit the new service item for consideration by the Deputy, or delegate, or the Director, Health Services Administration, depending on the financial implications of the decision. This submission will include the supporting documents available to the NSIC, including the recommended billing rules.

## I Appendix: Updating and Maintenance of the Schedule

**I.1** Updating and maintenance of the Insured Services Tariff (the "Schedule") is essential to reflecting care and to its continuing relevance to government and to physicians. Further, technology advances can necessitate revision to a fee service code and its constituent elements.

**I.2** Updating and maintenance of the Schedule can include any or all of:

a. Adding a code
b. Deleting a code
c. Changing the value of a code
d. Modifying a code descriptor, a billing rule, or a payment rule

**I.3** Responsibility for updating and maintenance of the Schedule rests with the Department of Health and Social Services (DHSS), and can include consultation and advice from the Northwest Territories Medical Association (NWTMA).

**I.4** Decision-making requires clearly articulated objectives and goals that are explicit, reasonable, and objective. Outcome measures should target the needs of patients, providers, and the payer.

**I.5** Evaluating the efficacy of the process of updating and maintenance of the Schedule requires identification of goals, measuring the outcome against those goals, and timeliness.

**I.6** The three sources of codes for annual review are:

a. New code approved through the process established by the New Service Item Committee (NSIC)
b. Codes submitted for consideration by either the DHSS or the NWTMA
c. A further total of fifty codes selected randomly from the top fifteen codes, by service volume, for each clinical specialty

**I.7** Each review will include a relativity assessment and determination of the impact of technology on the provision of the service.

**I.8** The relativity assessment will be the basis of valuating a new code or modifying the value of an existing code. The basis of the relativity assessment is the derivation of intensity and its measurement against an existing intensity rating. The existing intensity rating will be that of an anchor code for each specialty; the anchor code can be either a procedure or an assessment that is performed commonly and is easily understood.

**I.9** The intensity rating is a derived relative value for the code. These ratings have been calculated for most commonly used codes in the Northwest Territories; each will be confirmed for the anchor services. The service being evaluated will measure relative value as a function of knowledge and judgment, technical skills, communication skills, and risk and stress. These components of physician work and the typical time required to perform a service will be derived from consultation with the NWTMA and external resources, as required.

**I.10** Therefore, the valuation formula is, as follows:

$V_1 = V_2 \ (I_1 \ / \ I_2)$

where

| | | |
|---|---|---|
| $V_1$ | is | calculated value for the new or assessed code |
| $V_2$ | is | existing value for anchor code |
| $I_1$ | is | intensity rating for the new or assessed code |
| $I_2$ | is | intensity rating for anchor code |

where

| | | |
|---|---|---|
| I | is | sum of 1-7 ratings for each of knowledge and judgment, technical skills, communication skills, and risk and stress, multiplied by the average time required for the service |

| INDEX TO INSURED SERVICES TARIFF FOR PHYSICIANS | |
|---|---|
| **Please Note** | **The use of this schedule requires awareness and the application of the explanatory notes and billing rules that are detailed in the Preamble to the Insured Services Tariff for Physicians** |
| **Page** | **Clinical Sections** |

| Fee Code | Descriptor | Price | |
|---|---|---|---|
| | **SECTION AN<br>ANAESTHESIA** | | |
| | **Consultations and Assessments** | | |
| **AN-001** | Major consultation for a life-threatening condition, either by itself or in association with proposed anaesthesia and surgery | 155.37 | |
| **AN-002** | Minor consultation for a regional complaint which does not require a complete history and physical examination | 93.23 | |
| **AN-003** | Assessment and initiation of treatment of a non-anaesthetic condition, when requested and urgent | 62.15 | |
| | **Time-Based Benefits for Surgery** | | |
| **AN-004** | For up to the first 30 minutes of anaesthetic time | 136.71 | |
| **AN-005** | For up to the second 30 minutes of anaesthetic time | 74.59 | |
| **AN-006** | After one hour of anaesthetic time, for each subsequent 15 minutes or major portion of 15 minutes | 55.93 | |
| **AN-007** | After three hours of anaesthetic time, for each 7.5 minutes or major portion of 7.5 minutes | 55.93 | |
| | **Procedural Benefits for Surgery** | | |
| **Where the total surgical benefit is $200 or greater, additional anaesthetic procedural benefits are:** | | 0.00 | |
| **AN-008** | Where total surgical benefit exceeds $ 200 | 74.59 | |
| **AN-009** | Where total surgical benefit exceeds $ 250 | 111.85 | |
| **AN-010** | Where total surgical benefit exceeds $ 300 | 149.13 | |
| **AN-011** | Where total surgical benefit exceeds $ 350 | 186.44 | |
| **AN-012** | Where total surgical benefit exceeds $ 400 | 223.73 | |
| **AN-013** | Where total surgical benefit exceeds $ 450 | 261.01 | |
| **AN-014** | Where total surgical benefit exceeds $ 500 | 298.30 | |
| **AN-015** | Where total surgical benefit exceeds $ 550 | 335.58 | |

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| **AN-016** | Where total surgical benefit exceeds $ 600 | 372.87 | |
| **AN-017** | Where total surgical benefit exceeds $ 650 | 410.14 | |
| **AN-018** | Where total surgical benefit exceeds $ 700 | 447.43 | |
| **AN-019** | Where total surgical benefit exceeds $ 750 | 484.73 | |
| **AN-020** | Where total surgical benefit exceeds $ 800 | 522.02 | |
| **AN-021** | Where total surgical benefit exceeds $ 850 | 559.31 | |
| **AN-022** | Where total surgical benefit exceeds $ 900 | 596.60 | |
| **AN-023** | Where total surgical benefit exceeds $ 950 | 633.87 | |
| **AN-024** | Where total surgical benefit exceeds $ 1,000 | 671.18 | |
| | **Anaesthesia Modifiers** | | |
| **AN-025** | Body Mass Index (BMI) greater than 40 | 20% (of time-based benefits + procedural benefits) | |
| **AN-026** | Sleep apnea patient using C-PAP apparatus and with a Body Mass Index (BMI) less than 40 | 20% (of time-based benefits + procedural benefits) | |
| **AN-027** | ASA III | 49.70 | |
| **AN-028** | ASA IV | 155.37 | |
| **AN-029** | ASA V | 310.73 | |
| **AN-030** | Infant from 0-12 months | 80.78 | |
| **AN-031** | Age 1-8 years | 31.07 | |
| **AN-032** | Age 70 years or greater | 31.07 | |
| **AN-033** | Prone position | 62.15 | |
| **AN-034** | Awake intubation | 62.15 | |
| **AN-035** | Malignant hyperthermia susceptible | 80.78 | |

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| **AN-036** | Acute airway obstruction | 155.37 | |
| | **Nerve Blocks** | | |
| **AN-037** | Brachial plexus | 87.01 | |
| **AN-038** | Celiac ganglion | 124.29 | |
| **AN-039** | Combined 3-in-1 block of femoral, obturator, and lateral femoral cutaneous nerves - unilateral | 155.37 | |
| **AN-040** | Femoral nerve - unilateral | 87.01 | |
| **AN-041** | Femoral nerve - bilateral | 124.29 | |
| **AN-042** | Intercostal | 43.49 | |
| **AN-043** | Lumbar epidural or caudal epidural block | 192.64 | |
| **AN-044** | Lumbar epidural or intrathecal injection of sclerosing agent | 279.65 | |
| **AN-045** | Lumbar epidural injection of adrenal steroid or autologous blood | 111.85 | |
| **AN-046** | Lumbar epidural injection post-laminectomy into operative site | 149.13 | |
| **AN-047** | Obturator nerve - unilateral | 87.01 | |
| **AN-048** | Obturator nerve - bilateral | 124.29 | |
| **AN-049** | Occipital nerve - unilateral to maximum of 3 per day or 48 per calendar year | 43.49 | |
| **AN-050** | Other cranial nerve block | 111.85 | |
| **AN-051** | Other somatic or peripheral nerve blocks not specifically listed | 55.93 | |
| **AN-052** | Paravertebral - initial | 87.01 | |
| **AN-053** | Paravertebral - additional or repeat | 55.93 | |
| **AN-054** | Pudendal nerve - unilateral | 87.01 | |
| **AN-055** | Pudendal nerve - bilateral | 124.29 | |

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| **AN-056** | Sciatic nerve - unilateral | 87.01 | |
| **AN-057** | Sciatic nerve - bilateral | 124.29 | |
| **AN-058** | Supraorbital nerve | 55.93 | |
| **AN-059** | Sympathetic block - lumbar or thoracic - unilateral | 87.01 | |
| **AN-060** | Sympathetic block - lumbar or thoracic - bilateral | 124.29 | |
| **AN-061** | Transverse scapular nerve | 87.01 | |
| **AN-062** | Trigeminal ganglion | 124.29 | |
| | **Continuous Epidural Anaesthesia** | | |
| **AN-063** | Initial induction including consultation | 192.64 | |
| **AN-064** | Each additional injection | 49.70 | |
| **AN-065** | For each hour of continuous infusion | 24.87 | |
| | **Procedural Sedation Other Than in Operating Room** | | |
| **AN-066** | For first 30 minutes | 111.85 | |
| **AN-067** | For each 5 minutes greater than 30 minutes | 12.44 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION CC<br>CRITICAL CARE** | | |
| | **Life Threatening Critical Care** | | |
| **CC-001** | Life threatening critical care - first 15 minutes or part thereof for up to three physicians | 149.13 | |
| **CC-002** | Life threatening critical care - second 15 minutes or part thereof for up to three physicians | 74.59 | |
| **CC-003** | Life threatening critical care - per 15 minutes or part thereof after the first 30 minutes for up to three physicians | 49.70 | |
| | **Other Critical Care** | | |
| **CC-004** | Other critical care - first 15 minutes or part thereof for up to three physicians | 74.59 | |

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| **CC-005** | Other critical care - per 15 minutes or part thereof after the first 15 minutes for up to three physicians | 37.28 | |
| | **Critical Care Per Diem Charges** | | |
| **CC-006** | Critical Care per diem for physician-in-charge of patient in intensive care - day 1 | 372.87 | |
| **CC-007** | Critical Care per diem for physician-in-charge of patient in intensive care - day 2-30 | 186.44 | |
| **CC-008** | Critical Care per diem for physician-in-charge of patient in intensive care - day 31 onwards | 93.23 | |
| | **Ventilatory Support Per Diem Charges** | | |
| **CC-009** | Ventilatory Support per diem for physician-in-charge of ventilatory care of patient in intensive care - day 1 | 298.30 | |
| **CC-010** | Ventilatory Support per diem for physician-in-charge of ventilatory care of patient in intensive care - day 2-30 | 149.13 | |
| **CC-011** | Ventilatory Support per diem for physician-in-charge of ventilatory care of patient in intensive care - day 31 onwards | 74.59 | |
| | **Comprehensive Care Per Diem Charges** | | |
| **CC-012** | Comprehensive Care per diem for physician-in-charge of patient in intensive care - day 1 | 497.17 | |
| **CC-013** | Comprehensive Care per diem for physician-in-charge of patient in intensive care - day 2-30 | 248.58 | |
| **CC-014** | Comprehensive Care per diem for physician-in-charge of patient in intensive care - day 31 onwards | 124.29 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION DI<br>DIAGNOSTIC IMAGING** | | |
| | **Head** | | |
| | **Maximum of 2 CT scans may be claimed per patient per day** | 0.00 | |
| **DI-001** | Skull | 20.49 | |
| **DI-002** | Facial bones | 21.77 | |
| **DI-003** | Mandible | 16.76 | |
| **DI-004** | Panorex | 9.33 | |

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| **DI-005** | Nasal bones | 11.20 | |
| **DI-006** | Adenoids or nasopharynx | 12.44 | |
| **DI-007** | Adenoids or nasopharynx, lateral and AP | 18.64 | |
| **DI-008** | Mastoids | 18.64 | |
| **DI-009** | Sinuses-Paranasal | 16.76 | |
| **DI-010** | Temporo-mandibular joints | 16.76 | |
| **DI-011** | Sella turcica | 16.76 | |
| **DI-012** | Orbit - for foreign body | 14.92 | |
| **DI-013** | Orbit - for foreign body localization | 29.81 | |
| **DI-014** | Optic foramina | 19.89 | |
| **DI-015** | Internal auditory canal | 12.44 | |
| **DI-016** | Salivary gland regions | 14.92 | |
| **DI-017** | Sialography (interpretation only) | 22.37 | |
| **DI-018** | Sialography (injection of opaque material) | 87.01 | |
| | **Chest** | | |
| **DI-019** | Chest - single view | 12.44 | |
| **DI-020** | Chest - multiple view | 16.16 | |
| **DI-021** | Thoracic inlet views | 16.16 | |
| **DI-022** | Ribs | 12.44 | |
| **DI-023** | Chest - fluoroscopy | 12.44 | |
| **DI-024** | Chest - bronchography (interpretation only) | 37.28 | |

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| **DI-025** | Bronchogram - instillation of opaque material | 87.01 | |
| **DI-026** | Mammography (one breast) | 37.28 | |
| **DI-027** | Mammoductography | 49.70 | |
| **DI-028** | Mammocystography | 49.70 | |
| **DI-029** | Mammography (both breasts) | 62.15 | |
| **DI-030** | Needle localization under mammographic control prior to biopsy of the breast - single lesion | 42.26 | |
| **DI-031** | Sternum/sterno-clavicular joints | 17.40 | |
| | **Upper Extremity** | | |
| **DI-032** | Finger | 8.09 | |
| **DI-033** | Hand | 13.05 | |
| **DI-034** | Wrist/carpal bone (wrist & hand) | 14.92 | |
| **DI-035** | Carpal tunnel view additional benefits | 4.96 | |
| **DI-036** | Radius and ulna | 13.05 | |
| **DI-037** | Elbow | 13.67 | |
| **DI-038** | Humerus | 13.05 | |
| **DI-039** | Clavicle | 13.05 | |
| **DI-040** | Acromioclavicular joints | 13.05 | |
| **DI-041** | Shoulder girdle | 15.53 | |
| **DI-042** | Scapula | 14.30 | |
| **DI-043** | Arthrogram - any upper extremity joint (interpretation only) | 41.02 | |
| **DI-044** | Injection for arthrogram | 96.95 | |

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| | **Lower Extremity** | | |
| **DI-045** | Toe | 8.09 | |
| **DI-046** | Foot | 13.05 | |
| **DI-047** | Ankle | 14.92 | |
| **DI-048** | Os calcis | 12.44 | |
| **DI-049** | Tibia & fibula | 13.05 | |
| **DI-050** | Knee | 16.76 | |
| **DI-051** | Skyline tunnel view of knee, additional benefit | 4.96 | |
| **DI-052** | Arthrogram - any lower extremity joint (interpretation only) | 41.02 | |
| **DI-053** | Injection for arthrogram | 96.95 | |
| **DI-054** | Femur or thigh | 13.05 | |
| **DI-055** | Hip | 16.76 | |
| **DI-056** | Hip - arthrogram | 41.02 | |
| **DI-057** | Hip pinning | 24.87 | |
| **DI-058** | Hip pinning with fluoroscopy | 37.28 | |
| **DI-059** | Pelvis | 18.64 | |
| **DI-060** | Pelvis & one hip | 23.62 | |
| **DI-061** | Pelvis & both hips | 27.33 | |
| **DI-062** | Sacro-iliac joints | 18.64 | |
| | **Stress View of a Limb Additional Benefit** | | |
| **DI-063** | Stress View of a Limb Additional Benefit - unilateral | 5.59 | |

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| **DI-064** | Stress View of a Limb Additional Benefit - bilateral | 8.70 | |
| | **Spine** | | |
| **DI-065** | One area | 24.87 | |
| **DI-066** | One area - with obliques | 31.07 | |
| **DI-067** | Two areas | 41.02 | |
| **DI-068** | Two areas - of the spine with obliques of each area | 55.93 | |
| **DI-069** | Complete spine | 47.23 | |
| **DI-070** | Spine - flexion and extension additional benefit | 6.20 | |
| **DI-071** | Spine - lateral bending, additional benefit | 6.20 | |
| **DI-072** | Spine - both, additional benefits | 9.33 | |
| **DI-073** | Myelogram, x-ray and fluoroscopy | 43.49 | |
| **DI-074** | Myelogram, cervical or thoracic | 43.49 | |
| **DI-075** | Myelogram injection | 93.23 | |
| **DI-076** | Discogram injection | 161.58 | |
| | **Genito-Urinary** | | |
| **DI-077** | Kidney, Ureter, Bladder | 16.76 | |
| **DI-078** | Cystography (excluding catheterization, interpretation only) | 16.76 | |
| **DI-079** | Urethrography (excluding catheterization) | 14.30 | |
| **DI-080** | Excretory pyelography (interpretation only) | 44.73 | |
| **DI-081** | Pyelography (injection only) | 44.73 | |
| **DI-082** | Retrograde pyelogram | 24.87 | |

