

Payment Schedule

For Insured Services Provided by a Physician

April 1, 2019 (revised May 7, 2019)

Saskatchewan! 

Payment Schedule for Insured Services Provided by a Physician

TABLE OF CONTENTS

| | | |
|---|---|----|
| Introduction | | 7 |
| To Request a Change to the Payment Schedule | | 8 |
| Services Provided Outside Saskatchewan | <ul style="list-style-type: none"> • Out of Canada Services • Out of Saskatchewan Services • Coverage for Services Unavailable in Canada | 9 |
| Billing For Services Provided To Out-Of-Province Beneficiaries | | 9 |
| Definitions | | 10 |
| Documentation Requirements | | 14 |
| Services Billable by Entitlement or by Approval | | 15 |
| Assessment Rules | <ul style="list-style-type: none"> • Introduction • Visits • Hospital Care • Consultations • Procedures • Multiple Services – General Assessment Rules | 16 |
| General Information | <ul style="list-style-type: none"> • Services Supervised by a Physician • Submission of Accounts • Out of Province Patients • Location of Service Indicators • Practise Entirely Outside the Medical Care Plan • Special Contracts • Patient Identification • Temporary Health Coverage | 23 |
| Services Not Insured | | 28 |
| Assessment of Account | | 31 |
| Verification Program | | 32 |
| Information Sources | <ul style="list-style-type: none"> • Claims Analysis Unit • Processing Support • Medical Consultant • Financial Services • Casework • Policy, Governance and Audit • eHealth - Technical Issues • Fee for Services & Statistics | 33 |
| Reciprocal Billing | <ul style="list-style-type: none"> • For Patients from Other Provinces • Physician Services Excluded from Reciprocal billing | 36 |
| Explanatory Codes for Physicians | | 39 |

Payment Schedule for Insured Services Provided by a Physician

LIST OF INSURED SERVICES, PROCEDURES AND VISITS

| | |
|---|-----------|
| Miscellaneous Services | Section A |
| General Practice | Section B |
| Pediatrics | Section C |
| Internal Medicine | Section D |
| Psychiatry | Section E |
| Dermatology | Section F |
| Medical Genetics | Section G |
| Anesthesia | Section H |
| Cardiology | Section I |
| Surgical Assistant | Section J |
| Neurosurgery | Section K |
| General Surgery | Section L |
| Orthopedic Surgery | Section M |
| Plastic Surgery | Section N |
| Physical Medicine | Section O |
| Obstetrics and Gynecology | Section P |
| Neurology | Section Q |
| Urological Surgery | Section R |
| Ophthalmology | Section S |
| Otolaryngology | Section T |
| Pathology | Section V |
| Diagnostic Ultrasound | Section W |
| Diagnostic Radiology | Section X |
| Therapeutic Radiology and Nuclear Medicine | Section Y |

Payment Schedule for Insured Services Provided by a Physician

INTRODUCTION

1. This Payment Schedule is effective for services provided on and after **April 1, 2019**. It lists a payment for each insured service which will be made at 100% unless the "Assessment Rules" indicate that payment for the service:

- a) is included in the composite payment made for another service; or
- b) is subject to an adjustment when billed in addition to another service.

2. Medical Services Branch has the authority to pay physicians for medically required services. *The Saskatchewan Medical Care Insurance Act, 14 (1) states:*

Subject to sections 15 and 24, services that are medically required services provided in Saskatchewan by a physician are insured services.

3. Physicians who have entered into a Direct Payment Agreement with the Ministry of Health, which sets the payment for each service, must bill services to Medical Services Branch in accordance with the Payment Schedule:

The Saskatchewan Medical Care Insurance Payment Regulations 1999 2000, c. S-29, Reg. 19, stipulates at 6(1)(d) that:

6 (1) *Where an insured service is provided in Saskatchewan to a beneficiary by:*

- (d) *a physician, the minister shall make payment for that service in accordance with the physician payment schedule and the assessment rules contained in that schedule.*

4. All services billed to Medical Services Branch are the sole responsibility of the physician rendering the service with respect to appropriate documentation and billing (see also "Documentation Requirements for the Purposes of Billing").
5. If a specific fee code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution.
6. When a physician service is not listed in the Payment Schedule, the physician should write Medical Services Branch to request advice on the correct submission of the account:
3475 Albert Street, Regina SK, S4S 6X6 or fax 306-787-3761.

Your correspondence must outline:

1. The nature and description of the service;
2. The frequency of the service;
3. The length of time spent performing the service; and
4. The suggested fee and rationale.

INTRODUCTION

7. When unusual time, skill or attention is required in the management of any medical condition, a payment greater than the amount indicated in the Payment Schedule may be authorized upon receipt of a written report.

To request consideration of payment, please write to: Medical Services Branch, 3475 Albert Street, Regina SK, S4S 6X6 or fax 306-787-3761.

Your correspondence must outline:

1. The nature and description of the service;
2. The frequency of the service;
3. The length of time spent performing the service; and
4. The suggested fee and rationale.

TO REQUEST A CHANGE TO THE PAYMENT SCHEDULE

The Ministry of Health and the Saskatchewan Medical Association (SMA) consider implementation of new service codes, deletions or revisions to the Physician Payment Schedule upon approval by the Payment Schedule Review Committee (PSRC) comprised of both Ministry and SMA representatives.

To request/initiate a change, deletion or addition to the Payment Schedule, please contact:

Saskatchewan Medical Association Tariff Committee
201 – 2174 Airport Drive
SASKATOON SK S7L 6M6 www.sma.sk.ca

The SMA has additional information about the process on their website at:

<http://www.sma.sk.ca/104/new-fee-items-tariffs.html>

SERVICES PROVIDED OUTSIDE SASKATCHEWAN

1. Out-of-Canada Services

- a) Non-emergency (elective) services are only considered in **exceptional** circumstances and must have prior approval from the Ministry of Health.
- b) Emergency services -- Saskatchewan rates of payment apply and prior approval is not required.

2. Out-of-Saskatchewan Services

- a) Prior approval is not required for the vast majority of physician services received in other provinces and territories as long as these services are provided within the **publicly funded** health care system.
- b) If an insured service is unavailable in Saskatchewan, it should be sought in another province.
- c) Patients will not be billed for most services they receive in other provinces and territories.
- d) Quebec is an exception; patients may have to pay for physician services in Quebec and submit a bill to the Ministry of Health for payment at Saskatchewan rates.

3. Coverage for Services Unavailable in Canada

When an insured service is unavailable in Canada, special rates of payment may apply when the following conditions are met:

- a) A Saskatchewan listed specialist, within whose field of practice the required service lies, submits a written application for Ministry consideration of request for coverage of medical services unavailable in Canada to:

Director, Insured Services
Medical Services Branch, Ministry of Health
3475 Albert Street, Regina, Saskatchewan S4S 6X6

- b) The written application is made prior to referral of the patient for treatment outside Canada;
- c) The application must state:
 - the patient's name, address and valid Health Services Number;
 - pertinent clinical details and diagnosis;
 - the nature of the service required and confirmation by the specialist that, to the best of his knowledge, the service(s) being requested is not obtainable within Canada;
 - where possible the name and location of the physician who is to provide the service.
- d) **Prior approval** must be obtained from the Ministry of Health's Medical Services Branch. The Ministry's decision regarding the coverage request and the rate of payment to apply is provided in writing to both the referring specialist and the beneficiary.

BILLING FOR SERVICES PROVIDED TO OUT-OF-PROVINCE BENEFICIARIES

1. With the exception of patients from Quebec, Saskatchewan physicians should submit their accounts for insured services provided to any Canadian resident to Medical Services, Ministry of Health, for processing at Saskatchewan rates.
2. Certain items excluded from the Reciprocal Billing Agreement may be insured by the beneficiary's home province. It is suggested that in such cases a letter of inquiry be forwarded to the beneficiary's provincial plan for clarification.

DEFINITIONS

1. **Age Categories**
 - a) Premature -- a child weighing 2.2 kg or less;
 - b) Newborn -- a child in the first 10 days of life;
 - c) Infant -- a child in its first year of life;
 - d) Child -- any person under thirteen years of age, except where noted otherwise
 - e) Adult -- a person who has attained the age of 13 years; except where noted otherwise.

2. **Classifications** Designates the time span applied by the Assessment Rules to other services in arriving at an appropriate payment.
 - a) Diagnostic -- the day of the procedure;
 - b) "0" Day -- the day of the procedure;
 - c) "10" Day -- the day of and ten days following the procedure;
 - d) "42" Day -- the day of and forty-two days following the procedure.

3. **Clinic** The arrangement whereby two or more physicians are practising their profession, medical records and histories of the patients of those physicians are being maintained, and each of those physicians has access to those medical records and histories.

4. **Composite** A payment which includes the payment for more than one service associated with the treatment of a condition.

5. **Fee for Service** Services are to be billed on the basis of the individual appropriate visit or procedure items included in the Payment Schedule at the listed amount and are subject to the Assessment Rules.

6. **By Report** The claim must be made on one of the regular claim forms (not by automated submission) and must be accompanied by a detailed explanation of the circumstances and the services provided. Payment will be assessed on the basis of the information provided. An estimated appropriate fee may be provided.

7. **Hospital** A hospital as defined in The Hospital Standards Act.

8. **Palliative** As defined by the Saskatchewan Health Authority is a life-limiting/life threatening illness where the focus is on comfort rather than cure. The Drug Plan and Extended Benefits Branch of the Ministry of Health, further defines palliative as patients who are in the late stages of a terminal illness where life expectancy is measured in months.

9. **Pediatric Procedural Supplements** Are additional payment(s) for procedural services provided in the operating theatre and applies to patients receiving diagnostic (including section W and X applicable codes but excluding ECGs), 0, 10 or 42 day procedures only.

DEFINITIONS

10. **Referral** Is the request for a consultation and/or transfer of responsibility for the condition existing at the time of referral to:
- a) A physician by another physician;
 - b) A specialist by an optometrist;
 - c) A specialist in orthopedic surgery, plastic surgery, otolaryngology, neurology, neurosurgery or dermatology, by a dentist;
 - d) A specialist by a chiropractor.
 - e) A specialist by a registered nurse (nurse practitioner)
 - f) A specialist in obstetrics and gynecology, pediatrics, neonatology, anesthesia, radiology, psychiatry or pathology by a midwife.
11. **Physician** A legally qualified medical practitioner whose name is inscribed in the register kept by the Registrar of the College of Physicians and Surgeons of Saskatchewan as being qualified and licensed to practise medicine, surgery and midwifery in Saskatchewan and who is in good standing and not under suspension pursuant to any of the provisions of The Medical Professions Act.
12. **General Practitioner** A physician who engages in the general practice of medicine or a physician who is not a specialist as defined by the Act.
13. **Emergency Room Physician** A physician providing scheduled on-site regular service/coverage in the emergency departments as designated by the Saskatchewan Health Authority.
14. **Specialist** A physician whose name is on the list of physicians maintained by the Registrar of the College of Physicians and Surgeons of Saskatchewan as being entitled to receive payment at specialists' rates.
15. **Foreign Certified Specialist** A physician whose name is on the list of physicians maintained by the Registrar of The College of Physicians and Surgeons of Saskatchewan as having received specialty training and certification in a foreign country, is restricting his/her practice to the area of foreign specialist certification and will be paid at 'Specialists' rates for both visits and procedures. Physicians will be deemed to belong to the specialty of highest achieved certification for purposes of billing.
16. **Allied health care personnel** A person who is:
- a) Not a physician, dentist, optometrist, or chiropractor.
 - b) A pharmacist, registered or licensed practical nurse, public health nurse, psychiatric nurse, mental health worker, physiotherapist, occupational therapist, respiratory therapist, ambulance paramedic, psychologist, **podiatrist** etc.

This is not an all-inclusive list – see also 790A-791A, 793A.

DEFINITIONS

17. **Locum Tenens** A person who is:
- a) A fully licensed physician substituting and providing services for another fully licensed physician. In this case the locum must bill using their own physician number and name. The Ministry of Health will make payment to the locum;
 - b) A physician who has been granted a temporary license by the College of Physicians and Surgeons of Saskatchewan to do a locum tenens for a fully licensed principal physician. In this case, the locum must bill under the fully licensed physician number and appropriate locum clinic number. The Ministry of Health will make payment to the fully licensed physician, not to the locum. If a locum physician is going to be practising in Saskatchewan for more than three months, he/she will be assigned a unique physician billing number and be expected to bill as if fully licensed. The principal physician should ensure that the locum is advised regarding correct billing for services as the principal is legally responsible for inappropriate submissions.
 - c) A physician who has been granted a temporary licence by the College of Physicians and Surgeons of Saskatchewan to do a conditional locum. In this case, the locum must use his/her own physician number and name when billing. The Ministry of Health will make payment to the locum.
 - d) A fully licenced physician contracted through the Saskatchewan Medical Association's Rural Relief Program to provide locum services to a host clinic. In this case the locum must use his/her own physician number and name when billing. The Ministry of Health will make payment to the host clinic.
18. **Point-of-care ultrasound (POCUS)** An ultrasound examination provided and performed at the 'point-of-care' as an adjunct to the physical examination to identify or clarify the presence or absence (uncertainty) of a limited number of specific findings.
- An ultrasound examination to provide image guidance for the provision of carrying out a primary procedure.
- a) Is not intended as a "diagnostic" ultrasound.
 - b) Is considered a different examination than a comprehensive or limited sonographic evaluation.
 - c) Is considered an inclusion in a visit service or primary procedure and it is not billable as a separate ultrasound service code.
 - d) Should be recorded in the patient record, along with the physical examination as part of a patient assessment.

DEFINITIONS

19. **Technical Component**

Physician costs related to providing the service, including but not limited to:

- a) if a technician/non-physician is involved in performing the service, the fee includes a component to cover their service;
- b) Amortization of cost or leasing costs of any special equipment needed to carry out the procedure (costs incurred by physician only);
- c) Equipment maintenance;
- d) Capital cost of replacement equipment;
- e) Expendable costs (specific to the procedure such as contrast media);
- f) Fixed and variable costs of the premises (space and time); and
- g) Production of radiographs.

Note: For the purposes of billing a technical component, the physician should be prepared to provide documentation to the Ministry of Health demonstrating their ownership of equipment and/or employment of staff, on request.

DOCUMENTATION REQUIREMENTS FOR THE PURPOSE OF BILLING

Introduction

Documentation is an integral and fundamental component of a medical service. An adequate record will enhance quality and accountability, and provide protection for the physician, the beneficiary and the Ministry.

For billing purposes, the physician is responsible for documenting and maintaining an adequate medical record that appropriately supports the service being provided and billed, regardless of method of reimbursement to physician (fee-for-service, contract/shadow biller, etc).

To be considered adequate, a medical record must be legible and contain the information specifically designated in the Physician Payment Schedule service codes depending on the classification of the service. The record must also establish that:

1. An insured service was provided; and
2. The service for which the account is submitted is the service that was rendered; and
3. The service was medically required.

Requirements

Visit Services:

- All listed service code criteria must be recorded.

Time-based Services:

- In terms of a minimum required duration of time, the physician must document on the patient's record when the insured service started and ended. If the record does not include this required information, the service is *not eligible for payment*.
- Based upon the number of "units" of service rendered, the physician must document on the patient's record the time when the insured service started and ended. If the patient's record does not include this required information, the service is *not eligible for payment*.

Surgical procedures, diagnostic procedures, unclassified services, and laboratory services:

- All relevant information must be recorded, i.e. tracings, test results, discharge reports, operative reports, etc.

Time-of-Day Premiums and Special Call Surcharges:

- Based on the time of day the insured service was provided, the time and location of service must be documented in the record. If the patient's record does not include this required information, the service is *not eligible for payment*.
- MSB may also request documentation to establish that the physician was not in the same facility, hospital, etc. when the call was requested/initiated.

SERVICES BILLABLE BY ENTITLEMENT OR BY APPROVAL

Introduction

In order for a physician to commence billing for a service which is stated “by entitlement” or approval is required by the Saskatchewan Medical Association (SMA), prior approval must be sought, approved and received by Medical Services Branch.

- a) The effective date is the date the request was approved by the SMA.
- b) The effective date cannot pre-date the original request by the physician.
- c) If the effective date is older than 6 months when received by MSB, any billable service dates cannot exceed 6 months.
 - Accounts for insured services must be received by the Ministry of Health within six months following the date of service to be eligible for payment under The Medical Care Insurance Act.

Requirements

MSB requires that the following information be provided by the SMA:

1. Proof of request;
2. Proof of approval with the date that the approval was granted to the physician by the SMA, CPSS or SHA; and
3. Copies of all pertinent documents pertaining to the physician’s credentials that support the approval.

ASSESSMENT RULES

Introduction

1. Claims for insured services submitted by any mode of billing are subject to the assessment rules. This applies even in the event of claims being received under different modes of billing for services to a patient on the same day.
 - a) These assessment rules apply to services common to many sections of the Schedule (e.g. visits and consultations).
 - b) Other rules are listed in the specialty sections.
 - c) Assessment rules applying to services listed in only one section of the Schedule are listed as an introduction to the services:

| | | | |
|-----------|--------------------------------|-----------|------------------------------------|
| Section A | -- special call services; | Section S | -- refractions; |
| Section H | -- anesthesia, intensive care; | Section T | -- otolaryngology; |
| Section J | -- surgical assistance; | Section V | -- laboratory medicine; |
| Section M | -- fractures, dislocations; | Section W | -- diagnostic ultrasound; |
| Section N | -- microvascular surgery; | Section X | -- radiology, clinical procedures. |
| Section P | -- obstetrics; | | |
2. The relationship of the current service to prior or subsequent services may result in payment at an amount which differs from the payment listed in the Payment Schedule.
3. A previous payment may be adjusted due to the subsequent submission of a claim for a related service.
4. Where a claim is returned or the payment is different from the amount billed, an explanatory code, of two letters e.g. JO, is used to indicate the reason. A list of the explanatory codes is to be found at the end of this section.
5. When a request is made for an explanation or outline of circumstances in order to assess a claim, the Ministry of Health shall determine whether the explanation is acceptable.
6. No payment is made for a report or other information required to assess or review an account.
7. When the words "by report" are shown rather than a specific rate of payment, "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.

Visit Services

1. A visit service includes the assessment of one or more conditions during the same patient contact wherever the patient may be at the time the service is rendered.
2. Any claim submitted for a second visit on the same date of service by either the same physician or another in the same clinic and specialty should state the reason for the second visit, the time, location and service provided.
3. The rates of payment for visit services including consultations are those listed in the specialty of the physician providing the service - unless otherwise specified.
4. A special call or emergency visit by the same physician or another physician in the same specialty and clinic billed during a period of in-patient care requires an outline of the circumstances for the visit.
5. A visit billed with other services is assessed in accordance with the rules listed under "Multiple Services -- General Assessment Rules".
6. The rules for consultations; item (6) (rules a-g) also apply to visits.

ASSESSMENT RULES

Hospital Care

1. The claim must show the number of days of hospital care from the day of admission to the day of discharge. Payment is inclusive of all visits. An additional payment may be made for visits made on statutory holidays and weekends - see service codes 700A and 701A.
2. Payment will be made as if hospitalization had been continuous when a patient is transferred during the same admission to either a specialist in the same specialty or a general practitioner.

When a patient is readmitted to a hospital in the same locale within fourteen days after discharge for continued treatment of the same or related condition, by the same physician, or another physician in the same clinic, payment will be made at the initial hospital care rate provided that the word "**Readmission**" is indicated on the claim.

When a patient is transferred from ICU to a general medical ward, and at the same time from one physician to another, payment will be made at the initial hospital care rate provided that the words "**ICU Transfer**" are indicated on the claim.

3. Payment for concurrent hospital care by more than one physician may be approved only after the Ministry of Health is provided with a satisfactory explanation that care by more than one physician was required.
4. Hospital care billed with other services is assessed in accordance with the rules listed under "Multiple Services -- General Assessment Rules".
5. Hospital care (25B-T) is payable on day of admission to hospital.
 - a) Billing for patients in Health Centres – Patients who are admitted to a Health Centre for short term acute care may be billed as 25B in the same manner as an acute care hospital. Physicians may not use this option to cover new admissions to the long term care section of the Health Centre.
 - b) The hospital discharge code (725A) may be billed once per patient discharge for formally admitted hospital in-patients to the physician responsible for discharging the patient. The discharge summary should be billed on the date of discharge and a location of service 2.

Consultations

1. The rates of payment for consultation services are those listed in the specialty of the physician providing the services.
2. This service applies where a physician, having examined the patient, formally requests the opinion and advice of another physician because of the complexity, obscurity or seriousness of the current condition or conditions involved.
3. The 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 physician.
4. A consultant may take more than one visit to make a proper diagnosis, but only one payment is made.
5. **Repeat Consultation** -- a formal consultation for the same or related condition repeated within 90 days by the same physician. 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 either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.

ASSESSMENT RULES

6. When, for either the same or related condition, a physician provides:
- a) a consultation on the same day or within 90 days prior to or 90 days after another consultation by the same physician, the second consultation will be converted to a repeat consultation;
 - b) a consultation on the same day or within 42 days after a complete/initial assessment, the consultation will be converted to a partial/follow-up assessment;
 - c) a complete/initial assessment on the same day or within 42 days after a consultation, the complete/initial assessment will be converted to a partial/follow-up assessment;
 - d) a consultation on the same day or within 42 days after a partial/follow-up assessment, the consultation will be converted to a complete/initial assessment;
 - e) a complete/initial assessment on the same day or within 42 days after a repeat or minor consultation, the complete/initial assessment will be converted to a partial/follow-up assessment;
 - f) a consultation on the same day or within 42 days after a repeat consultation will be converted to a repeat consultation;
 - g) a complete/initial assessment on the same day or within 42 days prior to or 42 days after another complete/initial assessment, then the second complete or initial assessment will be converted to a partial/follow-up assessment.

Note: Rule (g) does not apply to general practitioners.

7. When for a different condition a physician provides a consultation on the same day or within 90 days prior to or 90 days after another consultation, by the same physician, the second consultation will be converted to a complete/initial assessment.
8. A consultation billed with other services is assessed according to the rules listed under "Multiple Services -- General Assessment Rules".
9. For patients whose chronic medical conditions require a comprehensive annual review with advice back to the referring physician, it is acceptable to bill a consultation code without a formal re-referral in the following circumstances:
- a) The patient was originally referred to the consultant for this condition;
 - b) The patient's medical condition requires annual review;
 - c) One year has elapsed since the last patient visit (consultation or other visit service);
 - d) The original referring physician is still the patient's family physician and is still in practice in Saskatchewan;
 - e) A consultation note is sent to the original referring physician.

ASSESSMENT RULES

Procedures

1. General classification of procedures (*See also Multiple Services - General Assessment Rules*)
 - 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.
2. No payment is made for the technical component when the procedure is provided in a hospital, in-patient or out-patient, or any other facility funded by the Ministry of Health.
3. At the time of surgery or when performed under the same Anesthetic as the surgery, by the surgeon or the surgical team, the following services are included within the composite payment for the procedure:
 - a) Tray service -- [to include the provision of cotton swabs, customary antiseptic solution, gloves – clean or sterile, necessary instruments, suture materials, dressings, syringes and needles] - except for in-office procedures listed under the description of codes 897L or 899L;
 - b) The application of any fixation appliances, casts, splints or dressings;
 - c) Regional anesthesia;
 - d) Cardiac massage -- external or through the same incisions;
 - e) The separation of adhesions;
 - f) Laparotomy when not the primary abdominal procedure;
 - g) Appendectomy when performed in addition to another intra-abdominal procedure and where not clinically indicated (ie. “en passant”), even if performed by a different surgeon;
 - h) Provision of ring block, local infiltration and topical or spray anesthetics by any physician.
4. When provided by the same physician, a general practitioner in the same clinic, or a specialist in the same specialty and clinic, the following services are included within the composite payment for the procedure:
 - a) the control of hemorrhage within twenty-four hours of surgery unless specifically exempted e.g. 147T, 46R;
 - b) the application of any fixation appliances, splints or dressings at the time of surgery or during the designated post-operative period;
 - c) the application of casts at the time of surgery or during the period prior to hospital discharge. The reapplication of a cast on the day of surgery is not payable.
5. The two days of pre-operative care in hospital are included in the payment for a "10" or "42" Day procedure when provided by the same physician or another physician in the same specialty and clinic.
6. Multiple procedures are assessed in accordance with the rules listed under "Multiple Services -- General Assessment Rules".

MULTIPLE SERVICES -- GENERAL ASSESSMENT RULES

These assessment rules apply:

| When this service is: | Is billed with one or more | Same day: | Post-Procedure |
|------------------------------|----------------------------|-----------|----------------|
| Visit or consultation | Diagnostic | 1 | |
| | 0 Day | 1,2 | |
| | 10 Day | 2 | 4 |
| | 42 Day | 3 | 4 |
| Hospital Care | Diagnostic | 1 | |
| | 0 Day | 1,2 | |
| | 10 Day | 2 | 4 |
| | 42 Day | 3 | 4 |
| Diagnostic | Diagnostic | 5 | 9 |
| | 0 Day | | |
| | 10 Day | | 7 |
| | 42 Day | 6 | 7 |
| 0 Day | 0 Day | 8 | 9,10 |
| | 10 Day | 8 | 10 |
| | 42 Day | 8 | 10 |
| 10 Day | 10 Day | 8 | 9,10 |
| | 42 Day | 8 | 10 |
| 42 Day | 42 Day | 8 | 9,10 |

Note: Multiple procedures on the same day are all assessed with the assessment rules for the procedure with the longest post-operative period.

Examples:

1. A visit and "0" day procedure provided on the same day are assessed with Rules 1 and 2.
2. A visit, a "10" day and a "42" day procedure provided on the same day are assessed with Rules 3 and 8 (not Rule 2).
3. A "0" day, a "10" day and a "42" day procedure provided on the same day are assessed with Rule 8.

MULTIPLE SERVICES -- GENERAL ASSESSMENT RULES

THE FOLLOWING RULES APPLY TO THE SAME PHYSICIAN (OR ANOTHER PHYSICIAN IN THE SAME SPECIALTY AND CLINIC) UNLESS OTHERWISE INDICATED WITHIN THE RULE.

1. When a **visit (including hospital care) or consultation** is billed for the same day in addition to a service listed as "includes visit", "included in visit", "when only procedure done", or "when only charge made", only the greater listed amount is paid.
2. **A visit (including hospital care) or consultation** on the day of a **"0" or "10" Day procedure** is paid at the greater of:
 - a) the procedure alone; or
 - b) the total of the visit (hospital care, consultation, or other) together with the procedure paid at 75% of the appropriate listed amount.

Procedures with possible unit values are paid at the listed fee.

3. **A visit (including hospital care) or consultation** on the day of a **"42" Day procedure** is included in the payment for the procedure when provided by the same physician or another physician in the same specialty and clinic (or part of the surgical team).

Notwithstanding the above:

- a) when a physician admits a patient to hospital for urgent surgery on an emergency basis and later on the same day provides surgical assistant services to the surgeon to whom the case has been referred, then both the visit and surgical assistant services will be paid;
 - b) the surgeon may be paid for a consultation on the same day as a 42 day procedure when that consultation initiates the surgery and is the first patient contact;
 - c) when a surgeon provides elective surgery for a patient not seen in the preceding 30 days, then both the surgical procedure(s) (42-day procedures only) and a partial or follow-up assessment will be paid if provided (a complete assessment will not be paid).
4. **Hospital care (including other hospital inpatient visits)** during the designated post-operative period of a related **"10" or "42" Day procedure** is included in the payment for the procedure when provided by the same physician, a general practitioner in the same clinic, or a specialist in the same specialty and clinic. **Visits after the discharge of the patient may be billed**
 5. Payment for a **diagnostic procedure done bilaterally** on the same day is based on the payment for the single procedure plus 75% unless otherwise listed.
 6. A diagnostic procedure performed on the day of a "42" Day procedure by the same physician or another physician in the same specialty and clinic (or part of the surgical team) is paid at 75% of the appropriate listed amount, unless included in the composite payment for the procedure, or unless the diagnostic procedure is the greater fee. If the diagnostic procedure is a greater value than the 42 day procedure, the diagnostic procedure will be paid at 100% and the 42 day procedure at 75%.
 7. A diagnostic procedure performed by the same physician, a general practitioner in the same clinic, or a specialist in the same specialty and clinic within the post-operative period of a related "10" or "42" Day procedure is paid at 75% of the appropriate listed amount.

MULTIPLE SERVICES -- GENERAL ASSESSMENT RULES

8. Payment for **two or more "0", "10" or 42" Day procedures** performed on the same day by the same physician or another physician in the same specialty and clinic (or part of the surgical team) is based on the higher procedure at 100% and all others at 75% of the appropriate listed amount, unless:
 - a) payment for the lesser procedure is included in the composite payment for one of the other procedures; or
 - b) the Payment Schedule:
 - i. lists a composite payment for the procedure(s) performed; or
 - ii. designates that the listing for the second procedure is to be paid when it is the only procedure performed; or
 - iii. lists a specific payment for additional procedures; or
 - iv. lists a specific payment for surgeons in different specialties.
9. Where **two similar unilateral procedures** are performed during the same hospital admission and a bilateral payment is listed in the Payment Schedule, payment is based on the bilateral listing.
10. **A subsequent "0", "10" or "42" Day procedure** within the designated post-operative of a related procedure is paid at 75% of the appropriate listed amount, unless the Payment Schedule stipulates otherwise.

GENERAL INFORMATION

Services Supervised By A Physician

A service which is insured by the Ministry of Health when provided by a physician is also insured when provided under the supervision of a physician. Payments can be made to the physician for this supervision as long as the physician is available to intervene promptly if necessary. Supervised services are provided by:

- a) a person during the period of registration on the educational register of the College of Physicians and Surgeons as an intern, a resident, an undergraduate junior rotating intern (JURSI) or as a person taking other postgraduate training in Saskatchewan as a physician, where that service is provided as part of the course of training being taken;
- b) another physician providing the service as part of a course of instruction being administered by the College of Medicine of the University of Saskatchewan and where that physician does not charge for the service;
- c) a person employed by a physician in the physician's office and for whose work the physician assumes overall responsibility and provides intermittent daily personal supervision, and the service is:
 - i. a laboratory service (V section codes)
 - ii. a diagnostic X-ray procedure (X section codes);
 - iii. a diagnostic procedure involving a tracing (including, but not limited to, W section codes, ECGs, spirometries, echocardiograms, etc);
 - iv. an intramuscular, intradermal, or subcutaneous injection (including, but not limited to 110A, 131A, 161A, etc);
 - v. a specimen collection (204A, 205A, 206A).
- d) a person in training as a health care worker under the supervision of the physician for a specific procedure and the worker does not have privileges through either independent licensure or transfer of function to independently perform the procedure (e.g. advanced clinical nurse, respiratory technologist);
- e). a person employed by a physician whose practice is restricted to dermatology may provide ultraviolet B therapy when the physician assumes overall responsibility and provides intermittent daily personal supervision.

Payment for a supervised service may only be made to the physician providing the supervision.

GENERAL INFORMATION

Submission of Accounts

1. Time Limit for Submission of Accounts

Accounts for insured services must be received by the Ministry of Health within six months following the date of service to be eligible for payment under The Medical Care Insurance Act.

The six months' time limit may be extended to twelve months by the Ministry of Health if it is determined that the delay was caused by very special circumstances beyond your control. Claims returned to the physician should be corrected and sent back to Medical Services Branch within 30 days; this will be strictly enforced once a claim becomes 5 months old.

The time limit applies to all persons submitting accounts to the Ministry of Health.

In cases where beneficiaries are billed directly, The Medical Care Insurance Act requires that they be provided with an itemized statement within 6 months following the date of service to enable them to claim payment from the Ministry of Health. If a physician does not provide the statement in time then the right to collect the account is lost. As long as the beneficiary is provided with a statement of account in time, the Act does not place any restriction upon the physician's right to collect the account.

2. Claim Submission:

- a) Automated Submission - Claims must be submitted via the Internet. Contact Operations Support for further information and assistance
- b) Required information - Payment for insured services provided to a beneficiary may be made by the Ministry of Health upon an account being presented, containing the following information:
 - a. patient's name in full;
 - b. patient's Health Services Number (HSN);
 - c. patient's month and year of birth, and sex;
 - d. location of service: office, hospital in-patient, hospital outpatient, home, other.
 - e. three-digit ICD diagnostic code;
 - f. where service is provided in Saskatchewan, service code corresponding to procedure or treatment performed;
 - g. where service is provided outside Saskatchewan, the service may be submitted to the physician's own provincial plan for direct reimbursement where such arrangements exist. For services received in Quebec, a description of the procedure or treatment provided;
 - h. date of each service, except that, with respect to hospital visits, only the dates of the first and last visits and the total number of visits need be shown;
 - i. amount charged for each service provided;
 - j. additional remarks if nature of service was unusual;
 - k. name and signature (not required if claim is submitted by computer) of person providing service;
 - l. four-digit referring physician number where applicable.

GENERAL INFORMATION

c) Out-of-Province Patients

A physician providing non-excluded insured services to a patient from another province or territory of Canada with the exception of Quebec, must submit his/her claim to the Ministry of Health in the usual manner indicating the patient's identification and in the form of account noted above and submit that account to the Ministry of Health directly for reimbursement.

3. Modes of Billing Accounts

A physician has two billing options. Accounts can be submitted:

a) Billing Direct to the Ministry of Health (Mode 1) – Fee-for-service

If a physician wishes to send accounts direct to the Ministry of Health for payment, then the physician is required to sign an agreement with the Ministry of Health. The agreement may be cancelled by either party giving one month's notice of termination.

Even though a physician enters into an agreement with the Ministry of Health, the other billing option remains open in certain circumstances. When a physician leaves Saskatchewan all direct deposit agreements terminate immediately and all outstanding payments will be paid by cheque mailed to the current correspondence address. Please ensure you file a forwarding address with the Medical Services Branch so cheques do not go astray.

b) Billing the Patient (Mode 3)

- i. a physician shall not knowingly charge a beneficiary an amount greater than that paid by the Ministry of Health for an insured service.
- ii. a specialist shall not charge a beneficiary the difference in amount between that payable by the Ministry of Health for a referred service and an unreferred service.

