Saskatchewan Medical Association

SMA Fee Guide (uninsured services)

EFFECTIVE APRIL 1, 2019

Saskatchewan Medical Association
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TABLE OF CONTENTS

CLASSIFICATION CODES

Each procedure listed in the guide is assigned a classification code.

D Diagnostic

0 Day surgery
includes the day of the procedure

10 Day surgery
includes the day of, and 10 days following, the procedure

42 Day surgery
includes the day of, and 42 days following, the procedure

INTRODUCTION / PREAMBLE

An understanding of this preamble is essential for the proper interpretation of the Guide

I Overview

This Guide lists by Specialty Section, SMA recommended fees for uninsured medical services. For the purposes of this Guide, uninsured medical services are those which are not paid by the Saskatchewan Medical Services Branch in accord with the Payment Schedule under The Medical Care Insurance Act.

The services may be requested by the patient or by a third party interested in adjudicating the patient's fitness or eligibility for certain benefits. It is inappropriate to bill the Medical Services Branch for uninsured services. The physician is entitled to charge either the patient for the service or the third party requesting the service. An appropriate record should be made of each uninsured service rendered.

The Guide is not binding upon any physician. The Guide should be interpreted from the point of view that it provides a tool for the determination of reasonable relativity between fees for services of average complexity. It is assumed that physicians will, at all times, exercise responsible judgement in establishing their fees.

The basic principle of the Guide is that a physician is entitled to appropriate compensation for services rendered. For circumstances where a fee might cause financial hardship to a patient, the physician may choose to reduce the fee. Alternatively, when unusual time, skill, or attention is required in the management of any condition, the physician is entitled to a greater fee. In either case of individual adjustment, the physician is advised to provide the patient with an explanation.

The Guide is divided into several sections with fee descriptions based as nearly as possible on the descriptions listed in the insured payment schedule. Section A consists of three parts: (A.1) lists rates for general uninsured services and third party requests; (A2) lists services that are negotiated with agencies other than Saskatchewan Health Medical Services Branch; (A3) lists miscellaneous services that correspond with Section A in the insured payment schedule. Other sections of this Guide are organized by specialty, to be consistent with the insured Payment Schedule. This format is not intended to restrict any physician and, therefore, a physician who performs a service listed in another specialty section may base the fee on the units listed in that section.

II Policy Statement on Third Party Requests and Uninsured Services

Most services provided by physicians are insured under *The Medical Care Insurance Act* or paid by other agencies such as the Cancer Foundation, the Workers' Compensation Board, etc. Some services provided by physicians are not insured. To clarify physicians' entitlements and responsibilities in this regard, the Saskatchewan Medical Association maintains that:

1. Physicians have a professional responsibility to expeditiously assist patients in obtaining those benefits to which they are legitimately entitled;

2. Physicians are entitled to reimbursement for the extra time and resources devoted to the provision of medical information to third parties and for providing any uninsured service;

3. Those parties requesting medical information, reports or certificates should be obliged to arrange for appropriate reimbursement;

4. Third parties who request medical information about individuals must be clear as to why they require the information and tailor any forms accordingly after consultation with the SMA about the design of their forms;

5. Third parties requesting information must ensure that the reason for the request is clearly communicated to the physician other than by word of mouth of the patient;

6. When providing medical information, physicians should not be expected to judge whether the subject patient is eligible for the benefits provided by the third party;

7. Physicians should not be considered by third parties as truant officers in dealing with absenteeism;

8. In establishing fees for responses to third party requests and for uninsured services, physicians are guided by, but not bound by, the SMA Guide to Fees;

9. The Association is prepared to facilitate adjudication of disputes over fees charged by physicians for these services.

III Definitions

1. A visit is defined as the service by a physician to, or on behalf of, a patient. When more than one visit is necessary on any given day, the physician is entitled to submit a fee for each service rendered. The physician is entitled to charge appropriately for visit services when rendered in the office, the home, the hospital or wherever the patient may be at the time of the service.

2. Hospital Care is defined as the professional services provided from the time of admission to the time of discharge. Procedures, emergency visits and continuous personal attention prior to, or during hospitalization command additional fees.

3. Consultation applies where a physician who has attended a patient requests the opinion and advice of another physician with respect to the diagnosis and/or management of the patient's current condition. The consultation includes the assessment of the patient, review of the relevant diagnostic data and the submission of a written opinion to the referring physician. No follow-up care by the consultant is assumed to be included in the fee for the consultation.

4. Repeat Consultation is defined as a formal consultation for the same or related condition repeated within 30 days by the same physician. A repeat consultation (service code 11), is only to be billed when it is generated by a new formal request by the referring physician. It should not be used for routine follow-up of the patient for which a partial assessment or subsequent review (service code 5) or follow-up assessment (service code 7) are appropriate.

5. Directive Care applies when the referring physician remains primarily responsible for the patient's care, but, because of the seriousness or complexity of the condition, requests ongoing advice from the consultant during the acute phase of the illness.

6. Multi-disciplinary care is the situation in which the complexity of the care, usually involving more than one diagnosis, requires the services of more than one physician with complementary skills in different fields or practice for adequate care of the patient.

7. Supportive care applies when the responsibility of the patient's care has been temporarily transferred by the referring physician to a consultant but it remains necessary and/or desirable for the referring physician to visit the patient for the purposes of continuity and coordination of care as well as support and reassurance for the patient and the family.

8. Classification Codes

   All procedures listed in the Guide are assigned a classification code as follows:
   D - Diagnostic - none
   0 - Day surgery - includes the day of the procedure
   10 - Day surgery - includes the day of, and 10 days following, the procedure
   42 - Day surgery - includes the day of, and 42 days following, the procedure

9. Fee for Service - means services are to be billed on the basis of the individual appropriate visit or procedure items.

10. By report - means that the bill should be accompanied by a detailed explanation of the circumstances and the services provided.

IV General Guidelines

1. For the purposes of this Guide, a specialist is a physician whose name is listed as a specialist with the Council of the College of Physicians and Surgeons of the Province of Saskatchewan.

2. For physicians who have completed their specialty training and are awaiting placement on the specialist register of the College of Physicians and Surgeons, it is suggested that they base their fees on the fee listed for general practice or on 90% of that listed for the specialist, whichever is the greater.

3. When a general practitioner performs any service listed in a section of the Guide other than Sections A1, A2 and B, H, and J, it is suggested that the fee be based on 90% of the listed fee without an asterisk (*). Codes with an asterisk (*) are considered to be single listed (i.e. the GP and specialist rates are the same).

4. A physician may render a fee only for those services which have been provided or supervised as well as the technical component of procedures performed in the office.

5. A written report for a third party is a separate service for which the physician may render a fee in addition to the fee for the medical service provided.

6. A diagnostic, therapeutic or laboratory procedure performed or supervised by a physician commands a fee in addition to the visit fee unless otherwise stated.

7. When a procedure, either diagnostic or therapeutic, is the sole reason for the visit, it is suggested that the procedure fee alone be charged.

8. When a procedure, either diagnostic or therapeutic, is performed in addition to an unrelated visit service, it is suggested that the charge be the visit fee plus 75 percentage of the procedure fee.

9. If, during any period of hospitalization, a patient develops an acute exacerbation of the illness present on admission, a complication, or an entirely new and unrelated illness, the physician is entitled to charge hospital care as for a new admission.

Surgical Fees

10. The concept of the composite surgical fee includes the base surgical procedure and associated care provided to the patient in hospital following the procedure. All other services provided pre- and post-operatively should be billed separately.

11. For diagnostic procedures related to the surgical procedure and performed by the same surgeon (e.g. cystoscopy, D and C, bronchoscopy, angiography) when done under the same anaesthetic as the surgery or during the hospitalization following surgery, it is suggested that the fee be based on an individually selected percentage of the fees listed.

12. If, during the post-operative period in the hospital, the patient develops a condition directly related to the original disease and requires another operation, it is suggested that the fee be based on an individually selected percentage of the fee(s) listed for the operation performed.

13. If a patient develops a condition unrelated to the original disease while still in hospital, then any procedure performed commands the full fee.

14. When two similar bilateral procedures are done at the same time or during the same admission to hospital, it is suggested that the fee for the second procedure be based on 75 percent of the listed fee unless otherwise listed.

15. When one surgeon performs two or more unrelated procedures at the same time, through the same or separate incisions, it is suggested that the fee for the lesser procedures be based on 75 percent of the listed fee unless otherwise listed.

16. If a surgical procedure for which one fee is listed must be performed by two specialist surgeons, it is suggested that the attending surgeon bill according to the listed units and the second surgeon according to an individually selected percentage of the listed fee.

V OBSERVATIONS ON SELECTED SERVICES

1. Transfer of Medical Charts[1]

Requests for information from the physician's office medical record may come from another physician, from the patient, or from lawyers and other third parties. Each request merits a slightly different approach.

Requests from Physicians

It is rarely essential that a new physician obtain the patient's total file from previous attending physicians because most patients can recount the significant features of their past history. Therefore, a physician's request to another physician should state specifically what information is required, e.g. results of diagnostic procedures, therapeutic measures taken, response to therapy, etc. In such cases, the physician might consider sending a written statement.

However, if a new physician sends a standard blanket request, the previous attending physician has two options:

- send a photocopy or electronic copy of the documents on file, or

[1] For SMA/CPSS jointly developed guidelines, visit:
http://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Transfer_of_Patient_Records.aspx

- send the entire chart and ask the new physician to make copies as needed and then return the original file. (The physician should retain original files for a minimum of six years).

  There would, in most situations, be no charge for sending information to another physician.

Requests from Patients

The Saskatchewan Health Information Protection Act (HIPA) enshrines patients' rights to access their own health information, and allows physicians to charge a "reasonable fee" for this access.

When a patient asks for a copy of the medical record, one option is to suggest that the patient have their new physician ask for specific information. If the patient requests his/her own personal copy (and a growing number of patients are doing so), the physician should provide a photocopy and may charge the patient the fee(s) suggested in this Guide.

Requests from Lawyers

When a lawyer requests a copy of the medical chart, the first step is to ensure that there is a valid consent signed by the patient to be placed on file. The next step is to offer to send a report to answer the lawyer's specific questions.

If that offer is not accepted by the lawyer, send a photocopy of the chart and charge the lawyer as suggested in the SMA Guide to Fees.

It is helpful to remember that such fees are almost always passed on to the patient. The fee(s) charged to lawyers should not exceed what the patient would have been charged for direct access to the information.

The Health Information Protection Act requires that physicians (and other information trustees) respond to information requests in a reasonable time frame. Saskatchewan's Privacy Commissioner has informally defined "within 30 days" as a reasonable amount of time to respond to non urgent requests.

2. Missed Appointments

Charging for missed appointments is not a general occurrence but there are circumstances which would clearly justify such charges. It would be wise to forewarn each patient individually when charges for missed appointments might be contemplated.

3. Renewals of Prescriptions by Telephone

Telephone prescription renewals initiated by a pharmacist are considered to be an insured service (unless provided to an RCMP or other uninsured beneficiary).

Patient-initiated telephone prescription renewals are considered to be uninsured. Practitioners are urged to exercise careful judgement when or if to charge for this service, as it is expected that such charges may come under scrutiny.

As with missed appointments, patients should be forewarned if a charge will be levied.

4. Uninsured Services Provided at the Same Time as Insured Services

It can happen that, while assessing a patient at the request of a third party for an uninsured service, it becomes obvious that the patient requires medical care. Providing necessary medical care would be insured and it would be acceptable to submit a claim to the Medical Services Branch for those services. However, that portion of the service relating to compliance with the third party's request such as completion of a report or certificate remains uninsured. The physician is entitled to charge separately for that.

It is expected that physicians will not charge for any of the following in addition to the insured fees for any medical services provided:

- writing a prescription
- referral note to a colleague
- completion of a standard requisition form for a diagnostic or therapeutic service
- completion of patient records
- charges for any long-distance telephone calls related to referrals to colleagues may be billed to the patient

VI Unlisted Services

When no unit is listed for service and the service cannot be readily compared to one that is listed, the physician may submit a request for a new listing to the SMA Committee on Uninsured Services through the office of the Saskatchewan Medical Association.

VII Disputed Fees

All cases requiring advice regarding a dispute over fees or over the interpretation of this preamble should be referred to the office of the SMA.

VIII Physicians' Guide to Third Party Requests and Uninsured Services

THE DIRECT BILLING PROCESS

1. <u>Ethics of Direct Billing</u>

The Canadian Medical Association's Code of Ethics lists the principles of ethical behaviour for physicians. One of these principles urges physicians to be "...responsible in setting a value on your services".

In this regard, the Code of Ethics states that an ethical physician:

- Will practise in a fashion that is above reproach and will take neither physical, emotional, nor financial advantage of the patient.
- When acting on behalf of a third party will ensure that the patient understands the physician's legal responsibility to the third party before proceeding with the examination.
- Will, upon a patient's request, supply the information that is required to enable the patient to receive any benefits to which the patient may be entitled.
- Will consider, in determining professional fees, both the nature of the service provided and the ability of the patient to pay, and will be prepared to discuss the fee with the patient.

2. Some Practical Guidelines

There are some practical guidelines physicians can follow when billing a patient directly to help make the process as comfortable and efficient as possible.

a) Keep Patients Well-Informed

Always ensure that fees have been discussed with the patient before providing the service. Most difficulties between a physician and patient arise from a lack of clear communication. Many patients simply do not realize that there are some services the government does not pay for and they may become upset when presented with a bill.

To prevent this from happening, physicians and their staff must ensure patients are well-informed about uninsured services and the direct billing policy well in advance of receiving treatment.

The following are a few suggestions on informing patients about direct billing.

- Clearly display in your patient waiting area a poster which outlines your billing policies
- Discuss fees when the patient books an appointment for an uninsured service
- Mention fees before you provide the uninsured service
- Provide patients a fact sheet or pamphlet which includes information on direct billing

b) Maintain simple and clear office policies and procedures for direct billing

To establish consistent office policies, physicians should first determine:

- Those services for which patients will be directly billed
- The fees attached to those services
- Any exemptions, such as low income earners
- Bookkeeping and collection procedures

A physician's office policies on direct billing must be specific and detailed so that staff and patients fully and clearly understand them. At the same time, they should allow sufficient flexibility to adapt to any unique or unexpected circumstances that may be encountered.

Once office policies have been established, they should be put in writing and distributed to staff members of the office staff. Procedures should be in place to apprise staff of any changes to office policies.

To minimize difficulties in direct billing, clinics should also:

- Maintain up-to-date accounts
- Collect payment from patients at the point of service as often as possible
- Follow-up in an orderly and consistent manner

c) Make adjustments for financial burden

When calculating fees, physicians should consider the financial burden such charges might place on the patient and be prepared to adjust fees based on these considerations.

SECTION A1:

UNINSURED SERVICES

The following is a categorized list of services for which physicians are entitled to charge, along with SMA recommended fees. The list is not exhaustive

I CHARGES BASED ON COST

This section includes services provided to patients for which reimbursement is calculated based on the actual cost to the physician. **The costs include the actual invoice cost, the applicable taxes plus staff time and other overhead costs.**

801A Long distance telephone calls on behalf of a patient .....COST
802A Medication by injection (hyposensitization serum, immunization, B12, etc.) .....COST
803A Bandages, splints, IUD or other materials .....COST
804A Uninsured Tray services .....COST

SECTION A1:

UNINSURED SERVICES

II CHARGES BASED ON INDEPENDENT CONSIDERATION

To determine a fee for third party or uninsured services, physicians may be guided by the fees listed in this Guide. To determine the fee for a service not listed in this Guide or to establish a fee independently, physicians may consider the following factors:

- the nature and complexity of the matter
- the experience and expertise required of the physician
- time spent with and/or on behalf of the patient
- the related office overhead costs

Services with fees set on an individual consideration basis include, but are not limited to:

- Preparation and transfer of a patient's health record at the request of the patient or the patient's representative. The physician may charge for any time spent in preparing information for transfer in addition to the related office overhead
- Surgery to alter appearance other than for abnormalities due to disease, trauma or congential defect
- An anaesthetic service rendered for the provision of uninsured surgical or dental services
- Acupuncture procedures
- Routine examination of eyes over age 17
- Electrolysis
- Reversals of sterilization
- Implantation of penile prosthesis
- Removal of minor skin lesions by cryo, laser, cautery or curettage (except actinic keratoses, pyogenic granuloma, keratoacanthoma or bleeding lesions)
- Dye tuned laser ablation of cutaneous lesions (except facial portwine stains in patients under age 18)
- Injection of asymptomatic varicose veins and spider telangiectasia
- Travel beyond the usual geographic area of practice to provide a medical service (insured or uninsured)
- Services which are part of uninsured group screening programs
- Visit or procedure services that are related to surveys or research
- Providing or refilling a prescription by telephone when requested by the patient or the patient's representative and no concomitant insured service is provided
- Missed appointments for visits or procedures
- Any other services or procedures which are not paid by Saskatchewan Health

Professional work other than direct patient care

917A includes administrative, advisory or committee work, and other than specific fees listed below
- per 15 minutes or major portion thereof……..$80.00

Transferring patient paper records

511A Photocopying/printing of records, base fee……$30.00*
512A - plus per page…… $0.30*

Transferring patient electronic records

513A Base fee……$40.00*

810A Physician time taken in reviewing the request/information and/or reviewing the chart if necessary, per 15 minutes or major portion thereof..... $80.00*

*Physicians may choose to waive all or part of the fee if it is fair to excuse payment.

Note: 810A should not be billed when patient has requested entire copy of the chart, unless there are circumstances, as set out in section 38(1) of the HIPA, in which a patient may be denied access to all or part of their medical record.

SECTION A1:

UNINSURED SERVICES

Missed appointments

516A For visit or procedure service
(if 24 hours notice of cancellation not given)..... Up to 50% of listed fee

Medical Advice to a Patient

517A - by telephone (including patient telephone prescription renewal)
per 15 minutes or major portion thereof..... $80.00*

518A - by letter, per 15 minutes or major portion thereof..... $80.00*

Time Spent on a Patient's Behalf

519A - representation with an allied health professional, health care facility, social service agency, etc.
- per 15 minutes or major portion thereof..... $80.00*

524A - case conference
- per 15 minutes or major portion thereof (917A)..... $80.00*

Physician Travel

525A - by commercial carrier ..... Cost

526A - by personal vehicle (per km).....$0.4283

Plus

- time - per 1 hour or major portion thereof $63.00

Plus

Expense Allowance
- In province – per day $80.00
- In province – overnight allowance..... $250.00
- Out-of-province – per day……..... $300.00

Telephone attendance

55A - per 15 minutes or major portion thereof..... $80.00*

528A **Acupuncture**
- per visit - per 15 minutes or major portion thereof $80.00*

*Physicians may choose to waive all or part of the fee if it is fair to excuse payment.

SECTION A1:

UNINSURED SERVICES

III RESPONSE TO A REQUEST FOR INFORMATION BY THIRD PARTIES

A third party service is defined as any service provided for a patient, which is necessary to satisfy the requirements of a party other than the patient.

1. A few third party services are paid for by the Medical Services Branch or by other agencies at negotiated rates. These are listed in Sections A.2 and A.3 of this Guide.

2. Other third party services which are not insured are also listed in the SMA Fee Guide. All medical services including assessments, examinations, diagnostic tests and/or reports for these requests are uninsured. Physicians are entitled to reimbursement for the time and resources devoted to the provision of these services. Examples of third party services include:

Certification of Health Status For:

- Admission to, or continued attendance in, day care, pre-school, elementary and secondary school, community college, technical institute, university or other educational institution
- Admission to, or continued attendance in, a camp or recreational/athletic program
- Issuing of a driver's, pilot's or other license
- Obtaining or continuing employment: pre-employment or annual/periodic medicals
- Meeting the requirements of provincial legislation or deriving the benefits of provincial health or social programs, e.g. community treatment services
- Application for, or the continuation of, life, disability or other insurance coverage
- Bank loan insurance
- Injury report to CAHA
- Assessment of claims for medical services abroad
- Abilities Council special parking permit
- Meeting the requirements of, or deriving the benefits of, certain services provided by health care facilities, e.g. out-patient dietary counselling, physiotherapy, etc.
- Continuing Care Assessment Form or Instruction Form

Certification of Illness for:

- Sick slips for employment or return to work
- Sick slips for school, day-care or recreation/athletic programs
- Meeting the requirements of federal legislation or deriving the benefits of federal health or social programs, e.g. Employment Insurance., Canada Pension Plan, Canada Revenue Agency Disability Tax Credit, disability/maternity benefits
- Entitlement to benefits under other disability insurance plans
- Air fare cancellation
- Student loan relief

Verification of death for:

- Validation of a life insurance claim

Legal reports and medical testimony in court

Note: Where the completion of a report requires a medical assessment of the patient, the physician is entitled to bill the appropriate visit fee plus a report fee to the third party (unless the services have been bundled, such as with the commercial drivers' medical fee).

SECTION A1:

UNINSURED SERVICES

Providing Medical Information

(The total fee for a report depends on the length of the form and the time taken to complete it)

Photocopy of Medical Records

527A - reply to an inquiry by submission of photocopy of a consultation or other written report ..... See 810A
(This will not normally be charged when photocopies are attached to written reports or report forms)

529A - completion of form or brief written statement (per 15 minutes or major portion thereof) $80.00*

535A - written letter (per 15 minutes or major portion thereof) $80.00*

Commercial Driver's Medical

805A - assessment plus form ..... $134.00-$198.00*
*The final amount is based on whether a partial or a complete assessment is conducted.

806A - form only $64.00

*Physicians may choose to waive all or part of the fee if it is fair to excuse payment.

IV MEDICAL-LEGAL SERVICES

It is important to understand why a lawyer is asking for a medical report or a medical-legal opinion and specifically what information is required. If the lawyer's request is unclear, the physician should contact the lawyer to seek clarification. If payment for the report is not assured, the lawyer should be contacted prior to responding to the request.

1. Medical Reports

560A - completion of form or brief statement (per 15 minutes or major portion thereof).....$80.00

561A - written letter (per 15 minutes or major portion thereof)) $80.00

Note: This is a factual report on past health and/or current condition based on review of office and/or hospital records submitted to a lawyer, insurance company or other third party.

563A Medical-legal report $640.00
- if more than one hour of the physician's time, for each subsequent 15 minutes or major portion thereof, add (917A).....$80.00

Note: This is a factual summary of the history, symptomatology, investigation, therapy, results and present condition. It may contain an estimate of the date that the person could return to work and perhaps some comment as to the likelihood of permanent disability.

564A Medical-legal opinion $720.00
- if more than one hour of the physician's time, for each subsequent 15 minutes (or major portion thereof) add (917A).....$80.00

Note: This is a medical-legal report plus an expert opinion concerning such matters as:
- cause and effect
- long-term consequences
- possible complications
- extent, or percentage, disability
- relationship of condition to factors in the work situation

This service involves the exercise of expert knowledge and judgement with respect to the medical facts and findings including a detailed prognosis for the person affected.

2. Medical testimony in Court

These codes are to be billed when Saskatchewan Justice tariff rates do not apply. Certain fees are paid by Saskatchewan Justice at rates negotiated with the SMA and prescribed in rules of Court (see page A12).

i) Attending Physician

566A - preparation time - per 15 minutes or major portion thereof (917A) $80.00
567A - court attendance or pre-trial briefing, first hour or part thereof $560.00
568A - time in court after the first hour, per quarter hour $176.00

ii) Physician Called As Expert

569A - preparation time - per 15 minutes or major portion thereof (917A).....$80.00
570A - court attendance - first hour or part thereof $720.00

SECTION A1:

UNINSURED SERVICES

571A - after the first hour, per quarter hour $176.00
572A - Failure to give two working days' notice of a court adjournment or cancellation $720.00

Note: Out-of-pocket expenses for meals, accommodation and travel should be billed in addition at cost.a1

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

This section consists of services that may be requested by a variety of Provincial and Federal agencies. The services listed in this section are not insured under the *Medical Care Insurance Act* and are, therefore not paid by MSB. They are, however, paid for by the agencies who request these services at fixed rates negotiated with the Saskatchewan Medical Association. Unless otherwise noted, these services should be charged directly to the agency requesting the service.

A. SASKATCHEWAN JUSTICE

1. Appearance as a material witness for the Crown in criminal proceedings (effective February 1, 2019)

Testimony
For first court appearance
589A - first hour or part of the first hour……$250.00
- for each subsequent 15 minutes or major portion thereof……$60.00

Subsequent court appearance
590A - first hour or part of the first hour……$250.00
- for each subsequent 15 minutes or major portion thereof……$60.00

i. Payment for preparation, pretrial briefing and waiting time is included in the testimony fee. Travel expenses will be fully reimbursed.

ii. Fees for payment as an "expert" witness are negotiable.

iii. Cancellation Notice……$200.00
Failure to give notification of adjournment or cancellation to the practitioner's office at least 2 business days before the date of the scheduled court appearance (a "flat rate fee will be paid)

Reimbursement of Expenses
580A i. Meal allowances (At Public Service Commission rates)
- breakfast $8.00
- lunch $14.00
- supper $19.00
581A ii. Accommodation
hotel (recommended rate/night; receipt required) ..... $125.00-$150.00
private (recommended rate/night) $35.00
582A iii. Travel- commercial carrier (receipt required) ..... Cost
- private vehicle, per km
- below 54th parallel..... $0.4483
- above 54th parallel $0.4828
- taxi (receipt required) ..... Cost

Medical Documentation - requested by Lawyer
583A (i) Letter..... $150.00
This is a factual report on past health and/or current condition based on review of office and/or hospital records which summarizes of the history, symptomatology, investigation, therapy, and results
585A (ii) Report (opinion) $300.00
This is an expert opinion concerning such matters as: cause and effect; long-term consequences; possible complications; and extent or percentage of disability. It involves the exercise

of expert knowledge and judgment including a detailed prognosis, and may contain some comment as to the likelihood of permanent disability

Note: Medical documentation fees are negotiable with the requesting lawyer if the report is complex.

2. Appearance as a witness in a civil proceeding

Payment arrangements in a civil proceeding should be discussed/negotiated with the lawyer requesting your services. If a suitable fee cannot be agreed upon, you may be subpoenaed in which case the following rates will be paid for your appearance in court.

Professional witness ..... $100.00 per half day
Consultant to give expert testimony..... $200.00 per half day

A reasonable fee for **preparation time** and reasonable fee in the **event of adjournment** or settlement of the action prior to testimony in Court is allowed at the discretion of the taxing officer.

If a **medical report** arising out of an examination is admitted in evidence, and the physician or surgeon who made the report does not personally attend to give evidence, the fee payable to the physician or surgeon who made the report is $200.00.

Expenses will be paid on submission of receipts for necessary travel, accommodation and meals.

Payment Arrangements:

Provincial Court
In Regina and Saskatoon submit claims for expenses, reports and court appearances to the prosecution office requesting your services. In all other areas of the province submit your claims to the RCMP or city police officer who requested your testimony.

Court of Queen's Bench
In all areas across Saskatchewan submit your claims for expenses, reports and court appearance to the prosecution office requesting your services.

For information contact: Public Prosecutions
Saskatchewan Justice
300-1874 Scarth Street
Regina, SK S4P 3V7

Telephone: 306-787-5490

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

B. POLICE SERVICES

I. **Investigation of Suspected Rape**
Bill the MSB under Code 39 A for medical documentation and initial assessment and treatment.

591A Additional time taken to gather and provide evidence for the..... $45.00
investigating officer - per 15 minutes or major portion thereof (917A)
(Charge to the police officer's local detachment)

2. **Collection of Sample for Blood Alcohol Determination**
Any medical services provided to a driver injured in a motor vehicle accident are insured by MSB.

An additional fee for drawing a blood alcohol sample may be submitted to the local detachment of the investigating police officer as follows:

592A Collection of blood sample and completion of forms for alcohol level determination..... $55.00
- plus 917A for any detention
- plus appropriate surcharge when called specially to collect the sample

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

C. DEPARTMENT OF SOCIAL SERVICES - CHILD AND FAMILY SERVICES BRANCH

All services are paid at rates equivalent to Saskatchewan Justice fees for criminal proceedings.

Submit to: Department of Social Services
Child and Family Services Branch
1920 Broad Street
Regina, SK S4P 3V6

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

D. WORKERS' COMPENSATION BOARD

Payments are made for certain services not listed in the MSB Payment Schedule:

Reports

650 - Initial (PPI) $61.44
651 - if submitted electronically via the WCB web portal..... add $12.95

660 - Progress (PPP)..... $38.17
661 - if submitted electronically via the WCB web portal..... add $12.95

Complicated Consultations - (Specialists Only)

119 a) conditions involving more than one area of the body, or
b) chronic clients (those with injuries older than 12 weeks) ..... add $98.20

Special Opinion, on request

97 (relationship of percentage of functional impairment)..... add $245.44

Research Fee (when requested by WCB) (per 10 minutes)

178 - specialist..... $49.15
177 - general practitioner..... $44.26

Telephone Consultations - initiated by the WCB or a health care provider currently treating the injured worker. Synopsis of the consultation to be included in patient's chart.

a) First 10 minutes:
126 - specialist..... $49.15
1126 - general practitioner..... $44.26

b) 10 to 15 minutes:
128 - specialist..... $65.46
1128 - general practitioner..... $58.72

c) Each additional 15 minutes:
164 - specialist..... $65.46
1164 - general practitioner..... $58.72

179 **RHCS4 – Treatment Implementation**……..$34.26
Note: If received by the WCB within five days of the report request, an additional……...$25.00 will be automatically added to the payment for this form.

640 **Counselling**……..$46.76
- For patient counselling for an early return-to-work (RTW), including completion of RTW form for the employer and provided to the patient at initial contact.
- Billable for counselling sessions occurring at initial visit and maximum of once every four weeks thereafter that patient not engaged in return-to-work plan.
- Must be documented in patient's chart. Per 10 minutes or major portion.

199 **Hospital Management**..... $129.45
Billed by most responsible physician (MRP) and/or physician completing discharge

summary, for inpatient hospital stays. Includes discussion with patient regarding expectations for recovery and return-to-work. Billed at or near time of discharge, with notation in patient's chart. Per hospital stay.

MEDICAL BOARDS

Traumatic Brain Injury Consultation

89	- Chair	$1,024.21
1189	- Actual time spent in excess of 2.5 hours (per hour)	$410.10
189	- Member	$819.16
1089	- Actual time spent in excess of 2.5 hours (per hour)	$327.25

Cardiac (per hour)

42	- Chair	$410.10
142	- Member	$327.25

Cardiopulmonary – Medical Consultation

5	- Chair	$1,229.26
1150	- Actual time spent in excess of 3 hours (per hour)	$410.10
150	- Member	$981.75
1050	- Actual time spent in excess of 3 hours (per hour)	$327.25

Medical Review Panel

15	- Chair	$1,637.28
1115	- Actual time spent in excess of 4 hours (per hour)	$410.10
1015	- Member	$1,310.03
1215	- Actual time spent in excess of 4 hours (per hour)	$327.25

Medical Board

190	- Member	$819.16
1190	- Actual time spent in excess of 2.5 hours (per hour)	$327.25

85 **Chaperone Fee** (per 15 minutes) $81.88

Submit to: Workers' Compensation Board
Health Care Services
200-1881 Scarth Street
Regina, SK S4P 4L1

Toll-free Fax: 1-888-844-7773

Note: The Workers' Compensation Board reserves the right to withhold payment for incomplete or illegible reports received.

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

E. SASKATCHEWAN POWER

800A Completion of Saskatchewan Power Practitioner's Report Form P148 ..... $40.00

Please return forms and submit claims to:

Submit to: Saskatchewan Power
Return to Work
10 SE, 2025 Victoria Avenue
Regina, SK S4P 0S1

Telephone: (306) 566-2416
Fax: (306) 566-2406

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

F. SASKATCHEWAN GOVERNMENT INSURANCE (SGI)

Includes SGI Injury Claims

Forms

Practitioner's (Initial Report)
For a complete, legible report:
- received within 30 days $50.00
- received within 7 calendar days after the visit or 14 days after request from the adjuster..... $60.00

Individual Written Rehabilitation Plan Form..... $20.00

SGI Claimant Assessment Form $20.00

Practitioner Pre-assessment Form $20.00

Case Conferences

These will be paid as per the telephone consultation fees. Individual consideration will apply if travel outside the practitioner's community is required.

The physician should bill the adjuster for the call.

Request for Information
Telephone Consultation:
0 to 10 minutes..... $20.00
10 to 15 minutes..... $38.50
Each subsequent 15 minutes (917A) $38.50

Photocopy of Report/Consult..... 810A/512A, page A2
Form or brief .....529A, page A4
Written letter - factual statement of patient's condition .....535A, page A4
Medical-legal report .....563A, page A4
Medical-legal opinion .....564A, page A4

If preparation of the report for 563A or 564A requires more than one hour's time, payment for additional time is based on 917A.

SGI officials are instructed to be very specific in their requests for reports and to indicate which code will be paid. If the fee submitted exceeds the code indicated, the physician may be asked for an explanation.

Follow-up reports should be submitted directly to SGI and only on request from an SGI official. Lawyers may obtain information from SGI.

Submit to: Saskatchewan Government Insurance
2260 - 11th Avenue
Regina, SK S4P 0J9

SGI Medical Review Unit (former SGI Driver Fitness Review)
Note: SGI will also reimburse physicians for requested drivers' medicals. See Section A3.

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

G. RCMP PERSONNEL (Effective April 1, 1987)

RCMP Health Services pays at SMA Guide to Fees listed rates. The fee includes reporting the relevant clinical findings on the form which becomes part of the officer's medical file. Submit on RCMP Form 2135, Clinical Report and Account Form to:

Submit to: RCMP Health Services
Box 6500
Regina, SK S4P 3J7

Telephone: 306-780-3836

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

H. VETERANS AFFAIRS CANADA

DVA has declared that it will pay at Medical Services Branch Payment Schedule rates.

Medical reports provided by a patient in support of a request for a benefit can be reimbursed at the following rates if supported by a receipt/invoice from the physician.

Source and Form of Information

Prescription only with no or only minor explanation, e.g. medication required for lower back pain ..... Nil

Phone call with physician's office (not physician) to obtain information ..... Nil

Phone conversation with physician.....$10.00 per call
- information provided verbally to support a request for Special Authorization payment of a drug or details provided regarding the drug utilization pattern of a client.

Completion of a VAC form $30.00
- information provided in writing on a VAC supplied form to support a request for Special authorization payment of a drug or details provided regarding the drug utilization pattern of a client.

1st page of original report by a General Practitioner $30.00
- information provided "in writing" to support a request for Special Authorization payment of a drug or for details provided regarding the drug utilization pattern of a client.

1st page of original report by a Specialist $50.00
- information provided "in writing" to support a request for Special Authorization payment of a drug or for details provided regarding the drug utilization pattern of a client.

Subsequent pages of original report by a GP or Specialist..... $20.00
- information provided "in writing" to support a request for Special Authorization payment of a drug or for details provided regarding the drug utilization pattern of a client.

Photocopied information $15.00
- copy of physician's note or report to / from a third party. This is provided to support a request for Special Authorization payment of a drug or details provided regarding the drug utilization pattern of a client.

Renewal of prescription by telephone (when fee not covered by province) $5.00
Physician call to request authorization for special authorization benefits

DVA beneficiaries are only those veterans who have been declared eligible for a pension related to a specified disability.

If there is any reason to believe that a veteran has been declared eligible, submit to DVA on the Saskatchewan

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

Blue Cross form provided in your supplier kit.

If the form is inadvertently sent to DVA and they are not responsible for the claim, they will forward it on to MSB rather than return it to you. If MSB receives a claim that is DVA responsibility, they will return it to you.

If you want to register as a supplier or if you require billing forms, please contact Saskatchewan Blue Cross at 1-800-301-6102, or in Saskatoon at 306-244-5839.

Submit to: Veterans Affairs Canada
PO Box 6050
Winnipeg, MB R3C 4G5

Telephone: 1-866-522-2122

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

I. CANADIAN FORCES

The Canadian Forces have declared that they will pay only at Medical Services Branch Payment Schedules rates.

Claims administration is handled through Saskatchewan Blue Cross, similar to the processes used for DVA claims. If you require billing forms or further information, please contact Saskatchewan Blue Cross directly at:

Saskatchewan Blue Cross
P.O. Box 4030
Saskatoon, SK S7K 3T2

Telephone
Toll-free: 1-800-301-6102
Saskatoon: 306-244-5839

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

J. CANADA POST

550A Physician's Modified Work Information Sheet .....Use 529A

Submit to:

Manulife Financial
2220 Laurier Avenue West, Suite 400
Ottawa, ON K1P 5Z9

SECTION A2:
THIRD PARTY SERVICES AT RATES NEGOTIATED WITH THE SASKATCHEWAN MEDICAL ASSOCIATION

K. CANADA PENSION PLAN (effective August 1, 2010)

CPP Disability Medical Report Form - The fee for completing the CPP Disability Form is a set fee. Completion of this six page form is paid at $85.00 (effective August 1, 2010). The level of the fee was set by CPP, based on a 40-minute estimated completion time.

The Federal government has recently issued a new guideline to assist physicians in responding to a specific request from CPP to provide a narrative report in regard to a patient's claim for disability benefits. The guideline allows for payment up to a maximum of $150.00 for these reports. The following scale provided by CPP is intended to assist physicians in determining the appropriate fee.

Billing for Medical Reports

Submit invoices for services to CPP. Upon receipt of your invoice, CPP will reimburse you:

553A Initial Medical Report ..... up to $85.00

554A Reassessment Medical Report..... up to $25.00

555A "Scanable Impairment Evaluation" and for the "Medical Report – Recurrence of the Same Medical Problem" (ISP2525) .....up to $50.00 each

552A A very complete and detailed narrative report that involves more extensive chart review and medical report preparation ..... up to $150.00

Note:

- CPP has indicated that a faster payment will result if you note on your bill the time required to comply with this request.
- Physicians may still charge their patients for the difference between the CPP payment rate and the physician's normal charge for a similar service. (See codes 527A/535A)
- Submit the bill to the patient who is expected to forward it to Health and Welfare Canada along with your report.
- Occasionally, CPP requests independent medical consultations or functional capacity evaluations during the application process, or to determine continuing eligibility. CPP pays the specialist or facility directly for these examinations.
- Fees mentioned in this section are set in consultation with the Canadian Medical Association and are subject to change.

SECTION A.3
THIRD PARTY SERVICES PAID BY THE MEDICAL SERVICES BRANCH

SGI Medical Review Unit (former SGI Driver Fitness Review)

*The services paid for listed on this page are paid by M.S.B. on an agency basis for SGI. These codes are not eligible for any additional charges, (i.e.) premium(s) or surcharges.

		GP	Specialist
70A	Telephone call from an SGI Driver Medical Review Unit or Manager, requesting the physician's clarification of a medical condition and affect on the patient's ability to operate a motor vehicle All calls must be recorded on the patient's file chart, including the name of the SGI representative.	$30.00 *	$30.00
71A	Written letter or facsimilie requested by an SGI Driver Medical Review Unit or manager, requesting a brief factual statement of the patient's medical condition and effect on the patient's ability to operate a motor vehicle • All reports must be retained in the patient's file. • SGI Requested Seizure Follow-up forms are also billable under 71A.	$55.00 *	$55.00
74A	Examination and Report requested by the SGI Driver Medical Review Unit requesting the physicians's assessment of the patient's ability to operate a motor vehicle . The following forms are billable under this code only: • SGI Requested Driver's License Medical Report • Cognitive Assessment Report • Driver's Psychiatric Examination Report (specialists only) • Report of Visual Functions (ophthalmologists only)	$75.00 *	$140.00

*No additional fee is paid for lab services required for 74A with the exception of 131A.

A visit provided on the same day as a 74A is paid by report.

74A includes services described in 70A or 71A.

70A, 71A and 74A are not payable for commercial license renewal.

GENERAL SERVICES

		Fee
	Procedures	
	Additional payments for diagnostic service excluding ECG's, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement for Procedural Fees.	
20A	Report requested by Saskatchewan Social Services to determine employability, rehabilitation potential, level of care, or other specified reason. The 20A and other associated visits and laboratory codes should be submitted with a diagnostic code of Z90 (Examination - Third Party Request from Saskatchewan Social Services) This code is locked with 20A in the Payment Schedule.	$31.50 *
37A	Examination and Report required for adoption -- child or parent or for a person becoming a foster parent -- a diagnostic code of V70 must be used	$129.00
39A	Rape victim (suspected or actual) -- includes medical history, examination, counselling, all medical documentation and initial treatment	$952.00 *
40A	Child abuse victim (suspected or actual) -- includes medical history, history of abuse obtained from social worker, police, parents or other individuals, examination, investigation and referral as necessary, counselling and treatment, medical documentation of findings and management	$630.00 *
	Foetal Alcohol Spectrum Disorder Assessment	
41A	FASD assessment and diagnosis -- per 15 minutes or major portion -- (max of 12 units per patient)	$83.40 *
	Clinical evaluation of the patient, review of information and consultation with other providers (verbal and written) for the purpose of Foetal Alcohol Spectrum Disorder (FASD) - assessment and diagnosis.	
	Includes a review of: -- birth and prenatal history; -- medical and surgical histories, including psychiatric and psychological reports; -- detailed family history focusing on genetic conditions which cause brain dysfunction; -- social history, including any social services records, pre-sentence reports, risk assessments, etc.	
	Limited to physicians with appropriate training and expertise in FASD assessment, including: -- geneticists with expertise in diagnosing birth defects; -- developmental paediatricians; -- any physician with training from a recognized training centre for FASD diagnosis (examples University of Washington, Seattle Washington; Lakeland Centre for Foetal Alcohol Syndrome, Cold lake Alberta; and the Motherisk Centre, Toronto).	

		Fee
	The physician should keep appropriate documentation of time and place. Physicians who intend to provide this service should apply to the SMA Tariff Committee to be considered eligible to bill MSB for this service. (This code is not to be used for third party uninsured requests for assessment such as requests from Saskatchewan Justice and others).	
56A	Report requested by Cancer Agency or Cancer Screening Program The following 4 forms are covered under this fee code: 1) Saskatchewan Cancer Agency request for follow-up of registered cancer patient - must be billed with a diagnositic code from 140 to 234 2) Program for the Prevention of Cervical Cancer - must be billed with diagnostic code Z52 3) Screening Program for Breast Cancer - must be billed with diagnostic code Z51 4) Colorectal Cancer Screening Program - must be billed with diagnostic code Z53	$27.00 *
60A	Required physician reporting forms The following form is covered under this fee code: 1) Physician Reporting Form for West Nile cases - must be billed with diagnostic code 066	$26.40
	Exceptional Drug Status	
153A	Multiple Sclerosis - payment for the completion and submission of the initial and yearly documentation required by the Saskatchewan Drug Program (SDP) to determine eligibility for Exceptional Drug Status (EDS) in the treatment of Multiple Sclerosis. Only one fee is payable every twelve months. Applicable visit fees may be submitted concurrently	$60.80 *
154A	Alzheimers Disease - payment for the completion and submission of the initial documentation required by the SDP to determine eligibility for Exceptional Drug Status (EDS) in the treatment of Alzheimers Disease. Follow-up status reports required by the Drug Program can be done by phone or fax and are billable using code 155A. Application visit fees may be submitted concurrently	$60.80 *
155A	Alzheimers Disease - follow-up status reports required by the SDP by phone or fax. Applicable visit fees may be submitted concurrently	$24.20 *
156A	Anklosing Spondylitis - payment for the completion and submission of the initial and renewal application form required by the Saskatchewan Drug Plan (SDP)	$60.80 *

		Fee
	to determine eligibility for Exceptional Drug Status (EDS) in the treatment of Ankylosing Spondylitis. Only one fee is payable every twelve months. Applicable visit fee may be submitted concurrently	
	Third party counselling for the provision of Medical Assistance in Dying (MAID) services provided by a willing practitioner 1. Billable on a third party basis when a family member, caregiver, relative, friend, spouse, etc is counselled because of the patient's request for Medical Assistance in Dying (MAID) services. 2. Third party counselling is billable to a maximum of 3 hours per day per patient. More than 3 hours is billable by report with a comment on the electronic claim with the total duration of time spent. 3. Third party counselling claims should be submitted in the name of the patient requesting MAID services (not the family member, relative, caregiver, etc). 4. Diagnosis must be Z37 (third party counselling, MAID). 5. May be billed by any physician. 6. Surcharges are not payable (815A-839A). 7. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.	
80A	Third Party Counselling – first 15 minutes, includes a) History review; d) Intervention; b) Counselling; e) Record of service provided c) Educational dialogue; f) Time spent counselling	$75.00
81A	Third Party Counselling – next 15 minutes or major portion thereof	$75.00
	Specified Forms	
752A	SSCN prioritization form completion and submission to SSCN	$23.40 *
753A	Physician completion and submission of an application filed with the court under the *Mandatory Testing and Disclosure (Bodily Substances) Act* - by report	$32.00 *
909A	Initiating protocol for the discontinuance of life-support systems following certification of brain death	$61.80 *
100A	Collection of blood from donor for transfusion	$32.60 *
101A	Phlebotomy for therapeutic reason e.g. polycythemia	$32.60 *
107A	Insertion of IV by physician where a nurse or health care worker is unavailable or unable to start the IV - if procedure is longer than 15 minutes, bill as 918A with explanation	$45.00 *
108A	Venipuncture - peripheral or central (jugular) for blood collection or phlebotomy by physician where a nurse or health care worker is unavailable or unable to perform the task	$45.00 *
	Injections -- medication extra	
110A	-- intramuscular or subcutaneous - (included in visit)	$32.60 *
111A	-- direct intravenous injection of medication (Not for	$32.60 *

		Fee
	injection into IV tubing nor for initiation if IV)	
112A	-- arterial puncture	$32.60 *
113A	Hyposensitization injections -- each -- included in visit maximum 3 units per session -- up to 9 units per session for venom desensitization	$13.90 *
114A	IVP/IVC injection when performed in the absence of a radiologist	$32.60 *
115A	Aspiration and/or injection of ganglion	$59.60 *
116A	Insertion of subcutaneous contraceptive implant	$91.80 *
117A	Removal of subcutaneous contraceptive implant	$125.00 *
118A	Pessary -- Initial fitting or review	$44.00 *
	Bladder catheterization	
120A	-- urethral	$13.90 *
121A	-- other than urethral	$21.00 *
122A	Peritoneal lavage	$210.00 *
123A	Insertion of I.U.D.	$102.00 *
125A	Paracentesis or diagnostic tap -- thorax or abdomen	$153.00 *
126A	Pericardial aspiration - by any method (17 years of age and older)	$336.00 *
130A	Pericardial aspiration - by any method (under 17 years of age)	$314.00 *
127A	Lumbar puncture	$126.00 *
128A	Gastric lavage	$38.50 *
129A	Percutaneous manipulations of gallstone(s)	$504.00 *
131A	Submission of Papanicolau smear (females only)	$40.00 *
132A	Relief of faecal impaction -- under general anaesthetic	$147.70 *
133A	Pleural punch biopsy -- with or without thoracentesis	$77.00 *
134A	Insertion of central venous catheter	$124.00 *
135A	Insertion of central venous catheter in infant	$248.00 *
136A	-- under general anaesthesia or IV sedation (includes post-op recovery)	$326.40 *
	Insertion of arterial line for measurement of systemic pressures - unilateral or bilateral	
140A	-- adult	$79.80 *
141A	-- child	$248.00 *
137A	Anoscopy	$15.50
150A	Physiotherapy procedures including heat or light lamps, traction -- per treatment	$8.60 *
925A	Intravenous chemotherapy or remicade treatment treatment	$40.70 *
	Communicable disease service	
160A	-- diagnostic skin tests (e.g. Schick	$6.40 *

		Fee
	test; Dick test) -- each	
161A	-- immunization -- per injection (included in visit)	$32.60 *
162A	-- vaccination and reading	$32.60 *
	Allergy Diagnosis (Testing)	
170A	Scratch test (inhalant-ingestant) - each -- maximum 35 units per annum	$4.30 *
	Patch test (contact dermatoses)	
171A	-- each -- maximum 50 units per annum	$6.40 *
	Intradermal test	
172A	-- each -- maximum 20 units per annum	$7.80 *
	Test for phototoxic or photoallergic reaction under controlled ultraviolet light source (e.g. hot quartz mercury vapor lamp or Wood's Blak-Ray light)	
173A	-- each -- maximum 30 units per annum	$8.40 *
174A	Allergy Challenge--patient challenged with an antigen in a graded fashion (repeated spirometry 600D-603D or 610D to 613D can be billed maximum 3 tests) (per complete 15 minute period)	$43.00
	For hyposensitization -- See service code 113A	
	Total Parenteral Nutrition When provided by other than the attending physician or surgeon **Note**: This service is included in visit/hospital care when provided by the attending physician or surgeon	
182A	-- consultation and initial set up including CVP line	$270.70 *
183A	-- subsequent care per day	$31.00 *
184A	-- outpatient TPN supervision not payable with visit (max 2 per week)	$31.40 *
	Botox Injections Botox fees below are intended for use in the relief of symptoms resulting from dystonias and other neuromuscular spasticity problems and hyhidrosis.	
	Entitlement to bill botulinum toxin injection codes is limited to Ophthalmologists, Otolaryngologists, Orthopaedic Surgeons, Physiatrists, Internists, Neurologists, Plastic Surgeons, General Surgeons, Urologists, Gynaecologists, Anaesthetists and Dermatologists. Others with appropriate training experience may apply to the Saskatchewan Medical Association Tariff Committee for entitlement.	

GENERAL SERVICES

		Fee
	Only one code from the Botox schedule is billable per patient contact. Botox injections include any EMG control and additional injections within 42 days.	
190A	Blepharospasm	$379.00
191A	Hemifacial spasm	$379.00
192A	Extraocular muscle(s) for strabismus or spastic dysphonia -- one or more muscles -- unilateral or bilateral (previously 473S)	$458.00
193A	Multiple muscle -- bilateral	$504.00
194A	Multiple muscle -- unilateral	$380.00
195A	Single muscle -- bilateral	$189.00
196A	Single muscle -- unilateral	$126.00
197A	Rectal spasm, anal fissure	$127.00
	Endoscopy for achalasia etc. -- see endoscopic codes - Section L.	
198A	Hyperhidrosis -- per side (left or right armpit) - to intiate billing, two physicians must have diagnosed the patient with hyperhidrosis (e.g. referring physician and consultant, or two family physicians with the second physician confirming the diagnosis)	$230.00
199A	Botox Injection of Detrusor Muscle via cystoscopy for neurogenic or non-neurogenic overactive bladder	$379.00
	Specimen collection and referral -- to be sent for a special test, when it is the only charge made	
	Urine	
204A	Collection and referral of specimen(s)	$11.40 *
	Blood	
205A	Collection and referral of specimen(s)	$11.40 *
	Other	
206A	Collection and referral of specimen(s)	$11.40 *
	Bone Marrow	
207A	-- aspiration	$97.40 *
208A	-- aspiration and needle biopsy	$152.00 *
209A	-- interpretation	$64.20 *
210A	Examination of blood smear and written clinical report -- by internist or paediatrician with special training in haematology	$40.10
	Cardiac Catheterization	
300A	-- right heart catheterization - to include catheter insertion and any or all of RA, RV, PA, and PAW pressures. Not to be billed during a routine coronary angiogram	$295.30 *
303A	-- left -- retrograde includes catheter insertion and LV and AO pressures	$344.50 *
304A	-- transeptal	$380.90 *
306A	Transvenous endocardial biopsy (right or left) -- independent procedure	$673.00
307A	-- when done in conjunction with any	$204.00

GENERAL SERVICES

		Fee
	catheterization procedure, add	
310A	Dye and/or thermodilution curve studies includes all curves obtained from a patient regardless of method	$190.50 *
311A	Oximetry	$190.50 *
312A	HIS bundle electrocardiography -- sinus node recovery time	$295.30
612A	Complete electrophysiological cardiac studies with drug intervention	$843.20
613A	Endocardial mapping	$541.40
614A	Intracardiac electrocardiography and/or atrial pacing	$215.10
316A	Insertion and measurements with Swan Ganz Catheter - to include all pressures, dye or thermodilution curves, recordings and interpretation	$319.90

Echocardiography

Echocardiography is an insured service when it is provided by a physician who is listed by the College of Physicians and Surgeons of Saskatchewan as having qualified to receive payment. Technical service is only billed if the physician owns the instrument. Multiple echocardiograms on a patient, except Doppler studies for patients under 17 years of age, by same physician or clinic within a period of one year are paid at a reduced rate. The first interpretation is paid at 100%: the second at 50%; third and fourth at 25%, and for the remainder no fee is payable. The technical fees are paid at 100%. The first echo of any type performed starts the series for that patient. Subsequent echos of any type are billed at the reduced rates. Although the physician may not be present for the entire exam, it is expected that he/she will be readily available when tests are being done. Serial Echocardiograms provided to patients receiving cardio-toxic onocology medications at the request of the Cancer Agency will be considered for payment at 100% for the first test in that 12 month period and each additional exam by report at 100%.

Example:

Apr. 30, 2004 Interpretation of M Mode & 2 dimensional echocardiogram - claim 321A.

May 15, 2004 Interpretation of M Mode & 2 dimensional echocardiogram - claim 521A.

July 12, 2004 Interpretation of M Mode, 2 dimensional & doppler echocardiogram - claim 533A.

Feb. 2, 2005 Technical & interpretation of M Mode & 2 dimensional echocardiogram - claim 530A and 531A.

March 6, 2005 Interpretation of M Mode & 2 dimensional echocardiogram - No fee payable.

May 4, 2005 Interpretation of M Mode & 2 dimensional echocardiogram (start of new series) - claim 321A.