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| **DI-083** | Nephrotomography (interpretation only) | 80.78 | |
| **DI-084** | Minute sequence excretory pyelography (interpretation only) | 68.36 | |
| **DI-085** | Pelvimetry | 26.10 | |
| **DI-086** | Hystero - salpingography (with or without fluoroscopy, interpretation only) | 31.07 | |
| **DI-087** | Hystero - salpingogram (insufflation or injection of opaque material) | 93.23 | |
| | **Gastrointestinal** | | |
| **DI-088** | Esophagus with fluoroscopy (interpretation only) | 49.70 | |
| **DI-089** | Stomach & duodenum with fluoroscopy (interpretation only) | 55.93 | |
| **DI-090** | Double contrast examination of stomach (additional fee) | 8.70 | |
| **DI-091** | Follow-up film taken following day | 6.20 | |
| **DI-092** | Stomach, duodenum and small bowel follow through and with fluoroscopy (including follow-up film taken next day if necessary) (interpretation only) | 74.59 | |
| **DI-093** | Small bowel only fluoroscopy (interpretation only) | 39.78 | |
| **DI-094** | Selective hypotonic duodenography | 49.70 | |
| **DI-095** | Small bowel studies including fluoroscopy & administration of cholinergic drugs (enteroclysis) | 99.44 | |
| **DI-096** | Intubation for duodenography | 62.15 | |
| **DI-097** | Colon (with fluoroscopy and films) (interpretation only) | 37.28 | |
| **DI-098** | Colon (with fluoroscopy) combined with air contrast examination (interpretation only) | 49.70 | |
| **DI-099** | Barium enema for reduction of intussuesception | 105.66 | |
| **DI-100** | Cholecystography (including repeat examination on following day if necessary) | 22.37 | |
| **DI-101** | Cholecystography with fluoroscopy | 45.99 | |
| **DI-102** | Trans-hepatic percutaneous cholangiography | 80.78 | |

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| **DI-103** | Operative cholangiogram (interpretation only) | 35.43 | |
| **DI-104** | T-tube cholangiogram (including injections) | 110.00 | |
| **DI-105** | Abdomen - single view | 16.16 | |
| **DI-106** | Abdomen - multiple views | 22.37 | |
| | **Skeletal Survey** | | |
| **DI-107** | Skull, shoulder, chest, spine and pelvis | 49.70 | |
| **DI-108** | Tomogram (laminogram & planogram) including stereos & fluoroscopy when necessary, any area | 43.49 | |
| **DI-109** | Fluoroscopy of areas not specified elsewhere in schedule | 74.59 | |
| **DI-110** | Bone age | 13.98 | |
| **DI-111** | Singogram or fistulogram without fluoroscopy | 28.90 | |
| | **Vascular** | | |
| **DI-112** | Artery or vein (interpretation only) | 43.49 | |
| **DI-113** | Peripheral venography (direct puncture and injection) | 93.23 | |
| | **Diagnostic Ultrasound Head and Neck** | | |
| **DI-114** | Echoencephalography, complete, diencephalic midline and ventricular size (Real Time) | 49.70 | |
| **DI-115** | Echography thyroid (Real Time) | 43.49 | |
| | **Diagnostic Ultrasound Heart** | | |
| **DI-116** | Echocardiography, pericardial effusion, M-mode | 37.28 | |
| **DI-117** | Pericardiocentesis by ultrasound guidance | 80.78 | |
| **DI-118** | Echocardiography, cardiac valve(s), M-mode | 62.15 | |
| **DI-119** | Echocardiography, M-mode (X-213 and X-215, combined and chamber dimensions) | 99.44 | |

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| **DI-120** | Real Time echocardiography, includes M-mode tracing | 99.44 | |
| **DI-121** | Doppler Echocardiography | 93.23 | |
| **DI-122** | Echocardiography, limited eg. follow-up or limited study | 37.28 | |
| **DI-123** | Echography, Pleural Effusion (Real Time) | 49.70 | |
| **DI-124** | Thoracentesis by ultrasound guidance | 74.59 | |
| **DI-125** | Echography breast, unilateral (Real Time) | 55.93 | |
| **DI-126** | Echography breast, bilateral (Real Time) | 87.01 | |
| | **Diagnostic Ultrasound Abdomen and Retroperitoneum** | | |
| **DI-127** | Complete, Real Time abdominal study including liver, gallbladder, pancreas, kidneys, aorta and including hard copy images of all areas described | 105.66 | |
| **DI-128** | Limited, eg. follow-up or limited study | 55.93 | |
| **DI-129** | Renal | 80.78 | |
| **DI-130** | Ultrasound guidance for aspiration or biopsy | 80.78 | |
| | **Diagnostic Ultrasound Obstetrics and Gynecology and Pelvis** | | |
| **DI-131** | Placenta localization or follow up | 49.70 | |
| **DI-132** | Pregnancy, complete under 14 weeks (including twins and triplets) | 74.59 | |
| **DI-133** | Pregnancy, complete over 14 weeks (including twins and triplets) | 111.85 | |
| **DI-134** | Pelvic | 62.15 | |
| **DI-135** | Transvaginal | 74.59 | |
| | **Diagnostic Ultrasound Peripheral Vascular** | | |
| **DI-136** | Peripheral flow study (Doppler), arterial | 55.93 | |
| **DI-137** | Venous (Doppler) | 55.93 | |

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| **DI-138** | Arterial & venous (X-245 and X-246) | 74.59 | |
| | **Diagnostic Ultrasound Miscellaneous** | | |
| **DI-139** | Scrotal ultrasound | 49.70 | |
| **DI-140** | Ultrasound, guidance only | 74.59 | |
| **DI-141** | Biophysical profile | 136.71 | |
| | **Diagnostic Ultrasound Real Time Extremities or Joints** | | |
| **DI-142** | Unilateral | 46.85 | |
| **DI-143** | Bilateral | 64.43 | |
| | **Computerized Tomography Head** | | |
| **DI-144** | Without contrast | 70.30 | |
| **DI-145** | With contrast | 99.58 | |
| **DI-146** | Double scan or 2 planes, without contrast | 128.88 | |
| **DI-147** | Double scan or 2 planes, with contrast | 146.44 | |
| | **Computerized Tomography Body** | | |
| **DI-148** | One area, without contrast | 140.60 | |
| **DI-149** | One area, with contrast | 152.30 | |
| **DI-150** | Double scan or 2 regions, without contrast | 210.90 | |
| **DI-151** | Double scan or 2 regions, with contrast | 251.89 | |
| **Fee Code** | **Descriptor**<br>**SECTION DT**<br>**DIAGNOSTIC AND THERAPEUTIC PROCEDURES** | **Price** | |
| | **Vascular System** | | |
| **DT-001** | Intravenous injection | 18.64 | |

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| **DT-002** | Cutdown of peripheral vein | 49.70 | |
| **DT-003** | Cutdown of peripheral artery | 310.73 | |
| **DT-004** | Obtaining blood sample for transport to distant laboratory if approved by facility responsible for the collection | 14.92 | |
| **DT-005** | Venipuncture of patient under 16 years of age | 31.07 | |
| **DT-006** | Scalp infusion or insertion of intravenous line where patient under 16 years of age | 43.49 | |
| **DT-007** | Phlebotomy | 31.07 | |
| **DT-008** | Arterial puncture | 24.87 | |
| **DT-009** | Insertion of Swan Ganz catheter and all related monitoring | 186.44 | |
| **DT-010** | Left ventricular pressures, aortic gradients | 310.73 | |
| **DT-010A** | Bone marrow aspiration | 56.23 | |
| **DT-010B** | Bone marrow core biopsy | 105.45 | |
| | **Gastrointestinal System** | | |
| **DT-011** | Stomach lavage and gavage | 62.15 | |
| **DT-012** | Esophageal dilation by sound bouginage - initial | 124.29 | |
| **DT-013** | Esophageal dilation by sound bouginage - repeat | 62.15 | |
| **DT-014** | Gastric cytology washings by a medical practitioner | 62.15 | |
| **DT-015** | Diagnostic laparoscopy with or without biopsy | 310.73 | |
| | **Other Systems** | | |
| **DT-016** | Intramuscular or subcutaneous injections | 12.44 | |
| **DT-017** | Allergy scratch or patch - each antigen - annual maximum $65.00 | 3.11 | |

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| **DT-018** | Allergy scratch or patch on patient less than 5 years old - each antigen - annual maximum $65.00 | 6.20 | |
| **DT-019** | Endotracheal aspiration of sputum | 62.15 | |
| **DT-020** | Interpretation of pulmonary function tests involving lung volumes, diffusing capacities, mixing efficiency, alveolar $CO_2$ | 37.28 | |
| **DT-021** | Lumbar puncture | 62.15 | |
| **DT-022** | Cardioversion | 155.37 | |
| **DT-023** | Insertion of intra-uterine contraceptive device | 68.36 | |
| **DT-024** | Compression sclerotherapy - includes multiple injections, compression bandaging and one post-injection visit | 99.44 | |
| **DT-025** | Repeat compression sclerotherapy | 37.40 | |
| **(+) DT-026** | Periodic papanicolaou smear with maximum of one per patient per 12 months and excluding smears provided in conjunction with a consultation or general assessment | 10.55 | |
| **(+) DT-027** | Additional papanicoloau smear provided as follow-up of abnormal or inadequeate smears | 10.55 | |
| **DT-028** | Papanicolau smear performed outside of hospital - tray fee | 13.54 | |
| **DT-029** | Split thickness skin graft or full thickness pedicle flap | 410.04 | |
| **DT-030** | Laser treatment of cutaneous vascular tumours, per session | 146.44 | |
| **Fee Code** | **Descriptor**<br>**SECTION EM**<br>**EMERGENCY MEDICINE** | **Price** | |
| | **Level I Emergency Care** | | |
| **EM-001** | Day | 43.49 | |
| **EM-002** | Evening | 55.93 | |
| **EM-003** | Night | 80.78 | |
| **EM-004** | Weekend and statutory holidays | 55.93 | |

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| | **Level II Emergency Care** | | |
| **EM-005** | Day | 80.78 | |
| **EM-006** | Evening | 105.66 | |
| **EM-007** | Night | 149.13 | |
| **EM-008** | Weekend and statutory holidays | 105.66 | |
| | **Level III Emergency Care** | | |
| **EM-009** | Day | 149.13 | |
| **EM-010** | Evening | 198.86 | |
| **EM-011** | Night | 248.58 | |
| **EM-012** | Weekend and statutory holidays | 198.86 | |
| | **Repeat Assessment in Emergency Department** | | |
| **EM-012A** | Repeat assessment of a patient in the Emergency Department required due to the acuity of illness of that patient, but who is not being admitted to hospital nor discharged from the Emergency Department after an initial assessment; the repeat assessment would normally occur two or more hours after the initial assessment | 105.66 | |
| **EM-012B** | Repeat assessment of a patient in the Emergency Department if seen earlier on the same day in the office, Emergency Department, or outpatient department | 105.66 | |
| | **Life Threatening Critical Care** | | |
| **EM-013** | Life threatening critical care - first 15 minutes or part thereof for up to three physicians | 149.13 | |
| **EM-014** | Life threatening critical care - second 15 minutes or part thereof for up to three physicians | 74.59 | |
| **EM-015** | Life threatening critical care - per 15 minutes or part thereof after the first 30 minutes for up to three physicians | 49.70 | |
| | **Other Critical Care** | | |
| **EM-016** | Other critical care - first 15 minutes or part thereof for up to three physicians | 74.59 | |
| **EM-017** | Other critical care - per 15 minutes or part thereof after the first 15 minutes for up to three physicians | 37.28 | |
| | **Procedural Sedation** | | |
| **EM-018** | For first 30 minutes | 111.85 | |

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| **EM-019** | For each 5 minutes greater than 30 minutes | 12.44 | |
| | **Other Services** | | |
| **EM-020** | Performance and interpretation of an ultrasound examination | 93.23 | |
| **EM-021** | Management of psychiatric emergency per 15 minutes | 49.70 | |
| **EM-022** | Certification of mental illness | 111.85 | |
| **EM-023** | Medivac preparation of a patient | 223.73 | |
| **EM-024** | Medivac detention time - outgoing trip per hour to maximum of 12 hours | 248.58 | |
| **EM-025** | Medivac detention time - return trip per hour to maximum of 5 hours | 124.29 | |
| **EM-026** | Insertion of chest tube | 62.15 | |
| **EM-027** | Pericardiocentesis | 186.44 | |
| **EM-028** | Emergency thoracotomy | 497.17 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION GP<br>GENERAL PRACTICE** | | |
| | **Office Visits** | | |
| **GP-001** | First visit requiring general assessment for new illness - maximum of one claim every six months | 105.45 | |
| **GP-001F** | First visit requiring general assessment for new illness - maximum of one claim every six months | 111.85 | |
| **GP-002** | First visit not requiring general assessment, and subsequent office visits other than a simple follow up visit | 46.85 | |
| **GP-002F** | First visit not requiring general assessment, and subsequent office visits other than a simple follow up visit | 53.46 | |
| **GP-003** | Simple follow up visit within two weeks of first visit | 23.44 | |
| **GP-003F** | Simple follow up visit within two weeks of first visit | 26.72 | |
| **GP-004** | Repeat office visit if seen earlier on the same day in the office, emergency department, or outpatient department | 38.65 | |

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| **GP-004F** | Repeat office visit if seen earlier on the same day in the office, emergency department, or outpatient department | 37.91 | |
| | **House Visits** | | |
| **GP-005** | Initial scheduled visit between 08:00 and 18:00 | 70.30 | |
| **GP-005F** | Initial scheduled visit between 08:00 and 18:00 | 105.66 | |
| **GP-006** | Each additional patient seen during visit | 29.29 | |
| **GP-006F** | Each additional patient seen during visit | 48.48 | |
| **GP-007** | Repeat visit same day at any time | 70.30 | |
| **GP-007F** | Repeat visit same day at any time | 106.88 | |
| **GP-008** | Initial visit on Saturday, Sunday, or statutory holiday, or emergency visit with sacrifice of office hours | 146.44 | |
| **GP-008F** | Initial visit on Saturday, Sunday, or statutory holiday, or emergency visit with sacrifice of office hours | 157.83 | |
| **GP-009** | Evening or night visit initiated and made between 18:00 and 08:00 | 146.44 | |
| **GP-009F** | Evening or night visit initiated and made between 18:00 and 08:00 | 157.83 | |
| | **In-Patient Hospital Visits** | | |
| **GP-010** | Initial visit after admission regardless of the time of day that this initial visit is provided | 105.45 | |
| **GP-010F** | Initial visit after admission regardless of the time of day that this initial visit is provided | 106.88 | |
| **GP-011** | Subsequent visit - most responsible physician | 31.07 | |
| **GP-012** | Concurrent care | 31.07 | |
| **GP-013** | Supportive care | 31.07 | |
| **GP-014** | Admission for respite care | 52.73 | |
| **GP-014F** | Admission for respite care | 49.70 | |
| **GP-015** | Chronic care visit to maximum of 3 visits per week or 15 visits per 3-months | 31.07 | |