You may bill your patient for uninsured services, or if the patient does not provide proof of coverage, etc. Payment of your account is the sole responsibility of the patient who may obtain the benefit of his medical care insurance by submitting his/her itemized account to the Ministry of Health.

The required information for payment must be provided to the beneficiary so that he may claim the medical care insurance benefit.

The Saskatchewan Medical Care Insurance Act states, in part, that "the physician shall not submit an account for payment to or otherwise demand or accept payment from the beneficiary for providing an insured service to the beneficiary or dependent of the beneficiary until he has first furnished the beneficiary with the information required to enable the Minister to make payment under this Act to the beneficiary in respect of the insured service."

GENERAL INFORMATION

4. Location of Service Indicators

| Day of Week: | | Weekdays | Weekdays Weekends & Stat Holidays | | Anytime |
|-------------------|------------|-------------------|---|---|----------------|
| Time: | | 8 am – 5pm | <u>Weekdays:</u> 7 pm – 7 am | <u>Weekdays:</u> 5 pm – 12 am | 12 am - 7 am |
| | | | <u>Weekends & Stats:</u> Anytime | <u>Weekends & Stats:</u> 5pm – 12 am Friday 7 am – 12 am Saturday/Sunday & Stat Holidays | |
| | | No premium | 10% | 50% | 100% |
| Office | Indicator: | 1 | F | 1 (no premium) | 1 (no premium) |
| Inpatient | Indicator: | 2 | Office only | B | K |
| Outpatient | Indicator: | 3 | Office only | C | M |
| Home | Indicator: | 4 | Office only | D | P |
| Other | Indicator: | 5 | Office only | E | T |
| ER | Indicator: | 9 | Office only | 9 (no premium) | 9 (no premium) |

Example: Inpatient service on Saturday at 7 pm would be indicator “B” (50%).

Example: Home service on Wednesday at 3 pm would be indicator “4” (no premium).

Practise Entirely Outside The Medical Care Plan

A physician may practise entirely outside the plan conditional upon:

- 1) The physician practises entirely outside the medical care plan for all patients and for all services, and
- 2) Access to insured services is not jeopardized, and
- 3) Prior to providing a service, the physician advises the patient that the service is not insured and the patient is not entitled to payment from the Ministry of Health and the patient agrees to such an arrangement.

Special Contracts -- Services Provided on a Group Basis

Services provided by a physician on a group basis, in a school, hall, auditorium, or other place of assembly or for the purpose of diagnostic screening or immunization, are not insured unless the Ministry of Health has been notified prior to the services being rendered and an agreement entered into between the Ministry of Health and the physician.

The agreement shall state the rate of payment and arrangements for the submission of claims.

Cancer Services

Cancer services are insured by the Ministry of Health. Physicians have an obligation to register cancer patients with the Saskatchewan Cancer Agency.

GENERAL INFORMATION

Patient Identification

A plastic Health Services Card is issued to identify registered beneficiaries of the Saskatchewan Medical Care Insurance Plan.

The card shows a Saskatchewan resident's lifetime nine-digit Health Services Number, name, sex, month and year of birth, effective date and expiry date of coverage. An individual card facilitates accurate patient identification that is essential to the speedy processing of accounts. Patients should be asked to produce a current Health Services Card at the time of each service.

Residents who are members of the Canadian Forces and inmates of the Federal Penitentiaries are not provided with health care coverage by the Ministry of Health. Their spouses and dependants, resident in Saskatchewan, must be registered for coverage.

If the Health Services Number is not available for the newborn, submit the claim with the mother's HSN and the newborn's identification data. The mother's name should be indicated in the comments record of the direct input claim or in the remarks area of a paper claim. If the mother has recently moved, the address should be indicated.

Temporary Health Coverage Forms (THC)

Residents who qualify under the Saskatchewan Assistance Plan for temporary health coverage are issued a Temporary Health Coverage form.

THC forms may reflect limited health coverage from one day to a maximum of two weeks. The Ministry of Social Services electronically submits the THC nomination to the Ministry of Health to register the client for a Saskatchewan Health Services Number for the period of the THC.

A THC nomination electronically generates a supplementary health letter that denotes the HSN for the period of the THC. No Plastic Health Card is issued until the client completes a Saskatchewan Health Services Card application.

SERVICES NOT INSURED BY THE MINISTRY OF HEALTH

1. **Workers' Compensation Board**

The Ministry of Health does not cover services required as a result of industrial accidents. Send accounts for those services to:

Workers' Compensation Board
Suite 200 - 1881 Scarth Street,
Regina, Saskatchewan S4P 4L1

Accounts received by the Ministry of Health and identified as being Workers' Compensation Board responsibility because of prior WCB registration are processed at \$0.00 on the physician's payment list with explanatory code CW. Payment for accounts under these circumstances can only be obtained by forwarding an account to WCB who will either pay the account or send it back to the physician for resubmission to the Ministry of Health.

2. **DVA Pensionable Disability**

The Ministry of Health does not cover services for the treatment of a condition related to a Department of Veterans' Affairs pensionable disability. Send accounts for these services to:

Department of Veterans' Affairs
Treatment Benefit Unit
Box 6050
Winnipeg, Manitoba R3C 4G5

Accounts received by the Ministry of Health and identified as being the responsibility of the Department of Veterans' Affairs because of a previous DVA registration are processed at \$0.00 on the physician's payment list with explanatory code CH. Payment for these accounts can only be made by the Department of Veterans' Affairs to whom the account should be submitted on claim form VAC 147. DVA will either pay the account or refer it back to the Ministry of Health for payment in the event that coverage is not available through their program for the service(s) provided.

3. **Saskatchewan Government Insurance -- Motor Vehicle Accidents**

The Ministry of Health provides coverage of insured services required as a result of motor vehicle accidents. However, where third party liability is involved, the Ministry of Health recovers monies from Saskatchewan Government Insurance for the cost of medical services provided. Where a person is entitled to Accident Benefits provided by The Automobile Accident Insurance Act, Saskatchewan Government Insurance may accept responsibility for costs incurred by the beneficiary for services not insured under the Medical Care Insurance Plan or the Hospital Services Plan, e.g. ambulance services, certain drugs, and appliances.

4. **General anesthesia** for dental procedures outside hospital other than by a specialist in anesthesia.
5. **Drugs and dressings**
6. **Ambulance services** or other forms of transportation of patient.
7. **Appliances**, such as eyeglasses, hearing aids, artificial limbs, cardiac pacemakers or artificial heart valves.

SERVICES NOT INSURED BY THE MINISTRY OF HEALTH

8. **Advice by telephone** with the exception of telephone calls from allied health care personnel (physicians, dentists, optometrists and chiropractors are not considered allied health care personnel) (see service codes 70A, 762A-769A and 790A-795A).
9. **Examinations or services to provide a medical report or certificate** required for the information of a third party, (except for adoption purposes, a person becoming a foster parent, cases regarding rape or child abuse and certification of mental ill health under The Mental Health Services Act), e.g.

| | |
|--|---------------------------------------|
| Attendance at camps; YMCA, YWCA, etc. | Judicial purposes |
| Autopsies | Motor vehicle or other licence |
| Certification or decertification for mental incompetence | Participation in sports |
| Daycare/childcare facility | Passport or visa |
| Employment | University or private school entrance |
| Employment Insurance Program | Vehicle seat belt exemption |
| Insurance purposes | |
10. **Immunization services** available under Ministry of Health programs and immunizations for the provision of travel, employment, insurance, emigration, or at the request of any third party.
11. **Group examinations** or diagnostic services, e.g. refractions, arranged by school unless an agreement has been entered into with the Ministry of Health prior to the services being rendered.
12. **Plastic or other surgery for cosmetic purposes**, e.g. liposuction.
13. **Services for:** reversals of sterilization; electrolysis; anesthesia for uninsured dental procedures, except where the person is under 14 years of age and for the above uninsured surgical procedures.
14. **Autopsy.**
15. **Travelling expenses incurred by practitioners.**
16. **Procedures in the experimental/developmental phase**
17. **Special duty nurse services.**
18. **Post-gastroplasty redundant skin fold removal (thigh and bat wing).**
19. **“Meet and greet” visits:** the first contact with a new patient may occur at a visit which some refer to as a meet-and-greet visit. The physician may use this visit to identify the patient's needs and expectations, take a medical history, and/or disclose information about their knowledge, skills, and limitations of practice, along with the organization of their practice, such as the mode of after-hours operation. The meet-and-greet visit is not an insurable service and the visit should not be used to review the medical history of the patient or otherwise provide medical services. Also see the College of Physicians and Surgeons of Saskatchewan guidelines “Patient-Physician Relationship”.
20. **Pre-departure travel medicine services** rendered solely for the purpose of travel. This includes assessments, counselling or administration of vaccines.

SERVICES NOT INSURED BY THE MINISTRY OF HEALTH

21. **Ultrasound for non-medical reasons:** Physicians must ensure that all diagnostic imaging examinations are ordered and conducted for appropriate clinical indications. Uninsured examples include, but are not limited to:

- Maternal reassurance or supportive care in the case of obstetric ultrasounds;
- Obtaining views of the fetus for the purposes of a picture or video;
- Determining gender of the fetus; or
- Any circumstances not clinically indicated, medically required, or relevant to the diagnosis or treatment of the patient, or both.

Ultrasounds for non-medical reasons such as those listed above are considered by Health Canada to be an unapproved use of a medical device.

Also see the College of Physicians and Surgeons of Saskatchewan policy “Ultrasound for non-medical reasons”.

ASSESSMENT OF ACCOUNTS

The Ministry of Health's assessment of a claim may be determined by referring to the explanatory code in the right hand margin of the payment statement. A review of the explanatory code, in conjunction with the Assessment Rules contained in the Payment Schedule, should enable a physician to determine the reason for a particular assessment.

If a physician does not agree with a particular assessment of an account he/she may:

1. (a) **For general reassessments:**

Complete a Request for Review of Claims Assessment and submit it to:

Supervisor, Claims Analysis Unit

Medical Services Branch

Ministry of Health

By mail:

3475 Albert Street
Regina, SK S4S 6X6

By Fax:

306-798-0582

Request for Review of Claims Assessment forms can be found here:

<https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/ministry-of-health-forms>

(b) **For audit reassessments:**

For services recovered under explanatory codes in the "Routine Audit and Recovery" Section:

Complete a Request for Information and Response Form and submit it to:

Audit Officer / Policy, Governance and Audit

Medical Services Branch

Ministry of Health

By Mail:

3475 Albert Street
Regina, SK S4S 6X6

By Fax:

306-787-3761

By Email:

MSBPaymentsandAudit@health.gov.sk.ca

Request for Information and Response Form forms can be found at this link:

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

ASSESSMENT OF ACCOUNTS

2. If dissatisfied with this review a further review may be requested by **writing** to:

Medical Consultant

Medical Services Branch
Ministry of Health

By mail:

3475 Albert Street
Regina, SK S4S 6X6

By fax:

306-798-0582

3. A physician who is not satisfied with the results of the review by a Medical Consultant, may request a further review by writing to:

The Medical Assessment Board

Medical Services Branch
Ministry of Health

By mail:

3475 Albert Street
Regina, SK S4S 6X6

By fax:

306-798-0582

VERIFICATION PROGRAM

Accounts paid by the Ministry of Health to either physicians or patients, are subject to verification. This in no way implies criticism of persons providing or receiving services but assists in maintaining an efficient public program and as a check to confirm that payments are recorded and paid correctly.

1. Routine Verification

Verification forms are sent to beneficiaries who are asked to complete and return them to the Ministry of Health if the details of services for which payment has been made do not correspond with the services provided. e.g. a service may have been billed for the wrong patient or date;

Where a beneficiary indicates disagreement with details on the verification form, the physician is advised by letter and asked to comment upon the beneficiary's disagreement.

2. Special Verification

Under certain circumstances a special verification may be carried out on a particular range and number of services. The physician concerned, the College of Physicians and Surgeons of Saskatchewan and the Saskatchewan Medical Association are notified at the time of any special verification.

INFORMATION SOURCES

A. CLAIMS ANALYSIS UNIT

1. **General Inquiries** Phone: 306-787-3475 or 1-800-667-7523
Fax: 306-798-0582

- a) Requests for claim forms and standard out-of-province forms.
- b) General information regarding in-Canada and out-of-country services.

2. **Physician Claim Inquiries** Phone: 306-787-3454 or 306-787-3457
Fax: 306-798-0582

- a) Diagnostic coding of claims.
- b) Routine assessment of claims.
- c) Inquiries regarding physician billings and payment of accounts.
- d) Inquiries regarding accounts submitted more than six months after the date of service.
- e) Requests for Review of Claims Assessment; reporting incorrectly billed and paid services.
- f) Billing education, online billing course.
- g) Request for Review of Claims Assessment form can be found at the following link:

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

3. **Processing Support** Phone: 306-787-3470 or 306-787-0182
Fax: 306-798-0582

- a) Specifications for internet claim submissions.
- b) Patient information file on CD.
- c) Diagnostic code and service code files.
- d) General handling or processing of submissions
- e) Identity problems on returned claims.

B. MEDICAL CONSULTANT

Phone: 306-787-8851
Fax: 306-798-0582

- a) Claims assessment support.
 - b) Assessment of complex claims.
 - c) Insurability of a service.
 - d) Review of assessment decisions.
 - e) Medical Assessment Board.
 - f) Services not available in Saskatchewan or Canada – out-of-country coverage.
-

INFORMATION SOURCES

C. FINANCIAL SERVICES

Phone: 306-787-2821
Fax: 306-787-3761
Email: AccountingUnitMSB@health.gov.sk.ca

- a) Direct bank deposit information.
- b) An annual statement of payments made by the Ministry of Health to a physician can be made available at the personal request of the physician at a cost of \$18.00.
Prepayment is required and should accompany your request form.
Please make cheque payable to the Minister of Finance.

Direct Deposit Payment Request and the Physician Request for Income Statement forms can be found online at the following link:

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

D. CASEWORK UNIT

Phone: 306-798-0013
Fax: 306-798-1124
Email: caseworkunitmsb@health.gov.sk.ca

- a) Notifications regarding:
 - 1) change of physician's address
 - 2) entering or leaving clinic or group practice
 - 3) employment of locum
 - 4) incorporating your health care practise
- b) Medical Statements
- c) Agreement for physicians to receive payment direct from the Ministry of Health.
- d) Agreements for computer claim submissions.
- e) Agreement for physicians to receive payment under the Quality Improvement Physician Compensation Program.

E. POLICY, GOVERNANCE & AUDIT

Phone: 306-787-0496
Fax: 306-787-3761
Email: MSBPaymentsandAudit@health.gov.sk.ca

- a) Responsible for all professional review matters.
- b) Physician audits and Joint Medical Professional Review Committee (JMPRC).
- c) Verification of accounts, patients and physicians.
- d) Routine audit of services.

Submission of information should be submitted on a Request for Information and Response form which can be found at the following link:

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

**RECIPROCAL MEDICAL BILLING SYSTEM FORMAT OF
PROVINCIAL/TERRITORIAL HEALTH IDENTIFICATION NUMBERS & CODES**

| Province | Provincial Code | Health Identification Format |
|-----------------------|-----------------|---|
| ALBERTA | AB | 9 DIGIT NUMBER 9 numeric individual registration |
| BRITISH COLUMBIA | BC | 10 DIGIT NUMBER 10 numeric individual registration |
| MANITOBA | MB | 9 DIGIT NUMBER 9 numeric individual registration |
| NEWFOUNDLAND | NF | 12 DIGIT NUMBER 12 numeric individual registration |
| NEW BRUNSWICK | NB | 9 DIGIT NUMBER 9 numeric individual registration |
| NORTHWEST TERRITORIES | NT | 8 DIGIT NUMBER One of the following ALPHA characters D, H, M, N or T (followed by 7 numeric) |
| NOVA SCOTIA | NS | 10 DIGIT NUMBER 10 numeric individual registration |
| NUNAVUT | NU | 9 DIGIT NUMBER 1 followed by 8 numeric individual registration |
| ONTARIO | ON | 10 DIGIT NUMBER 10 numeric individual registration |
| PRINCE EDWARD ISLAND | PE | 8 DIGIT NUMBER 8 numeric individual registration |
| SASKATCHEWAN | SK | 9 DIGIT NUMBER 9 numeric individual registration |
| YUKON | YT | 9 DIGIT NUMBER 9 numeric individual registration |

NOTE: Spaces or “-“ should never be submitted at the start or in the middle of a number.

**PHYSICIAN SERVICES EXCLUDED UNDER THE INTER-PROVINCIAL
AGREEMENTS FOR THE RECIPROCAL PROCESSING OF
OUT-OF-PROVINCE MEDICAL CLAIMS**

The following services should be billed directly to the non-resident:

1. Surgery for alteration of appearance (cosmetic surgery).
2. Gender reassignment surgery.
3. Surgery for reversal of sterilization.
4. Routine periodic health examinations including routine eye examinations.
5. In-vitro fertilization, artificial insemination.
6. Lithotripsy for gall bladder stones.
7. The treatment of port-wine stains on other than the face or neck, regardless of the modality of treatment.
8. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy.
9. Services to persons covered by other agencies: Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada (Federal penitentiaries).
10. Services requested by a "third party".
11. Team conference(s).
12. Genetic screening and other genetic investigations, including DNA probes.
13. Procedures still in the experimental/developmental phase/clinical research.
14. Anesthetic services and surgical assistant services associated with all of the foregoing.
15. Dental services (not including oral surgery) when provided by a dentist.
16. PET Scans
17. Gamma Knife
18. Telemedicine services.

The Ministry of Health Explanatory Codes For Physicians

INTRODUCTION

The alphabetic code listed in the payment list or file, reject file or returned claim identifies the related explanation.

PATIENT IDENTIFICATION

- AA** Not registered--no record of this person under this number. Please recheck the patient's Health Services Card.
- AC** Incorrect sex indicated on claim-Medical Services Branch (MSB) has paid this claim. Please use the sex shown on the Health Services Card for future claims.
- AD** Incorrect Health Services Number indicated on claim-Medical Services Branch (MSB) has paid this claim. Please use the number shown on this payment file/list for future claims.
- AE** Incorrect date of birth indicated on claim-Medical Services Branch (MSB) has paid this claim. Please use the birth date shown on the Health Services Card for future claims.
- AF** Please review this claim, the Health Services Number is inconsistent with the name, sex or birth date on the Health Services Card.
- AG** This claim is for a newborn (child less than one year old). The newborn may not be registered yet/or the patient identification data is incorrect. Please ensure the beneficiary data is correct or that the parents/guardians contact Health Registration, 2130 11th Avenue, Regina, S4P 0J5 in order to have the newborn registered.
- AH** Please review this claim. Our records indicate that the beneficiary registered under this number died prior to the date of service.
- AJ** The services involving emergency room coverage cannot be paid as:
- 1) The physician is not eligible to bill these codes;
 - 2) Another physician has been paid for the same time period in this community;
 - 3) The incorrect dummy HSN has been used for this community;
 - 4) An incorrect clinic has been used for this community;
 - 5) Another ICD code must be used for regular services provided to a beneficiary; or
 - 6) An incorrect service code, day of the week or amount has been used.
- AL** This claim was received at the Ministry of Health prior to the date of service indicated on the claim.
- AM** A letter sent to this patient by Health Registration regarding the validation renewal stickers has been returned. This patient will not have coverage after January 31. When you next attend to this patient, please advise him/her to immediately contact Health Registration at 1-800-667-7551 or 306-787-3251 to have their coverage updated. Please ignore this message if the patient now has a new expiry sticker.

The Ministry of Health Explanatory Codes For Physicians

- AO** A letter sent to this patient by the Ministry of Health has been returned. Therefore, the patient's coverage has been terminated. On your next contact with this patient, please advise the patient to immediately contact Health Registration at 1-800-667-7551 or 306-787-3251 to have their coverage updated.
- AP** The 9-digit Health Services Number is incorrect. Please recheck your files and/or the patient's Health Services Card.
- AQ** This claim was previously assessed by a medical consultant based on the report received. Please do not re-submit the same report. If you wish to request a review of this decision, please submit the additional information, including the reasons and details of the request, on a Request for Review of Claims Assessment form and fax to 306-798-0582 or mail to: Medical Consultants, Medical Services Branch, 3475 Albert Street Regina SK S4S 6X6
- AR** Patient not registered for coverage on this date of service. Please check the effective and expiry dates on the Health Services Card.
- If the patient is a resident, he/she should immediately contact Health Registration, phone 1-800-667-7551 or 306-787-3251, 2130 11th Avenue, Regina, S4P 0J5, in order to have coverage updated.

GENERAL

- AS** Your account had to be split for processing. Payment for the listed services was approved based on the Ministry of Health's Payment Schedule.
- AT** Diagnosis and Payment Schedule item are not compatible.
- AU** To assist in the assessment of this service please submit a request for review of claims assessment form with a copy of the operative report, medical record or a descriptive letter.
PLEASE NOTE:
- If an operative report is being submitted, it must contain surgical start & end times.
 - The run code and claim number must be included.
 - The claim itself should not be resubmitted electronically.
- AV** This service is not insured.
- AW** This Payment Schedule service code applies to a certain location of service; the location of service you submitted is not compatible.
- AX** A Medical Consultant has reviewed this claim. The circumstances described are not considered sufficient to warrant additional payment.
- AY** Assessed by a Medical Consultant.
- AZ** Please refer to correspondence.

The Ministry of Health Explanatory Codes For Physicians

- BA** Duplicate--same physician--payment has been made for the same service provided on the same day. Please check your records for a duplicate payment and only resubmit the claim if the service has not been previously submitted and paid.
- BB** Possible duplication of a payment for a similar service. If no duplication, please resubmit with a note in the "Remarks" area on the claim or a comment record in the automated claim submission.
- BC** Duplicate--same clinic--payment has been made to another physician in your clinic for a similar service on the same day. Please check your records for a duplicate payment and only resubmit the claim if the service has not been previously submitted and paid.
- BD** The beneficiary has been paid for a similar service provided on the same day.
- BE** This Payment Schedule service code applies to a specific age or sex.
- BF** Adjustment based on correspondence - Re: "Audit of Services".
- BG** This Payment Schedule service code was submitted at less than the listed rate.
1) If this claim has been returned to you, please correct and submit at the current rate.
2) If this claim has been adjusted by Ministry Officials, the appropriate rate for the date of service has been approved.
- BH** Payment Approved at:
1) Listed rate for a specialist in your specialty.
2) Equivalent service code and fee listed in your specialty.

Re: Definition of "Specialist".
- BI** Paid at the unreferral rate because of one of the following:
1) The referring physician has not practised in Saskatchewan during the past two years;
2) The 4-digit referring doctor is not valid;
3) We could find no record of the "referring physician" being licensed to practice; or
4) No referring doctor number was submitted.
- BJ** Payment for this item can only be made if the patient was referred and the 4-digit referring doctor number is indicated in the appropriate field. Please re-submit:
1) if referred, with the 4-digit referring doctor in the appropriate field;
2) if unreferral, using appropriate code and fee.
- BK** Payment based on the service code and related payment approved by the Ministry of Health.
- BL** Please be advised:
1) This service is currently being discussed with the Saskatchewan Medical Association Tariff Committee; OR
2) This item is not currently an insured service; please contact the Saskatchewan Medical Association Tariff Committee to apply for a new service code.
- BM** Unilateral/bilateral procedure--please re-submit indicating left/right or bilateral.

The Ministry of Health Explanatory Codes For Physicians

- BN** You were asked for additional information to assess this claim, no reply received -- without this information, the claim cannot be processed.
- BO** The approved service code and payment is based on your description of the service.
- BP** Payment adjustment based on:
- 1) your resubmission;
 - 2) our review of assessment; OR
 - 3) information received on Review of Claim Assessment form.
- BQ** The service code and/or amount submitted are incorrect. Please review and resubmit.
- BR** Invalid service code -- please review.
- BS** The service code submitted is not correct for the condition described; or the service(s) provided.
- BT** Approved at the maximum amount consistent with your description of the service provided.
- BU** Payment not approved for:
- 1) Surcharge alone;
 - 2) Surcharge with:
 - a) another surcharge code: 615A, 721A, 815A, 816A, 817A, 818A, 819A, 836A, 837A, 838A, 839A or 915A;
 - b) Service codes 41A, 56A, 60A, 70A, 71A, 74A, 80A, 81A, 153A-156A, 184A, 190A-198A, 600A, 626A, 680A, 681A, 708A-710A, 714A-718A, 725A-727A, 753A, 770A-770A, 42B-44B, 60B-68B, 73B, 85B, 200B, 205B, 206B, 207B, 30D, 31D, 32D, 130D, 131D, 145D, 278D, 279D, 281D-285D, 290D, 291D, 320D, 43E, 142E, 144E, 400H-424H, 667H, 80J-81J, 278K, 279K, 452L, 31M, 42O, 44O, 260P, 261P, 300T;
 - c) hospital care codes, including newborn care, supportive care (52B-53B) ;
 - d) a pre-arranged service; and
 - e) phone calls or faxes (70A, 761A-769A and 790A-795A).
 - 3) Surcharge for an extra patient not paid for the day and time indicated.
 - 4) Premium service codes should not be submitted based on the eligible service codes being paid. They are automatically generated by the Ministry of Health.
 - 5) Surcharges for emergency room physicians providing emergency room shifts or first on-call services.
 - 6) Hospital care surcharge: 700A for non-statutory holidays, and 701A if not Saturday or Sunday.
 - 7) Extra patient surcharge not paid with 335H to 339H. Initial patient surcharges paid only once per patient per day.
- BV** Payment based on the appropriate service code and amount listed for the date provided.
- BW** Billed more than listed payment - appropriate payment for the date of service has been approved.

The Ministry of Health Explanatory Codes For Physicians

- BX** This is a time-based service:
- 1) Time requirements have not been met; therefore, no payment can be made; or
 - 2) The service code descriptor states “greater portion thereof” or “major portion thereof”, and the greater/major portion of the time component has not been met; therefore, the additional time units are not payable.
- BY** Payment on a time basis--please designate the treatment time and resubmit.
- BZ** Payment is based on the amount payable to a Saskatchewan physician in the same specialty providing the same or similar service.

SERVICES NOT INSURED BY THE MINISTRY OF HEALTH

- CA** Medical examinations, services and provision of certificates or reports requested by a third party, e.g. for:
- Attendance at camps
 - Autopsies
 - Daycare
 - Employment
 - Employment Insurance Program
 - Insurance
 - Judicial purposes (other than adoption or commitment)
 - Motor vehicle or other license (MSB pays some services for SGI)
 - Participation in Sports
 - Passport or Visa
 - Seat belt exemption
 - Third party counselling
 - University or private school entrance
- CB** Materials & other services--e.g.:
- Acupuncture
 - Advice by telephone or letter(most)
 - Ambulance services
 - Anesthetic materials
 - Appliances (Prostheses)
 - Casts
 - Committee or Advisory service
 - Contractual Service for a government department or agency
 - Dentistry
 - Dressing or medication
 - Drugs
 - Eyeglasses or Contact Lenses
 - Facility fee
 - Medical testimony in court
 - Medical-legal opinion and report
 - Secretarial or reporting fee(s)
 - Services by a special duty nurse
 - Surgical supplies
 - Travel by a physician
 - Tray service (see service codes 897L and agency 899L for description)
- CC** Immunization services--when available under the Ministry of Health programs. If this patient was referred by the Ministry of Health personnel or there are medical factors which prohibited immunization under the Ministry of Health programs, please resubmit with an explanation.
- CD** Hospital Services:
- 1) Services provided by:
 - a) Hospital personnel; or
 - b) Any out-patient facility having a contract with the Ministry of Health.
 - 2) The technical component of a diagnostic procedure performed in a hospital utilizing hospital equipment, e.g. ECG, EEG

The Ministry of Health
Explanatory Codes For Physicians

- CE** A service by a physician who is not registered with or licensed by the appropriate agency of the Province, State or Country on the date the service was provided.
- CF** This service code is not valid for this date, because it is either:
- 1) Prior to implementation; or
 - 2) After deletion from the Payment Schedule.
- CG** The College of Physicians and Surgeons has declared it unethical for a physician to bill for services provided to him(her)self, spouse or children.
- CH** These services appear to be the responsibility of the Department of Veteran's Affairs (DVA.).
- Please send the appropriate form to DVA:
Treatment Benefit Unit, Box 6050, Winnipeg, R3C 4G5.
 - If they do not accept responsibility, please resubmit the claim electronically with the comment "Not responsibility of DVA".
- CI** The service provided cannot be paid for an out-of-province beneficiary; it is on the excluded list of services for reciprocal billing purposes or it cannot be billed under the reciprocal billing process.
- CJ** Our records indicate this patient was not in the hospital on this date. If this information is incorrect, please resubmit with the admission and discharge dates.
- CK** This service is not insured - our records indicate that the beneficiary died more than 30 days prior to date of service.
- CL** In-hospital services for which payment may be funded by the Ministry of Health.
- CM** Claims received more than six months after the date of service. A resubmitted claim must be returned within 1 month. If factors beyond your control prevented submission within 6 months, the following details must be received in writing addressed to the Manager, Claims Unit (fax: 306-798-0582):
- 1) List of claims for which you are requesting the time limit approval;
 - 2) Service codes and dollar amounts;
 - 3) Number of patients;
 - 4) Dates of service;
 - 5) Circumstances for the delay in submitting your accounts; and
 - 6) Date of submission.
- CN** Claim received more than twelve months after the date of service cannot be accepted for any reason.
- CO** Date of Service is prior to:
- 1) The physician's registration date; OR
 - 2) The effective specialty date as indicated by the College of Physicians and Surgeons of Saskatchewan.
- CP** Our latest information from the College of Physicians and Surgeons of Saskatchewan indicates that you are registered in Saskatchewan as a General Practitioner.

The Ministry of Health Explanatory Codes For Physicians

- CS** Department of Veterans' Affairs - has advised the Ministry of Health that they have paid you for this service.
- CT** Workers' Compensation Board has advised the Ministry of Health that they have paid you or another physician in your clinic for the same service, a similar related service or a service which includes post-operative care.
- CU** Payment is based on one of the following:
- 1) Payment is only approved for those physicians listed by the College of Physicians and Surgeons of Saskatchewan, State Board, Saskatchewan Health Authority or Saskatchewan Medical Association Tariff Committee in their practice locale as having qualified to receive payment for this service or approved according to requirements listed for a particular service code.
 - 2) List I and II laboratory services are only payable when provided in a medical laboratory which holds a Category I licence issued pursuant to The Medical Laboratory Licensing Act.
- CW** These services appear to be the responsibility of the Workers' Compensation Board (WCB.). Please submit a claim to the WCB. at Suite 200 - 1881 Scarth Street, Regina, S4P 4L1. If they do not accept responsibility, WCB. will forward the claim to you. If the claim has not yet been paid, please submit an automated claim to MSB with a comment "Not WCB" followed by the date submitted to and rejected by WCB.
- CY** This service not usually billed by a physician in your specialty.
- CZ** Service Code of 20A can be on the same claim number as visit codes, laboratory services, 131A, 204A, 205A, 206A, 30D, 31D, 32D and 815A-839A. Also a diagnostic code of Z90 should only be used in conjunction with a claim containing a service code of 20A.

VISITS

- DA** Only one visit type service is approved during a single patient contact. If there were 2 separate patient contacts, please resubmit with the reason and time of the second visit.
- DB** Please clarify the second visit on the same day by the same physician or the same specialty and clinic.
- DC** Multiple diagnoses during a single patient contact. Another agency appears to be responsible for the assessment and/or treatment of one condition. Payment of services for another condition is not approved.
- DD** Please verify date(s) of service and resubmit.
- DE** Included in the payment for another service provided during the same physician/patient contact.
- DF** Codes 64B-68B and **207B** are only payable once per patient every 90 days; we have adjusted your payment to a similar visit service.

The Ministry of Health Explanatory Codes For Physicians

- DG** Please resubmit under the Health Services Number of the patient to whom you provided the service.
- DH** Please identify the person(s) interviewed, e.g., wife, son, employer, teacher, etc.
- DI** A return visit on the same day by either the same physician or another physician in the same specialty and clinic for the purposes of reviewing or taking of x-rays and/or ultrasounds is regarded as an inclusion in the first visit service.
- DJ** Third party counselling billed under codes 40B/41B must be billed under the name of the person counseled, not the patient.
- DK** Third party counselling billed under codes 15C/16C must be billed under the name of the child (not the parent/caregiver/relative, etc) regardless of who is being counselled.
- DL** Surcharge 721A applies to a life-threatening situation and admission to hospital -- the information given on your claim does not indicate the necessity for an immediate "STAT" response regarding a life-threatening situation.
- Your surcharge may have been adjusted to another surcharge based on the information provided. If resubmitting, please provide further information or submit under an alternate surcharge.
- DM** Payment is made for this visit when provided in the physician's office only when the claim confirms a "Visit - Specially Called" made after regular office hours or on a holiday. Please resubmit with explanation.
- DN** Surcharge 721A does not apply where the patient is already hospitalized.
- DO** Our record and your service description indicate that this service appears to be inconsistent with the definition of a special call.
- DP** Service codes 220A-226A, 918A, 919A, 926A-928A, 335H to 339H and most 400H-424H services - include all services provided during this time. Payment based on your description of services.
- DQ** Additional patient--payment has been previously approved for a special call made to another patient at the same location on the same date.
- If you were "specially called" a second time and returned to provide this specific service please resubmit for the difference in payment under the initial service code with a notation confirming the return visit.
- DR** Service codes 220A-226A, 918A, 919A, 926A-928A, 335H-339H relate to the time actually spent with the patient, and all services provided during this time.
- Please indicate:
- 1) Time when service started and was completed.
 - 2) Clinical factors necessitating the personal attendance/indirect care/resuscitation.
 - 3) Services provided during that time.