	M Mode and Two - Dimensional same day	
320A	-- technical (first)	$154.10
520A	-- technical (second)	$107.00
530A	-- technical (third and fourth, each)	$107.00
321A	-- interpretation (first)	$160.50
521A	-- interpretation (second)	$80.30
531A	-- interpretation (third and fourth, each)	$39.60
	Doppler study, including M Mode plus two-dimensional studies on same day	
322A	-- technical (first) -- 17 years of age and older	$196.90
522A	-- technical (second) -- 17 years of age and older	$154.00
532A	-- technical (third and fourth, each) -- 17 years of	$154.00

		Fee
	age and older	
556A	-- technical -- under 17 years	$154.00
323A	-- interpretation (first) -- adult	$258.90
523A	-- interpretation (second) -- 17 years of age and older	$154.00
533A	-- interpretation (third and fourth, each) -- 17 years of age and older	$110.00
557A	-- interpretation -- under 17 years of age	$220.00
535A	-- technical for serial echocardiograms of patients receiving cardiotoxic oncology medication (second and subsequent)	$154.00
536A	-- interpretation for serial echocardiograms of patients receiving cardiotoxic oncology medication (second and subsequent)	$220.00
	Transoesophageal echocardiogram - to include insertion of transducer and interpretation. Within one year at same office or institution. The first and second transoesophageal echoes are paid at 100%, the third is paid at 25% and for remainder no fee can be charged.	
324A	-- first and second	$336.00
534A	-- third	$84.00
	Codes 443A to 447A, 545A, 548A and 648A are not for use by Radiologists - see Section X.	
	Angiography	
443A	-- angiocardiography -- right and/or left side	$258.90 *
444A	-- extremities, percutaneous -- unilateral	$198.00 *
	Aortography	
445A	-- any method when sole procedure	$301.70 *
446A	-- with selective catheterization of each additional artery to a maximum of 3, add	$44.90 *
545A	--when done as part of 447A and/or 443A or 145C, add	$138.00 *
	Coronary Angiography to include right	
447A	and left coronaries	$461.20 *
548A	-- with selective catheterization of venous and/or arterial bypass grafts each to a maximum of 3, add	$163.00 *
648A	-- with ergonovine stimulation, add	$160.50 *
	Clinical procedures listed below associated with diagnostic radiology may be charged in addition to those listed in Section X.	
331A	Intracoronary thrombolytic therapy	$1,409.20
	Transluminal angioplasty	
328A	-- coronary	$1,132.10
329A	-- each additional stenosis (maximum one per arterial branch)	$572.50
330A	-- peripheral	$469.00
332A	-- pulmonary valve or artery	$1,125.60

GENERAL SERVICES

		Fee
333A	-- pulmonary valve or artery where followed by corrective surgery within 24 hours	$572.50
334A	-- Aorta or aortic valve	$1,125.60
335A	-- insertion of coronary artery stent(s) associated with 328A (any number), add	$440.80
336A	-- subclavian artery	$479.00

Note: Post-angioplasty care for elective procedures (328A, 329A, 334A and 493A) is included in the payment for these procedures.

Procedures under fluoroscopic, C.T. or Ultrasound guidance are found in Section X.

Procedures under fluoroscopic, C.T. or Ultrasonic guidance

406A	Percutaneous nephrostomy with nephrogram	$628.00
407A	Manipulation of peritoneal dialysis catheter	$114.00 *
460A	Non-palpable breast lesion - needle localization provided by surgeon	$104.00 *
412A	Percutaneous fallopian tube cannulation and dilatation -- with selective salpingography, unilateral or bilateral	$255.00
463A	Injection of a sinus tract	$107.00
403A	Percutaneous intra-abdominal drainage	$384.00
462A	Sialography	$129.00 *
661A	Percutaneous insertion of pleural catheter for closed chest drainage	$182.00

Continuous Personal Attendance

The benefit payment is all inclusive, for medically required personal attendance given continuously by a physician, where no other item in the SMA Fee Guide applies. Certain procedures can be billed during a period of 918A, 926A-928A, 220A-226A in the same manner as they can be billed during a period of 335H-339H. (For example if closed chest drainage takes 15 minutes, code 95L can be billed but that 15 minutes should not also be billed as a 918A).

These codes infer that a physician is continually present at a patient's bedside.

Code 918A is not paid for maternity cases.

For intensive care in ICU or CCU -- see Section H.

For a claim to be processed, the physician must provide details of:
I) the clinical condition neccesitating continuous attendance;
ii) the treatment or care provided;
iii) time when continuous attendance on patient started and was completed.

May be billed with applicable surcharge where appropriate.

918A	Continuous personal attendance -- per 1/4 hour or major portion thereof (see requirements above)	$86.20

Indirect Patient Care = Emergency Situations = Emergency Department

		Fee
	This payment is for emergency situations in emergency departments where physician time is spent exclusively on any of the following aspects of patient care: (i) arranging hospital admission or transfer of the patient to another acute care facility (ii) arranging laboratory and diagnostic imaging services (iii) arranging the patient's surgical team (iv) coordinating acillary medical staff This code is billable on the same day as countinous personal attendance (918A) and emergency resuscitation codes (220A-226A), provided that the time periods do not overlap. It is also billable following minor assessments, major assessments and consultations. The physician cannot bill for other work during the same time as this service is being billed. This code may only be billed by general practitioners. For a claim to be processed, the physician must provide details of: (i) the patient's clinical condition (ii) the type of care being arranged (iii) the time when indirect patient care was started and was completed May be submitted with appropriate surcharge where applicable	
919A	Indirect patient care -- per 15 minutes or major portion thereof (see reporting requirements above)	$61.20

Physicians accompanying a patient on transfer by ambulance from one locale to another

These service codes are all inclusive, for medically required attendance during patient transfer by ambulance. Certain procedures can be billed during a period of 926A-928A in the same manner as they can be billed during a period of 335H-339H (see Section H). (For example if closed chest drainage takes 15 minutes, code 95L can be billed but that 15 minutes should not also be billed as a 926A or 927A). It may be billed with the apropriate emergency or special call surcharge.

For a claim to be processed, the physician must provide details of:
(i) the clinical condition necessitating continuous attendance
(ii) the treatment or care provided
(iii) time when continuous attendance on patient started and was completed

926A	Outbound journey with patient only -- per 15 minutes or major portion thereof	$98.00
927A	Homeward or return journey with or without patient -- per 15 minutes or major portion thereof	$56.20
928A	Standby at destination while patient is transferred to receiving physician (max of 4 units) -- per 15 minutes or major portion thereof	$63.00 *
725A	**Hospital discharge & documentation** (payable once per discharge of formally admitted hospital in-patients to the physician responsible for discharging patient -- must be a location of service 2 and billed on the date of discharge from the hospital)	$25.00 *

Emergency Resuscitation - "Code" Situations

Life Threatening Emergency Situation - Being in constant attendance for the

		Fee
	time billed to provide resuscitation in an emergency situation (cardiac arrest, multiple systems major trauma, cardio respiratory failure, resuscitation of newborn, severe shock, coma). The specific elements are those of an assessment, including immediate crisis related examination, on going monitoring of the patient's condition and the usual resuscitative procedures as required: defibrillation, cardioversion, cutdowns, intravenous lines, arterial and/or venous catheters, pressure infusion sets and pharmacological agents, urinary catheters, CVP lines, blood gases, nasogastric tubes, endotracheal intubation and tracheal toilet. Time is to be measured as the period of constant attendance excluding time required for any separately billable intervention (service). If a physician starts billing codes 220A to 223A, the resuscitation should finish with this series of codes.	
	Amount payable per physician per **life threatening emergency** situation for the first two physicians for which a claim is submitted and paid	
220A	- first 15 minutes	$204.00
221A	- second 15 minutes	$102.00
222A	- after first 30 minutes (per 15 minutes or major portion thereof)	$92.60
223A	Amount payable per physician per life threatening emergency for third and subsequent physicians for which a claim is submitted and paid -- per 15 minutes or major portion thereof	$92.60
	Other Resuscitation - is different from Life Threatening Emergency Situation only in that it applies to providing resuscitation in emergency situations other than listed above and only includes the following resuscitative procedures: cutdowns, intravenous lines, arterial and/or venous catheters pressure infusion sets and pharmacological agents, urinary catheters, CVP lines, blood gases, nasogastric tubes, with or without lavage, and tracheal toilet. Time is to be measured as the period of constant attendance excluding time required for any separately billable intervention (service). If a physician starts billing codes 224A to 226A, the resuscitation should finish with this series of codes.	
	Amount payable per physician per **Other Resuscitation** for the first two physicians for which a claim is submitted and paid	
224A	- first 15 minutes	$102.00
225A	- after first 15 minutes (per 15 minutes or major major portion thereof)	$92.60
226A	Amount payable per physician per other resuscitation for the third and subsequent physicians for which a claim is submitted and paid -- per 15 minutes or major portion thereof	$92.60
	Consultation or assessment rendered before or after provision of resuscitative care or neonatal intensive care may be claimed on a fee-for-service basis but not when claiming Intensive (Critical, Ventilatory or Comprehensive) Care per diem fees. When claiming Critical, Ventilatory, or Comprehensive Care per diem fees, no other Intensive Care codes may be claimed by the same physician(s).	
	SPECIAL CALL SERVICES AND SURCHARGES	

SECTION A.4:

GENERAL SERVICES

Fee

A. Preamble

I. Payment for a special call will be made only if the call is initiated by the patient, or someone other than the physician, on the patient's behalf.

II. Special call payments are claimable for where a physician attends a patient on a priority basis, and the visit causes a degree of disruption of work or of out of hours activity, and travel (except in the case of additional patients seen). When more than one patient is attended,

the surcharge for "additional patient" would apply. Please note - you cannot bill for additional patients seen from 8 a.m. to 5 p.m. weekdays. Payment for a special call does not apply where a physician is specially called to another location in the hospital when he is already in the building.

Surcharges may apply to a service at
a) the patient's home;
b) hospital out-patient or emergency department;
c) Special Care Home;
d) physician's office when the physician is called back from some other place;
e) other locations.

III. Payment will be made for the examination and/or procedure provided plus the appropriate surcharge.

IV. Where a surcharge is billed in connection with a major surgical procedure, fracture, dislocation or delivery, one surcharge is billable per case per physician.

V. Special call services are categorized by time of day.

VI. "Weekend" refers to the period from 5:00 p.m. on Friday to midnight on Sunday. "Statutory Holiday" refers to the entire 24 hour period of the specific day.

VII. The statutory holidays in each year are: January 1, Good Friday, Family Day (3rd Monday in February), Victoria Day, July 1, first Monday in August, Labour Day, Thanksgiving Day, Remembrance Day, Christmas and Boxing Day. If any of these days fall on Saturday or Sunday, they will be observed as stated in the Physician's Newsletter.

B. Special Calls

I. Weekdays

815A	Surcharge -- 8 a.m. to 5 p.m.	$77.40 *
817A	Surcharge -- first patient seen -- 5 p.m. to midnight **(Monday - Thursday)**	$113.00 *
837A	Surcharge -- each additional patient seen -- 5 p.m. to midnight **(Monday - Thursday)**	$56.00 *
819A	Surcharge -- first patient seen -- Midnight to 8 a.m.	$264.00 *
839A	Surcharge -- each additional patient seen -- Midnight to 8 a.m.	$76.00 *

II. Weekends and Statutory Holidays (or designated days)

816A	Surcharge -- first patient seen -- 8 a.m. to 5 p.m.	$102.00 *
836A	Surcharge -- each additional patient seen -- 8 a.m. to 5 p.m.	$51.00 *
818A	Surcharge -- first patient seen -- 5 p.m. to Midnight **(Friday to Sunday)**	$138.00 *

		Fee
838A	Surcharge -- each additional patient seen -- 5 p.m. to Midnight **(Friday to Sunday)**	$68.80 *
819A	Surcharge -- first patient seen -- Midnight to 8 a.m.	$264.00 *
839A	Surcharge -- each additional patient seen - Midnight to 8 a.m.	$76.00 *

III. Emergency -- day or night -- any day

721A -- Surcharge, in addition to payment for an appropriate assessment and/or procedure — $178.00 *

This surcharge is payable where a physician travels to respond immediately to a stat call involving a life-threatening situation, provides immediate care and arranges for the patient's emergency admission as a hospital in-patient.

On occasions where the factors in bold type pertain except that emergency admission to hospital is not required, e.g. hypoglycemic shock, the physician is expected to provide an explanation for billing this service code.

Note: Surcharge 721A is not payable when the patient is already hospitalized. Surcharge is not payable in addition to other surcharges.

C. Surcharges are NOT billed in the following circumstances:

(a) Where by prior arrangement, a patient may go to the out-patient department of a hospital, in lieu of an office visit;
(b) Special call initiated by the physician (except the house call surcharges 615A or 915A);
(c) With another surcharge: 615A, 700A, 701A, 721A, 815A, 816A, 817A, 818A, 819A, 836A, 837A, 838A, 839A, or 915A.
(d) With codes 41A, 80A, 81A, 153A-155A, 184A, 190A-199A, 600A, 626A, 680A, 681A, 708A-718A, 725A, 726A, 727A, 753A, 761A-769A, 790A-795A, 770A, 52B-53B, 57B, 60B-62B, 64B-68B, 200B, 205B, 206B, 207B, 30D, 31D, 32D, 130D, 131D, 145D, 278D, 279D, 281D-291D, 320D, 43E, 400H-424H, 667H, 80J, 81J, 278K, 279K, 31M, 260P and 300T. These codes include all services rendered as well as any travel;
(e) With hospital day care items, e.g. 25 to 28 section B to T, 35B;
(f) With emergency medicine visits (73B & 85B);
(g) SGI Medical Driver Fitness and Review (codes 70A to 74A);
(h) Extra patient surcharges are not billed with codes 335H to 339H. Initial patient surcharges billed only once per patient per day.

Statutory Holiday Hospital Care Surcharge

700A Premium payable for hospital care visit (25 to 28 B to T) or new born care visit (30, 31, 32 B or C) made on a statutory holiday (day in lieu if stat is weekend). — $20.00 *

Bill as 700A in addition to the hospital care day code. The 700A should be billed at the same time as the hospital care visit.

701A **Saturday and Sunday Hospital Care Surcharge** — $20.00

This charge is payable when a hospital care visit (25 to 28 B to T; 35B) is made on a Saturday or Sunday. Billed in addition to the hospital care visit, it should be billed at the same time as the hospital care visit.

House Calls - Not Specially Called - Surcharges

GENERAL SERVICES

		Fee
615A	House Call -- follow-up visit, not specially called - surcharge	$46.20 *
915A	House Call -- home care of cancer patient registered by the Saskatchewan Cancer Foundation - surcharge	$46.20 *

Payment will be made for the examination and/or procedure provided plus either of the surcharges 615A or 915A. Per “Documentation Requirements for the Purposes of Billing” the time and location of service must be documented in the medical record.

The intent of payment under surcharge codes 615A and 915A is for a visit to a patient at home (not special care or nursing homes), where the visit is not initiated by the patient but where the physician judges that a visit is required, e.g. a follow-up visit for a condition seen previously, or a periodic visit for a chronic condition as in the case of a house-bound patient.

Routine Nursing Home Visit
The fee is for a visit to a long term care facility on a routine basis to evaluate the patient's condition and to provide advice as necessary to the patient and/or the nursing staff concerning the management of the patient. The physician must either see and assess the patient or review the patient's history and condition with nursing staff. The physician needs to be able to verify that the visit occurred.

626A	**Routine Nursing Home Visit**	$60.00 *

This fee is for a visit made on a routine basis to evaluate the patient's condition and to provide advice as necessary to the patient and/or the nursing staff concerning the management of the patient. The physician must either see and assess the patient or review the patient's history and condition with nursing staff. The physician needs to be able to verify that the visit occurred.

GENERAL SERVICES

Fee

Patients in:
1. Special care homes as defined in The Facility Designation Regulations for patients receiving:
a. Convalescent care
b. Long-term care or long-stay care
c. Palliative care
d. Respite Care
2. Hospitals* or health centres as defined in The Facility Designation Regulations for patients receiving:
a. Convalescent care
b. Long-term care or long-stay care
c. Palliative care
d. Respite Care
e. Level 4 care
*Community, northern, regional, provincial, rehabilitation or district as defined by The Facility Designation Regulations.
Personal Care Homes as defined in The Personal Care Homes Act remain excluded from payment under this code.
Legislation can be found at the following links:
http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/R8-2R6.pdf
http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/P6-01.pdf

Geriatric Assessment Unit

600A Payment for assessment of patients attending Geriatric Assessment/Rehabilitation Unit
Physician must be physically present to consult and review patients as necessary. Documentation required for significant change orders only -- two per patient per 7 day period. $24.20 *

Group Counselling (instruction time only)

1. Group Counselling of 5 or more patients where the objective is to provide medical expertise regarding the patients' condition, to be billed in the name of one patient.
2. Claim must include a note or comment indicating the number of patients involved and the topic.
Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times recorded.

680A -- initial 15 minutes $119.00 *
681A -- additional complete 15 minute units (to a maximum of 3 units) $119.00 *

Paediatric Age Supplement for Procedural Fees

• This supplement includes all diagnostic, 0, 10 or 42 day procedure(s) including applicable section W and X code, surgical assistant and anesthetic payment (codes 94H to 161H, 220H & 500H to 505H).
• This supplement excludes ECGS (30D, 31D, 32D).

900A Patients less than 31 days of age, add 50 percent -- maximum of $1,500
901A Patients less than 91 days of age but older than 30 days, add 25 percent -- maximum of $1,500
902 A Patients less than 1 year of age but older than 90 days, add 10 percent -- maximum of $1,000

Note: Paediatric Supplements are based on the value of the diagnostic service, 0, 10, or 42 day procedure(s), surgical assist payment and the anaesthetic payment (codes 500H to 505H only) (excluding all premiums and surcharges).

Fee

Paediatric Weight Supplement for Procedural Fees

• This supplement includes all diagnostic, 0, 10 or 42 day procedure(s) including applicable section W and X codes in the case of the attending physician; the surgical assist payment in the case of the surgical assistant; and the anesthetic payment (codes 500H to 505H only) in the case of the anesthetist.
• This supplement excludes ECGS (30D, 31D, 32D).
• You are required to submit the following codes to obtain the weight supplement:

893A Patients greater than 30 days of age, less than 91 days and less than 3kg in body weight --add 25%, maximum of $1,500
894A Patients greater than 90 days of age and less than 3kg in body weight -- add 40%, maximum of $1,500
895A Patients greater than 90 days of age and less than 6kg in body weight -- add 15%, maximum of $1,500

Note: Paediatric Weight Supplements are based on the value of the procedures listed above. In all cases time of day premiums and surcharges are excluded from the calculation of the supplement. If applicable bill as one of the above codes with the correct calculated value (amount to be paid times the appropriate percentage) and indicate the weight of the patient in a comment.

Paediatric Age Supplements for visits with patients 0 to 5 years of age

1. These supplements provide the physician with increased compensation when he provides an eligible visit service for a patient under 6 years of age.
2. Eligible visit services include codes 3 to 11 sections C to T inclusive, 3B, 4B, 5B, 9B, 11B, 15B, 73B, 85B, 38G, 39G, 14K, 15K, 12S, 9X and 10X. Other serivces are not eligible for this supplement.

896A Visit supplement for patient 2 to 5 years of age - additional 20 percent
898A Visit supplement for patients less than 2 years of age - additional 35 percent

Specialist Visit Supplement for patients 65 years of age and older

1. These supplements provide the physician with increased compensation when providing an eligible visit service for a patient 75 years or age or older.
2. Eligible visit services include codes 3__, 5__, 7__, 8__, 9__, 10__ and 11__ in sections C to T and 14K and 15K. Any other services are not eligible for this supplement.

905A Visit supplement for patients 65 to 74 years of age - additional 15 percent
906A Visit supplement for patients 75 years of age and older - additional 25 percent

Note: Specialist Age Supplements are based on the value of the visit excluding other premiums and surcharges.

OUT-OF-HOURS PREMIUMS -- (to be referred to as a premium)

1. Premiums

(a) The premium provides the physician with increased compensation when they performs most services in a non-office environment initiated between the hours of 5:00 p.m. and 7:00 a.m., weekends or on a statutory holiday.
(b) Services starting in the time period from 5:00 p.m. to midnight and 7:00 a.m. through midnight for weekends and statutory holidays qualify for a 50% premium. **Use billing code 897A.**

(c) Services starting in the time period from midnight to 7:00 a.m. (including weekends) or anytime on a statutory holiday qualify for a 100% premium. **Use billing code 899A**.

2. All services are eligible for premiums except for:
(a) hospital visits (25 to 28B to T, 700A, 52B, 53B);
(b) surcharges, e.g. 815 to 839A, 615A, 721A, 915A;
(c) emergency room coverage services, e.g. 708-718A;
(d) special care homes and nursing home code, ie. 626A;
(e) lab services;
(f) services always done in the office, e.g. 320A, 322A, 520A, 522A, 530A, 532A, 535A, 556A, 4B, 207B, 4C, 30D, 32D, 50D, 54D, 65D, 142D, 267D, 269D, 271D, 276D, 320D, 401D, 13G, 897L, 899L, 31M, 260P, 261P, 330P, 338P, 438P, 439P, 109Q, 29R, 402R, 404R, 406R, 40S, 45S, 301S, 653S, 582S, 96T, 300T, 443T.
(g) other services 41A, 65A, 70A-74A, 153A-156A, 184A, 190A-199A, 600A, 680A, 681A, 725A, 726A, 727A, 732A, 734A, 752A, 753A, 761A-769A, 790A-795A, 60B-62B, 64B-68B, 145D, 121D, 123D, 124D, 128D-132D, 278D, 279D, 281D-291D, 300D, 500D, 501D, 43E, 400H-424H, 540H, 545H, 580H, 585H, 80J, 81J, 278K, 279K, 679K, 580L, 180M, 492N-494N, 580P, 581P, 400R, 500R.

3. Services must start in the time period 5:00 p.m. to 7:00 a.m. or anytime on a weekend or statutory holiday to qualify for the premium. The time period for determining the applicability of premiums for surgical services is based on the anaesthetic start time.

4. Premium for obstetrical delivery is paid if the time of delivery falls between 5:00 p.m. and 7:00 a.m. or anytime on a weekend or statutory holiday. A premium for repair of 3rd degree and 4th degree tears is paid if the delivery qualified for out-of-hours premium.

5. The premium will apply to time units (e.g. H and J codes) extending beyond 7:00 a.m. as long as the service began within the 5:00 p.m. to 7:00 a.m. time period, or anytime on a weekend or statutory holiday.

6. A premium starting before midnight (5:00 p.m. to midnight) and running into the next day should be billed at the before midnight rate.

7. The current rates are 50% for 5:00 p.m. to midnight (including weekends and stat holidays 7:00 a.m. to 5:00 p.m.) and 100% for midnight to 7:00 a.m.

After-Hours-Clinic Premium

1. The after-hours-clinic premium provides the physician with increased compensation when he performs most services in a office location outside the hours of 7:00 a.m. And 7:00 p.m. weekdays.

2. The premium applies to scheduled or unscheduled after-hours-clinic work.

3. This premium is restricted to general practice physicians in Moose Jaw, Prince Albert, Regina, Saskatoon, Balgonie, Clavet, Dalmeny, Emerald Park, Langham, Lumsden, Martensville, Pense, Pilot Butte, Warman, White City, Lloydminister, North Battleford, Swift

Current and Yorkton.

4. The service must be provided in an office location to be eligible. Services not eligible for an after-hours-clinic premium include:
(a) hospital visits (25 to 28B to T, 35B, 700A, 52B, 53B)
(b) surcharges, e.g. 815 to 839A, 615A, 721A, 915A
(c) emergency room coverage serviced, i.e. 708A to 718A
(d) special care homes and nursing home code, i.e. 626A
(e) lab services
(f) services always done in the hospital, e.g. 184A, 600A, 725A, 726A, 727A, 732A, 734A, 121D, 123D, 124D, 128D-132D, 278D, 279D, 281D-291D, 500D, 43E, 400H-424H, 540H, 545H, 580H, 585H, 80J, 81J, 278K, 279K, 679K, 580L, 180M, 580P, 581P, 400R, 500R
(g) SGI 70A, 71A, 74A
(h) other services 57B, 60B, 61B, 62B, 763A, 764A, 765A, 767A, 768A

5. When an after-hours-clinic premium applies to these services at an office location they must be billed with a location of service of F (after-hours-clinic).

6. Effective June 1, 2011 the rate is 10% for weekdays 7:00 p.m. To 7:00 a.m., weekends and statutory holidays. For this premium "Weekend" refers to the period from 7:00 p.m. on Friday to midnight on Sunday. "Statutory Holiday" refers to the entire 24-hour period of the specific day. **Use billing code 904A**

Telephone Calls/Facsimile/E-mail

(for prescription renewals see codes 794A-795A)

Telephone call initiated by allied health care personnel to discuss patient care and management - maximum of one per patient per day (codes 790A to 795A)

Allied health care personnel includes, but is not limited to:

- -- Home care coordinators
- -- Registered and licenced practical nurses
- -- VON
- -- Public health nurses
- -- Psychiatric nurses
- -- Mental health workers
- -- Physiotherapists
- -- Occuptional therapists
- -- Respiratory Therapists
- -- Ambulance Paramedics
- -- Social workers
- -- Psychologists
- -- School teachers/counsellors
- -- Pharamacists
- -- Private care home shift supervision

- -- Physicians, optometrists, dentists and chiropractors are not considered allied health care personnel, per “Definitions”.
- -- Payment is for telephone conversations initiated by allied health care workers.
- -- All calls must be recorded on the patient's chart, including the name and professional capacity of the health care worker involved and the advice given.
- -- No claim may be made for telephone calls in which only a physician proxy, e.g. nurse or clerk, speaks with the allied health care personnel.
- -- This code is for circumstances where it's necessary for the pharmacist to discuss the care of the patient and is not for prescription renewal, clarifying illegible prescription or switching to a generic form of a drug.
- -- No claim may be made for telephone calls regarding patients in hospital receiving acute care.

Fee

-- This service is not intended to cover calls insured as part of the Emergency room coverage codes (708A to 716A in the MSB Payment Schedule).
-- This service is intended to compensate the physician for unexpected interruptions to the physician's normal practice routine.
-- Where the allied health worker requests information or advice by facsimile transmission or electronic mail, the physician may respond by telephone, fax or electronic mail and submit a claim for this request.

-- Only one of codes 790A-795A should be billed per day.

On behalf of nursing home patients

790A Phone/Fax/E-mail -- Not payable in addition to any other payment for the same date of service $25.00 *

On behalf of all other patients

791A Phone/Fax/email -- Not payable in addition to any other payment for the same date of service $25.00 *

Telephone Calls/Facsimile/E-mail on behalf of a palliative patient

This code is billable for patients designated as palliative by their Regional Health Authority or by the Saskatchewan Drug Plan.

Billing is restricted to telephone calls, facsimile or email initiated by allied health care personnel, or telephone calls from the patient's designated family representatives.

Allied health care personnel includes, but is not limited to: Home Care Coordinators; Registered and Licenced Practical Nurses; VON; Public Health Nurses; Psychiatric Nurses; Mehtal health workers; Physiotherapists; Occupational Therapists; Respiratory Therapists; Ambulance Paramedics; Social Workers; Psychologists; School Teachers/Counsellors; Pharmacists; Private care home shift supervisor.

-- Home care coordinators
-- Registered and licenced practical nurses
-- VON
-- Public health nurses
-- Psychiatric nurses
-- Mental health workers
-- Physiotherapists
-- Occuptional therapists
-- Respiratory Therapists
-- Ambulance Paramedics
-- Social workers
-- Psychologists
-- School teachers/counsellors
-- Pharamacists
-- Private care home shift supervision

Physicians, optometrists, dentists and chiropractors are not considered allied health care personnel, per “Definitions”.

No claim may be made for telephone calls in which only a physician proxy, e.g. nurse or clerk, speaks with the allied health care personnel or family members. No claim may be made for telephone calls regarding patients in hospital receiving acute care.

Where the allied health personnel requests information or advice by facsimile, e-mail, or other electronic means, the physician may respond by telephone, facsimile, e-mail, or other electronic means. Contacts from the patient's family representative are restricted to telephone calls.

All interactions must be recorded on the patient's chart, including the name and professional capacity of the allied health care personnel involved and the advice given.

This code is for circumstances where it's necessary for the pharmacist to discuss the

		Fee
	care of the patient and is not for prescription renewal, clarifying illegible prescription or switching to a generic form of a drug. A maximum of three contacts are payable per day. Codes 790A and 791A are not billiable for this patient on the day this code is billed.	
793A	Telephone calls/facsimile/e-mail on behalf of palliative patient	$40.00
	Prescription renewal by telephone call, facsimile, e-mail or other electronic means Telephone call pharmacist initiated for the purpose of refilling a prescription	
	Prescription Renewal Phone Call	
794A	Phone call -- Not payable in addition to any other payment for the same date of service	$10.00 *
	Prescription Renewal Fax/E-mail	
795A	Fax call -- Not payable in addition to any other payment for the same date of service	$10.00 *
	Remote Telephone call from Primary Health Nurse/Triage Nurse in another community	
761A	Not payable in addition to any other payment for the same date of service (max per day - 1 call per patient) Additional calls or visits will only be paid by report. Payment is restricted to telephone conversations initiated by remote primary health nurse/triage nurse seeking advice about the management of a patient **All Calls** must be recorded on the patient's chart including the name of the primary health nurse/triage nurse involved	$50.00 *
	Remote Consultations Between Physicians Major Telephone Assessment and Advice	
769A	includes: pertinent family history, patient history, history of presenting complaint, discussion with referring physician of functional enquiry and examination of all parts and systems, review of laboratory and/ or other data, diagnosis/ assessment record and written submission of the consultant's opinion and recommendations to the referring doctor, but without the consulting physician seeing the patient If the patient is subsequently seen within 42 days for care or assessment, the physician would be unable to claim for a consultation, but could claim for a complete or initial assessment, depending upon the service provided	$101.00

SECTION A.4:

GENERAL SERVICES

		Fee
	Minor Telephone Assessment and Advice	
762A	includes: history review, history of presenting complaint, discussion of patient condition/ management and advice to referring physician but without the consulting physician seeing the patient A written opinion is not necessary for this fee. However, the referring physician's name, patient Information, the diagnosis and the advice given must be recorded. Where a General Practitioner requests information or advice by facsimilie transmission or electronic mail, the Specialist may respond by telephone, fax or electronic mail and submit a claim for this service	$50.00
770A	**Monitoring Home Parenteral Antimicrobial Intravenous Therapy – by telephone** 1. Payable for management of antimicrobial agents prescribed for administration at home through parenteral home intravenous programs. 2. Only payable to specialists recognized by the College of Physicians and Surgeons of Saskatchewan as being Infectious Disease specialists (both adult and pediatric) 3. Payable once per calendar week per patient; ie: only one physician is able to bill on the same patient per week. 4. This service is not eligible for premiums or surcharges. 5. This payment stops when the active treatment protocol ends. 6. Includes: a) monitoring the condition of a patient regarding antimicrobial therapy; b) ordering blood tests; c) interpreting the results; d) inquiry into possible complications; and, e) adjusting the dosage of the antimicrobial therapy. 7. Visit services for each patient contact would be paid per usual. 8. A record of the information and the physician's advice must be included in the patient's chart.	$50.00
	Monitoring Anticoagulant Therapy	
763A	Monitoring anticoagulant therapy by telephone, per month -- monitoring the condition of a patient with respect to anticoagulant therapy, including ordering blood tests, interpreting the results, inquiry into possible complications and adjusting the dosage of the anticoagulant therapy. Max patient per month (only one physician can be paid for each month)	$26.00 *
	Management of Diabetes Monthly fees for monitoring and managing patients with insulin-dependent diabetes. Includes monitoring patient's condition, blood sugars and insulin levels; ordering and interpreting any necessary tests; adjusting insulin dosage as necessary. The fees are only payable for months during which the	

		Fee
	patient has sent information to the physician (by phone, fax, e-mail or other electronic means) that requires a change in the patient's drug or insulin therapy. The physician must review the information personally (not billable if review undertaken by nurse or diabetes educator).	
	Only one physician may bill these codes for any given patient in any one month. A record of the information and the physician's advice must be included in the patient's chart.	
764A	Patients with Type 2 Diabetes on Insulin, per month	$46.20 *
765A	Patients with Type 1 Diabetes on Insulin, per month	$92.80 *
	Patients with Type 1 Diabetes on Insulin Pump	
766A	-- first 12 months, per month	$142.00 *
767A	-- after 12 months, per month	$92.80 *
768A	Pregnant Patients with Diabetes (Type 1 or 2) on insulin, per month	$139.00 *
	Telemedicine Supplement with Direct Interactive Video Link with the Patient	
732A	Initial daily supplement for any patient attended to using an approved telemedicine video link (maximum of one per day for all patients)	$62.80 *
734A	Subsequent daily supplement for additional patients attended to using an approved telemedicine video link - Payable in addition to appropriate visit codes only. Premiums and special call surcharges do not apply to these telemedicine codes. - On site assistant may be needed to assist with the on site aspects of the assessment (examination).	$25.00 *
	Telemedicine Technical Standby	
729A	-- for each 15 minutes, or major portion thereof (max 30 minutes)	$62.80 *
	Only applies if telemedicine service is delayed or interrupted for technical reasons. - No other service can be provided or billed in this interval. - Paid by report. (Please detail the nature of the problem and its resolution). - The time is calculated from the beginning to the end of the technical delay.	
	General Practice Assistant Service. Only applies if a general practitioner is required at the referring end, to assist with essential physical assessment without which the specialist service would be ineffective.	

		Fee
	- The time is calculated from the beginning to the end of the personal attendance. - No other service can be provided or billed in this interval. - Intervals of more than 30 minutes must include an explanation.	
	General Practitioner Assistant	
728A	-- for each 15 minutes, or major portion thereof	$62.80
	Video Case Conference Must be a formal scheduled session with an approved out-of-province referral centre. A single video case conference fee billed in the name of one patient covers all the patients reviewed during that videoconference. The physician should keep appropriate documentation of time and place. Entitlement to bill video case conference codes is limited to physicians who have applied to and been granted approval by the Saskatchewan Medical Association Tariff Committee.	
726A	First 15 minutes	$105.00 *
727A	-- subsequent 15 minutes, or major portion	$72.00 *

SECTION B:

GENERAL PRACTICE

		Fee
	General Practice Visits	
	Visit age supplement for patients 55 years of age and older: 1. These supplements provide the physician with increased compensation when providing an eligible visit service for a patient over 54 years of age. 2. Eligible visit services include codes 3B, 5B, 9B, 11B and 15B. Any other services are not eligible for this supplement.	
100B	for patients 55 to 64 years of age	15 percent
101B	for patients 65 to 74 years of age	25 percent
102B	for patients 75 years of age and older	35 percent
	NOTE: General Practice Age Supplements are based on the value of the visit excluding other premiums and surcharges.	
3B	**Complete assessment** -- includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of all parts and systems, assessment, diagnosis, necessary treatment, advice to patient and record of service provided	$134.00
5B	**Partial assessment or subsequent visit** --includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), assessment, diagnosis, necessary treatment, advice to the patient and record of service provided	$70.00
4B	**Well baby care in office** -- refers to the periodic office visits during the first year of life of a healthy infant and includes the necessary weights and measurements, examination and instruction to the parent regarding health care	$72.80
8B	**Pre-natal visit** after the first visit for maternity care or post-natal office visit	$72.80
9B	**Consultation** -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$150.00
11B	-- repeat consultation A formal consultation for the same or related condition repeated within 90 days by the same physician. Repeat consultation is only to be billed when it is generated by a new formal request by the referring physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$72.80
15B	**Pre-operative assessment** -- includes: pertinent family and social history, patient history, functional enquiry, examination of all relevant parts and systems,	$133.00

		Fee
	completion of required forms and advice to the patient as necessary (payable only to physicians other than the attending surgeon) Where this service is provided by the same physician within 30 days of a complete assessment it should be billed as a partial assessment.	

Counselling

1. Counselling is where the physician engages with the patient on an individual basis, where the goal of the physician and patient is to become aware of the patient's problems or situation and of the modalities for prevention and/or treatment

2. Counselling can also include an educational dialogue with the patient regarding prevention/health promotion, early detection of health problems, environmental issues related to the patient's health and occupational health and safety.

3. It is recognized that techniques may include hypnosis.

4. Payment for this service implies that it is a discrete service provided by the physician personally.

5. It is not a substitute for a visit involving a complete or partial examination or assessment.

6. This code is not to be used simply because an assessment and/or treatment took 15 minutes or longer, such as in the case of multiple complaints

Third party counselling:

1. NOTE: Third party counselling for the provision of Medical Assistance in Dying (MAID) related services are billable under service codes 80A/81A.

2. It is payable on a third party basis when a family member is counselled because of the patient's serious and complex problem.

3. It is not payable for routine briefing or advice to relatives, which is considered part of the visit service fee.

4. Third party counselling must be provided at a booked separate appointment.

5. Third party counselling claims are subject to a maximum of 30 minutes and should be submitted in the counselled individual's name.

6. Diagnosis must be confirmed or the diagnostic code Z84 must be indicated.

7. May be billed by any physician.

40B	Counselling -- first 15 minutes, includes: a) history review; b) counselling,; c) educational dialogue; d) intervention; e) record of service provided, and; f) time spent counselling.	$75.00
41B	-- next subsequent 15 minutes or major portion thereof	$75.00

		Fee
	Hepatitis C - Monthly stipend for overseeing treatment	
	Monthly stipend for managing the treatment of patients with a confirmed diagnosis of Hepatitis C. The fees are payable for months in which treatment is provided according to recognized protocols for Hepatitis C. Only one physician may bill this code per month. Patient contacts would continue to be paid as visit services. This fee is not eligible for premiums or surcharges. This payment stops when the active treatment protocol ends.	
57B	Each month	$102.00
	Palliative Hospital Care*	
	Palliative hospital care is billable by the physician responsible for the in-hospital care of patients designated as palliative by their Regional Health Authority or the Saskatchewan Drug Plan. Hospital care includes all of the routine services required to manage in hospital care. Additional services provided as a result of an acute episode may be payable with an explanation. An assessment or consultation may not be billed when palliative hospital care is transferred to another physician. This code cannot be billed on the same day as regular hospital care (25B to 28B).	
35B	- per diem *payable on day of admission	
	Spinal Pathway	
	The Spinal Pathway code provides payment to physicians for the time they spend completing and recording a spinal assessment algorithm using the approved Spinal Pathway form.	
200B	Spinal pathways # physicians that have completed the Saskatchewan Spine Pathways Course, "Assessment and Management of Low Back Pain" are eligible to bill this code. This code may be billed once per acute or chronic episode that requires completing the Spinal Pathway form and algorithm.	$30.00
	Chronic Pain Management	
	Entitlement Criteria: Chronic Pain Management initial and follow-up pain assessments (205B, 206B) are payable to general practitioners who have applied to and have been granted approval from the Saskatchewan Medical Association Tariff Committee. Approval will be based upon a combination of the following criteria: proof of expertise in chronic pain management (examples of proof must include <u>at least two</u> of the following: education, training, experience and references), <u>AND</u> a letter of recommendation from the College of Physicians and Surgeons of Saskatchewan based upon information from the Prescription Review Program and Quality of Care Department. For the purposes of billing, 205B and 206B are payable on the date that the approval from the SMA Tariff Committee is granted to the general practitioner. This assessment is payable to general practitioners once per patient every 5 years where a minimum of 45 minutes is spent on the following: • Complete medical assessment and documentation of: medical history, psychiatric history, family history, allergy and intolerance history, pertinent physical examination, pertinent past medical investigations and treatments, pain diagnosis and type (nociceptive, neuropathic, mixed, central). • Pain diagram, brief pain inventory and the DN4 Neuropathic Pain questionnaire. • Addiction Screening including opioid risk tool score (ORT). • Current psychological evaluation including one or more of the following tools: Beck's Inventory, Hospital Anxiety and Depression Score (HADS), PHQ-9 or equivalent, or the Pain Catastrophizing	

		Fee
	score (PCS). • Medication history including current medications (with verification by accessing the Pharmaceutical Information Program) and past medications trialed for the pain condition. • Opioid Use Agreement/Informed Consent and Urine Drug Test (UDT) if opioids are considered. • Initial education on chronic pain as a disease and self-management. The required documents can be found on the SMA website (www.sma.sk.ca), or an equivalent EMR checklist system can be used.	
205B	Chronic Pain Management - Initial Assessment	$408.00 #
206B	Chronic Pain - Follow-up Assessment	$140.00
	HIV/AIDS – Primary Care Management HIV/AIDS management is payable to general practitioners responsible for the primary care of patients with a diagnosis of HIV/AIDS once per patient every 90 days for the following: a) Review of medication and/or antiviral therapy; and b) Review and/or ordering of diagnostic and/or screening tests, such as lab work, (ie: CD4 counts, viral loads), tuberculosis, vaccinations, chest x-rays, hepatitis screening, etc; and c) Completion of approved flow sheets/templates with care consistent with approved guidelines; and d) Assessment of vital signs, weight, and body mass index (BMI), noting any abnormalities and/or changes in general appearance, body habitus, physical well-being, frailty, and mobility; and e) Review of current and past medical history, any relevant changes in social or family history, current functional inquiry and review of systems; and f) Review and management of any relevant underlying co-morbid conditions; and g) Review and evaluation of any substance or alcohol use; and h) Review of any psychosocial implications or factors; and i) Patient education and/or counselling regarding HIV/AIDS care. • Visits in excess of quarterly (90-day) limits would be billed using other applicable fee codes (ie: partial assessment (5B)) when all criteria of those codes are met. • Per “Documentation Requirements for the Purposes of Billing”, the documentation must demonstrate that all of the above components were performed. • No time-of-day premiums are eligible except in-office premium “F”; and • No surcharges/special calls are billable, as this is considered a prearranged service.	
207B	**HIV/AIDS – Primary Care Management**	$147.20

Case Conference
Must be a formal scheduled session. A single conference fee billed in the name of

		Fee
	one patient covers all the patients reviewed at that conference. Use 43B if case conference is part of Home Care Program. A maximum of two case conferences per patient per year is billable. The physician should keep appropriate documentation of time and place.	
42B	-- per conference (not patient) first 30 minutes or part thereof	$138.00
43B	-- per home care conference (not patient) first 30 minutes or part thereof	$138.00
44B	-- add to 42B or 43B for each additional 15 minutes or part thereof	$63.00
	Hospital Care* (Payable on day of admission)	
25B	-- first 10 days, per day	$69.80
26B	-- 11-20 days, per day	$69.80
27B	-- 21-30 days, per day	$69.80
28B	-- thereafter, per day	$69.80

Note: for hospital discharge by physician, see code 725A.
*Payable on day of admission.

25B may be billed for short-term acute care patients who are admitted to a Health Centre in the same manner as an acute care hospital. Physicians may not use this option to cover new admissions for long-term care patients.

Supportive Care
Supportive Care is billable by the patient's family physician for inpatient visits to patients formally admitted to hospital under a specialist where it is necessary and/or prudent for the family physician to visit the patient to:
-- promote continuity of care;
-- reassure the patient and liaise with the family;
-- become aware of the specialist's current and future treatment recommendations;
-- facilitate the continuing management of the patient in the community following discharge.

Note: This service must be documented in the patient's file (hospital chart). This service is not payable in addition to a case conference billed for the same patient on the same day or in conjunction with any surcharge or premium. Cases where the patient has spent less than 24 hours as a hospital in-patient will only be paid if this service has not been paid in the preceeding 30 days. Services in excess of six per year per patient are to be billed by report.

Services in excess of six per discrete hospital admission per patient are to be billed by report which means the claim must be accompanied by a detailed explanation of the circumstances. Payment will be assessed on the basis of the explanation.

52B	Initial Visit (to be billed once per admission - otherwise 53B)	$82.60
53B	Subsequent Visits - to be billed during the patient's stay as a hospital in-patient up to a maximum of once per week (i.e. 53B is not billable within 6 days of another 53B)	$82.60
	METHADONE - Monthly stipend for overseeing methadone management	

GENERAL PRACTICE

		Fee
60B	First 3 months - per patient (lifetime maximum)	$100.00
61B	Second 3 months - per patient (lifetime maximum)	$80.00
62B	Thereafter - per patient	$50.00

-- No restarts in the payment program, i.e. if the patient leaves the program and then at a later date re-enters the program, his payment would resume at the same level as when he/she opted out.

-- Only one physician will be paid the monthly stipend. Change of physician does not affect level of payment.

-- Visits for each patient contact would be paid as at present (5B's or 40B's) in addition to monthly stipend.

-- Not eligible for premiums or surcharges.

-- Entitlement to these monthly stipends is limited to physicians who:

1. Have a current valid license to prescribe methadone for addiction.

2. Are actively supervising the patient's continuing use of methadone or buprenorphine/naloxone (Suboxone) within the provincial methadone program.

Note: This payment stops when the patient stops taking methadone.

Chronic Disease Management

Chronic disease management (CDM) fees are designed to encourage the use of accepted clinical care pathways to optimize the patient management. CDM fees are billable only for patients with a confirmed diagnosis of diabetes mellitus, coronary artery disease, congestive heart failure or chronic obstructive pulmonary disease (COPD) who require ongoing longitudinal care management of these diseases.

CDM fees are billable only once per patient, every 90 days. To initiate billing of these codes, the physician's first CDM fee claim for the patient must include the comment: "will be providing ongoing care to the patient". Subsequent (after 90 days) CDM fee claims must be consecutive and continuous for the same patient/same physician or clinic and will not require a comment.

An SMA-approved flow sheet must be completed and care must be consistent with approved guidelines. The approved flow sheets are available on the SMA website.

Electronically available equivalent CDM tracking systems (e.g., Electronic Medical Records) that interface with the Chronic Disease Management Toolkit are also eligible.

The CDM fee includes a patient visit that involves at least 15 minutes of physician time. Visits in excess of one every 90 days, or involving less than 15 minutes of time, should be billed using appropriate visit codes (e.g., code 5B).

If the patient has more than one of these conditions, they will be dealt with at the same visit. An approved flow sheet must be completed for each condition and at least 5 minutes of additional time per condition will be spent.

63B	Examination and certification of need for psychiatric examination pursuant to The Mental Health Services Act with completion of Form A	$147.70

Note: Code 63B does not apply to examination, certification or decertification for mental incompetence/competence under the Mentally Disordered Persons Act. Accounts for those services should be submitted to the office of the Public Trustee.

		Fee
64B	Visit and quarterly review of chronic disease -- base fee	$70.00
	Plus add one or more of the following fees for chronic conditions assessed during the visit:	
65B	Diabetes -- add (billable for the following diagnostic codes: 250)	$70.00
66B	Coronary heart disease -- add (billable for the following diagnostic codes: 410-414 inclusive)	$70.00
67B	Congestive heart failure -- add (billable for the following diagnostic codes: 425, 428, 429)	$70.00
68B	COPD -- add (billable for the following diagnostic codes: 490, 491, 492, 496, 518, 519)	$70.00

As an example, if a patient has coronary artery disease, the physician can bill fee 64B and 66B. When a physician sees a patient with more than one chronic disease (e.g., diabetes and coronary artery disease), he/she would bill fee 64B, 65B, and 66B for a total of $167.70.

Emergency Medicine - Visits

The following listings apply to services provided by scheduled on-site emergency physicians providing services in hospital emergency departments.

-- Surcharges are not payable with these codes.

-- Other procedures and visits shall be billed using the General Practice codes and fees as listed in the various sections.

-- Physicians (e.g. on call) who choose to attend their patients in the Emergency Department but who are not the designated emergency physicians as defined above, shall not bill these service codes but shall use the appropriate General Practice codes (i.e. 3B to 5B). Physicians scheduled to work in hospital emergency departments on a call-in basis as opposed to an on-site basis shall not bill these services but shall use the appropriate General Practice codes. These services are not to be used for free standing treatment centres or non-hospital emergency clinics.

Visit age supplement for patients 55 years of age and older:

1. These supplements provide the physician with increased compensation when providing an eligible visit service for a patient over 54 year of age.
2. Eligible visit services include codes 9B, 11B, 15B, 73B and 85B. Any other services are not eligible for this supplement.