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| **GP-016** | Special visit to hospital inpatient initiated by hospital staff | 105.45 | |
| **GP-016F** | Special visit to hospital inpatient initiated by hospital staff | 111.85 | |
| **GP-017** | Special **visit** to long-term care facility resident, initiated by facility staff | 105.45 | |
| **GP-017F** | Special **visit** to long-term care facility resident, initiated by facility staff | 111.85 | |
| | **Consultation** | | |
| **GP-018** | Major consultation at the request of another medical practitioner | 140.60 | |
| **GP-018F** | Major consultation at the request of another medical practitioner | 136.71 | |
| **GP-019** | Minor or repeat consultation for same problem at the request of another medical practitioner | 70.30 | |
| **GP-019F** | Minor or repeat consultation for same problem at the request of another medical practitioner | 74.59 | |
| **GP-020** | Major consultation at the request of a nurse in a community health centre in which no physician resides | 140.60 | |
| **GP-020F** | Major consultation at the request of a nurse in a community health centre in which no physician resides | 136.71 | |
| **GP-021** | Minor or repeat consultation for same problem at the request of a nurse in a community health centre in which no physician resides | 70.30 | |
| **GP-021F** | Minor or repeat consultation for same problem at the request of a nurse in a community health centre in which no physician resides | 74.59 | |
| | **Counseling** | | |
| **GP-022** | Individual counselling by a general practitioner, per 15 minutes (maximum 1.5 hours per visit) | 52.73 | |
| **GP-022F** | Individual counselling by a general practitioner, per 15 minutes (maximum 1.5 hours per visit) | 53.46 | |
| **GP-023** | Group counselling by a general practitioner, per 15 minutes session (maximum 1.5 hours per visit) - bill to one patient | 52.73 | |
| **GP-023F** | Group counselling by a general practitioner, per 15 minutes session (maximum 1.5 hours per visit) - bill to one patient | 49.70 | |
| | **Special Examinations** | | |
| **GP-024** | Complete assessment of alleged sexual assault | 562.35 | |
| **GP-024F** | Complete assessment of alleged sexual assault | 278.73 | |

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| **GP-025** | Complete assessment of sexually transmitted disease | 70.30 | |
| **GP-025F** | Complete assessment of sexually transmitted disease | 62.15 | |
| | **Additional Hospitalist Services** | | |
| **GP-026** | Discharge planning session with patient, staff, and family where necessary | 64.43 | |
| **GP-026F** | Discharge planning session with patient, staff, and family where necessary | 62.15 | |
| **GP-027** | Additional visits to seriously ill patients while already in hospital | 35.14 | |
| **GP-027F** | Additional visits to seriously ill patients while already in hospital | 31.07 | |
| **GP-028** | Detention time per 15 minutes where a seriously ill inpatient requires undivided attention - after the first hour | 58.57 | |
| **GP-028F** | Detention time per 15 minutes where a seriously ill inpatient requires undivided attention - after the first hour | 55.93 | |
| | **Surgical Assisting** | | |
| **GP-029** | First hour | 217.52 | |
| **GP-030** | Each 15 minutes after first hour | 53.46 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION GS<br>GENERAL SURGERY** | | |
| | **Visits and Assessments** | | |
| **GS-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 174.01 | |
| **GS-002** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 87.01 | |
| **GS-003** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |
| **GS-004** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **GS-005** | Subsequent office visits if not included in surgical fee | 24.87 | |
| **GS-006** | Subsequent hospital visits if not included in surgical fee | 31.07 | |

| | Diagnostic Procedures | | |
|---|---|---|---|
| **GS-007** | Biopsy - muscle | 149.13 | |
| **GS-008** | Biopsy - skin or mucosa - incisional or excisional | 43.49 | |
| **GS-009** | Biopsy - skin or mucosa - incisional or excisional, tray fee | 24.87 | |
| **GS-010** | Biopsy (needle) - liver | 124.29 | |
| **GS-011** | Biopsy (needle) - thyroid or breast | 124.29 | |
| **GS-012** | Colonoscopy sigmoid and descending colon | 93.23 | |
| **GS-013** | Colonoscopy to splenic flexure | 93.23 | |
| **GS-014** | Colonoscopy to hepatic flexure | 186.44 | |
| **GS-015** | Colonoscopy to cecum | 248.58 | |
| **GS-016** | Colonoscopy into terminal ileum | 310.73 | |
| **GS-017** | Multiple screening biopsies for malignant changes in ulcerative colitis through colonoscope | 74.59 | |
| **GS-018** | Polypectomy - removal of up to two polyps through colonoscope | 186.44 | |
| **GS-019** | Polypectomy - removal of more than two polyps through colonoscope | 279.65 | |
| **GS-019A** | Multiple screening biopsies through colonoscope other than for maignant changes in ulcerative colitis or polypectomies | 74.59 | |
| **GS-020** | Sigmoidoscopy - rigid - with or without biopsy | 74.59 | |
| **GS-021** | Extended flexible sigmoidoscopy - greater than 20 cm | 124.29 | |
| **GS-022** | Gastroscopy and duodenoscopy - initial with or without biopsy | 248.58 | |
| **GS-023** | Gastroscopy and duodenoscopy - repeat within 3 months with or without biopsy | 186.44 | |
| **GS-024** | Esophagoscopy, with or without biopsy | 248.58 | |
| **GS-024A** | Esophagoscopy with removal of foreign body | 281.16 | |

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| **GS-025** | Thoracoscopy, with poudrage and catheter drainage | 310.73 | |
| **GS-026** | Thoracentesis | 62.15 | |
| **GS-027** | Paracentesis | 62.15 | |
| | **Integumentary System** | | |
| | **Verrucae - Keratoses - Naevi** | | |
| **GS-028** | Excision of first lesion | 43.49 | |
| **GS-029** | Excision of each additional lesion to maximum of five | 18.64 | |
| **GS-030** | Fulgaration of first lesion | 31.07 | |
| **GS-031** | Fulgaration of each additional lesion to maximum of five | 12.44 | |
| **GS-032** | Cryotherapy or chemotherapy of first lesion | 18.64 | |
| **GS-033** | Cryotherapy or chemotherapy of each additional lesion to maximum of five | 8.70 | |
| **GS-034** | Excision or fulgaration of first pigmented benign naevus, excluding face | 43.49 | |
| **GS-035** | Excision or fulgaration of first pigmented benign naevus of face | 74.59 | |
| **GS-036** | Each additional pigmented benign naevus to maximum of 5 | 43.49 | |
| **GS-037** | Excision of malignant melanoma with skin graft excluding face | 341.81 | |
| **GS-038** | Excision of malignant melanoma of face with skin graft | 497.17 | |
| **GS-039** | Plantar wart - single | 68.36 | |
| **GS-040** | Plantar warts - each additional | 18.64 | |
| | **Cysts** | | |
| **GS-041** | Excision of sebaceous cyst, dermoid cyst, or lipoma - 5 cm or less | 93.23 | |
| **GS-042** | Excision of sebaceous cyst, dermoid cyst, or lipoma - greater than 5 cm | 136.71 | |

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| **GS-043** | Excision of additional sebaceous cyst, dermoid cyst, or lipoma - 5 cm or less to maximum of 5 | 43.49 | |
| **GS-044** | Excision of sebaceous cyst or lipoma - tray fee | 24.87 | |
| **GS-045** | Dissection and removal of pilonidal cyst | 497.17 | |
| **GS-046** | Marsupialization of pilonidal cyst | 435.02 | |
| **GS-047** | Excision of branchial cyst | 497.17 | |
| **GS-048** | Excision of branchial sinus and fistula | 497.17 | |
| | **Abscesses** | | |
| **GS-049** | Incision and drainage - subcutaneous or submucous abscess | 74.59 | |
| **GS-050** | Incision and drainage - subcutaneous or submucous abscess - tray fee | 24.87 | |
| **GS-051** | Incision and drainage - palmar space or radial or ulnar bursa | 186.44 | |
| **GS-052** | Incision and drainage - tendon sheath | 186.44 | |
| **GS-053** | Incision and drainage - deep cervical abscess | 186.44 | |
| **GS-054** | Incision and drainage - suppurative bursitis | 93.23 | |
| | **Lacerations** | | |
| **GS-055** | Suture of minor laceration (5 cm or less) | 49.70 | |
| **GS-056** | Suture of minor laceration (5 cm or less) - tray fee | 24.87 | |
| **GS-057** | Suture of laceration (5.1 cm or more) - per cm | 12.44 | |
| **GS-058** | Suture of laceration (5.1 cm or more) - tray fee | 24.87 | |
| **GS-059** | Debridement of wound when it is the sole surgical procedure being performed on patient that day - per 15 minutes | 55.93 | |
| **GS-060** | Debridement of wound - tray fee | 24.87 | |

| | Nail Surgery | | |
|---|---|---|---|
| **GS-061** | Ingrown toenail - wedge excision | 62.15 | |
| **GS-062** | Ingrown toenail - wedge excision - tray fee | 24.87 | |
| **GS-063** | Ingrown toenail - radical excision | 124.29 | |
| **GS-064** | Ingrown toenail - radical excision - tray fee | 24.87 | |
| **GS-065** | Ingrown toenail - bilateral radical excision | 198.86 | |
| **GS-066** | Ingrown toenail - bilateral radical excision - tray fee | 24.87 | |
| | **Lymphatic System** | | |
| **GS-067** | Biopsy of superficial lymph node - excision | 99.44 | |
| **GS-068** | Biopsy of deep lymph node - excision | 149.13 | |
| **GS-069** | Radical dissection of axillary lymph nodes | 932.18 | |
| **GS-070** | Radical dissection of inguinal lymph nodes | 932.18 | |
| **GS-071** | Limited block dissection | 932.18 | |
| **GS-072** | Complete block dissection - unilateral | 1491.48 | |
| **GS-073** | Complete block dissection - bilateral | 2175.07 | |
| **GS-074** | Regional node excision for tuberculosis | 497.17 | |
| **GS-075** | Sentinel node biopsy | 248.58 | |
| **GS-076** | Excision of scalene fat pad | 310.73 | |
| **GS-077** | Excision of cystic hygroma | 310.73 | |
| | **Vascular System** | | |
| **GS-078** | External carotid artery ligation | 621.42 | |
| **GS-079** | Internal jugular vein ligation | 310.73 | |

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| **GS-080** | Saphenous vein ligation - unilateral | 372.87 | |
| **GS-081** | Saphenous vein ligation - bilateral | 559.31 | |
| **GS-082** | Ligation and stripping of long saphenous veins - unilateral | 621.42 | |
| **GS-083** | Ligation and stripping of long saphenous veins - bilateral | 932.18 | |
| **GS-084** | Ligation and stripping of long and short saphenous veins - unilateral | 870.03 | |
| **GS-085** | Ligation and stripping of long and short saphenous veins - bilateral | 1118.61 | |
| **GS-086** | Ligation and stripping of short saphenous veins | 372.87 | |
| **GS-087** | Radical multiple ligation of incompetent communicating veins of lower leg (extra-fascial ligation or Crockett procedure, sub-fascial ligation) - excludes stripping of long saphenous vein | 932.18 | |
| **GS-087A** | Individual ligation of a branch varicose vein elsewhere in leg | 87.86 | |
| **GS-088** | Post-phlebitic leg - ligation of deep vein and stripping of saphenous vein | 870.03 | |
| **GS-089** | Excision of fascia of calf or skin graft - add-on fee | 310.73 | |
| **GS-090** | Superficial femoral ligation | 372.87 | |
| **GS-091** | Introduction of venous catheter for central venous pressure monitoring or for intravenous hyperalimentation - percutaneously or by cut-down | 74.59 | |
| | **Thyroid and Parathyroid Glands** | | |
| **GS-092** | Thyroglossal duct cyst - excision | 870.03 | |
| **GS-093** | Thyroidectomy - subtotal - unilateral | 559.31 | |
| **GS-094** | Thyroidectomy - total unilateral | 1056.46 | |
| **GS-095** | Thyroidectomy - subtotal - bilateral | 870.03 | |
| **GS-096** | Thyroidectomy - total - bilateral | 1491.48 | |
| **GS-097** | Thyroidectomy - total - bilateral with formal neck dissection | 2175.07 | |

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| | **Breast** | | |
| **GS-099** | Excisional breast biopsy | 248.58 | |
| **GS-100** | Excisional breast biopsy with x-ray localization | 310.73 | |
| **GS-101** | Segmental resection of breast | 329.37 | |
| **GS-102** | Lumpectomy | 329.37 | |
| **GS-103** | Simple mastectomy | 310.73 | |
| **GS-104** | Limited radical mastectomy | 621.42 | |
| **GS-106** | Simple mastectomy - male - pathological breast disease | 466.11 | |
| **GS-107** | Mammoplasty - reduction - bilateral | 932.18 | |
| **GS-108** | Unilateral breast gynecomastia - male - benign - prior approval required | 248.58 | |
| **GS-109** | Bilateral breast gynecomastia - male - benign - prior approval required | 466.11 | |
| | **Abdomen** | | |
| **GS-110** | Laparotomy - with or without biopsy | 683.59 | |
| **GS-111** | Intraperitoneal abscess - incision and drainage | 994.31 | |
| **GS-112** | Subphrenic abscess - incision and drainage | 994.31 | |
| **GS-113** | Retroperitoneal tumor - biopsy | 621.42 | |
| **GS-114** | Retroperitoneal tumor - excision | 1118.61 | |
| **GS-115** | Percutaneous endoscopic gastrostomy (PEG) - one surgeon | 310.73 | |
| **GS-117** | Percutaneous endoscopic gastrostomy (PEG) - second of two surgeons | 155.37 | |
| **GS-118** | Adhesion bands or volvulus, without resection | 807.89 | |
| **GS-119** | Adhesion bands or volvulus, with resection | 1429.33 | |
| **GS-120** | Intussusception, without resection | 807.89 | |

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| **GS-121** | Intussusception, with resection | 1429.33 | |
| | **Hernia** | | |
| **GS-122** | Epigastric hernia | 621.42 | |
| **GS-123** | Inguinal or femoral hernia - unilateral | 745.74 | |
| **GS-124** | Inguinal or femoral hernia - bilateral | 932.18 | |
| **GS-125** | Inguinal or femoral - recurrent | 932.18 | |
| **GS-126** | Umbilical hernia - adults | 435.02 | |
| **GS-127** | Umbilical hernia - child | 497.17 | |
| **GS-128** | Diaphragmatic hernia | 1305.06 | |
| **GS-129** | Bochdalek hernia | 1677.92 | |
| **GS-130** | Strangulated with resection - all hernias | 1491.48 | |
| **GS-131** | Incarcerated - all hernias | 994.31 | |
| **GS-132** | Wound dehiscence - superficial | 310.73 | |
| **GS-133** | Wound dehiscence - complete | 745.74 | |
| **GS-134** | Incisional ventral hernia | 807.89 | |
| **GS-135** | Incisional ventral hernia with prosthetic mesh | 994.31 | |
| | **Gallbladder and Biliary Tree** | | |
| **GS-136** | Cholecystostomy | 559.31 | |
| **GS-137** | Cholecystectomy | 1305.06 | |
| **GS-138** | Cholecystectomy with cholangiogram | 1367.19 | |
| **GS-139** | Laparoscopic cholecystectomy | 1305.06 | |

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| **GS-140** | Cholecysto-gastrostomy or enterostomy | 1305.06 | |
| **GS-141** | Choledochostomy | 1367.19 | |
| **GS-142** | Transduodenal sphincteroplasty | 1615.77 | |
| **GS-143** | Choledocho-enterostomy | 1367.19 | |
| | **Liver** | | |
| **GS-144** | Open biopsy - sole procedure | 435.02 | |
| **GS-145** | Rupture with suture | 994.31 | |
| **GS-146** | Partial resection for tumor | 1242.91 | |
| | **Spleen** | | |
| **GS-147** | Splenectomy | 1367.19 | |
| **GS-148** | Laparoscopic splenectomy | 1180.76 | |
| | **Esophagus** | | |
| **GS-149** | Esophagostomy - fistulization | 870.03 | |
| **GS-150** | Esophagostomy - foreign body or benign tumor | 1367.19 | |
| **GS-151** | Endoscopic banding of esophageal varicosities | 136.71 | |
| **GS-152** | Esophageal balloon dilatation (gastroscopy additional) | 31.07 | |
| | **Stomach and Duodenum** | | |
| **GS-153** | Laparoscopic Nissen fundoplication | 1305.06 | |
| **GS-154** | Vagotomy - transthoracic | 870.03 | |
| **GS-155** | Vagotomy - transabdominal | 1180.76 | |
| **GS-156** | Gastrostomy with or without feeding tube | 745.74 | |