**The Ministry of Health
Explanatory Codes For Physicians**

- DS** Service codes 220A-226A and 918A are not paid when other service codes apply.
- DT** Continued hospital care—payment is based on continuous hospital care.
1) Assessment Rules – “Hospital Care”, #2.
- DU** Our records indicate that the beneficiary was a hospital in-patient on the date of service.
a) Payment adjusted to the appropriate item for hospital care.
b) Payment rejected. Please verify location of service.
- DV** 926A applies to the actual time spent in transit with the patient. Please resubmit indicating:
1) Location from which patient was transferred,
2) Location of hospital to which patient was transferred,
3) Times of departure and arrival.
- DW** Multiple visits--hospital--the payment for daily in-hospital care is a maximum regardless of the number of visits made by the physician.
1) Assessment Rules - "Hospital Care", #1.
- DX** Concurrent care -- payment has been made to another physician for daily hospital care for this period. Payment to a second physician is only approved when a satisfactory explanation is provided that care by two physicians was required.
- DY** Special Call or emergency visit--in-hospital care- will not be approved for a hospital in-patient without additional information.
Please resubmit with an indication of the factors requiring the visit.
Re: "Assessment Rules" - "Hospital Care", #4.
- DZ** "READMISSION" must be indicated in order to be eligible for the higher rate of payment when a patient is readmitted within 14 days.
Re: Assessment Rules - "Hospital Care", #2.

CONSULTATIONS

- EA** Consultation converted to a repeat.
Re: Assessment Rules - "Consultations", #6 (a) and (f).
- ED** A Medical Consultant has reviewed this claim. The diagnosis does not seem to indicate the necessity for a Consultation.
If resubmitting, please provide a copy of the consultation report.
- EL** Consultation converted to a partial/follow-up assessment.
Re: Assessment Rules - "Consultations", #6 (b).
- EM** Complete/initial assessment converted to a partial/follow-up assessment.
Re: Assessment Rules - "Consultations", #6 (c), (e), and (g).
- EN** Consultation converted to a complete/initial assessment.
Re: Assessment Rules - "Consultations" - #6 (d) and #7.

The Ministry of Health
Explanatory Codes For Physicians

- EO** An initial in-hospital consultation on the same day or within 42 days after a complete/initial assessment is converted to a complete/initial.
- EP** An initial in-hospital consultation on the same day or within 90 days after another consultation is converted to a complete/initial assessment.
- ER** Your claim has been assessed based on one of the following:
- 1) A previous 52B has been paid for this admission; only 1 payable. If this is a readmission, resubmit indicating the date of admission/discharge
 - 2) Second 53B is not payable within six days.
 - 3) This patient does not appear to be under the care of a specialist; please resubmit with the name of the attending specialist.
- ES** A follow-up visit on the day of a 42-day elective procedure, is not approved when seen by the physician within the previous 30 days
- ET** Per "Hospital Care" item (2): Payment will be made as if hospitalization has been continuous when a patient is transferred during the same admission to either a specialist in the same specialty or a general practitioner. Consultations and visit services are not payable for transfers of care in these circumstances.

PROCEDURES

- FA** Paid at the greater of the procedure or visit/consultation.
- 1) Assessment Rules - "Multiple Services", Rule 1.
 - 2) Payment Schedule Listing.
- FB** Minor procedures for which no payment is listed are considered an inclusion in the visit or consultation.
- FC** Second procedure paid at 75% when performed bilaterally.
Re: Assessment Rules - "Multiple Services", Rule 5.
- FD** This service code is listed as a bilateral procedure. Therefore, only one (1) is payable per patient contact.
- FE** The greater payment approved:
- 1) Procedure not approved in addition to another service.
 - 2) Included in the payment for the procedure.
 - 3) Assessment Rules - "Multiple Services", Rule 1.
 - 4) Payment Schedule listing.
- FF** Maximum approved--this service with prior services by the same physician or clinic would exceed the maximum.
- FG** Multiple interpretations billed on the same date. Please resubmit indicating if these interpretations are for tracings done on different days, the time and reason for multiple interpretations.

The Ministry of Health Explanatory Codes For Physicians

- FH** Technical component not approved. In order for a physician to be eligible for payment of technical fees:
- The physician must personally own the equipment and employ staff performing the testing (if testing is being performed by staff) as technical components are intended to offset physician costs associated with performing the service. If physician owns equipment and employs staff, please resubmit with this information.
 - It must not be performed in any part of a hospital. Only the interpretation component can be approved when this service is provided in any part of a hospital. If not provided to either an inpatient or an outpatient, please resubmit designating the locale.
- FI** Considered an inclusion within the payment for a related procedure.
- FK** Echocardiography service code and payment is adjusted or rejected based on prior services by the same physician or clinic in accordance with annual maximums.
- FM** Approved only with specified services as listed in the Payment Schedule.
- FP** A "0" or "10" day Procedure billed in addition to a visit (including hospital care) or consultation--approved at the greater of:
- 1) The procedure alone; OR
 - 2) The visit plus the procedure at 75%.
- Re: Assessment Rules - "Multiple Services", Rule 2.
- FS** Approved as repeat procedure--previously paid to you or to another physician in the same specialty and clinic.
- FT** Code 34F, PUVA therapy, is paid once only on alternate days. Repeat billings are converted to 150A.
- FY** A code and a fee have been approved by the Ministry of Health that are not yet available for billing. A temporary code has been used to process your claim.
- FZ** The calculated premium is based on the submitted service code and is paid as the premium approved service code. The amount has been calculated using the appropriate premium percentage multiplied by the approved amount plus the age (or pediatric) supplement when calculating time of day premium of the eligible service code

MEDICAL CONSULTANT REVIEW OF CLAIMS

- GA** This claim has been assessed by a Medical Consultant. No further action will be undertaken by MSB unless further review is formally requested in accordance with the policy outlined under "Assessment of Accounts" – point 1(a) - of the Physicians Payment Schedule. Requirements for review by a Medical Consultant are:
- Written request for review including rationale for additional consideration;
 - New Information which supports Request for Review; and/or
 - Operative Record indicating start and stop times for procedure.

The Ministry of Health Explanatory Codes For Physicians

GB This claim has been reviewed by a Medical Consultant. The documentation provided does not support the code(s) submitted. No further action will be undertaken by MSB unless new information is submitted which supports the claim(s).

GC This claim is being reviewed by a Medical Consultant; please provide a copy of the medical record/operative report with operative record within 30 days to support billing. Do not resubmit claim electronically. For inquiries related to this request, contact the Claims Analysis Unit at 306-798-3454, option 2.

ANESTHESIA

HA Based on the total payment (calculated at the specialist rate, regardless of "repeat surgery rule" or surgery by a general practitioner) for the procedure(s) performed.
Re: Section "H", item 3.

HB Service converted to the appropriate service code for the start-up approved.

HC Another service provided during a period of intensive care has been paid in lieu of that period of 335H-339H or 420H-424H series.

HD "Standby" - Please indicate:

- 1) The physician who requested the "standby",
- 2) The commencement and completion times of both the "standby" and the anesthesia, and
- 3) The services provided during the "standby".

Re: Section "H", item 7.

HE Included in payment of anesthesia. E.g., Consultation is not approved to the physician who also provided Anesthesia same day. Re: Section "H", item 1 and 2.

HG Paid as a second anesthetist. Re: Section "H", item 6.

HH This service, with previous 335H-339H or 400H – 424H services, exceeds the listed maximums (see Payment Schedule). Adjusted to the approved service code and fee.

HL Payment for general anesthesia for dental procedures outside a hospital restricted to specialists in anesthesia.

- 1) Definitions -- "Specialist".
- 2) Information for Physicians -- "Services Not Insured by the Ministry of Health".

HN Nerve Blocks, Section H.

1. Greater payment approved -- nerve block and other service(s).
2. Nerve blocks are not payable in addition to a surgical procedure on the same day when provided by the same surgeon:

See explanatory codes KB and KH; and

Assessment Rules, "Procedures", item 3 (c).

HO Greater payment approved -- Pain Clinic and other service.

HP Epidural anesthesia provided during labour and delivery should be billed as service codes 600H, 601H, and 667H.

HQ Approved only for services by a specialist in a designated Pain Clinic

The Ministry of Health Explanatory Codes For Physicians

SURGICAL ASSISTANCE

- JA** Payment for assistance is not approved for this procedure unless special circumstances satisfactory to the Ministry of Health are described. Please provide details.
Re: Section "J", item 2.
- JB** The additional time code did not correspond with the base code.
- JC** Payment is to be based on the induction of anesthetic to when the surgical assistant is no longer required – payment has been adjusted based on billed anesthetic time
- JD** Assistant standby not paid if assistant fees are billed.
- JE** Payment for more than one surgical assistant is not approved for this type of surgical procedure unless special circumstances satisfactory to the Ministry of Health are described. Re: Section "J", item 3.
- JF** We are unable to process this claim as the surgery claim has not been received. Please contact the surgeon to submit the surgical claim, and then resubmit your claim.
- JG** 1) 80J/81J are for office-based physicians who earn less than 50% of their income submitted and paid through the MSB billing system from surgical assisting.
2) 80J/81J is for scheduled surgeries performed between 8:00 am and 5:00 pm, Monday to Friday.
- If your claim has been rejected or converted to another surgical assistance code, it is because:
- The service was not provided between 8:00 and 5:00 pm Monday to Friday;
 - The service was billed with a premium location (B, K, M, C);
 - The service was billed with a surcharge (815A-839A);
 - The physician was not eligible to bill this service because he does not earn less than 50% of his/her income through surgical assisting;
 - The service was billed on a statutory holiday or weekend.
- JH** Service codes 540H, 545H, 580H, and 585H are not billable by the surgical assistant with "J Section" codes. These service codes are only payable to the anesthetist who is providing the anesthetic service with H section codes.
- JJ** BMI supplements are not billable by the surgical assistant with "J Section" codes.

PROCEDURES

- JM** Control of post-op hemorrhage in the first 24 hours is included in the composite fee for the surgical procedure.
- JN** Considered an inclusion within the payment for a more major procedure.

The Ministry of Health Explanatory Codes For Physicians

- JO** Paid in accordance with rules for two or more procedures performed on the same day by the same physician, another physician in same specialty and clinic or part of the surgical team. Re: Assessment Rules - "Multiple Services", Rule 8.
- JP** Claim is being rejected because this code has been billed and paid to another physician.
- JQ** Paid at the maximum listed for these multiple procedures. Re: Payment Schedule item.
- JR** Paid at 1/3 of listed payment when a surgical procedure is performed by 2 specialists and payment is not defined for the second surgeon.
- JS** Complex incisional hernia with Inlay mesh (246L):
1. Your claim is being rejected because you have not included the payment criteria as required under code 246L.
2. Your claim is being converted to 245L "incisional hernia" because the payment criteria have not been met; please do not resubmit this claim.
- JT** The bilateral procedure payment is approved when unilateral procedures are staged during the same hospital admission. Re: Assessment Rules - "Multiple Services", Rule 9.
- JW** Paid as a repeat or related procedure within the designated post-operative period.
Re: Assessment Rules - "Multiple Services", Rule 10.
- KA** An inclusion in the payment for the procedure when provided by the same physician, another physician in same specialty and clinic or part of the surgical team.
1) Assessment Rules - "Procedures", items b and d - "Multiple Services", Rule 8 (a).
2) Various Payment Schedule items.
- KB** The anesthetic is an inclusion in the surgical fee when provided by the same physician.
- KC** Initial visit or consultation provided on the same day as a 42 day procedure is converted to a partial/follow-up visit.
- KH** Only the greater payment is approved when a physician acts in more than one capacity, e.g. anesthetist, assistant or surgeon.
- KM** Diagnostic procedure on the day of a "42" Day procedure approved at 75%. If the diagnostic procedure is a greater value than the 42 day procedure, the diagnostic procedure is payable at 100% and the 42 day procedure at 75%.
Re: Assessment Rules - "Multiple Services", Rule 6.
- KN** Related diagnostic procedure during the designated post-operative period of a "10" or "42" Day procedure approved at 75%.
Re: Assessment Rules - "Multiple Services", Rule 7.
- KO** The two days of pre-operative care in hospital are included in the payment for a "10" or "42" Day procedure.

The Ministry of Health Explanatory Codes For Physicians

- KP** Visit (including hospital care) or consultation, same day, is included in the payment for a "42" Day procedure when provided by the same physician, another physician in same specialty and clinic or part of the team.
Re: Assessment Rules - "Multiple Services", Rule 3.
- KQ** Inpatient visits (including hospital care) or consultation during the designated post-operative period of a related "10" or "42" Day procedure is included in the payment for procedure when provided by same physician, a general practitioner in the same clinic or a specialist in the same specialty and clinic.
Re: Assessment Rules - "Multiple Services", Rule 4.
- KR** Only one special call is approved per major surgical procedure or dislocation.
- KS** Codes 232L and 142P are only payable for Malignancy. Code 142P is only payable in addition to 123P or 134P.
- LA** 348L included in payment for 355L.
- LB** The 898L is for removal of sutures and/or staples from lacerations or surgical incisions (i.e. 10 or 42 day procedures).
- LC** 890L - 895L -- please indicate:
1) The total length of the lacerations by site.
2) The length of the facial component of any laceration extending from facial to non-facial area. Re: Payment Schedule items.
- LD** Approved only with specified services as listed in the schedule under payment item 897L, 899L, 181S or 300T, where provided in a physician's office.
- LE** Please identify the site and extent of burn area. Re: Payment Schedule item.

ORTHOPEDICS

- MB** Included in the "composite" paid for the initial immobilization or closed reduction.
1) "Fractures", items 1, 2 and 3
2) "Dislocations", items 1 and 2.
- MC** Maximum for undisplaced fracture. Re: "Fractures", item 2.
- MD** Paid as closed reduction plus 50%. Re: "Fractures", item 3(c)(ii).
- ME** When an "open reduction" or a "closed reduction with external fixation" is performed by any physician within the post-operative period of a previous attempted reduction, the payment for the prior fracture is reduced by 50%.
1) "Fractures", item 3(c)
2) "Dislocations", item 2.

The Ministry of Health Explanatory Codes For Physicians

- MF** Payment for the previously attempted reduction is reduced by 50%.
1) "Fractures", item 3(b)
2) "Dislocations", item 2.
- MH** Reduction of a dislocated hip within the post-operative period is included in the arthroplasty payment.
- MI** "Fracture" and "dislocation" - same date - same site - greater payment approved.
- ML** 133M: the source of the autogenous bone from a different site has not been identified.
- MM** 31M, 32M, or 33M: NOT paid in addition to, or part of, another orthopedic procedure, performed through the same or extended incision by any physician.
- MP** Synovectomy not paid in addition to major joint surgery.
- NB** Care provided for cosmetic purposes is not an insured service.
Re: Information for Physicians - "Services Not Insured by the Ministry of Health."
- NC** 382N & 383N--restricted to a "plastic surgeon" treating a referred patient; 890L approved.
- ND** 287N for reconstruction of nose not paid in addition to rhinoplasty. April 1, 2013 IN.44

OBSTETRICS & GYNECOLOGY

- PA** Delivery bonus for GP physicians only – additional 25% payable on the first 25 of either 41P or 42P services in each year beginning April 1.
- PB** Included in the payment for delivery and post-natal care in hospital.
Re:"Obstetrics", item 4(a-g).
- PC** A therapeutic abortion code (50P, 250P) was billed with an office location.

Codes 50P (first trimester) and 250P (second trimester) are designated as '42-day' surgical procedures and can only be billed for the provision of performing surgical abortions. If a surgical procedure was performed, please resubmit with the correct location of service (outpatient or inpatient).

Prescribing or administering pharmaceutical agents such as **Mifegymiso** are included in the visit service and there is no additional billing. Please do not resubmit in these circumstances.
- PG** 42P approved - patient was turned over to consultant who provided the delivery.
Re: "Obstetrics", item 2.
- PH** 40P or 41P is only approved for the delivery of a viable fetus of 20 weeks or more.
- PI** Only one special call surcharge is approved per confinement (case).

The Ministry of Health Explanatory Codes For Physicians

- PL** Payment approved as subsequent pre-natal or post-natal care.
- PS** Two complications of pregnancy may be claimed per patient per pregnancy. Report required for more than 2.
- PU** Continuous personal attendance is not paid with a delivery

INCORRECT FEES

- QA** 1. The claim submitted has hospital dates that span two different Payment Schedule rates. Please resubmit claim(s), with correct fees for the date(s) of service; or
2. This claim has laboratory services and an ECG service; please resubmit with the ECG on a separate claim.
- QB** The fee submitted is incorrect for the Payment Schedule rate in effect on the date of service. Please update your system with the current Payment Schedule rate(s) OR if you've already updated your system with the new rate(s), please check the date of service if it is prior to the effective date of the new rate, and then resubmit your claim with the correct fees.
- QC** Number of units submitted is incorrect. Either this service does not have units or the number of units is greater than listed in the Payment Schedule. Resubmit with the correct number of units and fee. Services which do not have units must be submitted on an individual line.
- QD** 700A is only billable on a Statutory holiday (or on the day designated in lieu, when the statutory holiday falls on a Saturday or Sunday). 701A is only billable on a Saturday or Sunday. Resubmit with the correct date of service.

ROUTINE AUDIT AND RECOVERY

NOTE: All information and patient records being submitted as a result of a routine audit (all explanatory codes in the Routine Audit and Recovery section) should be forwarded to Policy, Governance and Audit (PGA):

Policy, Governance and Audit:

Phone: 306-787-0496 / Fax: 306-787-3761

Email: MSBPaymentsandAudit@health.gov.sk.ca

On the following form : Routine Audit – Request for Information and Response form

<https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx>

- RA** To assist Ministry officials in the routine monitoring and review of practitioner payments, please provide a copy of the medical record and/or the appropriate documentation within 30 days to support this billing.
- RB** This adjustment is being made as a result of a routine audit undertaken by Policy, Governance and Audit of Medical Services. For inquiries related to this payment, contact PGA.
- RC** This claim is being returned. Policy, Governance and Audit will adjudicate this claim and make the appropriate adjustment if warranted. Do not resubmit electronically. For inquiries, contact PGA.

The Ministry of Health Explanatory Codes For Physicians

- RD** This service appears to have been pre-planned/pre-arranged. If the claim was billed with a surcharge (815A-839A or 721A), please provide within 30 days:
- 1) the time of day that the service was provided;
 - 2) the physician's location when he/she was called out; and
 - 3) the reason for the special call.
- RE** This service was billed with a time-of-day premium (B, C, D, E, F, K, M, P, T). Within 30 days, please provide the time that the service was provided.
- RF** A special call/surcharge (815A to 839A) was billed. Within 30 days, please provide:
- 1) the time of day that the service was provided;
 - 2) the physician's location when he/she was called out; and
 - 3) the reason for the special call.
- RG** This service is being recovered or converted as a result of a routine audit pertaining to **540H** (anesthetic premium for cases starting before 5:00 p.m. and ending after 5:00 p.m.).
- a) If you have indicated that the anesthetic start time was before 5:00 pm on a weekday, **AND** you have billed 500H-507H with a time-of-day premium (B, C, K, M, etc), the service is not eligible for a time-of-day premium and your claim is being converted to a non-premium location of service.
 - b) If you have indicated that the anesthetic start time was after 5:00 p.m. on a weekday, then 540H is not eligible for payment and this service is being recovered.
 - c) If you have not indicated a start time, please provide the start time and submit to PGA for review
- RH** This service is being recovered or converted as a result of a routine audit pertaining to **545H** (anesthetic premium for cases starting before 12:00 a.m. and ending after 12:00 a.m.).
- a) If you have indicated that the anesthetic start time was before 12:00 a.m., **AND** you have billed 500H-507H with a time-of-day premium (K, M), the service is not eligible for a 100% time-of-day premium and your claim is being converted to the appropriate premium (B, C).
 - b) If you have not indicated a start time, please provide the start time and submit to PGA for review.
- RI** This service is being recovered as a result of a routine audit pertaining to injection services. If this service is for a routine, regularly scheduled visit for the purpose of providing an injection service (110A, 131A, 161, etc), please resubmit as the appropriate injection code.
- If the partial assessment (5B) was medically required and meets all the payment schedule criteria, submit to a copy of the medical record to PGA for review within 30 days. See PGA contact information in preamble above.

The Ministry of Health Explanatory Codes For Physicians

RJ The Ministry of Health performs post-JMPCR audits to ensure compliance with the Joint Medical Professional Review Committee's recommendations, and to ensure that the service codes submitted to the Ministry for payment meet the requirements as set out in the Physician Payment Schedule, the physician's Direct Payment Agreement with Medical Services Branch and *The Saskatchewan Medical Care Insurance Act*.

To assist Ministry officials in the routine post-JMPCR monitoring and review of physician payments, please provide a copy of the medical record and/or the appropriate documentation to support this billing. Please see correspondence from Policy Governance and Audit (PGA) if more information is required. See PGA contact information in preamble above.

RK The Ministry of Health performs post-JMPCR audits to ensure compliance with the Joint Medical Professional Review Committee's recommendations, and to ensure that the service codes submitted to the Ministry for payment meet the requirements as set out in the Physician Payment Schedule, the physician's Direct Payment Agreement with Medical Services Branch and *The Saskatchewan Medical Care Insurance Act*.

- An adjustment has been made to pay this claim as previously submitted and paid.
- No further information is required.

Please see correspondence from Policy Governance and Audit (PGA) if more information is required. See PGA contact information in preamble above.

RL The Ministry of Health performs post-JMPCR audits to ensure compliance with the Joint Medical Professional Review Committee's recommendations, and to ensure that the service codes submitted to the Ministry for payment meet the requirements as set out in the Physician Payment Schedule, the physician's Direct Payment Agreement with Medical Services Branch and *The Saskatchewan Medical Care Insurance Act*.

- An adjustment has been made to pay this claim with the appropriate service code and rate which is different than the original claim submitted and paid.

Please see correspondence from PGA if more information is required. See PGA contact information in preamble above.

RM Monthly methadone stipend codes (60B, 61B, 62B) are restricted to physicians who have been approved by the College of Physicians and Surgeons of Saskatchewan to prescribe methadone for addiction.

1. These codes are not billable for the management of patients with "pain"; and/or
2. These codes are not billable if the physician does not have a current approval from the College of Physicians and Surgeons of Saskatchewan.

RT This service is being recovered as the result of a routine audit pertaining to the billing of a technical component. Within 30 days, please submit documentation demonstrating physician ownership of equipment and/or employment of staff. See PGA contact information in preamble above.

The Ministry of Health Explanatory Codes For Physicians

RV This service is being recovered as a result of a routine or special verification. The beneficiary does not recall or is disputing receiving this service. Within 30 days, please provide a copy of the medical record that supports the service billed.

OPHTHALMOLOGY

SA 6S--A previous examination was provided to this beneficiary by yourself or another physician within the designated time span:

- 1) Age 18 - 64 minimum time - 24 months;
- 2) All other ages - minimum time - 12 months.

If resubmitting, please indicate:

- 1) Previous and current complete refractive errors.
- 2) Medical factors necessitating current refraction.

Re: "Ophthalmology", item A(c).

SB 170S-171S--included in payment for retinal detachment. Re: Section "S", item B.

SC 12S, 581S, 582S--approved only once within a period of 12 consecutive months for the same physician or clinic.

SF The factors indicated have been reviewed and are not considered sufficient to warrant payment of a second refraction within the designated time span.

SS Coverage for routine examination of the eyes (6S) is limited to those under the age of 18, Social Assistance recipients nominated to receive Supplementary Health benefits, recipients of Family Health Plan benefits and seniors receiving the Saskatchewan Income Plan supplement. According to our information, the patient is not eligible for coverage.

LABORATORY MEDICINE

VB Procedure not insured in office practice. Re: Lists 1 and 2.

VC 204-206A--not approved in addition to any other service. Re: Payment Schedule item.

VD 204-206A, 756-758V & 770V-772V --payment includes referral of multiple specimens of the same type.
Re: Payment Schedule item.

VE The appropriate Biochemistry Panel Code is approved based on the total number of tests per patient. Exceeds maximum number of units paid without an explanation.

VH Exceeds maximum number of units paid without an explanation.

VI Multiples of codes 32V plus urinalysis (60V) are being paid at the appropriate number of units for the composite code - 33V.

The Ministry of Health
Explanatory Codes For Physicians

VL According to information received from Laboratory Licensing, you have not been licensed to perform this test. Please review your licence. If any disagreements, please write to:
Laboratory Licensing, Ministry of Health
3475 Albert Street, Regina, Saskatchewan S4S 6X6
lablicensing@health.gov.sk.ca

VM The code and payment approved is the maximum for the series.

VN Included in the "composite" paid for the related laboratory procedure.

RADIOLOGY

XA Radiology is not insured when:
1) provided in a hospital, or any facility funded by the Ministry of Health.
2) performed by other than a radiologist.
Re: Section "X" - items 1 and 2.

XJ Considered an inclusion within the payment for a similar procedure on the same day. If resubmitting please clarify.

INCOMPLETE OR INCORRECT CLAIMS

YA Patient's Name--please clarify the full name.

YB Registration--indicate the complete 9-digit Health Services Number.

YC Date of Birth--indicate the month and year of birth recorded on the Health Services Card.

YD Family Head--please indicate the full name and address.

YE The province code is blank, invalid or not legible. Please provide the necessary information in the "REMARKS" area.

YF THE SIGNATURE BLOCK on this claim is completed differently than what you previously indicated to the Ministry of Health. The acceptable methods are:
1) Personal signature.
2) Impress a rubber stamp facsimile of the practitioner's signature
3) Impress a rubber stamp of the practitioner's name in capital letters.
4) Hand print the practitioner's name in capital letters.
5) Delegate a member of your staff to personally sign on the practitioner's behalf.

Prior to resubmission, please complete the signature block by either:

- 1) your previously designated method of signing; or
- 2) personal signature

If you wish to change your previously designated method of signing claims, you must first advise The Ministry of Health in writing of the specific acceptable method you intend to use in the future.

The Ministry of Health Explanatory Codes For Physicians

- YG** The Out of Province registration number provided on your claim is not correct. Please check your records and modify the number, if incorrect. If the number is correct according to your records, please indicate this on the claim.
- YH** Additional information requested--Please ensure all the following have been provided:
- 1) Diagnosis
 - 2) Site of lesion or injury
 - 3) Cause and site of edema
 - 4) Condition requiring the injection.
- YI** Clarification - please clarify the item(s) circled on the claim or recheck the entire claim.
- YJ** We cannot interpret the diagnosis. Please explain the term(s) used.
- YK** Code and Fee--please indicate the service code and amount charged for each service.
- YL** Date of Service--please indicate the proper day, month and year.
- YM** Hospital visits--please clarify the date of the first and last visit and the total number of days billed.
- YN** Please review this claim. The payment schedule code and/or diagnosis/diagnostic code is not consistent with the patient's age and/or sex.
- YP** The clinic number is invalid for the submitted dates of service or the hospital days span two clinics. Please review the dates of service and clinic number.
- YR** Please clarify the name, specialty and initials of the physician who provided each service.
- YS** We are unable to identify who referred the patient. A referring physician's name either has not been supplied, or if a name is present on the claim, he or she cannot be located in our listing of active Saskatchewan physicians. If the patient was referred, please resubmit the claim with the full name of the physician and the location of his or her practice.
- YT** Please resubmit the claim indicating the hospital admission and discharge dates.
- YU** Your claim has been returned because of the omission of one or both of the following items:
- 1) Designation of the operative procedure.
 - 2) The total time when additional time is billed.
- YV** Please indicate whether the dental anesthetic was administered in a hospital.
- ZA** The patient identity information on the claim (month or year of birth, sex or surname) does not correspond to information on the Health Services Card. Please check the Health Services Card, make the claim corrections and resubmit.
- ZC** The submitted claim contains invalid data other than patient identification data, e.g. September 31, the submitted fee at zero dollars, the 13 month, a lower case alpha character, a partially blank field as HSN, wrong location of service, a service not allowed for premiums etc.

The Ministry of Health Explanatory Codes For Physicians

- ZD** The dates of service or month of birth are invalid. The date of service may be greater than the date of computer processing, there are two months of service on the 50 record types with the same claim number or the number of hospital visits exceeds the number of days between the first and last hospital dates.
- ZF** The physician is not eligible to submit for services on the indicated dates of service
- ZG** A premium eligible and non-premium eligible service code cannot be billed on the same claim. Please verify your locations of service and resubmit on different claims if applicable.
- ZH** Only Hospital visits (25 to 28 and 35B) may be billed in the hospital visit area or on a hospital care record (57). Please resubmit other services on a non-hospital visit/procedure record (50). The number of units or number of days billed can never exceed 99. on a computer submission, the 50 record must precede all 57 records with the same claim number.
- ZL** The submitted referring physician number is invalid or an invalid referring physician number has been used for a non-cancer diagnosis or a nurse practitioner has referred to a physician that is not a specialist. Please check the referring physician name and number.
- ZM** The claim contains an invalid diagnostic code according to the International Classification of Diseases - 9th Revision. Please check the diagnosis, diagnostic code and table of invalid codes.
- ZN** The Ministry of Health has received multiple claims with the same clinic, physician, claim and Health Services Number. One of the claims is being processed; all other claims with the same claim number are being returned.
- ZP** An invalid mode of payment or incorrect service code has been used on the claims or mixed services are being submitted for an APS claim (eg. 74A (SGI) and 5B or 600B)
- ZR** The indicated location of service, service code or time is invalid for a premium payment on this date. (See "OUT OF HOURS PREMIUMS" section in Part A of this Payment Schedule).
- ZS** This claim was submitted as a Professional Corporation (PC) claim; however no PC information has been received or the PC claim is not valid on this date.
- ZT** Please refer to the comment record(s) being returned by MSB for a more detailed explanation.
- ZW** The direct input claim cannot be processed. Please resubmit on a regular claim form.
- ZY** The direct input claim cannot be processed. Please resubmit with comments or an explanation of the service provided. If an operative report or a detailed explanation is required, it should be submitted and attached to a regular claim form.