100B	for patients 55 to 64 years of age	15 percent
101B	for patients 65 to 74 years of age	25 percent
102B	for patients 75 years of age and older	35 percent

NOTE: Emergency Medicine Age Supplements are based on the value of the visit excluding other premiums and surcharges

73B	**Complete assessment** -- includes: pertinent family history, patient history, history of present complaint, functional enquiry, examination of all parts and systems, diagnosis --assessment, necessary treatment, advice to the patient and record of the service provided	$138.00

GENERAL PRACTICE

		Fee
85B	**Partial assessment or subsequent visit** -- includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis -- assessment, necessary treatment, advice to the patient and record of the service provided	$71.00

Payment for patients 0-5 years of age are automatically applied. See Section A - Paediatric Visit Age Supplement for details

SECTION C:

PAEDIATRICS

	Visits	Fee
3C	Complete assessment -- includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of all parts and systems, diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$182.00
4C	Well baby care in office -- refers to the periodic office visits during the first year of life of a healthy infant and includes the necessary weights and measurements, examination and instruction to the parent regarding health care	$73.80
5C	Partial assessment or subsequent visit -- includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$131.00
14C	Complex partial assessment or subsequent visit - for eligible conditions includes: history review history of presenting complaint, functional enquiry, examination of affected part(s) or systems(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided. For paediatric (under age 18) patient visits that involve at least 15 minutes physician time and the following eligible conditions: AIDS; other human immunodeficiency virus infection; Diabetes Mellitus, including complications; Coagulation defects (e.g. Haemophilia, other factor deficiencies); Haemorrhagic conditions (e.g. Thrombocytopenia Purpura); Multiple Sclerosis; Epilepsy; Hypertension; Congestive Heart Failure; Asthma; Pulmonary Fibrosis; Inflammatory Bowel Disease; Renal Failure; Systemic Lupus Erythematosus, Scleroderma, Polymyositis, Dermatomyositis; Ankylosing Spondylitis, and other Seronegative Spondyloarthropathies; Chronic Hepatitis; Systemic Vasculitis; Chronic Respiratory Failure; Child Psychosis or Autism; Behavioural disorders of childhood and adolescence; Specific delays in development (e.g Dyslexia, Dyslalia, Motor Retardation); Cerebral Palsy; Chromosomal Anomalies; Congenital Heart Disease; Myelomeningocele; Foster Care Child; Technology Dependent (tube fed, trach, CPAP, oxygen dependent); Chronic Lung Disease; Anerexia Nervosa; Anxiety/Mood Disorders;	$196.00

PAEDIATRICS

		Fee
	Panhypopituitarism; Pulmonary Fibrosis; Physical and Sexual Neglect and Abuse	
	Visits	
9C	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$270.00
11C	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician.	$110.00
	Extended/Complex Pediatric Consultation - for complex behavioural, neurodevelopmental, and/or psychiatric conditions in a child age 17 and under – includes a) physical exam; b) review of history/lab/x-ray; c) collection and review of data from collateral sources (parents, social workers, teachers, speech pathologists, allied health professionals, etc); d) counseling of patient and/or family; e) generation of referrals to other support agencies; and f) preparation of report.	
12C	Per complete 45 minute time period spent directly with the patient	$370.00
13C	For each additional 15 minutes, or major portion thereof, spent directly with the patien – bill units units (max 3)	$70.00
	Pediatric Counselling - where the pediatrician engages with the patient and/or relatives/caregivers where the goal is to become aware of the child's problem and/or to provide comprehensive advice related to the modalities for prevention and/or treatment due to the seriousness and complexity of the issue – includes: a) History review; b) Counselling; c) Educational dialogue; d) Intervention and/or treatment; e) Record of service provided, and; f) Time spent counselling.	
15C	Per first complete 15-minute time period for time spent directly with the child and/or relatives/caregivers counselling	$96.00
16C	For each additional 15-minute time period, or major portion thereof, for time spent directly with the patient and/or relatives/caregivers counselling – bill units (max 3)	$96.00

SECTION C:

PAEDIATRICS

		Fee
	Hospital Care	
	(Payable on day of admission)	
25C	-- first 10 days, per day	$65.80
26C	-- 11-20 days, per day	$65.80
27C	-- 21-30 days, per day	$65.80
28C	-- thereafter, per day	$65.80
	Note: for hospital discharge by physician, see code 725A, Section A.	
	Procedures	
	Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calcuated and paid as explained in Section A, Paediatric Age Supplements.	
39C	Attendance at intrauterine foetal transfusion	$143.00
	Procedures	
35C	Exchange transfusion -- first	$362.70
36C	Exchange transfusion-- repeat	$306.00
37C	Fontanelle or jugular or femoral vein puncture	$20.40
38C	Duodenal intubation for analysis	$40.70
	Cannulization of	
40C	-- umbilical artery in the newborn	$102.00
41C	-- umbilical vein in the newborn	$81.60
	Growth hormone studies	
42C	-- 2 hour insulin I.V. infusion	$510.00
43C	-- subsequent arginine I.V. Infusion (includes I.V. infusion set up - blood collection and treatment of side effects/complications)	$153.00
50C	Rashkind Septostomy	$714.00
	Cardiorespirogram	
60C	-- interpretation	$67.40
	The following codes are for use by Paediatric Cardiologists for patients diagnosed with congenital heart disease.	
100C	Cardiac catheterization -- right heart -- to include catheter insertion and any or all of RA, RV, PA, and PAW pressures. Not to be billed during a routine coronary angiogram	$408.00
105C	Cardiac catheterization -- left -- retrograde includes catheter insertion and LV and AO pressures	$408.00

SECTION C:

PAEDIATRICS

		Fee
110C	Oximetry during cardiac catherization	$204.00
115C	Transluminal angioplasty -- pulmonary valve or artery	$1,020.00
120C	Balloon dilatation of conduit or graft	$1,020.00
125C	Stent placement in aorta pulmonary artery or conduit	$1,223.00
130C	Balloon dilatation of coarcation or aorta	$1,020.00
135C	Atrial septal puncture by brockenbrough needle	$612.00
140C	Pulmonary angiography	$306.00
145C	Angiocardiography -- right and/or left side	$306.00
150C	Foetal echocardiogram and foetal rhythm	$312.00
155C	Pulmonary hypertension studies	$816.00

SECTION D:

INTERNAL MEDICINE

		Fee	Anae
	Visits		
3D	Complete assessment -- includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of all parts and systems, diagnosis, assessment, necessary treatment advice to the patient and record of service provided	$147.00	
5D	Partial assessment or subsequent visit -- includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$138.00	
14D	Complex partial assessment or subsequent visit - for eligible conditions - includes: history review, history of presenting complaint functional enquiry, examination of affected part(s) or sytems(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided. For patient visits that involve at least 15 minutes physician time and the following eligible conditions: AIDS; other human immunodeficiency virus infection; Diabetes Mellitus, including complications; Coagulation defects (e.g. Haemophilia, other factor deficiencies); Haemorrhagic conditions (e.g. Thrombocytopenia Purpura); Multiple Sclerosis; Epilepsy; Hypertension with complications; Congestive Heart Failure; Coronary Artery Disease; COPD; Asthma; Pulmonary Fibrosis; Inflammatory Bowel Disease; Cirrhosis; End Stage Renal Failure Systemic Lupus Erythematosus, Scleroderma, Polymyositis, Dermatomyositis; Rheumatoid Arthritis; Ankylosing Spondylitis, and other Seronegative Spondyloarthropathies; Adult onset Still's Disease Chronic Hepatitis; Systemic Vasculitis; Chronic Respiratory Failure; Sleep Apnea and complications Technology Dependent (tube fed, trach, CPAP, oxygen dependent); Chronic Lung Disease; Panhypopituitarism; Pulmonary Fibrosis	$203.00	
9D	Consultation - includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor.	$292.00	
11D	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$147.00	
	Hospital Care		

INTERNAL MEDICINE

		Fee	Anae
	(Payable on day of admission)		
25D	-- first 10 days, per day	$81.20	
26D	-- 11-20 days, per day	$75.40	
27D	-- 21-30 days, per day	$60.00	
28D	-- thereafter, per day	$60.00	
	Note: for hospital discharge by physician, see code 725A, Section A.		
350D	**Follow-Up of Transplant Patient** 350D is payable for a visit to provide assessment and ongoing management of a patient's condition following a heart, lung, liver or pancreas transplant. This service is payable to the physician designated as the most responsible physician for monitoring the post-transplant status of the patient. -- not payable in addition to other visit services or within 42 days of the previous 350D. -- limited to six 350D services per patient per year (beginning April 1 of each year).	$547.00	
	Procedures Additional payments for diagnostic service exdluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement.		
	Electrocardiogram or phonocardiogram		
30D	-- tracing only	$18.00 *	
31D	-- interpretation only (If multiple 31Ds are done on the same day, please use units and indicate the time as a comment. Interpretation should be billed using date of tracing)	$22.50 *	
32D	-- tracing and interpretation	$36.40 *	
35D	Tilt table testing for syncope - includes venous and /or arterial cannulation - provocative and/or blocking drugs - physician in constant attendance	$412.00	D
39D	Group exercise training sessions for cardiac or pulmonary rehabilitation patients in a hospital approved facility - per patient Maximum $230.00 per session (Includes supervision and all other services provided during the session. The session is to be billed in the name of one patient using the number of services (units) to represent the number of patients, up to a maximum of ten)	$33.20 *	D

SECTION D:

INTERNAL MEDICINE

		Fee	Anae	
62D	Maximal or sub-maximal exercise tolerance test using a bicycle ergometer or treadmill with continuous E.C.G. monitoring, full E.C.G.(s), blood pressure monitoring -- professional supervision and interpretation with physician in constant attendance -- in approved facility	$182.00	D	
63D	-- technical (if equipment owned and staff employed by physician)	$76.00	D	
64D	Cardiopulmonary Exercise Testing -- technical - maximal incremental or endurance exercise testing on a treadmill or cycle ergometer with ECG monitoring, gas exchange measurements and pre-/post-spirometry measurements (if equipment owned and staff employed by physician) Payable with code 67D and applicable visit; not payable with code 63D, 601D, 603D, 611D, 613D.	$354.00 *	D	
67D	-- professional includes 62D, 600D, 602D, 610D, 612D, and 277D Payable with applicable visit.	$332.00	D	
	Stress echocardiography (applicable to treadmill, dobutamine and pacing stress echocardiography). Physician in constant attendance.			
65D	-- technical	$308.00	D	
66D	-- professional	$398.00	D	
141D	Continuous or intermittent electrocardiogram monitoring (e.g. Holter or Cardiocassette) -- interpretation	$83.50 *	D	
142D	-- technical component and scanning (if instruments owned by physician)	$83.50 *	D	
144D	Dipyridamole thallium test to include supervision of ETT, infusion of medication and interpretation	$203.30	D	
145D	24-hour ambulatory blood pressure monitoring--professional component only -- maximum per year: -- General Practitioners – 2 per patient, any physician; -- Specialists – 3 per patient, any physician; -- Maximum of 5 per patient total	$54.20 *	D	
42D	Cardiac arrhythmia cardioversion	$222.00	0	L
	Electroencephalogram			
50D	-- tracing only	$46.40	D	
51D	-- interpretation only	$53.60	D	
59D	Electroclinical detailed interpretation of	$705.00	D	

		Fee	Anae
	a set of seizures (Telemetry)		
	Polysomnography		
54D	-- technical component	$113.40	D
55D	-- professional component	$221.50	D
56D	Electrocorticography	$344.50	D
57D	E.E.G. monitoring during carotid endarterectomy	$172.30	D
58D	Sodium Amytal testing	$172.30	D
360D	Transcranial Doppler	$102.00	D

Pulmonary

Spirometry – codes 600D-603D, 610-613D

1) No visit service will be paid in addition to the following procedures if the patient's visit is for the procedure alone.
2) Must be performed according to ATS standards with or without flow volume curves or the test is not eligible for payment.
3) The interpretation and report should include at least the specific components listed under each test but the fee also covers all other measurements, interpretations and the report of them which can be derived from the test.
4) 600D-603D are not eligible for payment same patient same day as 610D-613D.
5) Not payable when rendered to a patient who does not have symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances

Simple Spirometry
-Must include FVC, FEV1, FEV1/FVC, and may include calculation of FEF25-75
-Not paid with Peak Flow Meters

600D	Professional Component a) Interpretation only b) There is a permanent record that includes a written interpretation by the physician or the study is not eligible for payment	$36.90	D
601D	Technical Component a) If instruments owned by physician and staff conducting the test are employed by the physician	$22.50	
	Repeat after bronchodilators		
602D	Professional Component	$24.40	D
603D	Technical Component a) If instruments owned by physician and staff conducting the test are employed by the physician	$11.20	

INTERNAL MEDICINE

		Fee	Anae
	Full Spirometry -FVC, FEV1, FEV1/FVC, FEF25-75, Flow Volume Loop; and may include Volume Time		
610D	Professional Component a) Interpretation only b) There is a permanent record that includes a written interpretation by the physician or the study is not eligible for payment	$59.40 @	D
611D	Technical Component a) If instruments owned by physician and staff conducting the test are employed by the physician	$22.50 *	
	Repeat after bronchodilators		
612D	Professional Component	$24.40 @	D
613D	Technical Component a) If instruments owned by physician and staff conducting the test are employed by the physician	$11.20 *	
	@ Payment approved for general practitioners with training and expertise in spirometry as approved by the Saskatchewan Medical Association Tariff Committee. For the purposes of billing, 55D-57D are billable on the date that the approval is granted to the physician. # Physicians listed by the College of Physicians and * Technical components do not require entitlement. Physicians/staff should be prepared to provide to the Ministry documentation demonstrating their training, ownership of equipment or employment of staff on request only.		
	Measurement of subdivisions of lung volumes - TLC, FRC, VC, RV, TLV		
266D	-- Professional component	$70.40	D
267D	-- Technical component	$55.40	D
	Lung diffusing capacity DLco with or without bronchodilators at rest and after exercise each		
268D	-- Professional component	$70.40	D
269D	-- Technical component	$49.20	D
	Full pulmonary function studies (including 600D-603D, 610D-613D, 266D & 268D)		
69D	-- Professional component	$181.00	D
271D	-- Technical component (including 267D and 269D) (If instruments owned and staff employed by physician)	$105.00	D
	Maximum billable for any combination of above non-technical tests (pulmonary) is not to exceed listed fee for 69D.)		
272D	Hyperbaric medicine - interpretation of tissue oxygen concentrations/saturations to assess candidates for hyperbaric oxygen therapy	$40.80 *	D

INTERNAL MEDICINE

		Fee	Anae
280D	Overnight oximetry (not payable with polysomnography)	$60.00 *	D
	Airways resistance or conductance by body box		
400D	-- Professional component	$26.80	D
401D	-- Technical component	$44.90	D
	Maximum expiratory and inspiratory pressures		
402D	-- Professional component	$36.20	D
	Pulmonary compliance		
70D	-- Professional component	$66.30	D
	Static pressure volume curve with esophageal balloon - pulmonary compliance		
71D	Professional component	$93.10	D
	Histamine-Methacholine test		
77D	-- Professional component (Internist of Pediatrician ONLY)	$194.00	D
276D	-- Technical component	$44.90	D
	Pulse Oximetry with exercise		
277D	-- Professional component	$30.20	D
	G.I. Tract		
90D	Jejunal biopsy -- trans oral	$157.00	D
	Oesophageal motility study		
93D	-- interpretation only	$105.00	D
	Oesophageal motility study		
94D	-- physician in continuous attendance including interpretation	$155.00	D
	Extended pH studies with or without provocative drug testing		
95D	-- physician in attendance - includes insertion and removal of probes and interpretation	$162.00	D
96D	-- interpretation only	$83.60	D
215D	Tensilon test	$40.70 *	D
	Evoked response		
105D	Visual evoked response interpretation	$24.60 *	D
106D	Auditory evoked response interpretation	$38.50 *	D
107D	Somato-sensory evoked response interpretation	$38.50 *	D
	Peritoneal dialysis		
121D	Peritoneal dialysis -- each 24 hour period	$68.20	0

SECTION D:

INTERNAL MEDICINE

		Fee	Anae
131D	Supervision of dialysis at home, per week	$104.00	0
132D	Any subsequent dialysis in the centre -- each	$77.40	0
	Slide Examination		
320D	Nephrologist microscopic examination of urine sample in office	$37.40	D
	Haemodialysis		
122D	-- initial	$653.00	0
123D	-- second to fifth -- each	$370.00	0
124D	-- sixth and subsequent -- each (shunt established)	$104.00	0
128D	Dialysis and training in dialysis centre -- each	$213.00	0
129D	Any subsequent dialysis in the centre -- each	$83.50	0
130D	Supervision of dialysis at home, per week	$81.30	
135D	Continuous Renal Replacement Therapy (CRRT) - initial	$947.00	0
136D	Continuous Renal Replacement Therapy (CRRT) - subsequent - greater than 7 days by report	$357.00	0
	Therapeutic plasmapheresis (done by cell separator)		
155D	-- first	$333.00	0
156D	-- second to fifth	$223.00	0
157D	-- subsequent	$157.00	0
250D	Plethysmography for penile blood flow	$59.90	D
251D	Tumescence monitoring of penis	$59.90	D
270D	Impedance plethysmography for deep vein thrombosis -- professional component only	$23.50 *	D
	Endocrine Testing		
200D	Cortrosyn stimulation	$90.20	D
201D	Calcium pentagastrin stimulation	$90.20	D
202D	T.R.H. stimulation	$126.00	D
203D	Glucagon test	$272.00	D
204D	L.H.R.H. stimulation	$117.00	D
206D	Insulin tolerance test	$220.00	D
207D	Triple bolus test	$241.00	D
216D	Corticotropin Releasing Hormone Delineation Test	$133.00	D
217D	Water Deprivation Test with or without DDAVP	$287.00	D
	Botulinum Toxin Therapy See codes 190A to 198A		

		Fee	Anae
	Pacemaker Clinic Services Clinic supervision, review of interrogation record and adjustment if necessary. Includes ECG Interpretation (not paid in addition to 120L-122L, 622L)		
278D	Patient not seen	$57.00	
279D	Patient seen (Visit fee payable if patient reviewed for a condition unrelated to pacemaker function)	$83.60	0

POLYSOMNOGRAPHY

Diagnostic Polysomnography is an insured service when provided at a provincially designated sleep laboratory and is a supervised overnight sleep study with continuous monitoring of sleep (EEG, EOG, EMG), oxygen saturation, ECG, airflow and respiratory effort.

Therapeutic Polysomnography is a supervised overnight sleep study performed in a provincially designated sleep laboratory with continuous monitoring of sleep (EEG, EOG, EMG), oxygen saturation, ECG, airflow and respiratory effort during which specific therapy for sleep disordered breathing is administered (this may include CPAP/Bi-PAP or mandibular advancement device) and the effect monitored.

Split night diagnostic and therapeutic polysomnography provided as a one-night study should be billed as 281D and 282D.

Repeat Diagnostic Therapeutic polysomnography within 42 days must be accompanied by an explanation.

281D	Diagnostic (includes visit)	$597.00	D
282D	Therapeutic (includes visit)	$296.00	D
283D	Multiple Sleep Latency Testing (includes visit)	$296.00	D
284D	Portable sleep study	$111.00	D
285D	Actigraphy	$119.00	D
	Auto-CPAP Titration		
290D	-- professional	$187.00	D
291D	-- technical	$34.00	D

Codes 281D to 291D limited to physicians with Regional Health Authority sleep lab privileges.

SECTION E:

PSYCHIATRY

		Fee	Anae
	Visits		
5E	Initial assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$308.00	
7E	Follow-up assessment -- includes: history review, functional enquiry, examination, reassessment, necessary treatment and advice to the patient and record of service provided	$104.00	
	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor		
9E	-- adult	$444.00	
10E	-- child	$488.00	
11E	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$214.00	
	Hospital Care (Payable on day of admission)		
25E	-- first 10 days, per day	$68.50 *	
26E	-- 11-20 days, per day	$68.50 *	
27E	-- 21-30 days, per day	$60.00 *	

SECTION E:

PSYCHIATRY

		Fee	Anae
28E	-- thereafter, per day **Note:** for hospital discharge by physician, see code 725A, Section A.	$60.00 *	
62E	Examination and certification of need for psychiatric examination pursuant to The Mental Health Services Act with completion of Form A	$227.90	
63E	Consultation, examination, patient history, admission to hospital and certification of mental ill health with completion of Form G	$476.00	
64E	Consultation, examination and certification of mental ill health with completion of Form G - second psychiatrist	$476.00	
66E	Repeat examination and recertification of mental ill health - same psychiatrist as billed code 63E - within 22 days with completion of Form G	$212.00	
67E	Repeat examination and recertification of mental ill health- same psychiatrist as billed code 64E - within 22 days with completion of Form G	$212.00	
68E	Consultation, examination and a recertification of mental ill health when previous certifying psychiatrist is unavailable - includes completion of Form G	$476.00	
70E	Completion of certification of mental ill health with issuance of form G or form H.1/H.3/H.4	$85.00	
73E	Necessary examination and certification for E.C.T. on an involuntary patient - by the psychiatrist providing primary care who has billed under code 63E with completion of Form I	$85.00	
74E	Examination and certification for E.C.T. on an involuntary patient - by second	$85.00	

		Fee	Anae
	psychiatrist who billed 64E or who has prior knowledge of the case - with completion of Form I		
75E	Consultation, examination and certification for E.C.T. on an involuntary patient who has not been seen by the psychiatrist in the preceding 42 days -with completion of Form I	$470.00	
	Psychotherapeutic Visits -- Office, Home or Hospital		
31E	Psychiatric social interview (A maximum of three units of 31E, per person interviewed, is authorized for billing) Interview for a minimum of 15 minutes by a psychiatrist with a person who has close knowledge of, or association with, a patient under the care of or treatment by the psychiatrist, and without the patient being present, to assist in the treatment of the patient. A person being interviewed may be a spouse or another member of the family or for example, a community psychiatric nurse (psychiatric home care nurse), a teacher, or a member of the clergy or a social worker. The benefit payment for this service is for a minimum of 15 minutes structured interview on a one to one basis between the psychiatrist and the person being interviewed. This item is not paid for a case conference where a psychiatrist confers, in relation to several patients at one time, with a physician, nurse or some other professional person participating in the provision of services to the patients or in the supervision or monitoring of the patients.	$102.00	

SECTION E:

PSYCHIATRY

		Fee	Anae
	Service code 31E should be billed in the name of the patient, and indicate the person interviewed.		
	Case Conference		
	Is where a psychiatrist confers, in relation to several patients at one time, with a physician, nurse or some other professional person participating in the provision of services to the patients or in the supervision or monitoring of the patients.		
	Must be a formal scheduled session. A single conference fee billed in the name of one patient covers all the patients reviewed at the conference. A maximum of six case conferences per patient per year is billable. The physician should keep appropriate documentation of time and place.		
142E	- per conference (not patient) - first 30 minutes or part thereof	$204.00	
144E	- add to 142E for each additional 15 minutes or part thereof	$102.00	
	Psychotherapy		
	Psychotherapy is a form of treatment for mental illness, behavioral maladaptions and/or other problems, in which a physician establishes a professional relationship with a patient for the purposes of removing, modifying or retarding existing symptoms or attenuating or reversing disturbed patterns of behavior, by one or more approaches or methods from the generally recognized divisions of psychology (i.e. analytic, behavioristic, gestalt, hormic, introspective). It is recognized that techniques may include hypnosis.		
	Group Psychotherapy		
33E	Group size 7 to 9 persons -- first hour, per person	$62.00	
34E	-- each subsequent 30 minutes or major part thereof, per person	$31.00	
	A maximum of 2 hours applies to a combination of 33E and 34E		
	Family Psychotherapy (Billed in the name		

		Fee	Anae
	of head of family, indicating names of other members treated)		
35E	Concurrent treatment of two or more members -- first 45 minutes	$324.00	
37E	-- each subsequent 15 minutes or major part thereof	$108.00	
	Individual Psychotherapy or Psychiatric Counselling Payment for this service implies a planned series of sessions of at least 30 minutes duration.		
38E	-- minimum period of 30 minutes	$204.00	
39E	-- each subsequent 15 minutes or major part thereof	$102.00	

SECTION E:

PSYCHIATRY

		Fee	Anae

Psychiatric Care – Admitted patient to a hospital or health care centre

Psychiatric Care is defined as a single medical intervention or a series of medical interventions carried out by a psychiatrist involving an interview with a patient in a hospital setting and utilizing verbal and pharmacological therapies.

Psychiatric Care for patients admitted to a hospital or health care centre may entail a medical diagnostic and therapeutic evaluation and may involve changes in treatment regimens.

At least 15 minutes of time must be spent with the patient and consist of at least 3 of the following components. If less than 3 components are performed and documented and/or less than 15 minutes of time is spent, then the appropriate service code is hospital care (25E-28E):
a) History review;
b) Diagnostic evaluation;
c) Therapeutic evaluation;
d) Changes in therapy;
e) Pertinent positives and/or changes in mental status;
f) Assessment and diagnosis; and/or
g) Advice to patient.

Time-of-day premiums and surcharges/special calls are not eligible for payment when 100E and 101E are billed for routine daily inpatient rounds. If the service is not being billed for daily inpatient rounds, a satisfactory explanation must be submitted with the electronic claim for consideration of payment.

The record must include any of the above components that were performed including the start and stop times. As per “Documentation Requirements for the Purposes of Billing”.

	Total eligible billing is 2 hours per patient per day.		
100E	- minimum of 15 minutes	$102.00 #	

SECTION E:

PSYCHIATRY

		Fee	Anae
101E	- each subsequent 15 minutes or major part thereof to a maximum of 7, bill units	$102.00 #	

#Payment to GP is for a physician who has been designated by the College of Physicians and Surgeons of Saskatchewan. For the purposes of billing, 100E, 101E, 110E and 111E are billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.

Psychiatric Care – Patient not admitted to a hospital or health care centre

Psychiatric Care is defined as a single medical intervention or a series of medical interventions carried out by a psychiatrist involving an interview with a patient in a non-hospital setting and utilizing verbal and pharmacological therapies.

Psychiatric Care entails a medical diagnostic and therapeutic evaluation and may involve changes in treatment regimens consisting of the following components:
a) History review;
b) Diagnostic evaluation;
c) Therapeutic evaluation;
d) Changes in therapy;
e) Pertinent positives and/or changes in mental status;
f) Assessment and diagnosis; and
g) Advice to patient.

The record must include any of the above components that were performed including the start and stop times. As per “Documentation Requirements for the Purposes of Billing”.

Total eligible billing is 1.5 hours per patient per day

110E	- minimum of 15 minutes	$102.00 #	
111E	- each subsequent 15 minutes or major part thereof to a maximum of 5, bill units	$102.00 #	

SECTION E:

PSYCHIATRY

		Fee	Anae	
	#Payment to GP approved for a physician who has been designated by the College of Physicians and Surgeons of Saskatchewan. For the purposes of billing, 100E, 101E, 110E and 111E are billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.			
	Electroshock therapy -- per treatment			
42E	-- with anaesthetist	$165.00 *	0	L
	Repetitive Transcranial Magnetic Stimulation			
43E	-- technical component (if the equipment is owned and the staff are employed by the physician)	$163.00	D	
	- Professional (for patient assessment use 7E visit code, for continuous physician bedside attendance during procedure use 918A)			
	Interview with drugs			
45E	-- First 30 minutes	$101.00		
47E	-- each subsequent 15 minutes or major part thereof to a maximum of 6 units	$48.40		
	Psychological testing			
50E	-- simple	$80.80 *	D	
51E	-- complex	$155.20	D	
	Complex psychological testing applies to the following tests: -- Mood and Anxiety Disorder Questionnaire, Department of Psychiatry, University of Saskatchewan -- ADI-R Autism Diagnostic Inventory -- ADOS Autism Diagnostic Observation Scale -- BASC Behavioral Assessment Scale for Children -- Achenback Child Behavior Checklist (teacher's, parent's) -- Crowell Structured Assessment -- Continuous Performance Test -- Wisconsin Card Sorting Test -- Goodenough Draw a Person Test (IQ) -- PANSS etc., (for Schizophrenia) -- KiddieSADS			

PSYCHIATRY

		Fee	Anae
	-- Minnesota Multiphasic Personality Inventory (MMPI) -- Structured Clinical Interview for DSM IV Axis I (SCID I) -- Structured Clinical Interview for DSM IV Axis II (SCID I I) **Note:** Physicians wishing to add tests to the above list should write the SMA Tariff Committee for approval.		
52E	OPTAX assessment for Attention Deficit disorder	$208.00	D

SECTION F:

DERMATOLOGY

		Fee	Anae
	Visits		
5F	Initial Assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$108.00	
7F	Follow-up Assessment -- includes: history review, functional enquiry, examination, reassessment, record, necessary treatment, advice to the patient and record of service provided	$64.80	
9F	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$168.00	
11F	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$90.60	
	Hospital Care (Payable on day of admission)		
25F	-- first 10 days, per day	$64.00 *	
26F	-- 11-20 days, per day	$62.00 *	
27F	-- 21-30 days, per day	$60.00 *	
28F	-- thereafter, per day	$60.00 *	
	Note: for hospital discharge by a physician, see code 725A, page A28		
14F	**Complex partial assessment or subsequent visit** - - for the ongoing management of any of the diseases listed below where the complexity of the condition requires the continuing management by a dermatology specialist, for patient visits that involve at least 15 minutes physician time, includes: a) history review; b) history of presenting complaint;	$100.00	

DERMATOLOGY

		Fee	Anae

c) functional enquiry;
d) examination of affected part(s) or system(s);
e) diagnosis;
f) assessment;
g) necessary treatment;
h) advice to the patient; and,
i) record of service provided.

Conditions:
Complex systemic disease with skin manifestations for at least one of the following:
- Sarcoidosis;
- Systemic lupus erythematosis;
- Dermatomyositis;
- Scleroderma;
- Relapsing polychondritis;
- Inflammatory bowel diseases (pyoderma gangranosum, Sweet's syndrome, erythema nodos
- Prophyria;
- Autoimmune blistering diseases (pemphigus, pempihoid, linear IgA);
- Paraneoplastic syndrome involving skin;
- Vasculitis (including Behcet's disease); or
- Cutaneous lymphomas (including lymphomatoid papulosis).

OR
-Chronic pruritus with or without skin manifestations (prurigo nodularis).
OR
-Complex systemic drug reactions for at least one of the following:
- Drug hypersensitivity syndrome;
- Erythema multiforme major; or
- Toxic epidermal necrolysis.

OR
Complex psoriasis or complex dermatogitis as defined by at least one of the following conditio
- Involvement of body surface area of greater than 30%; or
- Treatment with systemic therapy (methorexate, acitretin, cyclosporine, biologics).

Procedures
Addditional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement.

30F	Ultraviolet A and B light sensitivity -- testing and interpretation	$146.00 *	D
33F	Radiotherapy - per body area	$50.60 *	0
34F	PUVA (Psoralen ultra violet) therapy -- one treatment per alternate day	$95.60 *	0
35F	Ultraviolet B therapy Visit service not paid same day as 34F or 35F unless an explanation is provided.	$29.40 *	0
38F	Application of nitrogen mustard -- per treatment	$80.40 *	0
	Special mycological investigations		
40F	-- direct examination of hair or scales	$30.00 *	D

SECTION G:

MEDICAL GENETICS^

		Fee	Anae
	Visits		
5G	Genetic Assessment -- includes the history of the presenting condition, the genetic history of the patient and of the family, examination of the affected part(s) or system(s) including any special techniques, diagnosis, necessary treatment, advice to the patient and record of service provided	$176.00	
7G	Follow-up Assessment	$119.00	
	All Follow-ups if a Visit -- Not Counselling -- may include a review and update of the recorded genetic history, the necessary examination, review of diagnostic findings, necessary treatment, advice to the patient and record of service		
9G	Consultation -- includes all visits necessary, history and examination, review of the laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$340.00	
11G	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$164.00	
13G	Review of Genetic Information -- Review of clinical information for patients seen exclusively by a genetic counsellor for the medical geneticist. Dictated letter generated from the visit must indicate medical geneticist involvement. Patient chart must include note that clinical information was reviewed by medical geneticist. Not payable if patient seen by geneticist within 30 days.	$102.00 *	
	Hospital Care (Payable on day of admission)		
25G	-- first 10 days, per day	$62.00	
26G	-- 11-20 days, per day	$62.00	
27G	-- 21-30 days, per day	$60.00	
28G	-- thereafter, per day	$60.00	
	Note: for hospital discharge by physicians, see code 725A, Section A.		
	Procedures Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A		

SECTION G:

MEDICAL GENETICS^

		Fee	Anae
	Genetic Interview or Counselling^ Billed in the name of the patient and indicating person interviewed and relationship to the patient		
31G	Interview with other than the patient to complete the genetic history	$60.80	
	Counselling -- individual or family		
38G	-- for each complete 30 minutes	$155.00	
39G	-- each additional 15 minutes or part thereof	$77.40	
40G	Chromosome analysis -- interpretation only	$144.00 *	D
	Determination of probability of		
43G	-- zygosity in twins	$66.60	D
50G	Genetic examination of the products of conception (fetus and/or placenta) following intrauterine fetal death or pregnancy termination for mutilple congenital anomalies -- includes visit (only payable to physicians with appropriate genetic training)	$340.00	0

^ This section is restricted to those physicians who have been designated by the College of the College of Physicians and Surgeons as eligible to receive payment for these services.

SECTION H:

ANAESTHESIA

	Fee	Anae

1. Payment for anaesthesia is for professional services for the administration of any type of anaesthesia, general, regional, sedation or monitored anaesthesia care in acccordance with the Canadian Society of Anaesthesiologist's Guidelines to the Practice of Anaesthesia. However, ring block, local infiltration and topical or spray anaesthetics will not be paid unless they meet the full definition of anaesthetic professional services as noted above. Payment for anaesthesia includes same day pre-anaesthetic as well as post-anaesthetic examinations and all supportive measures during anaesthesiabut does not include the cost of drugs, materials or facilities.

2. An anaesthestic payment for a beneficiary:
(a) is based on the time from the start of continuous attendance by the anaesthetist until such time as the attendance by the anaesthetist to that patient is no longer required. The Anaesthetic Fee Codes implying continuous attendance may only be billed for one patient at a time.

(b) includes a procedure carried out during administration of the anaesthetic or in the resuscitative period except that invasive monitoring will be approved to the primary anaesthetist in addition to the anaesthetic as follows:
(i) 687H, 134A, 135A, 136A, 316A, 140A, 141A or 142A at 100 percent of the appropriate listed amount;
(ii) 160L at 75 percent of the appropriate listed amount.

3. When more than one procedure is performed during the same anaesthetic, the payment to the anaesthetist shall be based on the highest anaesthetic complexity as noted in the section headed "Anaesthesia Categories by Surgical Procedure".

4. Pre-anaesthetic consultation on same day of surgery is approved for high risk cases by report.

Payment for a pre-anaesthetic consultation is intended to apply where the consultation is provided in potentially high risk situations to assess the fitness of the patient for the anaesthetic/surgical procedure and to advise on pre-anaesthetic treatment. It is expected that these consultations will apply predominantly to risk levels IV and V and are not intended to apply to a pre-anaesthetic assessment situation.

5. When a physician admits a patient to a hospital for urgent surgery on an emergency basis and later on the same day provides anaesthesia services for the surgeon to whom the case has been referred, then both the visit and anaesthesia services will be paid.

6. In special cases where the safety of the patient or the facilitation of the operation requires the services of a second anaesthetist, payment to the assisting anaesthetist will be based on 100 percent of the listed rate of payment in the same anaesthetic category as the principle anaesthetist for the calculated anaesthetic time according to the appropriate time units of 15 minutes.

7. "Anaesthetic Standby" is defined as professional services provided for a patient at the request of another physician during a procedure which normally would not require the presence of an Anaesthetist. The need for Anaesthetic Standby should be justified by high risk or complexity of the procedure. Anaesthetic standby services should be billed under Code 918A according to criteria provided in Section A.

ANAESTHESIA

		Fee	Anae

"Standby" followed by administration of anaesthesia must be clarified, for example the commencement and termination time for each service, an explanation for the necessity for "standby" with an outline of the services provided and the name of the physician who requested the "standby".

8. If an anaesthetic is provided for both dental and other surgery, the most favourable single base code is paid with the remainder paid as time units.

Visits
Consultation
-- includes all visit necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor

9H	-- major	$229.00 *	
11H	-- repeat	$115.00 *	

A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.

Special call surcharges for additional patients seen (refer to Section A, Special Call Services and Surcharges).

Out-of-Hours Premiums - see explanation in Section A.

Anaesthetics -- any type (excluding local infiltration, ring block, topical or spray anaesthetics)

Anaesthetics -- any type (excluding local infiltrations, ring block, topical or spray anaesthetics)

Where the anaesthetic category is listed as:

500H	Low Complexity: (Low) Startup	$55.70 *	
501H	-- Per 15 minutes	$86.90 *	
502H	Intermediate Complexity: (Med) Startup	$66.70 *	
503H	-- Per 15 minutes	$99.70 *	
504H	High Complexity: (High) Startup	$79.90 *	
505H	-- Per 15 minutes	$116.00 *	
506H	Dental Procedures: Startup	$66.70 *	
507H	Dental Procedures: -- Per 15 minutes	$99.70 *	

Note: All dental anesthesia for patients under age 14 is insured.

Complex Anaesthesia Premiums (billed in addition to regular codes (500H to 507H) the indicated conditions exist)

Anesthesia premiums are payable to the anesthetist billing “H” section codes. These services should not be billed by the surgical assistant billing “J” section codes; surgical assistant should use the applicable time-of-day premiums.

580H	Operative premium for complexity and risk - per 15 minutes - for patients up to 2 years of age, a weight of greater than the	$29.10 *	

		Fee	Anae
	97th percentile for age according to the WHO growth charts for Canada - for patients greater than 2 and up to 16 years old, a Body Mass Index, (weight[kg]/height[m]2) greater than the 97th percentile for age according to the WHO growth charts for Canada - for patients over the age of 16, a Body Mass Index, (weight[kg]/height[m]2) greater than 40 - patients with a massive blood loss requiring transfusion of 35 or more ml/kg of blood products		
585H	Operative premium for complexity and risk -- per 15 minutes -- Patients where there is recognition and agreement between the surgeon and anaesthetist that undue delay in surgical treatment would pose a significant risk to life or major body part -- Patients with multiple trauma involving at least 2 of the following: - Abdominal injury requiring laparotomy; - Thoracic injury requiring chest tube or thoractomy; - Head injury with GCS less than 9; - Fracture of cervical spine, pelvis, femur, proximal tibia or humerus; - Burns to more than 30 percent of the body surface. Codes 580H and 585H cannot be billed together. Codes 580H and 585H are not eligible for additional premiums.	$58.20 *	
	Premium for Anaesthesia beginning before 5:00 p.m. and ending after 5:00 p.m.		
540H	Bill for the number of 15 minute time units provided after 5:00 p.m. and indicate on comment record the start of the anaesthetic time (this is not eligible for other premiums) Example: A procedure provided on a weekday by an anaesthetic, started at 2:00 p.m. and ended at 7:00 p.m. and involved the transfusion of 40 ml/kg of blood products the codes to be billed are: - no regular time based premiums are billable. The location of service should 2 or 3; - 504H (normally medium but greater than 4 hours) = $58.50 - 505H at 20 units X $80.20 = $1,604.00 - 540H at 8 units (15 minute units after 5:00 p.m.) X $18.40 = $147.20 - 580H at 20 units (all 15 minute units) X $20.00 = $400.00 Total billing = $2,209.70 If this procedure started at 6:00 p.m. and ended at 11:00 p.m.: - the location of service would be submitted as a "B" resulting in an amount in the total premium field for each applicable service line; - the 540H would not be billed, and - the 580H would be billed as shown above. If the transfusion involved only 30 ml/kg of blood products the 580H would not be billed for the above example.	$58.20 *	
	Premiums for Anaesthesia beginning before midnight 11:59 p.m. and ending after 12:00 p.m.		
545H	Bill for the number of 15 minute time units	$58.20 *	

	Fee	Anae

provided after 12:01 a.m. using the date of service when the service was initiated, and indicate on comment record the start of the anaesthetic time (545H is not eligible for other premiums.) Bill the number of units after midnight only.
Example:
A procedure provided on a weekday by an anaesthetist, started at 9:00 p.m. and ended at 2:00 a.m. the codes to be billed are:
- evening based premiums are billable using the location of service. (See Section A, Out-of-hours Premiums)
- 504H (normally medium but greater than 4 hours) plus 25% evening premium = $58.50 + $14.63
- 505H at 20 units X $80.20 plus 25% evening premium = $1,604.00 + $401.00
- 545H at 8 units (15 minute units after 12:00 a.m.) X $18.40 = $147.20
Total billing = $1,662.50 + premiums (including 545H) paid at $562.83

ANAESTHESIA CATEGORIES BY SURGICAL PROCEDURE

GENERAL CONSIDERATIONS

Anaesthesia is paid on the basis of the complexity of the surgical procedure and the total anaesthetic time. The following outlines the classification of anaesthetic complexity according to the surgical procedure(s).

Low complexity:
- All percutaneous diagnostic and therapeutic procedures not otherwise listed.
- Superficial surgery on the integumentary system, nerves, vessels, muscles, tendons and bones not otherwise listed.

Medium complexity:
- Anaesthesia in locations remote from the Operating Room including diagnostic or invasive radiology.
- Anaesthesia for cases listed as "Low complexity" done in the prone or sitting position (requires note on claim).
- Debridement and grafting of burns greater than 20 percent BSA.
- Low complexity cases lasting longer than 90 minutes but less than 4 hours

High complexity :
- All multiple trauma cases lasting longer than 4 hours.
- Anaesthesia for live organ donor retrieval.
- All cases lasting longer than 4 hours.
- All cardiac catheterizations.
- All laser procedures in the airway.

HEAD

Low Complexity:
- All procedures on the external, middle or inner ear.
- All procedures on the eye (including cataracts) or eyelids not otherwise listed.
- Anaesthesia for ECT.

Medium Complexity:
- All procedures on the skull, mandible, maxilla, orbits and facial bones.
- All procedures inside the nose or accessory sinuses.
- All intraoral procedures except those listed as "High complexity".
- The following eye procedures: repair of open eyes, scleral buckling, vitroretinal procedures, strabismus correction, corneal transplants,

	Fee	Anae

glaucoma procedures, tumors and enucleation.
- All closed intracranial procedures done by needle techniques.

High Complexity:
- All open intracranial procedures on the brain, meninges or cerebral vessels.

NECK

Medium Complexity:
- All procedures on the thyroid gland, parathyroids, salivary glands, lymphatics and congenital branchial cleft defects.
- All endoscopic or open procedures on the larynx or trachea not otherwise listed.

High Complexity:
- All procedures on the major vessels.
- Anaesthesia for cystic hygroma, laryngectomy, or radical neck dissection.
- Epiglottitis, foreign body in the airway, traumatic disruption of the larynx.

THORAX

Low Complexity:
- Anaesthesia for pacemakers, cardioversion, indwelling central lines.
- All breast surgery except those procedures listed separately.

Medium Complexity:
- Anaesthesia for bronchosocpy, mediastinoscopy.
- All procedures on the ribs.
- Anaesthesia for reduction mammoplasty or (modified) radical mastectomy, axillary node dissection.

High Complexity:
- All intrathoracic procedures on the heart, lungs, lymphatics or great vessels.
- All mediastinal procedures including esophagus and thymus.

SPINE AND CORD

Medium Complexity:
- All procedures for decompression or disc surgery.
- All procedures on the neninges or spinal cord and nerves not otherwise listed.
- All procedures on the vertebrae (except biopsy) not otherwise listed.

High Complexity:
- All procedures for spine or spinal cord tumors.
- All procedures for multilevel spine instrumentation.

ABDOMEN

Low Complexity:
- All extraperitoneal procedures on the abdominal wall or urinary tract.
- All endoscopic procedures of the GI tract from esophagus to rectum.

Medium Complexity:
- All intra-abdominal procedures except those listed below as "High complexity".

High Complexity:

		Fee	Anae

- Resection of liver, pancreas, stomach, colon, kidney, adrenals or retroperitoneal tumors.
- All stomach procedures for weight reduction on morbidly obese patients.
- Radical cystectomy and ileal conduit surgery Radical prostatectomy, radical hysterectomy or Caesarean hysterectomy.
- All procedures on the aorta, its major intra-abdominal branches or vena cava.
- Repair of congenital gastroachisis or omphalocele.

PERINEUM

Low Complexity:

- All perianal or anorectal procedures (perineal approach).
- All endoscopic urology except those listed below as "Medium complexity".
- All procedures on the male external genitalia.
- All procedures on the female external genitalia except those listed below as "Medium complexity."

Medium Complexity:

- Transurethral resection of prostate or bladder tumor.
- Percutaneous nephrolithotripsy.

- Hysterosocpic endometrial ablation, vaginal hysterectomy.
- Radical vulvectomy with or without node dissection.
- Amputation of the penis with or without node dissection.
- Vaginal fistulae repairs, vaginectomy.

EXTREMITY SURGERY

Low Complexity:

- All distal or minor proximal orthopaedic procedures, including arthroscopy, not otherwise listed.
- All surgery for vascular access.

Medium Complexity:

- Arthroplasty of the hip, knee or shoulder.
- All open surgery on the pelvis, hip, femur or tibial plateau.
- Arterial vascular surgery outside the abdomen except AV fistulas.
- All limb amputation except fingers and toes.
- Myocutaneous flaps.
- Major tissue resections and/or regional node dissection for malignant disease.
- ACL reconstruction or shoulder repair.
- Major releases for clubfoot.

High Complexity:

- Revision of arthroplasty for hip or knee.
- Free flaps or microvascular revascularization.

Epidural Anaesthesia for Labour and Delivery

600H	Initial set-up and subsequent maintenance of epidural anaesthesia by intermittent top-ups or continuous infusion, including continuous attendance at bedside during labour (Premiums are determined by the time of the initial set-up)	$690.00 *	
601H	Restart of 600H of a previously functioning epidural. Not payable for anaesthesia shift changes. Please provide time of initial startup and restart. (Premiums are determined	$336.00 *	

		Fee	Anae
	by the time of the restart set-up)		
667H	Attendance during delivery, (after the first hour covered under Code 600H) per 15 minutes or portion thereof Epidural paid at 75 percent where Delivery and Epidural (600H and 601H) are provided by the same physician by report.	$83.40 *	
	Intra-operative Transoephageal Echocardiography		
687H	Intra-operative Transoephageal Echocardiography (billable with other echocardiogram or Swan-Ganz by report only)	$245.00 *	
	PAIN MANAGEMENT		
	Acute Pain Management		
190H	Initiation of patient controlled analgesia	$33.70 *	
191H	Injection of intrathecal opiate for post-operative pain management	$33.70 *	
192H	Insertion or reinsertion of continuous epidural catheter for acute pain control including initial infusion of analgesic agent (for obstetrical cases see 600H)	$117.00 *	
193H	Daily supervision of any acute pain control modality listed in this Acute Pain Management section starting the day after surgery (includes all patient visits and adjustments)	$59.20 *	
194H	Insertion or reinsertion of continuous catheter technique local naesthetic blockage (excluding epidural) for acute pain control including initial infusion of analgesic agent	$117.00 *	
195H	Injection of local anaesthetic to establish a major plexus block to assist in post-operative pain management (cannot be claimed for topical, local infiltration or peripheral nerve block)	$116.00 *	
	Nerve Blocks		
	The codes in this section are for use with conditions where pain is the presenting complaint or symptom, to diagnose (confirm nerve supply, etc.) and/or treat (sclerosis, etc.). These items are not for use with regional anaesthesia prior to surgery, delivery, reduction of fractures, manipulations, etc. Regional anaesthesia provided by the same physician providing the surgical services is an inclusion in that service. Nerve blocks can be billed at 75 percent with pain clinic services, visit services and consultations for pain.		
80H	Intubation for the management of the airway or ventilation, not associated with Anesthetic	$202.00	
	Facet Injection		
94H	-- single	$181.00 *	0

ANAESTHESIA

		Fee	Anae
95H	-- each additional to a maximum of 5	$89.20 *	0
	Trigger Point		
96H	-- single	$89.20 *	0
97H	-- one additional	$42.40 *	0
	Instances where more than two injections are required will be reviewed at the request of the physician, upon receipt of an explanation of the circumstances.		
	Peripheral or Paravertebral Nerves		
98H	-- single	$185.00 *	0
99H	-- each additional to a maximum of three additional units	$91.70 *	0
	-- with sclerosing agent		
100H	-- single nerve, add	$67.50 *	0
101H	-- each additional nerve to a maximum of three units, add	$44.50 *	0
102H	Sciatic or obturator nerve	$234.00 *	0
103H	-- with sclerosing agent	$306.00 *	0
111H	Trigeminal nerve, posterior root	$391.00 *	0
112H	-- with sclerosing agent	$612.00 *	0
113H	Intracranial nerve	$204.00 *	0
114H	-- with sclerosing agent	$353.00 *	0
120H	Somatic plexus, (e.g. Brachial)	$261.00 *	0
121H	-- with sclerosing agent	$308.00 *	0
130H	Stellate ganglion	$270.00 *	0
131H	Stellage ganglion -- with sclerosing agent	$308.00 *	0
132H	Lumbar sympathetic chain	$270.00 *	0
133H	-- with sclerosing agent	$313.00 *	0
134H	Other ganglion/plexus (e.g. Caelic)	$549.00 *	0
135H	-- with sclerosing agent	$612.00 *	0
	Epidural		
140H	-- lumbar or caudal	$405.00 *	0
141H	-- with sclerosing agent	$459.00 *	0
142H	-- cervical or thoracic	$405.00 *	0
143H	-- with sclerosing agent	$459.00 *	0
144H	Epidural blood patch	$405.00 *	0
145H	Differential diagnostic subarachnoid block	$459.00 *	0
	Subarachnoid		
150H	-- lumbar	$405.00 *	0
151H	-- with sclerosing agent	$612.00 *	0
152H	-- thoracic	$306.00 *	0
153H	-- with sclerosing agent	$612.00 *	0
158H	Injection of piriformis muscle	$173.00 *	0
160H	Diagnostic sympathetic thermal response monitoring (via thermo-couple -- paid in addition to 130H, 132H 133H	$51.00 *	0
161H	X-ray control in connection with service, codes 94H to 153H, add	$121.00 *	0
	Note: x-ray charges extra		
220H	Therapeutic intravenous regional -- anaesthesia	$306.00 *	0

ANAESTHESIA

		Fee	Anae

Anaesthesia

Pain Clinic

The following codes apply to services to patients with severe or chronic pain, which have been unresponsive to previous therapy; and who have been referred by a physician to a designated pain clinic centre recognized by Saskatchewan Health. The Initial Complete Assessment can be billed on an in-patient if the patient is admitted to the hospital as an alternative to the out-patient pain clinic in order to facilitate the work-up. 9H should be used for consultation on hospitalized patients with acute or chronic pain not specifically admitted for pain clinic work-up. Entitlement to these benefits is limited to a recognized specialist in anaesthesia or other physician with approved training. For other physicians involved in the pain control process the appropriate assessment within their own specialty section applies.

201H	Initial Complete Assessment -- includes pertinent family and patient history, pain history including review of previous therapies, functional enquiry, examination of all parts and systems necessary to diagnose and initiate treatment--complete record with written report to referring physician, and advice to patient	$424.00 *	
203H	Subsequent assessment -- in-patient or out-patient -- includes review of problems, reassessment of pain control, review of history and physical examination as necessary to maintain ongoing treatment, and advice to patient	$211.00 *	
205H	Minor routine follow-up assessment of patient hospitalized under pain clinic criteria -- routine follow-up of pain treatment, with evaluation, and necessary changes to ongoing care	$158.00 *	

Intensive Care

PREAMBLE

The intensive care payment section is intended to be used by physicians providing direct bedside care to critically ill and potentially unstable patients who are in need of intensive treatment. For less intensive situations, such as where patients are admitted to the CCU or ICU for monitoring it may be appropriate to use a visit fee (see below) along with codes 335H-339H.

This section will ordinarly be billed under the physician-in-charge of the patient for that day. Ventilatory support care is to be billed by the physician providing ventilator care, which could be the physician-in-charge or another physician. For patients who are readmitted to the unit greater than 72 hours after discharge, the first day rate will apply.

If another member of the team (physicians who share call for the ICU) sees the patient in an emergency situation with the physician-in-charge being unavailable, the use of a consultation fee may be permitted if accompanied by an informative comment or written explanation (by report).

Other physicians, such as surgeons, nephrologists and neurologists, concurrently involved in the patient's care can bill for consultations and/or visits. Physicians called in for a specific procedure (e.g. to insert a difficult arterial line) should

	Fee	Anae

bill a procedure fee only. For patients transferred from one hospital to another, the original ICU team can bill for the transfer day, while the receiving team can bill for a day 1 onwards (e.g. ICU A will bill for April 1 to 4 (last day) and the receiving ICU B will bill for April 4 and onward).

Premiums and surcharges are not payable with codes in this section, with the exception of the 335H-339H series of codes (less intensive patient fees).

Billing for Consultations/Procedures Concurrent with the Billing
Visits including consultations and some procedures are included in intensive care services when provided in the ICU/CCU units on the same day by the same physician, clinic or specialty.

INTENSIVE CARE PER DIEM LISTINGS

1. The fees under physician-in-charge (normally the most responsible physician) apply per patient treated, i.e. while the physician-in-charge may change during the course of treatment, the daily fee formula as set out should be billed by the physicians involved as if there was only one physician-in-charge during the treatment program; in this sense, the daily fees can be construed as team fees.

2. When billing Intensive (Critical, Ventilatory or Comprehensive) Care fees, no other Intensive Care codes may be billed by the same physician(s) or same clinic or specialty. If a physician provides both critical and ventilatory care it should be billed as the comprehensive care codes. In either event the total fees cannot exceed the comprehensive fees.

3. Other physicians apart from those providing Critical Care or Comprehensive Care may claim the appropriate consultation, visit and procedure fees not listed in the fee schedule for Intensive Care with a meaningful explanation.

4. If Ventilatory Support only is provided, for example, by the anaesthetist(s), claims should then be made under Ventilatory Support. Comprehensive Care per diem fees do not apply.

5. If the patient has been discharged from the Unit for more than 72 hours and is re-admitted to the Unit, the first day rate applies again on the day of re-admission. The discharge and re-admission times must accompany the billing submission.

6. The appropriate visit and procedural codes apply after stopping Critical Care, Ventilatory Support or Comprehensive Care.

7. The Intensive Care per diem fees should not be claimed for stabilized patients and those patients who are in an intensive care unit for the purposes of monitoring. The appropriate consultation, assessment and procedural codes may apply (see preamble).

8. Intensive Care per diem fees do not include:
- Echocardiography (321A, 521A, 531A, 323A, 523A, 533A, 324A, 534A, 557A, 150C);
- E.C.G. provided by non-team (ICU) physicians (31D);
- Closed Chest Drainage (95L);
- Cardiac Pacemaker Insertion (121L);
- Balloon Pump Insertion (132L);
- Insertion of central venous catheter 134A-135A;
- Intra-operative Transoephageal Echocardiography (687H);

		Fee	Anae

- Swan-Ganz Catheterization (316A);
- Cardiac Catheterization and Angiography (300A, 303A, 328A, 329A, 335A, 443A, 445A, 447A, 536A, 545A, 548A, 648A, 100C, 105C, 145C);
- Cardioversion (42D);
- Continuous Renal Replacement Therapy (CRRT) (135D, 136D);
- Transcranial Doppler (360D);
- Exercise Stress Test (62D);
- Stress Echo (66D);
- Peritoneal Dialysis (121D, 667L, 669L, 670L);
- Haemodialysis (122D-124D, 660L, 661L);
- Epidural Anaesthesia and Nerve Blocks (94H-161H, 192H-195H, 220H);
- Percutaneous Endoscopic Gastrostomy (Peg) (443L, 444L, 447L)
- Sigmoidoscopy (449L, 450L);
- Colonoscopy (448L);
- Oesophagogastroscopy (402L - 412L);
- Bronchoscopy (520L);
- ERCP (500L); or
- Intubation for Laryngeal Obstruction (171T)
- Tracheostomy (177T)
- Certification of brain death and organ donor assessment (140Q, 150Q)

Critical care codes (400H to 424H) can be billed at the same time as the procedures listed above with no reduction to the daily fees or units.

INTENSIVE CARE

Critical care - (Intensive Care Area) - includes provision of all aspects of care of a critically ill patient in an intensive Critical Care Area excluding ventilatory support and including initial consultation and assessment, emergency resuscitation, intravenous lines, endotracheal intubation, cutdowns, intraosseous infusion, pressure infusion sets and pharmacological agents, insertion of arterial, urinary catheters and nasograstric tubes, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases, and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device). These fees are not billable for services rendered to patients admitted for ECG monitoring or observation alone.

Physician-in-Charge is the physician(s) daily providing the above:

400H	1st day	$677.00 *	
401H	2nd day	$371.00 *	
402H	3rd to 7th days (inclusive) per diem	$341.00 *	
403H	8th to 30th days (inclusive) per diem	$171.00 *	
404H	thereafter, per diem	$61.80 *	

Ventilatory Support (Intensive Area) - includes provision of ventilatory care including initial consultation and assessment of the patient, intravenous lines, endotracheal intubation with positive pressure ventilation including insertion of arterial lines, tracheal toilet, use of artificial ventilator and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, transcutaneous blood gases and assessment.

Physician-in-Charge is the physician(s) daily providing the above:

410H	1st day	$591.00 *	
411H	2nd day	$296.00 *	
412H	3rd to 7th day (inclusive) per diem	$298.00 *	
413H	8th to 30th day (inclusive) per diem	$206.00 *	
414H	thereafter, per diem	$76.20 *	

ANAESTHESIA

COMPREHENSIVE CARE (Intensive Care Area)
These fees apply to Intensive Care physicians who provide complete care (both Critical Care and Ventilatory Support as defined above) to Intensive Care Area patients.
These fees include:
- arterial and/or venous catheters
- artificial ventilation and necessary measures for respiratory support
- cardioversion and usual resuscitative measures
- cutdowns
- defibrillation
- emergency resuscitation
- endotracheal intubation
- initial consultation and assessment and subsequent examinations of the patient
- insertion of intravenous lines
- insertion of urinary catheters and nasogastric tubes
- intracranial pressure monitoring, interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device).
- Intubation (80H) when performed by the same physician claiming ICU per diems (400H-424H)
- intraosseous infusion
- oximetry
- pressure infusion sets and pharmacological agents
- securing and interpretation of blood gases and laboratory tests
- tracheal toilet
- transcutaneous blood gases

If the patient has been reassigned from critical care to comprehensive care, the day of the transfer shall be deemed for payment purposes to be the second day of comprehensive care and may be billed with a meaningful explanation (e.g. A patient was in critical care from April 1 to 4 and then transferred to comprehensive care on April 4 to 6. The billing would be 400H, 401H, 402H, 421H, 422H and 422H).

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

		Fee	Anae
420H	1st day	$1,121.00 *	
421H	2nd day	$506.00 *	
422H	3rd to 7th days (inclusive) per diem	$506.00 *	
423H	8th to 30th day (inclusive) per diem	$253.00 *	
424H	thereafter per diem	$130.00 *	

Less Intensive Patients (such as Monitoring)
Payment of these fees is for care of less intensive patients provided in either an Intensive Care or Coronary Care Unit. Code 918A (continuous personal attendance) may apply for services provided in other locations.

Payment is intended for the time that a physician spends with the patient. The times of each visit must be indicated on the claim by the physician providing the service.

Payment for concurrent care is only acceptable if submitted with an explanation satisfactory to Saskatchewan Health.

The procedures excluded from intensive care per diem listings on pages H.16 and H.17 are also excluded from this section (e.g. echocardiography, dialysis, etc.). However the number of time units must be reduced accordingly for 335H to 339H.

As well, codes in this section are eligible for after-hours premiums and first patient surcharges (see page A36).

It may be appropriate to bill for a consultation/visit with these fee codes (see preamble page H.15). In some circumstances accurate times and meaningful explanations must be included with submission.

SECTION H:

ANAESTHESIA

		Fee	Anae
	Per 1/4 hour (please indicate the number of 1/4 hours as units)	$58.00 *	
335H	1st day - max per day	$348.00 *	
336H	2nd day - max per day	$290.00 *	
337H	3rd to 7th days - max per day	$174.00 *	
338H	8th to 30th day - max per day	$116.00 *	
339H	thereafter, per diem - max per day	$78.20 *	

Where a patient is transferred from critical care to less intensive care the care is considered a continuation of the same hospitalization and care is based on the number of days since the initial hospitalization or the first day of intensive care (e.g. If a patient was in critical care from April 1 to 4 and moved to less intensive care on April 4 to 6, the codes billed would be 400H, 401H, 402H and 337H etc.).

ECG interpretations may be billed in addition to 335H to 339H.

CARDIOLOGY

		Fee	Anae
	Visits		
3I	Complete assessment -- includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of all parts and systems, diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$153.00	
5I	Partial assessment or subsequent visit -- includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$148.00	
9I	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$299.00	
11I	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$144.00	
13I	Interpretation of telephone rhythm strips and/or ECGs by Cardiologist with prompt response and advice to the referring physician on immediate case management (not to be used for routine test interpretation) per patient	$71.40	
	Hospital Care (Payable on day of admission)		
25I	-- first 10 days, per day	$75.80 *	
26I	-- 11-20 days, per day	$60.00 *	
27I	-- 21-30 days, per day	$60.00 *	
28I	-- thereafter, per day	$60.00 *	
	Note: for hospital discharge by physician, see code 725A, Section A.		