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| **GS-157** | Gastrostomy with removal of tumor or foreign body | 1056.46 | |
| **GS-158** | Percutaneous endoscopic gastrostomy (PEG) - performed by one surgeon only | 310.73 | |
| **GS-159** | Percutaneous endoscopic gastrostomy (PEG) - performed by two surgeons, per surgeon | 186.44 | |
| **GS-160** | Closure of perforated gastric or duodenal ulcer | 1056.46 | |
| **GS-161** | Pyloromyotomy (Rammsteadt procedure) | 621.42 | |
| **GS-162** | Pyloroplasty with vagotomy | 1056.46 | |
| **GS-163** | Gastroenterostomy with vagotomy | 1056.46 | |
| **GS-164** | Gastrectomy - subtotal with or without vagotomy | 1553.63 | |
| **GS-165** | Gastrectomy - radical subtotal | 1677.92 | |
| **GS-166** | Gastrectomy -total | 2050.79 | |
| **GS-167** | Duodenal diverticulum | 994.31 | |
| **GS-168** | Balloon dilatation of upper GI tract including stomach, duodenum, and jejunum - gastroscopy additional | 99.44 | |
| | **Small Intestine** | | |
| **GS-169** | Balloon dilation of intestinal anastamoses (by endoscopy) | 310.73 | |
| **GS-170** | Enterostomy | 932.18 | |
| **GS-171** | Enterotomy with removal of foreign body or tumor, single | 994.31 | |
| **GS-172** | Enterotomy with removal of foreign body or tumors multiple | 1242.91 | |
| **GS-173** | Entero-enterostomy | 1242.91 | |
| **GS-174** | Small bowel resection | 1242.91 | |
| **GS-175** | Small bowel plication, any method | 1242.91 | |
| **GS-176** | Massive resection (over 60%) | 1242.91 | |

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| | **Colon** | | |
| **GS-177** | Appendectomy | 683.59 | |
| **GS-178** | Caecostomy | 745.74 | |
| **GS-179** | Colostomy (loop) | 745.74 | |
| **GS-180** | Decompression of sigmoid volvulus (trans-rectal) | 807.89 | |
| **GS-181** | Closure of colostomy | 559.31 | |
| **GS-182** | Colostomy with removal of foreign body or tumor, single | 1056.46 | |
| **GS-183** | Colostomy with removal of foreign body or tumors, multiple | 1242.91 | |
| **GS-184** | Segmental resection, single or multiple stages | 1491.48 | |
| **GS-185** | Hemicolectomy, single or staged and segmental resection | 1740.06 | |
| **GS-186** | Colectomy, total, without removal of rectum, with or without ileostomy (single or multiple stages) | 2237.21 | |
| | **Rectum** | | |
| **GS-187** | Rectal biopsy for Hirschsprung's disease | 248.58 | |
| **GS-188** | Rectal prolapse - massive - abdominal approach | 1429.33 | |
| **GS-189** | Rectal prolapse - massive - Thiersch procedure | 310.73 | |
| **GS-190** | Rectal prolapse - massive - perineal approach | 621.42 | |
| **GS-191** | Rectal resection - perineal | 1740.06 | |
| **GS-192** | Rectosigmoid resection - anterior segmental | 2237.21 | |
| **GS-193** | Rectovaginal or vesicovaginal fistula repair | 994.31 | |
| **GS-194** | Rectovesical fistula - resection | 1305.06 | |

| | Anus | | |
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| **GS-195** | Perianal abscess - incision and drainage | 149.13 | |
| **GS-196** | Fissure with rectal abscess - incision and drainage | 248.58 | |
| **GS-197** | Ischiorectal abscess - incision and drainage | 186.44 | |
| **GS-198** | External skin tag - excision | 49.70 | |
| **GS-199** | External skin tag - excision - tray fee | 24.87 | |
| **GS-200** | Thrombosed external haemorrhoid - excision or evacuation | 80.78 | |
| **GS-201** | Thrombosed external hemorrhoid - excision or evacuation - tray fee | 24.87 | |
| **GS-202** | Simple anal polyp, excision | 93.23 | |
| **GS-203** | Rectal polyp - excision | 167.79 | |
| **GS-204** | Villous adenoma - excision | 279.65 | |
| **GS-205** | Haemorrhoid banding (maximum of one visit per three week period) | 149.13 | |
| **GS-206** | Fissure - excision | 161.58 | |
| **GS-207** | Fistula-in-ano - simple | 298.30 | |
| **GS-208** | Fistula-in-ano - complicated - total sphincter involvement or multiple fistulae | 807.89 | |
| **GS-209** | Haemorrhoidectomy including sigmoidoscopy | 435.02 | |
| **GS-210** | Transanal polypectomy | 683.59 | |
| | **Peripheral Nerves** | | |
| **GS211** | Peripheral repair – major – primary | 971.70 | |
| **GS212** | Peripheral repair – major – secondary | 1050.02 | |
| **GS213** | Peripheral repair – minor – primary or secondary | 485.94 | |

| Fee Code | Descriptor | Price | |
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| | **SECTION GY<br>GYNECOLOGY** | | |
| | **Visits and Assessments** | | |
| **GY-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 174.01 | |
| **GY-002** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 87.01 | |
| **GY-003** | DELETED | 0.00 | |
| **GY-004** | DELETED | 0.00 | |
| **GY-005** | Subsequent office visits if not included in surgical fee | 24.87 | |
| **GY-006** | Subsequent hospital visits if not included in surgical fee | 31.07 | |
| | **Diagnostic Procedures** | | |
| **(+) GY-007** | Biopsy of vulva or vagina under local anaesthesia | 93.23 | |
| **(+) GY-008** | Vaginoscopy | 155.37 | |
| **(+) GY-009** | Removal of cervical polyp in office | 62.15 | |
| **(+) GY-010** | Biopsy and cauterization or cryotherapy of cervix | 62.15 | |
| **(+) GY-011** | Colposcopy | 37.28 | |
| **(+) GY-012** | Examination under anaesthetic | 111.85 | |
| **(+) GY-013** | Examination under anaesthetic - pre-adolescent female | 124.29 | |
| **(+) GY-014** | Hysterosalpingogram or hydrotubation | 155.37 | |
| **(+) GY-015** | Endometrial biopsy | 93.23 | |
| **GY-016** | Diagnostic laparoscopy | 310.73 | |
| **GY-017** | Diagnostic hysteroscopy | 310.73 | |
| **GY-018** | Hysteroscopy with endometrial ablation | 621.42 | |

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| **(+) GY-019** | Wet prep examination | 24.87 | |
| **GY-019A** | Performance and iunterpretation of urodynamics | 117.17 | |
| | **Urogynecology** | | |
| **(+) GY-020** | Cautery or excision of urethral caruncle | 155.37 | |
| **GY-021** | Urethrovaginal or vesicovaginal fistula repair | 1305.06 | |
| **GY-022** | Burch culposuspension | 621.42 | |
| **GY-023** | Transvaginal or transobturator tape urethral suspension | 621.42 | |
| | **Vulva** | | |
| **GY-024** | Excision or fulguration of vulvar lesion or genital warts under general anaesthesia | 186.44 | |
| **GY-025** | Perineorrhaphy or medically indicated labioplasty - unless part of a rectocoele repair | 372.87 | |
| **GY-026** | Repair of old third degree laceration | 683.59 | |
| **GY-027** | Bartholin's gland duct cyst or abscess - incision and drainage and marsupialization | 248.58 | |
| **GY-028** | Bartholin gland - excision | 248.58 | |
| | **Vagina** | | |
| **GY-029** | Excision of congenital septum | 248.58 | |
| **GY-030** | I and D of hematocolpos | 155.37 | |
| **GY-031** | Excision of congenital vaginal cyst or cysts | 372.87 | |
| **GY-032** | Cystocoele or rectocoele repair | 807.89 | |
| **GY-033** | Cystocoele and rectocoele repair | 1118.61 | |
| **GY-034** | Enterocoele repair, including posterior wall repair | 1118.61 | |
| **GY-035** | LeFort operation | 807.89 | |

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| **GY-036** | Diagnostic colpotomy - includes D&C if performed | 310.73 | |
| **GY-037** | Sacro-spinous ligament suspension | 1553.63 | |
| **GY-038** | Vault prolapse including anterior and posterior wall repair (Manchester or Fothergill type) or McCall culdoplasty | 1242.91 | |
| **GY-039** | Paravaginal repair | 435.02 | |
| | **Cervix** | | |
| **GY-040** | D & C - including EUA with removal of polyp and/or biopsy | 248.58 | |
| **GY-041** | Cone biopsy | 341.81 | |
| **GY-042** | LEEP excision of cervix under local anaesthesia | 248.58 | |
| **GY-043** | Cold knife cone biopsy under general or spinal anaesthesia | 341.81 | |
| **GY-044** | Removal of cervical cerclage under general or spinal anaesthesia | 248.58 | |
| **GY-044A** | Placement of cervical cerclage | 292.87 | |
| **GY-045** | Removal of cervical stump, abdominal | 1118.61 | |
| **GY-045A** | Removal of cervical stump, vaginal | 761.50 | |
| **GY-046** | DELETED | 0.00 | |
| **GY-047** | DELETED | 0.00 | |
| | **Uterus** | | |
| **GY-048** | Myomectomy - vaginal | 621.42 | |
| **GY-049** | Hysteroscopic myomectomy or septum excision | 621.42 | |
| **GY-050** | Myomectomy - abdominal | 944.59 | |
| **GY-051** | Subtotal hysterectomy | 1118.61 | |
| **GY-052** | Total abdominal hysterectomy - not including oophorectomy | 1242.91 | |

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| **GY-053** | Total abdominal hysterectomy with oophorectomy | 1405.87 | |
| **GY-053A** | Total abdominal hysterectomy, salpingo-oophorectomy, omentectomy, staging, and debulking for pelvic malignancy | 2108.78 | |
| **GY-054** | DELETED | 0.00 | |
| **GY-055** | Colposacropexy | 1553.63 | |
| **GY-056** | Total vaginal hysterectomy | 1242.91 | |
| **GY-056A** | Vaginal hysterectomy with oophorectomy | 1491.48 | |
| **GY-057** | Vaginal hysterectomy and repair | 1553.63 | |
| **GY-058** | DELETED | 0.00 | |
| **GY-059** | Laparoscopic supracervical hysterectomy | 994.31 | |
| **GY-060** | Laparoscopic total hysterectomy | 1491.48 | |
| **GY-061** | Endometrial ablation - any procedure | 497.17 | |
| **GY-062** | Repeat endometrial ablation - any procedure | 372.87 | |
| **GY-063** | Postoperative hemorrhage - laparotomy | 621.42 | |
| **GY-064** | Postoperative hemorrhage - vaginal approach | 310.73 | |
| | **Adnexae** | | |
| **GY-065** | Salpingectomy, ovarian cystectomy, and/or oophorectomy | 807.89 | |
| **GY-066** | DELETED | 0.00 | |
| **GY-067** | Removal of broad ligament cyst | 807.89 | |
| **GY-068** | Omentectomy for abdominal malignancy | 186.44 | |
| **GY-069** | Sterilization by tubal interruption - any approach | 559.31 | |
| **(+) GY-070** | Laparoscopic cauterization of endometriosis or adhesions, lysis of adhesions, or drainage of cyst or abscess | 186.44 | |

| Fee Code | Descriptor | Price | |
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| | **SECTION IM<br>INTERNAL MEDICINE** | | |
| | **Visits and Assessments** | | |
| **IM-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 298.30 | |
| **IM-002** | Major consultation for Inpatient or for patient in Emergency Department | 341.81 | |
| **IM-003** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 149.13 | |
| **IM-004** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |
| **IM-005** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **IM-006** | Initiation of Insulin therapy | 186.44 | |
| **IM-007** | Adjustment of Insulin therapy - minimum 15 minutes | 62.15 | |
| **IM-008** | Initiation of Insulin pump - one month of office visits, telephone consultations, written and verbal instructions | 435.02 | |
| **IM-009** | Adjustment of Insulin pump minimum 30 minutes | 93.23 | |
| **IM-010** | Subsequent office visits | 74.59 | |
| **IM-011** | Subsequent hospital visits | 49.70 | |
| | **Diagnostic Procedures** | | |
| **IM-012** | Electrocardiogram - interpretation | 18.64 | |
| **IM-013** | Holter monitor - interpretation | 43.49 | |
| **IM-014** | Continuous, personal medical practitioner monitoring of graduated maximal stress test - technical fee and monitoring | 124.29 | |
| **IM-015** | Continuous, personal medical practitioner monitoring of graduated maximal stress test - interpretation | 43.49 | |
| **IM-016** | Echocardiography, pericardial effusion, M-mode | 49.70 | |
| **IM-017** | Echocardiography, cardiac valve(s), M-mode | 62.15 | |

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| **IM-018** | Echocardiography, M-mode (X-213 and X-215, combined and chamber dimensions) | 99.44 | |
| **IM-019** | Real Time echocardiography, includes M-mode tracing | 99.44 | |
| **IM-020** | Doppler Echocardiography | 93.23 | |
| **IM-021** | Echocardiography - limited follow-up or limited study | 55.93 | |
| **IM-022** | Single chamber permanent programmable pacemaker testing - professional fee | 55.93 | |
| **IM-023** | Single chamber permanent programmable pacemaker testing - technical fee | 24.87 | |
| **IM-024** | Dual chamber permanent programmable pacemaker testing - professional fee | 87.01 | |
| **IM-025** | Dual chamber permanent programmable pacemaker testing - technical fee | 55.93 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION LP<br>LABORATORY AND PATHOLOGY** | | |
| | **Visits and Assessments** | | |
| **LP-001** | Complete blood count (haemoglobin, white blood count, differential, and either red blood count or haematocrit, with no additional charge for indices), by any method | 31.07 | |
| **LP-002** | Haemoglobin | 8.09 | |
| **LP-003** | White blood count only | 9.33 | |
| **LP-004** | Differential | 19.26 | |
| **LP-005** | Sedimentation rate | 8.09 | |
| **LP-006** | Haematocrit | 6.20 | |
| **LP-007** | Platelet count | 9.92 | |
| **LP-008** | Glucose | 14.92 | |
| **LP-009** | Stick test for glucose | 2.49 | |
| **LP-010** | Basic routine examination of urine, including examination of centrifuged sediment | 8.70 | |

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| **LP-011** | Urinalysis without microscopic examination of centrifuged sediment | 2.49 | |
| **LP-012** | Occult blood | 12.44 | |
| **LP-013** | Antibiotic tests, disc method - three or less | 12.44 | |
| **LP-014** | Antibiotic tests, disc method - four or more per organism | 24.87 | |
| **LP-015** | Routine culture | 26.10 | |
| **LP-016** | Anaerobic culture | 24.87 | |
| **LP-017** | Biochemical identification of micro-organism | 37.28 | |
| **LP-018** | Urinary and other bacteria counts | 24.87 | |
| **LP-019** | Smear, preparation and examination | 15.53 | |
| **LP-020** | Yeast identification, serological or by chlamydospores | 15.53 | |
| **LP-021** | Immunologic test for infectious mononucleosis | 15.53 | |
| **LP-022** | Latex agglutination slide test (rheumatoid arthritis) | 15.53 | |
| **LP-023** | Semen analysis, including sperm count | 24.87 | |
| **LP-024** | Examination for presence of sperm only | 12.44 | |
| **LP-025** | Pregnancy test | 18.64 | |
| | **Miscellaneous Procedures** | | |
| **LP-026** | Tissue, gross and microscopic examination with report | 111.85 | |
| **LP-027** | Pap smear | 31.07 | |
| **LP-028** | Chlamydia cultures | 5.29 | |
| **LP-029** | Rapid test for Group A Streptococcus (GAS) | 7.03 | |

| Fee Code | Descriptor | Price |
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| | **SECTION NP<br>NEPHROLOGY** | |
| | **Visits and Assessments** | |
| **NP-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 298.30 |
| **NP-002** | Major consultation for Inpatient or for patient in Emergency Department | 341.81 |
| **NP-003** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 149.13 |
| **NP-004** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 |
| **NP-005** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 |
| | **Procedures** | |
| **NP-006** | Hemodialysis - initial and acute - medical component | 372.87 |
| **NP-007** | Hemodialysis - initial and acute - surgical component | 372.87 |
| **NP-008** | Hemodialysis - subsequent - medical component | 310.73 |
| **NP-009** | Peritoneal dialysis - acute | 248.58 |
| **NP-010** | Peritoneal dialysis - repeat acute up to 48 hours | 223.73 |
| **NP-011** | Peritoneal dialysis - subsequent | 124.29 |
| | **Monitoring of Advanced Renal Insufficiency or Dialysis** | |
| **NP-012** | Multidisciplinary team meetings - in person or remotely no greater than once weekly and minimum of 30 minutes each - claim is per each 30 minutes or part thereof and made using one patient | 146.44 |
| **NP-012F** | Multidisciplinary team meetings - in person or remotely no greater than once weekly and minimum of 30 minutes each - claim is per each 30 minutes or part thereof and made using one patient | 167.79 |
| **Fee Code** | **Descriptor** | **Price** |
| | **SECTION NE<br>NEUROLOGY** | |
| | **Visits and Assessments** | |
| **NE-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 298.30 |