SECTION A – General Services

Specialist General Practitioner

SGI Medical Driver Fitness Review - Schedule of Rates

1. The services listed on this page are paid by MSB on an agency basis for SGI.
2. These codes are not eligible for any additional charges i.e., premium(s) or surcharges.
3. All reports must be retained in the patients file.
4. No additional fee is paid for lab services required for 74A with the exception of 131A.
5. 70A, 71A and 74A are not payable for commercial license renewal.
6. A visit provided on the same day as a 74A is paid by report.
7. 74A includes services described in 70A or 71A

| | | | |
|-----|---|---------|---------|
| 70A | Telephone call from an SGI Driver Medical Review Unit or Manager, requesting the physician's clarification of a medical condition and effect on the patient's ability to operate a motor vehicle. | \$30.00 | \$30.00 |
|-----|---|---------|---------|

All calls must be recorded on the patient's file chart, including the name of the SGI representative.

| | | | |
|-----|--|---------|---------|
| 71A | Written letter or facsimile 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. | \$55.00 | \$55.00 |
|-----|--|---------|---------|

- All reports must be retained in the patients file.
- SGI Requested Seizure Follow-up forms are also billable under 71A.

| | | | |
|-----|--|----------|---------|
| 74A | Examination and Report requested by the SGI Driver Medical Review Unit requesting the physician's assessment of the patient's ability to operate a motor vehicle. The following forms are billable under this code only: | \$140.00 | \$75.00 |
|-----|--|----------|---------|

- SGI Requested Driver's License Medical Report
- Cognitive Assessment Report
- Driver's Psychiatric Examination Report (specialists only)
- Report of Visual Functions (ophthalmologists only)

SECTION A – General Services

| | | Specialist | General Practitioner |
|-----|---|------------|----------------------|
| 20A | <p>Report requested by the Ministry of Social Services to determine employability, rehabilitation potential, Level of care, or other specified reason.</p> <p>The 20A and other associated visits and laboratory codes should be submitted with a diagnostic code of Z90 (Examination-Third Party Request from the Ministry of Social Services)</p> | \$31.50 | \$31.50 |
| 37A | <p>Examination and Report required for the purpose of adoption or determining whether a person may become a foster parent -- diagnostic code V70 must be used</p> | \$64.30 | \$57.90 |
| 39A | <p>Rape victim (suspected or actual) – includes:</p> <ul style="list-style-type: none"> a) medical history; b) examination; c) counselling; d) all medical documentation; and, e) initial treatment. | \$476.10 | \$476.10 |
| 40A | <p>Child abuse victim (suspected or actual) – includes:</p> <ul style="list-style-type: none"> a) medical history; b) history of abuse obtained from social worker, police, parents or other individuals; c) examination; d) investigation; e) referral as necessary; f) counselling and treatment; g) medical documentation of findings and management | \$315.00 | \$315.00 |
| 41A | <p>FASD assessment and diagnosis - per 15 minutes or major portion, max of 12 units per patient (3 hours)</p> <ol style="list-style-type: none"> 1. Clinical evaluation of the patient, review of information and consultation with other providers (verbal and written) for the purpose of Fetal Alcohol Spectrum Disorder (FASD) - assessment and diagnosis. Includes a review of: <ul style="list-style-type: none"> a) birth and prenatal history; b) medical and surgical histories, including psychiatric and psychological reports; c) detailed family history focusing on genetic conditions which can cause brain dysfunction; d) social history, including any social services records, pre-sentence reports, risk assessments, etc. 2. Limited to physicians with appropriate training and expertise in FASD assessment, including: <ul style="list-style-type: none"> a) geneticists with expertise in diagnosing birth defects; b) developmental pediatricians; c) any physician with training from a recognized training centre for FASD diagnosis (examples: University of Washington, Seattle Washington; Lakeland Centre for Fetal Alcohol Syndrome, Cold Lake, Alberta; and the Motherisk Centre, Toronto). 3. The physician should keep appropriate documentation of time and place. 4. @ Physicians who intend to provide this service should apply to the Saskatchewan Medical Association Tariff Committee to be considered eligible to bill MSB for this service. For the purposes of billing, 41A is payable on the date the approval is granted to the physician. See "Services Billable by Entitlement". 5. This code is not to be used for third party uninsured requests for assessment such as requests from Saskatchewan Justice and others. | \$41.70@ | \$41.70@ |

SECTION A – General Services

| | | Specialist | General Practitioner |
|-----|---|------------|----------------------|
| 56A | Report requested by Cancer Agency or Cancer Screening Program | \$13.50 | \$13.50 |
| | <u>The following are covered under this fee code:</u> | | |
| | <ol style="list-style-type: none"> 1. Saskatchewan Cancer Agency request for follow-up of registered cancer patient - must be billed with a diagnostic 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 | | |
| 60A | Required physician reporting forms | \$13.20 | \$13.20 |
| | <u>The following form is covered under this fee code:</u> | | |
| | Physician Reporting Form for West Nile Cases -- must be billed with diagnostic code 066 | | |
| | Third party counselling for the provision of Medical Assistance in Dying (MAID) services provided by a willing practitioner | | |
| | <ol style="list-style-type: none"> 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 | | |
| | <ol style="list-style-type: none"> a) History review; b) Counselling; c) Educational dialogue; d) Intervention; e) Record of service provided f) Time spent counselling | \$37.50 | \$37.50 |
| 81A | Third Party Counselling – next 15 minutes or major portion thereof | \$37.50 | \$37.50 |

SECTION A – General Services

| | | Specialist | General Practitioner |
|---------------------------------------|---|------------|----------------------|
| <u>Exceptional Drug Status</u> | | | |
| 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. a) Only one fee is payable every twelve months. b) Applicable visit fees may be submitted concurrently. | \$30.40 | \$30.40 |
| 154A | Alzheimer’s 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 Alzheimer’s Disease. a) Follow-up status reports required by the Drug Program can be done by phone or fax and are billable using code 155A. b) Applicable visit fees may be submitted concurrently. | \$30.40 | \$30.40 |
| 155A | Alzheimer’s Disease a) follow-up status reports required by the SDP by phone or fax. b) applicable visit fees may be submitted concurrently. | \$12.10 | \$12.10 |
| 156A | Ankylosing Spondylitis Payment for the completion and submission of the initial and renewal application form required by the Saskatchewan Drug Plan (SDP) to determine eligibility for Exceptional Drug Status (EDS) in the treatment of Ankylosing Spondylitis. a) Only one fee is payable every (12) twelve months. b) Applicable visit fee may be submitted concurrently. | \$30.40 | \$30.40 |
| <u>Specified Forms</u> | | | |
| 753A | Physician completion and submission of an application filed with the court under the <u>Mandatory Testing and Disclosure (Bodily Substances) Act</u> -- by report | \$16.00 | \$16.00 |
| 909A | Initiating protocol for the discontinuance of life-support systems following certification of brain death | \$30.90 | \$30.90 |

Payment Schedule for Insured Services Provided by a Physician

SECTION A – General Services

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| <u>Procedures:</u> | | | | | |
| 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. | | | | | |
| 100A | Collection of blood from donor for transfusion | \$16.30 | \$16.30 | 0 | |
| 101A | Phlebotomy for therapeutic reason e.g. polycythemia | \$16.30 | \$16.30 | 0 | |
| 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. | \$22.50 | \$22.50 | 0 | |
| 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 | \$22.50 | \$22.50 | 0 | |
| 110A | Injections a) included in visit b) medication extra c) intramuscular or subcutaneous | \$16.30 | \$16.30 | 0 | |
| 111A | Injections a) medication extra b) not for injection into IV tubing nor for initiation of IV c) direct intravenous injection of medication | \$16.30 | \$16.30 | 0 | |
| 112A | Injections a) medication extra -- arterial puncture | \$16.30 | \$16.30 | D | |
| 113A | Hyposensitization injections -- each a) Included in visit b) Max 3 units per session c) Up to 9 units per session for venom desensitization IV | \$6.40 | \$6.40 | | |
| 114A | IVP/IVC injection when performed in the absence of a radiologist | \$16.30 | \$16.30 | D | |
| 115A | Aspiration and/or injection of ganglion | \$29.80 | \$29.80 | 0 | |
| 116A | Insertion of subcutaneous contraceptive implant | \$45.90 | \$45.90 | 0 | L |
| 117A | Removal of subcutaneous contraceptive implant | \$62.40 | \$62.40 | 0 | L |
| 120A | Bladder catheterization -- urethral | \$5.90 | \$5.90 | 0 | |
| 121A | Bladder catheterization -- other than urethral | \$10.50 | \$10.50 | 0 | |
| 122A | Peritoneal lavage | \$105.00 | \$105.00 | D | |
| 123A | Insertion of IUD | \$51.00 | \$51.00 | 0 | |
| 125A | Paracentesis or diagnostic tap -- thorax or abdomen | \$76.40 | \$76.40 | 0 | |
| 126A | Pericardial aspiration -- by any method (17 years of age & older) | \$168.00 | \$168.00 | 0 | |
| 130A | Pericardial aspiration -- by any method (under 17 years of age) | \$157.00 | \$157.00 | 0 | |
| 127A | Lumbar puncture | \$62.90 | \$62.90 | D | L |
| 128A | Gastric lavage | \$17.80 | \$17.80 | 0 | |
| 129A | Percutaneous manipulations of gallstone(s) | \$251.80 | \$251.80 | 10 | L |
| 131A | Submission of Papanicolau smear (females only) | \$20.00 | \$20.00 | D | |
| 118A | Pessary Visit -- Initial fitting or review (no tray service) | \$22.00 | \$22.00 | 0 | L |
| 132A | Relief of fecal impaction -- under general anesthetic | \$68.80 | \$68.80 | 0 | |
| 133A | Pleural punch biopsy -- with or without thoracentesis | \$38.50 | \$38.50 | D | |

SECTION A – General Services

| | | Specialist | General Practitioner | Class | Anes |
|--------------------------------------|---|------------|----------------------|-------|------|
| 134A | Insertion of central venous catheter | \$62.10 | \$62.10 | D | L |
| 135A | Insertion of central venous catheter in infant | \$124.00 | \$124.00 | D | L |
| 136A | Insertion of central venous catheter in infant -- under general anesthesia or IV sedation (includes post-op recovery) | \$149.25 | \$149.25 | D | L |
| 140A | Insertion of arterial line for measurement of systemic pressures -- unilateral or bilateral -- adult | \$39.90 | \$39.90 | D | L |
| 141A | Insertion of arterial line for measurement of systemic pressures -- unilateral or bilateral -- child | \$124.10 | \$124.10 | D | L |
| 150A | Physiotherapy procedures including heat or light lamps, traction | \$3.10 | \$3.10 | 0 | |
| 925A | Intravenous chemotherapy or Remicade treatment | \$20.00 | \$20.00 | 0 | |
| Communicable Disease Services | | | | | |
| 160A | Diagnostic skin tests (e.g. Schick test; Dick test) -- each | \$3.10 | \$3.10 | D | |
| 161A | Immunization -- per injection (included in visit) -- bill units | \$16.30 | \$16.30 | | |
| 162A | Vaccination and reading | \$16.30 | \$16.30 | 0 | |
| Allergy Diagnosis (Testing) | | | | | |
| 170A | Scratch test (inhalant/ingestant) - each -- max 35 units per year | \$1.70 | \$1.70 | D | |
| 171A | Patch test (contact dermatoses) - each -- max 50 units per year | \$2.90 | \$2.90 | D | |
| 172A | Intradermal test - each -- max 20 units per year | \$3.90 | \$3.90 | D | |
| 173A | Test for phototoxic or photoallergic reaction under controlled ultraviolet light source (e.g. hot quartz mercury vapor lamp or Woods Blak-Ray light) -- each -- maximum 30 units per year | \$4.20 | \$4.20 | D | |
| 174A | Allergy Challenge -- patient challenged with an antigen in a graded fashion per complete 15 minute period (repeated spirometry 600D-603D or 610D to 613D can be billed maximum 3 tests) | \$19.40 | \$19.40 | D | |
| Total Parenteral Nutrition | | | | | |
| | <ol style="list-style-type: none"> 1. When provided by other than the attending physician or surgeon. 2. 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 | \$86.10 | \$86.10 | | |
| 183A | Subsequent care per day | \$15.50 | \$15.50 | | |
| 184A | Outpatient TPN supervision - not payable with visit, max 2 per week | \$15.70 | \$15.70 | | |

SECTION A – General Services

Specialist General Practitioner Class

Botox Injections

1. Botox is not insured for cosmetic purposes, migraines, pelvic pain or any other condition other than those listed in item 2.
2. **Botox is intended for use in the relief of symptoms resulting from dystonias, other neuromuscular spasticity problems, and hyperhidrosis only.**
3. Any other use of Botox requires written prior approval of MSB and the Saskatchewan Medical Association (SMA).
4. Entitlement to bill botulinium toxin injection codes is limited to:
 - Anesthetists • Neurologists • Psychiatrists
 - General Surgeons • Ophthalmologists • Plastic Surgeons
 - Gynecologists • Otolaryngologists • Urologists
 - Internists • Orthopedic Surgeons • Dermatologists
5. @ Others with appropriate training/experience may apply to the Saskatchewan Medical Association Tariff Committee for entitlement.
6. For the purposes of billing, Botox codes are billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.
7. Only one code from the Botox schedule is billable per patient contact.
8. Botox injections include any EMG control and additional injections within 42 days.

| | | | | |
|------|---|----------|-----------|----|
| 190A | Blepharospasm | \$189.60 | \$170.70 | 42 |
| 191A | Hemifacial spasm | \$189.60 | \$170.70 | 42 |
| 192A | Extraocular muscle(s) for strabismus or spastic dysphonia, one or more muscles, unilateral or bilateral (previously 473S) | \$228.90 | \$206.05 | 42 |
| 193A | Multiple muscle -- bilateral | \$251.80 | \$226.60@ | 42 |
| 194A | Multiple muscle – unilateral | \$190.00 | \$171.05@ | 42 |
| 195A | Single muscle -- bilateral | \$94.40 | \$84.90@ | 42 |
| 196A | Single muscle -- unilateral | \$62.90 | \$56.60@ | 42 |
| 197A | Rectal spasm, anal fissure | \$63.50 | \$57.15@ | 42 |
| | Endoscopy for achalasia etc. -- see endoscopic codes - Section L | | | |
| 198A | Hyperhidrosis | \$115.20 | \$103.70 | 42 |
| | a) per side (left or right armpit), bill units | | | |
| | b) to initiate billing, two physicians must have diagnosed the patient with hyperhidrosis (eg. referring physician and consultant, or two family physicians with the second physician confirming the diagnosis) | | | |
| 199A | Botox injection of detrusor muscle via cystoscopy for neurogenic or non-neurogenic overactive bladder. | \$189.60 | \$170.70 | 42 |

SECTION A – General Services

Emergency Resuscitation - "Code" Situations

APPLIES TO CODES: 220A to 226A – for intensive care in ICU or CCU – see Section H

1. These service codes are all inclusive, for medically required attendance because of code situations involving resuscitation.
2. Certain procedures can be billed during a period of 220A-226A 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-minute period should not also be billed as a 220A-226A).
3. **For a claim to be processed, the physician must provide details of:**
 - a) **the clinical condition necessitating continuous attendance;**
 - b) **the treatment or care provided;**
 - c) **time when continuous attendance on patient started and was completed.**
4. 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.
5. When claiming Critical, Ventilatory, or Comprehensive Care per diem fees, no other Intensive Care codes may be claimed by the same physician(s)
6. May be billed with the appropriate emergency or special call surcharge.

Life Threatening Emergency Situation

Being in constant attendance for the time billed to provide resuscitation in an emergency situation:

- | | |
|-----------------------------------|------------------------------|
| a) cardiac arrest; | d) resuscitation of newborn; |
| b) multiple systems major trauma; | e) severe shock; and, |
| c) cardio respiratory failure; | f) coma. |

The specific elements are those of an assessment, including immediate crisis related examination, ongoing monitoring of the patient's condition and the usual resuscitative procedures as required:

- | | |
|--------------------------------------|----------------------------|
| a) arterial and/or venous catheters; | h) intravenous lines; |
| b) blood gases; | i) nasogastric tubes; |
| c) cardioversion; | j) pharmacological agents; |
| d) cutdowns; | k) pressure infusion sets; |
| e) CVP lines; | l) tracheal toilet; and, |
| f) defibrillation; | m) urinary catheters. |
| g) endotracheal intubation; | |

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 | \$102.00 | \$102.00 |
| 221A | -- second 15 minutes | \$51.00 | \$51.00 |
| 222A | -- after first 30 minutes -- per 15 minutes or major portion thereof | \$46.30 | \$46.30 |
| 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 | \$46.30 | \$46.30 |

SECTION A – General Services

Specialist General
Practitioner

Other Life Threatening Resuscitation

1. **Other Resuscitation** - is different from Life Threatening Emergency Situation only in that it applies to providing resuscitation in emergency situations other than those listed under 220A-223A and only includes the following resuscitative procedures:
 - a) arterial and/or venous catheters;
 - b) blood gases;
 - c) cutdowns;
 - d) CVP lines;
 - e) intravenous lines;
 - f) nasogastric tubes with or without lavage;
 - g) pressure infusion sets and pharmacological agents;
 - h) tracheal toilet; and,
 - i) urinary catheters.

2. 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.

3. Amount payable per physician per Other Resuscitation for the first two physicians for which a claim is submitted and paid.

| | | | |
|------|---|---------|---------|
| 224A | -- first 15 minutes | \$51.00 | \$51.00 |
| 225A | -- after first 15 minutes -- per 15 minutes or major portion thereof | \$46.30 | \$46.30 |
| 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 | \$46.30 | \$46.30 |

SECTION A – General Services

| | Specialist | General Practitioner | Class | Anes | |
|--|---|----------------------|----------|------|---|
| Specimen collection and referral | | | | | |
| To be sent for a special test, when it is the only charge made: | | | | | |
| 204A | Urine Collection and referral of specimen(s) | \$5.70 | \$5.70 | D | |
| 205A | Blood Collection and referral of specimen(s) | \$5.70 | \$5.70 | D | |
| 206A | Other Collection and referral of specimen(s) | \$5.70 | \$5.70 | D | |
| 207A | Bone Marrow -- aspiration | \$48.70 | \$48.70 | D | L |
| 208A | Bone Marrow -- aspiration and needle biopsy | \$76.20 | \$76.20 | D | L |
| 209A | Bone Marrow -- interpretation | \$29.20 | \$29.20 | D | |
| 210A | Examination of blood smear and written clinical report -- by internist or pediatrician with special training in hematology | \$19.60 | | D | |
| 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 | \$92.80 | \$92.80 | D | H |
| 303A | Left heart catheterization -- retrograde includes catheter insertion | \$132.50 | \$132.50 | D | H |
| 304A | Transeptal heart catheterization | \$158.00 | \$158.00 | D | H |
| 306A | Transvenous endocardial biopsy (right or left) -- independent procedure | \$336.40 | \$302.80 | 0 | H |
| 307A | Transvenous endocardial biopsy (right or left) when done in conjunction with any catheterization procedure -- add | \$102.00 | \$91.80 | 0 | |
| 310A | Dye and/or thermodilution curve studies - includes all curves obtained from a patient regardless of method | \$81.60 | \$81.60 | D | |
| 311A | Oximetry during cardiac catheterization | \$81.60 | \$81.60 | D | |
| 613A | Endocardial mapping | \$210.00 | | D | H |
| 614A | Intracardiac electrocardiography and/or atrial pacing | \$89.70 | | D | |
| 316A | Insertion and measurements with Swan Ganz Catheter -- to include all pressures, dye or thermodilution curves, recordings and interpretations | \$105.00 | \$94.50 | D | |
| Angiography procedures for non-radiologists - use Section X | | | | | |
| 443A | Angiography -- angiocardiography -- right and/or left side | \$107.00 | \$107.00 | D | H |
| 444A | Angiography -- extremities, percutaneous-- unilateral | \$98.90 | \$98.90 | | |
| 445A | Aortography -- any method when sole procedure | \$134.60 | \$134.60 | D | H |
| 446A | Aortography -- with selective catheterization of each additional artery to a maximum of 3, add | \$20.40 | \$20.40 | D | H |
| 545A | Aortography -- when done as part of 447A and/or 443A/145C, add | \$68.80 | \$68.80 | D | H |
| 447A | Coronary Angiography -- to include right and left coronaries | \$178.40 | \$178.40 | D | H |
| 548A | Coronary Angiography -- with selective catheterization of venous and/or arterial bypass grafts each to a maximum of 3, add | \$81.60 | \$81.60 | D | H |
| 648A | Coronary Angiography -- with ergonovine stimulation, add | \$71.40 | \$71.40 | D | H |

Payment Schedule for Insured Services Provided by a Physician

SECTION A – General Services

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| Clinical procedures listed below associated with diagnostic radiology may be charged in addition to the payments listed in Section X. | | | | | |
| 331A | Intracoronary thrombolytic therapy | \$346.60 | | 0 | |
| 328A | Transluminal angioplasty -- coronary | \$509.80* | | 0 | |
| 329A | Transluminal angioplasty -- each additional stenosis (maximum one per arterial branch) -- bill units | \$198.80* | | 0 | |
| 330A | Transluminal angioplasty -- peripheral | \$234.50 | | 0 | H |
| 335A | Transluminal angioplasty -- insertion of coronary artery stent(s) associated with 328A (any number), add | \$152.90 | | 0 | |
| 332A | Transluminal angioplasty -- pulmonary valve or artery | \$420.00 | | 10 | |
| 333A | Transluminal angioplasty -- pulmonary valve or artery where followed by corrective surgery within 24 hours | \$210.00 | | 10 | |
| 334A | Transluminal angioplasty -- aorta or aortic valve | \$420.00* | | 0 | |
| 336A | Transluminal angioplasty -- subclavian artery | \$239.60 | | 0 | H |
| 337A | Stent placement following angioplasty of peripheral, renal or subclavian vessels – add to appropriate angioplasty code – each vessel – bill units | \$69.30 | | 0 | H |
| 338A | Selective Catheter Embolization | \$239.60 | | 0 | M |
| 493A | Transcatheter closure of ductus arteriosus | \$509.80* | | 0 | M |
| * Post-angioplasty care for elective procedures (328A, 329A 334A and 493A) is included in the payment for these procedures. | | | | | |
| Procedures under fluoroscopic, CT or ultrasonic guidance for non-radiologists - use Section X | | | | | |
| 406A | Percutaneous nephrostomy with nephrogram | \$314.00 | | 0 | L |
| 407A | Manipulation of peritoneal dialysis catheter | \$57.10 | \$57.10 | | |
| 460A | Non-palpable breast lesion - needle localization provided by surgeon -- bill units | \$52.00 | \$52.00 | D | L |
| 412A | Percutaneous fallopian tube cannulation and dilatation -- with selective salpingography, unilateral or bilateral | \$127.40 | \$127.40 | 10 | L |
| 463A | Injection of a sinus tract | \$53.30 | | D | L |
| 403A | Percutaneous intra-abdominal drainage | \$192.10 | | 0 | L |
| 462A | Sialography | \$64.30 | \$64.30 | D | L |
| 661A | Percutaneous insertion of pleural catheter for closed chest drainage -- bill units | \$91.00 | \$91.00 | 0 | L |

SECTION A – General Services

Echocardiography

1. # 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.
2. Interpretation of 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.
3. Technical service is paid only if the physician owns the instrument and employs the staff who are performing the service (if not performed by the physician personally). See “Definitions” (19) and “Services Supervised by a Physician”
4. The technical fees are paid at 100%.
5. The first echo of any type performed starts the series for that patient.
6. 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.
7. Serial echocardiograms provided to patients receiving cardio-toxic oncology medications at the request of the Cancer Agency may be billed without limit

Example:

| Date of Service: | Claim: | Service Provided: |
|------------------|----------------|--|
| April 30, 2010 | 321A | Interpretation of M Mode & 2D echo |
| May 15, 2010 | 521A | Interpretation of M Mode & 2D echo |
| July 12, 2010 | 533A | Interpretation of M Mode, 2D & Doppler echo |
| February 2, 2011 | 530A & 531A | Technical & interpretation of M Mode & 2D echo |
| March 6, 2011 | No fee payable | Interpretation of M Mode & 2D echo |
| May 4, 2011 | 321A | Interpretation of M Mode & 2D echo (start of new series) |

M Mode and Two-Dimensional (2-D) same day

| | | | | | |
|------|-------------------|--------------------------|--|----------|---|
| 320A | -- technical | - first | | \$53.50# | D |
| 520A | -- technical | - second | | \$53.50# | D |
| 530A | -- technical | - third and fourth, each | | \$53.50# | D |
| 321A | -- interpretation | - first | | \$77.10# | D |
| 521A | -- interpretation | - second | | \$38.50# | D |
| 531A | -- interpretation | - third and fourth, each | | \$19.30# | D |

Doppler study, including M Mode plus two-dimensional studies on same day

| | | | | | |
|------|-------------------|--------------------------|-----------------------------|-----------|--------|
| 322A | -- technical | - first | - 17 years of age and older | \$77.00# | D |
| 522A | -- technical | - second | - 17 years of age and older | \$77.00# | D |
| 532A | -- technical | - third and fourth, each | - 17 years of age and older | \$77.00# | D |
| 556A | -- technical | | - under 17 years | \$77.00# | D L |
| 323A | -- interpretation | - first | - 17 years of age and older | \$110.10# | D |
| 523A | -- interpretation | - second | - 17 years of age and older | \$77.10# | D |
| 533A | -- interpretation | - third and fourth, each | - 17 years of age & older | \$55.10# | D |
| 557A | -- interpretation | | - under 17 years | \$110.10# | D L |

Serial echocardiograms of patients receiving cardiotoxic oncology medication

| | | | | | |
|------|-------------------|--|--|-----------|---|
| 535A | -- technical | | | \$77.00# | D |
| 536A | -- interpretation | | | \$110.10# | D |

SECTION A – General Services

Specialist Class Anes

Transesophageal echocardiogram

1. To include insertion of transducer and interpretation
2. Within one year at same office or institution the first and second transesophageal echoes are paid at 100%, the third is paid at 25% and for remainder no fee can be charged.

| | | | | |
|------|---------------------|-----------|---|---|
| 324A | -- first and second | \$168.00# | D | M |
| 534A | -- third | \$42.00# | D | M |

Geriatric Assessment Unit

| | | | | |
|------|--|---------|--|---------|
| 600A | Payment for assessment of patients attending Geriatric Assessment/Rehab Unit | \$12.10 | | \$12.10 |
|------|--|---------|--|---------|

1. Physician must be physically present to consult and review patients as necessary. Documentation required for significant change orders only.
2. Two per patient per 7 day period

Group Counselling (instructional 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 | Group counselling -- initial 15 minutes | \$59.50 | | \$59.50 |
| 681A | Group counselling -- additional complete 15 minute units (to a maximum of 3 units) | \$59.50 | | \$59.50 |
| 615A | House Call Surcharge -- not specially called | \$23.10 | | \$23.10 |
| 915A | House Call Surcharge -- home care of cancer patient registered by the Saskatchewan Cancer Agency | \$23.10 | | \$23.10 |

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.

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.

SECTION A – General Services

| | Specialist | General Practitioner |
|--|------------|----------------------|
|--|------------|----------------------|

| | | | |
|------|-----------------------------------|---------|---------|
| 626A | Routine Nursing Home Visit | \$30.00 | \$30.00 |
|------|-----------------------------------|---------|---------|

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.

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>

1. Maximum payment of one (1) visit per patient by any physician every 7 days. Service must be billed on the day it was provided.
2. Where circumstances require that patients need more than the above number of visits, it is expected that the doctor will bill a partial assessment and fulfill all the requirements of that code.
3. Where a doctor visits a patient on a special call basis, payment will be at the special call rates depending upon time of day.

SECTION A – General Services

Surcharge – Special Call / Emergency / Hospital Visit / House Call

1. 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.
2. **Special call payments are claimable when 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 8:00 a.m. to 5:00 p.m. weekdays. Payment for a special call does not apply where a physician is specially called to another location in the hospital or a health centre 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.
3. Payment will be made for the examination and/or procedure provided plus the appropriate surcharge.
4. Where a surcharge is billed in connection with a major surgical procedure, fracture, dislocation or delivery, one surcharge is payable per case per physician.
5. Special call services are categorized by time of day.
6. "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.
7. The statutory holidays in each year are: New Year's Day, Good Friday, Family Day, Victoria Day, Canada Day, Saskatchewan Day, Labour Day, Thanksgiving Day, Remembrance Day, Christmas Day and Boxing Day. If any of these days fall on Saturday or Sunday, they will be observed as stated in the Physicians' Newsletter.
8. Surcharges are NOT paid 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 paid with codes 335H to 339H. Initial patient surcharges paid only once per patient per day.
9. Per "Documentation Requirements for the Purposes of Billing", the time and location of service must be documented in the medical record.

SECTION A – General Services

| | | | Specialist | General Practitioner |
|------|--|--------------------------------------|------------|----------------------|
| 700A | Statutory Holiday Hospital Care Surcharge | | \$10.00 | \$10.00 |
| | a) This surcharge is payable when a hospital care visit (25 to 28B to T; 35B) is made on a statutory holiday. | | | |
| | b) Billed in addition to the hospital care visit, it should be billed at the same time as the hospital care visit. | | | |
| | c) 700A is not paid on a statutory holiday when it falls on a Saturday or Sunday, it is paid on the day designated in lieu instead. | | | |
| 701A | Saturday and Sunday Hospital Care Surcharge | | \$10.00 | \$10.00 |
| | a) This surcharge is payable when a hospital care visit (25 to 28 B to T; 35B) is made on a Saturday or Sunday. | | | |
| | b) Must be billed in addition to the hospital care visit and it should be billed at the same time as the hospital care visit. | | | |
| 721A | Emergency Surcharge -- day or night -- any day - <u>please see preamble 77</u> | | \$88.80 | \$88.80 |
| | a) This surcharge is payable where a physician travels to respond immediately to a stat call involving a life-threatening situation and provides immediate care. | | | |
| | b) May be billed in addition to an appropriate assessment and/or procedure. | | | |
| | c) Note: Surcharge 721A is not payable when the patient is already hospitalized. | | | |
| | d) Not payable in addition to any other surcharge – see BU explanatory code or “Special Call/Surcharge” policy, item 8 c) | | | |
| | e) Per Documentation Requirements for the Purposes of Billing, the time and location of service must be documented in the medical record. | | | |
| | Hospital Discharge | | | |
| 725A | Hospital discharge & documentation: | | \$12.50 | \$12.50 |
| | a) payable once per discharge of formally admitted hospital in-patients to the physician responsible for discharging the patient; | | | |
| | b) must be a location of service 2; and, | | | |
| | c) billed on the date of discharge from the hospital. | | | |
| | <u>Surcharges – Special Calls – please see preamble on previous page</u> | | | |
| | Per Documentation Requirements for the Purposes of Billing, the time and location of service must be documented in the medical record. | | | |
| | Weekdays | | | |
| 815A | Surcharge -- first person seen <u>only</u> | 8:00 a.m. to 5:00 p.m. | \$38.70 | \$38.70 |
| 817A | Surcharge -- first patient seen | 5:00 p.m. to 12:00 a.m. (Mon - Thur) | \$56.70 | \$56.70 |
| 837A | Surcharge -- each additional patient seen | 5:00 p.m. to 12:00 a.m. (Mon - Thur) | \$28.00 | \$28.00 |
| 819A | Surcharge -- first patient seen | 12:00 a.m. to 8:00 a.m. | \$132.00 | \$132.00 |
| 839A | Surcharge -- each additional patient seen | 12:00 a.m. to 8:00 a.m. | \$38.00 | \$38.00 |
| | Weekends and Statutory Holiday | | | |
| 816A | Surcharge -- first patient seen | 8:00 a.m. to 5:00 p.m. | \$51.20 | \$51.20 |
| 836A | Surcharge -- each additional patient seen | 8:00 a.m. to 5:00 p.m. | \$25.50 | \$25.50 |
| 818A | Surcharge -- first patient seen | 5:00 p.m. to Midnight (Fri - Sun) | \$69.10 | \$69.10 |
| 838A | Surcharge -- each additional patient seen | 5:00 p.m. to Midnight (Fri - Sun) | \$34.40 | \$34.40 |
| 819A | Surcharge -- first patient seen | 12:00 a.m. to 8:00 a.m. | \$132.00 | \$132.00 |
| 839A | Surcharge -- each additional patient seen | 12:00 a.m. to 8:00 a.m. | \$38.00 | \$38.00 |

SECTION A – General Services

Pediatric 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).

1. You are not required to submit any codes or indicators to obtain this supplement. MSB will generate the payment of this supplement automatically and report the payment on your pay list or paid files using the total premium amount field or column at the following rates:
 - a) patients less than 31 days of age, add 50% -- maximum of \$1500
 - b) patients less than 91 days of age but older than 30 days, add 25% -- maximum of \$1500
 - c) patients less than 1 year of age but older than 90 days, add 10% -- maximum of \$1000
2. NOTE: Pediatric Supplements are based on the value of the diagnostic service, 0, 10 or 42 day procedure(s), surgical assist payment and the Anesthetic payment (codes 500H to 505H only) (excluding all premiums and surcharges).

Pediatric 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 anesthesiologist.
- 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 3 kg in body weight | -- maximum of \$1500 | 25% of applicable fee |
| 894A | Patients greater than 90 days of age and less than 3 kg in body weight | -- maximum of \$1500 | 40% of applicable fee |
| 895A | Patients greater than 90 days of age and less than 6 kg in body weight | -- maximum of \$1500 | 15% of applicable fee |

1. Pediatric 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.
2. The automatically generated age and billed weight pediatric supplements for patients under 1 year of age cannot exceed the following:

For patients less than 3 kg - 50% to a max of \$1500

- a) auto generated 50% for patients under 30 days of age - no submission required,
- b) auto generated 25% for patients greater than 30 days and less than 91 days of age requires submission of 893A (25%),
- c) auto generated 10% for patients greater than 90 days of age and less than one year of age requires submission of 894A (40%).

For patients greater than 3 kg and less than 6 kg - 25% to a max of \$1500

- a) auto generated 25% for patients greater than 30 days and less than 90 days of age - no submission required,
- b) auto generated 10% for patients greater than 90 days and less than one year of age requires submission of 895A (15%).

3. For patients greater than one year of age and less than 6 kg in weight will be given consideration by report.
 - a) Please submit separately to the Medical Consultant.

SECTION A – General Services

Pediatric Visit Age Supplement for 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, 55B, 73B, 85B, 12C/13C, 14C, 14D, 38G, 39G, 14K, 15K, 14O, 12S, 9X and 10X. Other services are not eligible for this supplement.
3. You are not required to submit any codes or indicators to obtain this supplement. MSB will generate the payment of this supplement automatically and report the payment on your pay list or paid files in the total premium amount field or column at the following rates:
 - a) visit supplement for patient 2 to 5 years of age -- additional 20%
 - b) visit supplement for patients less than 2 years of age -- additional 35%

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 65 years of age or older.
2. Eligible visit services include codes 3_, 5_, 7_, 8_, 9_, 10_, and 11_ in sections C to T and 12S, 14D, 14K, 14O and 15K. Any other services are not eligible for this supplement.
3. You are not required to submit any codes or indicators to obtain this supplement. MSB will generate the payment of this supplement automatically and report the payment on your pay list or paid files using the total premium amount field or column at the following rates:
 - a) visit supplement for patients 65 to 74 years of age -- additional 15%
 - b) visit supplement for patients 75 years of age and older -- additional 25%

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

SECTION A – General Services

Out-of-Hours Premiums

1. The out-of-hours premium provides the physician with increased compensation when he performs most services in a non-office environment between the hours of 5:00 p.m. and 7:00 a.m. weekdays or anytime on a weekend or statutory holiday.
2. The service must be provided in a location other than the office, or an alternate office, to be eligible. Services not eligible for an out-of-hours premium include:
 - a) hospital visits (700A, 701A, 25 to 28B to T, 35B, 52B, 53B);
 - b) surcharges, i.e. 815A to 839A, 615A, 721A, 915A;
 - c) emergency room coverage services, 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 office, i.e. 320A, 322A, 520A, 522A, 530A, 532A, 535A, 556A, 4B, 207B, 4C, 30D, 32D, 50D, 54D, 65D, 142D, 267D, 269D, 271D, 276D, 320D, 401D, 897L, 899L, 338P, 438P, 439P, 109Q, 29R, 402R, 404R, 406R, 15S, 40S, 45S, 181S, 301S, 535S, 579S, 651S, 653S, 582S, 96T and 443T, 260P, 300T, 13G; and
 - g) other service, ie: 41A, 56A, 60A, 65A, 70A-74A, 153A-155A, 184A, 190A-198A, 600A, 680A, 681A, 725A, 726A, 727A, 732A, 734A, 753A, 761A-769A, 790A-795A, 770A, 57B, 60B-62B, 64B-68B, 145D, 121D, 123D, 124D, 128D-132D, 278D, 279D, 281D-291D, 400H-424H, 540H, 545H, 580H, 585H, 80J, 81J, 278K, 279K, 679K, 580L, 180M, 580P, 581P, 400R, 500R, 580R.
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 out-of-hours premium.
4. Out-of-hours premium for obstetrical delivery is paid if the time of delivery falls between 5:00 p.m. and 7:00 a.m. weekdays or anytime on a weekend or statutory holiday.
5. The out-of-hours premium will apply to time units (e.g. H & 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. An out-of-hours premium may be billed for services in locations of 2, 3, 4 or 5:
 - a) Where an out-of-hours premium applies to these services at those locations for the 5:00 p.m. to midnight or 7:00 a.m. to midnight on weekends and statutory holidays, they must be billed with a location of service of B (in-hospital), C (out-patient), D (home) or E (other), respectively.
 - b) Where an out-of-hours premium applies to these services at those locations for the midnight to 7:00 a.m., they must be billed with a location of service of K (in-hospital), M (out-patient), P (home) or T (other), respectively.
7. An out-of-hours premium starting before midnight (5p.m. to midnight) and running into the next day will be paid at the before midnight rate.
8. Effective April 1, 2012, the rates are 50% for 5 p.m. to midnight weekdays, weekends and statutory holidays; 7:00 a.m. to 5:00 p.m. weekends and statutory holidays, and 100% for midnight to 7:00 a.m. weekdays, weekends and statutory holidays.
9. **Submission of Claims:**
 - a) by claim form:
 - tick the premium box 7 in the location of service area and put a B, C, D, E, K, M, P or T immediately before the box, e.g. C 7;
 - also check the location of service box 2 to 5;
 - if another out-of-office premium-eligible service is done outside of the 5:00 p.m. to 7:00 a.m. time period or on a different day or if one service is done before midnight and a second service is done after midnight or if done in a period yielding a different rate, submit it on a separate form or if submitting by direct input, please use a different claim number;

SECTION A – General Services

Example: If a 500H was provided at 9:00 a.m. and a 502H at 6:00 p.m., only the 502H would be eligible for an out-of-office premium. It should be submitted separately with a location of service of 2, a B before the premium box and the 7 ticked off. The appropriate location of service, B in this example, would be submitted if on direct input. The 500H should be submitted by separate claim form or on a different claim number by direct input.