CARDIOLOGY

		Fee	Anae
	Electrophysiology		
90I	Catheter ablation for atrial fibrillation and left-sided atrial flutters- Composite Fee to include services such as catheterization (s), ablation (s), electrophysiology study, and cardioversion (s) (if necessary) Payable 2 per patient per year (any further billing should be by report with appropriate explanation).	$3,527.00	L
105I	Full electrophysiology study - atrial and ventricular programmed electrical stimulation	$2,345.00	D
110I	Partial electrophysiological study - atrial or ventricular programmed electrical stimulation	$969.00	D
115I	Electrophysiological study using previously inserted electrode	$561.00	D
120I	Esophageal electrophysiological study	$408.00	D
125I	Intra-operative electrophysiological study	$1,081.00	
130I	Electrophysiological study/ablation - team fee - second physician must be certified electrophysiologist - maximum fee of $1,000.00	50% of Electrophysiologist fee	0
135I	Cardiac electrophsiologic drug infusion study - per 15 minutes or major portion thereof	$71.40	D
200I	Catheter ablation of supraventricular tachycardia (SVT) in addition to an electrophysiology study - add	$532.00	0
205I	Catheter ablation of ventricular tachycardia (VT) in addition to an electrophysiology study - add	$867.00	0
210I	Repeat catheter ablation at a second site during the same electrophysiology study	$275.00	0
300I	ICD clinic services - clinical supervision, review of interrogation record and and necessary adjustment - includes ECG interpretation	na	D
305I	Implantable cardioverter defibrillator (ICD) - defibrillation testing (DFT)	$805.00	0 H

SECTION J:

SURGICAL ASSISTANCE

		Fee
	1. Calculation of the payment to a surgical assistant is based on the time between the induction of anaesthesia and when continuous attendance by the surgical assistant is no longer required. When no anaesthetic is administered, the time is calculated from the beginning to the end of the procedure.	
	2. Payment for the services of an assistant during surgery will be made for:	
	(i) surgical procedures normally requiring an assistant;	
	(ii) surgical procedures not normally requiring an assistant where unusual circumstances occur necessitating the services of an assistant, and where an explanation satisfactory to Saskatchewan Health is provided.	
	3. Payment may be made for the services of more than one surgical assistant where a satisfactory explanation is received for the services of a second or additional assistants required during surgery.	
	4. Procedures performed by the surgical assistant during the same anaesthetic time for surgery are subject to "Assessment Rules -- Procedures".	
	Surgical Assistant -- billable by any physician	
30J	-- up to 60 minutes	$290.00 *
31J	-- for each additional 15 mins., or major portion thereof	$78.00 *
	Surgical Assistant for Unscheduled Emergency Surgery -- billable by physicians who are not participating in a Saskatchewan Health or RHA funded on call/coverage rota for surgical assists	
60J	-- first patient -- up to 60 minutes	$410.00 *
61J	-- for each additional 15 minutes, or major portion thereof	$78.00 *
70J	-- each additional patient -- up to 60 minutes	$340.00 *
	Surgical Assistant for Scheduled Surgery -- billable by office-based physicians who provide scheduled surgical assisting services on weekdays during regular office hours (8:00 am - 5:00 pm) and who earn less than 50% of their income through surgical assistance.	
80J	-- up to 60 minutes	$350.00
81J	-- for each additional 15 minutes, or major portion thereof	$94.00
	Surgical Assistant Standby	
40J	-- for each 15 minutes or major portion thereof (maximum 30 minutes)	$60.00 *
	e.g. claim if called to stand by during laparoscopy with the possibility of laparotomy.	
	Note: Not to be billed for time spent awaiting start of operation and not paid along with 30J, 31J, 60J, 61J, 70J, 80J, 81J, 331K, 332J, 333J or 334J	
	Out-of-Hours Premiums	
	See Section A, Out-of-hours Premiums	
	Specialist O/R Standby	
50J	-- for each 15 minutes or major portion thereof	$51.80

SURGICAL ASSISTANCE

		Fee
	not to be billed for time spent awaiting start of operation . Payable only if surgoen is required to participate in part of a surgical procedure and must remain immediately available to the O/R and is unable to perform any other billable work. Does not apply to delayed surgical start or cases where the current payment includes reimbursement for standby times.	
332J	**Surgical assist -- payment based upon first surgeon's assessed claim (Specialist only)** See applicable surgical codes at end of Section J.	1/3 of First Surgeons Claim
333J	**Surgical assist -- payment based upon first surgeon's assessed claim (General Practitioner designated by the SMA Tariff Committee as eligible only)** General Practitioners performing specialized assistance may apply to the SMA Tariff Committee for approval to bill 333J services for the appended list of services where their role as the first assistant is demonstrably essential to the performance of the procedure and in whose absence the procedure will be cancelled. See applicable surgical codes at end of Section J.	30% of First Surgeons Claim
334J	**Surgical assist - second assistant - payment based upon first surgeon's assessed claim (only General Practitioner designated by the SMA Tariff Committee is eligible).** General practitioner assistants may apply for approval to bill 334J services for cardiac surgery procedures where their specialized role is similar to that of a specialist assistant. See page J3 for applicable surgical codes	30% of First Surgeons Claim

Surgical Assistance

The following procedures because of their complexity may require the services of two specialist surgeons (includes FCS physicians). Where the second surgeon's involvement is more than routine assistance in the procedure, he/she may bill 1/3 of the surgeon's payment or the standard assist codes, whichever is greater. The services considered for this billing option includes the list below:

Codes for Optional Billing of 332J and 333J

57K	Craniotomy
58K	Cerebellar or cerebral arteriovenous malformation or aneurysm excision or obliteration
65K	Extra-axial brain tumor excision
92K, 93K	Lateral canthal advancements
117K, 118K	Skull fractures
150K	Removal of spinal tumor or bone fragments
175K	DREZ procedures for intractable pain
253K	Microsurgical decompression of cranial nerves
100L, 101L	Thoracoscopic lung resection
197T (30L, 31L, 33L)	Composite resection of mandible and floor or mouth, partial or total maxillectomy
149L, 150L, 153L, etc.	Cardiac surgery (procedures requiring bypass 161L or 138L)
169L	Femoro-popliteal
188L	Aorto-carotid; aorto-axillary; aorto-coeliac; aorto-superior mesenteric; aorto-innominate; renal; thoracic or abdominal aorta
246L	Complex incisional hernia with Inlay mesh
247L	Paraesophageal hernia repair
281L to 284L	Microvascular digital vessel revascularization
298L, 299L, 320L	Oesophagogastrectomy
305L	Total gastrectomy
342L, 343L, 344L or 442L	Laparoscopic colectomy
327L	Laparoscopic roux-en-y bypass
352L	Abdominoperineal resection
358L	Anterior resection
370L	Low anterior resection with total mesorectal excision (TME)
417L	Major liver resections

SURGICAL ASSISTANCE

		Fee
420L	Pancreatectomy	
426L	Laparoscopic Adrenalectomy	
428L	Laparoscopic Extra-adrenal phaeochromocytoma or other retroperitoneal tumor	
435L	Complete block dissection of the neck	
439L	Retroperitoneal lymphadenectomy	
462L	Femoro-tibial or peroneal	
463L	Femoro-pedal	
464L	Axillo-axillary, axillo-femoral; carotid-subclavian; cross femoral; illo-femoral; subclavian-subclavian; other arteries of next or extremities	
469L, 470L, 471L, 472L, 473L, 474L	Thromboendarterectomy (Independent Procedure) Femoral	
568L, 668L, 768L, 460L	Bifurcation Grafts	
652L	Bental procedure	
790L	Aorto femoral -- unilateral with thromboendarterectomy of profunda femoris	
791L	Aorto femoral - bilateral with thromboendarterectomy of profunda femoris	
50M	femur -- trochanteric or subtrochanteric	
103M	radical resection of bone for tumor with bone graft -- major bone	
192M	pelvis fracture – open reduction	
315M	tibia plateau open reduction	
375M	knee lateral collateral ligament and/or posterolateral corner - reconstruction with	
442M	total elbow replacement	
444M	total knee arthroplasty includes unicompartmental knee and patellar replacement	
445M/845M	total hip replacement or reconstructive arthroplasty	
446M/846M	total shoulder replacement	
448M	total wrist replacement	
449M/849M	total ankle replacement	
450M	arthrodesis – shoulder	
454M	arthrodesis – hip	
455M	arthrodesis – knee	
456M	arthrodesis – ankle	
520M	clubfoot surgery	
573M	hip (femur) -- congenital -- open reduction	
575M	pelvic osteotomy -- Salter, etc	
844M	total knee arthroplasty includes unicompartmental knee and patellar replacement – revision	
440N	Transverse rectus abdominis myocutaneous flap for breast reconstruction	
500N to 506N	Microvascular Surgery	
71P, 72P	Radical vulvectomy	
104P	Abdominoscacrocolpopexy	
124P	Total vaginal hysterectomy	
125P	Radical hysterectomy	
126P	Laparoscopic hysterectomy	
102R	Ileocystoplasty	
106R	Ileal conduit	
107R, 108R	Ureterosigmoid anastamosis	
124R	Radical prostatectomy	
136R	Laparoscopic nephrectomy	
138R	Radical nephrectomy	
142R	Ileal substitution of ureter	
95R, 96R, 97R	Cystectomy	
304R	Renal homotransplant - vascular surgeon	
193T	Total Laryngectomy	
197T, 30L, 31L	Composite resection of mandible and floor of mouth, Partial or total maxillectomy	

SECTION K:

NEUROSURGERY

		Fee	Class	Anae
	Visits			
5K	Initial Assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$176.00		
7K	Follow-up assessment -- includes: history review, functional enquiry, examination, reassessment, necessary treatment, advice to the patient and record of service provided	$104.00		
8K	Consultation -- spinal, complex -- at least 30 minutes documented duration including history, physical, review of imaging and recommendations to referring physician -- includes traumatic, tumor, infection, degenerative -- can be billed by all neurosurgeon specialists -- can also be billed by physicians who perform spinal instrumentation and fusion procedures	$326.00		
10K	Consultation -- spinal, routine -- less than 30 minutes documented duration including history, physical, review of imaging and recommendations to referring physician -- can be used for spine referral -- can be billed by all neurosurgeons and orthopaedic surgeons	$214.00		
9K	Consultation -- includes all visits necessary, history and examination, review of all laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$244.00		
11K	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$106.00		
14K	Follow-up visit, spinal, complex -- billable for those patients previously billed as initial spine consult, complex -- billable by physicians who have written prior approval by the SMA Tariff Committee	$122.00		

		Fee	Class	Anae
	-- can be billed by all neurosurgeon specialists -- can also be billed by physicians who perform spinal instrumentation and fusion procedures			
15K	Follow-up visit, spinal, routine -- can be billed by all neurosurgeons and orthopaedic surgeons	$93.40		
	Hospital Care (Payable on day of admission)			
25K	-- first 10 days, per day	$68.00 *		
26K	-- 11-20 days, per day	$60.00 *		
27K	-- 21-30 days, per day	$60.00 *		
28K	-- thereafter, per day **Note:** for hospital discharge by physician, see code 725A, Section A	$60.00 *		
	Procedures Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement			
31K	Subdural taps through fontanelle: initial or repeat	$77.00 *	D	L
32K	Ventricular puncture through previous burr or fontanelle	$129.50	D	M
35K	Implantation of an intracranial monitor for measuring intracranial pressure	$481.00	0	L
36K	Double blind morphine pain study	$227.90	D	
	Intracranial Procedures -- Non-traumatic			
50K	Operative management of brain abscess	$2,300.50	42	H
51K	Sub-occipital craniectomy for tractotomy or cranial nerve section	$2,473.80	42	H
253K	Micro surgical decompression of cranial nerve	$3,400.00	42	M
66K	Percutaneous thermocoagulation (Rhizotomy) of trigeminal nerve or ganglion	$1,421.00	42	L
	Craniotomy and orbital decompression			
55K	-- unilateral	$2,300.50	42	H
56K	-- bilateral	$2,731.70	42	H
57K	Cerebellar or cerebral tumor -- excision	$4,223.00	42	H
58K	Cerebellar or cerebral arteriovenous malformation or aneurysm -- excision or obliteration	$5,000.00	42	H
59K	Stereotactic procedures - framed or frameless to obtain deep tumor biopsy, localization and guidance during crainiotomy for tumor excision	$2,675.00	42	H
60K	Cortical excision for epilepsy, hypophysectomy or excision of choroid plexus	$2,675.00	42	H
61K	Intra-operative electrophysiological monitoring and/or stimulation -- add to any intracranial procedure	$642.00	42	

SECTION K:

NEUROSURGERY

		Fee	Class	Anae
	Excision of			
62K	-- osteomyelitis of skull	$1,489.40	42	M
63K	-- skull tumor	$1,489.40	42	M
64K	-- skull tumor with immediate cranioplasty	$1,489.40	42	M
65K	Extra-axial brain tumor (microdissection, CO2 laser, ultrasonic aspirator)	$5,626.00	42	H
80K	Ventriculocisternostomy	$1,599.70	42	M
81K	Repair of encephalocele	$1,759.10	42	H
82K	Shunts for hydrocephalus -- any type	$2,282.00	42	M
83K	-- revision during the same hospital admission as original procedure	$1,412.40	42	M
84K	-- revision - independent procedure upper end	$1,883.20	42	M
85K	-- lower end	$1,002.60	42	M
86K	Removal of ventriculo peritoneal shunt without simultaneous revision	$424.80	42	L
	Craniectomy for craniostenosis			
90K	-- single suture	$2,140.00	42	M
91K	-- multiple sutures	$2,140.00	42	M
92K	Lateral canthal advancement -- unilateral	$2,041.60	42	M
93K	-- bilateral	$2,595.80	42	M
	Burr holes			
100K	-- exploratory with or without biopsy	$524.30	42	M
101K	-- with external ventricular drainage	$806.80	42	M
102K	-- with C. T. guided biopsy	$769.30	42	M
103K	Sub-temporal decompression	$958.70	42	M
106K	Extracranial -- intracranial bypass	$3,383.30	42	H
	Procedures for Traumatic Intracranial Lesions			
	Evacuation of haematoma			
113K	-- via burr holes	$1,974.00	42	M
114K	-- via craniotomy	$2,579.00	42	H
116K	Elevation of simple depressed skull fracture	$1,407.00	42	M
117K	Compound depressed skull fracture with debridement of brain and repair of dura	$2,996.00	42	H
118K	Compound depressed fracture with sinus involvement or reconstruction of the orbit	$1,637.10	42	M
119K	Cranioplasty for skull defect	$1,664.00	42	M
121K	Craniotomy for cerebrospinal fluid rhinorrhea	$2,027.00	42	H
122K	Intracranial duraplasty -- for a deficiency greater than 2 cm. diameter -- add to intracranial procedure	$338.10	42	
	Peripheral Nerve Lesions			
156K	Biopsy of sural nerve	$408.00	D	L
157K	Removal of tumor -- major peripheral nerve (e.g. median or ulna)	$1,020.00	42	L

NEUROSURGERY

		Fee	Class	Anae
	Decompression of entrapment syndrome			
158K	-- median nerve	$655.00	42	L
159K	-- others	$1,020.00	42	L
160K	Section or crushing of nerve	$282.50	42	L
161K	Neuroma excision	$714.00	42	L
162K	Exploration of peripheral nerve injury, or neurolysis	$881.00	42	L
163K	Nerve suture (other than digital)	$1,230.00	42	L
164K	Nerve suture with special techniques to overcome gap	$1,430.00	42	L
165K	Digital nerve suture	$820.00	42	L
166K	Exploration of brachial or lumbar plexus with or without suture	$1,070.00	42	L
167K	Nerve anastomosis for intracranial nerve injury	$1,070.00	42	L
368K	Secondary or delayed nerve repair -- one month post injury, add	$310.00	42	L
468K	Fascicular instead of epineural nerve repair, add	$535.00	42	M
	Nerve grafting procedures			
168K	-- single cable	$978.00	42	L
268K	-- multiple cables	$1,430.00	42	L
169K	Transposition of ulnar nerve	$922.00	42	L
170K	Extracranial anastomosis for facial nerve lesion -- hypoglossal accessory, etc.	$1,020.80	42	L
171K	Radiofrequency spinal rhizotomy	$406.60	0	L
	Facial nerve - microsurgical graft			
172K	-- neurosurgeon	$1,020.80	42	L
173K	-- general surgeon	$614.00	42	L
174K	Selective dorsal rhizotomy for spasticity	$2,369.00	42	M
175K	DREZ procedure for intractable pain	$1,691.70	42	M
	Vegetative Nervous System			
	Cervical sympathectomy			
180K	-- unilateral	$1,002.60	42	M
181K	-- bilateral	$1,174.90	42	M
	Cervico-thoracic sympathectomy			
182K	-- unilateral	$886.00	42	H
183K	-- bilateral	$1,065.70	42	H
	Lumbar sympathectomy			
184K	-- unilateral	$1,020.80	42	M
185K	-- bilateral	$1,463.80	42	M
	Exposures for Neurosurgery			
210K	Transabdominal exposure of lumbar and lower thoracic spine for neurosurgical procedure	$920.00	42	M
211K	Transthoracic exposure of lower cervical or thoracic spine for neurosurgical procedure	$867.00	42	M

NEUROSURGERY

		Fee	Class	Anae
212K	Transphenoidal exposure of pituitary for hypophysectomy	$1,835.00	42	M
	Note: Standby time is billable as 50J for the period of time between the completion of opening and the start of the closure.			
	Example: if procedure is 3.5 hours in entirety and - opening and closure combined takes 1 hour - standby is then 2.5 hours			
	The total billing would be the appropriate K code (210K, 211K or 214K) and ten 15 minute units of 50J.			
	Codes 210K to 212K are exempt from the multiple surgery rules.			
	Deep Brain Electrode for Movement Disorders			
235K	Installation of deep brain electrode	$4,000.00	42	H
236K	- add - Micro-electrode recording and stimulation	$1,020.00	42	H
237K	- add - Internalization of deep brain electrode using single channel IPG	$510.00	42	H
238K	- add - Internalization of deep brain implant using dual channel IPG or pulse generator	$816.00	42	H
	Neuromodulation Clinic Services Clinic supervision, patient monitoring and adjustment of stimulation paramaters, drug dose and/or drug mix, includes advice to the patient, either directly or indirectly through the neuromodulation nurse.			
278K	Patient -- not seen	$58.80		
279K	Patient -- seen (Visit fee payable if patient reviewed for a condition unrelated to neuromodulation device function).	$86.80		0
	SPINE SURGERY **Anterior Decompression** **Cervical**			
500K	Odontoidectomy	$3,364.00	42	H
501K	-- exposure by separate surgeon	$2,596.00	42	H
502K	-- exposure by preimary surgeon -- add	$785.00	42	
503K	Discectomy -- 1 level	$2,178.00	42	M
504K	-- each additiona level -- add	$606.00	42	
505K	Vertebrectomy -- includes adjacent discs	$3,403.00	42	H
506K	-- each additiona level -- add	$587.00	42	
	(Maximum of 3 additional levels)			
507K	Artificial discs -- includes discectomy and fusion	$4,078.00	42	H
508K	-- each additiona level -- add (Maximum of 1 additional level)	$3,059.00	42	

NEUROSURGERY

		Fee	Class	Anae
	Fee codes 507K and 508K are not billable with any other cervical decompression, fusion or instrumentation code.			
	Thoracic			
514K	Discectomy	$2,039.00	42	M
714K	- each additional level - add	$577.00	42	M
515K	Vertebrectomy -- includes adjacent discs	$3,426.00	42	H
516K	-- each additional level -- add (Maximum of 3 additional levels)	$510.00	42	
517K	Exposure by primary surgeon	$897.00	42	M
	Lumba			
523K	Discectomy	$2,074.00	42	M
723K	- each additional level - add	$577.00	42	M
524K	Vertebrectomy -- includes adjacent discs	$3,322.00	42	H
525K	-- each additional level -- add (Maximum of 2 additional levels)	$510.00	42	
526K	Artificial disc -- includes discectomy and fusion	$4,078.00	42	H
527K	-- each additional level -- add (Maximum 1 additional level)	$3,059.00	42	
528K	Exposure by primary surgeon	$612.00	42	M
	Posterior Decompression			
	Cervical and Thoracic			
	Laminectomy, Laminotomy, Foraminotomy			
534K	-- unilateral	$1,764.00	42	M
535K	-- bilateral	$2,076.00	42	M
536K	-- each additional level -- add (Maximum 4 additional levels)	$459.00	42	
537K	-- Discectomy -- add	$622.00	42	
538K	-- Foramen magnum -- add	$1,038.00	42	
539K	Laminoplasty - includes strut and fixation	$2,698.00	42	M
540K	-- each additional level -- add (Maximum 5 additional levels)	$622.00	42	M
	Lumbar			
	Laminectomy, Laminotomy, Foraminotomy			
546K	-- unilateral	$1,876.00	42	M
547K	-- bilateral	$2,345.00	42	M
548K	-- each additional level -- add (Maximum 5 additional levels)	$528.00	42	
549K	-- descectomy -- add	$587.00	42	
	Pedicale subtraction osteotomy			
550K	-- above lumbar 2	$1,631.00	42	M
551K	-- below or at lumbar 2	$1,223.00	42	M
	For the purpose of fusion and instrumentation, a level is defined as two vertebral bodies with an intervening disc space.			
	Fusion (degenerative, tumour, trauma, or infective conditions)			
	Anterior			
	Cervical, Thoracic, Lumbar			
557K	-- first level fused	$1,056.00	42	M
558K	-- each additional level -- add	$353.00	42	M

		Fee	Class	Anae
	(Maximum 4 additional levels)			
	Posterior			
	Cervical, Thoracic, Lumbar			
564K	-- first level fused	$938.00	42	M
565K	-- each additional level -- add	$208.00	42	M
	(Maximum 5 additional levels)			
566K	Autologous bone graft harvest from distant site	$714.00	42	M
567K	Preparation of allograft	$510.00	42	M
	(Not including premade grafts)			
	Instrumentation			
	Anterior			
573K	Cervical	$938.00	42	M
574K	-- each additional level -- add	$234.00	42	M
	(Maximum 3 additional levels)			
575K	Odontoid screw	$3,042.00	42	H
	May claim fracture decompression in addition, not fusion.			
576K	Thoracic & Lumbar	$1,223.00	42	H
577K	-- each additional level -- add	$204.00	42	M
	(Maximum 3 additional levels)			
	Posaterior			
583K	Cervical 1-2 screw fixation	$2,579.00	42	M
584K	-- if occiput included -- add	$1,172.00	42	
585K	-- each additional level below Cervical 2 -- add	$469.00	42	
	(Maximum of 8 additional levels)			
586K	Cervical 1-2 wiring	$1,152.00	42	M
587K	-- if occiput included -- add	$1,020.00	42	
588K	-- each additional level below C2 -- add -- maximum of 8	$408.00	42	
589K	-- hook or wire construct added to another procedure	$510.00	42	
	Below C2			
590K	1st level	$1,876.00	42	M
591K	-- each additional level -- add -- maximum of 8	$408.00	42	
592K	-- each additional level beyond 8	$204.00	42	
	(Maximum of 5 additional levels)			
593K	Iliac screws -- add	$510.00	42	
594K	-- crossing cervicothoracic junction -- add	$408.00	42	
	Removal			
600K	Anterior or posterior -- per 15 minutes of surgical time May be billed with other procedures	$188.00	42	M
	Fractures			
606K	Decompression and/or reduction of fracture -- cannot be billed with other decompression codes -- instrumentation and fusion may also be billed	$1,631.00	0	
607K	Hal ring application	$918.00	0	
608K	Closed reduction and traction	$703.00	0	
609K	Halo jacket	$353.00	0	

NEUROSURGERY

		Fee	Class	Anae
610K	Thoracolumbar bracing	$469.00	0	
	Tumour/Infection/Vascular			
616K	Major decompression code -- add	30 percent of Decompression		
617K	Excision of mass without decompression	$520.00	42	M
618K	Excision of mass with nerve root decompression -- see posterior decompression -- add 30%	30 percent of Posterior Decompression		
619K	Removal intradural/extramedullary tumour Cannot be claimed with other decompression codes	$3,519.00	42	H
620K	Removal of intradural/intramedullary tumour Cannot be claimed with other decompression codes	$4,151.00	42	H
621K	Excision of intradural vascular malformation Cannot be claimed with other decompression codes	$3,568.00	42	H
622K	Interruption of spinal dural AV fistula Cannot be claimed with other decompression codes	$2,651.00	42	H
623K	Percutaneous vertebral biopsy	$353.00	42	M
624K	Open vertebral biopsy	$510.00	42	M
	Pain			
630K	Implantation of a single quadripolar electrode	$1,760.00	42	M
631K	-- additional quadripolar electrode (Maximum of 1 additional electrode)	$703.00	42	
632K	Implantation of a single quadripolar electrode -- if surgery in same area as a previous surgery	$2,072.00	42	M
633K	-- additional quadripolar electrode -- if surgery in same areas as previous surgery (Maximum of 1 additional electrode)	$748.00	42	
634K	Implantation of octopolar electrode	$1,876.00	42	M
635K	-- additional octopolar electrode (Maximum of 1 additional electrode)	$703.00	42	
636K	If laminectomy required for electrode insertion -- 8 contacts	$1,764.00	42	M
637K	-- 16 contacts	$2,512.00	42	M
638K	Internalization of stimulation system -- non-rechargeable	$587.00	42	M
639K	-- rechargeable	$822.00	42	M
640K	Removal of stimulating electrode	$469.00	42	M
641K	Adjustment of stimulating electrodes	$932.00	42	M
642K	Programming of pump	$234.00	42	
643K	Programming of pulse generator	$234.00	42	
644K	Myeoltomy for pain -- open or percutaneous Cannot be claimed with other decompression codes	$2,039.00	42	H
645K	Pain pump implantation	$1,760.00	42	M
646 K	Dorsal root entry zone lesioning or percutaneous CT guided cordotomy	$2,243.00	42	H
647K	Repair or replacement of blocked intrathecal catheter	$1,056.00	42	M
648K	Reanchoring a flipping pump	$703.00	42	M
649K	Replacement of pain pump	$938.00	42	M
650K	Removal of pain pump and catheters .	$703.00	42	M
651K	Replacement of Pulse generator -- rechargeable	$822.00	42	M
652K	Replacement of Pulse generator -- non-rechargeable	$587.00	42	M

SECTION K:

NEUROSURGERY

		Fee	Class	Anae
	Miscellaneous			
658K	Vertebroplasty	$1,241.00	42	M
659K	-- each additional level -- add (Maximum of 3 additional leels)	$418.00	42	
660K	-- in addition to another spinal procedure	$461.00	42	
661K	Kyphoplasty	$1,876.00	42	M
662K	-- each additional level -- add (Maximum of 1 additional level)	$1,172.00	42	
663K	-- in addition to another spinal procedure	$612.00	42	
664K	Spinal duraplasty	$577.00	42	M
665K	Syringosubarachnoid shunt	$1,835.00	42	H
666K	Syringopleural or syringoperitoneal shunt	$2,243.00	42	H
667K	Management of intradural congenital lesion -- includes diastematomyelia, tethered cord, lipoma	$2,284.00	42	H
668K	Intradural rhizotomy	$2,243.00	42	H
669K	Meningocele repair	$1,493.00	42	M
670K	Myelomeningocele repair	$1,994.00	42	M
671K	-- if plastic surgeon performs closure	$1,020.00	42	M
331K	Team Spinal Surgery -- where procedures requires the presence of two spine surgeons working in equal capacity - not for routine assisting. -- Can be billed by all neurosurgeons and and orthopaedic surgeons.	50% of First Surgeon's Claim		
	Premiums			
677K	Acute spinal cord injury (ASIA, A, B or C less than 6 weeks)	15% of Surgery		
678K	Monitoring - Electromyogram (EMG) - Motor Evoked Potentials (MEP) - Somatosensory Evoked Potentials (SSEP)	$612.00	42	
679K	Spine surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height[m]2) greater than 40 - Maximum of one 679K supplement per patient per day. - Supplement 679K may be billed by spine surgeons with all K Section spine procedures done in the operating room.	$343.00		
680K	Spinal stereotaxy for tumor, trauma, revision, pediatric, and greater than 3 levels of deformity	$1,172.00	42	M
681K	Revision surgery -- add	30 percent of Decompression		
682K	Revision surgery -- add	30 percent of Fusion		

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
	Visits			
	When the words 'Fee for Service' or 'By Report' are shown rather than a specific rate of payment, the following applies: **(a) Fee For Service** -- means services are to be billed on the basis of individual appropriate visit or procedure items included in the Payment Schedule, at the listed amount, and are subject to the Assesment Rules. **(b) By Report** -- Means that the claim must be accompanied by a detailed explanation of the circumstances and the services provided. Payment will be assessed on the basis of the explanation. These claims must be submitted on claim forms. **(c) Out of Hours Premiums** see -- A36.			
5L	Initial Assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis assessment, necessary treatment, advice to the patient and record of service provided	$116.00		
7L	Follow-up Assessment -- includes: history review, functional enquiry, examination, reassessment, necessary treatment, advice to the patient and record of service provided	$71.40 *		
9L	General, Thoracic and Vascular Surgery Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$230.00		
10L	Cardiac Surgery Consultation (only payable to physicians with approved training in cardiace surgery) -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$300.00		
11L	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$110.00		
13L	Written advice to referring physician on the management of a case based upon review of diagnostic imaging (payable once per case only)	$58.40		
	Hospital Care (Payable on day of admission)			
25L	-- first 10 days, per day	$60.00 *		
26L	-- 11-20 days, per day	$60.00 *		
27L	-- 21-30 days, per day	$60.00 *		
28L	-- thereafter, per day	$60.00 *		

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
	Note: for hospital discharge by physician, see code 725A, page A28			
	Procedures			
	Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, pages A34 and A35.			
	Head and Neck			
30L	Maxilla-partial resection	$1,778.30	42	M
31L	-- total resection	$2,165.70	42	M
32L	V-excision lip -- less than 1/3	$287.00 *	42	L
33L	Mandible -- one side at ramus excision	$1,082.80	42	M
35L	-- segmental resection	$856.00	42	M
	Tongue			
	Repair of laceration or excision of benign tumor of tongue			
45L	-- local anaesthetic	$134.80 *	10	
46L	-- under general anaesthetic or IV sedation (includes post op recovery)	$168.00 *	10	M
	Frenectomy -- See 139T			
	Glossectomy			
47L	-- partial	$749.00	42	M
48L	-- hemi	$858.00	42	M
49L	-- total	$1,353.60	42	M
50L	Excision carotid body tumor	$1,270.00	42	H
51L	-- with bypass or arterial graft	$1,637.10	42	H
52L	Scalenotomy	$554.30	42	L
53L	-- with cervical rib resection	$941.60	42	M
54L	Branchial cyst -- excision	$889.00	42	M
55L	Thyroglossal cyst or sinus or branchial sinus -- excision	$1,057.00	42	M
	Torticollis			
56L	-- tenotomy	$481.00	42	L
57L	-- resection of a tumor or wide fasciectomy	$805.00	42	L
58L	Cystic hygroma -- excision	$1,636.00	42	H
59L	Excision of congenital defects, angular or midline dermoids, branchial remnants, etc.	$725.50	42	M
	Salivary Glands			
60L	Submandibular or parotid stone removal (office procedure)	$134.80 *	10	
61L	Submandibular duct stone -- operative removal	$300.00 *	10	M
62L	Parotid duct stone -- operative removal	$577.00 *	42	M
63L	Local excision of parotid tumor and portion of gland without nerve dissection	$961.00	42	M
64L	Full excision of superficial lobe of parotid with nerve dissection	$2,034.00	42	M
65L	Total parotidectomy	$2,375.00	42	M
66L	Sublingual gland excision	$369.00 *	42	L
67L	Submandibular salivary gland excision	$841.00	42	M

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
	Thyroid			
68L	Aspiration of thyroid gland	$60.40 *	D	
69L	Needle biopsy of thyroid gland	$123.00 *	D	
	Thyroidectomy In instances of combined total and partial thyroidectomy, the maximum benefit billed will be at the rate of 72L for total bilateral thyroidectomy			
	-- Partial			
70L	-- unilateral	$1,416.00	42	M
71L	-- bilateral	$1,613.00	42	M
	-- total			
77L	-- unilateral	$1,691.00	42	M
72L	-- bilateral	$2,375.00	42	M
78L	-- Recurrent	$1,934.00	42	M
	Parathyroid			
75L	Parathyroidectomy -- adenoma or hyperplasia	$1,751.00	42	M
76L	-- with mediastinal exploration	$2,041.60	42	H
775L	Parathyroid, reimplantation, add to 72L, 75L, or 76L	$253.00	42	H
	Breast (For augmentation or reduction mammaplasty, prosthesis and nipple surgery see items 350N to 431N, 390N, 391N)			
79L	Breast cyst aspiration -- each to a maximum of 4	$42.80 *	D	
679L	Tru-cut needle biopsy of breast	$85.00 *	D	
80L	Abscess -- single or multilocular -- general anaesthetic	$347.00 *	42	L
82L	Segmental resection	$508.00	42	L
83L	Excision of tumor or biopsy	$405.00	10	L
86L	Excision of non-palpable breast lesion using wire localization	$732.00	10	L
84L	Simple mastectomy	$1,024.00	42	M
85L	Modified radical mastectomy	$1,912.00	42	M
87L	Radical mastectomy	$2,078.00	42	M
88L	-- with skin graft	$2,096.00		
89L	Subcutaneous mastectomy with preservation of nipple and areola	$1,113.00	42	L
	Thorax			
90L	Mediastinoscopy -- without biopsy	$474.00	D	M
689L	-- with biopsy	$640.00	10	M
690L	Mediastinotomy.	$265.00	42	M
91L	Funnel chest repair	$1,414.50	42	M
92L	Thoracotomy -- with or without biopsy -- (not billed in addition to thoracic surgery) Transthoracic exposure of lower cervical or thoracic spine for neurosurgical procedure -- see Section K, Exposures for Neurosurgery	$907.00	42	H
93L	Thoracotomy for cardiac -- referred	$779.00	42	H
94L	Sternal wound dehiscence, closure (service exempt from repeat surgical rule)	$398.00 *	42	M
95L	Closed drainage of chest	$371.00 *	0	L
96L	Open drainage of chest with rib resection	$553.00	0	M
	Intrapleural adhesions			
97L	-- endoscopic resection	$474.00	42	M
98L	Poudrage of chest	$508.00	42	M
99L	Decortication lung	$1,807.00	42	H
	Lobectomy -- lung			
100L	-- total or segmental	$2,041.00	42	H

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
101L	-- wedge resection - one	$1,603.00	42	H
103L	-- each additional to a maximum of 3, add	$210.00	42	
600L	Sleeve lobectomy	$2,304.00	42	
102L	Pneumonectomy	$2,127.00	42	
602L	Sleeve pneumonectomy	$2,294.00	42	
	Biopsy of lung			
106L	-- open	$954.00	42	H
	Drainage lung abscess			
108L	-- one stage	$991.00	42	H
109L	-- two stages	$1,024.00	42	H
110L	Resection first rib	$944.00	42	M
	Thoracoplasty			
111L	-- without first rib	$1,648.90	42	M
112L	-- with first rib	$1,274.00	42	M
	Mediastinal tumor includes thymectomy			
114L	-- removal	$1,576.00	42	H
115L	-- radical excision	$2,053.00	42	H
	Heart -- Closed Operations			
116L	Exploratory cardiotomy -- (not billed in addition to thoracic surgery)	$1,168.40	42	H
117L	Insertion of cardiac pacemaker via thoracotomy	$1,168.40	42	H
	Implantation of transvenous pacemaker or AV sequential pacemaker (includes programming)			
120L	-- permanent ventricular (one lead)	$877.00	42	L
820L	-- permanent AV sequential (two lead), add	$255.00	42	L
121L	-- temporary	$322.00	0	L
821L	Permanent pacemaker lead respositioning	$612.00		L
	<u>See Section D, Pacemaker Clinic Services</u>			
122L	Replacement of pacemaker power pack (service exempt from repeat surgical rule)	$479.00	42	L
622L	Reinsertion or repositioning of temporary pacemaker	$147.70	0	H
123L	Pericardiectomy	$1,835.00	42	H
623L	Partial pericardectomy -- minimum of 20 minutes	$510.00	42	H
124L	Patent ductus arteriosus -- ligation or division	$1,414.50	42	H
125L	Excision/exclusion of left atrial appendage	$408.00		H
126L	Mitral valvuloplasty -- closed	$1,648.90	42	H
128L	Cardiac wound repair	$1,168.40	42	H
129L	Pericardial window	$941.60	42	H
130L	Operative implantation of intra-aortic balloon pump	$603.50	0	H
131L	-- removal	$308.20	0	H
132L	Percutaneous intra-aortic balloon pump -- insertion (includes removal)	$334.00	0	H
135L	Thoracotomy for post-operative hemorrhage (service exept from repeat surgical rule)	$879.50	42	H
137L	Vascular ring	$1,133.00		
	Procedures With Cardio-Pulmonary Bypass			
138L	Aorto-coronary bypass with tissue stabilizing device	$1,093.00	42	H

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
161L	Extracorporeal bypass	$1,093.00	42	H
141L	Pulmonary embolectomy	$1,807.00	42	H
142L	ASD, secundum	$1,970.00	42	H
143L	ASD, primum	$1,987.00	42	H
145L	VSD, (direct closure or patch)	$1,987.00	42	H
148L	Total anomalous pulmonary venous return	$1,863.90	42	H
149L	Aortic valve replacement	$3,976.00	42	H
150L	Mitral valve replacement 100% -- 1st valve 75% -- each subsequent valve	$3,920.00	42	H
151L	Mitral valvuloplasty -- direct vision	$2,318.00	42	H
152L	Aortic valvuloplasty -- direct vision	$2,408.00	42	H
652L	Bental procedure (modified) -- includes 149L 188L, 189LX2 and 161L	$6,627.00	42	H
653L	Amplatzer device closure of arterial septal defect (does not include angiography if required)	$1,694.00	42	H
	Aorta-coronary bypass graft			
153L	-- single	$2,760.00	42	H
154L	-- for each additional	$566.00	42	H
155L	-- each coronary endarterectomy, add	$566.00	42	H
755L	Coronary patch angioplasty greater than 3 cm in length (includes endarterectomy) -- add	$775.00	42	H
654L	Use of internal mammary artery for bypass graft, add	$357.00	42	
655L	Use of radial artery for bypass graft, add	$367.00	42	
156L	Excision of ventricular aneurysm	$1,950.60	42	H
956L	Tricuspid annuloplasty or valvuloplasty	$2,069.00		
157L	Procuring heart/heart valves for transplant	$575.00	0	M
760L	Implantation of cardiodefribillator (ICD) any method	$1,631.00	42	H
761L	Radiofrequency of atrial fibrillation -- add	$1,020.00	42	H
762L	Implantation of bi-ventricular pacing device -- add	$612.00	42	H
	VEINS			
	Portacath, infusaport, hemocath, Hickman-Broviac for chemotherapy or long-term T.P.N.			
657L	-- insertion	$482.00	10	
957L	-- if second incision, add	$157.00		
658L	-- remove and replace	$695.00	10	
659L	-- remove or revise, same site	$288.00 *	0	
730L	Intravascular thrombolysis attendance and standby	$940.00	10	L
158L	Transvenous insertion of intra atrial pediatric feeding catheter	$158.00	0	L
160L	I.V. cutdown	$72.20 *	0	L
182L	Ligation or plication of iliac, or inferior vena cava	$1,066.00	42	H
183L	Ligation of femoral vein	$534.00	42	M
162L	Venous shunt - portocaval, splenorenal, mesocava	$2,590.50	42	H
	Venous Thrombectomy			
166L	-- trunk	$1,077.00	42	H
459L	-- vena cava - tumor thrombus	$1,810.00	42	H
167L	-- extremity - deep vein	$830.00	42	M
	Repair of Wounds^			
	Major Artery or Vein			

GENERAL SURGERY

		Fee	Class	Anae
	Trunk			
175L	-- suture	$1,268.00	42	H
176L	-- graft	$2,106.00	42	H
	Major Artery -- Extremity or Neck			
177L	-- suture	$875.00	42	M
178L	-- graft	$1,350.00	42	M
	Major Vein -- Extremity or Neck			
179L	-- suture	$532.00	42	L
180L	-- graft	$973.00	42	L
	^ If saphenous vein graft add 769L. Unlisted or unusually complicated -- by report			
	Digital Vessel Revascularization			
	Microvascular or loupe magnification revascularization of a digital vessel as part of a wound repair			
281L	Revascularization -- arterial	$1,330.00	42	H
282L	Revascularization -- arterial -- with vein graft	$1,530.00	42	H
283L	Revascularization -- venous	$1,325.00	42	H
284L	Revascularization -- venous -- with vein graft	$1,529.00	42	H
	Codes 281L to 284L only apply when provided by a recognized microvascular unit. Each individual code is billable once per anatomical site. The 75% rule will apply where all attempts to revascularize fail.			
	Renal			
660L	Haemodialysis - cutdown artery and vein	$85.20	0	
661L	Schribner or similar shunt, initial or repeat	$369.00	42	
662L	A/V fistula for dialysis	$715.00	42	
663L	Arterial venous fistula with graft -- prosthetic or venous (includes harvesting of vein)	$1,094.00	42	
666L	Ligation of fistula	$411.00	0	
	Peritoneal Dialysis			
667L	Chronic dialysis catheter -- insertion	$465.00 *	0	
669L	-- removal	$305.00 *	0	
670L	Acute dialysis catheter insertion includes first 24 hours of dialysis	$157.00	0	
671L	Externalization of buried chronic peritoneal dialysis catheter	$291.00	0	
	Arteries			
159L	Biopsy of artery	$293.00 *	10	L
181L	Ligation of carotid artery	$530.00	42	H
184L	Exploration of peripheral artery	$381.00	42	M
	Bypass Graft (Occlusive Disease or Aneurysm) 769L is billable in addition for harvesting of long saphenous - 770L is billable if in situ saphenous vein preparation			
769L	Harvesting long saphenous vein for use in peripheral vascular surgery, add	$284.00	42	
770L	In situ saphenous vein preparation, add	$557.00	42	
	Bifurcation Grafts^			
568L	Aorto-iliac - unilateral or bilateral	$2,886.00	42	H
668L	Aorto-unifemoral	$2,753.00	42	H
768L	Aorto-bifemoral	$3,001.00	42	H

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
460L	Juxta-renal aortobifemoral	$3,925.00	42	H
461L	Ilio-femoral obturator	$1,998.00	42	H
	^ Includes thromboendarterectomy and/or embolectomy			
191L	Ruptured aortic aneurysm (add to surgical procedure)	$652.00	42	H
	Peripheral Artery			
169L	Femoro-popliteal	$1,542.00	42	H
462L	Femoro-tibial or peroneal	$2,021.00	42	H
463L	Femoro-pedal	$2,290.00	42	H
464L	Axillo - axillary, axillo-femoral; carotid-subclavian; cross femoral; ilio-femoral; subclavian-subclavian; other arteries of neck or extremities	$1,743.00	42	H
	Thoracic or abdominal aorta			
188L	Aorto-carotid; aorto-axillary; aorto-coeliac; aorto-superior mesenteric; aorto-innominate; renal; thoracic or abdominal aorta	$2,722.00	42	H
189L	Reimplantation of each major branch, add	$391.00	42	H
174L	-- intra-operative arteriogram, add	$159.00 *	D	
	Complication of Grafts Repeat graft - within 42 days - 75% - after 42 days - 150%			
	Bypass graft with thromboendarterectomy. A thromboendarterectomy at site of a regular arterial bypass is included in the composite fee. However, where thromboendarterectomy of extensive atherosclerosis of profunda femoris artery is carried out in addition to aorto uni or bifemoral graft the following should be claimed by report.			
790L	Aorto femoral - unilateral with thromboendarterectomy of profunda femoris	$3,893.00	42	H
791L	Aorto femoral - bilateral with thromboendarterectomy of profunda femoris	$4,149.00	42	H
465L	Profundoplasty - (sole procedure) Profundoplasty up to the first major branch is included in the fee for bypass procedure. If a bypass graft is accompanied by a profundoplasty extending beyond the first major branch of the profundo femoris artery, add 466L to the bypass fee. If the repair extends beyond the second major branch, add 467L. Payment for profundoplasty includes thromboendarterectomy. Claim 465L if a profundoplasty is done alone.	$1,525.00	42	H
466L	Profundoplasty beyond first major branch, add	$824.00	42	H
467L	Profundoplasty beyond second major	$1,028.00	42	H

		Fee	Class	Anae
	branch, add			
	Arteriotomy with Embolectomy			
163L	-- trunk	$1,416.00	42	M
164L	-- neck	$1,095.00	42	H
165L	-- extremity	$1,078.00	42	M
468L	-- visceral	$1,731.00	42	H
	Thromboendarterectomy (Independent Procedure)			
469L	Femoral (unilateral)	$1,623.00	42	M
470L	-- iliac; carotid; renal; subclavian; superior mesenteric; vertebral	$1,813.00	42	H
471L	-- aorta innominate	$2,587.00	42	H
472L	-- aorto-iliac - unilateral or bilateral; aorto ilio-femoral unilateral	$2,718.00	42	H
473L	-- aorto ilio-femoral, bilateral	$3,107.00	42	H
474L	Carotid endarterectomy with patch angioplasty greater than 3 cm -- add	$732.00	42	H
920L	Vascular Re-do Procedure -- add to 163L, 164L, 165L, 169, 188L, 460L, 461L, 462L, 463L, 464L, 465L, 468L, 469L, 470L, 471L, 472L, 473L,668L, 768L, 790L, 791L	$411.00	42	H
	Excision AV fistula			
192L	-- extremity	$928.00	42	L
193L	-- trunk	$1,625.00	42	M
	Varicose Veins			
	Saphenous axis -- section and ligation			
200L	-- unilateral	$430.00 *	42	L
201L	-- bilateral	$809.00 *	42	L
	Ligation of multiple veins, with or without long saphenous stripping, with saphenous axis ligation			
209L	-- unilateral	$759.00 *	42	L
210L	-- bilateral	$1,472.00 *	42	L
211L	Multiple ligation of veins -- each -- maximum - 10 veins	$74.20	10	L
212L	Endovenous Laser Therapy (excludes transcutaneous laser treatment of spider veins) ….. -- Payment will only be made for services provided in hospital (including outpatient setting) for treatment of major varicosities of the lesser and greater saphenous systems, which could otherwise require surgical stripping.	$804.00	42	
	Ligation and dissection short saphenous vein at saphenopopliteal junction			
213L	-- unilateral	$362.00 *	42	L
214L	-- bilateral	$532.00 *	42	L
215L	Subfascial ligation of one incompetent communicating vein	$113.40 *	0	L
	Follow-up operation to 209L or 210L			
216L	-- unilateral	$308.20 *	42	L
217L	Subfascial ligation -- complete (Linton)	$941.60	42	L
	Injection of <u>symptomatic</u> varicose veins (Injection of spider veins is uninsured)			
218L	-- first vein	$80.30 *	0	L

		Fee	Class	Anae
618L	-- each additional vein (one leg max. 15, both legs max. 25)	$59.90 *	0	
219L	Stripping and ligation of short saphenous vein	$608.00 *	42	L
	Abdomen Transabdominal exposure of lumbar and lower thoracic spine for neurosurgical procedure -- see Section K, Exposures for Neurosurgery			
	Laparotomy			
220L	-- diagnostic - including removal of F.B., such as I.U.C.D. - (Not paid in addition to abdominal surgery)	$965.00 *	42	M
531L	-- extended - including gland and liver biopsies	$1,394.00	42	M
532L	-- staged - for Hodgkins Disease - including biopsies and splenectomy	$3,012.00	42	H
533L	-- for acute trauma - by report	$1,429.00	42	M
	-- with repair of bowel			
534L	-- single add	$515.00	42	M
535L	-- multiple and/or resection, add	$816.00	42	M
536L	-- with splenectomy or repair, add	$890.00	42	H
537L	-- with lacerated liver, add	$734.00	42	H
538L	-- with repair of diaphragm, add	$438.00	42	M
539L	-- insertion of tubes and post-operative continuous peritoneal lavage, add	$335.00	42	M
221L	Staging and/or Diagnostic Peritoneoscopy -- with or without biopsy 1. Peritoneoscopy is not payable with laparoscopic surgery unless it precedes the surgery as a diagnostic and/or staging procedure. 2. Diagnostic peritoneoscopies are billable when the diagnosis or condition is uncertain or unknown. 3. Staging peritoneoscopies are billable for the diagnosis/staging of malignancies to determine extent of disease and treatment options (ie: gastric, pancreatic, and peritoneal). 4. Claim must indicate whether the service was for diagnostic or staging purposes	$387.30	D	M
222L	Abdominal wound dehiscence -- (exempt from repeat surgical rule)	$584.00 *	42	M
224L	Sub-phrenic abscess -- incision and drainage − When performed as an independent procedure. − Not billable in addition to other abdominal surgery.	$1,523.00	42	M
	Abdominal or pelvic abscess			
225L	-- incision and drainage	$876.00 *	42	M
226L	Transrectal drainage of pelvic abscess	$438.00 *	42	L
	Incision and drainage of			
227L	-- supra-levator, pelvi-rectal or retro-rectal abscess	$541.00	42	L
228L	-- ischio-rectal abscess	$483.00 *	42	L
229L	-- perianal abscess	$373.00 *	10	L
230L	Pneumoperitoneum	$187.00	0	L
231L	Insertion of Leveen/Denver shunt	$1,778.00	42	H
232L	Debulking of intra-thoracic or intra-abdominal tumor when primary procedure	$991.00	42	H
233L	Intraoperative surgical intervention **Note:** To be paid to the surgeon when he is	$582.00	42	M

		Fee	Class	Anae
	called in by the primary surgeon during the course of the operation and performs a surgical procedure for which there is no listed fee (e.g., adhesiolysis). This service is paid as a flat fee. Consultation is not paid in addition. If the surgeon does not have to carry out any procedure and only provides advice, a consultation alone is the proper claim.			
	Hernia Repairs			
240L	Diaphragmatic hernia	$1,632.00	42	M
241L	Fundoplication and/or hiatus hernia repair	$1,603.00	42	M
248L	Esophagogastric fundoplasty (Nissen) with gastroplasty (Collis)	$2,400.00	42	H
242L	Epigastric hernia	$660.00 *	42	L
243L	Reduction of hernia	$67.20 *	0	L
244L	-- with anaesthetic.	$94.40	0	L
245L	Incisional ventral hernia	$1,147.00 *	42	L
246L	Complex incisional hernia with inlay mesh (retrorectus or intraperitoneal) 1. Billable when hernia is repaired with Inlay mesh AND 2. Two (2) of the following 3 components are present: a) Component separation; or b) Hernia width is more than 8 cm on preoperative CT; or c) Multiple fascial defects are seen on preoperative CT; AND 3. Surgery is a minimum duration of 2.5 hours. 4. Physician must indicate on the electronic claim which 2 components are present and the total duration of time. Physician may state “component 2 a) and c)” etc, if there is not enough room on the comment line. 5. If the criteria are not met, the code should be converted to “incisional ventral hernia” (245L).	$1,850.00	42	H
247L	Paraesophageal hernia repair	$2,056.00 *	42	H
	Umbilical Hernia - not billable in addition to other abdominal surgery except where clinically indicated and billed by report			
	Umbilical hernia			
	Not paid in addition to other laparoscopic abdominal surgery			
251L	-- child	$705.00 *	42	L
252L	-- adult	$760.00 *	42	L
253L	-- incarcerated or recurrent, child or adult	$993.00	42	M
	Omphalocele			
255L	-- one stage	$812.10	42	H
256L	-- staged -- each stage	$845.00	42	H
258L	Patent urachus -- includes excision of urachal cycst or sinus	$795.00	42	M
260L	Inguinal or femoral herniorrhaphy	$853.00 *	42	L
261L	-- incarcerated, strangulated or recurrent	$997.00	42	M
262L	Simple herniotomy -- unilateral	$764.00 *	42	L
263L	-- bilateral - includes unilateral herniotomy with negative contralateral exploration (open or by laparascopy)	$1,042.00 *	42	L
	Herniotomy with orchidopexy, only the larger fee is paid			
264L	Spigelian hernia	$888.00	42	L
265L	Lumbar hernia	$936.00	42	L
266L	Obturator hernia	$929.00	42	L
267L	Patent vitello-intestinal duct or excision	$1,109.00	42	M
	Meckel's diverticulum includes excision of omphalomesenteric duct fistula, cyst or sinus			

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
	Biliary Tract			
271L	Cholecystostomy	$876.00	42	M
	Choledochostomy			
272L	-- with or without cholecystectomy	$1,692.00	42	M
273L	Cholecysto-enterostomy	$1,258.00	42	M
274L	Choledocho-enterostomy or transduodenal sphincterotomy	$1,720.00	42	M
674L	Choledochojejunostomy with Roux-en-Y	$2,364.00	42	M
275L	Repair stricture common bile duct	$2,664.00	42	M
	Cholecystectomy			
276L	-- without operative cholangiography	$1,233.00	42	M
277L	-- with cholangiogram	$1,379.00	42	M
278L	Biliary atresia -- exploration with cholangiogram - not paid with portoenterostomy - with liver biopsy add 416L at 75%	$1,297.00	42	M
279L	Hepatico -- enterostomy - includes portoenterostomy (Kasai procedure) for bilary atresia	$3,383.00	42	H
	Oesophagus and Stomach			
292L	Oesophagomyotomy (Heller)	$2,031.00	42	H
293L	Congenital tracheo-oesophageal fistula - with or without esophageal atresia repair - includes esophageal atresia repair without TEF and cervical repair of congenital TEF	$2,025.00	42	H
	Oesophageal diverticulum			
294L	-- transthoracic repair	$1,376.00	42	H
	Pharyngo-oesophageal diverticulum			
295L	-- repair	$1,187.00	42	M
	Ruptured oesophagus			
296L	-- transthoracic repair	$1,313.00	42	H
297L	-- transcervical repair	$940.00	42	M
298L	Oesophagogastrostomy or oesophagojejunostomy	$2,023.00	42	M
	Oesophagectomy or oesophagogastrectomy			
299L	-- with or without pyloroplasty	$2,966.00	42	H
320L	-- with replacement	$3,781.00	42	H
300L	Total oesophagectomy with cervical fistula and gastrostomy	$2,436.40	42	H
301L	Replacement of oesophagus by transplant	$2,966.00	42	H
302L	Vagotomy -- truncal or selective -- abdominal or thoracic	$1,168.00	42	H
321L	Highly selective vagotomy, with or without pyloroplasty	$1,637.10	42	M
	Gastrectomy (with or without splenectomy)			
303L	-- partial	$1,998.00	42	H
304L	-- partial with vagotomy	$2,031.00	42	H
305L	-- total	$3,213.00	42	H
306L	Pyloroplasty	$1,108.00	42	M
607L	-- with oversewing of bleeding ulcer, add	$292.00	42	M
308L	Gastro-enterostomy	$1,143.00	42	M
309L	-- with vagotomy	$1,605.00	42	M
310L	Gastrotomy -- with or without removal of foreign body or tumor	$1,082.80	42	M
	Gastrostomy			
311L	-- simple	$910.00	42	M
312L	-- with living tube	$1,178.00	42	M
313L	Decompression gastrostomy -- in conjunction with other abdominal surgery, add	$200.00 *	42	M
314L	Rammstedt pyloromyotomy	$981.00	42	M
315L	Perforated ulcer -- repair	$1,143.00 *	42	M