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| **NE-002** | Major consultation for Inpatient or for patient in Emergency Department | 341.81 | |
| **NE-003** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 149.13 | |
| **NE-004** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |
| **NE-005** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| | **Diagnostic Procedures** | | |
| **NE-006** | Electroencephalogram - professional fee | 49.70 | |
| **(+) NE-007** | Major electromyography or nerve conduction study - professional fee | 111.85 | |
| **(+) NE-008** | Minor electromyography or nerve conduction study - professional fee | 55.93 | |
| **NE-009** | Electromyography or nerve conduction study - technical fee | 80.78 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION OB<br>OBSTETRICS** | | |
| | **Visits and Assessments** | | |
| **OB-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 174.01 | |
| **OB-002** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 87.01 | |
| **OB-003** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |
| **OB-004** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **OB-005** | Subsequent office visits if not included in surgical fee | 24.87 | |
| **OB-006** | Subsequent hospital visits if not included in surgical fee | 31.07 | |
| **OB-007** | Initial major prenatal assessment | 124.29 | |
| **OB-008** | Routine prenatal and postnatal visits including minor conditions related to pregnancy | 49.70 | |

| | Diagnostic Procedures | | |
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| **OB-009** | Fetal monitoring interpretation | 49.70 | |
| **(+) OB-010** | Amniocentesis | 124.29 | |
| **(+) OB -011** | Fetal scalp sampling | 93.71 | |
| **(+) OB - 011F** | Fetal scalp sampling | 62.15 | |
| **(+) OB-012** | Non-stress test - interpretation and documentation | 37.28 | |
| **(+) OB-013** | Fetal fibronectin or equivalent test for pre-term labour | 37.28 | |
| **(+) OB-014** | Ferning test for ruptured membranes | 24.87 | |
| **(+) OB-015** | Performance and interpretation of an ultrasound examination for gestation less than 14 weeks | 74.59 | |
| **(+) OB-016** | Performance and interpretation of an ultrasound examination for gestation greater than 14 weeks | 111.85 | |
| **(+) OB-017** | Performance and interpretation of an ultrasound examination for biophysical profile of fetus | 136.71 | |
| **(+) OB-018** | Performance and interpretation of an ultrasound examination during third trimester for fluid checks and deepest pocket | 62.15 | |
| **(+) OB-019** | Performance and interpretation of a limited ultrasound examination for estimated fetal weight | 74.59 | |
| **(+) OB-020** | Performance and interpretation of a limited ultrasound examination for doppler umbilical artery in high risk patient | 93.23 | |
| **(+) OB-021** | Performance and interpretation of a limited ultrasound examination for presentation, position, or placental localization | 55.93 | |
| **(+) OB-021A** | Ultrasound guidance at amniocentesis or external cephalic version | 74.59 | |
| | **Therapeutic Procedures** | | |
| **(+) OB-022** | D&C for incomplete abortion | 248.58 | |
| **(+) OB-023** | Postpartum D&C for retained products of conception | 248.58 | |
| **(+) OB-024** | Medical management of postpartum hemorrhage | 124.29 | |
| **OB-025** | Medical termination for gestation less than 7 weeks - includes all visits, ultrasound examinations, and injections | 372.87 | |
| **(+) OB-026** | Insertion of laminaria tent prior to abortion | 74.59 | |

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| **OB-027** | Therapeutic abortion by D&C for gestation less than 14 weeks | 372.87 | |
| **OB-028** | Therapeutic abortion by D&E for gestation 14-18 weeks | 559.31 | |
| **OB-029** | Therapeutic abortion by D&E for gestation greater than 18 weeks | 745.74 | |
| **OB-030** | Surgical management of ectopic pregnancy | 745.74 | |
| **OB-031** | Medical management of ectopic pregnancy | 372.87 | |
| **OB-032** | Resuscitation by a physician of a seriously depressed infant in the case room | 124.29 | |
| **(+) OB-033** | Manual removal of retained placenta | 263.61 | |
| **(+) OB-033F** | Manual removal of retained placenta | 124.29 | |
| **(+) OB-034** | Repair of extensive laceration of cervix, vagina or perineum including third degree lacerations, including consultation | 186.44 | |
| **OB-035** | Evacuation of vulvar or paravaginal hematoma under regional or general anaesthesia | 322.17 | |
| **OB-035F** | Evacuation of vulvar or paravaginal hematoma under regional or general anaesthesia | 217.52 | |
| **(+) OB-035A** | Repair of fourth degree tear | 292.87 | |
| | **Confinement Services** | | |
| **OB-036** | Care of healthy newborn in hospital on date of birth | 62.15 | |
| **OB-037** | Care of healthy newborn in hospital on date of discharge | 62.15 | |
| **OB-038** | Daily care of newborn in hospital other than date of birth or discharge | 31.07 | |
| **(+) OB-039** | Intravenous syntocinon induction or augmentation of labour - continuous care by physician - per hour | 99.44 | |
| **OB-040** | Vaginal delivery including application of fetal scalp electrodes and provision of routine postpartum care | 621.42 | |
| **(+) OB-041** | Breech vaginal delivery | 527.20 | |
| **(+) OB-041F** | Breech vaginal delivery | 807.89 | |
| **(+) OB-041A** | Mid-cavity or rotational forceps or vacuum delivery | 372.87 | |

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| **(+) OB-042** | Other operative vaginal delivery including application of fetal scalp electrodes and provision of routine postpartum care | 807.89 | |
| **OB-043** | Attendance during labour and delivery if circumstances require the delivery to be performed by another physician | 310.73 | |
| **OB-044** | Attendance of a second physician at a high risk delivery when requested to provide assistance by the primary physician | 292.87 | |
| **OB-044F** | Attendance of a second physician at a high risk delivery when requested to provide assistance by the primary physician | 248.58 | |
| **OB-045** | Management of high risk labour by consulting Obstetrician if delivery subsequently performed by general practitioner | 372.87 | |
| **OB-045A** | Management of labour, attendance at delivery, and routine postpartum care for patient delivered by emergency Caesarean Section | 527.20 | |
| **OB-046** | Vaginal delivery after previous Caesarean Section, including induction using syntocinon | 994.31 | |
| **OB-047** | Delivery by Caesarean Section | 932.18 | |
| **OB-048** | Multiple births - any method of delivery - for each additional child | 248.58 | |
| **(+) OB-049** | Low/outlet vacuum or forceps delivery | 186.44 | |
| **(+) OB-050** | External cephalic version with or without ultrasound guidance - attempted or successful | 248.58 | |
| **+ OB-051** | Midcavity forceps rotation or vacuum extraction during vaginal delivery | 372.87 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION OP<br>OPHTHALMOLOGY** | | |
| | **Visits and Assessments** | | |
| **OP-001** | Major consultation including complete history, examination, biomicroscopy, tonometry, ocular motility and report | 136.71 | |
| **OP-002** | Major consultation for Inpatient or for patient in Emergency Department | 149.13 | |
| **OP-003** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 93.23 | |
| **OP-004** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 99.44 | |
| **OP-005** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **OP-006** | Examination of eyes - complete | 111.85 | |

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| **OP-007** | Subsequent office visits | 31.07 | |
| | **Diagnostic Procedures** | | |
| **OP-008** | A-scan - one or both eyes | 62.15 | |
| **OP-009** | B-scan - one or both eyes | 111.85 | |
| **OP-010** | Photography - external eye | 37.28 | |
| **OP-011** | Photography - ocular fundus | 55.93 | |
| **OP-012** | Gonioscopy - diagnostic | 31.07 | |
| **OP-013** | Orthoptic analysis - interpretation | 124.29 | |
| **OP-014** | Orthoptic analysis - reassessment | 62.15 | |
| **(+) OP-015** | Manual (Goldman) perimetry - 2 or more isopters | 55.93 | |
| **(+) OP-016** | Computerized perimeter - professional fee | 49.70 | |
| **(+) OP-017** | Conjunctival scraping - diagnostic | 24.87 | |
| **(+) OP-018** | Colour vision, perception lantern test and other tests | 62.15 | |
| **(+) OP-019** | Fluorescein angiography, A scan (Axial length measurement, computerized, performed by technician) for cataract surgery | 186.44 | |
| **(+) OP-020** | A-scan (Axial length measurement, computerized, performed by technician) for cataract surgery | 186.44 | |
| **OP-021** | Corneal pachymetry | 12.44 | |
| **(+) OP-021A** | Slit lamp examination when provided as a service other than part of a consultation | 52.73 | |
| | **Therapeutic Procedures** | | |
| **OP-022** | Bandage contact lens, only where pathology is present or suspected | 37.28 | |
| **OP-023** | Cauterization of lids or corneal ulcers | 87.01 | |
| **OP-024** | Injections - subconjunctival - per eye | 49.70 | |

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| **OP-025** | Injections - retrobulbar or sub-Tenon's - first, per eye | 87.01 | |
| **OP-026** | Injections - retrobulbar - subsequent, per eye | 49.70 | |
| **OP-027** | Injections - retrobulbar - alcohol | 223.73 | |
| **OP-028** | Measurement and fitting artificial eye | 497.17 | |
| **OP-029** | Botulinum A toxin injection - ocular muscle | 198.86 | |
| | **Eyelids** | | |
| **OP-030** | Chalazion - surgical removal under local anaesthetic | 74.59 | |
| **OP-031** | Chalazion - surgical removal under general anaesthetic | 124.29 | |
| **OP-032** | Epilation - electrolytic and non-electrolytic | 49.70 | |
| **OP-033** | Tumor of lid - benign - surgical excision | 93.23 | |
| **OP-034** | Blepharoplasty: plastic repair of eyelid with or without graft any type - minor | 435.02 | |
| **OP-035** | Blepharoplasty: plastic repair of eyelid with or without graft any type - major | 1118.61 | |
| **OP-036** | Incision - hordeolum, hematoma, lid abscess | 62.15 | |
| **OP-037** | Ectropion and entropion - repair by cautery puncture | 149.13 | |
| **OP-038** | Ectropion and entropion - plastic repair | 870.03 | |
| **OP-039** | Quickert suture for lower lid entropion | 223.73 | |
| **OP-040** | Tarsorrhaphy | 323.16 | |
| **OP-041** | Tarsorrhaphy - temporary | 99.44 | |
| | **Lacrimal Apparatus** | | |
| **OP-042** | Irrigation or probing of adult nasolacrimal duct under local anaesthesia | 62.15 | |
| **OP-043** | Probing or irrigation of infant or adult lacrimal duct(s) under general anaesthesia | 186.44 | |

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| **OP-044** | Catheterization of nasolacrimal duct | 223.73 | |
| **OP-045** | "Three Snip" operation on punctum | 99.44 | |
| **OP-046** | Occlusion of lacrimal gland tubules | 217.52 | |
| **OP-047** | Drainage of lacrimal gland abscess | 217.52 | |
| **OP-048** | Lacerated canaliculi repair | 901.10 | |
| **OP-049** | Dacryocystectomy | 683.59 | |
| **OP-050** | Dacryocystorhinostomy | 1367.19 | |
| **OP-051** | Conjunctival dacroystorhinostomy | 1367.19 | |
| **OP-052** | Dacryoadenectomy | 683.59 | |
| **OP-053** | Lacrimal gland tumor excision | 1367.19 | |

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| | **Conjunctivae** | | |
| **OP-054** | Removal of foreign body from surface, under general anaesthesia | 49.70 | |
| **OP-055** | Removal of foreign body from surface, under local anaesthesia | 49.70 | |
| **OP-056** | Removal of foreign body from surface, under local anaesthesia, tray fee | 14.92 | |
| **OP-057** | Repair of lacerated conjunctiva | 186.44 | |
| **OP-058** | Biopsy of conjunctiva - local anaesthesia | 124.29 | |
| **OP-059** | Biopsy of conjunctiva - general anaesthesia | 167.79 | |
| **OP-060** | Removal of simple tumor | 167.79 | |
| | **Cornea** | | |
| **OP-061** | Removal foreign body, under local anaesthetic | 124.29 | |
| **OP-062** | Removal foreign body, under local anaesthesia, tray fee | 37.28 | |

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| **OP-063** | Removal foreign body, under general anaesthetic | 124.29 | |
| **OP-064** | Paracentesis | 236.16 | |
| **OP-065** | Dermoid excision | 776.80 | |
| **OP-066** | Malignant tumor of cornea | 1056.46 | |
| **OP-067** | Pterygium | 298.30 | |
| **OP-068** | Recurrent pterygium and graft | 807.89 | |
| **OP-069** | Tattoo | 155.37 | |
| **OP-070** | Corneal transplant (keratoplasty) - penetrating | 2112.93 | |
| **OP-071** | Corneal transplant (keratoplasty) - lamellar | 1740.06 | |
| **OP-072** | Corneal wound repair with sutures or conjunctival flap | 1118.61 | |
| **OP-073** | Superficial keratectomy | 870.03 | |
| | **Sclera** | | |
| **OP-074** | Sclerotomy | 372.87 | |
| **OP-075** | Scleral resection - myopia, scleromalacia perforans, etc. | 1864.32 | |
| **OP-076** | Scleral wound repair - tissue prolapse through laceration or split in sclera | 1118.61 | |
| | **Iris, Ciliary Body, Choroid** | | |
| **OP-077** | Laser iridotomy | 403.94 | |
| **OP-078** | Glaucoma - all major procedures, including shunts and trabeculectomy | 1491.48 | |
| **OP-079** | Cyclodialysis | 870.03 | |
| **OP-080** | Laser trabeculoplasty | 901.10 | |

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| | **Lens** | | |
| **OP-081** | Needling, capsulotomy, discission, synechotomy | 435.02 | |
| **OP-082** | Needling, simple only | 248.58 | |
| **OP-083** | Cataract extraction with intraocular lens implant | 994.31 | |
| **OP-084** | Secondary insertion of intraocular lens | 745.74 | |
| **OP-085** | Removal or repositioning of anteriorly dislocated pseudophakos with secondary suturing | 745.74 | |
| **OP-086** | Removal or repositioning of posteriorly dislocated pseudophakos into vitreous, with secondary suturing | 1491.48 | |
| **OP-087** | Dislocated lens - removal | 807.89 | |
| **OP-088** | YAG laser capsulotomy | 186.44 | |
| | **Vitreous** | | |
| **OP-089** | Total posterior vitrectomy | 1242.91 | |
| **OP-090** | Intra vitreal surgical section of scar tissue with scissors | 1242.91 | |
| **OP-091** | Anterior vitrectomy | 621.42 | |
| | **Retina** | | |
| **OP-092** | Scleral resection - buckling - partial tubing | 1864.32 | |
| **OP-093** | Encircling tubing | 2112.93 | |
| **OP-094** | Posterior vitrectomy with vitreous implant | 2112.93 | |
| **OP-095** | Light coagulation or cryopexy - posterior segment | 745.74 | |
| | **Ocular Muscles** | | |
| **OP-096** | Strabismus, repair - one or two muscles | 559.31 | |
| **OP-097** | Strabismus, repair - per additional muscle | 217.52 | |
| **OP-098** | Muscle transplant - Hummelsheim, etc. | 745.74 | |

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| | **Eyeball** | | |
| **OP-099** | Enucleation or evisceration - without implant | 745.74 | |
| **OP-100** | Enucleation or evisceration - with implant | 994.31 | |
| **OP-101** | Exenteration | 1677.92 | |
| **OP-102** | Replacement of implant | 994.31 | |
| **OP-103** | Magnetic extraction of intraocular foreign body - anterior chamber | 1056.46 | |
| **OP-104** | Magnetic extraction of intraocular foreign body - other than anterior chamber | 1367.19 | |
| **OP-105** | Intraocular foreign body extraction (anterior or posterior route) non-magnetic extraction with enucleation if necessary | 1615.77 | |
| **OP-106** | Extraction of non-magnetic intraocular foreign body from elsewhere in eye | 2112.93 | |
| | **Orbit** | | |
| **OP-107** | Abscess - incision and drainage | 497.17 | |
| **OP-108** | Removal of anterior orbital tumor | 621.42 | |
| **OP-109** | Removal of posterior orbital tumor | 1864.32 | |
| **OP-110** | Orbitotomy - exploration or biopsy or both | 497.17 | |
| **OP-111** | Orbitotomy - exploration and decompression | 1242.91 | |
| **Fee Code** | **Descriptor**<br>**SECTION OR ORTHOPAEDIC SURGERY** | **Price** | |
| | **Visits and Assessments** | | |
| **OR-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 174.01 | |
| **OR-002** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 87.01 | |
| **OR-003** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |

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| **OR-004** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **OR-005** | Subsequent office visits if not included in surgical fee | 24.87 | |
| **OR-006** | Subsequent hospital visits if not included in surgical fee | 31.07 | |
| | **Diagnostic Procedures** | | |
| **OR-007** | Vertebral body or disc - needle biopsy | 372.87 | |
| **OR-008** | Biopsy bone tumor - superficial | 186.44 | |
| **OR-009** | Biopsy bone tumor - deep | 372.87 | |
| **OR-010** | Diagnostic arthroscopy - shoulder | 192.64 | |
| **OR-011** | Diagnostic arthroscopy - wrist | 192.64 | |
| **OR-012** | Diagnostic arthroscopy - knee | 310.73 | |
| | **Amputation** | | |
| **OR-013** | Finger - single | 310.73 | |
| **OR-014** | Finger - each additional | 155.37 | |
| **OR-015** | Metacarpal - entire ray | 497.17 | |
| **OR-016** | Through metacarpal or metacarpal-phalangeal joint | 279.65 | |
| **OR-017** | Hand - transmetacarpal | 994.31 | |
| **OR-018** | Disarticulation at wrist | 994.31 | |
| **OR-019** | Forearm | 745.74 | |
| **OR-020** | Disarticulation at elbow | 932.18 | |
| **OR-021** | Arm - through humerus | 745.74 | |
| **OR-022** | Toe - single | 124.29 | |

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| **OR-023** | Toe - each additional | 62.15 | |
| **OR-024** | Metatarsal - entire ray | 435.02 | |
| **OR-025** | Foot - transmetatarsal | 621.42 | |
| **OR-026** | Foot - mid-tarsal | 621.42 | |
| **OR-027** | Ankle - Symes | 994.31 | |
| **OR-028** | Leg - below knee | 870.03 | |
| **OR-029** | Disarticulation at knee - supracondylar | 994.31 | |
| **OR-030** | Thigh | 994.31 | |
| | **Arthrodesis** | | |
| **OR-031** | Arthrodesis - shoulder | 1367.19 | |
| **OR-032** | Arthrodesis - elbow | 1118.61 | |
| **OR-033** | Arthrodesis - wrist | 745.74 | |
| **OR-034** | Arthrodesis or tenodesis - finger or thumb | 310.73 | |
| **OR-035** | Arthrodesis - sacroiliac | 1118.61 | |
| **OR-036** | Arthrodesis - hip | 1864.32 | |
| **OR-037** | Arthrodesis - knee | 1273.96 | |
| **OR-038** | Arthrodesis - ankle | 1336.12 | |
| **OR-039** | Arthrodesis - single tarsal joint, including bone block | 745.74 | |
| **OR-040** | Triple arthrodesis | 1491.48 | |
| **OR-041** | Panarthrodesis | 1864.32 | |
| **OR-042** | Metatarsal-phalangeal joint great toe - unilateral | 497.17 | |

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| **OR-043** | Metatarsal-phalangeal joint great toe - bilateral | 994.31 | |
| **OR-044** | Interphalangeal joint - great toe | 372.87 | |
| **OR-045** | Other toe joints - single | 186.44 | |
| **OR-046** | Other toe joints - each additional | 93.23 | |
| | **Arthroplasty** | | |
| **OR-047** | Arthroplasty - acromio-clavicular or sterno-clavicular | 870.03 | |
| **OR-048** | Arthroplasty - shoulder | 1367.19 | |
| **OR-049** | Arthroplasty - elbow | 1367.19 | |
| **OR-050** | Arthroplasty - lower radio-ulnar joint | 621.42 | |
| **OR-051** | Arthroplasty - wrist | 1118.61 | |
| **OR-052** | Arthroplasty finger - single joint including Flatt replacement arthroplasty | 559.31 | |
| **OR-053** | Each additional joint | 248.58 | |
| **OR-054** | Total hip replacement - including acetabulum and femoral head | 1864.32 | |
| **OR-055** | Revision of total hip replacement - Exeter/Ling system or similar | 2175.07 | |
| **OR-055A** | Arthroplasty hip - Austin Moore/Girdlestone or equivalent | 1874.48 | |
| **OR-056** | Arthroplasty knee - resurfacing of tibia and femoral condyles - with or without patellar replacement - one or both condyles/plateaus may be replaced | 1553.63 | |
| **OR-057** | Total knee replacement | 1864.32 | |
| **OR-058** | Revision of total knee replacement, with or without bone graft | 2175.07 | |
| **OR-059** | Arthroplasty - ankle | 1242.91 | |
| **OR-060** | Arthroplasty great toe - single including bunionectomy | 497.17 | |
| **OR-061** | Arthroplasty great toe - bilateral - including bunionectomy | 932.18 | |

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| **OR-062** | Arthroplasty - other toes - including hammer toes - single joint excision metatarsal head (Hoffmann's procedure) | 211.28 | |
| **OR-063** | Each additional toe | 62.15 | |
| | **Arthrotomy** | | |
| **OR-064** | Arthrotomy - temporomandibular including menisectomy | 621.42 | |
| **OR-065** | Arthrotomy - shoulder | 932.18 | |
| **OR-066** | Arthrotomy - elbow | 745.74 | |
| **OR-067** | Arthrotomy - wrist | 621.42 | |
| **OR-068** | Operative arthroscopy - wrist | 932.18 | |
| **OR-069** | Arthrotomy - finger | 248.58 | |
| **OR-070** | Arthrotomy - knee - including menisectomy or meniscal cyst | 807.89 | |
| **OR-071** | Arthroscopic meniscectomy | 683.59 | |
| **OR-072** | Arthroscopic debridement of knee | 683.59 | |
| **OR-073** | Arthroscopic repair of meniscus of knee | 683.59 | |
| **OR-074** | Arthrotomy - ankle | 807.89 | |
| **OR-075** | Arthrotomy - other joints - lower extremity | 683.59 | |
| **OR-076** | Arthrotomy metatarsophalangeal joint - great toe including excision sesmoids | 403.94 | |
| **OR-077** | Arthrotomy - other toes | 155.37 | |
| **OR-078** | Arthroscopy if procedure followed immediately by arthrotomy | 155.37 | |
| | **Back Surgery** | | |
| **OR-079** | Laminectomy - thoracic or lumbar - single level | 1305.06 | |
| **OR-080** | Laminectomy - thoracic or lumbar - multiple levels | 1646.84 | |

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| | **Bone Grafting** | | |
| **OR-081** | Bone graft - clavicle | 994.31 | |
| **OR-082** | Bone graft - humerus | 1180.76 | |
| **OR-083** | Bone graft - radius or ulna | 807.89 | |
| **OR-084** | Bone graft - radius and ulna | 1118.61 | |
| **OR-085** | Bone graft - carpal scaphoid | 745.74 | |
| **OR-086** | Bone graft - metacarpal | 497.17 | |
| **OR-087** | Bone graft - phalanges | 497.17 | |
| **OR-088** | Bone graft - femur | 1491.48 | |
| **OR-089** | Bone graft - tibia | 1180.76 | |
| **OR-090** | Bone graft - medial malleolus | 683.59 | |
| **OR-091** | Bone graft - calcaneus | 932.18 | |
| **OR-092** | Bone graft - metatarsal | 497.17 | |
| **OR-093** | Bone graft - mandible | 1056.46 | |
| | **Bone Tumours** | | |
| **OR-094** | Excision tumor, saucerization, sequestrectomy- large bone | 994.31 | |
| **OR-095** | Excision tumor, saucerization, sequestrectomy- large bone - with bone graft | 1491.48 | |
| **OR-096** | Excision tumor, saucerization, sequestrectomy - metacarpal, metatarsal, phalanx | 372.87 | |
| **OR-097** | Excision tumor, saucerization, sequestrectomy - metacarpal, metatarsal, phalanx - with bone graft | 559.31 | |
| | **Bursa, Ganglion, and Tendon** | | |
| **OR-098** | Excision tendon sheaths - forearm or wrist | 807.89 | |

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| **OR-099** | Excision olecranon or prepatellar bursa | 310.73 | |
| **OR-100** | Excision subacromial, ischial, or trochanteric bursa | 590.37 | |
| **OR-101** | Excision calcaneous deposits shoulder cuff | 683.59 | |
| **OR-102** | Excision ganglion | 310.73 | |
| **OR-102A** | Rotator cuff repair with acromioplasty | 995.82 | |
| **OR-103** | Excision ganglion - joint | 279.65 | |
| **OR-104** | Excision Baker's cyst | 683.59 | |
| **OR-105** | Subacromial bursa - aspiration and injection | 49.70 | |
| **OR-105A** | Hip or trochanteric burssa - aspiraton and injection | 70.30 | |
| **OR-106** | Other bursae, tendon sheaths, ganglion of wrist or ankle - aspiration and injection | 31.07 | |
| **OR-107** | Repair of mallet finger - open | 279.65 | |
| **OR-108** | Repair of mallet finger - closed with pin | 223.73 | |
| **OR-109** | Primary repair of flexor tendon | 807.89 | |
| **OR-110** | Primary repair of extensor tendon | 403.94 | |
| **OR-111** | Primary repair - each additional tendon | 310.73 | |
| **OR-112** | Primary repair - Achilles tendon | 683.59 | |
| **OR-113** | Secondary repair - flexor tendon | 807.89 | |
| **OR-114** | Secondary repair - extensor tendon | 403.94 | |
| **OR-115** | Secondary repair - each additional tendon | 217.52 | |
| **OR-115A** | Tendon or muscle transfer | 1054.40 | |
| **OR-116** | Repair of trigger finger or thumb | 248.58 | |

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| **OR-117** | Tenolysis - single | 745.74 | |
| | **Casts** | | |
| **OR-118** | Minerva jacket | 217.52 | |
| **OR-119** | Shoulder or hip - spica | 155.37 | |
| **OR-120** | Shoulder or hip - spica - bilateral | 198.86 | |
| **OR-121** | Body cast | 261.01 | |
| **OR-122** | Upper extremity - excluding finger | 55.93 | |
| **OR-123** | Finger | 31.07 | |
| **OR-124** | Long leg cast | 55.93 | |
| **OR-125** | Below the knee cast | 43.49 | |
| **OR-126** | Wedging of plaster cast | 31.07 | |
| **OR-127** | Unna's boot | 31.07 | |
| | **Deformities** | | |
| **OR-128** | Congenital club foot - metatarsus varus - unilateral - manipulation and plaster - closed treatment - per manipulation and cast | 149.13 | |
| **OR-129** | Congenital club foot - metatarsus varus - bilateral - manipulation and plaster - closed treatment - per manipulation and cast | 223.73 | |
| | **Dislocations** | | |
| **OR-130** | Sterno-clavicular dislocation - closed reduction | 155.37 | |
| **OR-131** | Sterno-clavicular dislocation - open reduction | 807.89 | |
| **OR-132** | Acromio-clavicular dislocation - closed reduction | 155.37 | |
| **OR-133** | Acromio-clavicular dislocation - open reduction | 807.89 | |
| **OR-134** | Shoulder dislocation - closed reduction including radiological confirmation | 217.52 | |

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| **OR-135** | Shoulder dislocation - open reduction | 994.31 | |
| **OR-136** | Elbow dislocation - closed reduction | 217.52 | |
| **OR-137** | Elbow dislocation - open reduction | 1118.61 | |
| **OR-138** | Carpal bone or bones dislocation - closed reduction | 403.94 | |
| **OR-139** | Carpal bone or bones dislocation - open reduction | 807.89 | |
| **OR-140** | Carpo-metacarpal dislocation - closed reduction | 93.23 | |
| **OR-141** | Carpo-metacarpal dislocation - open reduction | 745.74 | |
| **OR-142** | Finger, thumb or toe - metacarpal, metatarsal, or interphalangeal dislocation - closed reduction | 49.70 | |
| **OR-143** | Finger, thumb or toe - metacarpal, metatarsal, or interphalangeal dislocation - open reduction | 435.02 | |
| **OR-144** | Hip dislocation - closed reduction | 559.31 | |
| **OR-145** | Hip dislocation - open reduction | 1491.48 | |
| **OR-146** | Hip dislocation - open reduction and internal fixation of acetabulum | 1740.06 | |
| **OR-147** | Knee dislocation (tibio-femoral) - closed reduction | 559.31 | |
| **OR-148** | Knee dislocation (tibio-femoral) - open reduction | 1305.06 | |
| **OR-149** | Knee dislocation (patello-femoral) - closed reduction | 155.37 | |
| **OR-150** | Knee dislocation (patello-femoral) - open reduction | 994.31 | |
| **OR-151** | Ankle dislocation - closed reduction | 403.94 | |
| **OR-152** | Ankle dislocation - open reduction | 932.18 | |
| **OR-153** | Tarsus dislocation - closed reduction | 435.02 | |
| **OR-154** | Tarsus dislocation - open reduction | 932.18 | |
| **OR-155** | Metatarsal dislocation - single - closed reduction | 93.23 | |

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| **OR-156** | Metatarsal dislocation - each additional - closed reduction | 62.15 | |
| **OR-157** | Metatarsal dislocation - single - open reduction | 466.11 | |
| **OR-158** | Metatarsal dislocation - each additional - open reduction | 142.92 | |
| **OR-159** | Temporomandibular dislocation - closed reduction | 174.01 | |
| **OR-160** | Mandible dislocation - without displacement - reduction | 174.01 | |
| **OR-161** | Malar dislocation - without displacement - reduction | 62.15 | |
| | **Epiphyseal Stapling Arrest** | | |
| **OR-162** | One epiphysis - one side | 745.74 | |
| **OR-163** | One epiphysis - both sides | 1118.61 | |
| **OR-164** | More than one epiphysis | 1491.48 | |
| **OR-165** | Removal of staples | 372.87 | |
| | **Fascia and Tendon Sheath** | | |
| **OR-166** | Carpal tunnel release | 372.87 | |
| **OR-167** | Dupuytren’s contracture - radical fasciectomy | 994.31 | |
| **OR-168** | Dupuytren’s contracture - partial fasciectomy or fasciotomy | 683.59 | |
| **OR-169** | Ulnar nerve release with or without transposition of nerve | 497.17 | |
| **OR-170** | Incision of tendon sheath - digit | 155.37 | |
| **OR-171** | Fasciotomy - leg or arm - one compartment for compartment syndrome | 372.87 | |
| **OR-172** | Each additional compartmental release - maximum of 3 compartments | 155.37 | |
| **OR-173** | Plantar fasciotomy | 621.42 | |

| | Fractures - Upper Limbs | | |
|---|---|---|---|
| **OR-174** | Clavicle - adult - closed reduction | 217.52 | |
| **OR-175** | Clavicle - child - closed reduction | 99.44 | |
| **OR-176** | Clavicle - open reduction | 497.17 | |
| **OR-177** | Humerus - surgical neck - closed reduction | 435.02 | |
| **OR-178** | Humerus - surgical neck - closed reduction with anaesthesia and manipulation | 559.31 | |
| **OR-179** | Humerus - surgical neck - open reduction | 1056.46 | |
| **OR-180** | Humerus - shaft - closed reduction | 497.17 | |
| **OR-181** | Humerus - shaft - closed reduction with anaesthesia and manipulation | 683.59 | |
| **OR-182** | Humerus, shaft, open reduction | 1056.46 | |
| **OR-183** | Humerus - supracondylar - adult - closed reduction | 497.17 | |
| **OR-184** | Humerus - supracondylar - child - closed reduction with anaesthesia and manipulation | 683.59 | |
| **OR-185** | Humerus - supracondylar - traction or external skeletal fixation | 870.03 | |
| **OR-186** | Humerus - supracondylar - open reduction | 1305.06 | |
| **OR-187** | Elbow - one or more bones - closed reduction | 310.73 | |
| **OR-188** | Elbow - medial and/or lateral condyle - open reduction | 994.31 | |
| **OR-189** | Olecranon - open reduction - excision or internal fixation | 745.74 | |
| **OR-190** | Radius head - closed reduction | 248.58 | |
| **OR-191** | Radius head - closed reduction with manipulation and anaesthesia | 372.87 | |
| **OR-192** | Radius head or neck - excision or open reduction | 870.03 | |
| **OR-193** | Radius shaft - closed reduction | 372.87 | |
| **OR-194** | Radius shaft - open reduction | 807.89 | |