Example: An ineligible service, e.g. 819A and eligible service, e.g. 5B, could be submitted on the same claim form or same direct input claim number which requests an out-of-office premium for the 5B. The Saskatchewan Health computer system would not generate an out-of-hours premium for the 819A.

Example: An eligible service starting before 5:00 p.m. but running into 5:00 p.m. to 7:00 a.m. does not receive an out-of-hours premium. An eligible service must begin within the 5:00 p.m. to 7:00 a.m. time period or anytime on the weekend to qualify for the out-of-hours premium.

Example: An eligible service starting in the 5:00 p.m. to midnight period and running beyond midnight qualifies for the out-of-hours premium and must be submitted with one of the before midnight codes B, C, D or E.

b) by electronic submission

For out-of-hours premiums in the periods 1) 5:00 p.m. through midnight or 2) 7:00 a.m. to midnight on weekends and statutory holidays -- indicate B (in-hospital), C (out-patient), D (home) or E(other) in the location of service field when billing for eligible services provided during the out-of-hours premium period.

For out-of-hours premiums in the period midnight to 7:00 a.m. -- indicate K (in-hospital), M (out-patient), P (home) or T(other) in the location of service field when billing for eligible services provided during the out-of-office premium period.

10. **Payment of Claims:**

- a) the Saskatchewan Health computer system automatically calculates the premium;
- b) the amount paid in the total premium amount field of the adjusted service is:
 - 50% (5:00 p.m. through midnight and 7:00 a.m. through midnight for weekends and stat holidays) or
 - 100% (midnight through 7:00 a.m.) of the out-of-hours premium performed service (plus the age visit supplement or the Pediatric supplement if applicable (i.e. premiums/supplements are stacked).
- c) if multiple eligible services are done in the specified time period, they are first assessed by standard assessment rules e.g. 75% before the premium is applied to the total;
- d) the pay list will show the basic service code submitted and on the same record a payment amount in the total premium field equal to the value of the applicable premiums.
- e) The premium amount will be generated and will appear on the original line (record) in the Total Premium amount field. If an adjustment is generated by MSB, it will appear as code 897 or 899 A, J, or H for time of day premium.

11. Please do not submit any premium service codes or amounts; all calculations are done at the Ministry of Health.

12. Per "Documentation Requirements for the Purposes of Billing", the time and location of service must be documented in the medical record.

SECTION A – General Services

After-Hours-Clinic Premium For General Practitioners

1. The after-hours-clinic premium provides the physician with increased compensation when he performs most services in an office location outside the hours of 7:00 a.m. and 7:00 p.m. weekdays.
2. This 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, Lloydminster, 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 (700A, 701A, 25 to 28B, 35B, 52B, 53B);
 - b) surcharges/premiums, e.g. 815 to 839A, 615A, 721A, 915A, 700A, 701A;
 - c) emergency room coverage services 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, 43E, 400H-424H, 540H, 545H, 580H, 585H, 80J, 81J, 278K, 279K, 679K, 580L, 180M, 580P, 581P, 400R, 500R;
 - g) SGI services (70A, 71A, 74A); and
 - h) other services 57B, 60B, 61B, 62B, 763A, 764A, 765A, 766A, 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.
7. **Submission of Claims**
 - (a) by claim form:
 - tick the premium box 7 in the location of service area and put an F immediately before the box, e.g. F 7;
 - also check the location of service box as 1.
 - (b) by electronic submission - For after-hours-clinic premiums in the period 7:00 p.m. to 7:00 a.m. weekdays, weekends and statutory holidays -- indicate F (Office-after-hours) in the location of service field when billing for eligible services provided during the after-hours-clinic premium period.
8. **Payment of Claims**
 - a) the Saskatchewan Health computer system automatically calculates the premium;
 - b) the amount paid in the total premium amount field of the adjusted service is: 10% of the after-hours-clinic premium performed service (plus the age visit supplement or the Pediatric supplement if applicable (i.e. premiums/supplements are stacked)).
 - c) if multiple eligible services are done in the specified time period, they are first assessed by standard assessment rules e.g. 75% before the premium is applied to the total;
 - d) the pay list will show the basic service code submitted and on the same record a payment amount in the total premium field equal to the value of the applicable premiums.
 - e) the premium amount will be generated and will appear on the original line (record) in the Total Premium amount field. If an adjustment is generated by MSB, it will appear as code 891A for after-hours-clinic premium.
9. Please do not submit any premium service codes or amounts; all calculations are done by the Ministry of Health. Per Documentation Requirements for the Purposes of Billing, the time and location of service must be documented in the medical record.

SECTION A – General Services

Emergency Room Coverage

A. Preamble

1. Payment for Emergency Room Coverage is intended to improve and stabilize the provision of emergency room coverage in rural Saskatchewan.
2. Emergency Room Coverage is paid according to defined categories of communities with varying emergency room characteristics.

Category "A" - facilities serving a large catchment area with high volume emergency department.

Category "B" - smaller acute care facilities or health centres designated by the Saskatchewan Health Authority (SHA) as requiring 24-hour coverage.

3. Physicians can only be paid emergency room coverage for coverage of one facility or site at a time.
4. Claims for 708A-710A and 714A-718A are to be billed electronically with:

| | |
|--------------------|---|
| HSN | The "dummy" HSN should correspond to the community as shown on Designated Category "A" Centres, Designated Category B Centres or Designated Provincial and Regionals Hospitals, as per the Coverage Areas listings. |
| DOB | January 1, 1970 |
| SEX | Male |
| NAME | Community name is entered in lieu of the patient's name (ie: Arcola, ER Coverage). |
| DIAGNOSIS | Z56 |
| LOCATION | 3 (outpatient) |
| CLINIC | Usual clinic billing number (itinerant physicians see clinic 996 note below); |
| HOURS | Actual hours of coverage as a comment if you are billing for less than the maximum period on any day. |
| POSTAL CODE | Use the postal code as listed under the category designations |

5. MSB will pay to the maximum number of hours allowed in one day.
6. When the maximum has been exceeded, the claims will be returned for review between the physician(s) and possibly the Saskatchewan Health Authority.
7. It is important that the designated on-call physician only submit the actual hours on-call.
8. Itinerant physicians are to use clinic 996 (and advise MSB) rather than their home clinic when submitting service claims for patients seen while providing weekend coverage in a community where they are not part of the normal coverage group.
9. Itinerant locum physicians should use their regular clinic number.

SECTION A – General Services

General Practitioner

Emergency Room Coverage

B. Category A

1. Emergency Room Coverage - **Category "A"** services are categorized by time of day.
2. Physicians who participate in the emergency rota are eligible for payment subject to RHA emergency coverage plans. It is expected the emergency on-call physician will:
 - a) remain on-call at all times and be available to respond in person to all emergency or emergent cases within 15-30 minutes, 24 hours a day, 7 days a week.
 - b) provide telephone/triage consultation to nursing units, ambulance attendants, health centres and other hospitals as required
3. Payment is to the designated roster physician on an hourly basis as outlined below. Only one physician may bill for emergency room coverage for any complete hour per designated facility.
4. Each day or session must be billed individually.
5. A new day starts every midnight.
6. Premiums are not paid for these emergency room services (708A to 710A).

| | | | | | |
|------|---|----------------------|--|----------------------|---------|
| 708A | Weekdays Monday to Thursday | 5 p.m. to 12:00 a.m. | -- per hour | max 7 units per day | \$16.80 |
| 709A | Weekdays Tuesday to Friday | 12:00 am to 8 am | -- per hour | max 8 units per day | \$16.80 |
| 710A | Weekends and Statutory Holidays or designated days | | -- per hour | max 24 units per day | \$41.80 |
| | | 5p.m. to 12:00 a.m. | -- Fridays; or, -- day prior to statutory holiday; or -- all day Saturday, Sunday, stat holidays | | |
| | | 12:00 a.m. to 8 a.m. | -- Monday; or, -- day following statutory holiday. | | |

Designated Category 'A' Facilities

| <u>City / Town</u> | <u>Postal Code (s)</u> | <u>Dummy HSN</u> | <u>City / Town</u> | <u>Postal Code (s)</u> | <u>Dummy HSN</u> |
|--------------------|-------------------------|------------------|--------------------|------------------------|------------------|
| Arcola/Carlyle | SOC 0G0/SOC 0R0 | 000091448 | Melfort | S0E 1A0 | 000091162 |
| Assiniboia | SOH 0B0 | 000091014 | Melville | SOA 2P0 | 000091170 |
| Biggar | SOK 0M0 | 000091022 | Moosomin | SOG 3N0 | 000091197 |
| Esterhazy | SOA 0X0 | 000091030 | Nipawin | S0E 1E0 | 000091200 |
| Estevan | S4A | 000091049 | Outlook | S0L 2N0 | 000091367 |
| Fort Qu'Appelle | SOG 1S0 | 000091057 | Oxbow | S0C 2B0 | 000091456 |
| Gravelbourg | SOH 1X0 | 000091421 | Radville | S0C 2G0 | 000091464 |
| Hudson Bay | S0E 0Y0 | 000091065 | Redvers | S0C 2H0 | 000091499 |
| Humboldt | SOK 2A0 | 000091073 | Rosetown | S0L 2V0 or S0L 3P0 | 000091235 |
| Kamsack | SOA 1S0 | 000091081 | Rosthern | SOK 3R0 | 000091243 |
| Kelvington | SOA 1W0 | 000091413 | Shellbrook | SOJ 2E0 | 000091251 |
| Kindersley | SOL 1S0/SOL 1S1/SOL 1S2 | 000091103 | Tisdale | S0E 1T0 | 000091286 |
| Kipling | SOG 2S0 | 000091383 | Turtleford | S0M 2Y0 | 000091405 |
| La Loche | SOM 1G0 | 000091111 | Unity, Wilkie | SOK 4W0 or SOK 4L0 | 000091332 |
| La Ronge | SOJ 1L0 | 000091138 | Wadena | SOA 4J0 | 000091430 |
| Lloydminster | S9V or T9V (Alta.) | 000091146 | Watrous | SOK 4T0 | 000091472 |
| Maple Creek | SON 1N0 | 000091359 | Weyburn | S4H | 000091294 |
| Meadow Lake | SOM 1V0 or S9X | 000091154 | Wynyard | SOA 4T0 | 000091375 |

SECTION A – General Services

Emergency Room Coverage

C. Category B

1. Payment is made to physicians who provide emergency room coverage to eligible facilities in accordance with an approved RHA plan. This plan may include concurrent coverage of more than one community or more than one facility.
2. It is expected that the RHA, in consultation with the physicians, will develop plans for shared call rotas that will ensure:
 - a) the ideal rota will provide for "one in three" (1:3) coverage for designated sites.
 - b) one physician will remain on-call at all times and be available to respond in person to all emergency or emergent cases within 30-45 minutes, 24 hours a day, 7 days a week. It may include coverage of more than one community or more than one facility as agreed to above.
 - c) provide telephone/triage consultation to nursing units, ambulance attendants, health centres and other hospitals as required.
3. Physicians can only be paid ER coverage for coverage of one facility or site at a time.
4. Payment is to the designated roster physician on an hourly basis as outlined below
5. Only one physician may bill for emergency room coverage for any complete hour per designated Facility.
6. Each day or session must be billed individually.
7. A new day starts every midnight.
8. Premiums are not paid for these emergency room services (714A to 716A).

| | | | | | |
|------|---|-------------------|---|-------------------------|---------|
| 714A | Weekdays Monday to Thursday | 5 p.m. to 12 a.m. | -- per hour | maximum 7 units per day | \$8.50 |
| 715A | Weekdays Tuesday to Friday | 12 a.m. to 8 a.m. | -- per hour | maximum 8 units per day | \$8.50 |
| 716A | Weekends and Statutory Holidays or designated days | | -- per hour | maximum 24 per day | \$33.95 |
| | | 5 p.m. to 12 a.m. | -- Fridays; or, -- day prior to statutory holiday; or, -- all day Saturday, Sunday, stat holidays | | |
| | | 12 a.m. to 8 a.m. | -- Monday; or, -- day following statutory holiday. | | |

Designated Category 'B' Facilities

| <u>City / Town</u> | <u>Postal Code (s)</u> | <u>Dummy HSN</u> | <u>City / Town</u> | <u>Postal Code (s)</u> | <u>Dummy HSN</u> |
|--------------------|------------------------|------------------|--------------------|------------------------|------------------|
| Balcarres | SOG 0C0 | 000092029 | Indian Head | SOG 2K0 | 000092274 |
| Black Lake | SOJ 0H0 | 000092614 | Kerrobot | SOL 1R0 | 000092290 |
| Broadview | SOG 0K0 | 000092045 | Lanigan | SOK 2M0 | 000092347 |
| Cabri/Gull Lake | SON 0J0 or SON 1A0 | 000092053 | Leader | SON 1H0 | 000092355 |
| Central Butte | SOH 0T0 | 000092754 | Lestock | SOA 2G0 | 000092363 |
| Davidson | SOG 1A0 | 000092142 | Porcupine Plain | SOE 1H0 | 000092509 |
| Eston | SOL 1A0 | 000092177 | Wakaw | SOK 4P0 | 000092630 |
| Herbert | SOH 2A0 | 000092231 | Wolseley | SOG 5H0 | 000092703 |
| Ile a la Crosse | SOM 1C0 | 000092258 | | | |

SECTION A – General Services

D. Family Physician On-Call Coverage - Provincial and Regional Hospitals

1. Payment is made to physicians who provide on-call coverage services to Provincial and Regional hospitals to assist health regions in managing patient care in these facilities. Saskatchewan Health Authority (RHA) plans for these medical services must be developed in conjunction with and be endorsed by the physician coverage group and must be approved by the Emergency Room Coverage Committee.
2. Each rotation will be expected to provide coverage on a continuous basis, 24 hours per day, 7 days per week. A formal call schedule must be developed and submitted in advance to the facility/RHA being covered.
3. Physicians are eligible to receive payment for coverage of only one facility at any given time. Physicians may not bill 717A or 718A for the same hour that they bill 708A, 709A, 710A, 714A, 715A, 716A, or for the same period in which they receive payments under the Specialist Emergency Coverage Program.
4. If a physician participates in more than one call coverage program, the combined total amount of call reimbursed cannot exceed "1 in 2" for the year.
5. Each day or session must be billed individually, with each new day starting at midnight. Premiums are not payable with these call coverage services.

| | | | | |
|------|---|-------------|----------------------|---------|
| 717A | Coverage for Provincial Hospitals (Regina/Saskatoon) | -- per hour | max 24 hours per day | \$11.10 |
| 718A | Coverage for Regional Hospitals, | -- per hour | max 24 hours per day | \$11.10 |

Designated Family Physician Coverage Facilities - Effective October 1, 2013

| <u>Facility</u> | <u>Postal Code(s)</u> | <u>Dummy HSN</u> |
|-------------------------------------|---|------------------|
| Regina General Hospital | S4L, S4N, S4P, S4R, S4S, S4T, S4V, S4X, S4Y | 000093017 |
| Regina Pasqua Hospital | S4L, S4N, S4P, S4R, S4S, S4T, S4V, S4X, S4Y | 000093114 |
| Saskatoon City Hospital | S7H, S7J, S7K, S7L, S7M, S7N, S7P, S7S, S7T, S7V, S7W | 000093211 |
| Saskatoon Royal University Hospital | S7H, S7J, S7K, S7L, S7M, S7N, S7P, S7S, S7T, S7V, S7W | 000093416 |
| Saskatoon St. Paul's Hospital | S7H, S7J, S7K, S7L, S7M, S7N, S7P, S7S, S7T, S7V, S7W | 000093319 |
| Battlefords Union Hospital | S9A, S0M | 000094102 |
| Cypress Regional Hospital | S9H | 000094315 |
| Lloydminster Hospital | S9V or T9V | 000094501 |
| Moose Jaw Union Hospital | S6H or S6J | 000094013 |
| Prince Albert Victoria Hospital | S6V or S6X | 000094218 |
| Yorkton Regional Hospital | S3N | 000094412 |

SECTION A – General Services

Specialist General
Practitioner Practitioner

Telemedicine Supplement with Direct Interactive Video Link with the Patient

Payment is limited to MSB approved facilities and practitioners who must both be in Saskatchewan. MSB is responsible for approving facilities and practitioners; exceptions will only be considered with prior approval by MSB.

732A **Initial daily supplement** - for any patient attended to using an approved telemedicine video link (maximum of one per day for all patients) \$31.40 \$31.40

734A **Subsequent daily supplement** - for additional patients attended to using an approved telemedicine video link \$12.50 \$12.50

- a) Payable in addition to appropriate visit codes only. Premiums and special call surcharges do not apply to these telemedicine codes.
- b) Payment limited to approved facilities and practitioners who must both be in Saskatchewan (exceptions will only be considered with prior approval by MSB).
- c) Payment for non-Saskatchewan beneficiaries requires prior approval by MSB.
- d) On site assistant may be needed to assist with the on-site aspects of the assessment (examination).

729A **Telemedicine Technical Standby** -- for each 15 minutes, or major portion thereof, max 30 minutes \$31.40 \$31.40

- a) Only applies if telemedicine service is delayed or interrupted for technical reasons.
- b) No other service can be provided or billed in this interval.
- c) Paid by report - please detail the nature of the problem, its resolution and the start time and end times.
- d) The time is calculated from the beginning to the end of the technical delay.

728A **General Practitioner Assistant** -- for each 15 minutes, or major portion thereof, more than 2 units require an explanation \$31.40

- a) 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.
- b) The time is calculated from the beginning to the end of the personal attendance and documented in the medical record.
- c) No other service can be provided or billed in this interval.

Video Case Conference

- a) Must be a formal scheduled session with an approved out-of-province referral centre.
- b) A single video case conference fee billed in the name of one patient covers all the patients reviewed during that videoconference.
- c) The physician should keep appropriate documentation of time and place.
- d) @ 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.
- e) For the purposes of billing, 726A and 727A are billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

726A Video case conference -- first 15 minutes \$52.40@ \$52.40@

727A Video case conference -- subsequent 15 minutes, or major portion \$36.00@ \$36.00@

SECTION A – General Services

Specialist General Practitioner

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 (1 call per patient per day maximum) | \$25.00 | \$25.00 |
|------|--|---------|---------|

- a) Additional calls or visits will only be paid by report.
- b) Payment is restricted to telephone conversations initiated by remote primary health nurse/triage nurse seeking advice about the management of a patient.
- c) All calls must be recorded on the patient's chart, including the name of the primary health nurse/triage nurse involved.

Monitoring Anticoagulant Therapy

| | | | |
|------|--|---------|---------|
| 763A | Monitoring anticoagulant therapy by telephone, per month – | \$13.00 | \$13.00 |
|------|--|---------|---------|

- a) monitoring the condition of a patient with respect to anticoagulant therapy;
- b) ordering blood tests;
- c) interpreting the results;
- d) inquiry into possible complications; and,
- e) adjusting the dosage of the anticoagulant therapy.

Max per patient per month - only 1 physician can be paid for each month.

Monitoring Diabetic Patients on Insulin

Monthly fees for monitoring and managing patients with insulin-dependent diabetes.

Includes:

- a) monitoring patient's condition;
- b) blood sugars and insulin levels;
- c) ordering and interpreting any necessary tests; and,
- d) adjusting insulin dosage as necessary.

1. The fees are only payable for months in which information (by phone, fax, e-mail or other electronic means) has been sent to the physician that requires a change in the patient's drug or insulin therapy.
2. The physician must review the information personally (not billable if review undertaken by nurse or diabetes educator).
3. Only one (1) physician may bill these codes for any given patient in any one month.
4. A record of the information and the physician's advice must be included in the patient's chart.

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|------|--|---------------------------------|---------|---------|
| 764A | Patients with type 2 diabetes on insulin | -- per month | \$23.10 | \$23.10 |
| 765A | Patients with type 1 diabetes on insulin | -- per month | \$46.40 | \$46.40 |
| 766A | Patients with type 1 diabetes on insulin pump | -- first 12 months -- per month | \$70.90 | \$70.90 |
| 767A | Patients with type 1 diabetes on insulin pump | -- after 12 months -- per month | \$46.40 | \$46.40 |
| 768A | Pregnant patients with diabetes (type 1 or 2) on insulin | -- per month | \$69.50 | \$69.50 |

-- includes gestational diabetes

SECTION A – General Services

Specialist General
Practitioner

Remote Consultation Between Physicians

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|------|---|---------|----------|
| 769A | <p>Major Telephone Assessment -- includes:</p> <ul style="list-style-type: none"> a) pertinent family history; b) patient history; c) history of presenting complaint; d) discussion with referring physician of functional enquiry and examination of all parts and systems; e) review of laboratory and/or other data; f) diagnosis/assessment; and, g) record and written submission of the consultant's opinion and recommendations to the referring doctor, but without the consulting physician seeing the patient. | \$50.50 | \$50.50@ |
|------|---|---------|----------|

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.

| | | | |
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| 762A | <p>Minor Telephone Assessment -- includes:</p> <ul style="list-style-type: none"> a) history review; b) history of presenting complaint; and, c) discussion of patient condition/management and recommendation to referring physician, but without the consulting physician seeing the patient. <ol style="list-style-type: none"> 1. A written opinion is not necessary for this fee. However, the referring physician's name, patient information, the diagnosis and the recommendation must be recorded. 2. The specialist may respond by telephone, fax or e-mail. <p>@ General practitioners approved to provide coverage under the Specialist Emergency Coverage Program may be entitled to bill 762A and 769A.</p> | \$25.00 | \$25.00@ |
|------|---|---------|----------|

| | | | |
|------|--|---------|--|
| 770A | <p>Monitoring Home Parenteral Antimicrobial Intravenous Therapy – by telephone</p> <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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. | \$25.00 | |
|------|--|---------|--|

SECTION A – General Services

Specialist General Practitioner

Telephone Calls/Facsimile/Email initiated by Allied Health Care Personnel to Discuss Patient Care and Management

1. Allied health care personnel includes, but is not limited to:
 - Home Care Coordinators
 - Registered and licensed practical nurses
 - VON
 - Public health nurses
 - Psychiatric Nurses
 - Mental health workers
 - Physiotherapists
 - Occupational Therapists
 - Respiratory Therapists
 - Ambulance Paramedics
 - Social Workers
 - Psychologists
 - School Teachers/counsellors
 - Pharmacists
 - Private care home shift supervisor
2. Physicians, optometrists, dentists and chiropractors are not considered allied health care personnel, per “Definitions”.
3. Payment is restricted to telephone calls, facsimile or email initiated by allied health care personnel.
4. Telephone calls initiated by the patient's family members may not be billed under this code.
5. 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.
6. 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.
7. 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 prescriptions or switching to a generic form of a drug.
8. No claim may be made for telephone calls regarding patients in hospital receiving acute care.
9. This service is not intended to cover calls insured as part of the Emergency Room Coverage codes (708A to 716A) and Family Physician On-Call Coverage codes (717A and 718A).
10. This fee code is intended to compensate the physician for unexpected interruptions to the physician's normal practice routine.
11. Where the allied health personnel requests information or advice by facsimile, email or other electronic means, the physician may respond by telephone, facsimile, email or other electronic means and submit a claim for this request.
12. Only one of codes 790A, 791A, 794A and 795A is payable per day.
13. If other services are provided on the same day codes 790A/791A are not payable
14. Phone calls related to the care of patients designated as palliative are billed under code 793A.
15. This code is not intended to cover calls regarding patients being billed under code 770A (antimicrobial management stipend).

On Behalf Of Nursing Home Patients

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|------|-----------------------------|---|---------|---------|
| 790A | Telephone/facsimile/email - | Not payable in addition to any other payment for the same date of service | \$12.50 | \$12.50 |
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On Behalf Of All Other Patients

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|------|-----------------------------|---|---------|---------|
| 791A | Telephone/facsimile/email - | Not payable in addition to any other payment for the same date of service | \$12.50 | \$12.50 |
|------|-----------------------------|---|---------|---------|

SECTION A – General Services

Specialist General
Practitioner Practitioner

Telephone Calls/Facsimile/Email on behalf of a Palliative Patient

1. This code is billable for patients designated as palliative by the Saskatchewan Health Authority or by the Saskatchewan Drug Plan.
2. Billing is restricted to telephone calls, facsimile or email initiated by allied health care personnel, or telephone calls from the patient's designated family representative.
3. Allied health care personnel includes, but is not limited to:
 - Home Care Coordinators;
 - Registered and licensed practical nurses;
 - VON;
 - Public health nurses;
 - Psychiatric Nurses;
 - Mental health workers;
 - Physiotherapists;
 - Occupational Therapists;
 - Respiratory Therapists;
 - Ambulance Paramedics;
 - Social Workers;
 - Psychologists;
 - School Teachers/counsellors;
 - Pharmacists;
 - Private care home shift supervisor.
4. Physicians, optometrists, dentists and chiropractors are not considered allied health care personnel, per "Definitions".
5. 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 member.
6. No claim may be made for telephone calls regarding patients in hospital receiving acute care.
7. Where the allied health personnel requests information or advice by facsimile, email or other electronic means, the physician may respond by telephone, facsimile, email, or other electronic means.
8. Contacts from the patient's family representative are restricted to telephone calls.
9. 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
10. 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 prescriptions or switching to a generic form of a drug.
11. A maximum of three contacts are payable per day.
12. Codes 790A, 791A, 794A, and 795A are not billable for this patient on the day this code is billed.
13. This code is not intended to cover calls regarding patients being billed under code 770A (antimicrobial management stipend).

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|------|---|---------|---------|
| 793A | Telephone calls/facsimile/email on behalf of palliative per patient -- bill units – max 3 | \$20.00 | \$20.00 |
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SECTION A – General Services

Specialist General
Practitioner Practitioner

Prescription Renewal By Telephone Call, Facsimile, Email Or Other Electronic Means

1. Payment is restricted to prescription renewals initiated by a pharmacist by telephone, facsimile, email or other electronic means.
2. This service is not to be used as a routine practice or to authorize repeat prescriptions for which long term repeats would more properly have been authorized at the time of writing of the initial prescription.
3. All requests must be recorded on the patient's chart, including the name of the pharmacist involved and the purpose of the request.
4. This code is not intended to cover calls made to clarify a prescription or decipher an illegible prescription, switching to a generic form of a drug or requesting EDS, these services are part of the visit service that involved the writing of the initial prescription.
5. No claim may be made for telephone calls in which only a physician proxy, e.g. nurse or clerk, speaks with the pharmacist.
6. No claim may be made when a physician directs a patient to request the pharmacist to call, fax or e-mail a renewal request.
7. No claim may be made for telephone calls regarding patients in hospital receiving acute care.
8. This service code is not intended to cover calls insured as part of the Emergency Room Coverage codes 708A to 716A and Family Physician On-Call Coverage codes 717A and 718A.
9. Where the pharmacist requests a prescription renewal by facsimile, email or other electronic means, the physician may respond by telephone, facsimile, email or other
10. This service code includes oxygen renewals through the SAIL program.
11. Only one of the service codes 790A, 791A, 794A and 795A are payable per day. If other services are provided on the same day, codes 794A and 795A are not payable.
12. This code is not intended to cover calls regarding patients being billed under code 770A (antimicrobial management stipend).

| | | | | |
|------|-----------------------------------|---|--------|--------|
| 794A | Prescription renewal phone call - | Not payable in addition to any other payment for the same date of service | \$5.00 | \$5.00 |
| 795A | Prescription renewal fax/email - | Not payable in addition to any other payment for the same date of service | \$5.00 | \$5.00 |

SECTION A – General Services

Specialist General Practitioner

Continuous Personal Attendance

1. This service code is all inclusive, for medically required personal attendance given continuously by a physician, where no other item in the Payment Schedule applies.
2. This code requires that the physician is continuously present at the patient's side.
3. For example, if a physician spends 45 minutes providing care continuously to a person, 15 minutes is for closed chest drainage (95L) and the remaining 30 minutes is for services where no other items in the payment schedule apply, then the physician should bill 95L plus two units of 918A.
4. Certain procedures may be billed in conjunction with a period of 918A in the same manner as they may be billed in conjunction with a period of 335H-339H (see Section H).
5. It may be billed with the appropriate emergency or special call surcharge.
6. For intensive care in ICU or CCU -- see Section H.
7. Code 918A is not paid for maternity cases.
8. **For a claim to be processed, the physician must provide details of:**
 - a) the clinical condition necessitating continuous attendance;
 - b) the treatment or care provided;
 - c) time when continuous attendance on patient started and was completed.

| | | | |
|------|---|---------|---------|
| 918A | Continuous personal attendance -- per 15 minutes or major portion thereof | \$43.10 | \$38.80 |
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Physician Accompanying a Patient on Transfer By Ambulance from one Locale to Another

1. These service codes are all inclusive, for medically required attendance during patient transfer by ambulance.
2. 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).
3. 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).
4. It may be billed with the appropriate emergency or special call surcharge.
5. **For a claim to be processed, the physician must provide details of:**
 - a) the clinical condition necessitating continuous attendance;
 - b) the treatment or care provided;
 - c) time when continuous attendance on patient started and was completed.

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|------|--|--|--------------|---------|---------|
| 926A | Outbound journey with patient only | -- per 15 minutes or major portion thereof | - bill units | \$49.00 | \$44.10 |
| 927A | Homeward or return journey with or without patient | -- per 15 minutes or major portion thereof | - bill units | \$28.10 | \$25.30 |
| 928A | Standby at destination while patient is transferred to receiving physician (max 2 units) | -- per 15 minutes or major portion thereof | - bill units | \$31.50 | \$31.50 |

SECTION A – General Services

General
Practitioner

Indirect Patient Care - Emergency Situations - Emergency Department

1. This service code is limited to emergency situations in emergency departments where physician time is used exclusively for indirect patient care. This code may only be billed by general practitioners.
2. Indirect patient care includes arranging and coordinating:
 - a) diagnostic imaging required for immediate treatment;
 - b) hospital admission;
 - c) laboratory investigations necessary for immediate treatment;
 - d) necessary ancillary medical staff;
 - e) surgical team;
 - f) telephone calls to arrange immediate specialist intervention; and
 - a) transfer of the patient to another acute care facility.
3. Indirect patient care does not include:
 - a) completion of hospital admission documents;
 - b) discussing the patient's condition with the family;
 - c) patient conversations;
 - d) recording of exam findings;
 - e) research or discussion about the case;
 - f) telephone calls to other physicians for advice; and
 - g) telephone calls to arrange non-urgent specialist care.
4. This code is billable on the same day as continuous personal attendance (918A) and emergency resuscitation codes (220A-226A), provided that the time periods do not overlap.
5. It is billable following minor assessments, major assessments and consultations.
6. It may be billed with the appropriate emergency or special call surcharge.
7. Physicians cannot bill for other work during the same time as this service is being billed.
8. For a claim to be processed, the physician must provide details of:
 - a) the patient's clinical condition, and;
 - b) the type of care being arranged, and;
 - c) the time when indirect patient care was started and was completed.