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
317L	Resection of anastomotic ulcer	$2,152.00	42	M
318L	Repair duodenal tear	$1,178.00	42	M
319L	Traumatic duodenal fistula	$1,626.00	42	M
327L	Laparoscopic Roux-en-Y Bypass	$3,135.00	42	H
328L	Laparoscopic sleeve gastrectomy	$2,056.00	42	H
	Small Bowel			
330L	Perforated small bowel repair	$1,250.00 *	42	M
	Small bowel obstruction			
331L	-- without resection	$1,283.00 *	42	M
332L	Small bowel resection	$1,603.00	42	M
333L	Appendectomy -- (not paid in addition to abdominal surgery, except where clinically inidcated and billed by report)	$837.00 *	42	M
334L	Entero-enterostomy	$1,523.00	42	M
335L	Enterotomy for foreign body or tumor	$1,227.00	42	M
	Ileostomy revision			
336L	-- minor (service exempt from repeat surgical rule)	$776.00	42	L
337L	-- major (service exempt from repeat surgical rule)	$1,082.80	42	M
338L	Feeding jejunostomy	$1,026.00	42	M
638L	Tube jejunostomy when performed with other surgery	$512.00	42	
339L	Continent ileostomy (Koch's) -- independent procedure	$2,237.00	42	M
340L	Enterostomy or cecostomy -- service exempt from repeat surgical rule	$1,073.00 *	42	M
639L	Closure of loop or double barrelled ileostomy (service exempt from repeat surgical rule)	$1,083.00	42	M
	Bowel Obstruction -- Infant			
	--excluding intussusception			
631L	-- without resection - includes Ladd's procedure for malrotation and/or correction of volvulus	$1,365.30	42	M
632L	-- with resection - includes duodenal atresia repair, repair of jejunoileal atresia (single atresia)	$1,778.00	42	M
	Large Bowel, Rectum and Anus			
342L	Colectomy -- hemi or segmental	$2,070.00	42	H
442L	Hartmann's procedure	$2,080.00	42	H
343L	Total colectomy with or without ileostomy	$2,598.00	42	H
344L	Total colectomy and proctectomy	$4,060.00	42	H
644L	Continent ileostomy (Koch's) -- with 343L or 344L, add	$1,168.00	42	H
645L	Total colectomy with mucosal proctectomy and ileo-pouch with ileo-anal anastomosis and loop ileostomy	$4,750.00	42	M
345L	Ileorectal anastomosis	$1,560.00	42	M
346L	Proctectomy	$1,168.00	42	M
347L	Colostomy (service exempt from repeat surgical rule)	$1,083.00	42	M
348L	Closure of loop or double barrelled colostomy (service exempt from repeat surgical rule)	$1,083.00	42	M
548L	Colonic reanastomosis following Hartmann's procedure	$2,080.00	42	M
	Colostomy revision			
349L	-- minor (service exempt from repeat surgical rule)	$663.00	42	L
350L	-- major (service exempt from repeat surgical rule)	$1,082.80	42	M

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
	Abdomino-perineal resection - includes any type of pullthrough procedure for Hirschsprung's disease			
352L	-- one team -- surgeon	$3,104.00	42	H
353L	-- two team -- abdominal surgeon	$2,771.00	42	H
354L	-- perineal surgeon	$1,057.00	42	H
355L	Proctosigmoidectomy	$2,364.00	42	H
	Colotomy			
356L	-- for foreign body	$1,332.00	42	M
357L	-- for tumor	$1,464.00	42	M
358L	Anterior resection -- without total mesorectal excision	$2,393.00	42	H
359L	Posterior resection	$2,418.00	42	H
370L	Low anterior resection – with total mesorectal excision (TME)	$3,020.00	42	H
	Anus and Rectum			
	Massive rectal prolapse			
365L	-- perineal repair	$1,024.00	42	L
366L	-- abdominal repair	$1,457.00	42	M
367L	-- with sigmoid resection	$1,838.00	42	H
368L	-- abdominal-perineal repair	$2,078.00	42	M
369L	Insertion of ring or wire for rectal prolapse	$608.00	42	L
373L	Closure of rectovesical or rectourethral fistula	$1,402.00	42	M
374L	--with colostomy	$1,539.00	42	M
377L	Banding of hemorrhoids -- each -- (maximum of of three)	$98.60 *	10	L
	Hemorrhoids			
378L	-- injection	$59.90 *	0	L
379L	-- incision or excision external thrombosed	$125.00 *	10	L
380L	Polyp -- anal -- excision	$220.00 *	10	L
381L	Hemorrhoidectomy	$705.00 *	42	L
	Imperforate anus			
383L	Low imperforate anus repair	$1,377.00	42	M
384L	High imperforate anus repair - by any method includes division of vaginal, uretheral or bladder fistula	$1,756.00	42	M
386L	Rectal polyp or tumor -- excision or fulguration -- under anaesthetic	$292.00 *	42	L
387L	Transanal excision of giant villous adenoma of rectum	$944.00	42	M
388L	Deep transrectal or perirectal biopsy for Hirschsprung's disease	$270.70	10	L
371L	Transanal endoscopic microsurgery (TEM), resection of rectal tumor 371L is limited to physicians with advanced fellowship training in colorectal surgery or surgical oncology, as approved by the Saskatchewan Medical Association Tariff Committee.	$1,706.00	42	M
389L	Excision sacro-coccygeal teratoma	$1,457.00	42	M
	Pilonidal			
391L	-- cyst or sinus -- excision or marsupialization	$777.00 *	42	L
394L	Major anal sphincter repair for stricture or incontinence	$1,180.00	42	M
396L	Fissure-in-ano -- incision or excision and/or subcutaneous sphincterotomy	$496.00 *	42	L
	Fistula-in-ano -- excision			
397L	-- superficial	$637.00 *	42	L
398L	-- deep involving sphincter	$981.00 *	42	L

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
399L	-- high	$1,178.00	42	L
562L	Fissure-in-ano -- cleansed and obliterated with Tiseel	$425.00 *	10	L
400L	Anal dilatation - Manual or by balloon (under anaesthetic or IV sedation) (includes post op recovery) Not to be billed with other anorectal surgery such as hemorrhoidectomy, fissure codes etc.	$116.00 *	0	L
	Liver, Spleen, Adrenals			
	Liver			
413L	-- rupture -- repair	$1,507.00	42	H
414L	-- abscess -- incision and drainage	$1,250.00	42	M
415L	-- needle biopsy	$188.00	D	L
416L	-- open biopsy	$927.00	42	M
417L	-- hemi-hepatectomy	$3,383.00	42	H
418L	-- segment hepatectomy	$1,895.00	42	H
	Pancreatectomy			
419L	-- partial	$1,895.00	42	H
420L	-- partial with duodenectomy or total with or without duodenectomy	$6,000.00	42	H
421L	Pancreatic pseudocyst marsupialization or adenoma excision	$1,802.00	42	M
620L	Pancreatic abscess drainage	$1,314.00	42	M
621L	Pancreatico-enterostomy with Roux-en-Y	$2,810.00	42	M
	Splenectomy			
422L	-- abdominal or repair	$1,603.00	42	M
423L	-- thoraco-abdominal	$1,590.00	42	M
426L	Adrenalectomy -- unilateral	$1,783.00	42	H
428L	Extra-adrenal phaeochromocytoma or other retroperitoneal tumor	$2,260.00	42	H
	Lymph Nodes			
	Biopsy			
430L	-- superficial node	$360.00 *	10	L
431L	-- deep node -- beneath deep fascia	$600.00 *	10	L
432L	-- scalene node	$427.00	10	L
433L	-- mediastinal	$608.00	10	M
434L	Suprahyoid block dissection	$1,249.00	42	M
635L	Sentinel lymph node biopsy - with malignant melanoma and breast cancer surgery	$1,042.00	42	M
73L	Central neck dissection - thyroid cancer - add to 72L	$576.00	42	M
	Complete block dissection			
435L	-- neck	$2,277.00	42	H
436L	-- axilla	$1,375.00	42	M
437L	-- groin-wide inguinal	$1,519.00	42	M
438L	-- groin-deep with common iliac dissection	$2,134.00	42	M
439L	-- retroperitoneal -- including pelvic, aortic and renal	$2,499.00	42	H
440L	Scalene fat pad dissection	$672.00	42	L
	Integumentary System			
	Biopsy of palpable superficial lesion - unless otherwise listed			
840L	-- by fine needle biopsy or aspiration	$59.90 *	D	L
841L	-- by core needle biopsy	$82.80 *	D	L
849L	Aspiration of haematoma or cyst	$42.20 *	0	L
850L	Incision and drainage of abscess, etc.	$106.00 *	10	L
851L	Abscess -- multilocular	$131.00 *	10	L

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
852L	Carbuncle, deep (beneath deep fascia) or pilonidal cyst abscess -- unroofing under general anaesthetic	$187.00 *	10	L
853L	Intramuscular abscess	By Report	10	L
854L	Muscle biopsy	$234.00 *	10	L
	Ablation of actinic keratosis, pyogenic granuloma, keratoacanthoma or bleeding lesions by electrocautery, chemical cautery, cryotherapy, laser and/or curettage			
	Abalation of seborrheric keratosis, molluscum contagiosum, skin tags and warts			
603L	- first lesion	$50.00 *	10	L
604L	- second to seventh, each	$19.00 *	10	L
605L	- eighth and over, each	$7.60 *	10	L
	(Venereal Warts, see codes 420R to 422R)			
610L	Laser ablation of actinic keratosis, pyogenic granuloma, keratoacanthoma, plantars warts, bleeding lesions under local anaesthesia --laser owned by physician-- first 15 minute session	$137.00 *	10	L
611L	Each subsequent 15 minutes (maximum of two additional units), add	$79.20 *	10	L
	Pulsed dye turned laser ablation of facial port-wine stains is insured under the age of 18. Pre-authorization required for other symptomatic or bleeding curtaneous angiomata.			
795L	-- removal by electrocautery or laser under local anesthesia - first lesion	$50.30		
796L	- second to seventh, each	$18.60		
797L	- eighth and over, each	$7.90		
798L	-- laser therapy of cutaneous lesions in physician's office - laser owned by physician - first 15 minute session	$125.00	10	
799L	- each subsequent 15 minutes to a maximum of two additional, add	$62.20	10	
780L	Dye-tuned laser ablation of cutaneous lesion - laser owned by physician - per 15 minute session or major part thereof	$101.70 *	0	
781L	- for each unit of up to five pulses, add (Note: Billings also to be made in units; 1 unit = 5 pulses)	$15.00 *	0	
	Lesion removal by surgical excision with suture closure: the various diameter categories below relate to the size of the lesion, not the size of the excision			
	These codes are intended for removal of any lesion type (ie: malignant/non-malignant) where a wide excision has not been carried out. If the pathology report returns with a malignant diagnosis, but a wide excision was not carried out at the time the lesion was excised, it cannot be converted to codes 684N/685N.			
	-- under 1 cm. diameter -- any area			
857L	-- 1st lesion	$106.00 *	10	L
858L	-- 2nd to 7th, each .	$52.60 *	10	L
859L	-- 8th and over, each	$35.20 *	10	L

		Fee	Class	Anae
	-- over 1 cm. diameter --face, palm of hand or fingers, sole of foot or toes			
860L	-- 1st lesion	$164.00 *	10	L
861L	-- 2nd to 7th, each	$84.60 *	10	L
862L	-- 8th and over, each	$56.00 *	10	L
	-- over 1 cm. diameter --other areas, including scalp			
863L	-- 1st lesion	$128.00 *	10	L
864L	-- 2nd to 7th, each	$61.40 *	10	L
865L	-- 8th and over, each	$35.40 *	10	L
	Sebaceous cyst or intradermal cyst (any area)			
866L	Excision and suture closure	$147.00 *	10	L
	Lipoma or subcutaneous tumor -- excision			
867L	-- up to 5 cm.	$144.00 *	10	L
868L	-- over 5 cm. up to 10 cm.	$239.00 *	42	L
869L	-- larger than 10 cm.	$481.00 *	42	L
	Lipomas are only insured when medically necessary (ie. Initial biopsy or causing symptoms in functional area) -- maximum of four services.			
	Beneath deep fascia			
870L	Lipoma or other benign tumor	$720.00	42	L
871L	Malignant tumor	By Report	42	M
971L	Resection of sarcoma (non-retroperitoneal) #Entitlement to bill 971L is limited to physicians with advancec fellowship training in surgical ongology or other proof of expertise in surgical oncology as approved by the Saskatchewan Medical Association Tariff Committee. 1. Physician must indicate on the electronic claim the total duration of time spent performing the resection. 2. Do not send the operative report manually unless requested by MSB. 3. Fee will be applied by MSB based on total duration of time.	By Report#	42	M
	Removal of Foreign Body			
	-- without anaesthesia	Visit Fee		
872L	-- under local anaesthesia	$179.00 *	10	L
873L	-- under general anaesthesia or IV sedation (includes post op recovery)	$239.00 *	10	L
874L	-- complicated	By Report	42	L
974L	Removal of deep metallic foreign body under x-ray or fluoroscopic guidance	$308.00 *	10	L
	Plantar warts -- Excision or fulguration plus curettage			
875L	-- 1st lesion	$57.20 *	10	L
876L	-- each additional (maximum of 4)	$19.20 *	10	L
	Plantar warts -- Treatment by cryotherapy laser, cautery or or chemical ablation			
877L	-- 1st lesion	$28.40 *	10	L
878L	-- 2nd to 7th, each (max. of 6 units for this code)	$11.00 *	10	L
879L	-- 8th and over, each	$3.20 *	10	L
	Removal of fingernail or toenail			

SECTION L:

GENERAL SURGERY

		Fee	Class	Anae
880L	-- simple avulsion or wedge excision	$115.00 *	10	L
881L	-- radical excision of nail bed or hemiphalangectomy	$291.00 *	10	L
882L	-- wedge resection with phenol ablation or cautery or cryo ablation	$200.00 *	10	L
883L	Trimming of toenails, corns or calluses where medically necessary (max. of 1 per day)	$50.00 *	0	L
884L	Soft tissue nail-fold excision for ingrown toenails -- Vandenbos surgery	$245.00	10	L
	Lacerations -- Repair of lacerations - where approximation of wound edges needs to be achieved and maintained. (Laceration repair is categorized below by body location. When billing for multiple repairs add the lengths of all individual lacerations for the same location category, i.e., (A) or (B), and submit as a single total laceration under the appropriate code(s). Where lacerations involve both location categories apply the same procedure within each category).			
	(A) -- face, palm of hand, fingers, sole of foot or toes			
890L	-- up to 2.5 cm.	$113.00 *	10	L
891L	-- each additional 2.5 cm.	$56.00 *	10	L
	(B) -- other areas, including scalp			
894L	-- up to 2.5 cm.	$75.00 *	10	L
895L	-- each additional 2.5 cm.	$37.60 *	10	L
896L	-- complicated - times and details must be provided	By Report	42	L
897L	Tray service --only for office procedures which require sutures or staples, the use of sterilized instruments and are performed under local anaesthetic e.g. excision of skin lesions with sutures or staples, biopsies requiring local anaesthesia and sutures or staples, wedge resection of toenails, vasectomy, sigmoidoscopy or endometrial biopsies (can be paid in addition to the following office procedures only 117A, 100F with sutures, 102F with sutures, 45L, 159L, 430L, 449L, 450L, 684N, 685N, 854L, 857L, 860L, 863L, 866L, 867L, 868L, 869L, 872L, 880L, 881L, 882L, 890L (with sutures or staples), 894L (with sutures or staples), 380N, 382N, 31P, 39P, 59R, 190R, 72S, 89S or 100S)	$51.00 *		
899L	Minor tray service -- -- only for office procedures which require two of suturing, the use of sterilized instruments or are performed under local anaesthetic, -- only payable with the following procedures; 116A, 123A, 100F without sutures, 102F without sutures, 888F, 94H, 158H, 379L,380M, 381M, 382M, 108P, 63S, 91S, 92S, 250S and 88T	$23.00 *		
898L	Removal of sutures from lacerations or sugical incisions of any length by **any** physician	$35.60 *	0	
700L	Surgical debridement; excision of damaged necrotic or otherwise non-viable tissue - payment will include payment for office tray service where applicable	By Report	10	

		Fee	Class	Anae
	(This item is not billed in addition to burns or complicated laceration suture, see code 896L) Physician must provide times and details of procedure.			
	For a claim to be processed, the physician must provide details of: i) the patient's clinical condition ii) the treatment or procedure provided iii) time when the debridement started and was completed			
	Penetrating wound (e.g. gunshot or stab wound)			
720L	-- of chest	FFS	42	H
721L	-- of abdomen	FFS	42	M
	Internalization of Epidural Catheter			
725L	-- tunnelling	$475.00	10	L
726L	-- establishment and connection of catheter	$218.00	0	L
	Burns -- Emergency Treatment e.g. as out-patient 5B or 918A (also see Section N, Burns)			
	Vascular Laboratory (applies to ultrasound vascular studies done in an approved hospital based Vascular Laboratory only)			
	Peripheral Arterial			
750L	Resting arterial assessment -- to include multiple wave form and/or segmental pressure analysis calculation and ankle/arm index	$30.00 *		D
751L	Reactive hyperemia with sequential pressure	$30.00 *		D
752L	Vasospastic assessment -- to include digital pressures and/or plethysmography, cold and hot stress responses and /or multiple extremity wave form analysis	$30.00 *		D
753L	Sympathetic tone response --to include resting arterial assessment plus plethysmography and or impedence monitoring and/or digital wave forms, response to Valsalva monoevers or other stimuli	$30.00 *		D
756L	Digital index assessment (finger or toe), PPG wave forms, pulse volume recordings (not including resting arterial ankle brachial indexes)	$25.40		D
	Peripheral Venous			
754L	Laboratory assessment for interpretation of peripheral venous system	$30.00 *		D
	BMI Supplement			
580L	General surgery supplement for patients with a Body Mass Index, (Weight[kg]/Height[m]2) greater than 40 - Maximum of one 580L supplement per patient per day. - Supplement 580L may be billed by all physicians with all Section L procedures done in the operating room - Supplement 580L may be billed by general surgeons with all L Section procedures done	$117.00		

		Fee	Class	Anae
	in the operating room.			
	- Bariatric surgery fee codes (327L) are exempt from this supplement.			

General Surgery - Endoscopy

ENDOSCOPY

Preamble:
1. Base fees include full endoscopic exam with or without biopsies.
2. Base fees include intravenous injection of medication for sedation if provided by physician performing procedure
3. Unusually complicated or difficult endoscopies by report
4. Biopsy for Barrett's esophagitis and inflammatory bowel disease are listed in endoscopic interventions
5. Cryotherapy for bleeding from polypectomy site is included in polypectomy code

402L	**Oesophagoscopy -- base**	$171.00 *	D	L
403L	-- Bleeding varices management (banding, sclerotherapy, glue, endoloops, hemoclips or other) - any combination -- add	$250.00 *	D	
404L	-- Removal of benign tumor -- add	$124.00 *	D	
	-- Dilatations via endoscope			
405L	-- by means of pneumatic bag or balloon, with or without thread or wire guidance -- add	$248.00 *	D	
406L	-- by means of sound or bougie -- add	$126.00 *	D	
407L	-- Stenting with or without dilatation -- add	$257.00 *	D	
408L	**Gastroduodenoscopy -- base** includes oesophagoscopy	$262.00 *	D	L
409L	Management of bleeding (varices, ulcers, GAVE Banding, sclerotherapy, glue, endoloop, hemoclips or other) - Any combination of above -- add	$257.00 *	D	
410L	Nasojejunostomy tube placement -- add	$126.00 *	D	
411L	Extended enteroscopy -- add	$253.00 *	D	
412L	Dilatation of pylorus -- add	$124.00 *	D	
475L	Endoscopic mucosal resection (EMR) for Barrett’s esophagus -- add 1. Payable in addition to 408L; and 2. Must be billed with diagnosis of Barrett’s esophagus (530).	$220.00	D	
499L	Radiofrequency ablation for Barrett's Oesophagus	$424.00	D	L
590L	Placement of gastric or duodenal self expanding metal stent -- add	$366.00	D	L
	Endoscopic Ultrasound			
490L	Upper endoscopic ultrasound - base	$530.00	D	L
492L	Lower endoscopic ultrasound - base	$318.00	D	L
495L	Fine needle aspiration biopsy - one or more - add	$106.00	D	L
496L	Injection of one or more metastases, nodes, masses or celiac plexus-add	$324.00	D	L
497L	Drainage of pseudo cyst, one or more-add	$424.00	D	L
	Percutaneous gastrostomy under gastroscopic control -- by two physicians			
	-- endoscopic gastrostomy or jejunostomy			
443L	-- 1st physician	$379.00 *	0	L
444L	-- 2nd physician	$253.00 *	0	L
	-- endoscopic gasterostomy and jejunostomy same day			
445L	-- 1st physician	$557.00 *	0	L
446L	-- 2nd physician	$369.00 *	0	L

GENERAL SURGERY

		Fee	Class	Anae
	PEG tube change			
447L	External approach PEG tube removal -- external via gastroscope	$50.40 *	D	L
448L	**Colonoscopy -- base**	$406.00 *	D	L
449L	**Sigmoidoscopy (Flexible) - base code**	$141.00 *	D	L
450L	**Sigmoidoscopy (Rigid) - base code**	$70.80 *	D	L
453L	**Ileoscopy/jejunoscopy when done through ileostomy– base code** (Considered an inclusion when performed same day as 448L or 408L)	$141.00	D	L
	Gastrointestinal Endoscopic Interventions biopsy included in base code except:			
480L	-- For inflammatory bowel disease 10 or more specimens -- add	$125.00 *	D	
481L	-- Barrett's esophagus -- 4 or more specimens -- add	$63.00 *	D	
	Polypectomy (any G.I. Site) -- by loop, electrocautery, submucosal injection etc.			
482L	-- 1st polyp -- add	$126.00 *	D	
483L	-- 2nd to 5th polyp each (maximum of 5 total) -- add	$95.80 *	D	
484L	Sclerotherapy by any thermal means (eg. heater or bicapprobe) or any injectable method (eg. Adrenalin, sclerosing solution) or by gluing -- add	$124.00 *	D	
485L	Dilatations -- all GI dilatations other than esophageal, adc	$123.00 *	D	
486L	Tattoo - any G.I. site -- add	$63.00 *	D	
487L	Botox - any G.I. or bonchial site -- add	$125.00 *	D	
488L	Foreign body removal - any G.I. site -- add Usually complicated or difficult endoscopies by report.	$126.00 *	D	
500L	**Endoscopic Retrograde Cholangiopancreatography -- base** includes routine sweeps of common duct -- maximum procedural billing per base code same day $800.00	$486.00 *	D	L
501L	-- plus papillotomy/sphincterotomy -- add -- with removal of common duct stones and sludge	$186.00 *	D	
502L	-- 1 to 4 stones and/or sludge add	$124.00 *	D	
503L	-- with removal of 5 or more stones - (includes 1 to 4 stones) -- add	$248.00 *	D	
504L	-- with mechanical lithotripsy -- add	$124.00 *	D	
505L	-- with brush cystology -- add	$61.80 *	D	
	-- with Biliary or pancreatic duct balloon dilatations			
506L	-- 1st add	$124.00 *	D	
507L	-- 2nd add	$61.80 *	D	
	-- with stenting (any type of stent) -- stent insertion			
508L	-- 1st add	$124.00 *	D	
509L	-- 2nd add	$61.80 *	D	
510L	-- stent removal -- one or more add	$61.80 *	D	
511L	-- stent removal and replacement -- add	$124.00 *	D	
512L	-- with Brachytherapy catheter placement -- add	$110.00 *	D	
513L	-- with nasobilary tube placement -- add	$119.00 *	D	
514L	With cholangioscopy / pancreatoscopy -- add	$242.80	D	
520L	**Bronchoscopy** -- (unilateral or bilateral with or without biopsy) -- **base**	$253.00 *	D	L
521L	-- with fluroscopy -- add	$121.00 *	D	
522L	-- with tracheobronchial toilet -- add	$126.00 *	D	
523L	-- with removal of benign tumor -- add	$110.00 *	D	
524L	-- with endobronchial malignant tumor debulking -- add	$520.00 *	D	

GENERAL SURGERY

		Fee	Class	Anae
525L	-- with tracheo esophageal fistula creation -- add	$112.00 *	D	
526L	-- with removal of foreign body (rigid or flexscope) -- add	$369.00 *	D	
515L	Endobronchial Ultrasound Base-includes bronchoscopy-516L may be added	$541.00	D	
516L	Transbronchial needle aspiration-add maximum of 3 lesions or stations	$108.00	D	
452L	Video Capsule Endoscopy -- 15 minute units -- maximum of 10 units	$109.00	D	
	Balloon Endoscopies			
527L	Antegrade Double Balloon Enteroscopy	$551.00	D	L
627L	Antegrade Single Balloon Enteroscopy	$551.40	D	L
528L	Retrograde Double Balloon Enteroscopy	$695.60	D	L
628L	Retrograde Single Balloon Enteroscopy	$695.60	D	L
529L	Double Balloon Colonoscopy	$609.00	D	L
530L	Double Balloon Endoscopic Retrograde Cholangiopancreatography	$696.00	D	L

SECTION M:

ORTHOPAEDIC SURGERY

		Fee	Class	Anae
	When the words 'Fee for Service' or 'By Report' are shown rather than a specific rate of payment, the following applies: (a) Fee For Service-- means services are to be biled on the basis of individual appropriate visit or procedure items included in the Payment Schedule, at the listed amount, and are subject to the Assesment Rules. (b) By Report -- Means that the claim form must be accompanied by a detailed explanation of the circumstances and the services provided. Payment will be assessed on the basis of the explanation. These claims must be submitted on claim forms. (c) For out of hours premiums see Section A.			
	Visits			
5M	Initial assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$96.00		
7M	Follow-up assessment -- includes: history review, functional enquiry, examination, reassessment, necessary treatment, advice to the patient and record of service provided	$87.40 *		
9M	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$193.00		
10M	-- consultation for patients referred for back pain only	$159.00		
11M	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$74.40		
13M	Written advice to referring physician on the management of a case based upon review of x-rays by Orthopaedic Surgeon (billable once per case only)	$102.00		
	Hospital Care (Payable on day of admission)			
25M	-- first 10 days, per day	$62.80 *		
26M	-- 11-20 days, per day	$62.80 *		

		Fee	Class	Anae
27M	-- 21-30 days, per day	$62.80 *		
28M	-- thereafter, per day	$62.80 *		

Note: for hospital discharge by physician, see code 725A, Section A.

Procedures

Additional payments for diagnostic service excluding ECG's, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement.

Bones

Incision

30M	Incision of deep soft tissue, abscess from osteomyelitis -- billed by report	$1,020.00 *	10	L

Internal Fixation Removal

Not paid in addition to or part of another orthopaedic procedure unless the internal fixation device is removed from a separate operative site.

31M	Removal of percutaneous pins/wires by any physician done in an office	$71.40 *	0	
32M	Operative removal of metal bone fixation device(s), any number of screws, nails or wires per operative site	$233.30 *	10	L
33M	-- plate (including screws, intramedullary nail)	$663.00 *	10	L

Osteotomy -- with or without internal fixation

40M	Clavicle	$1,070.00	42	L
44M	Humerus or ulna or radius	$1,070.00	42	L
48M	Radius and ulna	$1,070.00	42	L
49M	Femur -- neck or supracondylar	$1,070.00	42	M
50M	-- trochanteric or subtrochanteric	$1,070.00	42	M
56M	Tibia and Fibula	$1,070.00	42	M
64M	Femur, supracondylar, and tibia and fibula	$1,020.00	42	M
60M	Metacarpal, metatarsal or phalanx -- one	$800.00	42	L
68M	Os calcis (Dwyer or wedge tarsectomy)	$1,070.00	42	L

Excision

81M	Biopsy bone	$612.00	42	L
107M	Radio-ulnar synostosis	$1,937.00	42	L
90M	Coccygectomy	$816.00	42	L
	Excision of bone cyst, chondroma or exostosis			
93M	-- large bone	$714.00	42	L
94M	-- with bone graft	$714.00	42	L
95M	-- small bone	$714.00	42	L
96M	-- with bone graft	$714.00	42	L
98M	Partial ostectomy, excision of distal end of ulna or radius .	$510.00	42	L
	Saucerization and/or sequestrectomy			
100M	-- large bone	$682.70	42	L
101M	-- small bone	$663.00	42	L
	Radical resection of bone for tumor with bone graft			
103M	-- major bone	$2,243.00	42	M
104M	-- minor bone	$2,243.00	42	M
	Claviculectomy			
83M	-- partial	$367.00	42	L

SECTION M:

ORTHOPAEDIC SURGERY

		Fee	Class	Anae
84M	-- total	$1,529.00	42	L
86M	Excision of head of radius	$714.00	42	L
88M	Carpectomy	$800.00	42	M
89M	-- each additional (same field only)	$612.00	42	L
87M	Metacarpectomy or metatarsectomy	$714.00	42	L
102M	Excision of head of femur	$744.70	42	M
	Patellectomy			
91M	-- partial	$445.00	42	L
92M	-- total	$1,325.00	42	L
97M	Shaving of patella - when only procedure done	$524.30	42	L
85M	Astragalectomy	$800.00	42	L
79M	Excision of 4 metatarsal heads (Hoffman)	$663.00	42	L
	BMI Supplement			
180M	Orthopaedic surgery supplement for patients with a Body Mass Index, (Weight[kg]/Height[m]2) greater than 40 1. Maximum of one 180M supplement per patient per day. 2. Supplement 180M may be billed by orthopedic surgeons with all M Section procedures done in the operating room. 3. BMI supplements are not payable to the surgical assistant billing “J section codes”.	$336.00		
	Introduction			
110M	Insertion of Kirschner wire or metal pins for traction or cast fixation	$306.00 *	0	L
111M	Application of caliper or tongs	$306.00 *	0	L
	Repair			
	Osteoplasty -- shortening of bone			
120M	-- femur, tibia or humerus	$918.00	42	M
121M	-- radius or ulna	$612.00	42	L
122M	-- both radius and ulna	$1,427.00	42	L
123M	-- other bones	$612.00	42	L
	-- lengthening of bone			
124M	-- major	$1,529.00	42	M
125M	-- minor (hand or foot)	$1,000.00	42	L
126M	Acromioplasty includes excision of distal clavicle	$744.70	42	L
	Note: Spinal fusion with partial excision of intervertebral disc (for excision of disc see 134K to 140K)			
150M	Scapulopexy	$1,835.00	42	M
	Epiphyseal-diaphyseal fusion, epiphyseal arrest or epiphysiodesis			
152M	-- femur or tibia and fibula	$918.00	42	L
154M	-- combined (femur, tibial and fibular) epiphyseal arrest	$1,223.00	42	L
155M	-- combined (upper and lower tibial and fibular) epiphyseal arrest	$1,223.00	42	L

Fractures

1. Definitions

(a) Immobilization means the treatment of a fracture by any method other than that designated in (b) or (c) below.

(b) Closed reduction means the reduction of a fracture by non-operative methods (includes skin traction, K wire or Steinmann's pin for balanced traction).

Fee Class Anae

(c) Open reduction means the reduction of a fracture by an operative procedure to include the exposure of the fracture and fixation with intramedullary or other type of appliance.
(d) Long bones are clavicle, humerus, radius, ulna, femur, tibia and fibula

(e) Large bones are the above long bones plus mandible, facial bones, scapula, pelvis, vertebra, patella, os calcis and talus.

2. Immobilization
Payment is made on a fee-for-service basis for non-operative management (conservative treatment) of stable fractures requiring immobilization only unless otherwise noted in the SMA Guide to Fees.

3. Reduction
Payment includes all manipulations and re-manipulations to achieve and maintain satisfactory reduction during the designated post-operative period.

Payment may be made for the reapplication of casts after the discharge of a hospital in patient. The reapplication of a cast on the day of surgery is not billable.

(a) Payment may be made to a physician who provides emergency care to a patient with a fracture before referral to a specialist.

(b) When the attending physician attempts a closed reduction but fails to achieve satisfactory reduction:
(i) subsequent closed reduction billed by the same physician (or another physician in the same clinic and specialty) is deemed to be an inclusion within the payment made for the previous attempted reduction.
(ii) a subsequent closed reduction by any other physician (not in the same specialty and clinic) will be billed at 100% and payment for the initial attempt shall be reduced by 50%.
(iii) A subsequent closed reduction with external fixation by any physician is paid at 100% and payment for the initial closed reduction shall be reduced by 50%.

(c) Open reduction:
(i) if a fracture is ununited within the designated post-operative period, and an open operation with or without bone graft becomes necessary by any physician, the payment for the original open or closed reduction shall be reduced by 50%.
(ii) When a payment for open reduction is not listed, the listing for a closed reduction may be raised by 50%.
(iii) Intramedullary fixation (closed or open) is payable at the same rate as open reduction.

(d) Multiple fractures:
(i) Multiple fractures requiring closed or open reduction will be paid at 100% for the major reduction and 75% of the listed payment(s) for the remainder, unless:
-- a composite payment is listed for the multiple fractures, or
-- a specific payment is listed for the "additional" procedures, or
-- a specific assessment rule applies for the type and locale of the fractures.
(ii) When multiple major fractures involving different long bones of the same or different extremity occur at the same time, the management of each fracture under the same anaesthetic may be paid at 100% of the listing unless specified otherwise.

(e) Unless otherwise listed, the payment for treatment of a compound fracture is the closed reduction payment plus 50% except where this would exceed the listed payment for open reduction . The maximum payment for reduction of a compound fracture by closed or open reduction is the listed payment for open reduction.

(f) Payment for open treatment of a fracture which remains ununited after the

		Fee	Class	Anae
	designated post-operative period is based on 150% of the SMA Guide to Fees item for primary open reduction.			
	Fracture and Dislocation 1. Only the greater listed amount is paid when a Fracture and Dislocation are billed for the same day, same site.			
	2. Unless otherwise indicated, the rules for Fractures and Dislocations apply: (a) on the same day -- to the same physician or another physician in the same specialty and clinic (or part of the surgical team); (b) during the designated post-operative period -- to the surgeon, a general practitioner in the same clinic, or a specialist in the same specialty and clinic.			
	Bone Graft			
133M	Use of bone graft -- autogenous bone from different site -- add to the amount payable for the procedure done. Cannot be billed for spine surgery cases.	add 50%		
134M	-- bone bank oral surgeon Cannot be billed for spine surgery cases.	add 25%		
135M	Harvesting of bone graft for use of Oral Surgeon	$1,200.00	42	L
136M	Extensive harvesting of cadaver bone	$1,835.00	42	
	Fractures			
	Spine and Trunk			
	Sacrum			
166M	-- operative management	$430.10	42	L
	Clavicle			
173M	-- open reduction	$867.00	42	L
	Scapula			
174M	-- closed reduction	$282.50 *	42	L
177M	-- open reduction	$1,529.00	42	L
	Sternum			
179M	-- open reduction	$313.50	42	L
	Pelvis (Ilium, Ischium, Pubis)			
	Fracture			
192M	-- one or more bones -- open reduction	$2,039.00	42	M
193M	-- unstable -- closed reduction with external fixation	$1,121.00	42	M
	Acetabulum -- with or without other fractures of pelvis			
195M	-- central -- with displacement	$689.10	42	L
196M	-- open reduction	$2,549.00	42	M
	Upper Extremity			
	Humerus			
	-- surgical neck or epiphyseal separation			
201M	-- closed reduction	$300.00 *	42	L
203M	-- open reduction	$1,070.00	42	L
204M	-- shaft -- closed reduction	$357.00 *	42	L
206M	-- open reduction	$1,070.00	42	L
210M	-- reduction with external fixation device	$904.20	42	L
	Elbow			
	-- epicondyle only			
207M	-- closed reduction	$295.30 *	42	L
208M	-- open reduction	$714.00	42	L

ORTHOPAEDIC SURGERY

		Fee	Class	Anae
	Distal end of humerus, proximal end of radius or ulna, condyle -- one or more bones			
209M	-- closed reduction	$313.50 *	42	L
212M	-- open reduction	$1,070.00	42	L
214M	Supracondylar -- displaced -- closed reduction by manipulation or traction	$406.60	42	L
218M	Olecranon -- open reduction	$612.00	42	L
	Radius			
	-- head			
220M	-- closed reduction	$408.00 *	42	L
222M	-- open reduction	$714.00	42	L
	-- shaft			
225M	-- closed reduction	$300.00 *	42	L
229M	-- open reduction	$663.00 *	42	L
	-- distal end (Colles' including ulnar styloid)			
233M	-- closed reduction	$408.00 *	42	L
235M	-- open reduction	$918.00 *	42	L
237M	Colles -- reduction with external fixation device	$561.00 *	42	L
	Ulna			
	-- shaft			
240M	-- closed reduction	$295.30 *	42	L
243M	-- open reduction	$612.00 *	42	L
244M	-- Monteggia fracture -- dislocation	$663.00	42	L
	Radius and Ulna (excluding Colle's)			
247M	-- closed reduction	$459.00 *	42	L
249M	-- open reduction	$1,070.00 *	42	L
250M	-- reduction with external fixation device	$806.80 *	42	L
	Carpal bone			
251M	-- closed reduction	$295.30 *	42	L
252M	-- open reduction	$1,070.00 *	42	L
253M	-- reduction with external fixation device	$765.00 *	42	L
	Metacarpal			
255M	-- closed reduction	$408.00 *	42	L
257M	-- open reduction	$714.00	42	L
256M	Reduction of Bennett's fracture by internal fixation	$714.00 *	42	L
	Phalanx -- finger or thumb			
260M	-- closed reduction	$408.00 *	42	L
262M	-- open reduction	$714.00 *	42	L
	Lower Extremity			
	Femur			
	-- neck			
291M	-- internal fixation	$1,440.00	42	M
	Intertrochanteric			
295M	-- internal fixation	$1,440.00	42	M
	-- slipped epiphysis			
296M	-- closed reduction	$763.00	42	L
297M	-- open reduction -- acute	$1,440.00	42	M
298M	-- reconstructive later	$1,529.00	42	M
	-- shaft -- including supracondylar			
299M	-- closed reduction	$689.10 *	42	L
303M	-- open reduction	$1,427.00	42	M
	Patella			

SECTION M:

ORTHOPAEDIC SURGERY

		Fee	Class	Anae
305M	-- immobilization only	$343.00 *	42	L
307M	-- open reduction or excision -- complete or partial	$714.00	42	L
	Tibia			
	-- shaft			
310M	-- closed reduction -- includes fibular shaft	$541.40 *	42	L
312M	-- open reduction -- includes fibular shaft	$1,020.00 *	42	M
314M	-- plateau -- closed reduction	$430.10	42	L
315M	-- open reduction	$1,223.00	42	M
316M	-- malleolus -- closed reduction	$300.00 *	42	L
317M	-- open reduction	$663.00	42	L
	Fibula			
318M	-- shaft -- closed reduction	$306.00 *	42	L
319M	-- open reduction	$663.00	42	L
320M	-- malleolus -- closed reduction	$492.20 *	42	L
321M	-- open reduction	$663.00	42	L
330M	Tibia and Fibula -- reduction with external fixation device	$969.00 *	42	L
	Ankle -- bimalleolar (including Potts)			
323M	-- closed reduction	$313.50 *	42	L
325M	-- open reduction	$918.00	42	L
340M	-- reduction with external fixation device	$969.00	42	L
	-- trimalleolar			
326M	-- closed reduction	$313.50 *	42	L
328M	-- open reduction	$1,070.00	42	L
341M	-- reduction with external fixation device	$969.00	42	L
	Tarsal -- (except astragalus and os calcis)			
329M	-- closed reduction	$306.00 *	42	L
331M	-- open reduction	$918.00	42	L
	Astragalus			
332M	-- closed reduction	$306.00 *	42	
334M	-- open reduction	$1,070.00 *	42	L
	Os calcis			
335M	-- closed reduction	$306.00 *	42	L
337M	-- open reduction	$1,070.00	42	L
338M	-- skeletal pinning with external fixation	$765.00	42	L
	Metatarsal			
339M	-- closed reduction	$295.30 *	42	L
343M	-- open reduction	$510.00	42	L
	Phalanx			
345M	-- closed reduction	$306.00 *	42	L
348M	-- open reduction	$510.00 *	42	L
	Treatment of un-united fractures by bone stimulator -- total carenot payable for stress fractures			
350M	External application (Bi-Osteogen)	$445.00		L
351M	Percutaneous insertion	$879.50		L
352M	Operative implantation -- add 100% of benefit			M

		Fee	Class	Anae
	rate for open reduction (50% for ununited fracture; 50% for operative implantation) -- with bone bank graft -- add 25% of benefit rate of open reduction, under code 134M -- with autogenous bone graft -- add 50% of benefit rate of open reduction, under code 133M			
	Note: Specialist in Orthopaedic Surgery only			
	Joints			
359M	**Arthroscopy**	$357.00	D	L
	Incision			
	Arthrotomy or capsulotomy with exploration, drainage or removal of loose body, e.g. osteochondritis or foreign body			
360M	Shoulder	$969.00	42	L
361M	Elbow	$969.00	42	L
362M	Wrist	$969.00	42	L
363M	Other joints of upper extremity	$969.00	42	L
364M	Hip	$969.00	42	L
365M	Knee	$969.00	42	L
366M	Ankle .	$969.00	42	L
367M	Other joints of lower extremity	$969.00	42	L
379M	Sesamoid bone -- excision -- one or more -- unilateral	$250.00 *	42	L
	Arthrocentesis -- puncture for aspiration of joint and/or injection of medication			
380M	-- hip	$66.30 *	0	L
381M	-- shoulder, elbow, knee	$50.00 *	0	L
382M	-- others	$51.00 *	0	L
	Excision			
	Arthrectomy -- Excision of joint			
390M	Punch biopsy of synovial membrane	$79.20	D	L
	Temporomandibular joint			
391M	-- meniscectomy	$572.50	42	L
392M	-- condylectomy	$682.70	42	L
384M	Chemonucleolysis of intervertebral disc	$898.80	42	L
385M	Percutaneous automated discectomy	$744.70	42	L
398M	Excision of neural arch and nerve exploration for spondylolisthesis	$1,679.90	42	L
	Major meniscal tears and extensive articular debridement are each billable.			
399M	Meniscectomy -- knee	$589.00	42	L
397M	meniscus repair includes limited trimming of The fee for open or arthroscopic meniscectomy or meniscus repair includes limited trimming of chondromalacia, plica and minor tears of other meniscus.	$774.70	42	L
840M	Debridement of Shoulder Joint (Arthroscopic -- major debridement should take more than 20 minutes. Minor debridement, taking less than 20 min. is included in arthroscopy code 359M)	$693.00	42	L
841M	Debridement of Knee Joint (Arthroscopic -- major debridement should take more than 20 minutes. Minor debridement, taking	$589.00	42	L

		Fee	Class	Anae
	less than 20 min. is included in arthroscopy code 359M)			
170M	Acetabular labral debridement or repair	$1,772.00	42	**L**
	Synovectomy (not paid in addition to major joint surgery)			
400M	-- elbow	$969.00	42	L
401M	-- wrist	$918.00	42	L
402M	-- finger -- MP joint -- one	$714.00	42	L
404M	-- finger -- IP joint	$612.00	42	L
406M	-- thumb -- MP joint -- one	$714.00	42	L
407M	-- thumb -- IP joint	$612.00	42	L
408M	-- toe -- one	$612.00	42	L
410M	-- hip	$879.50	42	L
411M	-- knee	$731.90	42	L
412M	-- ankle	$731.90	42	L
413M	-- foot	$714.00	42	L

(Arthrodesis - see page M16) (Excision of ganglion see 671M)

Arthroplasty

Plastic or reconstructive operation on joint, any type includes reconstruction of ligaments, etc. (Payment for revision of a previous hip arthroplasty, revision of a total hip replacement or reconstructive arthroplasty and total replacement knee arthropoasty, is made at 150% of the benefit rates of service codes 435M, 445M and 444M respectively).

The reduction of a dislocated hip within the post-operative period is included in the payment for the arthroplasty.

For a two stage revision of a total hip replacement, the payment is made on the basis of 435M for the first stage and 885M for the second stage.

Synovectomy is an inclusion within the payment for major joint surgery.

430M	Shoulder	$969.00	42	M
446M	Total	$1,655.30	42	M
846M	Total shoulder replacement -- revision	$3,059.00	42	M
431M	Elbow	$969.00	42	L
442M	Total elbow replacement	$1,937.00	42	L
842M	Total elbow replacement -- revision .	$3,874.00	42	L
432M	Wrist .	$1,223.00	42	L
448M	Total wrist replacement	$1,937.00	42	L
848M	Total wrist replacement -- revision	$3,874.00	42	L
433M	Finger -- one joint	$714.00	42	L
434M	Arthroplasty - finger - one joint - with prosthesis	$492.20	42	L
834M	Arthroplasty - finger - one joint - with prosthesis -- revision	$803.00	42	L
634M	-- with extensor tendon transfer	$602.00	42	L
435M	Hip	$1,082.80	42	M
835M	Hip -- revision	$2,141.00	42	M
445M	Total hip replacement or reconstructive arthroplasty -- revision	$1,655.30	42	M
845M	-- with extensive acetabular reconstruction with bone graft, add	$430.10	42	M
885M	Total hip replacement or reconstructive arthroplasty -- revision	$3,059.00	42	M
436M	Knee	$969.00	42	M
444M	Total knee arthroplasty includes unicompartmental	$1,655.30	42	M

		Fee	Class	Anae
	knee and patellar replacement			
844M	Total knee arthroplasty includes unicompartmental knee and patellar replacement -- revision	$3,059.00	42	M
437M	Ankle	$969.00	42	L
449M	Total ankle replacement -- revision	$1,937.00	42	L
849M	Total ankle replacement -- revision	$3,059.00	42	L
438M	Toe--one joint (except great toe)	$714.00	42	L
439M	Metatarsophalangeal joint -- first -- bunion operation -- unilateral	$387.30	42	L
441M	Bunionectomy with metatarsal osteotomy -- unilateral	$816.00	42	L
460M	Hallux rigidus -- repair	$816.00	42	L
	Arthrodesis			
450M	Shoulder	$2,243.00	42	M
451M	Elbow	$1,529.00	42	L
452M	Wrist	$1,529.00	42	L
453M	Finger or thumb -- one joint	$714.00	42	L
853M	Arthrodesis - finger or thumb - one joint - with autogenous bone graft (includes harvesting)	$1,837.00	42	L
454M	Hip	$2,243.00	42	M
455M	Knee	$2,243.00	42	M
456M	Ankle	$1,529.00	42	L
	Triple arthrodesis			
464M	-- unilateral	$1,631.00	42	L
467M	-- with tendon transplantation, add	$612.00	42	L
	Hammer and claw toe -- repair includes excision, arthrodesis and arthroplasty of IP joints; capsulotomy of MTP joint; all tenotomies, tendon lenghtening and transfers			
457M	-- one toe (except great toe)	$357.00 *	42	L
459M	-- great toe -- interphalangeal joint	$714.00	42	L
462M	Tarsal joints -- one or more	$816.00	42	L
463M	Other joints -- lower extremity	$816.00	42	L
468M	Flat foot plasty or Grice	$1,529.00	42	L
469M	Stabilization of joints by bone block	$714.00	42	L
470M	Sacro-iliac fusion	$1,223.00	42	M
	Capsulorrhaphy -- suture or repair of joint capsule and ligaments			
	Shoulder			
480M	-- recurrent dislocation	$1,020.00	42	M
	Acromioclavicular joint			
489M	-- repair	$714.00	42	M
490M	-- reconstruction	$1,223.00	42	L
	Knee Reconstruction			
370M	Knee anterior cruciate ligament-reconstruction, repair or reattachment of bony avulsion	$1,070.00	42	M
371M	Knee posterior cruciate ligament-reconstruction, repair or reattachment of bony avulsion	$1,070.00	42	M
372M	Knee posterior cruciate ligament-reconstruction with allograft or autograft	$1,607.00	42	M
373M	Knee medial collateral ligament-reconstruction with allograft or autograft	$1,070.00	42	M
374M	Knee medial collateral ligament-repair, reattachment or advancement	$714.00	42	M

ORTHOPAEDIC SURGERY

		Fee	Class	Anae
375M	Knee lateral collateral ligament and/or posterolateral corner-reconstruction with autograft or allograft	$1,835.00	42	M
376M	Knee lateral collateral ligament and/or posterolateral corner-repair, reattachment or advancement	$1,070.00	42	M
	Ankle			
486M	-- repair of ligament(s)	$600.00	42	L
487M	-- reconstruction of ligament(s)	$867.00	42	L
	Hand			
488M	-- reconstruction metacarpophalangeal or interphalangeal ligament(s)	$714.00	42	L
500M	Manipulation of any peripheral joint under general anaesthesia -- (includes shoulder or hip)	$141.20 *	0	L
	Clubfoot			
520M	-- extensive posterior release (includes Achilles tendon lengthening, flexor hallucis longus lengthening, capsulotomy of the ankle and subtalar joints)	$2,039.00	42	M
521M	-- complete extensive postero-medial release (includes code 520M)	$1,194.10	42	M
	Club foot -- non operative management	By report		
	Dislocations 1. The fee listed includes: (i) all manipulations to achieve and maintain satisfactory reduction, and (ii) visits and the reapplication of any casts or fixation media for a related condition on the date of reduction and during the period prior to the discharge of hospital in patients. 2. Subsequent attempts at reduction are subject to the rules within the preamble to "Fractures". 3. Payment for compound dislocations is based on 150% of the fee for closed reduction. 4. Only the greater listed amount is paid when a fracture and dislocation are billed for the same day, same site.			
	Temporomandibular			
530M	-- closed reduction with or without anaesthesia	$53.30 *	10	L
	Clavicle			
	-- sternoclavicular			
537M	-- closed reduction	$250.00 *	10	L
539M	-- open reduction	$900.00	42	L
	-- acromioclavicular			
540M	-- closed reduction	$400.00 *	42	L
541M	-- open reduction	$572.50	42	L
	Shoulder (humerus)			
542M	-- closed reduction	$408.00 *	42	L
	-- open reduction			
543M	-- fresh	$430.10	42	L
544M	-- old	$744.70	42	L
	Elbow			
545M	-- closed reduction	$460.00	42	L
	-- open reduction			

ORTHOPAEDIC SURGERY

		Fee	Class	Anae
547M	-- fresh	$510.00	42	L
548M	-- old	$1,020.00	42	L
546M	Radial head -- closed reduction (pulled elbow)	$250.00 *	0	L
	Wrist -- carpal			
	-- one bone			
549M	-- closed reduction	$250.00 *	10	L
551M	-- open reduction	$510.00	42	L
	Metacarpal			
555M	-- closed reduction	$250.00 *	10	L
557M	-- open reduction	$612.00	42	L
	Metacarpophalangeal joint			
558M	-- closed reduction	$250.00 *	10	L
560M	-- open reduction	$561.00	42	L
	Interphalangeal joint			
561M	-- closed reduction	$250.00 *	42	L
562M	-- open reduction	$561.00	42	L
	Hip (femur)			
568M	-- closed reduction	$510.00 *	42	L
569M	-- open reduction	$1,020.00	42	M
570M	-- with fracture of posterior portion of acetabulum	$1,325.00	42	M
	-- congenital -- closed treatment	By report		
573M	-- open reduction	$1,529.00	42	M
574M	-- with shelving	$1,325.00	42	M
575M	Pelvic osteotomy -- Salter, etc.	$2,243.00	42	M
576M	-- with arthrotomy	$1,310.80	42	M
	Knee (tibia)			
577M	-- closed reduction	$250.00 *	42	L
579M	-- open reduction	$663.00	42	L
	Patella			
580M	-- closed reduction	$250.00 *	10	L
582M	-- open reduction	$313.50	42	L
	Reconstruction for recurrent patellar dislocation			
583M	-- lateral retinacular release	$408.00	42	L
581M	-- soft tissue realignment	$1,427.00	42	L
589M	-- bony realignment including soft tissue realignment	$703.00	42	L
	Ankle			
584M	-- closed reduction	$408.00 *	42	L
585M	-- open reduction	$663.00	42	L
	-- subastragalar			
586M	-- closed reduction	$408.00	42	L
587M	-- open reduction	$663.00	42	L
	Tarsal			
588M	-- closed reduction	$408.00 *	42	L
590M	-- open reduction	$663.00	42	L
	Metatarsal -- one bone			
591M	-- closed reduction	$250.00 *	10	L
594M	-- open reduction	$510.00	42	L
	Toe			
596M	-- closed reduction	$250.00 *	10	L