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| **OR-195** | Radius - Colles - closed reduction | 372.87 | |
| **OR-196** | Radius - Colles - skeletal fixation | 559.31 | |
| **OR-197** | Radius - Colles - open reduction | 807.89 | |
| **OR-198** | Styloid process radius - closed reduction | 186.44 | |
| **OR-199** | Styloid process ulna - closed reduction | 74.59 | |
| **OR-200** | Ulna shaft - closed reduction | 372.87 | |
| **OR-201** | Ulna shaft - open reduction | 745.74 | |
| **OR-202** | Monteggia fracture - closed reduction | 559.31 | |
| **OR-203** | Monteggia fracture - open reduction | 870.03 | |
| **OR-204** | Radius and ulna - adult - closed reduction | 559.31 | |
| **OR-205** | Radius and ulna - child - not requiring reduction | 186.44 | |
| **OR-206** | Radius and ulna - child - greenstick - requiring reduction | 341.81 | |
| **OR-207** | Radius and ulna - child - complete requiring reduction | 621.42 | |
| **OR-208** | Radius and ulna - open reduction | 1118.61 | |
| **OR-209** | Carpal bone or bones - closed reduction | 372.87 | |
| **OR-210** | Carpal scaphoid - closed reduction | 403.94 | |
| **OR-211** | Carpal bone or bones - open reduction | 932.18 | |
| **OR-212** | Metacarpal - closed reduction | 248.58 | |
| **OR-213** | Metacarpal or metatarsal - each additional - closed reduction | 55.93 | |
| **OR-214** | Metacarpal - open reduction | 497.17 | |
| **OR-215** | Bennett's - closed reduction | 372.87 | |

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| **OR-216** | Bennett's - open reduction | 683.59 | |
| **OR-217** | Phalanx - single - closed reduction | 248.58 | |
| **OR-218** | Finger - simple distal phalanx | 49.70 | |
| **OR-219** | Phalanx - each additional - closed reduction | 74.59 | |
| **OR-220** | Phalanx - single - open reduction | 435.02 | |
| **OR-221** | Phalanx - each additional - open reduction | 186.44 | |
| | **Fractures - Pelvis and Lower Limbs** | | |
| **OR-222** | Pelvis - fracture - simple - no reduction | 372.87 | |
| **OR-223** | Acetabulum - closed reduction | 745.74 | |
| **OR-224** | Central dislocation pelvis - displaced - skeletal traction | 1118.61 | |
| **OR-225** | Central dislocation pelvis - open reduction acetabulum | 1615.77 | |
| **OR-226** | Femur neck - intertrochanteric fracture - undisplaced | 621.42 | |
| **OR-227** | Femur neck - internal fixation | 1491.48 | |
| **OR-228** | Femur - intertrochanteric - skeletal traction | 870.03 | |
| **OR-229** | Femur - intertrochanteric - internal fixation | 1491.48 | |
| **OR-230** | Slipped upper femoral epiphysis - closed reduction | 745.74 | |
| **OR-231** | Slipped upper femoral epiphysis - internal fixation | 1491.48 | |
| **OR-232** | Slipped upper femoral epiphysis - osteotomy and nail | 1740.06 | |
| **OR-233** | Femur - shaft - closed reduction - adult | 994.31 | |
| **OR-234** | Femur - shaft - closed reduction - child | 745.74 | |
| **OR-235** | Femur including single femoral condyle - displaced lower femoral epiphysis - open reduction | 1491.48 | |

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| **OR-236** | Fracture femoral condyle - simple - open reduction | 745.74 | |
| **OR-237** | Fracture femoral condyle - complicated supracondylar - open reduction | 1118.61 | |
| **OR-238** | Patella - closed reduction | 279.65 | |
| **OR-239** | Patella - open reduction | 683.59 | |
| **OR-240** | Tibial plateau - closed reduction and traction | 621.42 | |
| **OR-241** | Tibial plateau - open reduction | 1056.46 | |
| **OR-242** | Tibial shaft with or without fibula - closed reduction - adult | 621.42 | |
| **OR-243** | Tibial shaft with or without fibula - closed reduction - child | 621.42 | |
| **OR-244** | Tibia - open reduction internal fixation | 1242.91 | |
| **OR-245** | Tibia - external fixation | 932.18 | |
| **OR-246** | Medial malleolus - closed reduction | 372.87 | |
| **OR-247** | Medial or lateral malleolus with displacement of astragalus - closed reduction | 497.17 | |
| **OR-248** | Medial malleolus - open reduction | 683.59 | |
| **OR-249** | Fibula or lateral malleolus - closed reduction | 279.65 | |
| **OR-250** | Fibula or lateral malleolus - open reduction | 683.59 | |
| **OR-251** | Ankle - bi-malleolar - closed reduction | 559.31 | |
| **OR-252** | Ankle - bi-malleolar - open reduction | 838.94 | |
| **OR-253** | Ankle - tri-malleolar - closed reduction | 745.74 | |
| **OR-254** | Ankle - tri-malleolar - open reduction with fixation | 1118.61 | |
| **OR-255** | Talus - closed reduction | 372.87 | |
| **OR-256** | Talus - open reduction | 932.18 | |

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| **OR-257** | Calcaneus - closed reduction | 372.87 | |
| **OR-258** | Calcaneus - external skeletal fixation | 807.89 | |
| **OR-259** | Calcaneus - open reduction and bone graft | 1242.91 | |
| **OR-260** | Other tarsal bones - closed reduction | 279.65 | |
| **OR-261** | Other tarsal bones - open reduction | 621.42 | |
| **OR-262** | Metatarsal - single - closed reduction | 223.73 | |
| **OR-263** | Metatarsal - each additional - closed reduction | 99.44 | |
| **OR-264** | Metatarsal - single - open reduction | 497.17 | |
| **OR-265** | Metatarsal - each additional - open reduction | 149.13 | |
| **OR-266** | Phalanx or phalanges - one toe - closed reduction | 62.15 | |
| **OR-267** | Phalanx or phalanges - each additional toe - closed reduction | 31.07 | |
| **OR-268** | Phalanx or phalanges - one toe - open reduction | 310.73 | |
| **OR-269** | Phalanx or phalanges - each additional toe - open reduction | 111.85 | |
| **OR-270** | Femur - intramedullary fixation | 1615.77 | |
| **OR-271** | Insertion proximal and/or distal locking screw femur - completed on separate day from intramedullary fixation procedure | 124.29 | |
| **OR-272** | Tibia - intramedullary fixation | 1615.77 | |
| **OR-273** | Insertion distal locking screw tibia - completed on separate day from intramedullary fixation procedure | 124.29 | |
| | **Osteotomy** | | |
| **OR-274** | Osteotomy - clavicle | 745.74 | |
| **OR-275** | Osteotomy - humerus | 994.31 | |
| **OR-276** | Osteotomy - radius | 994.31 | |

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| **OR-277** | Osteotomy - ulna | 994.31 | |
| **OR-278** | Osteotomy - metacarpal | 372.87 | |
| **OR-279** | Osteotomy - femur | 1491.48 | |
| **OR-280** | Osteotomy - tibia | 994.31 | |
| **OR-281** | Osteotomy malunited fracture-dislocation - ankle | 1491.48 | |
| **OR-282** | Osteotomy - calcaneus | 994.31 | |
| **OR-283** | Osteotomy - lesser bones of foot | 497.17 | |
| | **Repair and Reconstruction** | | |
| **OR-284** | Repair recurrent sterno-clavicular, acromioclavicular dislocation | 994.31 | |
| **OR-285** | Repair recurrent dislocation, shoulder | 1367.19 | |
| **OR-286** | Repair recurrent dislocation, elbow | 1367.19 | |
| **OR-287** | Repair recurrent dislocation metacarpal-phalangeal, metatarsal-phalangeal, or interphalangeal joint | 621.42 | |
| **OR-288** | Repair torn collateral ligaments knee - early | 1118.61 | |
| **OR-289** | Repair torn collateral and cruciate ligaments knee - early | 1367.19 | |
| **OR-290** | Arthroscopic anterior cruciate ligament reconstruction | 1740.06 | |
| **OR-291** | Reconstruction of one ligament of knee - old tear | 1491.48 | |
| **OR-292** | Reconstruction of two or more ligaments of knee - old tear | 1740.06 | |
| **OR-293** | Recurrent dislocation patella - reconstruction - patellar tendon transplant | 1180.76 | |
| **OR-294** | Repair ligaments of ankle - old tear | 1180.76 | |
| **OR-295** | Repair recurrent dislocation peroneal tendons | 932.18 | |

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| | **Therapeutic Procedures - Miscellaneous** | | |
| **OR-296** | Morton's neuroma - excision | 372.87 | |
| **OR-297** | Excision foreign body muscle | 248.58 | |
| **OR-298** | Removal of plate, screw, nail - superficial - unless hardware inserted only for temporary fixation | 223.73 | |
| **OR-299** | Removal of plate, screw, nail - deep - unless hardware inserted only for temporary fixation | 397.73 | |
| **OR-300** | Incision and drainage subperiosteal abscess - acute osteomyelitis | 310.73 | |
| **OR-301** | Manipulation of major joints, or spine under anaesthesia | 149.13 | |
| **OR-302** | Manipulation of minor joints or examination under anaesthesia | 62.15 | |
| **OR-303** | Neurolysis of lateral cutaneous nerve of thigh | 248.58 | |
| **(+) OR-303A** | Joint aspiration, injection - hip | 58.57 | |
| **(+) OR-303B** | Joint aspiration, injection - other joints | 46.85 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION OT<br>OTOLARYNGOLOGY** | | |
| | **Visits and Assessments** | | |
| **OT-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 174.01 | |
| **OT-002** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 87.01 | |
| **OT-003** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |
| **OT-004** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **OT-005** | Subsequent office visits if not included in surgical fee | 24.87 | |
| **OT-006** | Subsequent hospital visits if not included in surgical fee | 31.07 | |
| | **Diagnostic Procedures** | | |
| **(+) OT-007** | Audiogram interpretation | 24.87 | |

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| **OT-008** | Impedance audiometry - procedure and interpretation | 37.28 | |
| **OT-009** | Pure tone audiometry | 24.87 | |
| **OT-010** | Otoacoustic emissions | 24.87 | |
| **(+) OT-011** | Acoustic reflexes | 24.87 | |
| **(+) OT-012** | Speech discrimination | 24.87 | |
| **(+) OT-013** | Speech audiometry | 24.87 | |
| **(+) OT-014** | Doerfler-Stewart and other special tests for malingering | 24.87 | |
| **OT-015** | Audiometry work-up, including four or more of the above | 74.59 | |
| **OT-016** | Oral cavity or oropharyngeal biopsy | 93.23 | |
| **OT-017** | Biopsy nasopharynx - local anaesthetic | 87.01 | |
| **OT-018** | Biopsy or examination nasopharynx -general anaesthetic | 136.71 | |
| **OT-019** | Examination under anaesthesia | 74.59 | |
| **OT-020** | Tympanogram (including procedure and interpretation) | 24.87 | |
| **(+) OT-021** | Nasal endoscopy | 55.93 | |
| **(+) OT-022** | Laryngoscopy, direct | 149.13 | |
| **(+) OT-023** | Laryngoscopy, with biopsy | 174.01 | |
| **(+) OT-024** | Laryngoscopy, with removal of foreign body | 422.59 | |
| **OT-025** | Bronchoscopy | 310.73 | |
| **OT-026** | Bronchoscopy, with biopsy | 341.81 | |
| **OT-027** | Bronchoscopy, with aspiration | 341.81 | |
| **OT-028** | Differential caloric tests | 62.15 | |

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| **OT-029** | Differential with electro-nystagmography - initial | 62.15 | |
| **OT-030** | Central vestibular testing | 37.28 | |
| **OT-031** | Video nystagmography interpretation | 186.44 | |
| **OT-032** | Excisional face biopsy and plastic repair | 186.44 | |
| | **Lips** | | |
| **OT-033** | Simple excision of carcinoma or precancerous lesion of lip | 155.37 | |
| **OT-034** | Major excision of carcinoma of lip | 310.73 | |
| **OT-035** | Major excision of carcinoma of lip with major plastic repair | 870.03 | |
| **OT-036** | Leucoplakia vermilionectomy | 621.42 | |
| | **Tongue** | | |
| **OT-037** | Partial glossectomy | 435.02 | |
| **OT-038** | Hemiglossectomy | 932.18 | |
| **OT-039** | Complete glossectomy - with or without tracheostomy | 1615.77 | |
| **OT-040** | Release of tongue tie | 111.85 | |
| | **Salivary Glands** | | |
| **OT-041** | Salivary duct calculus - extraction or surgical removal | 248.58 | |
| **OT-042** | Submaxillary gland excision | 621.42 | |
| **OT-043** | Parotid gland - complete removal of superficial lobe with preservation of facial nerve | 1242.91 | |
| **OT-044** | Parotidectomy - total with preservation of facial nerve | 1864.32 | |
| | **Throat** | | |
| **OT-045** | Tonsillectomy and adenoidectomy - less than 16 years of age | 435.02 | |

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| **OT-046** | Tonsillectomy - greater than 16 years of age or over | 527.20 | |
| **OT-047** | Adenoidectomy | 161.58 | |
| **OT-047A** | Incision and drainage of peritonsillar abscess | 164.02 | |
| **OT-048** | Post tonsillectomy haemorrhage - consultation with treatment | 248.58 | |
| | **Ears** | | |
| **OT-049** | Fitting of hearing aid | 62.15 | |
| **OT-050** | Aural polyp removal, general anaesthesia | 161.58 | |
| **OT-051** | Aural polyp removal, local anaesthesia | 80.78 | |
| **OT-052** | Simple removal of cerumen | 31.07 | |
| **OT-053** | Excision of preauricular pit | 372.87 | |
| **OT-054** | Removal of foreign body requiring general anaesthetic | 161.58 | |
| **OT-055** | Closure of post-auricular fistula | 372.87 | |
| **OT-056** | Myringotomy - with or without insertion of ventilation tube - general anaesthesia | 142.92 | |
| **OT-057** | Lavage with or without tube | 217.52 | |
| **OT-058** | Cautery of tympanic membrane | 149.13 | |
| **OT-059** | Removal of myringotomy tube under general anaesthesia | 62.15 | |
| **OT-060** | Stapedectomy, stapedoplasty or stapedotomy | 1491.48 | |
| **OT-061** | Decompression and shunt of endolymphatic sac | 1740.06 | |
| **OT-062** | Labyrinthine repositioning | 37.28 | |
| **OT-063** | Trans-tympanotomy approach to excision of glomus tumour | 932.18 | |
| **OT-064** | Incomplete atresia | 994.31 | |

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| **OT-065** | Complete atresia | 1864.32 | |
| **OT-066** | Removal of osteoma or exostosis ear canal | 466.11 | |
| **OT-067** | Protruding ear - unilateral - requires prior approval | 621.42 | |
| **OT-068** | Protruding ear - bilateral - requires prior approval | 1056.46 | |
| **OT-069** | Canalplasty | 466.11 | |
| | **Mastoid** | | |
| **OT-070** | Simple mastoidectomy | 932.18 | |
| **OT-071** | Simple mastoid-facial recess | 372.87 | |
| **OT-072** | Radical or modified radical mastoidectomy | 1491.48 | |
| **OT-073** | Radical or modified radical mastoidectomy with tympanoplasty | 1740.06 | |
| **OT-074** | Tympanoplasty | 1615.77 | |
| **OT-075** | Ossiculoplasty or insertion of middle ear prosthesis | 1615.77 | |
| **OT-076** | Tympanotomy - exploratory with elevation of tympanomeatal flap | 435.02 | |
| | **Sinuses** | | |
| **OT-077** | Maxillary sinus - puncture and irrigation - initial | 74.59 | |
| **OT-078** | Maxillary sinus - puncture and irrigation - repeat | 74.59 | |
| **OT-079** | Intranasal maxillary antrostomy - unilateral | 279.65 | |
| **OT-080** | Caldwell Luc and closure of antra-oral fistula | 1242.91 | |
| **OT-081** | Radical maxillary sinusectomy with obliteration by abdominal fat graft | 1429.33 | |
| **OT-082** | Postoperative nasal/sinus cavity cleaning and debridement | 111.85 | |
| **OT-083** | Intranasal ethmoidectomy | 870.03 | |