919A **Indirect patient care** -- per 15 minutes or major portion thereof -- bill units \$30.60

SECTION B – General Practice

General
Practitioner

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, 55B, 9B, 11B, 15B, 73B, and 85B. Any other services are not eligible for this supplement
3. You are not required to submit any codes or indicators to obtain this supplement. MSB will generate the payment of this supplement automatically and report the payment on your pay list or paid files using the total premium amount field or column at the following rates:
 - a) for patients 55 to 64 years of age ----- 15%
 - b) for patients 65 to 74 years of age ----- 25%
 - c) for patients 75 years of age and older ----- 35%

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

| | | | | | | | | | | | | |
|---|--|------------------------------|----------------|-------------------------------------|---------------|-------------------------------------|-------------------------|--|--------------------------------|--|--------------------------------|----------|
| 3B | <p>Complete assessment--includes:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a) pertinent family history;</td> <td style="width: 50%;">f) assessment;</td> </tr> <tr> <td>b) patient history;</td> <td>g) diagnosis;</td> </tr> <tr> <td>c) history of presenting complaint;</td> <td>h) necessary treatment;</td> </tr> <tr> <td>d) functional enquiry;</td> <td>i) advice to the patient; and,</td> </tr> <tr> <td>e) examination of all parts and systems;</td> <td>j) record of service provided.</td> </tr> </table> | a) pertinent family history; | f) assessment; | b) patient history; | g) diagnosis; | c) history of presenting complaint; | h) necessary treatment; | d) functional enquiry; | i) advice to the patient; and, | e) examination of all parts and systems; | j) record of service provided. | \$67.00* |
| a) pertinent family history; | f) assessment; | | | | | | | | | | | |
| b) patient history; | g) diagnosis; | | | | | | | | | | | |
| c) history of presenting complaint; | h) necessary treatment; | | | | | | | | | | | |
| d) functional enquiry; | i) advice to the patient; and, | | | | | | | | | | | |
| e) examination of all parts and systems; | j) record of service provided. | | | | | | | | | | | |
| 4B | <p>Well baby care in office -- refers to the periodic office visits during the first year of life of a healthy infant and includes:</p> <ol style="list-style-type: none"> a) the necessary weights and measurements; b) examination; c) instruction to the parent regarding health care; and, d) record of service provided. | \$36.40* | | | | | | | | | | |
| 5B | <p>Partial assessment or subsequent visit -- includes:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a) history review;</td> <td style="width: 50%;">e) assessment;</td> </tr> <tr> <td>b) history of presenting complaint;</td> <td>f) diagnosis;</td> </tr> <tr> <td>c) functional enquiry;</td> <td>g) necessary treatment;</td> </tr> <tr> <td>d) examination of affected part(s) or system(s);</td> <td>h) advice to the patient; and,</td> </tr> <tr> <td></td> <td>i) record of service provided.</td> </tr> </table> | a) history review; | e) assessment; | b) history of presenting complaint; | f) diagnosis; | c) functional enquiry; | g) necessary treatment; | d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | i) record of service provided. | \$35.00* |
| a) history review; | e) assessment; | | | | | | | | | | | |
| b) history of presenting complaint; | f) diagnosis; | | | | | | | | | | | |
| c) functional enquiry; | g) necessary treatment; | | | | | | | | | | | |
| d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | | | | | | | | | | |
| | i) record of service provided. | | | | | | | | | | | |
| <p>Use 55B instead of 5B for a visit where a specialist referral is made and continue using 5B for visits where a specialist referral is not made</p> | | | | | | | | | | | | |
| 55B | <p>Partial assessment or subsequent visit involving a specialist referral -- includes:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a) history review;</td> <td style="width: 50%;">e) assessment;</td> </tr> <tr> <td>b) history of presenting complaint;</td> <td>f) diagnosis;</td> </tr> <tr> <td>c) functional enquiry;</td> <td>g) necessary treatment;</td> </tr> <tr> <td>d) examination of affected part(s) or system(s);</td> <td>h) advice to the patient; and,</td> </tr> <tr> <td></td> <td>i) record of service provided.</td> </tr> </table> | a) history review; | e) assessment; | b) history of presenting complaint; | f) diagnosis; | c) functional enquiry; | g) necessary treatment; | d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | i) record of service provided. | \$35.00* |
| a) history review; | e) assessment; | | | | | | | | | | | |
| b) history of presenting complaint; | f) diagnosis; | | | | | | | | | | | |
| c) functional enquiry; | g) necessary treatment; | | | | | | | | | | | |
| d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | | | | | | | | | | |
| | i) record of service provided. | | | | | | | | | | | |
| 8B | <p>Prenatal visit after the first visit for maternity care or post-natal office visit</p> | \$36.40 | | | | | | | | | | |

* Payment for patients 0-5 years of age is automatically applied. See Section A-Pediatric Visit Age Supplement for details.

SECTION B – General Practice

General
Practitioner

9B **Consultation** – includes: \$75.00*
 a) all visits necessary;
 b) history and examination;
 c) review of laboratory and/or other data; and
 d) written submission of the consultant's opinion and recommendations to the referring doctor

11B **Repeat Consultation** \$36.40*
 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.

15B **Pre-operative assessment** --includes: \$66.60*
 a) pertinent family and social history;
 b) patient history;
 c) functional enquiry;
 d) examination of all relevant parts and systems, and;
 e) completion of required forms and advice to the patient as necessary.

1. Payable only to physicians other than the attending surgeon
2. Where this service is provided by the same physician within 30 days of a complete assessment it should be billed as a partial assessment.

* Payment for patients 0-5 years of age is automatically applied. See Section A-Pediatric Visit Age Supplement for details.

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery.

Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | |
|-----|---------------------------|-----------------------------------|---------|
| 25B | -- 1-10 days | -- per day -- bill units (max 10) | \$34.90 |
| 26B | -- 11-20 days | -- per day -- bill units (max 10) | \$34.90 |
| 27B | -- 21-30 days | -- per day -- bill units (max 10) | \$34.90 |
| 28B | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$34.90 |

SECTION B – General Practice

General
Practitioner

Palliative Hospital Care – Payable on day of admission

Palliative hospital care is billable by the physician responsible for the in-hospital care of patients designated as palliative by the Saskatchewan Health Authority or the Saskatchewan Drug Plan.

1. Hospital care includes all of the routine services required to manage in hospital care.
2. Additional services provided as a result of an acute episode may be payable with an explanation.
3. An assessment or consultation may not be billed when palliative hospital care is transferred to another physician.
4. This code is billed instead of regular hospital care codes (25B to 28B).

35B Palliative hospital care -- per day, bill units (maximum 99 per line; 1 unit = 1 day) \$43.20

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.

Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.

40B Counselling -- first 15 minutes, includes: \$37.50

| | |
|--------------------------|-------------------------------------|
| a) history review; | d) intervention; |
| b) counselling,; | e) record of service provided, and; |
| c) educational dialogue; | f) time spent counselling. |

41B Counselling -- next 15 minutes or major portion thereof \$37.50

SECTION B – General Practice

Case Conference

1. Must be a formal scheduled session.
2. A single conference fee billed in the name of one patient covers all the patients reviewed at that conference.
3. Use 43B if case conference is part of Home Care Program.
4. A maximum of two case conferences per patient per year is billable.
5. The physician must keep appropriate documentation of start and stop times and place; per Documentation Requirements for the Purposes of Billing.
6. May be billed by any physician.

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|-----|---|---|---------|
| 42B | -- per conference (not patient) | -- first 30 minutes or part thereof | \$69.10 |
| 43B | -- per home care conference (not patient) | -- first 30 minutes or part thereof | \$69.10 |
| 44B | -- add to 42B or 43B | -- for each additional 15 minutes or part thereof | \$31.50 |

Supportive Care

1. 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:
 - a) promote continuity of care;
 - b) reassure the patient and liaise with the family;
 - c) become aware of the specialist's current and future treatment recommendations;
 - d) facilitate the continuing management of the patient in the community following discharge.
2. This service must be documented in the patient's file (hospital chart).
3. 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.
4. 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 preceding 30 days.
5. 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 | Supportive care, initial visit -- to be billed once per admission - otherwise use 53B | \$41.30 |
| 53B | Supportive care, 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) | \$41.30 |

Hepatitis C - Monthly Stipend For Overseeing Treatment

1. Monthly stipend for managing the treatment of patients with a confirmed diagnosis of Hepatitis C.
2. The fees are payable for months in which treatment is provided according to recognized protocols for Hepatitis C.
3. Only one physician may bill this code per month per patient.
4. Patient contacts would continue to be paid as visit services.
5. This fee is not eligible for premiums or surcharges.
6. This payment stops when the active treatment protocol ends.
7. @ May be billed by physicians granted entitlement by the Saskatchewan Medical Association Tariff Committee only. For the purposes of billing, 57B is billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

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| 57B | Hepatitis C - Monthly Stipend For Overseeing Treatment -- each month | \$51.00@ |
|-----|--|----------|

SECTION B – General Practice

General
Practitioner

Monthly stipend for Overseeing Methadone Management – Addiction patients only

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|-----|-----------------|-----------------------------------|---------|
| 60B | First 3 months | -- per patient (lifetime maximum) | \$50.00 |
| 61B | Second 3 months | -- per patient (lifetime maximum) | \$40.00 |
| 62B | Thereafter | -- per patient | \$25.00 |

1. No restarts in the payment program; 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.
2. Only one physician will be paid the monthly stipend.
3. Change of physician does not affect level of payment.
4. Visits for each patient contact would be paid as at present (5B's or 40B's) in addition to monthly stipend.
5. Not eligible for premiums or surcharges.
6. Entitlement to these monthly stipends is limited to physicians who:
 - a) have been approved by the College of Physicians and Surgeons of Saskatchewan to prescribe methadone for addiction; and
 - b) are actively supervising the patient's continuing use of methadone or buprenorphine/naloxone (Suboxone) within the provincial methadone program.
7. This payment stops when the patient stops taking methadone.

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|-----|--------------------------------|--|---------|
| 63B | Psychiatric Examination | | \$72.10 |
|-----|--------------------------------|--|---------|

1. Examination and certification of need for psychiatric examination pursuant to The Mental Health Services Act with completion of Form A.
2. 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.

SECTION B – General Practice

Chronic Disease Management

1. Chronic disease management (CDM) fees are designed to encourage the use of accepted clinical care pathways to optimize the patient management.
2. CDM fees are billable only for patients with a confirmed diagnosis of diabetes mellitus, coronary artery disease, heart failure or chronic obstructive pulmonary disease (COPD) who requires ongoing longitudinal care management of these diseases.
3. Frequency:
 - a) CDM fees are billable only once per patient, every 90 days.
 - b) 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".
 - c) Subsequent (after 90 days) CDM fee claims must be consecutive and continuous for the same patient by the same physician or clinic and will not require a comment.

Flow Sheets:

- a) A patient CDM flow sheet approved by the Saskatchewan Medical Association must be completed and care must be consistent with approved guidelines.
 - b) The approved CDM flow sheets are available on the Saskatchewan Medical Association website.
4. More Than One Condition:
 - a) If the patient has more than one of these conditions, they will be dealt with at the same visit.
 - b) An approved patient CDM flow sheet must be completed for each condition and at least 5 minutes of additional physician time per condition will be spent.
 5. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.

| | | |
|--|---|---------|
| 64B | Chronic Disease Management -- base fee | \$35.00 |
| <u>Add one or more of the following fees for chronic condition(s) assessed during the visit:</u> | | |
| 65B | Diabetes mellitus -- add - billable for diagnostic codes: 250 | \$35.00 |
| 66B | Coronary artery disease -- add - billable for diagnostic codes: 410-414 inclusive | \$35.00 |
| 67B | Heart failure -- add - billable for diagnostic codes: 425, 428, 429 | \$35.00 |
| 68B | COPD -- add - billable for diagnostic codes: 490, 491, 492, 496, 518, 519 | \$35.00 |

Examples:

- If a patient has coronary artery disease, the physician can bill fee 64B and 66B with the completion of a flow sheet after 15 minutes of physician time.
- If a physician sees a patient with more than one chronic disease such as diabetes and coronary artery disease, he/she would bill fee 64B, 65B and 66B with the completion of a both flow sheets after 20 minutes of physician time.

SECTION B – General Practice

General
Practitioner

Emergency Medicine-Visits

1. The following apply to services provided by scheduled on-site physicians providing services in hospital emergency departments.
2. Surcharges are not payable with these codes.
3. Other procedures and visits shall be billed using the General Practice codes and fees as listed in the various sections.
4. 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 and 5B).
5. 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.
6. These services are not to be used for free standing treatment centers or non-hospital emergency clinics
7. Service codes 73B and 85B are eligible for increased compensation when providing an eligible visit service for a patient over 54 years of age. See Preamble at the beginning of the section for details.

| | | | | | | | | | | | | |
|--|---|------------------------------|---------------|---------------------|----------------|-------------------------------------|-------------------------|------------------------|--------------------------------|--|--------------------------------|----------|
| 73B | <p>Complete assessment --includes:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a) pertinent family history;</td> <td style="width: 50%;">f) diagnosis;</td> </tr> <tr> <td>b) patient history;</td> <td>g) assessment;</td> </tr> <tr> <td>c) history of presenting complaint;</td> <td>h) necessary treatment;</td> </tr> <tr> <td>d) functional enquiry;</td> <td>i) advice to the patient; and,</td> </tr> <tr> <td>e) examination of all parts and systems;</td> <td>j) record of service provided.</td> </tr> </table> | a) pertinent family history; | f) diagnosis; | b) patient history; | g) assessment; | c) history of presenting complaint; | h) necessary treatment; | d) functional enquiry; | i) advice to the patient; and, | e) examination of all parts and systems; | j) record of service provided. | \$69.10* |
| a) pertinent family history; | f) diagnosis; | | | | | | | | | | | |
| b) patient history; | g) assessment; | | | | | | | | | | | |
| c) history of presenting complaint; | h) necessary treatment; | | | | | | | | | | | |
| d) functional enquiry; | i) advice to the patient; and, | | | | | | | | | | | |
| e) examination of all parts and systems; | j) record of service provided. | | | | | | | | | | | |

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|--|--|--------------------|---------------|-------------------------------------|----------------|------------------------|-------------------------|--|--------------------------------|--|-------------------------------|----------|
| 85B | <p>Partial assessment or subsequent visit --includes:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a) history review;</td> <td style="width: 50%;">e) diagnosis;</td> </tr> <tr> <td>b) history of presenting complaint;</td> <td>f) assessment;</td> </tr> <tr> <td>c) functional enquiry;</td> <td>g) necessary treatment;</td> </tr> <tr> <td>d) examination of affected part(s) or system(s);</td> <td>h) advice to the patient; and,</td> </tr> <tr> <td></td> <td>i) record of service provided</td> </tr> </table> | a) history review; | e) diagnosis; | b) history of presenting complaint; | f) assessment; | c) functional enquiry; | g) necessary treatment; | d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | i) record of service provided | \$35.50* |
| a) history review; | e) diagnosis; | | | | | | | | | | | |
| b) history of presenting complaint; | f) assessment; | | | | | | | | | | | |
| c) functional enquiry; | g) necessary treatment; | | | | | | | | | | | |
| d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | | | | | | | | | | |
| | i) record of service provided | | | | | | | | | | | |

* Payment for patients 0-5 years of age is automatically applied. See Section A-Pediatric Visit Age Supplement for details.

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.

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|------|--|---------|
| 200B | <p>Spinal pathway</p> <ol style="list-style-type: none"> 1. Physicians that have completed the Saskatchewan Spine Pathways course, "Assessment and Management of Low Back Pain" are eligible to bill this code. 2. This code may be billed once per acute or chronic episode that requires completing the "Spinal Pathway" form and algorithm. | \$15.00 |
|------|--|---------|

SECTION B – General PracticeGeneral
Practitioner**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 at least two of the following: education, training, experience and references), AND 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. See “Services Billable by Entitlement”.

The initial assessment is payable to general practitioners once per patient every 5 years where a minimum of 45 minutes is spent on the following:

- 1) Complete medical assessment and documentation of:
 - a) medical history;
 - b) psychiatric history;
 - c) family history;
 - d) allergy and intolerance history;
 - e) pertinent physical examination;
 - f) pertinent past medical investigations and treatments; and
 - g) pain diagnosis and type (nociceptive, neuropathic, mixed, central).
- 2) Pain diagram, brief pain inventory and the DN4 Neuropathic Pain questionnaire.
- 3) Addiction screening including Opioid Risk Tool score (ORT).
- 4) Current psychological evaluation including one or more of the following tools:
 - a) Beck's Inventory;
 - b) Hospital Anxiety and Depression Score (HADS);
 - c) PHQ-9 or equivalent; or.
 - d) Pain Catastrophizing score (PCS).
- 5) Medication history including current medications (with verification by accessing the Pharmaceutical Information Program) and past medications trialed for the pain condition.
- 6) Opioid use agreement/informed consent and urine drug test (UDT) if opioids are considered
- 7) Initial education on chronic pain as a disease and self-management.
- 8) The required documents can be found on the Saskatchewan Medical Association website (www.sma.sk.ca), or an equivalent EMR checklist system can be used
- 9) Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

205B **Chronic Pain Management - Initial Assessment**

\$203.90@

SECTION B – General Practice

General
Practitioner

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 at least two of the following: education, training, experience and references), AND 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. See “Services Billable by Entitlement”.

The follow-up assessment is payable to general practitioners once per patient every 90 days to the same physician who provided the initial assessment, where a minimum of 15 minutes is spent on the following:

1. Physicians must track patient care using the approved check list on the Saskatchewan Medical Association website (www.sma.sk.ca) or equivalent Electronic Medical Record (EMR) tracking system, which would include an assessment of:
 - a) Analgesia (pain scores);
 - b) Activities, including physical and psychosocial functioning;
 - c) Adverse effects (analysis of side effects that have occurred and physician recommendations to address);
 - d) Aberrant drug-taking behaviour with physician advice as necessary;
 - e) Accurate medication record outlining exact medication, dose, frequency of use and amount prescribed; and
 - f) Effect on patient’s mood and mental health status
2. The above will include a brief pain inventory (BPI), urine drug screen, update of Beck’s (or equivalent) Depression/Anxiety score.
3. Visits in excess of annual limits (or those lasting less than 15 minutes’ duration) would be billed using the partial assessment (5B) fee.
4. Physicians are expected to schedule the patient’s follow-up visit before the pain prescription runs out.
5. Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

206B **Chronic Pain Management – Follow-up Assessment**

\$69.90@

SECTION B – General Practice

General
Practitioner

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**

\$73.60

SECTION C – Pediatrics

Specialist in Pediatrics

Referred Not Referred

Visits

| | | | |
|-----|--|-----------|----------|
| 3C | <p>Complete assessment -- includes:</p> <ul style="list-style-type: none"> a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) examination of all parts and systems; f) diagnosis; g) assessment; h) necessary treatment; i) advice to the patient; and, j) record of service provided. | \$91.10* | \$82.10* |
| 4C | <p>Well baby care in office -- refers to the periodic office visits during the first year of life of a healthy infant and includes:</p> <ul style="list-style-type: none"> a) the necessary weights and measurements; b) examination; c) instruction to the parent regarding health care; and, d) record of service provided. | \$33.40* | \$30.15* |
| 5C | <p>Partial assessment or subsequent visit -- includes:</p> <ul style="list-style-type: none"> a) history review; b) history of presenting complaint; 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. | \$64.70* | \$58.20* |
| 9C | <p>Consultation—includes:</p> <ul style="list-style-type: none"> a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; d) written submission of the consultant’s opinion; and, e) recommendations to the referring doctor. | \$135.00* | |
| 11C | <p>Repeat consultation</p> <p>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.</p> <p>Extended/Complex Pediatric Consultation - for complex behavioural, neurodevelopmental, and/or psychiatric conditions in a child age 17 and under – includes:</p> <ul style="list-style-type: none"> 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. <ol style="list-style-type: none"> 1. Stop and start times must be included on the claim and in the patient record. 2. Maximum of one (1) per patient per physician per 12-month period. 3. Any follow-up assessments should be billed using 14C or 5C. | \$55.00* | |
| 12C | <p>Extended/Complex Pediatric Consultation - per complete 45 minute time period spent directly with the patient</p> | \$185.00* | |
| 13C | <p>Extended/Complex Pediatric Consultation - for each additional 15 minutes, or major portion thereof, spent directly with the patient – bill units units (max 3)</p> | \$35.00* | |

* Payment for patients 0-5 years of age and older are automatically applied.

SECTION C – Pediatrics

Specialist in Pediatrics

Referred Not Referred

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|-----|--|----------|----------|
| 14C | Complex partial assessment or subsequent visit - for eligible conditions a) history review; b) history of presenting complaint; 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. | \$98.20* | \$88.30* |
|-----|--|----------|----------|

Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

For Pediatric (under age 18) patient visits that involve at least 15 minutes physician time and the following eligible conditions:

- AIDS; Other human immunodeficiency virus infection
- Ankylosing Spondylitis and other Seronegative Spondyloarthropathies;
- Anorexia Nervosa;
- Anxiety/Mood Disorders;
- Asthma;
- Behavioural disorders of childhood and adolescence;
- Cerebral Palsy;
- Child Psychosis or Autism;
- Chromosomal Anomalies;
- Chronic Hepatitis;
- Chronic Lung Disease;
- Chronic Respiratory Failure;
- Coagulation defects (e.g. Hemophilia, other factor deficiencies);
- Congenital Heart Disease;
- Congestive Heart Failure;
- Diabetes Mellitus, including complications;
- Epilepsy;
- Foster Care Child;
- Hemorrhagic conditions (e.g. Thrombocytopenia Purpura);
- Hypertension;
- Inflammatory Bowel Disease;
- Multiple Sclerosis;
- Myelomeningocele;
- Panhypopituitarism;
- Physical and Sexual Neglect and Abuse
- Pulmonary Fibrosis;
- Renal Failure;
- Specific delays in development (e.g. Dyslexia, Dyslalia, Motor Retardation);
- Systemic Lupus Erythematosus, Scleroderma, Polymyositis, Dermatomyositis;
- Systemic Vasculitis;
- Technology Dependent (tube fed, tracheostomy, CPAP, oxygen dependent)

Hospital Care - Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25C | -- 1-10 days | -- per day -- bill units (max 10) | \$32.90 | \$32.90 |
| 26C | -- 11-20 days | -- per day -- bill units (max 10) | \$32.90 | \$32.90 |
| 27C | -- 21-30 days | -- per day -- bill units (max 10) | \$32.90 | \$32.90 |
| 28C | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$32.90 | \$32.90 |

* Payment for patients 0-5 years of age and older are automatically applied.

SECTION C – Pediatrics

Specialist in Pediatrics

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| Referred | Referred |

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; | d) Intervention and/or treatment; |
| b) Counselling; | e) Record of service provided, and; |
| c) Educational dialogue; | f) Time spent counselling. |

1. Stop and start times must be included on the claim and in the patient record.
2. It is not payable for routine briefing or advice to relatives/caregivers, which is considered part of the visit service fee (ie: 9C, 3C, 5C, 14C, etc).
3. It is not a substitute for a visit involving an initial or partial examination or assessment (14C, 5C, 3C, etc).
4. This code is not to be used because an assessment (9C, 14C, 5C, 3C, etc) and/or treatment took 15 minutes or longer, such as in the case of multiple complaints.
5. Maximum of 2 per child per physician per year.
6. Third party counselling must be billed in the name of the child using ICD diagnostic code Z84. The name and relationship to the child must be included with the claim.

| | | | |
|-----|---|---------|---------|
| 15C | Pediatric counselling - per first complete 15-minute time period for time spent directly with the child and/or relatives/caregivers counselling | \$48.00 | \$48.00 |
| 16C | Pediatric counselling - 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) | \$48.00 | \$48.00 |

SECTION C – Pediatrics

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| 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. | | | | | |
| 35C | Exchange transfusion – first | \$152.90 | \$137.60 | 0 | |
| 36C | Exchange transfusion – repeat | \$152.60 | \$137.20 | 0 | |
| 37C | Fontanel or jugular or femoral vein puncture | \$10.20 | \$9.20 | D | |
| 38C | Duodenal intubation for analysis | \$15.80 | \$14.30 | D | |
| 39C | Attendance at intrauterine fetal transfusion | \$71.40 | | 0 | |
| 40C | Cannulization of umbilical artery in the newborn | \$51.00 | \$45.90 | 0 | |
| 41C | Cannulization of umbilical vein in the newborn | \$40.80 | \$36.70 | 0 | |
| 42C | Growth hormone studies -- 2-hour insulin IV infusion | \$254.90 | | D | |
| 43C | Growth hormone studies -- subsequent arginine IV infusion (includes IV infusion set up, blood collection and treatment of side effects and/or complications) | \$76.50 | | D | |
| 50C | Rashkind Septostomy | \$356.80 | \$321.10 | 10 | |
| 60C | Cardiorespirogram -- interpretation | \$26.30 | | D | |
| The following codes are for use by pediatric 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. | \$203.90 | | D | H |
| 105C | Cardiac catheterization -- left retrograde, includes catheter insertion and LV and AO pressures. | \$203.90 | | D | H |
| 110C | Oximetry during cardiac catheterization | \$102.00 | | D | |
| 115C | Transluminal angioplasty -- pulmonary valve or artery | \$509.80 | | 10 | H |
| 120C | Balloon dilation of conduit or graft | \$509.80 | | 10 | H |
| 125C | Stent placement in aorta pulmonary artery or conduit | \$611.70 | | 10 | H |
| 130C | Balloon dilatation of coarctation of aorta | \$509.80 | | 10 | H |
| 135C | Atrial septal puncture by Brockenbrough needle | \$305.90 | | 10 | H |
| 140C | Pulmonary angiography | \$152.90 | | D | |
| 155C | Pulmonary hypertension studies | \$407.80 | | D | |
| 145C | Angiocardiology -- right and/or left side | \$152.90 | | D | H |
| 150C | Fetal echocardiogram and fetal rhythm | \$156.00 | | D | H |

SECTION D – Internal Medicine

Specialist in Internal
Medicine
Referred Not
referred

Visits

| | | | | |
|-----|---|--|-----------|----------|
| 3D | Complete assessment -- includes: a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) examination of all parts and systems; | f) diagnosis; g) assessment; h) necessary treatment; i) advice to the patient; and, j) record of service provided. | \$73.30* | \$58.60* |
| 5D | Partial assessment or subsequent visit – includes: a) history review; b) history of presenting complaint; 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. | \$69.00* | \$47.65* |
| 9D | Consultation – includes: a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; and, d) written submission of the consultant's opinion; and e) recommendations to the referring doctor. | | \$146.20* | |
| 11D | 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. | | \$73.50* | |

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25D | -- 1-10 days | -- per day -- bill units (max 10) | \$40.60 | \$40.60 |
| 26D | -- 11-20 days | -- per day -- bill units (max 10) | \$37.00 | \$37.00 |
| 27D | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28D | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION D – Internal Medicine

Specialist in Internal
Medicine

Referred Not
referred

| | | | |
|-----|---|-----------|----------|
| 14D | Complex partial assessment or subsequent visit for eligible conditions -- includes: | \$101.50* | \$91.40* |
| | <ul style="list-style-type: none"> a) history review; b) history of presenting complaint; c) functional enquiry; d) examination of affected part(s) or system(s); | | |
| | <ul style="list-style-type: none"> e) diagnosis; f) assessment; g) necessary treatment; h) advice to the patient; and, i) record of service provided. | | |

Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

For patient visits that involve at least 15 minutes physician time and the following eligible conditions:

- Adult onset of Still's Disease;
- AIDS; Other HIV infection;
- Ankylosing Spondylitis, and other seronegative spondyloarthropathies;
- Asthma;
- CAD, CHF, COPD;
- Chronic Hepatitis;
- Chronic Kidney Disease
- Chronic Lung Disease;
- Chronic Respiratory Failure;
- Cirrhosis;
- Coagulation defects (e.g. hemophilia, other factor deficiencies);
- Diabetes Mellitus, including complications;
- Hemorrhagic conditions (eg: thrombocytopenia purpura)
- Hypertension with complications;
- Inflammatory Bowel Disease;
- Panhypopituitarism;
- Pulmonary Fibrosis;
- Rheumatoid Arthritis;
- Sleep Apnea with complications;
- Systemic Lupus Erythematosus, Scleroderma, Polymyositis, Dermatomyositis;
- Systemic Vasculitis;
- Technology Dependent (e.g. tube fed, trach, CPAP, oxygen dependent);

SECTION D – Internal Medicine

| | | Specialist | General Practitioner | Class |
|--|---|------------|----------------------|-------|
| <u>Procedures</u> | | | | |
| 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. | | | | |
| 30D | Electrocardiogram or phonocardiogram -- tracing only | \$9.00 | \$9.00 | |
| 31D | Electrocardiogram or phonocardiogram -- interpretation only (If multiple 31Ds are done on the same day, please use units and indicate the times as a comment. Interpretation should be billed using date of tracing) | \$9.70# | \$9.70# | |
| 32D | Electrocardiogram or phonocardiogram -- tracing and interpretation # Physicians listed by the College of Physicians and Surgeons of Saskatchewan as qualified | \$18.10# | \$18.10# | |
| 35D | Tilt table test for syncope -- includes venous and/or arterial cannulation - provocative and/or blocking drugs -- physician in constant attendance | \$174.30 | \$156.90 | D |
| 39D | Group exercise training sessions for cardiac or pulmonary rehabilitation patients in an approved facility - per patient 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. Maximal or sub-maximal exercise tolerance test using a bicycle ergometer or treadmill with continuous ECG monitoring, full ECG(s), blood pressure monitoring: | \$16.60 | \$16.60 | D |
| 62D | -- professional supervision and interpretation with physician in constant attendance -- in approved facility | \$91.00 | \$81.95# | |
| 63D | -- technical (if equipment owned and staff employed by physician) See "Definitions" (19) and "Services Supervised by a Physician" | \$38.00 | \$38.00# | D |
| | # Payment for service by a general practitioner is limited to those physicians listed by the College of Physicians and Surgeons of Saskatchewan as being qualified to perform stress testing | | | |
| Cardiopulmonary Exercise Testing | | | | |
| 64D | 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.) See "Definitions" (19) and "Services Supervised by a Physician" a) payable with code 67D and applicable visit. b) not payable with codes 63D, 601D, 603D, 611D, 613D. | \$177.00 | \$177.00 | D |
| 67D | Professional -- a) includes 62D, 600D, 602D, 610D, 612D, and 277D b) payable with applicable visit. | \$166.20 | \$156.20 | D |

SECTION D – Internal Medicine

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| | Stress echocardiography (applicable to treadmill, dobutamine and pacing stress echocardiography) -- physician in constant attendance. For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | |
| 65D | -- technical component | \$60.20 | | D | |
| 66D | -- professional component | \$198.80 | | D | |
| | Continuous or intermittent electrocardiogram monitoring (e.g. Holter or Cardiocassette). For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | |
| 141D | -- interpretation/professional component | \$41.40 | \$41.40# | D | |
| 142D | -- technical component and scanning (if instruments owned by physician) | \$35.70 | \$35.70 | D | |
| 144D | Dipyridamole thallium test to include supervision of ETT, infusion of medication and interpretation | \$86.70 | | D | |
| 145D | 24 hour ambulatory blood pressure monitoring - professional component only -- maximum per year: a) General Practitioners – 2 per patient, any physician; b) Specialists – 3 per patient, any physician; c) Maximum of 5 per patient total. | \$27.10 | \$27.10 | D | |
| 42D | Cardiac arrhythmia cardioversion Electroencephalogram For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | \$111.10 | \$100.00 | 0 | L |
| 50D | -- tracing/technical | \$23.20 | \$20.90 | D | |
| 51D | -- interpretation | \$26.80 | \$24.10 | D | |
| 59D | Electroclinical detailed interpretation of a set of seizures (Telemetry) | \$352.70 | \$317.50 | D | |
| | Polysomnography For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician".) | | | | |
| 54D | -- technical component | \$46.40 | | D | |
| 55D | -- professional component | \$90.70 | \$81.60@ | D | |
| 56D | Electrocorticography | \$148.80 | \$134.00@ | D | |
| 57D | EEG monitoring during carotid endarterectomy | \$76.60 | \$68.90@ | D | |
| 58D | Sodium Amytal testing | \$80.80 | \$72.80 | D | |
| 360D | Transcranial Doppler | \$51.00 | \$45.90 | D | |

@ Physicians with written approval 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. See "Services Billable by Entitlement".

Physicians listed by the College of Physicians and Surgeons of Saskatchewan as qualified

SECTION D – Internal Medicine

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| Pulmonary | | | | | |
| Measurement of subdivisions of lung volumes - TLC, FRC, VC, RV, TLV. For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | | |
| 266D | -- interpretation/professional component | \$35.20 | \$31.70 | D | |
| 267D | -- technical component | \$27.70 | \$24.85 | D | |
| Lung diffusing capacity DLco with or without bronchodilators at rest and after exercise, each. For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | | |
| 268D | -- professional component | \$35.20 | \$31.70 | D | |
| 269D | -- technical Component | \$24.60 | \$22.10 | D | |
| Full pulmonary function studies (including 600D-603D, 610D-613D, 266D & 268D). For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | | |
| 69D | -- professional component | \$90.30 | \$81.30 | D | |
| 271D | -- technical component -- including 267D and 269D (if instruments owned and staff employed by physician) | \$52.60 | \$47.40 | D | |
| Maximum payable for any combination of above non-technical tests (pulmonary) is not to exceed listed fee for 69D. | | | | | |

SECTION D – Internal Medicine

Specialist General Practitioner Class

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 & may include calculation of FEF25-75
- Not paid with Peak Flow Meters

| | | | | |
|------|--|---------|---------|---|
| 600D | Simple spirometry -- professional component | \$18.45 | \$18.45 | D |
| | 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. | | | |
| 601D | Simple spirometry -- technical component | \$11.25 | \$11.25 | |
| | a) If instruments owned by physician and staff conducting the test are employed by the physician. | | | |

Repeat after bronchodilators

| | | | | |
|------|--|---------|---------|---|
| 602D | Simple spirometry, repeat after bronchodilators -- professional component | \$12.20 | \$12.20 | D |
| 603D | Simple spirometry, repeat after bronchodilators -- technical component | \$5.60 | \$5.60 | |
| | a) If instrument owned by physician and staff conducting the test are employed by the physician. | | | |

Full Spirometry

- FVC, FEV1, FEV1/FVC, FEF25-75, flow volume loop & may include volume time.

| | | | | |
|------|--|---------|----------|---|
| 610D | Full spirometry -- professional component | \$29.70 | \$29.70@ | D |
| | 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. | | | |
| 611D | Full spirometry -- technical component | \$11.25 | \$11.25* | |
| | a) If instrument owned by physician and staff conducting the test are employed by the physician. | | | |

Repeat after bronchodilators

| | | | | |
|------|---|---------|----------|---|
| 612D | Full spirometry, repeat after bronchodilators -- professional component | \$12.20 | \$12.20@ | D |
| 613D | Full spirometry, repeat after bronchodilators -- technical component | \$5.60 | \$5.60* | |
| | a) If instruments owned by physician and staff conducting the test are employed by the physician. | | | |

@ 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, 610D and 612D are billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.

* 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.