ORTHOPAEDIC SURGERY

		Fee	Class	Anae
598M	-- open reduction	$510.00 *	42	L
	Bursae			
610M	Incision & drainage of infected bursa	$61.00 *	10	L
611M	Removal of subdeltoid calcareous deposits	$313.50	42	L
612M	Removal of subtrochanteric calcareous deposits	$313.50	42	L
	Removal of calcareous deposits -- other joints -- see Arthrotomy			
614M	Puncture for aspiration or needling with or without irrigation or injection of medication	$31.00 *	0	L
620M	Radical excision of bursae -- forearm, viz. tenosynovitis, fungosa, Tbc., and other granulomas	$541.40	42	L
	Excision of bursa			
621M	-- olecranon	$510.00 *	42	L
622M	-- prepatellar	$510.00 *	42	L
623M	-- subacromial	$357.00	42	L
624M	-- ischial	$430.10	42	L
	Muscles			
630M	Quadriceps plasty	$918.00	42	L
631M	Repair of ruptured limb muscle -- belly, origin, or insertion (for lacerations -- see 890L, 896L)	$387.30	42	L
	Tendons, Tendon Sheaths and Fascia			
	Incision			
	Drainage of tendon sheath			
640M	-- one digit	$408.00 *	42	L
641M	-- single palm and/or wrist, ulnar or radial bursa -- in hospital	$510.00	42	L
642M	Injection of tendon sheath	$58.40 *	0	L
643M	Incision of fibrous sheath of tendon for stenosing tenosynovitis	$510.00	42	L
644M	Division of iliotibial band -- open reduction	$326.00	42	L
	Ober and Yount fasciotomy, combine (or Soutter procedure) with spica cast, pins in tibia, wedging of casts, etc.			
645M	-- unilateral	$1,692.00	42	L
646M	Compartment Pressure Monitoring	$154.10	D	L
	Hip adductors			
	-- unilateral			
649M	-- percutaneous	$306.00	42	L
650M	-- open	$765.00	42	L
	-- bilateral			
651M	-- percutaneous	$408.00	42	L
652M	-- open	$918.00	42	L
	-- with peripheral obturator neurectomy			
653M	-- unilateral	$308.00	42	L
	Intrapelvic obturator neurectomy			
655M	-- unilateral	$361.00	42	M
657M	Sever (or similar procedure) of shoulder for Erb's palsy	$1,631.00	42	L
	Excision			
671M	Excision of lesion of tendon or fibrous	$510.00 *	42	L

		Fee	Class	Anae
	sheath, or ganglion Radical excision of bursae, forearm, viz. tenosynovitis, fungosa, Tbc., and other granulomas -- See 620M			
673M	Excision of Baker's cyst	$612.00	42	L
674M	Fasciotomy -- single -- palm or sole -- subcutaneous -- blind	$408.00	42	L
677M	Fasciectomy -- open -- plantar -- unilateral	$714.00	42	L
678M	Compartment syndrome release -- for trauma	$744.70	42	L
	Repair			
680M	Tendon sheath reconstruction -- insertion of silastic rod	$663.00	42	L
681M	-- each additional	$357.40	42	L
780M	Repair boutonniere deformity	$393.80	42	L
	Repair or suture -- extensor tendon			
690M	-- single hand or foot -- distal to wrist or ankle	$561.00 *	42	L
	-- each additional tendon			
691M	-- foot	$306.00 *	42	L
692M	-- hand	$561.00 *	42	L
693M	-- single -- forearm or leg	$510.00 *	42	L
	-- each additional tendon			
694M	-- leg	$56.00 *	42	L
695M	-- forearm	$510.00 *	42	L
	Repair or suture -- flexor tendon			
696M	-- single unless otherwise listed	$816.00	42	L
697M	-- each additional	$612.00 *	42	L
	Transfer or transplant of tendon -- single			
698M	-- distal to elbow, distal to knee	$867.00	42	L
700M	-- each additional	$714.00	42	L
701M	-- elbow or shoulder, knee or hip	$867.00	42	L
702M	-- each additional	$306.00	42	L
781M	Free extensor tendon graft -- single	$800.00	42	L
782M	-- each additional	$418.00	42	L
703M	Free flexor tendon graft -- single	$1,070.00	42	L
704M	-- each additional	$1,033.60	42	L
	Tenolysis			
705M	-- single -- flexor	$714.00	42	L
706M	-- each additional	$459.00	42	L
725M	-- single -- extensor	$510.00	42	L
726M	-- each additional	$408.00	42	L
727M	Tenodesis	$867.00 *	42	L
707M	Lengthening or shortening tendon	$612.00	42	L
708M	Opponens transfer	$816.00	42	L
709M	Intrinsic transplant active or passive	$603.50	42	L
710M	Intrinsic release (Littler) or incision	$510.00	42	L
711M	-- additional fingers	$306.00	42	L
712M	Free fascial graft for reconstruction tendon pulley or repair bowstring tendon -- single	$612.00	42	L
714M	Abdominal fascial transplants -- bilateral	$639.90	42	L
716M	Ruptured quadriceps tendon - repair	$714.00	42	L
481M	Raptured patellar ligament - repair	$900.00	42	L

		Fee	Class	Anae
721M	Ruptured patellar ligament or Achilles tendon -- repair with fascial or tendon graft	$900.00	42	L
717M	Ruptured biceps tendon - elbow - repair	$714.00	42	L
718M	Flexor-plasty -- elbow	$900.00	42	L
719M	Repair ruptured supraspinatus tendon or musculotendinous shoulder cuff -- with or without acromioplasty	$969.00	42	M
	Tenotomy			
722M	-- percutaneous	$510.00 *	10	L
723M	-- open	$510.00 *	10	L
724M	-- each additional (of either 722M or 723M)	$306.00 *	10	L
	Extremities			
	Incision			
731M	Drainage of single infected space of hand (lumbrical, hypothenar, thenar, middle palmar, etc.) with or without tendon sheath involvement	$714.00	42	L
732M	Drainage of multiple infected spaces of hand with or without tendon sheath involvement	$1,121.00	42	L
	Amputation			
	Upper Extremity			
740M	Interthoracoscapular	$1,529.00	42	M
741M	Disarticulation of shoulder	$1,529.00	42	M
742M	Arm through humerus	$1,600.00	42	M
743M	Forearm, through radius and ulna	$1,529.00	42	M
745M	-- with subsequent revision or reamputation	$1,529.00	42	M
746M	Cineplasty -- complete procedure	$1,253.00	42	M
747M	Disarticulation of wrist	$1,529.00	42	M
748M	Hand, through metacarpal bones	$1,529.00	42	M
749M	Metacarpal, with finger or thumb, one with split or Wolff graft, or skin-plasty and/or tenodesis with definitive resection palmar digital nerves	$1,529.00	42	L
750M	Finger, any joint, or phalanx, one -- with split or Wolff graft, or skin-plasty and/or tenodesis, with definitive resection volar digital nerves	$816.00 *	10	L
	Lower Extremity			
760M	Interpelviabdominal	$1,365.30	42	H
761M	Disarticulation of hip	$1,937.00	42	M
762M	Disarticulation of knee	$1,179.00	42	M
763M	Thigh through femur, including supracondylar	$1,199.00	42	M
765M	-- Revision or reamputation	$261.00	42	M
766M	Leg, through tibia and fibula	$1,600.00	42	M
768M	-- Revision or reamputation	$265.00	42	M
769M	Ankle (Syme, Pirogoff) -- with skin-plasty and resection nerves	$1,529.00	42	M
770M	Foot -- transmetatarsal	$1,600.00	42	M
771M	Midtarsal	$1,529.00	42	M
772M	Metatarsal, with toe, split or Wolff graft or skin-plasty and/or tenodesis, with definitive resection digital nerves	$816.00	42	L
774M	Toe, any joint or phalanx, one -- with split or Wolff graft, or skin-plasty and/or	$612.00 *	10	L

		Fee	Class	Anae
	tenodesis, with definitive resection digital nerves			
	Plaster Casts Service codes 800M to 822M are payable in conjunction with a consultation, complete assessment or initial assessment service when the physician personally the casts. Payment may be made for the reapplication of casts the day of surgery. Finger or Toe -- bill as a visit fee			
	Plaster Casts			
800M	-- forearm	$93.20	*	0
801M	-- elbow to fingers	$93.20	*	0
802M	-- hand or wrist	$91.80	*	0
803M	-- shoulder to hand	$102.00	*	0
804M	-- shoulder spica	$102.00	*	0
805M	-- ankle (foot to midleg)	$102.00	*	0
806M	-- knee (foot to thigh)	$114.00	*	0
808M	Ambulatory leg cast	$102.00	*	0
809M	Molded plaster to leg	$153.00	*	0
	Spica			
810M	-- unilateral (rib margin to toe)	$1,070.00	*	0
	Body			
812M	-- shoulder to hip	$510.00	*	0
813M	-- including head	$160.50	*	0
814M	Unna boot	$104.00	*	0
815M	Wedging of cast	$102.00	*	0
820M	Risser, or similar, cast for scoliosis	$1,070.00		0
821M	Halo cast	$406.60		42
822M	Application of hinged brace on knee cast -- composite fee for brace and cast	$154.10	*	0
825M	Cast removal (when physician personally removes the cast)	$30.60	*	0
	Bracing Billable only when the physician personally applies the brace -- adjustments performed by the physician are billable as visits/assessments -- billable by only one physician once per brace			
830M	Thoracolumbar brace for spine deformity	$469.00		0

SECTION N:

PLASTIC SURGERY

		Fee	Class	Anae
	Visits			
5N	Initial Assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$91.80		
7N	Follow-up Assessment -- includes: history review, functional enquiry, examination, reassessment, necessary treatment, advice to the patient and record of service provided	$79.20 *		
9N	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$179.00		
11N	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$91.80		
13N	Written advice to referring physician on the management of a case based upon review of x-rays by Plastic Surgeon (payable once per case only)	$91.80		
	Hospital Care (Payable on day of admission)			
25N	-- first 10 days, per day	$62.00 *		
26N	-- 11-20 days, per day	$61.00 *		
27N	-- 21-30 days, per day	$61.00 *		
28N	-- thereafter, per day	$61.00 *		

Note: for hospital discharge by physician,
see code 725A, page A28

For out of hours surgery premiums - see page A36

SURGERY OF APPEARANCE

PREAMBLE

Surgery to restore or improve function altered by disease, trauma or congenital deformity is insured.

Surgery to alter appearance is insured for certain facial and nonfacial abnormalities due to disease, trauma or congenital defect as listed below.

Specific criteria for insurability in the most common conditions are outlined below.

Face and Neck

1. Revision of scars due to trauma, disease, or surgery is insured. Revision of scars resulting from cosmetic surgery is insured only in the case of post-operative complications.

2. Correction of functionally disabling or disfiguring abnormalities of deep structures due to disease, trauma or congenital defect is insured.

Repair of traumatic or disease induced hair loss is insured. Medical or
3. surgical therapy for familial hair loss is uninsured.

4. Correction of facial or neck deformity due to aging is uninsured.

5. Repair of protruding or congenitally deformed ears is insured under the age of 18. For those 18 and over, repair is insured under exceptional circumstances such as early unwarranted parental opposition, unavailability of service, financial limitations, etc.

6. Rhinoplasty is insured if the nasal malformation is due to trauma, disease, neoplasm, or birth defect.

Rhinoplasty to alter appearance due to a familial trait or aging is uninsured.

Rhinoplasty for appearance, when done with a septoplasty, is uninsured and the costs of the former are the responsibility of the patient.

7. Ablation of facial or neck port-wine stain by dye tuned laser is insured under the age of 18. Pre-authorization required for other symptomatic or bleeding cutaneous angiomata or for individuals over the age of 18.

Other Body Areas

1. Scar revision is insured if scars cause a functional disability, are painful, are unstable, or if revision is part of a pre-planned staged reconstructive procedure.

Scar revision is also insured if there is a history of post-operative complication or condition affecting wound healing.

2. Tattoo ablation or excision is insured only if it has been placed involuntarily. Otherwise, cost of removal is the responsibility of the patient.

3. Augmentation mammoplasty is insured for congenital or post-surgical amastia. If unilateral augmentation mammoplasty is done for the above reasons, then a balancing operation such as augmentation, reduction, or mastopexy is insured for the opposite breast.

Augmentation mammoplasty may be insured for a severely hypoplastic breast where the second breast is not hypoplastic, subject to prior approval by MSB Medical Consultant(s).

4. Reduction mammoplasty is insured if, due to the size of the breast, there are symptoms such as, painful shoulder grooves, intertrigo, breast pain, backache, or significant posture changes.

Reduction mammoplasty is insured if there is significant size discrepancy between the breasts.

5. Abdominal panniculectomy (354N) is insured when
a) The patient has experienced weight loss with a previous body mass index (BMI) of at least 40 or
greater, **AND**
b) Has a current BMI of 30 or less, **AND**
c) Has maintained this weight for a period of no less than 12 months, **AND**
d) Has a chronic and recurrent skin condition (cellulitis, skin necrosis, ulcers) which has failed to respond to (or be managed by) conservative medical treatment for 6 months of medically supervised therapy.

The following conditions are not indications for abdominal panniculectomy: back pain, multiple gestations, previous cesarean section, tethered abdominal scars, postural changes or rectus diastasis.

PLASTIC SURGERY

		Fee	Class	Anae
	Abdominal panniculectomy is only insured by prior approval with submission of pictures and a "Prior Approval Request Form" which can be found at http://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/ministry-of-health-forms			
	6. Spider vein (telangiectasia) treatment by injection, excision, thermal ablation, or laser therapy is not insured. Treatment of symptomatic varicose veins is insured.			
	7. Sex reassignment surgery is insured only if performed on patients for whom surgery has been recommended by an authority recognized by Medical Services Branch			
	Procedures			
	Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, pages A34 and A35.			
32N	Removal of interdental and/or intermaxillary wiring and/or arch bar	$140.00 *	0	L
	Treatment of Soft Tissue Injury – grafts, burns, wounds			
	Grafts (100N to 111N, 241N to 244N, and 280N)			
	a) Grafting codes 100N to 111N are on referral to a plastic surgeon.			
	b) Grafting codes 241N to 244N, and 280N are on referral to a plastic surgeon, otolaryngologist, ophthalmologist or urologist.			
	c) Multiple body areas for the above service codes are eligible for payment at 100% of the listed payment when performed on different body areas.			
	Defects:			
	a) Resection of tissue, meticulous suture technique, multiple tie-overs and other fixation.			
	Body Areas:			
	a) One body area is defined as: face, neck, scalp, chest, abdomen, back, upper arm, forearm, hand, genitalia, buttock, thigh, lower leg and foot.			
	b) Only one code per body area is billable.			
	c) When claiming for multiple debridements of the same body area, add the size of all individual debridements and submit as a single total debridement under the appropriate code.			
	d) If multiples of the same code or any combination of codes (grafts, burns, or wounds) are billed, there must be a comment on the electronic claim identifying which body area(s) are/is involved			
	Split Thickness Grafts			
100N	-- less than 26 sq. cm	$432.20	10	L
103N	-- 26 to 103 sq. cm	$1,000.00	42	L
105N	-- 103 to 350 sq. cm	$1,400.00	42	M
107N	-- more than 350 sq cm	$1,600.00	42	M
109N	Finger -- split graft of skin – plasty	$611.80	42	L
111N	Mesh grafting - paid in addition to split thickness grafts when 2 or more carriers are meshed	$206.00	42	L
	Full Thickness Grafts			
241N	Free graft, full thickness, facial (eyelids, canthi, alae of nose, ears)	$800.00	10	L
242N	Free graft, full thickness, other -- less than 5 sq. cm.	$620.00	10	L
243N	Free graft, full thickness, other -- over 5 sq. cm. and up to 10 sq. cm.	$770.00	42	L
244N	Free graft, full thickness, other -- more than 10 sq. cm.	$920.00	42	L
280N	Composite graft (full thickness of external ear)	$540.40	42	L
	Treatment of Soft Tissue Injury – grafts, burns, wounds			

PLASTIC SURGERY

		Fee	Class	Anae
	Burns (120N to 125N, 130N, 132N)			
	a) Initial management of severe burns ---- bill under 918A according to time b) Subsequent dressings and surgical debridements for severe burn patients per 5% body surface area up to a total of 100% body surface area c) Fees do not include grafting or other treatments. If grafting is done at the same time as debridement then grafting codes should be used alone.			
	Body Areas: a) One body area is defined as: face, neck, scalp, chest, abdomen, back, upper arm, forearm, hand, genitalia, buttock, thigh, lower leg and foot. b) When claiming for multiple debridements of the same body area, add the size of all individual debridements and submit as a single total debridement under the appropriate code. c) If multiples of the same code or any combination of codes (grafts, burns, or wounds) are billed, there must be a comment on the electronic claim identifying which body area(s) are/is involved			
	Surgical Debridement and/or Dressings - without anesthesia or under local anesthesia			
120N	-- per 5% total body surface area (TBSA), bill units	$80.00	0	
	Surgical Debridement – under general anesthesia, including dressings			
123N	-- initial 5% total body surface area (TBSA), bill units	$100.00	0	L
125N	-- each additional 5% or major part thereof – add, bill units	$80.00	0	L
	Escharotomy			
130N	-- all body areas other than trunk, per escharotomy site	$326.20	42	L
132N	-- trunk, per escharotomy site	$242.60	42	L
	Treatment of Soft Tissue Injury – grafts, burns, wounds			
	Wounds (140N-144N, 382N, 383N, 420N, 421N)			
	a) Wound repair codes (140N-144N, 382N and 383N) are on referral to a plastic surgeon.			
	Body Areas: a) One body area is defined as: face, neck, scalp, chest, abdomen, back, upper arm, forearm, hand, genitalia, buttock, thigh, lower leg and foot. b) Only one code per body area is billable (140N-144N) c) When claiming for multiple debridements of the same body area, add the size of all individual debridements and submit as a single total debridement under the appropriate code. d) If multiples of the same code or any combination of codes (grafts, burns, or wounds) are billed, there must be a comment on the electronic claim identifying which body area(s) are/is involved			
	Wound Debridement • Under general or regional anesthesia • Not requiring skin grafting/flap at same time			
140N	-- Less than 65 sq cm, any body area	$236.60	42	L
142N	-- 65 to 103 sq cm, any body area	$469.00	42	L
144N	-- Greater than 103 sq cm, any body area	$632.00	42	L
	Wound Repair - Face • Single or multiple			
382N	-- up to 5 cm	$360.00	10	L
383N	-- each additional 2.5 cm, bill units	$210.00	10	L
	Wound Management			
420N	Vacuum assisted wound management – when set up completed by a physician - setup, initial	$300.00		L
421N	Vacuum assisted wound management – when set up and completed by a physician - Follow-up (includes visit)	$160.00		
	Flaps or Tubes of Skin from a Distance			

PLASTIC SURGERY

		Fee	Class	Anae
	Major stage(s)			
252N	-- raising of large direct flap or tube pedicle with closure of donor area	$639.90	42	L
253N	-- raising of large direct flap or tube pedicle and skin graft to donor area	$892.40	42	L
	Minor stage(s) -- transposition of pedicle			
254N	-- intermediate transfer or sectioning of pedicle with direct closure	$438.00	42	L
255N	-- delay of pedicle	$510.00	42	L
256N	Muscle flap with skin graft	$2,651.00	42	M
257N	Myo-cutaneous flaps with donor closure	$2,450.00	42	M
258N	Myo-cutaneous flaps with skin grafts to donor area	$1,937.00	42	M
	Fascio-cutaneous flap -- greater than 19 sq. cm.			
250N	-- with donor closure	$2,040.00	42	M
251N	-- with skin graft to donor area	$2,450.00	42	M
361N	Neurovascular pedicle flap	$817.50	42	M
440N	Transverse rectus abdominis myocutaneous flap for breast reconstruction	$2,447.00	42	M
	Excision and/or Repair by Adjacent Tissue Transfer or Rearrangement i.e., Z-plasty, rotation flap, advanced flap, double pedicle flap, etc.			
	Defect up to 6 square cm.			
260N	-- trunk	$400.00	42	L
261N	-- scalp, arms and legs	$440.00	42	L
262N	-- forehead, cheeks, chin, mouth, neck, axilla, genitalia, feet or hands	$520.00	42	L
263N	-- eyelids, nose, ears and lips	$620.00	42	L
	Defect 7-19 square cm.			
264N	-- trunk	$550.00	42	L
265N	-- scalp, arms and legs	$600.00	42	L
266N	-- forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands or feet	$720.00	42	L
267N	-- eyelids, ears, nose and lips	$770.00	42	L
268N	More than 19 square cm. -- unusual or complicated, by report	$1,020.00	42	L
	Syndactly			
371N	-- release with flaps	$670.00	42	L
372N	-- release with flaps and skin grafts	$1,020.00	42	L
	Lymphoedema excision			
	Minor excision -- use codes 260N - 268N			
659N	-- major excision and grafting	By Report	42	M
	Eyelids -- full thickness Excision and Repair By advancement flaps			
270N	-- up to 1/4 of eyelid margin	$528.60	42	L
271N	-- over 1/4 of eyelid margin	$621.70	42	L
	By transfer flaps of tarso conjunctiva from opposing eyelid			
272N	-- up to 2/3 of eyelid	$621.70	42	L
	-- total eyelid 1 or more stages			
	Transplantation of Tissues Other than Skin			
281N	Mucous membrane graft	$363.00	42	L
283N	Fascia grafts for facial nerve paralysis	$918.00	42	L
285N	Slings for ptosis	$738.30	42	L
286N	Cartilage -- autogenous transplant	$843.20	42	L
	Bone -- autogenous transplant			

		Fee	Class	Anae
287N	-- nose, chin, orbit, forehead	$1,261.50	42	M
	Abrasive Surgery			
	Facial resurfacing - total face for removal of scars, etc.			
290N	mechanical -- primary	$751.10	42	L
291N	mechanical -- secondary	$344.50	42	L
292N	Regional -- cheeks, chin, forehead or elsewhere -- any method including laser	$196.90	42	L
	Nose			
300N	Rhinoplasty	$1,033.60	42	M
301N	Rhinoplasty with Septoplasty or Submucous Resection	$1,230.50	42	M
302N	Rhinophyma -- removal by shaving	$566.00	42	L
303N	Silastic implant -- when only procedure	$461.20	42	L
305N	Bone graft with 300N and 301N -- add	$455.80	42	L
	Ear			
310N	Preauricular fistula	$387.30	42	L
	Protruding ears -- otoplasty			
311N	-- unilateral	$600.00	42	L
313N	Segmental ear resection	$344.50	42	L
	Cleft Lip and Cleft Palate			
	Plastic repair of cleft lip, primary			
320N	-- unilateral	$1,530.00	42	M
323N	Plastic repair of cleft lip, secondary, by recreation of defect and closure	$1,230.00	42	M
325N	Repair of nasal deformity due to cleft lip	$966.20	42	M
	Plastic operation for cleft palate			
326N	-- partial -- primary	$1,530.00	42	M
327N	-- complete -- primary	$1,840.00	42	M
328N	-- major revision -- secondary	$1,800.00	42	M
329N	Palate -- pharyngo-plasty	$1,427.00	42	M
	Lips, Cheeks and Jaws			
330N	Vermilionectomy or gingivectomy	$570.00	42	L
331N	Transverse wedge excision, lip	$410.00	42	L
631N	Rectangular or square through and through resection of the lower lip	$714.00	42	L
332N	Radical resection of lip -- 1/2 or more with primary reconstruction	$953.40	42	M
333N	Total reconstruction of lip	$1,335.40	42	M
634N	LeFort I osteotomy of maxilla	$2,313.30	42	M
635N	-- with bone grafting	$2,590.50	42	M
	Excision of cyst of dental origin -- intraoral approach			
336N	-- under 1 cm.	$93.10	42	M
337N	-- 1-2.5 cm.	$241.00	42	M
338N	-- over 2.5 cm.	$566.00	42	M
339N	Interposed bone-graft augmentation of atrophic mandible	$1,421.00	42	M
	Fractures of the Facial Bones			
	Nose			
340N	-- intranasal reduction and splinting	$510.00	42	M
341N	-- total refracture and fixation	$528.60	42	M
	Mandible			
342N	-- interdental wiring (horizontal)	$510.00	42	M
343N	-- intermaxillary wiring including interdental wiring	$1,230.00	42	M
344N	-- open reduction of single fracture, excluding interdental or intermaxillary	$820.00	42	M

		Fee	Class	Anae
	wiring			
345N	-- multiple compound or comminuted fractures excluding interdental or intermaxillary wiring	$1,230.00	42	M
	Maxilla			
346N	-- displaced -- open reduction	$1,230.00	42	M
347N	-- open reduction with antrostomy (Caldwell Luc and packing)	$812.10	42	M
348N	Malar bone and zygomatic arch open elevation or temporal approach (Gillies)	$820.00	42	M
349N	Complete facial smash with cranial facial separation, complicated, open reduction, multiple surgical approaches, internal fixation, wiring teeth, etc.	By Report		
	Trunk			
	Mammaplasty reduction			
350N	-- unilateral	$1,494.80	42	M
	Breast augmentation -- prosthetic			
352N	-- unilateral	$738.30	42	L
	Subcutaneous tissue space expander			
400N	-- implantation	$1,138.00	42	L
401N	-- removal (including replacement by prosthesis)	$1,138.00	42	L
430N	Nipple reconstruction, post mastectomy	$720.00	42	L
431N	Repair of inverted nipple	$360.00	42	L
432N	Removal of single breast prosthesis	$210.00	42	L
433N	Removal of single breast prosthesis with capsulectomy and/or skin plasty	$676.20	42	L
354N	Abdominal Panniculectomy - see criteria in the preamble to this section	$1,430.00	42	L
	Post-gastroplasty redundant skin fold removal			
654N	-- bat wing, unilateral	$498.60	42	L
655N	-- thigh, unilateral	$498.60	42	L
355N	Decubitus ulcer -- repair by excision of bursa and underlying bone with rotation flap -- total care	$2,700.00	42	M
	Hypospadias			
360N	Removal of axillary sweat glands (unilateral)	$621.70	42	L
	Extremities			
362N	Phalangization	$639.90	42	L
363N	Pollicization	$1,230.50	42	M
364N	Cross finger flap -- total care	$958.70	42	L
365N	Transposition of digit	$958.70	42	L
366N	Needle aponeurotomy release - prominent Dupuytren's band, unilateral - Not billable in multiples on the same hand when more than one cord or finger is treated at the same patient contact.	$510.00	42	L
367N	Palmar fasciectomy for Dupuytren's contracture -- primary	$1,130.00	42	L
368N	Dupuytren's contracture - recurrent	$1,330.00	42	L
	Thumb - M.C.P. joint - collateral ligament reconstruction			
369N	-- by local tissue rearrangement	$712.00	42	L
370N	-- using tendon graft	$1,068.00	42	L
	Skin			
	Excision of Lesions			
	Benign			

PLASTIC SURGERY

		Fee	Class	Anae
	-- non-facial (see Section L)			
380N	-- facial on referral	$200.00	10	L
	Malignant -- by wide excision and suture These codes are for removal of lesions that are confirmed or suspected as malignant and require a wide-excision and suture at the time the procedure was performed.			
684N	-- non-facial	$306.00	10	L
685N	-- facial (not including neck and scalp)	$408.00	10	L
	Excision of malignant skin lesions with skin graft or flap repair - (use appropriate codes)			
	Wounds -- face -- single or multiple -- on referral to a plastic surgeon -- plastic repair			
382N	-- up to 5 cm.	$360.00	10	L
383N	-- each additional 2.5 cm.	$210.00	10	L
410N	Percutaneous inflation of tissue expander, first	$44.80	0	L
411N	-- each additional expander, per patient contact, same day -- maximum of 3, bill units	$22.40	0	L
	Wound Management			
420N	Vacuum assisted wound management, setup (indicate start time, stop time and size of wound on claim submission)	By Report		L
421N	Vacuum assisted wound management, follow-up (includes visit) (complicated cases may be billed by report)	$160.00		
	Microvascular Surgery			
500N	Preparation and harvesting of graft and closure of donor site	$2,000.00	42	H
501N	Preparation of distant recipient site including repair of nerves, tendons, bones and skin	$2,000.00	42	H
502N	Preparation of adjacent donor and recipient sites including repair of nerves, tendons, bones and skin .	$2,243.00	42	H
	Revascularization			
503N	-- arterial	$1,300.00	42	H
504N	-- with vein graft	$1,427.00	42	H
505N	-- venous	$1,300.00	42	H
506N	-- with graft .	$1,500.00	42	H

Assessment Rules for Microvascular Surgery

1. Codes apply only when provided by a recognized microvascular surgical unit.

2. Codes represent composite payments for all related microvascular surgical services provided at time of surgery, i.e. no codes outside the group (500N - 506N) are payable.

3. Each individual code is billable only once per anatomical site.

4. Normal surgical rules do not apply for the following:

(a) if multiple sites, payment is at 100% per site;
(b) combination of discrete codes within the group (500N - 506N) are payable at 100%;
(c) if initial vascularization fails and a second attempt is necessary, no payment will be made for the repeat procedure.

	Fee	Class	Anae

5. The 75% rule would apply for amputation where all attempts to revascularize fail.

6. Code 502N is not payable with 500N or 501N.

7. 503N and 504N are not payable together.
505N and 506N are not payable together.

8. All Claims will be assessed by a Medical Consultant.

Under this arrangement the maximum payable site would be $4,200.00.

SECTION O:

PHYSICAL MEDICINE

		Fee
	Visits	
3O	Complete assessment -- includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of all parts and systems, diagnosis,assessment, necessary treatment, advice to the patient and record of service provided	$184.00
5O	Partial assessment or subsequent visit -- includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$164.00
9O	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$392.00
11O	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$214.00
14O	**Hospital Inpatient Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor**	$543.00
	Hospital Care*	
	(*Payable on day of admission)	
25O	-- first 10 days, per day	$60.00 *
26O	-- 11-20 days, per day	$60.00 *
27O	-- 21-30 days, per day	$60.00 *
28O	-- thereafter, per day	$60.00 *

Note: for hospital discharge by physician, see code 725A, in Section A

PHYSICAL MEDICINE

		Fee
	Case Conference Must be a formal scheduled session. A single conference fee billed in the name of one patient covers all the patients reviewed at the conference. A maximum of six case conferences per patient per year is billable. The physician should keep appropriate documentation of time and place.	
42O	per conference (not patient) -- first 30 minutes or part thereof	$190.00
44O	- add to 42O for each additional 15 minutes or part thereof	$94.00

SECTION P:

OBSTETRICS/GYNAECOLOGY

		Fee	Class	Anae
	Visits			
5P	Initial Assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis,assessment, necessary treatment, advice to the patient and record of service provided	$112.00		
7P	Follow-up Assessment -- includes: history review, functional enquiry, examination, reassessment, necessary treatment, advice to the patient and record of service provided	$63.50	*	
9P	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$172.00		
11P	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$83.80		
	Hospital Care (Payable on day of admission)			
25P	-- first 10 days, per day	$60.00	*	
26P	-- 11 -20 days, per day	$60.00	*	
27P	-- 21-30 days, per day	$60.00	*	
28P	-- thereafter, per day	$60.00	*	
	Note: for hospital discharge by physician, see code 725A, page A28			
8P	Pre-natal visit subsequent to a first visit under 5P for maternity care or post-natal office visit	$63.50		
13P	Interpretation of telephonic foetal monitoring by consultant with immediate response, per patient	$72.80		

SECTION P:

OBSTETRICS/GYNAECOLOGY

		Fee	Class	Anae

Obstetrics

1. Payment for prenatal and postnatal office visits is made on a "fee-for-service" basis.
2. If during the course of labour, the attending physician calls a consultant to deliver his/her patient because complications have arisen, payment may be made:
(a) to the consultant for the **consultation and** delivery, and
(b) to the referring physician for the pre-natal care he/she has provided plus 42P.

Note: A 42P is not paid when one general practitioner refers a patient to another general practitioner in the same clinic or vaginal delivery. However in the situation where no consultant obstetrician is available and the general practitioner is acknowledged to have special training and/or skills in obstetrics, it can be paid on report.

Also if during the course of labour the attending physician has to call another physician who may be a general practitioner in the same clinic to deliver his patient by caesarian section because the referring physician does not have surgical privileges, then he may bill under code 42P. He will also be paid for surgical assistant services at caesarian section if provided.
3. When the patient is referred for a caesarian section the surgeon is responsible for post-operative care.
4. Payment for "vaginal delivery" includes the following services by the same physician, a general practitioner in the same clinic, or a specialist in the same speciality and clinic:
(a) medical and surgical induction except for code 47P;
(b) the treatment of false labour and primary uterine inertia during the two days prior to delivery;
(c) the management of labour; no visit service or hospital care is payable for a patient in normal labour. This is included in the composite vaginal delivery fee.
(d) hypnotherapy;
(e) vaginal delivery (including version--internal or external, use of forceps repair of lacerated cervix, repair of vaginal and first and second degree perineal lacerations and /or pudendal block or other infiltration or regional anaeasthesia, repair of episiotomy);
(f) services for the control of haemorrage within 24 hours of delivery;
(g) visit (including hospital care) or consultation services during the patient's stay in hospital following delivery.
5. Out of hours service premiums in Section A.
6. To support and encourage family physicians to remain or become involved in obstetrics, a bonus of 25% will be paid in each fiscal (beginning April 1 of each year) on the first 25 Vaginal Delivery (41P) or Continuing Care at Delivery (42P) services provided by a family physician. The bonus will be paid automatically in a claim run following the end of each quarter as an adjustment to 41P or 42P. Physicians are encouraged to submit claims for 41P and 42P in a timely manner to ensure that they receive the bonus payment to which they are entitled.

42P	Continuing care provided by the attending physician during the course of labour prior to calling a consultant to deliver the patient and including post-natal care in hospital when provided.This service code is applicable only if during the course of labour and after a substantial amount of time has lapsed because of complications, e.g., foetal distress, failure to progress, the attending physician	$1,183.00 *		

		Fee	Class	Anae
	finds it necessary to call a consultant to deliver the patient; please indicate on the claim the name of the consultant to whom the case was referred			
	Vaginal delivery and post-natal care in hospital			
40P	-- specialist	$1,219.00		
41P	-- general practitioner	$1,219.00		
241P	Delivery of stillborn (claim only where a foetus was a minimum of 500 grams and/or had reached 20 weeks gestation)	$1,230.00 *		
	Multiple pregnancy			
44P	-- each additional child	$296.00 *		
45P	Intrauterine manual separation and removal of retained placenta	$236.00 *	0	M
	Caesarian section^			
46P	-- any type and post-operative care	$1,270.00 *		M
246P	-- intrapartum, add	$189.00 *		
47P	Chemical induction or augmentation of labour -- payable once per delivery, add	$75.80 *		
48P	Ectopic gestation -- removal	$1,020.00 *	42	M
248P	Ectopic gestation salpingotomy, embryectomy and salpingorraphy	$1,100.00	42	M
49P	Occlusive suture of cervix in pregnancy	$416.00	10	M
	Removal of occlusive suture of cervix			
269P	-- office procedure	$49.60 *	0	
279P	-- hospital procedure under anaesthesia	$208.00 *	0	L
	^ Tubal resection and/or ligation performed for sterilization at the time of Caesarian Section is payable under Code 135P at 75%			
	Complications of Pregnancy Two of these codes may be paid per patient per pregnancy to one or two physicians. If a third or subsequent code is requested, there should be an accompanying explanation.			
200P	Breech presentation -- delivered vaginally, add	$250.00		
201P	Face or brow presentation -- delivered vaginally, add	$165.90		
202P	Transverse or occiput posterior -- forceps extraction or vacuum extraction (excludes outlet or elective forceps), add	$178.70		
203P	Prolonged rupture of membranes for over 24 hours, add	$178.70		
204P	Abruptio placenta, add	$178.70		
205P	Placenta previa, add	$178.70		
206P	Vaginal delivery following previous caesarian section, add	$220.00		
207P	Pregnancy - severe hypertension requiring pharmacological therapy and monitoring, add	$221.50		
208P	Pharmacological suppression of premature labour, add	$178.70		
209P	Repair of significant cervical laceration, add	$203.30		
210P	Previous stillbirth after 20 weeks, add	$178.70		

SECTION P:

OBSTETRICS/GYNAECOLOGY

		Fee	Class	Anae
211P	Cephalic version under ultrasound control with or without tocolysis add	$178.70		
212P	Cephalic version under ultrasound control with tocolysis, add	$203.30		
213P	Diabetes requiring insulin antepartum, add	$178.70		
214P	IUGR (birth weight < 5th percentile), add	$178.70		
215P	Pregnancy and heart disease (New York Heart Association Class 3 or 4), add	$178.70		
216P	Pregnancy and pre-existing hypertension (on antipypertensive therapy before pregnancy), add	$178.70		
217P	Pregnancy and anitphospholipid antibody syndrome, add	$178.70		
218P	Pregnancy and significant medical disease (Not listed above) requiring active concurrent management	$178.70		
	Therapeutic abortion (includes incomplete and missed abortion)			
50P	-- first trimester -surgical	$387.30 *	42	L
250P	-- second trimester -surgical	$528.60	42	L
350P	-- D&C for incomplete or missed abortion	$387.30 *	42	L
	Note: 50P and 250P cannot be billed for administering or prescribing pharmaceutical abortion agents such as Mifegymiso.			
	Administering or prescribing pharmaceutical abortion agents are an inclusion in the visit service.			
51P	Intrauterine foetal transfusion	$608.80	10	
52P	Repair of fourth degree tear following delivery	$386.00	42	L
54P	Repair of 3rd degree tear following delivery or secondary repair of episiotomy	$191.00	10	L
	Note: Repair of episiotomy is included in the delivery fee.			
53P	Replacement of inverted uterus	$380.90	42	L
55P	Insertion of intrauterine pressure catheter	$60.50 *	D	
56P	Application of scalp electrodes for internal foetal EKG monitoring	$59.30		
258P	Transvaginal fetal scalp blood sampling (payable twice per pregnancy)	$126.00 *	D	
	Amniotic tap -- trans-abdominal			
57P	-- second trimester	$173.00 *	D	
58P	-- third trimester	$126.00 *	D	
59P	Fetoscopy -- including fetal blood sample, cell harvest or amniocentesis	$327.00	D	
	Non stress test -- in office (if equipment owned by physician)			
260P	-- First foetus	$75.20	D	
261P	-- Second and subsequent, per foetus add	$56.00	D	

OBSTETRICS/GYNAECOLOGY

		Fee	Class	Anae
	Procedures Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, pages A34 and A35.			
	Gynaecology			
30P	Vaginal sperm examination	$79.20 *	D	
338P	Sperm washing prior to insemination (performed in physician's own office)	$79.20 *	0	
31P	Tubal insufflation or hysterosalpingogram or sonohysterogram -- Rubins (bilateral)	$106.00 *	D	L
32P	Pelvic examination under anaesthesia (when only procedure done)	$137.00 *	D	L
34P	Culdoscopy or laparoscopy (laparoscopy not paid with laparoscopic surgery unless it precedes the surgery as a diagnostic procedure) -- with or without biopsy	$387.30	D	M
35P	-- with division of adhesions or cautery for endometriosis with or without peritoneal lavage	$506.00	10	M
334P	Hysteroscopy, with or without D & C, with or without other intrauterine procedures	$246.10	D	L
335P	Endometrial ablation, to include excision of endometrial polyps and/or fibroids	$707.00	42	M
336P	Excision of endometrial polyps and/or fibroids -- add to 334P or 335P only	$142.00 *	42	L
232P	Hysteroscopic division of uterine septum	$590.00	42	L
233P	Fallopian tube cannulation by hysteroscopy, unilateral or bilateral	$505.00	42	L
36P	Hydrotubation	$93.10 *	0	L
37P	Colposcopy **--** not in office	$119.80 *	D	L
38P	-- with biopsy **--** not in office	$154.10 *	D	L
438P	Colposcopy - in office	$79.20 *	D	
439P	-- with biopsy - in office	$93.20 *	D	
39P	Endometrial tissue biopsy by aspiration	$105.90 *	D	L
	Menopausal gonadotropin therapy -- add to appropriate visit fee			
314P	-- initial set-up per treatment cycle	$158.00		
315P	-- subsequent injections, add to appropriate visit fee .	$52.80		
	Vulva			
	Venereal warts -- see 420R, 421R, 422R			
60P	Hymenectomy (in hospital -- general anaesthetic)	$227.90 *	0	L
	Bartholin cyst			
61P	-- incision	$82.00 *	10	L
78P	-- marsupialization	$237.00 *	42	L
62P	-- excision	$301.70 *	42	L
63P	Skene's glands -- cautery or excision	$109.00 *	10	L
	Urethra -- caruncle			
65P	-- cautery	$233.30 *	0	L
66P	-- excision	$237.00 *	10	L
67P	-- diverticulum -- repair	$476.00	42	L
68P	-- prolapse -- repair	$259.00	42	L
69P	Correction of atresia of vulva	$268.00	42	L
70P	Vulvectomy	$923.00	42	M

OBSTETRICS/GYNAECOLOGY

		Fee	Class	Anae
71P	-- with bilateral inguinal node excision	$1,667.10	42	M
72P	-- with bilateral inguinal and pelvic node excision	$2,134.70	42	M
73P	Surgical denervation of vulva for pruritus vulvae	$313.50	42	L
	Vagina			
80P	Dilatation of vagina under general anaesthesia or IV sedation (includes post op recovery)	$117.70 *	0	L
81P	Colpotomy	$301.70 *	42	L
	Fistula			
82P	-- recto-vaginal -- repair	$687.00	42	M
83P	-- urethro-vaginal -- repair	$762.90	42	M
84P	-- vesico-vaginal -- repair	$2,133.00	42	M
	Vaginal cysts			
85P	-- inclusion -- removal	$164.00 *	10	L
86P	-- congenital -- removal	$387.30	42	L
87P	Vaginal atresia -- plastic reconstruction	$910.60	42	L
88P	Vaginectomy	$1,327.00	42	M
89P	Vaginal septum -- excision of	$301.70	10	L
	Genital Prolapse			
	Colporrhaphy			
90P	anterior or posterior	$549.00 *	42	L
91P	-- repeat	$590.00	42	L
105P	Paravaginal repair (alternative to anterior repair)	$643.10	42	L
92P	-- anterior and posterior .	$722.00 *	42	L
93P	-- repeat	$767.00	42	L
193P	Mesh augmented prolapse repair	$555.00	42	L
	Complete repair			
96P	Vaginal vault prolapse -- repair	$762.90	42	L
97P	Enterocele repair	$633.00	42	L
98P	Le Fort operation	$762.90	42	L
99P	Manchester operation	$608.80	42	L
100P	Third degree laceration (old) repair	$910.60	42	L
101P	Urethra -- suspension procedure	$995.10	42	L
103P	-- repeat after 42 days	$1,046.50	42	L
102P	Urethra -- pubo vaginal sling	$1,071.10	42	L
104P	Abdominoscacrocolpopexy	$1,070.00	42	M
	Cervix and Uterus			
108P	Artificial insemination, per insemination	$79.20 *	0	
109P	Cryoconization or loop diathermy of cervix	$178.70	0	L
	Cervix			
110P	-- biopsy with or without electro-cauterization	$64.20 *	D	L
111P	-- electro-cauterization	$27.20 *	0	L
112P	-- polyp -- removal -- with or without electro-cauterization	$64.20 *	0	L
113P	-- conization with D and C, with or without deep cautery, with or without polyp removal	$461.20	10	L
114P	-- biopsy -- excision	$74.10 *	10	L
115P	-- repair or amputation	$387.30	42	L

OBSTETRICS/GYNAECOLOGY

		Fee	Class	Anae
	Removal of cervical stump			
116P	-- abdominal	$608.80	42	M
117P	-- vaginal	$680.00	42	L
118P	Dilatation and curettage	$196.90 *	0	L
228P	Insertition of brachytherapy stent/sleeve	#N/A		
120P	Hysterotomy	$732.00	42	M
	Hysterectomy			
122P	not billed in addition to adnexal surgery -- subtotal	$1,080.00	42	M
123P	-- Total	$1,080.00	42	M
124P	-- abdominal	$1,080.00	42	M
125P	-- vaginal	$2,129.30	42	H
	-- Wertheim			
	Hysterectomy -- laparoscopic or laparoscopic assisted (not paid in			
126P	**addition to adnexal surgery)**	$1,344.00	42	M
	Hysterectomy -- subtotal or total -- includes 34P and 134P			
130P		$910.60	42	M
131P	Conservative surgery for endometriosis includes presacral neurectomy	$762.00	42	M
132P	Myomectomy by laparotomy, laporoscopy or hysterectomy-- single or multiple -- not billed in addition to adnexal surgery -if done by hysterescopy then hysterescopy and other intrauterine procedure are included	$1,070.00	42	M
133P	Uteroplasty	$563.00	42	M
134P	Uterus -- suspension	$819.00 *	42	M
135P	Salpingectomy and/or oophorectomy and/or ovarian cystectomy -- unilateral or bilateral -- (when second ovary requires cystectomy, the surgery and the contra lateral side may be paid at 75% by report)	$500.00 *	42	M
	Tubal resection and/or ligation for sterilization -- unilateral or bilateral -- (payable at 75%, by report when performed as a second and unrelated procedure at the time of other gynaecological surgery in which fertility would otherwise be preserved)			
	Salpingostomy -- not billed in addition to			
236P	other adnexal surgery	$820.00	42	M
237P	-- unilateral	$971.00	42	M
238P	-- bilateral	$812.00	42	M
138P	Tubo-uterine implantation -- not billed in addition to other adnexal surgery	$762.90	42	M
139P	Broad ligament cyst -- enucleation -- not billed in addition to other adnexal surgery	$762.90 *	42	M
140P	Ovarian suspension or neurectomy -- not billed in addition to other adnexal surgery	$500.00 *	42	M
141P	Tubal ligation through laparoscope -- unilateral or bilateral	$495.00	42	M
142P	Hysteroscopic sterilization by tubal occlusion (Essure)	$233.30 *	42	M
143P	Omentectomy - when done in addition to 123P or 134P in cases of malignancy, add	$1,009.00	42	M
	Reconstruction of fallopian tubes following pathological occlusion -- unilateral (second			

OBSTETRICS/GYNAECOLOGY

		Fee	Class	Anae
144P	tube is payable at 75%) Reanastamosis of fallopian tubes	$945.00	42	M
150P	**Laser Vaporization**	$461.20	10	L
151P	-- cervix -- full circumference	$516.80	0	L
251P	-- intraepithelial neoplasia of vulva, vagina or cervical segment -- extensive -- vulva and/or vagina and/or cervix	$725.50	10	L

For laser therapy of venereal warts (time 30 minutes or less) use 422R. Claim 150P and 422R for circumferential laser ablation of cervix for CIN plus removal of genital warts -- claims for 251P for CIN and/or venereal warts (over 30 minutes) are payable at $6.00 per minute.

BMI Supplement

BMI supplements are not payable to the surgical assistant who is billing “J” section codes.

580P	Obstetrics and Gynecology supplement for patients with a body mass index (weight[kg]/height[m] 2) -- greater than 40 or -- greater than 45 if pregnant and in the third trimester	$120.00 *		
581P	Obstetrics and Gynaecology supplement for patients with a Body Mass Index, (Weight[kg]/ Height[m]^2) greater than 50	$177.00 *		

Obstetrics and Gynaecology supplement (580P and 581P) may be billed with service codes 31P to 40P, 41P, 44P to 46P, 48P to 140P, 141P, 143P, 150P, 151P, 211P, 212P, 232P to 241P, 248P to 279P, 334P, 335P, 350P, 438P and 439P.

Maximum of one 580P or 581P supplement per patient per day.
Codes 580P and 581P cannot be billed together.

SECTION P:

OBSTETRICS/GYNAECOLOGY

	Fee	Class	Anae

SECTION Q:

NEUROLOGY

		Fee	Class
	Visits		
3Q	Complete assessment -- includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of all parts and systems, diagnosis -- assessment, complete record, necessary treatment and advice to the patient -- includes neurological history (family, past patient and presenting with functional inquiry); examination of all parts of the nervous systems; diagnostic assessment, complete writen record-ing with mnagement recommendations and advice to patient and referring physician if any.	$161.00	
5Q	Partial assessment or subsequent visit -- includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis -- assessment, record, necessary treatment and advice to the patient -- includes brief review of presenting neurological complaint; examination of the appropriate part/parts ofo the nervous system; diagnostic assessment with brief written record and management recommenda-ations to patient and referring physician if any.	$155.00	
9Q	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor -- full neurological history and examination of the nervous system with review of available investigation data/submission of written opinion, to referring physician and appropriate explanation to the patient.	$321.00	
11Q	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$171.00	
	Hospital Care (Payable on day of admission)		
25Q	-- first 10 days, per day	$64.00 *	
26Q	-- 11-20 days, per day	$62.00 *	

NEUROLOGY

		Fee	Class
27Q	-- 21-30 days, per day	$60.00 *	
28Q	-- thereafter, per day	$60.00 *	

Note: for hospital discharge by physician, see code 725A, in Section A

Procedures

Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement.

101Q	Manual muscle testing - complete	$40.80	D
102Q	Manual muscle testing - regional	$16.00	D
103Q	Major myoneural study - complete - 11 or more units	$153.00	D
104Q	Minor myonerual study - 6 to 10 units	$102.00	D
105Q	Limited study 1 to 5 units	$72.00	D

Note: a unit is either a segment of a nerve conduction study or an individual muscle

106Q	Interpretation of nerve conduction study - not payable with a visit service	$30.60	D
107Q	Repetitive nerve stimulation of 2 or more muscles	$77.40	D
108Q	Blink reflex bilateral stimulation of facial nerve with ipsilateral and contralateral recording or blink reflex	$40.80	D
109Q	Technical fee for physician performance of the Nerve Conduction Studies and/or EMG only.	$64.00 *	D
110Q	Complex study - add to appropriate procedure or technical code - requires examination (e.g. ICU neuromuscular assessment)	$40.80 *	D
120Q	Ischemic or Non-ischemic forearm test - professional component	$306.00	D

Organ Donor Assessment

140Q	Certification of brain death and organ donor assessment for specialists with appropriate training, following health authority protocols	$297.00	
150Q	Certification of brain death and organ donor assessment by specialist with appropriate training who was providing ICU care to the patient following health authority protocols	$147.00	

SECTION R:

UROLOGICAL SURGERY

		Fee	Class	Anae
	Visits			
5R	Initial Assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$111.00		
7R	Follow-up Assessment -- includes: history review, functional enquiry, examination, reassessment, necessary treatment, advice to the patient and record of service provided	$70.60		
9R	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$166.00		
11R	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$84.60		
13R	Written advice to referring physician on the management of a case based upon review of IVP and/or other x-rays by Urological Surgeon (payable once per case only)	$84.80		
	Hospital Care (Payable on day of admission)			
25R	-- first 10 days, per day	$60.00 *		
26R	-- 11-20 days, per day	$60.00 *		
27R	-- 21-30 days, per day	$60.00 *		
28R	-- thereafter, per day	$60.00 *		

Note: for hospital discharge by a physician, see code 725A, in Section A.