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| **OT-084** | External ethmoidectomy | 1044.05 | |
| **OT-085** | Intranasal sphenoidectomy | 646.31 | |
| **OT-086** | Frontal sinus - trephine | 497.17 | |
| **OT-087** | Intranasal frontal sinusectomy | 870.03 | |
| **OT-088** | External (Lynch or Howarth type) frontal sinusectomy | 994.31 | |
| **OT-089** | Osteoplastic flap with obliteration by fat or bone graft. | 1864.32 | |
| **OT-090** | Trans-antral orbital decompression | 1615.77 | |
| | **Nose and Proximal Respiratory** | | |
| **OT-091** | Rhinoplasty - performed for airway obstruction | 932.18 | |
| **OT-092** | Rhinoplasty - simple - prior approval is required | 932.18 | |
| **OT-093** | Rhinoplasty and reconstruction of nasal septum - prior approval required | 1242.91 | |
| **OT-094** | Rhinoplasty with composite graft | 932.18 | |
| **OT-094A** | Fractured nose, intra-nasal reduction and splinting | 323.80 | |
| **OT-095** | Removal of nasal foreign body - simple | 49.70 | |
| **OT-096** | Removal of foreign body - simple - tray fee | 18.64 | |
| **OT-097** | Removal of nasal foreign body - general anaesthesia | 161.58 | |
| **OT-098** | Cauterization of nasal turbinate | 62.15 | |
| **OT-099** | Turbinectomy | 248.58 | |
| **OT-100** | Submucous resection of nasal septum | 621.42 | |
| **OT-101** | Nasal reconstruction using auricular cartilage graft | 248.58 | |
| **OT-102** | Nasal polypectomy - unilateral | 217.52 | |

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| **OT-103** | Nasal polypectomy - bilateral | 298.30 | |
| **OT-104** | Initial epistaxis visit including anterior packing or cautery | 74.59 | |
| **OT-105** | For first visit including anterior packing or cautery - tray fee | 37.28 | |
| **OT-106** | Nasal cautery - general anaethesia | 136.71 | |
| **OT-107** | Repeat anterior packing or cautery | 31.07 | |
| **OT-108** | Repeat anterior packing or cautery - tray fee | 37.28 | |
| **OT-109** | Epistaxis - anterior and posterior packing | 174.01 | |
| **OT-110** | Ligation of ethmoid vessels in-orbit unilateral | 310.73 | |
| **OT-111** | Trans-antral ligation of internal maxillary artery - unilateral | 870.03 | |
| **OT-112** | Sphenopalatine artery cautery or ligation | 372.87 | |
| **OT-113** | Lateral rhinotomy | 1118.61 | |
| **OT-114** | Sublabial rhinotomy | 870.03 | |
| **OT-115** | Excision of nasopharyngeal tumor - via oropharnyx | 621.42 | |
| **OT-116** | Excision of nasopharyngeal tumor - trans-palatine | 1242.91 | |
| | **Larynx and Distal Respiratory** | | |
| **OT-117** | Cricopharyngeal myotomy | 1242.91 | |
| **OT-118** | Laryngoscopy with removal of benign tumor | 559.31 | |
| **OT-119** | Laryngoscopy suspension | 310.73 | |
| **OT-120** | Suspension microlaryngoscopy | 372.87 | |
| **OT-121** | Laryngoscopy and laryngeal dilation | 310.73 | |
| **OT-122** | Laryngoscopy and laryngeal dilation - repeat | 310.73 | |

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| **OT-123** | Bronchoscopy with removal of foreign body or tumor | 621.42 | |
| **OT-124** | Thyrotomy laryngofissure | 1242.91 | |
| **OT-125** | Decompression of recurrent laryngeal nerve | 932.18 | |
| **OT-126** | Thyroplasty | 1242.91 | |
| **OT-127** | Injectable implantation vocal cords | 932.18 | |
| **OT-128** | Glottic stenosis - repair | 1429.33 | |
| **OT-129** | Supraglottic stenosis - repair | 1988.63 | |
| **OT-130** | Infraglottic stenosis - repair | 1988.63 | |
| **OT-131** | Tracheostomy | 497.17 | |
| **OT-132** | Tracheal fenestration | 932.18 | |
| | **Plastic Surgery** | | |
| **OT-133** | Closed reduction and external fixation of fracture of mandible | 878.66 | |
| **OT-134** | Open reduction and internal fixation of single fracture of manadible | 995.82 | |
| **OT-135** | Open reduction and internal fixation of multiple fractures of manadible | 1523.01 | |
| **OT-136** | Hook or temporal elevation of malar fracture | 322.17 | |
| **OT-137** | Hook and antral packing of malar fracture | 456.90 | |
| **OT-138** | Open reduction and fixation of malar fracture | 820.09 | |
| **OT-139** | Orbital floor fracture | 1288.70 | |
| **OT-140** | Open reduction and suspension of maxilla fracture | 1230.13 | |
| **OT-141** | Full thickness skin graft - face or hands - up to five (5) square inches | 644.34 | |
| **OT-142** | Full thickness skin graft - face or hands - greater than five (5) square inches | 995.82 | |

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| **OT-143** | Flaps or tubes from a distance - major stage | 948.96 | |
| **OT-144** | Flaps or tubes from a distance - minor stage | 620.93 | |
| **OT-145** | Transplantation of costal cartilage or bone graft autogenous nose, orbit, forehead, other | 1112.97 | |
| **OT-146** | Transplantation of mucous membrane | 503.76 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION PA<br>PAEDIATRICS** | | |
| | **Visits and Assessments** | | |
| **PA-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 298.30 | |
| **PA-002** | Major consultation for Inpatient or for patient in Emergency Department | 341.81 | |
| **PA-003** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 149.13 | |
| **PA-004** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |
| **PA-005** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **PA-006** | Standby fee for attendance at delivery at the request of the obstetrician or surgeon - per 1/4 hour | 43.49 | |
| **PA-007** | Subsequent office visits | 74.59 | |
| **PA-008** | Subsequent hospital visits | 49.70 | |
| | **Procedures** | | |
| **PA-009** | Resuscitation of a seriously depressed infant in the case room at the request of the attending medical practitioner | 186.44 | |
| **PA-010** | Replacement transfusion | 435.02 | |
| **PA-011** | Repeat replacement transfusion | 310.73 | |
| **PA-012** | Umbilical venous catheterization | 37.28 | |
| **PA-013** | Umbilical arterial catheterization | 74.59 | |

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| **PA-014** | Insertion of artificial surfactant via endotracheal tube in premature infant with hyaline membrane disease | 55.93 | |
| **PA-015** | Suprapubic aspiration of urine for culture where catheterization of infant has been unsuccessful | 55.93 | |
| | **Child Development Team Conferences** | | |
| **PA-016** | Multidisciplinary team meetings - in person or remotely no greater than once weekly and minimum of 30 minutes each - claim is per each 30 minutes or part thereof and made using one patient | 146.44 | |
| **Fee Code** | **Descriptor** | **Price** | |
| | **SECTION PS<br>PSYCHIATRY** | | |
| | **Visits and Assessments** | | |
| **PS-001** | Major consultation including complete history, examination, and a written report | 298.30 | |
| **PS-002** | Major consultation for Inpatient or for patient in Emergency Department | 341.81 | |
| **PS-003** | Repeat consultation for same problem within six months | 149.13 | |
| **PS-004** | Minor consultation for dealing with one particular problem | 62.15 | |
| **PS-005** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 | |
| **PS-006** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 | |
| **PS-007** | Initial assessment of one hour - complete examination and investigation | 223.73 | |
| **PS-008** | Psychiatric care other than psychotherapy - one hour | 223.73 | |
| **PS-009** | Subsequent office visits | 74.59 | |
| **PS-010** | Subsequent hospital visits | 49.70 | |
| **PS-011** | Evaluation interview with family member without presence of patient - per 5 minute intervals - maximum 3 claims per day | 14.92 | |
| **PS-012** | Environmental intervention on a psychiatric patient's behalf with agencies, employers or institutions per 5 minute intervals - maximum 3 claims per day | 14.92 | |
| **PS-013** | Interpreting results of psychological, psychiatric or other medical examinations to family or other responsible persons per 5 minute intervals - maximum 3 claims per day | 14.92 | |

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| | **Individual Psychotherapy** | |
| **PS-014** | Per 30 minute intervals or major portion thereof - maximum of 2 1/2 hours per day | 111.85 |
| | **Group Psychotherapy** | |
| **PS-015** | 6-7 patients - per patient per 1/2 hour - maximum 1 1/2 hours daily | 18.64 |
| **PS-016** | 8-9 patients - per patient per 1/2 hour - maximum 1 1/2 hours daily | 14.92 |
| **PS-017** | 10-12 patients - per patient per 1/2 hour - maximum 1 1/2 hours daily | 12.44 |
| **PS-018** | Family - per 1/2 hour - maximum 1 1/2 hours daily | 111.85 |
| **Fee Code** | **Descriptor** | **Price** |
| | **SECTION TE<br>TELEHEALTH AND TELECONFERENCE** | |
| **TE-001** | Participation in remote telehealth consultation by consultant using audio-video-data communications | 186.44 |
| **TE-002** | Participation in remote telehealth consultation by the medical practitioner initiating the consultation - per 1/4 hour - maximum of 1.5 hours per telehealth session | 55.93 |
| **TE-003** | Review of radiograph by non-radiologist medical practitioner without patient consultation | 31.07 |
| **TE-004** | Teleconference with physician when initiated by another physician, nurse practitioner, midwife in different community | 18.64 |
| **Fee Code** | **Descriptor** | **Price** |
| | **SECTION UR<br>UROLOGY** | |
| | **Visits and Assessments** | |
| **UR-001** | Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report | 174.01 |
| **UR-002** | Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months | 87.01 |
| **UR-003** | Non-referred or transferred patient, first visit requiring complete history and physical examination | 111.85 |
| **UR-004** | Non-referred or transferred patient, first visit not requiring complete history and physical examination | 49.70 |
| **UR-005** | Subsequent office visits if not included in surgical fee | 24.87 |
| **UR-006** | Subsequent hospital visits if not included in surgical fee | 31.07 |

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| | **Diagnostic Procedures** | | |
| **UR-007** | Cystoscopy with or without biopsy, urethral dilation, or meatotomy | 167.79 | |
| **UR-008** | Cystoscopy with retrograde pyelography | 186.44 | |
| **UR-009** | Ureteroscopy includes cystoscopy - unilateral or bilateral | 372.87 | |
| **UR-010** | Cystogram and voiding cystourethrogram | 80.78 | |
| **UR-011** | Cystometrogram | 62.15 | |
| **UR-012** | Needle biopsy - prostate | 124.29 | |
| **UR-013** | Open prostatic biopsy - perineal or retropubic | 621.42 | |
| **UR-014** | Urethra and bladder testing for urinary incontinence in the female - professional fee | 62.15 | |
| **UR-015** | Urethra and bladder testing for urinary incontinence in the female - technical fee | 37.28 | |
| **UR-016** | Testicular biopsy | 161.58 | |
| | **Urethra** | | |
| **(+) UR-017** | Catheterization - therapeutic | 31.07 | |
| **UR-018** | Caruncle or prolapse of urethral mucosa, fulguration or excision | 310.73 | |
| **UR-019** | Extraction foreign body - anterior urethra | 93.23 | |
| **UR-020** | Urethral dilation - initial | 62.15 | |
| **UR-021** | Urethral dilation - subsequent | 31.07 | |
| **UR-022** | Urethral meatotomy | 62.15 | |
| **UR-023** | Internal or external urethrotomy | 497.17 | |
| **UR-024** | Excision or urethral diverticulum | 745.74 | |
| **UR-025** | Repair - urethral rupture - cystotomy and catheter | 621.42 | |

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| **UR-026** | Repair - urethral rupture, cystotomy and catheter - suprasphincteric | 745.74 | |
| **UR-027** | Repair - urethral stricture - infrasphincteric - one stage | 683.59 | |
| **UR-028** | Repair - urethral stricture - infrasphincteric - first stage | 528.23 | |
| **UR-029** | Repair - urethral stricture - suprasphincteric - one stage | 1242.91 | |
| **UR-030** | Repair - urethral stricture - suprasphincteric - first stage | 901.10 | |
| **UR-031** | Repair - urethral stricture - infrasphincteric or suprasphincteric - second stage | 372.87 | |
| **UR-032** | Endoscopic internal urethrotomy | 217.52 | |
| **UR-033** | Transurethral fulgaration of condylomata - including cystoscopy | 248.58 | |
| | **Bladder** | | |
| **(+) UR-034** | Cystotomy - aspiration with needle | 62.15 | |
| **UR-035** | Cystotomy - trochar and tube | 161.58 | |
| **UR-036** | Cystotomy - open | 621.42 | |
| **UR-037** | Partial cystectomy | 478.51 | |
| **UR-038** | Total cystectomy | 994.31 | |
| **UR-039** | Removal of vesical calculus - transurethral or suprapubic | 621.42 | |
| **UR-040** | Repair of ruptured bladder | 1118.61 | |
| **UR-041** | Removal of foreign body and/or calculus including cystoscopy | 341.81 | |
| **UR-042** | Transurethral resection bladder tumour - moderate - less than 30 minutes of resecting | 310.73 | |
| **UR-043** | Transurethral resection bladder tumour/s - large or multiple tumours - more than 30 minutes of resecting | 745.74 | |
| **UR-044** | Excision of bladder diverticuum | 528.23 | |
| **UR-044A** | Therapeutic injection into bladder for chronic dysfunction | 380.76 | |

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| | **Ureter and Kidney** | | |
| **UR-045** | Renal exploration, including nephrostomy, open renal biopsy, drainage of renal or perirenal abscess, drainage of renal cyst | 683.59 | |
| **UR-046** | Nephrectomy - complete | 1242.91 | |
| **UR-047** | Nephrectomy - radical - any approach to include surrounding tissue | 1491.48 | |
| **UR-048** | Ruptured kidney repair | 1242.91 | |
| **UR-049** | Nephrolithotomy | 1242.91 | |
| **UR-050** | Uretero-ureterostomy - contralateral | 1553.63 | |
| **UR-051** | Endoscopic removal of ureteral calculus - basket extraction | 279.65 | |
| **UR-052** | Removal of calculus from ureter by percutaneous, ureteroscopic, or open surgery approach | 870.03 | |
| **UR-053** | Nephroureterectomy with excision of bladder cuff | 1491.48 | |
| **UR-054** | Pyeloplasty | 1056.46 | |
| **UR-055** | Removal of renal calculus by percutaneous, ureteroscopic, or open surgery approach | 1305.06 | |
| **UR-056** | Uretero-ureterostomy - ipsilateral | 932.18 | |
| **UR-057** | Uretero-neocystostomy | 932.18 | |
| **UR-058** | Uretero-neocystostomy with bladder flap | 1087.53 | |
| **UR-059** | Insertion of double J stent - includes cystoscopy | 217.52 | |
| **UR-060** | Removal of double J stent - includes cystoscopy | 186.44 | |
| | **Penis** | | |
| **UR-061** | Circumcision - newborn - including consultation | 93.23 | |
| **UR-062** | Circumcision - newborn - tray fee | 37.28 | |
| **UR-063** | Circumcision - child | 298.30 | |

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| **UR-064** | Circumcision - adult | 298.30 | |
| **UR-065** | Repair hypospadias - first stage | 621.42 | |
| **UR-066** | Repair hypospadias - second stage | 1242.91 | |
| | **Testis** | | |
| **UR-067** | Orchidectomy - unilateral | 323.16 | |
| **UR-068** | Orchidectomy - bilateral | 596.60 | |
| **UR-069** | Orchidopexy | 901.10 | |
| **UR-070** | Torsion of testicle, or suspected torsion, excision of sperm granuloma, correction of torsion of epididymis or appendix testes | 621.42 | |
| **UR-071** | Exploration of undescended testicle without orchidopexy | 621.42 | |
| **UR-072** | Ruptured testicle - repair | 497.17 | |
| **UR-073** | Repair of communicating hydrocele | 559.31 | |
| **UR-074** | Radical orchidectomy with resection of cord | 621.42 | |
| | **Scrotum and Vas Deferens** | | |
| **UR-075** | Hydrocoele - aspiration - initial | 62.15 | |
| **UR-076** | Hydrocoele - aspiration - initial - tray fee | 18.64 | |
| **UR-077** | Hydrocoele - radical | 621.42 | |
| **UR-078** | Varicocele - resection | 435.02 | |
| **UR-079** | Avulsion of penile skin and scrotum repair | 1242.91 | |
| **UR-080** | Bilateral vasectomy | 279.65 | |
| **UR-081** | Bilateral vasectomy - tray fee | 37.28 | |
| | **Prostate Gland** | | |
| **UR-082** | Prostatectomy - transurethral, suprapubic or retropubic | 1491.48 | |
| **UR-083** | Perineal drainage of prostatic abscess | 621.42 | |
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