Payment Schedule for Insured Services Provided by a Physician

SECTION D – Internal Medicine

| | | Specialist | General Practitioner | Class |
|------|---|------------|----------------------|-------|
| 272D | Hyperbaric medicine -interpretation of tissue oxygen concentrations /saturations to assess candidates for hyperbaric oxygen therapy | \$20.40 | \$20.40 | D |
| 280D | Overnight oximetry (not payable with polysomnography) | \$30.00 | \$30.00 | D |
| | Airways resistance or conductance by body box | | | |
| | For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | |
| 400D | -- professional component | \$13.00 | \$11.70 | D |
| 401D | -- technical component | \$20.40 | \$18.40 | D |
| 402D | Maximum expiratory and inspiratory pressures—professional component | \$18.10 | \$16.30 | D |
| 70D | Pulmonary compliance—professional component | \$31.80 | \$28.60 | D |
| 71D | Static pressure volume curve with oesophageal balloon - pulmonary compliance -- professional component | \$44.90 | \$40.35 | D |
| | Histamine-Methacholine test | | | |
| | For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | |
| 77D | -- professional component (internist or pediatrician only) | \$97.20 | | D |
| 276D | -- technical component | \$21.70 | \$21.70 | D |
| 277D | Pulse Oximetry with exercise -- professional component | \$15.10 | \$13.50 | D |
| | GI Tract | | | |
| 90D | Jejunal biopsy—trans oral | \$78.70 | \$70.85 | D |
| 93D | Esophageal motility study -- interpretation only | \$52.60 | | D |
| 94D | Esophageal motility study -- physician in continuous attendance including interpretation | \$77.50 | | D |
| | Extended pH studies with or without provocative drug testing | | | |
| 95D | -- physician in attendance -- includes insertion and removal of probes and interpretation | \$81.20 | | D |
| 96D | -- interpretation only | \$41.80 | | D |
| 215D | Tension test | \$20.10 | \$20.10 | D |
| | Evoked response | | | |
| 105D | Visual evoked response -- interpretation | \$12.30 | \$12.30 | D |
| 106D | Auditory evoked response -- interpretation | \$14.40 | \$14.40 | D |
| 107D | Somato-sensory evoked response -- interpretation | \$14.40 | \$14.40 | D |
| | Peritoneal dialysis | | | |
| 121D | Peritoneal dialysis -- each 24 hour period | \$34.10 | \$30.70 | 0 |
| 131D | Supervision of dialysis at home -- per week | \$52.20 | \$47.00 | |
| 132D | Any subsequent dialysis in the centre – each | \$38.70 | \$34.80 | 0 |
| 320D | Slide Examination- nephrologist microscopic examination of urine sample in office | \$17.60 | | D |
| | Hematology Supervision (Hematologist only) | | | |
| 122D | Hemodialysis -- initial | \$326.40 | \$293.75 | 0 |
| 123D | Hemodialysis -- second to fifth -- each | \$184.80 | \$166.35 | 0 |
| 124D | Hemodialysis -- sixth and subsequent -- each (shunt established) | \$52.20 | \$47.00 | 0 |
| 128D | Dialysis and training in dialysis centre -- each | \$106.70 | \$96.00 | 0 |
| 129D | Any subsequent dialysis in the centre -- each | \$38.70 | \$34.80 | 0 |

SECTION D – Internal Medicine

| | | Specialist | General Practitioner | Class |
|---|---|------------|----------------------|-------|
| Hematology Supervision (Hematologist only) | | | | |
| 130D | Supervision off dialysis at home, per week | \$40.40 | \$36.50 | |
| 135D | Continuous Renal Replacement Therapy (CRRT) -- initial | \$473.30 | \$426.00 | 0 |
| 136D | Continuous Renal Replacement Therapy (CRRT) -- subsequent - greater than 7 days by report | \$178.30 | \$160.50 | 0 |
| 155D | Therapeutic Plasmapheresis (by cell separator) -- first | \$166.40 | \$149.75 | 0 |
| 156D | Therapeutic Plasmapheresis (by cell separator) -- second to fifth | \$111.30 | \$100.15 | 0 |
| 157D | Therapeutic Plasmapheresis (by cell separator) -- subsequent | \$78.70 | \$70.85 | 0 |
| 250D | Plethysmography for penile blood flow | \$25.40 | \$22.85 | D |
| 251D | Tumescence monitoring of penis | \$24.00 | \$21.60 | D |
| 270D | Impedance plethysmography for deep vein thrombosis -- professional component only | \$11.60 | \$11.60 | D |
| Endocrine Testing | | | | |
| 200D | Cortrosyn stimulation | \$45.10 | \$40.55 | D |
| 201D | Calcium pentagastrin stimulation | \$45.10 | \$40.60 | D |
| 202D | TRH stimulation | \$63.20 | \$56.90 | D |
| 203D | Glucagon test | \$136.20 | \$122.55 | D |
| 204D | LHRH Stimulation | \$58.60 | \$52.80 | D |
| 206D | Insulin tolerance test | \$110.10 | \$99.10 | D |
| 207D | Triple bolus test | \$120.30 | \$108.30 | D |
| 216D | Corticotropin Releasing Hormone Delineation Test | \$66.70 | \$60.00 | D |
| 217D | Water Deprivation Test with or without DDAVP | \$143.70 | \$129.40 | D |

SECTION D – Internal Medicine

Specialist General Practitioner Class

Pacemaker Clinic Services

1. Clinic supervision, review of interrogation record and adjustment if necessary.
2. Includes ECG Interpretation; not paid in addition to 120L to 122L & 622L.

| | | | | |
|------|---------------------|---------|---------|---|
| 278D | Patient -- not seen | \$28.50 | \$25.70 | |
| 279D | Patient -- seen | \$41.80 | \$37.60 | 0 |

Polysomnography

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

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

For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician".

| | | | | |
|------|---|----------|----------|---|
| 281D | Diagnostic (includes visit) | \$298.30 | \$268.40 | D |
| 282D | Therapeutic (includes visit) | \$148.10 | \$133.25 | D |
| 283D | Multiple Sleep Latency Testing (includes visit) | \$148.10 | \$133.25 | D |
| 284D | Portable sleep study | \$55.70 | \$50.20 | D |
| 285D | Actigraphy | \$59.40 | \$53.45 | D |
| 290D | Auto-CPAP Titration—professional | \$93.50 | \$84.15 | D |
| 291D | Auto-CPAP Titration—technical | \$17.00 | \$15.30 | D |

| | | | | |
|------|--|----------|----------|--|
| 350D | Follow-up of Transplant Patient | \$273.40 | \$246.05 | |
|------|--|----------|----------|--|

- a) Is payable for a visit to provide assessment and ongoing management of a patient's condition following a heart, lung, liver or pancreas transplant.
- b) This service is payable to the physician designated as the most responsible physician for monitoring the post-transplant status of the patient.
- c) Not payable in addition to other visit services or within 42 days of the previous 350D
- d) Limited to six 350D services per patient per year (beginning April 1 of each year)

SECTION E – Psychiatry

Specialist in Psychiatry

Referred Not Referred

Visits

| | | | | | | | | | | | | | |
|---|--|------------------------------|---------------|---------------------|----------------|-------------------------------------|-------------------------|------------------------|--------------------------------|---|--------------------------------|--|--|
| 5E | Initial assessment -- of a specific condition includes: | \$154.00* | \$123.15* | | | | | | | | | | |
| | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a) pertinent family history;</td> <td style="width: 50%;">f) diagnosis;</td> </tr> <tr> <td>b) patient history;</td> <td>g) assessment;</td> </tr> <tr> <td>c) history of presenting complaint;</td> <td>h) necessary treatment;</td> </tr> <tr> <td>d) functional enquiry;</td> <td>i) advice to the patient; and,</td> </tr> <tr> <td>e) examination of affected part(s) and system(s);</td> <td>j) record of service provided.</td> </tr> </table> | a) pertinent family history; | f) diagnosis; | b) patient history; | g) assessment; | c) history of presenting complaint; | h) necessary treatment; | d) functional enquiry; | i) advice to the patient; and, | e) examination of affected part(s) and system(s); | j) record of service provided. | | |
| a) pertinent family history; | f) diagnosis; | | | | | | | | | | | | |
| b) patient history; | g) assessment; | | | | | | | | | | | | |
| c) history of presenting complaint; | h) necessary treatment; | | | | | | | | | | | | |
| d) functional enquiry; | i) advice to the patient; and, | | | | | | | | | | | | |
| e) examination of affected part(s) and system(s); | j) record of service provided. | | | | | | | | | | | | |

| | | | | | | | | | | | |
|------------------------|--|--------------------|-------------------------|------------------------|--------------------------------|-----------------|--------------------------------|------------------|--|--|--|
| 7E | Follow-up assessment -- includes: | \$52.00* | \$43.65* | | | | | | | | |
| | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">a) history review;</td> <td style="width: 50%;">e) necessary treatment;</td> </tr> <tr> <td>b) functional enquiry;</td> <td>f) advice to the patient; and,</td> </tr> <tr> <td>c) examination;</td> <td>g) record of service provided.</td> </tr> <tr> <td>d) reassessment;</td> <td></td> </tr> </table> | a) history review; | e) necessary treatment; | b) functional enquiry; | f) advice to the patient; and, | c) examination; | g) record of service provided. | d) reassessment; | | | |
| a) history review; | e) necessary treatment; | | | | | | | | | | |
| b) functional enquiry; | f) advice to the patient; and, | | | | | | | | | | |
| c) examination; | g) record of service provided. | | | | | | | | | | |
| d) reassessment; | | | | | | | | | | | |

Consultation -- includes :

- a) all visits necessary;
- b) history and examination;
- c) review of laboratory and/or other data; and,
- d) written submission of the consultant's opinion, and;
- e) recommendations to the referring doctor.

| | | | |
|----|---------------------------|-----------|--|
| 9E | Adult consultation | \$222.00* | |
|----|---------------------------|-----------|--|

| | | | |
|-----|---------------------------|-----------|--|
| 10E | Child Consultation | \$244.00* | |
|-----|---------------------------|-----------|--|

| | | | |
|-----|----------------------------|-----------|--|
| 11E | Repeat Consultation | \$107.00* | |
|-----|----------------------------|-----------|--|

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.

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

Hospital Care - Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25E | -- 1-10 days | -- per day -- bill units (max 10) | \$34.25 | \$34.25 |
| 26E | -- 11-20 days | -- per day -- bill units (max 10) | \$34.25 | \$34.25 |
| 27E | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28E | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION E – Psychiatry

Specialist in Psychiatry
 Referred Unreferred

Psychiatric Social Interview

1. 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.
2. A person being interviewed may be a spouse or another member of the family, for example, a community psychiatric nurse (psychiatric home care nurse), a teacher, or a member of the clergy or a social worker.
3. The benefit payment for this service is for a structured interview on a one-to-one basis between the psychiatrist and the person being interviewed.
4. This item is not paid for a case conference.
5. Service code 31E should be billed in the name of the patient, and indicate the person interviewed.
6. Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

| | | | |
|-----|--|---------|---------|
| 31E | Psychiatric social interview | \$51.00 | \$45.90 |
| | a) each complete 15 minute period | | |
| | b) maximum of three units of 31E per person interviewed – bill units | | |

Case Conference

Is where a psychiatrist confers, in relation to several patients at once, with a physician, nurse or some other professional person participating in the provision of services to the patient(s) or in the supervision or monitoring of the patient(s).

- a) Must be a formal scheduled session.
- b) A single conference fee billed in the name of one patient covers all the patients reviewed at the conference.
- c) A maximum of six (6) case conferences per patient per year is billable.
- d) The physician should keep appropriate documentation of the start and stop time, and place.

| | | | |
|------|--|----------|---------|
| 142E | Case conference -- per conference (not patient) -- first 30 minutes or part thereof | \$102.00 | \$81.55 |
| 144E | Case conference -- add to 142E for each additional 15 minutes or part thereof – bill units | \$51.00 | \$40.70 |

SECTION E – Psychiatry

Specialist in Psychiatry
Unreferred/
Referred By Entitlement

| Certification | | | |
|----------------------|--|----------|------------|
| 62E | Examination and certification of need for psychiatric examination pursuant to <i>The Mental Health Services Act</i> a) with completion of Form A | \$105.00 | See 63B |
| 63E | Consultation, examination, patient history, admission to hospital and certification of mental ill health a) with completion of Form G | \$238.00 | \$214.25@ |
| 64E | Consultation, examination and certification of mental ill health a) with completion of Form G b) second psychiatrist | \$238.00 | \$214.25** |
| 66E | Repeat examination and recertification of mental ill health a) same psychiatrist as billed code 63E b) within 22 days c) with completion of Form G | \$106.00 | \$95.40** |
| 67E | Repeat examination and recertification of mental ill health a) same psychiatrist as billed code 64E b) within 22 days c) with completion of Form G | \$106.00 | \$95.40** |
| 68E | Consultation, examination and recertification of mental ill health when previous certifying psychiatrist is unavailable a) includes completion of Form G | \$238.00 | \$214.25** |
| 70E | Completion of certification of mental ill health a) with issuance of Form G, H.1, H.3 or H.4. | \$42.50 | \$38.25** |
| 73E | Necessary examination and certification for ECT on an involuntary patient a) by the psychiatrist providing primary care who has billed under code 63E b) with completion of Form I | \$42.50 | \$38.25** |
| 74E | Examination and certification for ECT on an involuntary patient a) by second psychiatrist who billed 64E or who has prior knowledge of the case b) with completion of Form I | \$42.50 | \$38.25** |
| 75E | Consultation, examination and certification for ECT on an involuntary patient who has not been seen by the psychiatrist in the preceding 42 days a) with completion of Form I | \$235.00 | \$211.55** |

** Payment to eligible General Practitioners as approved by the Saskatchewan Health Authority

SECTION E – Psychiatry

Specialist in Psychiatry
Unreferred/
Referred By entitlement

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 -- group size 7 to 9 persons

Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

| | | | |
|-----|---|---------|----------|
| 33E | Group Psychotherapy, first hour, per person | \$31.00 | \$27.80@ |
| 34E | Group Psychotherapy, each subsequent 30 minutes or major part thereof, per person, bill units | \$15.50 | \$13.95@ |

A maximum of 2 hours applies to a combination of 33E and 34E.

Family Psychotherapy

1. Billed in the name of head of family, indicating names of other members treated.
2. Concurrent treatment of two or more members
3. Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

| | | | |
|-----|--|----------|-----------|
| 35E | -- first 45 minutes | \$162.10 | \$145.90@ |
| 37E | -- each subsequent 15 minutes or major part thereof – bill units | \$54.00 | \$48.60@ |

Individual Psychotherapy or psychiatric counselling

1. Payment for this service implies a planned series of sessions of at least 30 minutes duration.
2. Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

| | | | |
|-----|--|----------|----------|
| 38E | -- minimum period of 30 minutes | \$102.00 | \$91.80@ |
| 39E | -- each subsequent 15 minutes or major part thereof – bill units | \$51.00 | \$45.90@ |

@ Payment to General Practitioners and other physicians with training in psychotherapy with approval from the Saskatchewan Medical Association. For the purposes of billing, 35E-39E are billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.

SECTION E – Psychiatry

| | | Specialist in Psychiatry | | Class | Anes |
|-----|---|--------------------------|-------------------------------|-------|------|
| | | Referred | Unreferred/ By entitlement | | |
| 42E | Electroshock therapy -- per treatment -- with anesthetist | \$82.50 | \$82.50# | 0 | L |
| 43E | Repetitive Transcranial Magnetic Stimulation (TMS) -- technical component -- if the equipment is owned and the staff are employed by the physician. For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | \$81.60 | \$73.40 | D | |
| | Repetitive Transcranial Magnetic Stimulation (TMS) – professional component - for patient assessment use 7E visit code (for physician bedside attendance during procedure use 918A) | | | | |
| 45E | Interview with drugs, first 30 minutes | \$50.70 | \$45.70# | | |
| 47E | Interview with drugs, each subsequent 15 minutes or major part thereof to a maximum of 6 units | \$24.20 | \$21.80# | | |
| 50E | Psychological testing -- simple -- bill units | \$39.65 | \$39.65# | D | |
| 51E | Psychological testing -- complex | \$59.30 | \$53.30# | D | |

Complex psychological testing applies to the following tests:

- a) Achenbach Child Behavior Checklist (teacher's, parent's)
- b) ADI-R Autism Diagnostic Inventory
- c) ADOS Autism Diagnostic Observation Scale
- d) BASC Behavioral Assessment Scale for Children
- e) Continuous Performance Test
- f) Crowell Structured assessment
- g) Goodenough Draw a Person Test (IQ)
- h) KiddieSADS
- i) Minnesota Multiphasic Personality Inventory (MMPI)
- j) Mood and Anxiety Disorder Questionnaire, Department of Psychiatry, University of Saskatchewan
- k) PANSS etc, (for Schizophrenia)
- l) Structured Clinical Interview for DSM IV Axis I (SCID I)
- m) Structured Clinical Interview for DSM IV Axis II (SCID II)
- n) Wisconsin Card Sorting Test

Physicians wishing to add tests to the above list should write to the Saskatchewan Medical Association Tariff Committee for approval.

| | | | | | |
|-----|---|----------|----------|---|--|
| 52E | OPTAX assessment for Attention Deficit Disorder | \$104.00 | \$93.60# | D | |
|-----|---|----------|----------|---|--|

Payment approved for a physician who has been designated by the College of Physicians and Surgeons of Saskatchewan.

SECTION E – Psychiatry

Specialist in Psychiatry
Unreferred/
Referred By entitlement

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 | \$51.00 | \$45.90# |
| 101E | -- each subsequent 15 minutes or major part thereof to a maximum of 7, bill units | \$51.00 | \$45.90# |

Payment 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”.

SECTION E – Psychiatry

Specialist in Psychiatry
Unreferred/
Referred 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 | \$51.00 | \$45.90# |
| 111E | -- each subsequent 15 minutes or major part thereof to a maximum of 5, bill units | \$51.00 | \$45.90# |

Payment 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”.

SECTION F – Dermatology

Specialist in Dermatology

Referred Not Referred

Visits

| | | | |
|-----|--|----------|----------|
| 5F | Initial assessment -- of a specific condition includes: | \$54.00* | \$43.20* |
| | <ul style="list-style-type: none"> a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) examination of all parts and systems; | | |
| | <ul style="list-style-type: none"> f) diagnosis; g) assessment; h) necessary treatment; i) advice to the patient; and, j) record of service provided. | | |
| 7F | Follow-up assessment -- includes: | \$32.40* | \$31.15* |
| | <ul style="list-style-type: none"> a) history review; b) history of presenting complaint; c) functional enquiry; d) examination of affected part(s) or system(s); | | |
| | <ul style="list-style-type: none"> e) diagnosis; f) assessment; g) necessary treatment; h) advice to the patient; and, i) record of service provided. | | |
| 9F | Consultation – includes: | \$83.90* | |
| | <ul style="list-style-type: none"> a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; d) written submission of the consultant's opinion, and; e) recommendations to the referring doctor. | | |
| 11F | Repeat Consultation | \$45.30* | |
| | <p>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.</p> | | |
| | <p>* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.</p> | | |

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25F | -- 1-10 days | -- per day -- bill units (max 10) | \$32.00 | \$32.00 |
| 26F | -- 11-20 days | -- per day -- bill units (max 10) | \$31.00 | \$31.00 |
| 27F | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28F | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION F – Dermatology

Specialist in Dermatology

Referred Not Referred

| | | | | | | | | | | | | | |
|--|---|--------------------|---------------|-------------------------------------|----------------|------------------------|-------------------------|--|--------------------------------|--|--------------------------------|----------|----------|
| 14F | <p>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 <u>at least 15 minutes physician time</u>, includes:</p> <table border="0"> <tr> <td>a) history review;</td> <td>e) diagnosis;</td> </tr> <tr> <td>b) history of presenting complaint;</td> <td>f) assessment;</td> </tr> <tr> <td>c) functional enquiry;</td> <td>g) necessary treatment;</td> </tr> <tr> <td>d) examination of affected part(s) or system(s);</td> <td>h) advice to the patient; and,</td> </tr> <tr> <td></td> <td>i) record of service provided.</td> </tr> </table> | a) history review; | e) diagnosis; | b) history of presenting complaint; | f) assessment; | c) functional enquiry; | g) necessary treatment; | d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | i) record of service provided. | \$50.00* | \$50.00* |
| a) history review; | e) diagnosis; | | | | | | | | | | | | |
| b) history of presenting complaint; | f) assessment; | | | | | | | | | | | | |
| c) functional enquiry; | g) necessary treatment; | | | | | | | | | | | | |
| d) examination of affected part(s) or system(s); | h) advice to the patient; and, | | | | | | | | | | | | |
| | i) record of service provided. | | | | | | | | | | | | |

Limited to 6 per patient, per physician, per 12-month period. Services in excess of this limit will be adjusted to a lesser assessment fee (7F).

Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

Eligible conditions:

Complex systemic disease with skin manifestations for at least one of the following:

- Sarcoidosis;
- Systemic lupus erythematosus;
- Dermatomyositis;
- Scleroderma;
- Relapsing polychondritis;
- Inflammatory bowel diseases (pyoderma gangranosum, Sweet’s syndrome, erythema nodosum);
- Porphyria;
- Autoimmune blistering diseases (pemphigus, pemphigoid, 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 conditions:

- Involvement of body surface area of greater than 30%; or
- Treatment with systemic therapy (methotrexate, acitretin, cyclosporine, biologics).

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

SECTION F – Dermatology

| | | Specialist | General Practitioner | Class |
|--|--|------------|----------------------|-------|
| 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. | | | | |
| 30F | Ultraviolet A and B light sensitivity -- testing and interpretation | \$72.90 | \$72.90 | D |
| 33F | Radiotherapy – per body area | \$25.30 | \$25.30 | 0 |
| 34F | PUVA (Psoralen ultraviolet) therapy -- one treatment per alternate day | \$47.80 | \$47.80 | 0 |
| 35F | Ultraviolet B Therapy | \$14.70 | \$14.70 | 0 |
| Visit service not paid same day as 34F or 35F unless an explanation satisfactory to the Ministry of Health is provided | | | | |
| 38F | Application of nitrogen mustard -- per treatment | \$40.20 | \$40.20 | 0 |
| 40F | Special mycological investigations -- direct examination of hair or scales | \$11.40 | \$11.40 | D |
| 42F | Wood’s light examination | \$8.50 | \$8.50 | D |
| Biopsy of skin or mucous membrane | | | | |
| 100F | Punch or shave biopsy -- 1st biopsy | \$26.60 | \$26.60 | D |
| 101F | Punch or shave biopsy -- each additional biopsy (maximum of 4) – bill units | \$7.10 | \$7.10 | D |
| 102F | Marginal (incisional) biopsy of skin or mucosa -- 1st biopsy | \$40.40 | \$40.40 | 0 |
| 103F | Marginal (incisional) biopsy of skin or mucosa -- each additional biopsy (maximum of 4) – bill units | \$14.40 | \$14.40 | 0 |
| Only one of the codes below can be claimed per case (110F-112F) | | | | |
| 110F | Comedos, acne pustules, milia - drainage or removal -- 1 to 5 | \$11.60 | \$11.60 | 0 |
| 111F | Comedos, acne pustules, milia - drainage or removal -- 6 to 14 | \$21.80 | \$21.80 | 0 |
| 112F | Comedos, acne pustules, milia - drainage or removal -- 15 or more | \$33.40 | \$33.40 | 0 |
| 120F | Intralesional injections by dermojet or similar means | \$9.50 | \$9.50 | 0 |
| Only one of the codes below can be claimed per case (121F, 122F) | | | | |
| 121F | Intralesional injections by needle -- up to 5 injections | \$26.70 | \$26.70 | 0 |
| 122F | Intralesional injections by needle -- 6 or more injections (maximum) | \$40.40 | \$40.40 | 0 |
| 888F | Treatment of localized cutaneous malignancy by curettage & cautery -- any area | \$92.80 | \$92.80 | 42 |
| 130F | Extra corporal photophoresis | \$75.50 | \$75.50 | 0 |
| 131F | Serum autologous skin test | \$37.80 | \$37.80 | D |

SECTION G – Medical Genetics *

Specialist in Medical Genetics

Referred Not Referred

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

Visits

| | | | |
|-----|---|-----------|----------|
| 5G | <p>Genetic assessment – includes:</p> <p>a) the history of the presenting condition;</p> <p>b) the genetic history of the patient and of the family;</p> <p>c) diagnosis;</p> <p>d) necessary treatment;</p> <p>e) examination of the affected part(s) or system(s) including any special techniques;</p> <p>f) advice to the patient; and,</p> <p>g) record of service provided.</p> | \$87.80* | \$79.00* |
| 7G | <p>Follow-up assessment -- All Follow-ups, if a Visit -- Not Counselling -- may include:</p> <p>a) a review and update of the recorded genetic history;</p> <p>b) necessary examination;</p> <p>c) review of diagnostic findings;</p> <p>d) necessary treatment;</p> <p>e) advice to the patient; and,</p> <p>f) record of service provided</p> | \$59.30* | \$53.40* |
| 9G | <p>Consultation – includes:</p> <p>a) all visits necessary, history and examination;</p> <p>b) review of the laboratory and/or other data;</p> <p>c) written submission of the consultant's opinion, and;</p> <p>d) recommendations to the referring doctor</p> | \$170.00* | |
| 11G | <p>Repeat Consultation</p> <p>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.</p> <p>* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.</p> | \$81.90* | |
| 13G | <p>Review of genetic information</p> <ol style="list-style-type: none"> 1. Review of clinical information for patients seen exclusively by a genetic counsellor for the medical geneticist. 2. Dictated letter generated from the visit must indicate medical geneticist involvement. 3. Patient chart must include note that clinical information was reviewed by medical geneticist. 4. Not payable if patient seen by geneticist within 30 days. | \$51.00 | \$51.00 |

SECTION G – Medical Genetics

Specialist in Medical Genetics

Referred Not Referred

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25G | -- 1-10 days | -- per day -- bill units (max 10) | \$31.00 | \$31.00 |
| 26G | -- 11-20 days | -- per day -- bill units (max 10) | \$31.00 | \$31.00 |
| 27G | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28G | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION G – Medical Genetics

Specialist in Medical Genetics

Referred Not Referred Class

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

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

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 | \$30.40 | \$27.30 |
|-----|---|---------|---------|

Counselling -- individual or family

Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

| | | | |
|-----|---|----------|----------|
| 38G | Counselling -- minimum period of 30 minutes | \$77.70* | \$69.90* |
|-----|---|----------|----------|

| | | | |
|-----|---|----------|----------|
| 39G | Counselling -- each additional 15 minutes or part thereof -- bill units | \$38.70* | \$34.90* |
|-----|---|----------|----------|

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied. See SECTION A for details.

| | | | | |
|-----|--|---------|---------|---|
| 40G | Chromosome analysis -- interpretation only | \$72.20 | \$72.20 | D |
|-----|--|---------|---------|---|

| | | | | |
|-----|---|----------|--|---|
| 50G | Genetic examination of the products of conception (fetus and/or placenta) following intrauterine fetal death or pregnancy termination for multiple congenital anomalies – only payable to physicians with appropriate genetic training. | \$170.00 | | 0 |
|-----|---|----------|--|---|

SECTION H – Anesthesia

1. Payment for anesthesia is for professional services for the administration of any type of anesthesia, general, regional, sedation or monitored Anesthesia care in accordance with the Canadian Society of Anesthesiologist's Guidelines to the Practice of Anesthesia. However, ring block, local infiltration and topical or spray Anesthetic will not be paid unless they meet the full definition of anesthetic professional services as noted above. Payment for anesthesia includes same day pre-anesthetic as well as post-anesthetic examinations and all supportive measures during anesthesia but does not include the cost of drugs, materials or facilities.
2. An anesthetic payment for a beneficiary:
 - (a) is based on the time from the start of continuous attendance by the anesthetist until such time as the attendance by the anesthetist to that patient is no longer required. The anesthetic 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 anesthetic or in the resuscitative period except that invasive monitoring will be approved to the primary anesthetist in addition to the anesthetic as follows:
 - 687H, 134A, 135A, 136A, 316A, 140A or 141A at 100% of the appropriate listed amount;
 - 160L at 75% of the appropriate listed amount.
3. When more than one procedure is performed during the same anesthetic, the payment to the anesthetist shall be based on the highest anesthetic complexity as noted in the section heading 'Anesthesia Categories by Surgical Procedure'.
4. Pre-anesthetic consultation on same day of surgery is approved for high risk cases by report.

Payment for a pre-anesthetic consultation is intended to apply where the consultation is provided in potentially high risk situations to assess the fitness of the patient for the anesthetic/surgical procedure and to advice on pre-anesthetic 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-anesthetic assessment situation.
5. When a physician admits a patient to hospital for urgent surgery on an emergency basis and later on the same day provides anesthesia services for the surgeon to whom the case has been referred, then both the visit and anesthesia 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 anesthetist, payment to the assisting anesthetist will be based on 100% of the listed rate of payment in the same anesthetic category as the principle anesthetist for the calculated anesthetic time according to the appropriate time units of 15 minutes.
7. "Anesthetic 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 anesthetist. The need for anesthetic standby should be justified by high risk or complexity of the procedure. Anesthetic standby services should be billed under Code 918A following the reporting criteria.

"Standby" followed by administration of anesthesia must be clarified, i.e. 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 anesthetic is provided for both dental and other surgery, the most favourable single base code is paid with the remainder paid as time units.
9. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.

SECTION H – Anesthesia

Specialist in Anesthesia

Specialist General
Practitioner

Visits

Consultation - includes

- a) all visits necessary;
- b) history and examination;
- c) review of laboratory and/or other data;
- d) written submission of the consultant's opinion, and;
- e) recommendations to the referring doctor

| | | |
|-----|----------------------------|-----------|
| 9H | Major Consultation | \$114.25* |
| 11H | Repeat Consultation | \$57.25* |

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.

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied. See Section A for details.

Anesthetics -- any type; excluding local infiltration, ring block, topical or spray anesthetics.

Special call surcharges and out of hours premiums - see Section A

Where the anesthetic category is listed as:

| | | | | | |
|------|--------------------------|----------|---------------|---------|---------|
| 500H | Low Complexity: | (Low) | -- Start-up | \$27.85 | \$27.85 |
| 501H | Low Complexity: | (Low) | -- Per 15 min | \$43.45 | \$43.45 |
| 502H | Intermediate Complexity: | (Medium) | -- Start-up | \$33.35 | \$33.35 |
| 503H | Intermediate Complexity: | (Medium) | -- Per 15 min | \$49.85 | \$49.85 |
| 504H | High Complexity: | (High) | -- Start-up | \$39.95 | \$39.95 |
| 505H | High Complexity: | (High) | -- Per 15 min | \$58.00 | \$58.00 |
| 506H | Dental Procedures^ | | -- Start-up | \$33.35 | \$33.35 |
| 507H | Dental Procedures^ | | -- Per 15 min | \$49.85 | \$49.85 |

^ All dental anesthesia for patients under age 14 is insured.

^ Anesthesia is only billable for insured oral and maxillofacial surgery or when medically necessary for other dental procedures submitted with a comment indicating the medical condition. (i.e. autism, cerebral palsy, etc.)

SECTION H – Anesthesia

Specialist General
Practitioner

Complex Anesthesia Premiums

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

| | | | |
|------|--|---------|---------|
| 580H | Operative premium for complexity and risk – per 15 minutes | \$14.55 | \$14.55 |
| | <ol style="list-style-type: none"> 1. Patients up to 2 years of age, a weight of greater than the 97th percentile for age according to the WHO growth charts for Canada 2. Patients greater than 2 and up to 16 years old, a Body Mass Index, (weight[kg]/height[m]²) greater than the 97th 3. Patients over the age of 16, a Body Mass Index, (weight [kg]/height [m] ²) greater than 40 4. 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 | \$29.10 | \$29.10 |
| | <ol style="list-style-type: none"> 1. Patients where there is recognition and agreement between the surgeon and anesthetist that undue delay in surgical treatment would pose a significant risk to life or a major body part 2. Patients with multiple trauma involving at least 2 of the following: <ol style="list-style-type: none"> a) Abdominal injury requiring laparotomy; b) Thoracic injury requiring chest tube or thoracotomy; c) Head injury with GCS less than 9; d) Fracture of cervical spine, pelvis, femur, proximal tibia or humerus; e) Burns to more than 30% of the body surface. 3. Codes 580H & 585H may be billed together and are not eligible for additional premiums. | | |
| 540H | Premium for anesthesia beginning before 5:00 p.m. & ending after 5:00 p.m. | \$29.10 | \$29.10 |
| | <ol style="list-style-type: none"> 1. Bill for the number of 15 minute time units provided after 5:00 p.m. and indicates on comment record the start of the Anesthetic time 2. 540H is not eligible for other premiums. | | |

Example:

A procedure provided on a weekday by an anesthetist, 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 be 2 or 3;
- 504H (normally medium but greater than 4 hours)
- 505H at 20 units
- 540H at 8 units (15 minute units after 5:00 p.m.)
- 580H at 20 units (all 15 minute units)

- 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;
- 504H (normally medium but greater than 4 hours)
- 505H at 20 units
- 580H at 20 units (all 15 minute units)

SECTION H – Anesthesia

| | |
|------------|-------------------------|
| Specialist | General Practitioner |
|------------|-------------------------|

| | | | |
|------|--|---------|---------|
| 545H | Premium for anesthesia beginning before midnight (11:59 p.m.) & ending after 12:00 midnight | \$29.10 | \$29.10 |
| | <ol style="list-style-type: none"> 1. Bill for the number of 15 minute time units 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 anesthetic time. 2. 545H is not eligible for other premiums. 3. Bill the number of units after midnight only. | | |

Example:

A procedure provided on a weekday by an anesthesiologist, started at 9:00 p.m. and ended at 2:00 a.m. the codes to be billed are:

- the location of service would be submitted as a 'B' resulting in an amount in the total premium field for each applicable service line; ;
- 504H (normally medium but greater than 4 hours)
- 505H at 20 units
- 545H at 8 units (15 minute units after 12:00 a.m.)