SECTION R:

UROLOGICAL SURGERY

		Fee	Class	Anae
	Procedures			
	Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement.			
29R	Diagnostic bladder catheterization -- in office procedure	$16.70 *	D	L
30R	Cystoscopy	$218.00	D	L
31R	-- with ureteral catheterization or retrograde pyelography	$270.00	D	L
33R	-- Split function renal study with interpretation	$281.00	D	L
38R	-- Voiding cystourethrogram in operating room, add	$68.20 *	D	L
	Seminal fluid analysis			
35R	-- count, motility and morphology	$43.60 *	D	
36R	Prostatic secretion (microscopic examination) ...	$9.20	D	
37R	Intra-penile vasoactive injection, each to a maximum of 2 units per day	$27.80 *	0	
39R	Assessment of penile and/or testicular blood flow and/or varicocele, including measurement of penile blood pressure .	$29.40 *	D	
	Urodynamics Investigation			
	Cystometrogram (Cmg)			
400R	-- technical component	$82.20 *	D	
500R	-- technical component using disposable catheter	$144.00 *	D	
401R	-- professional component	$124.00 *	D	
	Electromyography (Emg)			
402R	-- technical component	$77.60 *	D	
403R	-- professional component	$191.00 *	D	
	Urethral pressure profile			
404R	-- technical component	$82.50 *	D	
405R	-- professional component	$124.00 *	D	
	Uroflow			
406R	-- technical component	$27.00 *	D	
407R	-- professional component	$55.40 *	D	
	Venereal warts -- either sex			
	Electrocoagulation or chemocoagulation of venereal warts (includes treatment with Podophyllin)			
420R	-- initial	$218.00 *	0	
421R	-- repeat within 10 days	$67.60 *	0	
422R	Venereal warts -- operation -- in hospital	$220.00 *	10	L
	Endoscopic			
40R	Fulguration or biopsy of bladder -- tumors and/or other lesions	$347.00	42	L

SECTION R:

UROLOGICAL SURGERY

		Fee	Class	Anae
	Transurethral			
41R	-- lithopexy	$888.00	42	L
42R	-- removal of ureteral stone by manipulation	$553.00	42	L
43R	Periurethral injection of teflon for incontinence (includes cystoscopy)	$553.00	10	L
44R	-- bladder tumor resection	$1,036.00	42	M
46R	-- secd'y haemorrhage -- endoscopic treatment -- exempt from repeat surgical rule	$347.00	42	L
47R	-- bladder neck resection	$823.00	42	L
48R	-- resection of ureterocele	$347.00	42	L
49R	-- resection of posterior urethral valve	$743.00	42	L
50R	Ureteroscopy - with or without biopsy (includes cystoscopy)	$1,028.00	D	L
51R	-- with removal of stone	$1,375.00	42	
52R	-- with ultrasonic disintegration add to 51R	$175.00	42	
53R	Uteroplasty-- endoscopic with balloon dilitation of uteric stricture with or without stent not billable with 51R	$653.00	0	L
	Penis			
59R	Incisional biopsy of glans penis	$149.00 *	10	L
60R	-- amputation	$1,643.00	42	M
61R	-- with excision (radical) of nodes	$2,408.00	42	M
62R	-- partial	$1,375.00	42	M
	Penile implant			
63R	-- semi-rigid	$1,037.00		
64R	-- hydraulic	$1,556.00		
71R	Intralesional Verapamil injection for Peyronie's plaque - Not billable in multiples, only one treatment/service is billable per patient contact	$170.00	10	L
	Circumcision (routine circumcision is not insured)			
65R	-- without anaesthesia	$236.00 *	0	
66R	-- under anaesthesia -- child	$534.00 *	42	L
67R	-- adult	$534.00 *	42	L
68R	Dorsal slit or preputial adhesiolysis under EMLA	$270.00 *	0	L
	Urethra			
69R	-- meatotomy -- with plastic repair	$190.00	10	L
70R	-- dilation	$137.00 *	0	L
73R	-- surgical repair anterior urethral rupture	$1,375.00	42	L
74R	-- repair posterior -- primary repair including suprapubic cystotomy	$1,823.00	42	M
79R	Repeat repair of anterior or posterior urethral rupture or stricture (related to 73R or 74R)	$1,788.00	42	L
80R	Urethral stent for prostatic hypertrophy or stricture - includes cystoscopy	$587.00	42	L

SECTION R:

UROLOGICAL SURGERY

		Fee	Class	Anae
75R	Urethrotomy	$415.00	42	L
76R	Removal of foreign body from urethra	$371.00	10	L
77R	Urethral diverticulectomy	$1,097.00	42	L
78R	Urethrocutaneous fistula -- repair	$1,229.00	42	L
	Bladder			
89R	Chemotherapeutic bladder irrigation for treatment of malignancy or of interstitial cystitis	$137.00	0	L
189R	Bladder hydrodistension for patients with intersticial cystitis or clinical presentation strongly suggestive of interstitial cystitis (payable in addition to cystoscopy)	$137.00	0	L
	Cystotomy			
90R	-- with trochar	$345.00 *	10	L
91R	-- with removal of stone, foreign body, etc.	$888.00	42	L
92R	-- excision, electro-resection or fulguration of bladder tumor with or without radiation implants	$614.00	42	L
	Cystectomy			
93R	-- partial	$1,375.00	42	M
94R	-- partial with ureteral reimplantation	$1,936.00	42	M
95R	-- total cystectomy with ureterointestinal transplant	$4,607.00	42	H
96R	-- with ureteroileal conduit	$6,866.00	42	H
97R	-- with rectal bladder and colostomy	$5,611.00	42	H
100R	Diverticulectomy	$1,652.00	42	M
101R	Resection ureteral stump	$986.00	42	L
102R	Ileocystoplasty	$4,120.00	42	H
103R	Surgical repair of ruptured bladder	$1,375.00	42	M
	Ureterocutaneous anastomosis			
104R	-- unilateral	$783.00	42	M
105R	-- bilateral	$1,156.00	42	M
106R	Ileal conduit	$3,429.00	42	H
109R	Bladder neck plasty	$1,296.00	42	M
110R	Insertion of artificial urinary sphincter	$1,897.00	42	M
	Prostate			
120R	Prostate -- abscess -- incision	$289.00 *	42	L
121R	Prostate -- biopsy -- needle	$178.00	D	L
122R	Open perineal prostatic biopsy	$1,126.00	42	L
126R	Ultrasound guided prostate biopsy	$271.00	D	L
123R	Prostatectomy -- or laser ablation	$1,375.00	42	M
124R	Radical prostatectomy (excludes exploration and biopsy of pelvic lymph nodes)	$4,120.00	42	H
125R	Seminal vesiculectomy	$1,866.00	42	M
	Kidney and Ureter			
130R	Kidney -- rupture -- repair	$2,342.00	42	H
131R	Renal biopsy -- percutaneous -- unilateral	$255.00	D	L

SECTION R:

UROLOGICAL SURGERY

		Fee	Class	Anae
133R	Renal biopsy -- open exposure	$860.00	42	M
134R	Perinephric abscess -- drainage	$952.00	42	M
135R	Exploration of kidney (not paid in addition to Renal surgery)	$1,296.00	42	M
	Nephrectomy			
136R	-- complete or partial	$2,744.00	42	H
138R	-- thoraco-abdominal radical nephrectomy	$3,291.00	42	H
139R	Nephrolithotomy or nephrotomy, pyelolithotomy or pyelotomy	$1,888.00	42	M
140R	Nephropexy -- (not paid in addition to Renal surgery)	$573.00	42	M
141R	Nephrostomy or pyelostomy and ureterostomy	$1,375.00	42	M
142R	Ileal substitution for ureter	$2,802.00	42	H
143R	Exploration ureter for lesion or trauma in conjunction with or for other surgeons	$980.00	42	M
144R	Plastic -- renal pelvis and/or ureter	$2,470.00	42	M
145R	Ureterolysis or pelviolysis	$1,380.00	42	M
	Ureterolithotomy			
146R	-- upper 2/3	$1,326.00	42	M
147R	-- lower 1/3	$1,271.00	42	M
158R	-- following previous ureteral surgery .	$1,285.00	42	M
148R	Resection of ureterovesical junction	$986.00	42	M
149R	Horseshoe symphysiotomy	$1,234.00	42	M
150R	Hypothermia to kidney, add	$93.20 *	42	
	Ureteroneocystostomy			
151R	-- single	$1,790.00	42	M
152R	-- bilateral	$2,229.00	42	M
153R	Repair of ureteral fistula	$1,683.00	42	M
154R	Intubated ureterotomy and/or ureterolysis	$1,341.00	42	M
155R	Renal cyst -- excision of -- single or multiple -- one kidney	$1,375.00	42	M
	Nephrostomy tube			
156R	-- routine change	$51.80 *	0	L
157R	-- emergency reinsertion	$115.00	0	L
	Ureteral stent			
258R	-- placement -- unilateral	$358.00	10	L
259R	-- replacement	$358.00	10	L
659R	-- removal	$266.00	0	L
	Scrotum and Contents			
160R	Open testicular biopsy	$270.00	0	L
161R	Epididymectomy -- unilateral	$839.00	42	L
	Hydrocele or epididymal cyst			
162R	-- aspirate	$67.60 *	0	L

SECTION R:

UROLOGICAL SURGERY

		Fee	Class	Anae
163R	-- surgical repair	$578.00 *	42	L
	Varicocele			
164R	-- repair	$682.00 *	42	L
165R	-- with exploration of inguinal canal	$682.00 *	42	L
	Orchidectomy			
166R	-- unilateral	$352.00 *	42	L
167R	-- bilateral	$682.00 *	42	L
168R	Retroperitoneal exploration for testicle	$1,009.00	42	M
169R	Orchidopexy -- unilateral. Includes simple herniotomy. Herniorrhaphy paid in addition	$1,229.00	42	L
170R	Orchidolysis	$93.00 *	42	L
171R	Torsion -- testis or appendix testis with fixation of contralateral testis	$1,120.00 *	42	L
180R	Orchidectomy with excision at internal ring -- unilateral	$682.00	42	L
190R	Vasectomy -- unilateral or bilateral	$550.00 *	42	L
191R	Vasovasostomy limited to the treatment of post vasectomy pain syndrome -- unilateral	$1,570.00	42	L
192R	Epididymo-vasostomy -- unilateral	$1,130.00	42	L
193R	Insertion of testicular prosthesis, independent procedure	$1,120.00 *	42	L
194R	Vasogram - unilateral or bilateral	$122.00 *	D	L
	-- in conjuction with open scrotal procedure, add			
195R	-- independent procedure unilateral or bilateral	$112.00 *	D	L
	Intra-abdominal			
202R	Exploration and biopsy of pelvic lymph nodes	$1,375.00	42	M
203R	Pelvic lymphadenectomy	$2,058.00	42	M
	Percutaneous Nephrolithotripsy			
251R	Dilatation of nephrostomy tract, add	$270.00	0	
252R	Nephroscopy through nephrostomy tract, add	$347.00	D	
253R	Removal of calculi by basket, ultrasonic disintegration or electrohydraulic lithotripsy -- small -- single	$823.00	42	M
254R	-- multiple	$1,375.00	42	M
255R	-- large -- (greater than 2 cm)	$1,924.00	42	M
256R	Extracorporal Shockwave Lithotripsy (ESWL) --unilateral	$1,053.00	42	M

Renal Homotransplantation

All services are billed in the name of the recipient by the surgeons and internists and include all services to a living donor and the recipient on day of transplant and for 42 days thereafter except:

(a) a consultation by a physician other than

		Fee	Class	Anae
	the Urological or Vascular surgeons, or Internists; (b) anaesthetic services.			
	Donor nephrectomy -- living donor or cadaver			
300R	One surgeon	$3,135.00	42	M
301R	Two surgeons -- first	$1,340.00	42	M
311R	-- second	$1,217.00	42	M
302R	Renal perfusion by other than a member of the transplant team	$327.00	0	
	Renal implantation			
303R	-- Urology component	$1,091.00	42	M
304R	-- Vascular component	$2,288.00	42	H
340R	Intra-operative biopsy of donor kidney -- add	$105.00	D	
305R	-- Internist services -- total (includes 306R and 307R)	$6,594.00	42	
306R	Internist services in donor kidney procurement in other than the transplant center	$416.00	0	
307R	Internist services in the provision of renal implant and follow-up services	$6,668.00	42	
308R	Follow-up of renal implant patient	$541.00		
	308R is payable for a visit to provide assessment and ongoing management of a patient's condition following a kidney transplant. This service is payable to the physician designated as the most responsible physician for monitoring the post-transplant status of the patient. -- not payable in addition to other visit services or dialysis, or within 42 days of the previous 308R. -- limited to six 308R services per patient per year (beginning April 1 of each year). -- not payable in the first 12 months following a transplant.			
	Hypospadias			
356R	-- first stage repair	$728.00	42	L
357R	-- second stage (urethroplasty)	$1,038.00	42	L
657R	Single stage hypospadius repair	$2,133.00	42	L
358R	-- urethral fistula repair	$304.00	42	L
359R	Epispadias	$628.00	42	L
	BMI Supplement			
580R	Urology surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height [m] 2) greater than 40 1. Maximum of one 580R supplement per patient per day. 2. Supplement 580R may be billed by urologists with all R Section procedures done in the operating room.	$118.00		

UROLOGICAL SURGERY

	Fee	Class	Anae

3. Service codes 30R and 31R are exempt from this supplement.
4. BMI supplements are not payable to the surgical assistant billing “J” section codes.

SECTION S:

OPHTHALMOLOGY

		Fee	Class	Anae
	Visits			
5S	Initial Assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis, assessment, necessary treatment, advice to the patient and record of service provided	$133.00		
7S	Follow-up assessment -- includes: history review, functional enquiry, examination reassessment, necessary treatment, advice to the patient and record of service provided	$82.00		
8S	Neuro-Ophthalmology follow assessment -- includes history review, functional enquiry, examination reassessment, necessary treatment, advice to the patient and record of service provided (only payable to to physicians with approved training in neuro-ophthalmology)	$94.00		
9S	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$169.00		
10S	Neuro-ophthalmology consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor (only payable to physicians with approved training in neuro-ophthalmology	$251.00		
11S	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$89.80		
12S	Low vision assessment (limited to one benefit per beneficiary per 12-month period)	$267.00		
6S	Routine examination of eyes -- means an examination of the eyes that shall include: case history; visual acuity; external examination; assessment of extraocular muscles; convergence testing; pupil response;	$139.00		

		Fee	Class	Anae
	accommodation; examination of cornea, lens, media, fundus; determination of refractive error or change; instruction, information and advice to the patient with respect to the status of his/her or their vision and its future management; provision of the necessary prescription.			
	Hospital Care (Not payable with a visit or consultation service on day of admission)			
25S	-- first 10 days, per day	$60.00 *		
26S	-- 11-20 days, per day	$60.00 *		
27S	-- 21-30 days, per day	$60.00 *		
28S	-- thereafter, per day	$60.00 *		
	Note: for hospital discharge by physicians, see code 725A in Section A.			
	Procedures Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement.			
32S	Tension -- measured with a tonometer -- bilateral	$25.00 *		D
332S	Diurnal tension curve -- bilateral	$147.00		D
33S	Gonioscopy -- bilateral	$25.00 *		D
534S	Formal orthoptic assessment interpretation	$60.00		D
580S	Corneal pachymetry (repeat by report only) - bilateral	$16.30 *		D
15S	Cycloplegic Retinoscopy-under 11 years age	$60.00		D
535S	Orthopic technical fee a) Bilateral b) Add to 5S, 6S, 7S, 9S, 10S, 11S, 12S, 534S	$60.00		D
651S	Automated perimetry/specular microscopy/topography a) Technical fee b) Bilateral c) Add to 34S, 35S, 36S, 650S, 671S d) 1 per patient visit	$27.00		D
579S	Screening visual fields (FDT or similar) a) Technical fee b) Bilateral c) Limit of 1 per visit d) Only payable with 34S	$4.00		D
	Optical Coherence Tomography (OCT) Not to be used for routine screening of patients and limit of one per year (professional and technical) when billed for monitoring glaucoma patients			
581S	Optical coherence tomography (OCT) - bilateral	$51.00		D
582S	Optical coherence tomography	$51.00 *		D

SECTION S:

OPHTHALMOLOGY

		Fee	Class	Anae
	(OCT) - technical fee			
	Visual Field			
34S	Screening visual field including tangent screen, auto plot-arc perimetry and frequency doubling screening -- bilateral	$31.00 *	D	
35S	-- central threshold visual field -- bilateral	$38.80 *	D	
36S	-- peripheral and central visual field -- bilateral	$79.60 *	D	
422S	Manual static and kinetic perimetry -- bilateral	$79.60 *	D	
37S	Provocative tests for glaucoma -- bilateral	$24.40 *	D	
	Fundus examination under general anaesthetic			
39S	-- unilateral or bilateral	$351.00 *	D	L
	Forced Duction Test			
424S	-- local	$53.60 *	D	
425S	-- general	$95.40 *	D	L
	Fundus or Slit Lamp Photography			
652S	Professional component -- bilateral	$13.90 *	D	
653S	Technical component -- bilateral	$13.90 *	D	
	Fluorescein Angiography			
40S	-- technical (Apparatus owned by physician and injection by physician. Use 111A if I.V. injection only by the physician)	$70.00 *	D	
41S	-- professional	$110.00 *	D	
42S	Visually evoked occipital response interpretation	$30.00 *	D	
43S	Electroretinography interpretation	$74.00 *	D	
44S	Electro-oculography interpretation	$74.00 *	D	
	Color vision assessment (F.M. 100 Hue Test or Pickford Anomaloscope)			
45S	-- technical component	$17.10 *	D	
46S	-- professional component	$32.60 *	D	
650S	Contact or non-contact specular microscopy of corneal endothelium -- professional component -- unilateral	$44.80 *	D	
429S	Laser Inferometry	$11.00 *	D	
430S	Potential Acuity Meter	$4.20 *	D	
656S	Exophthalmometry	$12.80 *	D	
658S	Dark adaptation curve -- both eyes -- professional component	$40.40 *	D	
661S	Hess or Lees test	$40.80 *	D	
664S	Indirect ophthalmoscopy with scleral depression for complete examination of fundus and diagraming -- unilateral or bilateral	$36.80 *	D	
680S	Infrared pupillography -- bilateral	$42.40	D	
681S	Eye movement videography/ photography -- bilateral	$42.40	D	
682S	Quantification of relative afferent pupillary defect with neural density filters -- bilateral	$42.40	D	
683S	Diagnostic pupillary drop testing -- bilateral	$53.00	D	

SECTION S:

OPHTHALMOLOGY

		Fee	Class	Anae
	Codes 680S to 683S are only billable by physicians with approved neuro-ophthalmology training.			
	Eyelids			
60S	Abscess -- incision	$45.40 *	0	L
	Blepharoplasty 1. When one eyelid is altered due to the below, trauma, or ablative cancer surgery then a contralateral balancing procedure is insured. 2. Fee for correction of blepharoptosis includes associated blepharoplasty. 3. Ptosis repair includes associated blepharoplasty. 4. Prior approval is not required. 5. See Cosmetic Surgery Protocol - Section N – Surgery of Appearance. Upper lids: a) Blepharoplasty of the upper eyelids is insured if there is obstruction of the visual axis caused by the redundant eyelid skin and/or lash inversion with ocular irritation. b) Sufficient evidence to support this must be documented in the patient record. Lower lids: a) Blepharoplasty of the lower eyelids is insured when: □ The deformity results in exophthalmos, ectropion, or interferes with wearing eyeglasses, or □ Orbital fat/orbital septal pathology due to endocrine or other disease, or □ Ophthalmological confirmation of interference with bifocal lens. b) Sufficient evidence to support this must be documented in the patient record.			
61S	Blepharoplasty -- excision of skin and/or muscle, unilateral, upper lid	$244.60	10	L
62S	Blepharoplasty -- excision of skin and/or muscle, unilateral, lower lid	$244.60	10	L
276S	Blepharoplasty -- with orbital fat excision or repositioning, unilateral, upper lid	$509.80	42	L
277S	Blepharoplasty -- with orbital fat excision or repositioning, unilateral, lower lid	$473.00	42	L
	Ptosis repair includes associated blepharoplasty.			
63S	Chalazion -- removal	$122.00 *	10	L

SECTION S:

OPHTHALMOLOGY

		Fee	Class	Anae
64S	-- under general anaesthetic or IV sedation (includes post-op recovery)	$245.00 *	10	L
65S	Cauterization -- lid	$40.80 *	0	L
	Trichiasis			
66S	Epilation -- unilateral	$44.80 *	0	L
431S	Electrolysis -- unilateral	$62.10 *	10	L
432S	Cryotherapy -- unilateral	$121.00	10	L
	Districhiasis			
436S	Permanent repair -- per lid	$492.20	42	L
67S	Ziegler puncture	$58.90 *	10	L
	Tarsorrhaphy			
68S	-- temporary or reversal	$133.00	10	L
69S	-- permanent -- double adhesion	$326.00	42	L
	Ectropion			
80S	-- surgical repair	$652.00	42	L
	Entropion			
81S	-- surgical repair	$652.00	42	L
	Ptosis			
75S	-- simple repair	$816.00	42	L
439S	-- complicated repair with graded tarsomeuller resection, add	$196.90	42	L
440S	-- with fascia lata sling, add	$196.90	42	L
441S	-- with levator excision, add	$196.90	42	L
442S	-- with aponeurosis reinsertion, add	$196.90	42	L
	Blepharoplasty included in the bill for ptosis repair.			
	Lid Lengthening			
444S	Graded Meullerectomy	$738.30	42	L
445S	-- with levator recession, add	$124.10	42	L
446S	-- with scleral graft, add	$124.10	42	L
	Eyelid or Conjunctival Tumor			
70S	Excision -- without sutures	$102.00 *	10	L
	Excision -- repair with sutures (Use 380N)			
77S	Full thickness excision of benign or malignant tumor with plastic repair using conjunctiva	$367.00	42	L
	Lid Laceration			
72S	-- simple repair	$122.00 *	10	L
448S	-- full thickness	$308.20	42	L
449S	full thickness -- lid margin	$369.20	42	L
454S	full thickness plus levator division	$485.00	42	L
73S	-- repair of canaliculus -- old or recent	$816.00	42	L
	Lid Defect			
450S	closure with rotation flap	$492.20	42	L
451S	closure with rotation flap plus cantholysis, add	$124.10	42	L
452S	closure with temporal flap and cantholysis, add	$326.00	42	L
453S	closure with free posterior lamellar	$308.20	42	L

		Fee	Class	Anae
	graft, add			
	Upper or lower eyelid bridge flap			
455S	-- first stage	$984.40	42	L
456S	-- second stage	$184.00	42	L
457S	Free composite eyelid graft	$984.40	42	L
458S	Medial Canthoplasty	$615.30	42	L
	Medial Canthal tendon injury			
459S	-- repair	$485.00	42	L
460S	-- with boney fixation, add	$184.00	42	L
461S	Medial or lateral cantholysis	$247.00	42	L
462S	Lateral canthopexy -- primary	$485.00	42	L
	Lacrimal Tract			
	Duct Probing			
50S	-- local anaesthesia	$40.80 *	0	
51S	-- general anaesthesia	$245.00 *	0	L
52S	Duct probing and insertion of plastic tube or similar method -- total care	$334.00	10	L
464S	-- with turbinate fracture, add	$51.00 *	0	L
466S	Tube change or reinsertion -- local or general after 10 days	$124.10	0	L
54S	Dacryocystectomy	$453.70	42	L
55S	Dacryocystorhinostomy	$1,070.00	42	M
468S	-- with lacrimal bypass or canalicular reconstruction, add	$147.70	42	L
469S	"Three Snip" procedure on punctum	$147.70	10	L
470S	Canaliculotomy	$73.80 *	0	L
471S	Closure of punctum by cautery -- unilateral or bilateral	$147.70	0	L
472S	Drainage of lacrimal sac abscess	$125.00 *	0	L
573S	Punctual Plugs - per punctum - maximum of 2	$133.00	10	
	Extraocular Muscles			
	Recession, resection, myotomy, myectomy, oblique weakening or strengthening			
130S	-- first muscle	$909.00	42	M
131S	-- second muscle -- either eye -- add	$679.00	42	M
132S	-- any additional muscle(s) -- either eye -- add	$234.00	42	M
133S	-- adjustable suture technique per muscle adjusted -- add	$510.00	42	M
134S	-- two muscle transposition procedure	$1,633.00	42	M
	Corneal Collagen Cross-Linking			
690S	-- professional fee	$1,087.00	42	L
691S	-- technical fee	$1,020.00		L
	Conjunctiva -- Cornea -- Sclera			
88S	Removal of corneal tattooing	$139.00	10	L
89S	Biopsy of conjunctiva	$85.60 *	D	L
	Foreign body or bodies -- removal			

SECTION S:

OPHTHALMOLOGY

		Fee	Class	Anae
90S	-- unembedded --embedded	$41.00 *	0	L
91S	-- local anaesthesia	$68.40	0	L
106S	-- general anaesthesia	$226.00	10	L
671S	Corneal topography - interpretation fee (only for corneal pathology, i.e. not billable for refractive surgical assessments) - unilateral or bilateral	$53.00	D L
92S	Keratectomy -- superficial	$734.00	42	L
	Keratoplasty			
93S	-- lamellar	$1,121.00	42	L
94S	-- penetrating	$2,029.00	42	M
95S	Pterygium -- any method	$612.00	42	L
96S	Subconjunctival injection	$30.60 *	0	L
97S	Corneal ulcer -- cauterization -- initial or repeat	$36.40 *	0	L
98S	Relaxing corneal incisions following corneal transplantation (Does not apply to radial keratotomy)	$510.00	42	L
	Phototherapeutic keratectomy for anterior scarring, hereditary congenital dystrophy or recurrent erosion syndrome - requires prior approval			
300S	-- professional fee	$734.00	42	L
301S	-- technical fee (physician owned equipment)	$1,957.00 *	42	L
250S	Removal of corneal sutures, by different surgeon or same surgeon beyond post-op period (does not apply to cataract or trabeculectomy corneal suture removal)	$133.00 *	0	
	Conjunctival flap over ulcer or wound			
99S	-- simple .	$449.00	42	L
107S	-- Gunderson or complicated	$1,020.00	42	M
	Wounds -- suture			
100S	-- conjunctiva	$245.00 *	10	L
101S	-- corneal or sclera -- without complication	$1,121.00	42	M
102S	-- with prolapse by conjunctivaplasty	$1,376.00	42	M
103S	Retrobulbar injection of alcohol	$122.00 *	0	L
104S	Excision of corneal dermoid	$612.00	42	L
474S	EDTA removal of band keratopathy	$500.00	10	L
475S	Conjunctival resection for corneal melt	$308.20	0	L
476S	Cyanoacrylate for corneal melt	$459.00	0	L
522S	Re-operation through conjunctivia-for glaucoma, stabismus and sclera buckling surgery-unilateral-can add to 160S, 130S, 131S, 132S, 133S, 169S	$204.00	42	M
477S	Epikeratophakia	$1,353.60	42	L
	Pre-authorization required. Insured if: 1. Adult aphakia with low endothelial count and intolerance to contact or intraocular lens. 2. Pediatric aphakia with failure of visual rehabilitation 3. Keratoconus --with contact lens intolerance			

SECTION S:

OPHTHALMOLOGY

		Fee	Class	Anae
	Not an insured service when done as cosmetic procedure.			
	Iris			
	Iridotomy			
182S	-- laser per eye	$290.00	10	
478S	-- surgical	$449.00	42	L
163S	Iridectomy -- surgical	$449.00	42	L
105S	Iridodialysis repair	$510.00	42	
164S	Irrigation -- anterior chamber, through corneal incision	$449.00	42	L
	Synechotomy			
165S	-- anterior chamber, surgical	$246.10	42	L
187S	-- anterior chamber, laser	$163.00		L
	Paracentesis			
166S	-- aqueous	$65.20	0	L
167S	-- vitreous	$102.00	0	L
186S	Photomydriasis	$270.70	10	L
	Glaucoma			
180S	Laser trabeculoplasty -- per eye	$330.00	10	
159S	Cyclodiathermy, cycloelectrolysis or cyclocryothermy	$467.60	42	
	Filtering operation			
160S	-- standard	$1,223.00	42	M
520S	-- with any seton device in the anterior chamber or through pars plana, add	$530.00	42	
521S	-- with the use of anti-metabolite drugs -- add	$184.00	42	M
190S	Cyclodialysis	$184.00	10	L
	Goniotomy and/or goniopuncture			
161S	-- unilateral	$393.80	42	L
162S	-- repeat	$246.10	42	L
480S	Post op trabeculectomy - cutting of sutures	$124.10	0	L
	Lens			
	Cataract			
135S	-- complete treatment -- all forms, child or adult	$935.20	42	L
136S	-- Implantation of prosthetic intraocular lens, add	$196.90 *	42	L
	Prosthetic Intraocular lens			
236S	-- repositioning	$290.00	0	L
336S	-- removal	$268.60	10	L
479S	Removal and replacement	$795.00	42	L
539S	Repositioning with suture of haptic to scleral	$1,200.00	42	L
	Secondary implantation of lens prosthesis			
142S	-- simple -- intact vitreous	$714.00	42	L

OPHTHALMOLOGY

		Fee	Class	Anae
	Complicated with vitrectomy, use vitrectomy codes			
	Crystalline Lens - Removal of Dislocated			
139S	-- anterior chamber	$738.30	42	L
137S	Capsulectomy	$510.00	42	L
138S	Capsulotomy or discission of secondary membranes (surgical)	$306.00	42	L
189S	Posterior capsulotomy (laser)	$276.00	10	L
	Complex Cataracts			
673S	Pupil expansion device, insertion and removal-unilateral-can be added to 135S, 139S, 142S, 226S, 236S, 220S, 230S	$175.00	42	L
674S	Capsular tension ring or segment insertion-unilateral-can be added to 135S, 139S, 142S, 226S, 236S	$175.00	42	L
675S	Capsular staining by any method-unilateral-can be added to 135S, 139S, 142S, 226S, 236S	$51.00	42	L
	Sclera			
481S	Scleral Patch Graft	$861.40	42	M
482S	Noniatrogenic scleral dehiscence or rupture -- repair	$369.20	42	M
483S	Tumor of ciliary body	By Report	42	M
171S	Posterior sclerotomy with or without insufflation of anterior chamber	$306.00	10	L
	Orbit			
108S	Harvesting of donor eyes -- one or both -- for corneal transplant	$612.00	0	L
109S	Exenteration	$1,427.00	42	M
110S	Abscess -- incision and drainage	$563.00	42	L
111S	Enucleation	$918.00	42	M
112S	-- with insertion of an integrated orbital ocular implant in scleral shell, add	$245.00	42	M
113S	Extruded implant - replace - secondary operation	$581.00	42	L
540S	Secondary drilling of integrated orbital implant	$381.00	42	L
	Dermal Fat Graft			
313S	Immediate following enucleation	$430.10	42	L
485S	-- delayed replacement of extruded implant by graft	$984.40	42	L
78S	Fornix Restoration -- minor	$714.00	42	L
487S	-- with mucous membrane graft, add	$247.00	42	L
488S	-- with autogenous conjunctival transplant, add	$246.10	42	L
413S	Reversal of anophthalmic socket with secondary integrated implant	$683.00	42	L
	Tumor			
114S	Excise anterior tumor -- simple removal	$999.00	42	M
489S	Excise posterior tumor	$1,554.00	42	M

OPHTHALMOLOGY

		Fee	Class	Anae
490S	Biopsy anterior tumor	$667.00	10	L
491S	Biopsy posterior tumor	$918.00	10	L
292S	Exploration of orbital floor or medial wall for suspected blowout fracture	$450.00	42	M
293S	Repair of orbital blowout fracture (floor or medial wall) -- first wall	$1,000.00	42	M
294S	Repair of orbital blowout fracture (floor or medial wall) -- second wall, add -- by report	$600.00	42	M
119S	Lateral orbitotomy (Kronlein's procedure) or other decompression by report	$1,937.00	42	M
	Retina			
170S	Retinal tear, complete treatment by diathermy, cryosurgery or laser	$492.20	42	L
174S	Retinal tumor -- treatment by laser	$800.40	42	L
670S	Retinal photography - interpretation fee -- bilateral	$53.00 *	D	
	Diabetic retinopathy or similar vascular abnormality, treatment by laser -- per eye			
175S	-- initial treatment session	$590.60	42	L
176S	-- subsequent treatment per session	$296.00	0	L
177S	Retinal degeneration or detachment -- treatment by diathermy, cryosurgery, or laser with or without hole	$492.20	42	L
178S	Peripheral retinal diathermy, cryosurgery or photocoagulation	$492.20	42	L
169S	Scleral buckling for retinal detachment includes -- diathermy, cryo or laser (includes 232S)	$1,580.00	42	M
251S	Removal of scleral buckle hardware by different surgeon or same surgeon beyond post-op period	$212.00	10	L
275S	Retinopathy of prematurity (preterm infants) (by laser), unilateral	$1,020.00	42	H
	Macula			
493S	Photocoagulation of choroidal neovascular membrane	$492.20	42	L
494S	-- subsequent treatment	$369.20	42	L
495S	Focal Photocoagulation of significant diabetic macular edema	$492.20	42	L
496S	-- subsequent treatment	$369.20	42	L
	Grid and focal therapy not billed together. Maximum benefit billable under codes 493S to 496S in any six consecutive month period per eye. May be exceeded if extenuating circumstances (by report)	$1,476.60		
497S	Photodynamic therapy (Visudyne) approved for cases of pathologic myopia or the classic form or age related macular degeneration in patients with predominately subfoveal choroidal neovascularization **and choroidal neurovascularization secondary to histoplasmosis** -- unilateral	$697.00	42	L

OPHTHALMOLOGY

		Fee	Class	Anae
	Vitreous			
	Anterior vitrectomy -- planned			
220S	-- with or without penetrating wound	$577.80	42	M
222S	-- with corneoscleral laceration repair, add	$209.70	42	M
223S	-- with uveal tissue prolapse and repair, add	$147.70	42	M
224S	-- with lensectomy, add	$196.90	42	L
136S	-- Implantation of prosthetic intraocular lens, add	$196.90 *	42	L
	Posterior vitrectomy -- planned (includes anterior vitrectomy)			
230S	-- pars plana	$1,448.00	42	M
757S	-- with intravitreal injection of silicone oil, add	$184.00	42	L
232S	-- with endophotocoagulation, add	$247.00 *	42	L
224S	-- with lensectomy, add	$196.90	42	L
225S	-- with preretinal membrane peeling, add	$492.20	42	L
136S	-- Implantation of prosthetic intraocular lens, add	$196.90 *	42	L
325S	-- removal of dislocated crystalline lens or cataract from the vitreol cavity, add	$734.00	42	L
226S	Posterior vitrectomy with cataract extraction via separate anterior approach (includes lensectomy), add	$674.10	42	M
515S	Air/gas/fluid exchange, add	$308.20	42	L
516S	Air/gas/fluid exchange, repeat	$184.00	0	L
233S	Removal of foreign body from anterior chamber (magnetic or non magnetic), add	$124.10	42	L
234S	Removal of foreign body from posterior chamber (magnetic or non magnetic), add	$247.00	42	M
141S	Removal of foreign body from anterior or posterior chamber or vitreous without vitrectomy -- any method	$612.00	42	M
252S	Post-operative vitreous cavity washout by different surgeon or same surgeon beyond post-op period	$246.10	0	L
	Intraocular fluid/gas exchange			
254S	-- independent procedure	$369.20	42	L
517S	-- removal	$247.00	42	L
755S	Vitreous tap with intravitreal injection of antiobiotic/steroids in the management of bacterial endophthalmitis	$387.00	0	L
756S	Intravitreal injection of drugs	$204.00	0	L
518S	Pneumatic retinopexy with cryotherapy	$1,009.00	42	M
	Dissection of vitreous bands or membranes with Yag laser			
285S	-- anterior segment	$345.00	42	
286S	-- posterior segment	$738.30	42	

SECTION S:

OPHTHALMOLOGY

		Fee	Class	Anae
625S	Amniotic membrane transplantation-unilateral-second eye same day paid at 75%	$765.00	42	M
	Laser Technical Fees			
181S	-per eye (unilateral)-may be added to 170S, 174S, 175S, 176S, 178S, 180S, 182S, 186S, 187S, 189S, 285S, 286S, 493S, 494S, 495S, 496S, 497S - laser owned and maintained by physician	$60.00		D

SECTION T:

OTOLARYNGOLOGY

		Fee	Class	Anae
	Visits			
5T	Initial assessment -- of a specific condition includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, clinical examination of affected part(s) or system(s), diagnosis, tentative or final, necessary treatment, advice to the patient and record of service provided	$106.00		
7T	Follow-up assessment -- includes: history review, functional enquiry, clinical examination diagnosis, tentative or final, necessary treatment, advice to the patient and record of service provided	$101.00		
9T	Consultation -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$174.00		
11T	-- repeat A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$102.00		
	Hospital Care (Payable on day of admission)			
25T	-- 1-10 days, per day	$106.00 *		
26T	-- 11-20 days, per day	$106.00 *		
27T	-- 21-30 days, per day	$100.00 *		
28T	-- thereafter, per day	$100.00 *		
	Note: for hospital discharge by physician, see code 725A, Section A.			
	Procedures Additional payments for diagnostic service excluding ECGs, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paed. Age Supplement.			
430T	Screening audiogram (not to be billed for	$32.00 *	D	

SECTION T:

OTOLARYNGOLOGY

		Fee	Class	Anae
	Welch Allyn type audioscope)			
	Diagnostic pure tone audiogram in sound-proof room including thresholds and four frequencies			
431T	-- air	$32.00 *	D	
432T	-- air and bone	$50.30 *	D	
433T	Speech reception threshold	$8.60 *	D	
434T	Discrimination score	$17.10 *	D	
435T	One or more of -- most comfortable level, speech detection threshold, stenger test, ABLB or tone decay, total	$17.10 *	D	
537T	Impedance hearing testing (e.g. Impedance tympanometry and/or acoustic reflexes)	$13.90 *	D	
438T	Reflex decay	$13.90 *	D	
439T	Conditioned play audiometry	$50.30 *	D	
440T	V.R.A. requiring two testers	$67.40 *	D	
441T	T.R.O.C.A. requiring two testers	$67.40 *	D	
442T	Vestibular caloric test	$17.10 *	D	
	Electronystagmography including gaze, positional and caloric testing			
443T	-- test and interpretation	$165.90 *	D	
444T	-- interpretation only	$58.90 *	D	
445T	Canalolith repositioning maneuver for benign paroxysmal positional vertigo	$20.40	D	
	Ear		D	
51T	Catheter inflation .	$34.20 *	0	
	Cerumen -- removal includes syringing			
52T	-- simple (bilateral) -- not payable with a consultation	$60.00 *	0	
53T	-- impacted -- under injected local or general anaesthesia.	$203.30 *	10	L
350T	Removal of cerumen under magnification (e.g. Hotchkiss otoscope or binocular) (bilateral)	$34.20 *	0	
	Foreign body -- removal			
54T	-- simple	$40.80 *	0	L
55T	-- complicated -- under injected local or general anaesthesia	$203.30 *	10	L
56T	-- involving post-aural incision	$510.00	42	L
57T	Paracentesis of eardrum	$102.00 *	0	L
	Polyp			
58T	-- removal -- simple	$62.10 *	10	L
59T	-- removal under local or general anaesthesia	$203.30 *	10	L
61T	Labyrinthotomy - total	$1,243.30	42	L
62T	Endolymphatic sac surgery -- initial or revision	$1,544.00 *	42	L

SECTION T:

OTOLARYNGOLOGY

		Fee	Class	Anae
	Mastoidectomy			
70T	-- infant -- antrotomy	$1,020.00	42	L
71T	-- simple -- complete any age	$1,020.00	42	L
72T	-- radical -- classical -- revision	$1,070.00	42	L
74T	-- revision -- same surgeon	$1,020.00	42	L
75T	-- revision -- different surgeon	$1,020.00	42	L
76T	-- revision -- with musculoplasty, add to 72T, 74T, 75T or 87T	$124.10	42	L
77T	Review of radical mastoid cavity -- removal of cerumen and debris -- unilateral	$71.40 *	0	L
	Post-aural fistula			
78T	-- closing	$204.00	42	L
79T	-- with sliding or pedicle graft	$408.00	42	L
80T	-- stapedectomy with prosthesis (fenestration of the oval window)	$1,529.00	42	L
81T	Stapes mobilization	$621.70	42	L
	Sinus thrombosis			
82T	-- operative management with mastoidectomy	$861.40	42	L
83T	Tympanotomy, exploratory (internal) (not paid in addition to inner ear surgery)	$467.60	42	L
283T	Tympanotomy with ossicular chain reconstruction	$816.00	42	L
84T	Myringoplasty -- per canal approach only	$492.20	42	L
85T	Tympanoplasty with widening of external auditory canal and exploration of attic with or without antrotomy	$990.80	42	L
86T	-- with ossicular reconstruction	$1,223.00	42	L
87T	-- with radical mastoidectomy	$1,835.00	42	L
88T	Myringotomy with insertion of tube (total care)	$172.30	42	L
89T	Cochlear implant, unilateral, with or without mastoidectomy Includes: posterior tympanotomy, free tissue harvest for cochleostomy obliteration and musculopiosteal temporalis muscle fotation flap	$2,800.00	42	H
100T	Percutaneous insertion of bone-anchored hearing aid, unilateral (all-inclusive code)	$820.00	10	L
250T	Facial nerve monitoring – add to 61T, 62T, 70T, 71T, 72T, 74T, 75T, 76T, 81T, 82T, 85T, 87T, 89T, and 283T. Not payable in multiples; one per patient contact to the physician performing the monitoring.	$274.10	42	
	Nose			
	Antrum -- puncture and/or irrigation			
90T	-- unilateral diagnostic or therapeutic	$51.00 *	0	L
92T	Anterior packing for epistaxis (unilateral or bilateral)	$92.00 *	0	L
93T	Post nasal packing -- unilateral or bilateral	$246.10 *	0	L

SECTION T:

OTOLARYNGOLOGY

		Fee	Class	Anae
292T	Post nasal packing -- bilateral	$51.00		
393T	Epistaxis, for anterior packing and post nasal packing (unilateral or bilateral)	$408.00 *	0	L
	Foreign body removal			
94T	-- simple	$58.40 *	0	L
95T	-- complicated -- general anaesthetic	$204.00 *	10	L
	Polyp removal			
96T	-- single -- in office	$204.00 *	10	L
296T	-- in operating room	$206.00 *	10	L
97T	-- multiple -- unilateral -- in operating room	$221.50	10	L
98T	-- choanal	$203.30	10	L
	-- electrocoagulation -- unilateral or bilateral			
99T	-- per treatment	$42.80	0	L
	-- maximum fee for full treatment	$171.20		
	Choanal atresia			
105T	-- emergency treatment in newborn, transnasal procedure and insertion of tube	$246.10	0	L
106T	-- repair -- anterior nasal approach -- unilateral	$612.00	42	M
107T	-- repair -- transpalatal approach	$1,020.00	42	M
108T	-- choanal dilation	$92.00 *	0	L
109T	Cauterization of nose -- general anaesthetic	$204.00 *	0	L
	Septum cauterization (unilateral or bilateral)			
110T	-- chemical	$40.80 *	0	L
111T	-- electro-cautery or diathermy	$204.00 *	0	L
112T	Submucous resection	$610.00	42	L
113T	Septoplasty -- utilizing transfixion incision with mobilization of cartilagenous septum	$612.00	42	M
	Septal dermoplasty			
114T	-- septum only	$918.00	42	L
115T	-- septum, floor and lateral wall	$918.00	42	L
	Sinus -- unilateral operation			
	-- **maxillary** antrum			
116T	-- radical (Caldwell-Luc, etc.)	$918.00	42	M
117T	-- radical with closure of oral fistula	$910.60	42	M
118T	-- intranasal	$240.00	42	M
	-- ethmoidectomy			
119T	-- external	$1,020.00	42	M
520T	-- intranasal -- anterior or complete	$360.00	42	L
122T	-- **frontal** -- external -- trephine	$612.00	42	M
123T	-- obliteration -- osteoplastic flap with fat or similar graft	$1,181.30	42	M
124T	-- obliteration -- removal of anterior wall and floor	$873.10	42	M

SECTION T:

OTOLARYNGOLOGY

		Fee	Class	Anae
125T	-- including either ethmoid and/or sphenoid	$1,040.00	42	M
126T	-- intranasal	$360.00	42	M
127T	-- **sphenoid** -- intranasal	$360.00	42	M
	Transphenoidal exposure of pituitary for hypophysectomy see Section K, Spine Surgery.			
	Transantral Orbital Decompression			
128T	-- unilateral	$1,020.00	42	M
129T	-- bilateral	$1,641.40	42	M
	Turbinate			
130T	-- cauterization -- cautery or diathermy (unilateral or bilateral)	$124.10 *	0	L
131T	-- resection -- partial	$160.50	10	M
132T	-- submucous resection of	$246.10	10	M
450T	-- sinuscopy -- unilateral or bilateral	$71.40	D	L
	Throat and Mouth			
	Frenectomy			
139T	-- under general anaesthesia	$204.00 *	10	M
138T	-- without anaesthesia	$87.60 *	10	L
	Abscess -- incision and drainage with scalpel			
140T	-- peritonsillar or retropharyngeal	$510.00 *	10	M
142T	Adenoidectomy	$510.00	42	M
145T	Tonsillectomy (with or without adenoidectomy)	$700.00 *	42	M
147T	Post T & A hemorrhage -- surgical treatment	$1,020.00 *	42	M
149T	Post T & A hemorrhage -- treatment by different surgeon	$328.00	42	
	Endoscopic			
165T	-- removal of foreign body from larynx	$612.00	42	M
	Laryngoscopy			
	-- direct			
173T	-- diagnostic	$203.30 *	D	L
174T	-- with biopsy	$408.00	D	M
175T	-- with benign tumor removal or cord stripping	$408.00	42	M
275T	-- with microscope - with biopsy or cord stripping	$408.00	42	L
171T	Intubation -- for laryngeal obstruction	$612.00 *	0	M
176T	Hypopharyngeal -- removal of foreign body	$204.00 *	0	M
177T	Tracheostomy	$726.00	42	M
178T	Complete change of tracheostomy tube or Blom Singer prosthesis	$204.00 *	0	L
	Miscellaneous			
192T	Arytenoidopexy or arytenoidectomy	$910.60	42	M
193T	Total laryngectomy	$2,447.00	42	H
293T	Primary creation/insertion of voice prothesis	$204.00	42	H
194T	Partial laryngectomy -- not laryngofissure	$1,852.20	42	H
195T	Laryngofissure	$1,631.00	42	M

SECTION T:

OTOLARYNGOLOGY

		Fee	Class	Anae
196T	Anterior or lateral pharyngotomy	$910.60	42	M
197T	Total maxillectomy with or without orbital exenteration	$1,852.20	42	M
198T	Transoral cricopharyngeal myotomy	$1,223.00	42	M
199T	Transoral cricopharyngeal myotomy with another procedure, add	$204.00	42	M
	Tympanic neurectomy			
200T	-- unilateral	$621.70	42	M
201T	-- bilateral	$1,138.50	42	M
300T	Laryngoscope or nasal sinuscope tray fee -- for cleaning and maintaining endoscopic instruments (can be paid in addition to the following office procedures only 173T, 174T, 175T, 450T)	$24.40 *		

SECTION V:

LABORATORY MEDICINE

Laboratory Medicine

Laboratory services in lists 1, 2 and 3, provided outside of a hospital or any other facility in which laboratory costs are funded by the Saskatchewan Health, Regional Accountability Branch are insured as defined in the lists:

Physician	**Payment Approved For**
Pathologist	Lists 1, 2, 3
Physician with a registered Laboratory Technician	Lists 1, 2
Other Physicians	Lists 1

"Pathologist" -- means a specialist whose name appears on the list of specialists maintained by the College of Physicians and Surgeons of the Province of Saskatchewan as being a pathologist.

List 1 — **Fee**

Classification: Diagnostic

14V	HAEMOGLOBIN	$8.80
15V	HAEMATOCRIT or PCV	$7.20
31V	BLOOD SUGAR -- diagnostic stick --whole blood	$8.00
32V	BLOOD SUGAR -- serum -- machine read (when done on an Ames seralyzer or a similar machine)	$9.40
59V	URINALYSIS -- dipstick	$8.00
60V	URINALYSIS -- complete -- dipstick and microscopic	$9.40
62V	TEST FOR PREGNANCY -- any method	$18.00
70V	EXAMINATION OF SLIDE FOR TRICHOMAS, YEAST, SCALES (Lab Licence not required to perform this service.)	$9.40
80V	OCCULT BLOOD	$9.40
90V	MICROALBUMIN TESTING max one per year per patient (for diabetic patients with negative albumin only) urine dipstick	$15.20

Note:
Tests performed on the Ames Glucometer or similar equipment providing blood surgar readings on whole blood should be billed as service code 31V Blood sugar -- diagnostic stick, not as 32V.

List 2

Classification: Diagnostic

The following services are insured when provided by a physician or by a registered laboratory technologist or a certified combined laboratory and x-ray technician in a medical laboratory which holds a Category II licence issued pursuant to *The Medical Laboratory Licensing Act*.

A Category II laboratory must employ a registered laboratory technologist or certified combined laboratory and x-ray technician.

12V	BLOOD PROFILE (includes Hb, WBC, Smear and Differential) (not to be used when any portion of the result is obtained by the use of automated or semi-automated analyzers)	$20.80
14V	HAEMOGLOBIN	$8.80
15V	HAEMATOCRIT OR PCV	$7.20

SECTION V:

LABORATORY MEDICINE

17V	SEDIMENTATION RATE (ESR)	$7.20
18V	SMEAR WITH DIFFERENTIAL COUNT	$10.00
19V	WHITE BLOOD CELL COUNT	$6.20
904V	AUTOMATED OR SEMI-AUTOMATED HAEMATOLOGY PROFILE, COUNTS and INDICIES (includes haemoglobin, RBC, WBC, haematocrit, MCH, MCHC, and MCV, when performed)	$18.20
27V	BLOOD UREA NITROGEN -- SERUM -- machine read (when done on an Ames seralyzer or a similar machine)	$6.40
		Fee
29V	BLOOD UREA NITROGEN -- DIAGNOSTIC STICK -- whole blood	$4.20
31V	BLOOD SUGAR -- DIAGNOSTIC STICK -- whole blood	$8.00
32V	BLOOD SUGAR SERUM -- machine read (when done on an Ames seralyzer or a similar machine)	$9.40
33V	BLOOD GLUCOSE TEST or GLUCOSE TOLERANCE TEST (including urine test), per unit	$11.00
59V	URINALYSIS -- dipstick	$8.00
60V	URINALYSIS -- complete -- dipstick and microscopic	$9.40
62V	TEST FOR PREGNANCY -- any method	$18.00
70V	EXAMINATION OR SLIDE FOR TRICOMONAS, YEAST, SCALES (Lab Licence not required to perform this service.)	$9.40
80V	OCCULT BLOOD	$9.40
512V	PROTHROMBIN -- Quick's one stage prothrombim time with control	$11.40
627V	SPOT TEST FOR MONONUCLEOSIS	$17.00
90V	MICROALBUMIN TESTING -- max one per year per patient (for diabetic patients with negative albumin only) urine dipstick	$15.20

Note:
Tests performed on the Ames Glucometer or similar equipment providing blood surgar readings on whole blood should be billed as service code 31V Blood sugar -- diagnostic stick, not as 32V.

Specialist in Pathology

List 3
Classification: Diagnostic

1. The following services are insured when provided in a medical laboratory which holds a Category III or Category IV licence issued pursuant to The Medical Licensing Act. A Category III laboratory is a laboratory outside of a hospital which is supervised by a pathologist. A Category IV laboratory is a satellite laboratory afiliated with a Category III laboratory whose manager is responsible for the satellite laboratory.

Payment includes both the technical and professional components unless otherwise specificed.

2. Supervision by a pathologists means that he/she shall:

(a) live in the town or city where the laboratory is located;
(b) personally visit the laboratory at least three times a week;
(c) supervise the recruitment and work of the laboratory personnel and the purchasing of equipment and supplies;
(d) be available at all times for consultation;

		Specialist in Pathology
	(e) accept responsibility for the procedures used in the work of the laboratory; and (f) if the specialist is hospital-based, then his/her supervision of a non-hospital laboratory should be restricted to one such laboratory. The listed payment for a service applies to the provision of the service by any method unless otherwise specified in the description of the service.	
	Pathologist Assessment	
65A	Assessment -- includes all visits necessary, history and examination, review of laboratory and/or other data, written submission of the consultant's opinion and recommendations to the referring doctor and advise to the patient as required. -- only payable to physician providing a surgical biopsy (standard assessment rule apply)	$56.20
	Specimen Collection and Referral	
751V	Phlebotomy, venipuncture	$48.40
752V	Phlebotomy, pediatric (0 to 6 years)	$72.80
771V	Referral - Blood	$24.60
770V	Referral - urine	$24.60
772V	Referral - other	$31.40
756V	Referral - TDG - blood (transfer of dangerous goods)	$76.40
757V	Referral - TDG - urine (transfer of dangerous goods)	$76.40
758V	Referral - TDG - other (transfer of dangerous goods)	$76.40
	Chemistry **Blood Gases**	
111V	Blood gases (pH, p02, pC02, 02 saturation)	$17.00
112V	Blood gas (pH only)	$12.00
113V	Blood gas and metabolytes - (pH, p02, pC02, 02 saturation, sodium, potassium, chloride, glucose, lactate)	$24.80
114V	Blood gas and metabolytes - pH, p02, pC02, 02 saturation, sodium, potassium, chloride, glucose, lactate and ionized calcium	$26.80
118V	CoOximetry (any single test)	$12.00
119V	CoOximetry (methemoglobin, carboxyhemoglobin)	$15.20
120V	Blood gas, metabolytes and CoOximetry (pH, p02, pC02, 02 saturation, sodium, potassium, chloride, glucose, lactate, ionized calcium, methemoglobin, carboxyhemoglobin, oxyhemoglobin, hemoglobin-arterial)	$33.00
121V	Ionized Ca whole blood	$12.00
122V	Ionized calcium - serum	$12.00
	Routine	
130V	Specimen may be serum/plasma/urine/fluids -- single analyte	$12.00
131V	For each additional analyte performed on the same specimen from the following menu add - albumin, alk phos, ALT, amylase, AST, total bili, direct bili, calcium, creat CK, CKMB, chloride, TC02, glucose, GGT, ethanol, total protein, magnesium cholestrol, triglyceride, HDL chol,	$1.60

		Specialist in Pathology
	iron + total iron binding, uric acid, sodium, potassium, LD, lactate, phos, urea, amonia, acetaminaphen, salicylate	
	Urinalysis/Urine Testing	
132V	Routine urinalysis includes: bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrates, pH, protein, specific gravity & urobilinogen	$14.20
133V	Urine microscopy	$12.00
134V	Myoglobin urine	$45.00
135V	Occult bld (Stool/gastric)	$12.00
136V	Osmolality urine/serum	$41.00
137V	Ketones, reducing substances (urine/feces)	$4.00
138V	24-hour urine, creatinine clearance	$34.00
139V	24-hour urine, total protein	$32.40
141V	Alb/Creat Ratio	$80.20
433V	Microalbumin - by automated method	$33.20
140V	Pregnancy test HCG (urine or serum)	$46.80
	Chemistry - Immunology/Rheumatology	
151V	A 1 antitrypsin	$33.20
152V	C3	$33.20
153V	C4	$33.20
162V	Ceruloplasmin	$33.20
155V	C-reactive protein	$33.20
240V	Electrophoresis (serum)	$80.20
156V	Electrophoresis CK	$80.20
157V	Electrophoresis CSF/urine	$101.00
158A	IgA	$24.60
159V	IgG	$33.20
161V	IgM	$33.20
163V	Immunofixation (serum/CSF/urine)	$195.00
630V	Rheumatoid factor	$33.20
166V	Transferrin	$33.20
167V	Cryoglobulins	$50.00
	Chemistry - Endocrinology and Therapeutic Drug Monitoring	
171V	For any single analyte ordered on the same specimen from the following group	$22.20
172V	For each additional analyte ordered from the following group add: alpha fetoprotein, carbazamepine, CEA, digoxin, ferritin, follicle stimulating hormone, gentamicin leutenizing hormone, phenobarbital, phenytoin, prolactin, serum beta HCG quantitative, theophylline, tobramycin, troponin 1, valproic acid, vancomycin	$7.20
173V	Estradiol	$61.00
174V	Free T3	$16.60
175V	Free T4	$16.60
270V	TSH	$16.60
271V	TSH (Free T4 reflexed)	$22.40
181V	TSH (Free T4 & Free T3 reflexed)	$28.60
182V	Amikacin	$27.80
183V	Cortisol	$27.80
185V	Cyclosporine	$38.80
186V	Methotrexate	$27.80

		Specialist in Pathology
187V	PSA	$22.20
188V	Secobarbital, phenytoin, amobarbital, butalbarbital, pentobarbital, phenobarbital (unine/serum) (when done as a panel of six)	$111.00
189V	Tacrolimus	$44.20
190V	Thiopental	$83.00
203V	Toxicology screen (serum or urine)	$192.00
	Chemistry - Miscellaneous	
204V	B2 microglobulin	$27.80
205V	Bili aminiotic - B12/RBC folate - see hematology section	$76.40
302V	Calculus analysis	$61.00
142V	Carotene	$139.00
206V	Chylomicrons (refridge & visual)	$44.20
207V	Chymex	$83.00
208V	Cryofibrinogen	$83.00
168V	Cryoglobulin	$50.00
209V	Ethanol, isopropanol, methanol (when done as a panel of three)	$88.60
210V	Ethylene glycol	$88.60
211V	Fat globule (prep, stain, interp)	$111.00
412V	Fecal fat assay	$305.00
212V	FEP assay	$105.00
213V	Gastric analysis	$33.00
214V	Glucose by glucose meter	$14.20
215V	Haptoglobin	$33.20
216V	Hemoglobin A1C - iron/iron binding/%saturation - see hematology section	$24.00
249V	Lithium	$22.40
217V	LS/PG on amniotic fluid	$277.00
338V	Melanin	$55.20
202V	Methemalbumin	$116.00
425V	Mucin	$27.80
218V	pH - ph meter (fluid)	$12.00
219V	Phenylalanine	$83.00
221V	Plasma hemoglobin	$83.00
349V	Porphobilinogen scrn	$50.00
222V	Porphyrin screen (feces/urine/serum)	$59.10
224V	Prealbumin	$33.20
225V	Pregnancy test/HCG in serum	$46.80
227V	Sweat chloride analysis (does not include specimen collection	$33.00
418V	Trypsin	$61.00
229V	Xylose	$44.20
	Chemistry - Allergy	
235V	IgE	$139.00
236V	Food mix screen	$139.00
237V	Inhalant screen IgE	$139.00
238V	For each additional specific allergen ordered with total IgE or a screen, add	$19.40
239V	For each allergen, if ordered individually - some common allergens are: dog dander, dust, milk, yellow hornet, honney bee, peanut	$139.00

SECTION V:

LABORATORY MEDICINE

		Specialist in Pathology
	Haematology - Routine	
422V	CBC 8 parameters + histograms, three or five part diff	$25.40
423V	CBC 8 parameters or less (Hb, Hct, RBC, WCB, MCV, MCH, MCHC + platlets)	$15.20
	Miscellaneous	
251V	B12	$22.20
253V	Cell count and diff CSF	$107.00
434V	Erythrocyte sedimentation rate	$20.40
464V	Estimate - platelet/WBC	$15.20
254V	RBC folate	$55.20
180V	Iron, TIBC and % saturation	$25.80
255V	Manual differential	$56.20
257V	Manual hemoglobin	$56.20
476V	Manual WBC	$31.80
259V	Monotest	$31.80
260V	Morphology	$15.20
470V	Reticulocyte count	$46.20
494V	Blood parasites (malarial & others)	$113.00
261V	Bone marrow - assist, stain, differential, iron	$471.00
262V	Bone marrow - for each additional 500 cells counted, add	$102.00
263V	Bone marrow - for each additional slide stained	$102.00
265V	Buffy coat preparation	$81.80
481V	Cell count and diff	$92.20
266V	Cytospin	$35.80
267V	Eosinophil smear (sputum)	$41.00
268V	Eosinophil smear (urines)	$76.60
550V	Esterase, iron, peroxidase, sudan black, TRAP	$103.00
274V	Fluid crystals	$31.80
497V	Heinz bodies (direct)	$76.60
346V	Hemoglobin pigments (qual)	$61.40
275V	Hemolysate preparation	$87.20
276V	Iron stain hematology	$25.40
277V	Luik, Alk phos score	$185.00
278V	Hemosiderin - urine	$31.80
	Haematology - Coagulation	
279V	PT/NR & aPTT	$23.00
280V	Prothrombin time/INR	$20.40
281V	aPTT	$20.40
282V	DDIMER - automated	$188.00
283V	Factor assays (each)	$134.00
506V	Fibrinogen	$20.40
	Haematology - Flow Cytometry	
284V	CD4/CD8	$748.00
285V	CD34-Peripheral bld	$551.00
287V	CD34-apheresis	$734.00
	Transfusion Medicine	
560V	ABO & RH typing (group & type)	$87.40
563V	Antibody screen	$78.80
289V	Antibody panel	$131.00
290V	Each additional panel	$131.00
291V	Antigen typing	$78.80

		Specialist in Pathology
600V	Direct antiglobulin test (coombs & fractionation)	$96.20
559V	Cross match (group & type, antibody screen & 2 units of packed cells)	$192.00
293V	Each additional unit of packed cells	$34.80
295V	HLA typing (ABC/DR typing)	$2,439.00
	Microbiology - Routine	
297V	Blood C & S for bacteria &/or yeast - automated	$89.20
690V	Blood C & S for bacteria &/or yeast - manual	$160.00
299V	Cervix C & S	$88.60
300V	CSF C & S	$136.00
301V	Dermatophyte culture	$312.00
305V	Direct Gram Stain Only	$67.60
306V	Effluent Culture	$120.00
307V	Enviromental Culture	$66.80
309V	Fluids C & S	$173.00
311V	Fungal C & S	$312.00
312V	Lower Respiratory CBS with Gram Stain	$123.00
724V	Microscopic Exam for Fungus	$46.80
313V	Miscellaneous C & S	$188.00
314V	MRSA Culture	$108.00
731V	Parasite examination - pinworm paddle	$46.80
725V	Parasite examination - skin scrapings	$94.00
317V	Parasite examination - stool - full O & P workup	$204.00
318V	Parasite examination - stool - giardia/crytosporidium screen	$46.80
319V	Parasite examination - trichomonas	$46.80
729V	Parasite examination - urine	$99.00
321V	Pneurnocystis examination	$246.00
322V	Stool for C & S	$106.00
323V	Stool for C. difficile toxin	$57.20
324V	Streptozyme screen	$36.20
325V	Throat C & S	$57.20
326V	Ureaplasma urealyticum testing	$65.20
327V	Urethra C & S	$88.60
329V	Urine C & S	$52.20
331V	Vaginal or vaginal/rectal swab for group B strep	$68.40
333V	Vaginal swab for bacterial vaginosis examination	$67.60
334V	VRE screen	$68.80
335V	Wound culture - deep site	$173.00
337V	Wound culture - surface site	$141.00
	Microbiology - TB	
344V	Bronchial washing TB culture	$434.00
345V	CSF TB culture	$413.00
347V	Fluid TB culture	$474.00
351V	Gastric washing TB culture	$333.00
352V	PCR for M. tuberculosis	$483.00
242V	PCR for mycobacteria species	$483.00
722V	Smear only	$192.00
354V	Sputum TB culture	$474.00
355V	Stool TB smear	$192.00
356V	Miscellaneous TB culture	$413.00
357V	Tissue TB culture	$474.00
358V	Urine TB culture	$375.00

LABORATORY MEDICINE

		Specialist in Pathology
	Microbiology - Virology	
359V	CMV antigenemia	$847.00
360V	CMV IgG	$133.00
361V	EBV serology (EBNA, VCA IgM, VCA IgG) - if ordered individually	$119.00
363V	If added to an existing order -- add	$44.60
368V	EBV EA - if ordered individually	$295.00
369V	- if added to an existing order -- add	$223.00
370V	Hepatitis testing - single marker	$148.00
371V	For each additional marker added to order -- add Includes the following list of markers: Hepatitis A Antibody, Hepatitis A IgG, Hepatitis A ImG, Hepatitis B Core Antibody, Hepatitis B Core IgM, Hepatitis B Surface Antibody, Hepatitis B Surface Antigen, Hepatitis C Antibody	$74.00
373V	Herpes antibody	$133.00
374V	Mycoplasma pneum. AB	$133.00
375V	Parvovirus serology (B19 - IgG & IgM)	$326.00
376V	Rubella IgG antibody	$119.00
377V	Rubella IgM	$104.00
379V	Toxoplasma IgG	$104.00
383V	Toxoplasma IgM	$104.00
384V	Varicella IgG antibody	$133.00
385V	Chlamydia culture	$284.00
386V	Respiratory specimen for viruses by direct fluorescent antibody tests	$415.00
387V	Rotavirus antigen test	$119.00
388V	Viral culture - CSF	$431.00
389V	Viral culture - Eye	$448.00
390V	Viral culture - genital	$291.00
391V	Viral culture - miscellaneous	$671.00
392V	Viral culture - respiratory	$490.00
393V	Viral culture - skin	$525.00
394V	Viral culture - stool	$532.00
395V	Viral culture - tissue	$699.00
396V	Viral culture - urine	$413.00
	Microbiology - DMP	
398V	Chlamydia trachomatis PCR	$317.00
399V	Hepatitis C PCR	$697.00
400V	Herpes simplex virus PCR	$392.00
401V	Pertussis PCR	$380.00
402V	Varicella PCR	$249.00
	Cytology	
	Cytology - Gyne	
403V	Cytology - gyne specimen - 1 slide (PAP)	$49.80
405V	Cytology - gyne specimen - each additional slide (PAP)	$16.80
	Cytology - Med	
407V	Fine needle biopsy - (cytospin. Handling. 1 slide)	$579.00
409V	Fluid for cells (1 slide)	$232.00
411V	Sputum for cells (1 slide)	$220.00
413V	Urine for cells (1 slide)	$232.00
415V	Urine for cells -- each additional slide	$52.60

SECTION W:

DIAGNOSTIC ULTRASOUND

Multiple Procedures -- are paid at 100% of the listed units for each procedure.

		Technical Component	Interpretation Component	Technical and Interpretation
	Head and Neck			
11W	Echoencephalography (midline and ventricular size)	$62.10	$46.90	$109.00
12W	Thyroid sonography	$97.40	$53.50	$150.90
13W	With 7.5 or 10 mhz. transducer	$133.50	$53.50	$187.00
16W	Biometry for measuring axial length - unilateral (second eye not billable if done for comparison purposes)	$55.60	$40.80	$96.40
17W	Ophthalmic sonography for diagnostic examination of the posterior segment - unilateral (second eye not billable if done for comparison purposes)	$53.00	$37.80	$90.80
14W	Transfontanel neonatal brain sonography	$107.70	$59.30	$167.00
	Chest			
20W	Echocardiography, M-mode	$124.20	$77.00	$201.20
21W	ultrasonically guided -- pericardiocentesis, or -- thoracocentesis	$94.00	$77.00	$171.00
22W	Sonography for pleural effusion	$79.20	$27.80	$107.00
23W	Sonography for breast mass (per breast)	$95.60	$58.40	$154.00
	Abdomen			
30W	Sonography for kidneys, liver, pancreas, gall bladder, spleen, aorta, and related structures	$187.00	$105.00	$292.00
31W	Renal sonography -- independent study only	$111.60	$77.40	$189.00
32W	Ultrasonically guided biopsy or cyst aspiration	$94.00	$56.90	$150.90

Obstetrics

Documentation: Complete and limited obstetric scans require archived image documentation of all of the included below definition findings to support the diagnostic interpretation.
Only 'dynamic' findings are beyond the scope of such image archiving, and these are usually part of biophysical profiles, though fetal heart M-modes must be archived.

Point-of-Care ultrasounds are not billable as complete or limited ultrasounds. See “Definitions” section.

First Trimester (0 to 13 weeks)

First trimester complete ultrasound must include image documentation of

DIAGNOSTIC ULTRASOUND

		Technical Component	Interpretation Component	Technical and Interpretation
	• Fetal heart rate (m-mode where at all possible); • Biometry with estimated gestational age; • Sagittal and transverse embryo/fetus images (if visible yet); • Yolk sac (if seen); and • Sagittal and transverse gestational sac images plus other planes as required to document the sac fully, especially in regard to peri-gestational collections or other abnormalities (e.g. fibroids), cul-de-sac especially for fluid and maternal ovaries/adnexal areas. • Including an interpretation and comprehensive report. **NOTES:** The following services are not payable in the first trimester of pregnancy: • 50W (Doppler flow study) • 20W (echocardiography M-mode) • Limited obstetrical ultrasounds			
401W	Complete	$174.30	$102.50	$276.80
	Second Trimester (14 to 26 weeks) Second trimester complete ultrasound must include image documentation of: • Presentation, lie, placentation, fluid, fetal heart rate, cervix, fetal anatomy (see SOGC/CAr standards for specifics), biometry, EFW, +/- maternal findings. • Including an interpretation and comprehensive report.			
402W	Complete – singleton	$174.30	$102.50	$276.80
412W	Complete – twins – not to be billed before 16 weeks	$214.50	$129.50	$344.00
422W	Complete – triplets or greater - not to be billed before 16 weeks	$253.10	$168.90	$422.00
	Second Trimester (14 to 26 weeks) Second and third trimester limited ultrasounds are: • For problem solving, such as rechecking a low placenta, high/low AFV, LGA/SGA, rechecking anatomy previously obscured or questionably abnormal. • To answer a specific question such as in the following situations: to assess fetal life, assess fetal well-being, fetal presentation, estimate amniotic fluid, follow up fetal growth, evaluate the cervix or to assess a specific area or areas that could not be adequately imaged on prior examination due to fetal or maternal causes. In most cases, a limited examination is appropriate only when a prior complete examination has been done. • Typically, such scans should include all 'full' 2nd trimester scan findings except not repeating a full anatomy scan. • Including an interpretation and comprehensive report			
432W	Limited – singleton, twins or triplets or greater	$89.20	$52.20	$141.40

DIAGNOSTIC ULTRASOUND

		Technical Component	Interpretation Component	Technical and Interpretation
	Third trimester (27 to 40 weeks)			
	Third trimester complete ultrasounds are performed when medically required, as per the second trimester criteria; otherwise see “Limited”.			
403W	Complete – singleton	$174.30	$102.50	$276.80
413W	Complete – twins	$214.50	$129.50	$344.00
423W	Complete – triplets or greater	$253.10	$168.90	$422.00
433W	Limited – singleton, twins or triplets or greater	$89.20	$52.20	$141.40
42W	Sonography for I.U.C.D. localization	$97.40	$59.90	$157.30
43W	Pelvic Sonography	$152.00	$82.00	$234.00
45W	Transvaginal ultrasound study add to 40W or 43W	$71.50	$38.50	$110.00
149W	Nuchal translucency screening -- first trimester (in an approved facility, only physicians designated by the SMA Tariff Committee as eligible) -- one per pregnancy	$83.80	$52.20	$136.00
150W	- each additional foetus	$61.20	$38.20	$99.40
49W	Transvaginal ultrasound study as an independent procedure -- initial (Serial studies for infertility are uninsured and not billable. Follicle tracking for insured services is payable as 49W for the first exam and 449W for subsequent exams within 22 days).	$141.70	$76.30	$218.00
449W	Transvaginal ultrasound follicle tracking follow-up study -- subsequent exam within 22 days	$81.00	$48.00	$129.00
44W	Ultrasonically guided amniocentesis	$96.40	$60.90	$157.30
46W	Biophysical profile of fetus (not to be billed before 28 weeks) max of 1 per day	$147.70	$103.80	$251.50
446W	Biophysical profile per additional multiple fetus (not to be billed before 28 weeks)	$95.60	$61.40	$157.00
	Doppler Studies			
50W	Flow studies including arterial or venous or foetal monitoring or shunt assessment, etc. max of 1 per day	$128.40	$57.60	$186.00
54W	peripheral venous (per limb)	$224.00	$85.00	$309.00
51W	- each additional foetus	$92.60	$42.40	$135.00
	Miscellaneous			
60W	Transrectal ultrasonography of prostate	$122.00	$77.00	$199.00
62W	Ultrasonography of testicles	$103.30	$56.70	$160.00
72W	Ultrasonography of parotid glands or similar	$86.00	$58.00	$144.00

Miscellaneous continued….

SECTION W:

DIAGNOSTIC ULTRASOUND

		Technical Component	Interpretation Component	Technical and Interpretation
73W	Hypertrophic pyloric stenosis	$114.70	$64.30	$179.00
	Soft Tissue Ultrasounds 1. Soft tissue ultrasounds are not billable in conjunction with any other ultrasound (joint, testicles, thyroid, etc) when done as routine practice for a brief cursory scan of the surrounding soft tissues as part of the primary procedure requested by the referring physician. 2. There may be instances where a brief scan of the surrounding tissues may reveal an abnormality that should be characterized, if so, the findings and medical necessity of the additional ultrasound must be documented.			
120W	Head and Neck - excluding thryroid or partoid glands	$114.70	$64.30	$179.00
122W	Torso - excluding axilla or groin	$114.70	$64.30	$179.00
124W	Back	$114.70	$64.30	$179.00
126W	Shoulder to Elbow *	$114.70	$64.30	$179.00
128W	Elbow to fingers *	$114.70	$64.30	$179.00
130W	Axilla *	$114.70	$64.30	$179.00
132W	Hip to Knee *	$114.70	$64.30	$179.00
134W	Knee to Toes *	$114.70	$64.30	$179.00
136W	Groin *	$114.70	$64.30	$179.00
	*two units may be billed for bilateral			
	Joint Ultrasound Additional units done for comparison purposes are not billable.			
200W	Spine	$155.60	$76.40	$232.00
202W	Neck	$155.60	$76.40	$232.00
204W	Complete Shoulder or Acromio-Clavicular Joint *	$155.60	$76.40	$232.00
206W	Elbow *	$155.60	$76.40	$232.00
208W	Wrist *	$155.60	$76.40	$232.00
210W	Hand--Fingers--Thumb *	$155.60	$76.40	$232.00
212W	Hip *	$155.60	$76.40	$232.00
214W	Knee *	$155.60	$76.40	$232.00
216W	Ankle *	$155.60	$76.40	$232.00
218W	Foot-Toes *	$155.60	$76.40	$232.00
	*two units may be billed for bilateral			

SECTION X:

DIAGNOSTIC RADIOLOGY

		Fee
9X	Special review of x-rays by Radiologist with written report to referring physician(s) by report	$146.00

Classification: Diagnostic

1. A radiologist should only bill for a service where he/she has performed the procedure personally or the technical component was performed by qualified staff for whom he/she assumes responsibility and provides daily supervision.
2. The billing for diagnostic x-rays of any one region includes payment for a sufficient number of films to establish a diagnosis in the average case. Payment includes the customary media and its administration, but not the specialist clinic procedures listed in Section A of the Payment Schedule for which an additional payment may be made.
3. Multiple Diagnostic Procedures -- may be billed at 100 percent of the listed payment for each procedure both from Section X and Section A.

		Technical Component	Interpretation Component	Technical and Interpretation
	Head			
100X	Skull	$61.60	$26.00	$87.60
101X	Nasal sinuses	$60.00	$28.20	$88.20
102X	Mastoids	$66.60	$33.40	$100.00
103X	Facial bones and/or zygoma	$60.10	$29.70	$89.80
104X	Nasal bones	$44.40	$15.20	$59.60
105X	Salivary duct	$45.90	$27.30	$73.20
106X	Internal auditory meati	$60.50	$22.50	$83.00
107X	Mandible	$54.30	$20.90	$75.20
108X	Temporomandibular joints	$60.00	$25.00	$85.00
109X	Eye (without localization)	$51.20	$24.00	$75.20
110X	Sella turcica	$44.20	$22.00	$66.20
120X	Pantomography - not insured for routine dental care	$38.80	$26.00	$64.80
	Teeth			
121X	-- isolated area	$12.00	$9.60	$21.60
122X	-- quarter set	$20.40	$11.60	$32.00
123X	-- half set	$26.30	$13.90	$40.20
124X	-- full set	$38.40	$21.20	$59.60
125X	Eye -- Sweet (or equivalent) localization for foreign body in eye or orbit	$71.50	$44.50	$116.00

SECTION X:

DIAGNOSTIC RADIOLOGY

		Technical Component	Interpretation Component	Technical and Interpretation
	Spine and Pelvis			
130X	Cervical	$87.60	$32.40	$120.00
131X	Thoracic	$70.00	$26.00	$96.00
132X	Lumbar	$87.60	$32.40	$120.00
133X	Sacro-iliac joints	$43.80	$25.60	$69.40
134X	Sacrum and coccyx	$43.80	$25.60	$69.40
135X	Scoliosis survey (limited)	$40.10	$19.90	$60.00
136X	Oblique views of spine, add	$33.40	$16.20	$49.60
137X	Lumbar spine with flexion and extension	$81.30	$37.70	$119.00
138X	Cervical spine with flexion and extension	$81.30	$37.70	$119.00
140X	Scoliosis survey -- full	$69.30	$37.70	$107.00
141X	Myelogram	$180.00	$102.00	$282.00
142X	Discogram	$179.40	$93.60	$273.00
143X	Pelvis	$46.50	$20.90	$67.40
144X	Pelvis and one or both hips	$80.90	$30.10	$111.00
145X	Smith-Peterson pinning	$141.00	$81.00	$222.00
	Thorax			
150X	Chest	$67.70	$29.30	$97.00
151X	Thoracic inlet	$38.80	$18.20	$57.00
152X	Ribs	$50.50	$19.90	$70.40
153X	Clavicle	$44.40	$17.20	$61.60
154X	Sternum or sterno-clavicular joints	$44.40	$18.20	$62.60
157X	Bronchogram (unilateral)	$88.20	$40.80	$129.00
158X	Chest films with fluoroscopy	$53.60	$34.60	$88.20
159X	Heart survey and/or cardiac pacemaker evaluation	$55.00	$21.40	$76.40
	Extremities			
160X	Acromio-clavicular joint	$44.40	$18.20	$62.60
161X	Shoulder	$47.90	$20.50	$68.40
361X	Shoulder -- specialty view -- 4 (views) unilateral	$62.10	$21.90	$84.00
162X	Humerus	$44.40	$17.20	$61.60
163X	Elbow	$44.40	$17.20	$61.60
164X	Forearm -- radius and ulna	$44.40	$17.20	$61.60
165X	Wrist	$44.40	$17.20	$61.60
166X	Carpals	$44.40	$17.20	$61.60
167X	Hand	$55.10	$23.50	$78.60
168X	Scapula	$44.20	$18.80	$63.00
170X	Femur	$44.20	$18.80	$63.00
171X	Knee	$55.10	$23.50	$78.60
172X	Tibia and fibula	$44.20	$18.80	$63.00
173X	Ankle	$52.90	$22.70	$75.60

DIAGNOSTIC RADIOLOGY

		Technical Component	Interpretation Component	Technical and Interpretation
373X	Ankle -- special view -- (4 views) unilateral -- bill units	$73.20	$24.60	$97.80
174X	Tarsus	$52.90	$22.70	$75.60
175X	Forefoot	$44.20	$18.80	$63.00
176X	Os calcis	$44.20	$18.80	$63.00
190X	Single digit, same hand or foot	$41.80	$18.20	$60.00
191X	Digits, same hand or foot	$44.40	$18.20	$62.60
192X	Orthoroentgenograms	$42.80	$22.40	$65.20
	Bone Survey			
193X	Bone survey	$120.80	$50.20	$171.00
194X	Joint survey	$118.00	$49.00	$167.00
195X	Wrist -- four views	$46.40	$24.60	$71.00
196X	Knee -- four views	$62.10	$27.70	$89.80
197X	Skeletal survey -- infant	$81.50	$36.50	$118.00
	Abdomen			
200X	Single film of abdomen (K.U.B.)	$37.70	$18.30	$56.00
201X	Acute abdomen survey with erect and/or lateral views	$54.50	$31.70	$86.20
	Gastro-Intestinal Tract			
210X	Oesophagus	$73.80	$32.20	$106.00
211X	G.I. Series	$135.80	$66.20	$202.00
212X	Small bowel study	$106.20	$40.80	$147.00
213X	Colon -- enema	$166.20	$72.80	$239.00
214X	Colon -- double contrast enema	$236.60	$92.40	$329.00
215X	Fluoroscopy for position of tube in abdomen	$29.40	$27.00	$56.40
216X	Hypotonic duodenography	$74.40	$43.60	$118.00
217X	Double contrast G.I. with glucagon	$135.70	$40.80	$176.50
	Biliary System			
220X	Cholecystogram	$64.70	$29.30	$94.00
	Cholangiogram			
221X	-- intravenous	$164.60	$62.40	$227.00
222X	-- operative	$114.40	$50.60	$165.00
223X	-- post-operative (T-tube)	$102.00	$48.00	$150.00
224X	-- transhepatic, percutaneous	$172.60	$72.40	$245.00
	Urinary System			
228X	Percutaneous renal cystography	$47.40	$16.80	$64.20
229X	Intravenous pyelogram (hypertensive survey)	$144.80	$39.20	$184.00
230X	Cystogram	$74.60	$27.40	$102.00
	Pyelogram			
231X	-- intravenous	$187.80	$48.20	$236.00

DIAGNOSTIC RADIOLOGY

		Technical Component	Interpretation Component	Technical and Interpretation
232X	-- retrograde	$57.80	$16.10	$73.90
233X	I.V.P. -- with voiding cystourethrogram	$157.40	$50.60	$208.00
234X	Voiding cystourethrogram	$145.60	$66.40	$212.00
235X	Drip infusion pyelogram	$172.60	$70.40	$243.00
239X	Urethrogram (retrograde)	$59.40	$24.60	$84.00
	Obstetrics and Gynaecology			
	Foetus			
240X	-- scout film	$31.20	$19.00	$50.20
241X	-- maturity and/or position	$31.20	$19.00	$50.20
243X	Pelvimetry	$54.60	$28.40	$83.00
244X	Utero-salpingogram	$58.60	$31.40	$90.00
245X	Intrauterine blood transfusion	$52.60	$28.40	$81.00
	Miscellaneous -- without contrast media			
300X	Diagnostic Mammography (unilateral) (repeats within 42 days by report)	$125.50	$80.50	$206.00
312X	Repeat mammography for radiological localization of non-palpable breast lesion	$195.00	$51.00	$246.00
301X	Soft tissues of the neck	$42.40	$15.60	$58.00
302X	-- Laryngogram	$74.80	$40.20	$115.00
	Planigraphy			
303X	-- first cut	$48.40	$19.40	$67.80
304X	-- each additional cut	$17.60	$10.20	$27.80
306X	Cinefluorograph or videotape		$25.70	$31.60
307X	Cardiac catheterization	$66.00	$40.00	$106.00
	Miscellaneous -- with contrast media			
320X	Fistula or sinus tract	$50.00	$17.80	$67.80
321X	Sialogram	$108.20	$59.80	$168.00
322X	Arthrogram	$130.00	$57.00	$187.00
323X	Lymphangiography -- upper and lower extremities, including pelvis, chest and abdomen	$270.60	$46.20	$316.80
324X	Dacryocystography	$52.60	$27.40	$80.00
325X	Venogram	$100.20	$44.80	$145.00
327X	Selective cavogram	$105.80	$44.20	$150.00
328X	Azygography	$105.80	$44.20	$150.00
329X	Ventriculogram or encephalogram	$105.80	$44.20	$150.00
	Arteriography			
330X	-- peripheral	$105.80	$44.20	$150.00
331X	-- cerebral	$125.80	$58.20	$184.00
	Aortography			
332X	-- aortic	$105.80	$44.20	$150.00

DIAGNOSTIC RADIOLOGY

		Technical Component	Interpretation Component	Technical and Interpretation
333X	-- selective -- coronary, renal, mesenteric, bronchial, etc.	$105.80	$44.20	$150.00
334X	Cardiac angiography	$125.80	$58.20	$184.00
335X	Portogram through umbilical vein	$125.80	$58.20	$184.00
336X	Posterior fossa myelogram	$141.00	$55.00	$196.00

		Specialist in Radiology
10X	Consultation -- requires formal referral -- includes all visits necessary, history and examination, review of radiology and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor. This code does not apply when the radiologist is only providing information to the patient and/or getting consent for a procedure.	$125.00

Classification: Radiologist Clinical Procedures
1. The following procedures are insured services where provided by a radiologist.
2. Payment to a radiologist will be made only where the radiologist has performed the procedure personally.
3. Multiple Diagnostic Procedures are paid at 100 percent of the listed payment.
4. Other Multiple Procedures (Codes 600X and greater) -- are paid using the procedural rules for 0 and 10 day procedures, i.e. could be paid at 75 percent.

Angiography
These codes are for use by Radiologists Only. (Cardiologists will find applicable Angiography in the "A" SECTION).

501X	Vascular access - for angiography purposes only -- maximum of 2 per case	$125.00
502X	Aortography - for a dedicated Aortogram(s) only-- maximum of once per case	$128.00
503X	Large vessel angiography - for angiograms of the main cerebral and visceral trunks of the aorta to a maximum of 3 per case	$146.00
504X	Extremity angiogram - for visualization of vascular structures in either arm or leg -- maximum of two per case - one per extremity	$138.00

DIAGNOSTIC RADIOLOGY

		Specialist in Radiology	Class
	Transluminal angioplasty		
600X	--peripheral	$480.00	0
601X	-- renal	$564.00	0
602X	--subclavian artery	$491.00	0
603X	-- Aorta or aortic valve	$877.00	0
604X	Stent placement following angioplasty of peripheral, renal or subclavian vessels --add to appropriate angioplasty code --each vessel	$153.00	0

Note: Post-angioplasty care for elective procedures is included in the payment for 603X.

Radiology Clinical Procedures

Clinical procedures associated with diagnostic radiology may be charged in addition to the payments listed in Section X as codes 100X to 336X.

Procedures 600X to 663X may be charged by other physicians recognized by the College of Physicians and Surgeons as having adequate training in radiology and confining their practice to radiology.

	Selective catheterization of renal vein By Seldinger technique or cut down.		
606X	--unilateral	$150.00	D
607X	--bilateral	$217.00	D
608X	Selective catheter embolization	$491.00	0
609X	Intravascular thrombolysis --composite professional fee	$982.00	0
610X	--repeats within 48 hours (composite professional fee)	$491.00	0
612X	Selective transarterial catherization with infusion	$445.00	0
613X	Azygography	$83.80	D
614X	Peripheral venography --unilateral	$139.00	D
615X	Cavography (percutaneous or catheter)	$179.00	D
616X	Lymphangiography --unilateral including pelvis abdomin and chest	$165.00	D
617X	Arthrography each	$127.00	D
618X	Bronchogram --unilateral	$105.00	D
619X	Laryngogram	$68.60	D
620X	Myelography	$199.00	D
621X	Discography --one or more discs	$109.00	D
622X	Sialography each	$136.00	D
623X	Injection of a sinus tract	$110.00	D
624X	Reduction or attempted reduction of intussusception by barium enema	$136.00	0

DIAGNOSTIC RADIOLOGY

		Specialist in Radiology	Class
625X	Percutaneous cholangiography	$271.00	D
626X	Percutaneous renal cystography .	$101.00	D
627X	--with alcohol obliteration of renal cyst	$163.00	0
628X	Dacryocystography each	$109.00	D
629X	Portogram through umbilical vein	$83.80	D
630X	Bronchial Brushing	$130.00	D
631X	Pelvic Venography	$68.60	D
632X	Tube positioning for small bowel study	$59.00	D
639X	Epidurography	$121.00	D
640X	Lumbar Epidural Venography	$165.00	D
641X	Utereal stent placement via nephrostomy tract	$277.00	0
	Procedures under fluoroscopic, C.T. or Ultrasonic Guidance		
642X	Percutaneous intrathoracic biopsy	$245.00	D
643X	Percutaneous intra-abdominal biopsy	$245.00	D
644X	Percutaneous intra-abdominal drainage	$368.00	0
645X	Percutaneous biliary drainage	$574.00	0
646X	Change of drainage tube in relation to procedures 644X, 645X, 647X, 650X, and 651X	$126.00	0
647X	Percutaneous nephrostomy with nephrogram	$627.00	0
648X	Manipulation of peritoneal dialysis catheter	$117.00	0
649X	Transjugular liver biopsy	$480.00	0
650X	Percutaneous gastrotomy	$350.00	0
651X	Percutaneous jejunostomy	$392.00	0
652X	Percutaneous insertion of Vena Cava filter	$324.00	0
653X	Fallopian tube cannulation and dilatation --with selective salpingography, unilateral or bilateral….	$263.00	10
654X	Removal of intravascular foreign body --composite fee	$470.00	0
655X	Transjugular portosystemic shunts (TIPS) --composite fee	$1,128.00	0
656X	Non-palpable breast lesion --needle localization each	$136.00	D
657X	Stereotactic mammographic guided breast biopsy each	$61.20	D
658X	Mammographic or ultrasound guided breast biopsy	$303.00	D
659X	Fluoroscopic control of clinical procedures done by another physician per 1/4 hour or major part thereof --technical component	$18.80	0
660X	--professional component	$43.80	0
661X	Percutaneous insertion of Pleural catheter for closed chest drainage (includes 659X and 660X) each	$183.00	0
662X	Percutaneous intravenous central catheter (PICC) includes placement, removal, venography and ultrasound - composite fee	$441.00	0

DIAGNOSTIC RADIOLOGY

		Fee	Class
663X	Portacath, infusaport, hemocath, Hick-Broviac for chemotherapy or long-term T.P.N. (PORT) - insertion (composite fee)	$482.00	10
664X	Portacath, Infusaport, Hemocath, Hickman-Broviac for chemotherapy or long-term TPN - remove and replace	$695.00	10
665X	Portacath, Infusaport, Hemocath, Hickman-Broviac for chemotherapy or long-term TPN - remove or revise, same site	$288.00	0
670X	Tunnelled paracentesis drainage catheter - insertion	$464.00	0
671X	Tunnelled paracentesis drainage catheter - removal	$305.00	0
672X	Tunneled Pleural Catheter Drainage - Insertion	$380.00	
673X	Tunneled Pleural Catheter Drainage - Removal	$141.00	
680X	Rhizotomy - sacroiliac (SI) joint - medial branch nerves of multiple facets and SI joints - includes all ablations of multiple target zones	$1,034.00	0
681X	Radiofrequency Spinal Rhizotomy	$368.00	0
	Percutaneous radiofrequency ablation of solid tumors using CT/ultrasound guidance • Payable for solid tumors/cancer of lung, liver and kidney. • CT/MRI or ultrasound guidance is included in the fee and cannot be billed in addition.		
682X	-- First lesion	$1,089.00	0
683X	-- Each additional lesion at the same patient contact (max of 3), bill units	$592.00	
	COMPUTED TOMOGRAPHY		
	Head		
700X	no contrast	$82.00	
701X	with contrast	$109.00	
702X	with and without contrast	$138.00	
	Neck - skull base to thoracic inlet		
703X	no contrast	$109.00	
704X	with contrast	$123.00	
705X	with and without contrast	$138.00	
	Thorax		
706X	no contrast	$123.00	
707X	with contrast	$138.00	
708X	with and without contrast	$164.00	
	Abdomen		
709X	no contrast	$123.00	
710X	with contrast	$139.00	
711X	with and without contrast	$164.00	
	Pelvis		
712X	no contrast	$123.00	
713X	with contrast	$139.00	
714X	with and without contrast	$164.00	

	Spine - cervical, thoracic, or lumbar	
715X	no contrast	$116.00
716X	with contrast	$130.00
717X	with and without contrast	$144.00
	Extremity - arm or leg	
718X	no contrast	$109.00
719X	with contrast	$123.00
720X	with and without contrast	$139.00
	MAGNETIC RESONANCE IMAGING	
800X	Head - Multislice SE	$123.00
801X	Repeat another **plane** or sequence to max to 3	$54.60
	Neck (area below the brain and above the chest)	
802X	Multislice SE	$123.00
803X	Repeat another **plane** or sequence to max to 3	$54.60
		Fee
	Thorax or Abdomen or Pelvis	
804X	Multislice SE	$139.00
805X	Repeat another plane or sequence to max to 3	$68.90
	Extremities	
807X	Multislice SE	$109.00
808X	Repeat another plane or sequence to max to 3	$54.60
	One Spine Zone	
809X	Multislice SE	$109.00
810X	Repeat another plane or sequence to max to 3	$54.60
	Two adjoining spine zones	
811X	Multislice SE	$109.00
812X	Repeat another plane or sequence to max to 3	$54.60
	Three adjoining spine zones	
813X	Multislice SE	$178.00
814X	Repeat another **plane** or sequence to max to 3	$82.00

Note:

1. Multislice SE refers to a multislice spin echo sequence whether it is one or two echoes. This applies to a combination of a T1W1 and T2W1. Only one such sequence can be billed per patient at one sitting.

2. Repeat refers to another plane or different pulse sequence, but may not exceed three of these.

3. Maximum billing will be for four sequences no matter how many are done.

SECTION Y:

THERAPEUTIC RADIOLOGY

This Section refers to therapeutic radiology procedures when performed by physicians considered by the Council of the College of Physicians and Surgeons to be qualified to perform the procedures.

	Visits	Technical Component	Interpretation Component	Technical and Interpretation
7Y	Subsequent or follow-up examination after completion of treatment		$34.40	
9Y	Consultation - major - with written report - superficial radiation therapy		$87.90	
19Y	- deep or supervoltage therapy		$95.00	$95.00
29Y	- radioisotope therapy		$95.00	$95.00
10Y	Consultation - minor - without written report - superficial radiation therapy		$17.80	
11Y	- deep or supervoltage radiation therapy		$55.80	$55.80
12Y	- radioisotope therapy		$55.80	$55.80
13Y	- treatment planning, dosage schedule and preparation of any special treatment device for radiation therapy	$184.20	$93.80	$278.00

Procedures

1. Those units under Technical Component are to cover the technical costs of administration and measurements. Those units listed under Interpretation Component represent the professional component of the physicians, i.e. the interpretation and report. The costs of the isotopes or other medications are extra charges.
2. Multiple examinations done at the same sitting may be billed at the sum total of the individual items unless otherwise stated.

	Radiation Therapy			
100Y	Superficial radiotherapy - per treatment	$11.90	$11.80	$23.70
101Y	Hemangioma - complete treatment	$23.70	$23.80	$47.50
103Y	Keloid - complete treatment	$23.70	$23.80	$47.50
104Y	Plantar wart - complete treatment	$23.70	$23.80	$47.50
105Y	Kidney transplant - per course	$23.70	$23.80	$47.50
120Y	Deep radiotherapy (up to 1 Mev energy) per treatment	$26.10	$26.00	$52.10
122Y	Supervoltage radiotherapy (above 1 Mev energy) - per treatment	$55.90	$17.80	$73.70
	Radioisotope Therapy			
201Y	p32 for polycythemia - per course	$112.20	$74.80	$187.00
202Y	p32 for metastatic bone disease - complete treatment	$185.00	$149.00	$334.00
203Y	For ascites or pleural effusion due to malignancy - per course - one side	$184.00	$133.00	$317.00

This section refers to diagnostic and therapeutic radio-isotope procedures when performed by physicians certified in Nuclear Medicine by the Royal College of Physicians and Surgeons of Canada.

		Technical Component	Professional Component	Technical and Professional
	VISITS			
7Z	Consultation - major - with written report - Re: radionuclide therapy		$130.00	
9Z	Subsequent or follow-up examinations after treatment		$54.60	
11Z	Consultation - minor - when a Nuclear Medicine procedure is not performed			
	PROCEDURES			
	1. Those fees under Technical Component are to cover the cost of preparation and administration of the radio-pharmaceutical, technical components of the procedure and the associated quality control procedures. Those fees under **Professional** Component represent the **clinical** component of the **nuclear medicine** physician providing the service, including patient supervision, computer manipulation of data, interpretation and consultation report.			
	2. Multiple examinations done at the same sitting may be billed at the sum total of the individual items unless otherwise stated.			
	3. The specialist clinical procedures listed in Section A constitute an additional charge.			
	4. The professional component of the fee for computer based studies requires that the Nuclear Medicine **physician** performs that portion of the data processing which requires clinical knowledge and judgement.			
	5. For single photon emission tomography add 30 percent to the Technical Component and 100 percent to the Professional Components of the appropriate procedure.			
	6. For additional computer analysis for any procedure add 30 percent (per unique analysis) to the corresponding professional fee.			
	Endocrine System			
100Z	Thyroid uptake - single	$776.50	$27.50	$804.00
101Z	Thyroid uptake - multiple	$88.20	$41.20	$129.40
102Z	Thyroid uptake - stimulation or suppression	$91.30	$42.70	$134.00
105Z	Thyroid imaging with uptake	$246.00	$95.00	$341.00
107Z	Thyroid imaging without uptake	$150.50	$72.50	$223.00
110Z	Thyroid carcinoma - metastatic survey	$355.00	$145.00	$500.00
120Z	Parathyroid imaging	$383.00	$150.00	$533.00
130Z	Adrenal imaging - cortex	$441.00	$145.00	$586.00
131Z	medulla	$497.00	$145.00	$642.00
140Z	Therapy for hyperthyroidism, per course excluding uptake and scan	$245.40	$54.60	$300.00
	Haematopoietic, R.E. and Lymphatic Systems			
150Z	Bone marrow imaging - limited study	$237.00	$82.40	$319.40
151Z	Bone marrow imaging - multiple areas or whole body	$423.00	$151.00	$574.00
160Z	Blood or plasma volume - labelled HSA	$106.70	$33.30	$140.00
161Z	Red cell mass - labelled RBC	$143.70	$33.30	$177.00
162Z	Combined plasma volume and red cell mass - dual label	$190.60	$95.60	$286.20
170Z	Red cell survival	$146.40	$140.00	$286.40
171Z	Red cell sequestration	$48.40	$238.00	$286.40
172Z	Red cell survival and sequestration	$273.00	$144.00	$417.00
175Z	Plasma iron clearance rate	$882.00	$28.70	$910.70
176Z	Red cell utilization of iron	$253.40	$52.60	$306.00
178Z	Iron metabolism (clearance, utilization and distribution	$323.00	$133.00	$456.00
179Z	Combined iron metabolism and red cell survival	$564.00	$218.00	$782.00
180Z	Spleen imaging	$246.00	$113.00	$359.00
181Z	Spleen imaging with vascular flow	$301.00	$138.00	$439.00
182Z	Lymphoscintigraphy	$437.00	$185.00	$622.00
183Z	Sentinel Node Lymphoscintigraphy	$531.00	$266.00	$797.00
	Gastrointestinal System			

		Technical Component	Professional Component	Technical and Professional
200Z	Liver and spleen imaging	$342.00	$151.00	$493.00
201Z	Liver and spleen imaging with vascular flow	$362.00	$164.00	$526.00
205Z	Hepatobiliary study	$437.00	$185.00	$622.00
206Z	CCK stim/GBEF	$272.40	$92.60	$365.00
212Z	Salivary gland imaging	$178.50	$85.50	$264.00
213Z	repeat with stimulation	$91.70	$46.30	$138.00
220Z	Gastric mucosa imaging	$335.00	$157.00	$492.00
221Z	Gastric emptying time - solid meal	$390.00	$226.00	$616.00
222Z	Gastric emptying time - liquid meal	$390.00	$226.00	$616.00
225Z	Schilling test	$150.30	$42.70	$193.00
226Z	Schilling test with intrinsic factor or pancreatic enzymes	$150.30	$42.70	$193.00
227Z	Schilling test - combined stage I and stage II	$184.50	$72.50	$257.00
229Z	Gastrointestinal blood loss - in vivo imaging	$2,432.00	$178.00	$2,610.00
230Z	Gastrointestinal blood loss - fecal measurement	$2,518.40	$91.60	$2,610.00
231Z	Gastrointestinal protein loss	$2,808.40	$91.60	$2,900.00
232Z	Gastrointestinal absorption - in vitro measurement	$3,196.40	$91.60	$3,288.00
233Z	Gastroesophageal reflux/aspiration	$390.00	$226.00	$616.00
234Z	LaVeen shunt patency	$307.00	$107.00	$414.00
235Z	Bile acid study	$2,720.00	$158.00	$2,878.00
236Z	Oesophageal motility - single	$3,067.80	$88.20	$3,156.00
237Z	- repeat (at same time)	$3,503.60	$50.40	$3,554.00
238Z	Carbon breath test	$3,300.40	$91.60	$3,392.00
	Musculo-Skeletal System			
250Z	Bone imaging - limited area	$491.60	$82.40	$574.00
251Z	Bone imaging - multiple areas or whole body	$369.00	$151.00	$520.00
252Z	SI joint analysis		$25.10	$25.10
255Z	Joint imaging - limited area	$178.50	$85.50	$264.00
256Z	Joint imaging - multiple areas or whole body	$382.00	$157.00	$539.00
260Z	Bone densitometry - single photon energy	$178.40	$54.60	$233.00
261Z	Bone densitometry - dual photon energy, per site	$253.00	$76.00	$329.00
262Z	Body Composition - dual photon energy	$253.00	$76.00	$329.00
270Z	Radionuclide synovectomy	$273.00	$136.00	$409.00
	Cardio-Vascular System			
300Z	Determination of ventricular function - gated cardiac blood pool (computer based wall motion and ejection fraction) rest	$441.00	$263.00	$704.00
301Z	repeat (up to three) per rest	$86.00	$190.00	$276.00
302Z	exercise - per level	$145.00	$131.00	$276.00
303Z	Cardiac Phase Analysis		$85.50	$85.50
304Z	Determination of ventricular function, first pass (computer based)	$402.00	$185.00	$587.00
305Z	Myocardial imaging - regional myocardial perfusion rest	$382.00	$157.00	$539.00
306Z	stress	$457.00	$157.00	$614.00
307Z	Myocardial imaging - infarct avid	$313.00	$157.00	$470.00
308Z	Myocardial imaging - viability	$457.00	$157.00	$614.00
309Z	Cardiac neuroimaging	$457.00	$157.00	$614.00
310Z	Cardiac shunt evaluation (computer based)	$307.00	$138.00	$445.00
315Z	Vascular flow imaging (arterial or venous)	$307.00	$138.00	$445.00
316Z	Venography (labelled RBC)	$273.00	$138.00	$411.00
320Z	Intravascular thrombosis study	$245.50	$85.50	$331.00
325Z	Cardiac output	$124.50	$72.50	$197.00
330Z	Supervision - stress for myocardial perfusion exercise		$226.00	$226.00
331Z	pharmacologic		$226.00	$226.00
	Respiratory System			
350Z	Pulmonary perfusion study	$362.00	$157.00	$519.00
352Z	Pulmonary ventilation-multiple projections-aerosol	$362.00	$157.00	$519.00
353Z	Pulmonary ventilation - all phases - gas	$390.00	$164.00	$554.00
354Z	Pulmonary ventilation - technegas	$362.00	$157.00	$519.00

		Technical Component	Professional Component	Technical and Professional
355Z	Combined pulmonary ventilation and perfusion study	$477.00	$253.00	$730.00
356Z	Pulmonary clearance	$362.00	$157.00	$519.00
357Z	Quantitiative analysis - pulmonary function		$46.30	$46.30
	Central Nervous System			
400Z	Brain imaging	$354.00	$157.00	$511.00
401Z	Brain imaging with vascular flow	$472.00	$185.00	$657.00
402Z	Regional cerebral blood flow	$477.00	$185.00	$662.00
403Z	Regional cerebral metabolism	$477.00	$185.00	$662.00
404Z	Cerebral receptor-site imaging	$477.00	$185.00	$662.00
405Z	Cisternography	$457.00	$164.00	$621.00
408Z	Shunt patency study	$198.50	$85.50	$284.00
409Z	CSF leakage (imaging and sample counting)	$347.00	$164.00	$511.00
420Z	Dacrocystography	$301.00	$138.00	$439.00
	Genitourinary			
450Z	Renal imaging single image	$150.50	$85.50	$236.00
451Z	serial images	$362.00	$157.00	$519.00
452Z	Renal imaging with vascular flow single static image	$212.00	$113.00	$325.00
453Z	serial static images	$362.00	$185.00	$547.00
455Z	Renal function study (computer based) single radionuclide	$403.00	$226.00	$629.00
456Z	dual radionuclide	$477.00	$253.00	$730.00
457Z	Renal clearance (computer based)	$347.00	$164.00	$511.00
458Z	Renal - Captopril challenge	$403.00	$226.00	$629.00
459Z	Renal - diuretic	$403.00	$226.00	$629.00
460Z	Residual urine study .	$150.50	$85.50	$236.00
462Z	Ureteral reflux study	$211.50	$85.50	$297.00
464Z	Testricular imaging	$246.00	$113.00	$359.00
470Z	GFR	$150.50	$85.50	$236.00
471Z	ERPF	$136.00	$76.00	$212.00
480Z	Hysterosalpingography	$362.00	$164.00	$526.00
	Miscellaneous			
500Z	Tumor localization (67Ga etc.) limited area	$246.00	$113.00	$359.00
501Z	multiple areas or whole body	$390.00	$157.00	$547.00
502Z	Tumor localization (Immunoscintigraphy) multiple areas or whole body	$477.00	$185.00	$662.00
503Z	Tumor localization (other receptors) multiple areas or whole body	$477.00	$185.00	$662.00
505Z	Inflammation localization (67Ga/Ig etc) limited area	$246.00	$113.00	$359.00
506Z	multiple areas or whole body	$390.00	$157.00	$547.00
507Z	Inflammation localization (WBC) limited area	$246.00	$113.00	$359.00
508Z	multiple areas or whole body	$390.00	$157.00	$547.00
509Z	Inflammation imaging (labelled antibodies, etc.) multiple areas or whole body	$477.00	$185.00	$662.00
510Z	Receptor-site imaging-multiple areas or whole body	$477.00	$185.00	$662.00
511Z	Receptor-site imaging - limited area	$226.00	$107.00	$333.00
	Miscellaneous continued			
514Z	Infection imaging (labelled antibiotics, etc.), limited area	$235.00	$108.00	$343.00
515Z	multiple areas or whole body	$374.00	$150.00	$524.00
516Z	Imaging amyloid, etc. limited area	$235.00	$108.00	$343.00
517Z	multiple areas or whole body	$374.00	$150.00	$524.00
520Z	Breast milk assay	$150.30	$42.70	$193.00

		Technical Component	Professional Component	Technical and Professional
	Radionuclide Therapy			
600Z	32P therapy polycythaemia - per administration	$226.20	$74.80	$301.00
602Z	131Iodine ablative therapy - per administration	$112.20	$74.80	$187.00
604Z	Metastatic disease - palliative - 99Sr etc.	$112.20	$74.80	$187.00
606Z	Malignant ascites or plural effusion per administration	$190.00	$133.00	$323.00
608Z	Radioimmunotherapy per administration	$190.00	$133.00	$323.00
	Tomography			
700Z	Liver and spleen SPECT	$458.00	$330.00	$788.00
702Z	Hepatic blood pool SPECT	$459.00	$344.00	$803.00
704Z	Bone SPECT	$458.00	$330.00	$788.00
706Z	Joint SPECT	$458.00	$330.00	$788.00
708Z	Gated Cardiac Wall Motion (Blood Pool) SPECT	$459.00	$344.00	$803.00
710Z	Myocardial Perfusion SPECT rest	$458.00	$330.00	$788.00
711Z	stress	$458.00	$330.00	$788.00
712Z	ventricular wall motion/thickening		$109.00	$109.00
713Z	ventricular volumes/ejection fraction		$109.00	$109.00
714Z	Myocardial viability SPECT	$459.00	$344.00	$803.00
716Z	Brain SPECT	$458.00	$330.00	$788.00
718Z	Regional Cerebral Perfusion SPECT	$459.00	$360.00	$819.00
719Z	with acetozolamide etc.	$458.00	$322.00	$780.00
720Z	Cerebral Receptor-site SPECT	$459.00	$360.00	$819.00
722Z	CSF Flow SPECT	$458.00	$330.00	$788.00
724Z	Renal SPECT	$458.00	$330.00	$788.00
726Z	Inflammation SPECT	$458.00	$330.00	$788.00
728Z	Bone Marrow SPECT	$458.00	$330.00	$788.00
730Z	Lymph node SPECT	$458.00	$330.00	$788.00
732Z	Tumor SPECT	$458.00	$330.00	$788.00
	Position Emission Tomography			
800Z	Whole body (planar)	$772.00	$249.00	$1,021.00
801Z	Whole body PET	$891.00	$249.00	$1,140.00
802Z	Partial body PET	$772.00	$197.00	$969.00
803Z	Attenuation correction		$126.00	$126.00
804Z	Specific uptake valves		$35.60	$35.60
805Z	Volume rendering		$61.70	$61.70

Hand Surgery Appendix

		Fee		Class	Anae
	Nerves				
	Decompression				
	Decompression of entrapment syndrome				
158K	-- median nerve	$655.00		42	L
159K	-- others	$1,020.00		42	L
169K	Transposition of ulnar nerve	$922.00		42	L
	Repair				
165K	Digital nerve suture	$820.00		42	L
163K	Nerve suture (other than digital)	$1,230.00		42	L
164K	Nerve suture with special techniques to overcome gap	$1,430.00		42	L
368K	Secondary or delayed nerve repair -- one month post injury, add	$310.00		42	L
468K	Fascicular instead of epineural nerve repair, add	$535.00		42	M
	Nerve grafting procedures				
168K	-- single cable .	$978.00		42	L
268K	-- multiple cables	$1,430.00		42	L
162K	Exploration of peripheral nerve injury, or neurolysis	$881.00		42	L
	Excisions - Peripheral Nerve Lesions				
157K	Removal of tumor -- major peripheral nerve (e.g. median or ulna)	$1,020.00		42	L
161K	Neuroma excision	$714.00		42	L
	Tendons				
	Repair or suture -- flexor tendon				
696M	-- single unless otherwise listed	$816.00		42	L
697M	-- each additional	$612.00	*	42	L
	Repair or suture -- extensor tendon				
690M	-- single hand or foot -- distal to wrist or ankle	$561.00	*	42	L
	-- each additional tendon				
691M	-- foot	$306.00	*	42	L
692M	-- hand	$561.00	*	42	L
693M	-- single -- forearm or leg	$510.00	*	42	L
	-- each additional tendon				
694M	-- leg	$56.00	*	42	L
695M	-- forearm	$510.00	*	42	L
	Repair				
680M	Tendon sheath reconstruction -- insertion of silastic rod	$663.00		42	L
681M	-- each additional	$357.40		42	L
780M	Repair boutonniere deformity	$393.80		42	L
	Tenolysis and Transfers				
	Transfer or transplant of tendon -- single				
698M	-- distal to elbow, distal to knee	$867.00		42	L
700M	-- each additional	$714.00		42	L
781M	Free extensor tendon graft -- single	$800.00		42	L
782M	-- each additional	$418.00		42	L
703M	Free flexor tendon graft -- single	$1,070.00		42	L
704M	-- each additional	$1,033.60		42	L

Hand Surgery Appendix

		Fee	Class	Anae
	Tenolysis			
705M	-- single -- flexor	$714.00	42	L
706M	-- each additional	$459.00	42	L
725M	-- single -- extensor	$510.00	42	L
726M	-- each additional	$408.00	42	L
707M	Lengthening or shortening tendon	$612.00	42	L
708M	Opponens transfer	$816.00	42	L
709M	Intrinsic transplant active or passive	$603.50	42	L
710M	Intrinsic release (Littler) or incision	$510.00	42	L
711M	-- additional fingers	$306.00	42	L
712M	Free fascial graft for reconstuction tendon pulley or repair bowstring tendon - single	$612.00	42	L
727M	Tenodesis	$867.00 *	42	L
	Tenotomy			
722M	-- percutaneous	$510.00 *	10	L
723M	-- open	$510.00 *	10	L
724M	-- each additional (of either 722M or 723M)	$306.00 *	10	L
	Bone			
	Fractures			
	Carpal Bone			
251M	-- closed reduction	$295.30	42	L
252M	-- open reduction	$1,070.00	42	L
253M	-- reduction with external fixation device	$765.00	42	L
	Metacarpal			
255M	-- closed reduction	$408.00	42	L
257M	-- open reduction	$714.00	42	L
256M	Reduction of Bennett's fracture by internal fixation	$714.00	42	L
	Phalanx -- finger or thumb			
260M	-- closed reduction	$408.00	42	L
262M	-- open reduction	$714.00	42	L
110M	Insertion of Kirschner wire or metal pins for traction or cast fixation	$306.00	0	L