SECTION H – Anesthesia

Anesthesia Categories By Surgical Procedure

General Considerations

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

- A. **Low Complexity:**
 - a) All percutaneous diagnostic and therapeutic procedures not otherwise listed.
 - b) Superficial surgery on the integumentary system, nerves, vessels, muscles, tendons and bones not otherwise listed.

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

- C. **High Complexity:**
 - a) All multiple trauma cases lasting longer than 4 hours.
 - b) Anesthesia for live organ donor retrieval.
 - c) All cases lasting longer than 4 hours.
 - d) All cardiac catheterizations.
 - e) All laser procedures in the airway.

1. HEAD

Low complexity:

- a) All procedures on the external, middle or inner ear.
- b) All procedures on the eye (including cataracts) or eyelids not otherwise listed.
- c) Anesthesia for ECT.

Medium Complexity:

- a) All procedures on the skull, mandible, maxilla, orbits and facial bones.
- b) All procedures inside the nose or accessory sinuses.
- c) All intraoral procedures except those listed as "High complexity".
- d) The following eye procedures: repair of open eyes, scleral buckling, vitreoretinal procedures, strabismus correction, corneal transplants, glaucoma procedures, tumors and enucleation.
- e) All closed intracranial procedures done by needle techniques.

High Complexity:

All open intracranial procedures on the brain, meninges or cerebral vessels.

2. NECK

Medium Complexity:

- a) All procedures on the thyroid gland, parathyroids, salivary glands, lymphatics and congenital brachial cleft defects.
- b) All endoscopic or open procedures on the larynx or trachea not otherwise listed.

High Complexity:

- a) All procedures on the major vessels.
- b) Anesthesia for cystic hygroma, laryngectomy, or radical neck dissection.
- c) Epiglottitis, foreign body in the airway, traumatic disruption of the larynx.

SECTION H – Anesthesia

3. THORAX

Low Complexity:

- a) Anesthesia for pacemakers, cardioversion, indwelling central lines.
- b) All breast surgery except those procedures listed separately.

Medium Complexity:

- a) Anesthesia for bronchoscopy, mediastinoscopy.
- b) All procedures on the ribs.
- c) Anesthesia for reduction mammoplasty or (modified) radical mastectomy, axillary node dissection.

High Complexity:

- a) All intrathoracic procedures on the heart, lungs, lymphatics or great vessels.
- b) All mediastinal procedures including oesophagus and thymus.

4. SPINE AND CORD

Medium Complexity

- a) All procedures for decompression or disc surgery.
- b) All procedures on the meninges or spinal cord and nerves not otherwise listed.
- c) All procedures on the vertebrae (except biopsy) not otherwise listed.

High Complexity

- a) All procedures for spine or spinal cord tumors.
- b) All procedures for multi-level spine instrumentation.

5. ABDOMEN

Low Complexity:

- a) All extraperitoneal procedures on the abdominal wall or urinary tract.
- b) All endoscopic procedures of the GI tract from oesophagus to rectum.

Medium Complexity:

- a) All intra-abdominal procedures except those listed below as "High complexity".

High Complexity:

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

6. PERINEUM

Low Complexity:

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

Medium complexity:

- a) Transurethral resection of prostate or bladder tumor.
- b) Percutaneous nephrolithotripsy.
- c) Hysteroscopic endometrial ablation, vaginal hysterectomy.
- d) Radical vulvectomy with or without node dissection.
- e) Amputation of the penis with or without node dissection.
- f) Vaginal fistulae repairs, vaginectomy.

SECTION H – Anesthesia

7. EXTREMITY SURGERY

Low Complexity

- a) All distal or minor proximal orthopedic procedures, including arthroscopy, not otherwise listed.
- b) All surgery for vascular access.

Medium Complexity

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

High Complexity

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

Payment Schedule for Insured Services Provided by a Physician

SECTION H - Anesthesia

| | | Specialist | General Practitioner | Class |
|------|--|------------|----------------------|-------|
| 80H | Intubation for the management of the airway or ventilation, not associated with anesthetic | \$100.80 | \$90.70 | 0 |
| | Considered an inclusion in ICU per diem codes (400H-424H) or resuscitation codes (220A-226A) when billed by the same physician. | | | |
| | Nerve Blocks | | | |
| 94H | Facet Injection -- single | \$90.45 | \$90.45 | 0 |
| 95H | Facet Injection -- each additional to a maximum of 5 | \$44.60 | \$44.60 | 0 |
| 96H | Trigger Point -- single | \$44.60 | \$44.60 | 0 |
| 97H | Trigger Point -- one additional | \$21.20 | \$21.20 | 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 | \$92.30 | \$92.30 | 0 |
| 99H | -- each additional to a maximum of three additional units | \$45.85 | \$45.85 | 0 |
| 100H | -- with sclerosing agent -- single nerve, add | \$33.75 | \$33.75 | 0 |
| 101H | -- each additional nerve to a maximum of three units, add | \$22.25 | \$22.25 | 0 |
| 102H | Sciatic or obturator nerve | \$117.20 | \$117.20 | 0 |
| 103H | Sciatic or obturator nerve -- with sclerosing agent | \$152.90 | \$152.90 | 0 |
| 120H | Somatic plexus (eg brachial) | \$130.50 | \$130.50 | 0 |
| 121H | Somatic plexus (eg brachial) -- with sclerosing agent | \$154.10 | \$154.10 | 0 |
| 130H | Stellate ganglion | \$135.05 | \$135.05 | 0 |
| 131H | Stellate ganglion -- with sclerosing agent | \$154.10 | \$154.10 | 0 |
| 132H | Lumbar sympathetic chain | \$135.05 | \$135.05 | 0 |
| 133H | Lumbar sympathetic chain -- with sclerosing agent | \$156.60 | \$156.60 | 0 |
| 134H | Other ganglion/plexus (e.g. celiac) | \$274.40 | \$274.40 | 0 |
| 135H | Other ganglion/plexus (e.g. celiac) -- with sclerosing agent | \$305.90 | \$305.90 | 0 |
| 140H | Epidural -- lumbar or caudal | \$202.60 | \$202.60 | 0 |
| 141H | Epidural -- lumbar or caudal -- with sclerosing agent | \$229.40 | \$229.40 | 0 |
| 142H | Epidural -- cervical or thoracic | \$202.60 | \$202.60 | 0 |
| 143H | Epidural -- cervical or thoracic -- with sclerosing agent | \$229.40 | \$229.40 | 0 |
| 144H | Epidural blood patch | \$202.60 | \$202.60 | 0 |
| 150H | Subarachnoid -- lumbar | \$202.60 | \$202.60 | 0 |
| 151H | Subarachnoid -- lumbar -- with sclerosing agent | \$305.90 | \$305.90 | 0 |
| 153H | Subarachnoid -- thoracic -- with sclerosing agent | \$305.90 | \$305.90 | 0 |
| 158H | Injection of piriformis muscle | \$86.50 | \$86.50 | 0 |
| 161H | X-ray control in connection with service codes 94H to 153H, add (X-ray charges extra) | \$60.50 | \$60.50 | 0 |
| 220H | Therapeutic intravenous regional anesthesia | \$152.90 | \$152.90 | 0 |

SECTION H - Anesthesia

Specialist General Practitioner Class

PAIN MANAGEMENT

Acute Pain Management

| | | | |
|--|---|----------|----------|
| 190H | Initiation of patient controlled analgesia | \$16.85 | \$16.85 |
| 191H | Injection of intrathecal opiate for post-operative pain management | \$16.85 | \$16.85 |
| 192H | Insertion or reinsertion of continuous epidural catheter for acute pain control including initial infusion of analgesic agent -- for obstetrical cases see 600H | \$58.30 | \$58.30 |
| 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 | \$29.60 | \$29.60 |
| 194H | Insertion or reinsertion of continuous catheter technique local anesthetic blockade (excluding epidural) for acute pain control including initial infusion of analgesic agent. | \$58.30 | \$58.30 |
| 195H | Injection of local anesthetic to establish a major plexus block to assist in post-operative pain management -- cannot be claimed for topical, local infiltraton or peripheral nerve block | \$57.80 | \$57.80 |
| Epidural Anesthesia for Labour and Delivery | | | |
| 600H | Initial set-up and subsequent maintenance of epidural anesthesia 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. | \$345.00 | \$345.00 |
| 601H | Restart of 600H of a previously functioning epidural a) not payable for anesthesia shift changes; b) please provide time of initial start-up and restart; and c) premiums are determined by the time of the restart set-up. | \$167.75 | \$167.75 |
| 667H | Attendance during delivery (after the first hour covered under code 600H), per 15 minutes or portion thereof | \$41.70 | \$41.70 |
| 687H | Intra-operative Transoesophageal Echocardiography -- billable with other echocardiogram or Swan-Ganz by report only | \$122.45 | \$122.45 |

SECTION H – Anesthesia

Specialist General
Practitioner

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 the Ministry of 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 anesthesia 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: a) pertinent family and patient history; b) pain history including review of previous therapies; c) functional enquiry; examination of all parts and systems necessary to diagnose and initiate treatment; d) advice to patient; e) written report to referring physician; and, f) record of service provided. | \$211.80 | \$211.80@ |
| 203H | Subsequent assessment -- in-patient or out-patient – includes: a) review of problem; b) reassessment of pain control; c) review of history and physical examination as necessary to maintain on-going treatment; d) advice to patient; and, e) record of service provided. | \$105.55 | \$105.55@ |
| 205H | Minor routine follow-up assessment of patient hospitalized under pain clinic criteria – a) routine follow-up of pain treatment with evaluation; b) necessary changes to on-going care; and, c) record of service provided. | \$79.15 | \$79.15@ |

@ With approved training

SECTION H - Anesthesia

INTENSIVE CARE

A. Preamble

1. 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.
2. This section will ordinarily 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.
3. 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).
4. 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 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 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).
5. Premiums and surcharges are not payable with codes in this section, with the exception of the 335H-339H series of codes.
6. Billing for consultations/procedures concurrent with the billing of intensive care:
 - a) 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.
 - b) For consultations/visits/procedures done outside the unit Medical Services Branch requires:
 - c) The consultation/visit was provided to determine the need for ICU/CCU admission not to determine the management in ICU/CCU.
 - d) Confirmation the service was provided outside the ICU/CCU unit.
 - e) The times of the service indicate a definite interval between the consultation/visit and intensive care services or admission time to the ICU/CCU unit.
 - f) For procedures provided in or out of the ICU/CCU unit times provided should be exclusive of less intensive units (e.g. 335H).
 - g) For Emergency Resuscitative procedures provided outside of the unit see section A.
 - h) The patient record for less intensive care should accurately identify intervals of service on a daily basis.

B. 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 claimed 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 claiming Intensive (Critical, Ventilatory or Comprehensive) Care fees, no other Intensive Care codes may be claimed 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.

SECTION H - Anesthesia

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 anesthetist(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:
 - a) balloon pump insertion (132L);
 - b) bronchoscopy (520L);
 - c) cardiac catheterization and angiography (300A, 303A, 328A, 329A, 335A, 443A, 444A, 445A, 447A, 536A, 545A, 548A, 648A, 100C, 105C, 145C);
 - d) cardiac pacemaker insertion (121L);
 - e) cardioversion (42D);
 - f) certification of brain death and organ donor assessment (140Q, 150Q);
 - g) closed chest drainage (95L);
 - h) colonoscopy (448L);
 - i) continuous renal replacement therapy (CCRT) (135D, 136D);
 - j) ECG provided by non-team (ICU) physicians (31D);
 - k) echocardiography (321A, 521A, 531A, 323A, 523A, 533A, 324A, 534A, 557A), 150C;
 - l) epidural anesthesia and nerve blocks (94H-161H, 192H-195H, 220H);
 - m) ERCP (500L);
 - n) exercise stress test (62D);
 - o) hemodialysis (122D-124D, 660L, 661L);
 - p) insertion of central venous catheter (134A-135A);
 - q) intra-operative transesophageal echocardiography (687H);
 - r) intubation for laryngeal obstruction (171T);
 - s) esophagogastrosocopy (402L-412L);
 - t) percutaneous endoscopic gastrostomy (PEG) (443L,444L,447L);
 - u) peritoneal dialysis (121D, 667L, 669L, 670L);
 - v) sigmoidoscopy (449L, 450L);
 - w) stress echo (66D) ;
 - x) Swan-Ganz catheterization (316A);
 - y) tracheostomy (177T);
 - z) transcranial Doppler (360D).
9. 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.

SECTION H - Anesthesia

General
Specialist Practitioner

LESS INTENSIVE PATIENTS (such as Monitoring)

1. 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.
 - a) Payment is intended for the time that a physician spends with the patient.
 - b) The start and end times of each visit must be indicated on the claim by the physician providing the service.
2. Payment for concurrent care is only acceptable if submitted with an explanation satisfactory to the Ministry of Health.
3. The procedures excluded from intensive care per diem 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.
4. Codes in this section are eligible for after-hours premiums and first patient surcharges.
5. It may be appropriate to bill for a consultation/visit with these fee codes see preamble section H. In some circumstances, accurate times and meaningful explanations must be included with submission.
6. 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.).
7. ECG interpretations may be billed in addition to 335H to 339H.

Billed in units of 15 minutes each

| | | | | |
|------|----------------------|--|---------|---------|
| 335H | Day 1 | per unit -- maximum of 6 units per day | \$39.10 | \$39.10 |
| 336H | Day 2 | per unit -- maximum of 5 units per day | \$39.10 | \$39.10 |
| 337H | Days 3 to 7 | per unit -- maximum of 3 units per day | \$39.10 | \$39.10 |
| 338H | Days 8 to 30 | per unit -- maximum of 2 units per day | \$39.10 | \$39.10 |
| 339H | Days 31 & thereafter | per unit -- maximum of 1 unit per day | \$39.10 | \$39.10 |

SECTION H - Anesthesia

Specialist General
Practitioner

CRITICAL CARE (Intensive Care Area)

1. Includes provision of all aspects of care of a critically ill patient in an Intensive Critical Care Area, excluding ventilatory support, but including:
 - a) cutdowns, intraosseous infusion
 - b) emergency resuscitation
 - c) endotracheal intubation
 - d) insertion of arterial lines
 - e) initial consultation and assessment
 - f) intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device).
 - g) intravenous lines
 - h) oximetry
 - i) pressure infusion sets and pharmacological agents
 - j) securing and interpretation of laboratory tests
 - k) transcutaneous blood gases
 - l) urinary catheters and nasogastric tubes

2. 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 | Day 1 | -- per diem | \$338.50 | \$338.50 |
| 401H | Day 2 | -- per diem | \$170.30 | \$170.30 |
| 402H | Days 3 to 7 | -- per diem | \$170.30 | \$170.30 |
| 403H | Days 8 to 30 | -- per diem | \$85.60 | \$85.60 |
| 404H | Days 31 & thereafter | -- per diem | \$29.20 | \$29.20 |

VENTILATORY SUPPORT (Intensive Care Area)

Includes:

- a) endotracheal intubation with positive pressure ventilation including insertion of arterial lines
- b) obtaining and interpretation of blood gases
- c) intravenous lines
- d) Intubation (80H) when performed by the same physician claiming ICU per diems (400H-424H)
- e) oximetry
- f) provision of ventilatory care including initial consultation and assessment
- g) tracheal toilet
- h) transcutaneous blood gases and assessment
- i) use of artificial ventilator and all necessary measures for its supervision

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

| | | | | |
|------|----------------------|-------------|----------|----------|
| 410H | Day 1 | -- per diem | \$295.70 | \$295.70 |
| 411H | Day 2 | -- per diem | \$147.80 | \$147.80 |
| 412H | Days 3 to 7 | -- per diem | \$148.80 | \$148.80 |
| 413H | Days 8 to 30 | -- per diem | \$102.90 | \$102.90 |
| 414H | Days 31 & thereafter | -- per diem | \$38.10 | \$38.10 |

SECTION H - Anesthesia

Specialist General
Practitioner

COMPREHENSIVE CARE (Intensive Care Area)

1. 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
2. These fees include:
 - a) arterial and/or venous catheters
 - b) artificial ventilation and necessary measures for respiratory support
 - c) cardioversion and usual resuscitative measures
 - d) cutdowns
 - e) defibrillation
 - f) emergency resuscitation
 - g) endotracheal intubation
 - h) initial consultation and assessment and subsequent examinations of the patient
 - i) insertion of intravenous lines
 - j) insertion of urinary catheters and nasogastric tubes
 - k) intracranial pressure monitoring, interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device)
 - l) intubation (80H) when performed by the same physician claiming ICU per diems (400H-424H)
 - m) intraosseous infusion
 - n) oximetry
 - o) pressure infusion sets and pharmacological agents
 - p) securing and interpretation of blood gases and laboratory tests
 - q) tracheal toilet
 - r) transcutaneous blood gases
3. Intensive care fees are not billable for services rendered to patients admitted for ECG monitoring or observation alone.
4. 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:

| | | | | |
|------|----------------------|-------------|----------|----------|
| 420H | Day 1 | -- per diem | \$560.70 | \$560.70 |
| 421H | Day 2 | -- per diem | \$252.80 | \$252.80 |
| 422H | Days 3 to 7 | -- per diem | \$252.80 | \$252.80 |
| 423H | Days 8 to 30 | -- per diem | \$126.40 | \$126.40 |
| 424H | Days 31 & thereafter | -- per diem | \$65.20 | \$65.20 |

SECTION I – Cardiology

Specialist in Cardiology

Referred Not Referred

Visits

| | | | | |
|----|---|---|----------|----------|
| 3I | Complete assessment -- includes: a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) examination of all parts and systems; | f) diagnosis; g) assessment; h) necessary treatment; advice to the patient; and, i) record of service provided | \$76.60* | \$61.25* |
|----|---|---|----------|----------|

| | | | | |
|----|---|---|----------|----------|
| 5I | Partial assessment or subsequent visit -- includes: a) history review; b) history of presenting complaint; 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 | \$74.00* | \$50.95* |
|----|---|---|----------|----------|

| | | | | |
|----|--|-----------|--|--|
| 9I | Consultation – includes: a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; d) written submission of the consultant's opinion, and e) recommendations to the referring doctor | \$149.70* | | |
|----|--|-----------|--|--|

| | | | | |
|-----|---|----------|--|--|
| 11I | 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. | \$71.90* | | |
|-----|---|----------|--|--|

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25I | -- 1-10 days | -- per day -- bill units (max 10) | \$37.90 | \$37.90 |
| 26I | -- 11-20 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 27I | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28I | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION I – Cardiology

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|--------------------------------|-------|------|
| 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. | | | | | |
| 13I | Interpretation of telephonic 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 | \$35.70 | \$28.50@ | | |
| @ Payment approved for a physician with training and expertise in this section | | | | | |
| 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). a) payable 2 per patient per year b) any further billing should be by report with an appropriate explanation | \$1763.70 | | 0 | L |
| 105I | Full electrophysiology study - atrial and ventricular programmed electrical stimulation | \$1172.40 | | D | |
| 110I | Partial electrophysiology study - atrial and ventricular programmed electrical Stimulation | \$484.30 | | D | |
| 115I | Electrophysiological study using previously inserted electrode | \$280.40 | | D | |
| 130I | Electrophysiological study/ablation - team fee a) second physician must be a certified electrophysiologist b) maximum fee of \$1,019.50. | | 50% of Electrophysiologist Fee | | |
| 135I | Cardiac electrophysiologic drug infusion study -- per 15 minutes or major portion thereof | \$35.70 | | D | |
| 200I | Catheter ablation of supraventricular tachycardia (SVT) in addition to an electrophysiology study – add | \$266.10 | | 0 | |
| 205I | Catheter ablation of ventricular tachycardia (VT) in addition to an electrophysiology study – add | \$433.30 | | 0 | |
| 210I | Repeat catheter ablation at a second site during the same electrophysiology Study | \$137.60 | | 0 | |
| 300I | ICD clinic services - clinical supervision, review of interrogation record and necessary adjustment - includes ECG interpretation | \$49.70 | | D | |
| 305I | Implantable cardioverter defibrillator (ICD) - defibrillation testing (DFT) | \$402.70 | | 0 | H |

SECTION J – Surgical Assisting

General
Specialist Practitioner

1. Calculation of the payment to a surgical assistant is based on the time between the induction of anesthesia and when continuous attendance by the surgical assistant is no longer required. When no anesthetic 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:
 - a) surgical procedures normally requiring an assistant;
 - b) surgical procedures not normally requiring an assistant where unusual circumstances occur necessitating the services of an assistant, and where an explanation satisfactory to the Ministry of 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 anesthetic time for surgery are subject to "Assessment Rules -- Procedures".
5. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.

Surgical Assistant -- billable by any physician

| | | | |
|-----|---|----------|----------|
| 30J | -- up to 60 minutes | \$145.00 | \$145.00 |
| 31J | -- for each additional 15 minutes, or major portion thereof | \$39.00 | \$39.00 |

Surgical Assistant for Unscheduled Emergency Surgery

| | | | |
|-----|---|----------|----------|
| 60J | -- first patient | \$205.00 | \$205.00 |
| 70J | -- each additional patient | \$170.00 | \$170.00 |
| 61J | -- for each additional 15 minutes, or major portion thereof | \$39.00 | \$39.00 |

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 submitted and paid through the MSB billing system from surgical assistance.

| | | | |
|-----|---|----------|----------|
| 80J | -- up to 60 minutes | \$175.00 | \$175.00 |
| 81J | -- for each additional 15 minutes, or major portion thereof | \$47.00 | \$47.00 |

SECTION J – Surgical Assisting

Specialist General Practitioner

| | Specialist | General Practitioner |
|------|--|-------------------------------|
| 40J | Surgical Assistant Standby | \$30.00 |
| | a) For each 15 minutes or major portion thereof (maximum 30 minutes), e.g. claim if called to stand by during laparoscopy with the possibility of laparotomy. | \$30.00 |
| | b) 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 | |
| | c) Bill units | |
| 50J | Specialist O/R Standby | \$25.90 |
| | a) For each 15 minutes or major portion thereof, not to be billed for time spent awaiting start of operation. | |
| | b) Payable only if surgeon 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. | |
| | c) Does not apply to delayed surgical start or cases where the current surgical payment includes reimbursement for standby times. | |
| 332J | Surgical assist | 1/3 of First Surgeons Claim |
| | a) Payment based upon first surgeon's assessed claim | |
| | b) Specialist only | |
| | c) Include a notation/comment of the services billed by the first surgeon with your claim(s) to the MSB | |
| | d) See table on following page for applicable surgical codes | |
| 333J | Surgical assist | 30% of First Surgeons Claim @ |
| | a) Payment based upon first surgeon's assessed claim | |
| | b) @ Only general practitioners designated by the Saskatchewan Medical Association Tariff Committee is eligible. | |
| | c) @ General practitioners performing specialized assistance may apply to the Saskatchewan Medical Association 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. | |
| | d) For the purposes of billing, 333J is billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement". | |
| | e) See table on following page for applicable surgical codes. | |
| 334J | Surgical assist -- second assistant | 30% of First Surgeons Claim @ |
| | a) Payment based upon first surgeon's assessed claim | |
| | b) @ Only general practitioners designated by the Saskatchewan Medical Association Tariff Committee is eligible | |
| | c) For the purposes of billing, 333J is billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement". | |
| | d) 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. | |
| | e) See table on following page for applicable cardiac surgical codes. | |

SECTION J – Surgical Assisting

1. The following procedures, because of their complexity, may require the services of two specialist surgeons (includes FCS physicians).
2. 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.
3. The services considered for this billing option includes the list below:

Codes for optional billing of 332J or 333J, 334J

| | |
|------------------------------------|--|
| 57K | Craniotomy |
| 58K | Cerebellar or cerebral arteriovenous malformation or aneurysm excision or |
| 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 |
| 197L (30L, 31L, 33L) | Composite resection of mandible and floor of 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 | Esophagogastrectomy |
| 305L | Total gastrectomy |
| 328L | Laparoscopic sleeve 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 |
| 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; ilio-femoral; subclavian-subclavian; other arteries of neck 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 |

SECTION J – Surgical Assisting

1. The following procedures, because of their complexity, may require the services of two specialist surgeons (includes FCS physicians).
2. 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.
3. The services considered for this billing option includes the list below:

Codes for optional billing of 332J or 333J, 334J

| | |
|----------------------|---|
| 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 autograft |
| 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 | Abdominosacrocolpopexy |
| 124P | Total vaginal hysterectomy |
| 125P | Radical hysterectomy |
| 126P | Laparoscopic hysterectomy |
| 102R | Ileocystoplasty |
| 106R | Ileal conduit |
| 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, 33L) | Composite resection of mandible and floor of mouth, partial or total maxillectomy |

SECTION K– Neurosurgery

Specialist in Neurosurgery

Referred Not Referred

Visits

| | | | |
|-----|--|-----------|----------|
| 5K | <p>Initial assessment -- of a specific condition includes:</p> <ul style="list-style-type: none"> a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) examination of affected part(s) or system(s); f) diagnosis; g) assessment; h) necessary treatment; advice to the patient; and, i) record of service provided. | \$88.00* | \$70.45* |
| 7K | <p>Follow-up assessment -- includes:</p> <ul style="list-style-type: none"> a) history review; b) reassessment; c) functional enquiry; d) examination; e) necessary treatment; f) advice to the patient; and, g) record of service provided. | \$52.00* | \$47.75* |
| 8K | <p>Consultation -- spinal, complex</p> <ul style="list-style-type: none"> a) at least 30 minutes documented duration including history, physical, review of imaging and recommendations to referring physician b) includes traumatic, tumour, infection, degenerative c) can be billed by all neurosurgeons d) can also be billed with entitlement** by physicians who perform spinal instrumentation and fusion procedures | \$160.00* | |
| 9K | <p>Consultation – includes:</p> <ul style="list-style-type: none"> a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; and, d) written submission of the consultant's opinion, and e) recommendations to the referring doctor | \$122.00* | |
| 10K | <p>Consultation -- spinal, routine</p> <ul style="list-style-type: none"> a) less than 30 minutes documented duration including history, physical, review of imaging and recommendations to referring physician; b) can be used for any spine referral; and c) can be billed by all neurosurgeons and orthopedic surgeons | \$107.00* | |
| 11K | <p>Repeat consultation</p> <p>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.</p> | \$52.80* | |
| 14K | <p>Follow-up visit, spinal, complex</p> <ul style="list-style-type: none"> a) billable for those patients previously billed as initial spine consult, complex b) can be billed by all neurosurgeons c) can also be billed with entitlement** by physicians who perform spinal instrumentation and fusion procedures | \$60.00* | \$54.00* |
| 15K | <p>Follow-up visit, spinal, routine - can be billed by all neurosurgeons and orthopedic surgeons</p> | \$46.70* | \$42.00* |

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

**For the purposes of billing, 8K and 14K are billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.

SECTION K– Neurosurgery

Specialist in Neurosurgery

Referred Not Referred

Hospital Care – Payable on the day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25K | -- 1-10 days | -- per day -- bill units (max 10) | \$34.00 | \$34.00 |
| 26K | -- 11-20 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 27K | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28K | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION K – Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| 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. | | | | | |
| 31K | Subdural taps through fontanel -- initial or repeat | \$33.80 | \$33.80 | D | L |
| 32K | Ventricular puncture through previous burr or fontanel | \$56.50 | \$50.90 | D | M |
| 35K | Implantation of an intracranial monitor for measuring intracranial pressure | \$240.60 | \$216.50 | 0 | L |
| 36K | Double blind morphine pain study | \$110.10 | \$98.90 | D | |
| Intercranial Procedures – Non-traumatic | | | | | |
| 50K | Operative management of brain abscess | \$1,089.80 | \$980.90 | 42 | H |
| 51K | Suboccipital craniectomy for tractotomy or cranial nerve section | \$937.90 | \$844.10 | 42 | H |
| 253K | Micro-surgical decompression of cranial nerve | \$1,700.00 | \$1,529.95 | 42 | M |
| 66K | Percutaneous thermocoagulation (rhizotomy) of trigeminal nerve or ganglion | \$633.10 | \$569.80 | 42 | L |
| 55K | Craniotomy and orbital decompression – unilateral | \$668.80 | \$601.50 | 42 | H |
| 56K | Craniotomy and orbital decompression – bilateral | \$805.40 | \$724.90 | 42 | H |
| 57K | Cerebellar or cerebral tumor – excision | \$2,111.40 | \$1,900.20 | 42 | H |
| 58K | Cerebellar or cerebral arteriovenous malformation or aneurysm -- excision or obliteration | \$2,500.00 | \$2,250.00 | 42 | H |
| 59K | Stereotactic procedures -- framed or frameless to obtain deep tumor biopsy, localization and guidance during craniotomy for tumor excision | \$905.30 | \$814.80 | 42 | H |
| 60K | Cortical excision for epilepsy, hypophysectomy or excision of choroid plexus | \$1,273.40 | \$1,146.00 | 42 | H |
| 61K | Intra-operative electrophysiological monitoring and/or stimulation -- add to any intracranial procedure | \$181.50 | \$163.30 | 42 | |
| 62K | Excision of osteomyelitis of skull | \$673.90 | \$606.50 | 42 | M |
| 63K | Excision of skull tumor | \$532.20 | \$479.20 | 42 | M |
| 64K | Excision of skull tumor with immediate cranioplasty | \$617.80 | \$556.60 | 42 | M |
| 65K | Extra-axial brain tumor (microdissection, CO2 laser, ultrasonic aspirator) | \$2,813.00 | \$2,531.65 | 42 | H |
| 80K | Ventriculocisternostomy | \$674.90 | \$607.40 | 42 | M |
| 81K | Repair of encephalocele | \$715.70 | \$644.30 | 42 | H |
| 82K | Shunts for hydrocephalus -- any type | \$1,141.00 | \$1,026.90 | 42 | M |
| 83K | Shunts for hydrocephalus -- revision during the same hospital admission as original procedure | \$429.20 | \$386.30 | 42 | M |
| 84K | Shunts for hydrocephalus - revision – independent procedure upper end | \$867.60 | \$780.80 | 42 | M |
| 85K | Shunts for hydrocephalus -- lower end | \$468.00 | \$421.20 | 42 | M |
| 86K | Removal of ventriculo peritoneal shunt without simultaneous revision | \$211.00 | \$189.90 | 42 | L |
| 90K | Craniectomy for craniostenosis -- single suture | \$621.90 | \$559.70 | 42 | M |
| 91K | Craniectomy for craniostenosis -- multiple sutures | \$879.80 | \$791.80 | 42 | M |

SECTION K – Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 92K | Lateral canthal advancement – unilateral | \$851.30 | \$766.70 | 42 | M |
| 93K | Lateral canthal advancement – bilateral | \$1,047.00 | \$942.00 | 42 | M |
| 100K | Burr holes -- exploratory with or without biopsy | \$242.60 | \$218.20 | 42 | M |
| 101K | Burr holes -- with external ventricular drainage | \$362.90 | \$326.60 | 42 | M |
| 102K | Burr holes -- with C T guided biopsy | \$370.10 | \$333.10 | 42 | M |
| 103K | Sub-temporal decompression | \$407.80 | \$367.00 | 42 | M |
| 106K | Extracranial to intracranial bypass | \$959.30 | \$863.50 | 42 | H |
| | Procedures for Traumatic Intracranial Lesions | | | | |
| 113K | Evacuation of hematoma -- via burr holes | \$987.00 | \$888.30 | 42 | M |
| 114K | Evacuation of hematoma -- via craniotomy | \$1,289.70 | \$1,160.70 | 42 | H |
| 116K | Elevation of simple depressed skull fracture | \$703.50 | \$633.10 | 42 | M |
| 117K | Compound depressed skull fracture with debridement of brain and repair of dura | \$921.60 | \$829.50 | 42 | H |
| 118K | Compound depressed fracture with sinus involvement or reconstruction of the orbit | \$794.20 | \$714.70 | 42 | M |
| 119K | Cranioplasty for skull defect | \$831.90 | \$748.70 | 42 | M |
| 121K | Craniotomy for cerebrospinal fluid rhinorrhea | \$1,013.40 | \$912.00 | 42 | H |
| 122K | Intracranial duraplasty -- for a deficiency greater than 2 cm. diameter -- add to intracranial procedure | \$163.10 | \$146.80 | 42 | |
| | Peripheral Nerve Lesions | | | | |
| 156K | Biopsy of sural nerve | \$203.90 | \$183.50 | D | L |
| 157K | Removal of tumor -- major peripheral nerve (e.g. median or ulna) | \$509.80 | \$458.80 | 42 | L |
| 158K | Decompression of entrapment syndrome -- median nerve | \$327.30 | \$294.50 | 42 | L |
| 159K | Decompression of entrapment syndrome -- others | \$509.80 | \$458.80 | 42 | L |
| 160K | Section or crushing of nerve | \$128.50 | \$115.20 | 42 | L |
| 161K | Neuroma excision | \$356.80 | \$321.10 | 42 | L |
| 162K | Exploration of peripheral nerve injury or neurolysis | \$440.40 | \$396.40 | 42 | L |
| 163K | Nerve suture (other than digital) | \$615.00 | \$553.45 | 42 | L |
| 164K | Nerve suture with special techniques to overcome gap | \$715.00 | \$643.45 | 42 | L |
| 165K | Digital nerve suture | \$410.00 | \$369.00 | 42 | L |
| 166K | Exploration of brachial or lumbar plexus with or without suture | \$382.30 | \$343.60 | 42 | L |
| 167K | Nerve anastomosis for intracranial nerve injury | \$414.90 | \$373.10 | 42 | L |
| 368K | Secondary or delayed nerve repair -- one month post-injury, add | \$155.00 | \$139.50 | 42 | L |
| 468K | Fascicular instead of epineural nerve repair, add | \$185.50 | \$166.20 | 42 | M |
| 168K | Nerve grafting procedures -- single cable | \$390.00 | \$350.75 | 42 | L |
| 268K | Nerve grafting procedures – multiple cables | \$715.00 | \$643.45 | 42 | L |
| 169K | Transposition of ulnar nerve | \$460.80 | \$414.70 | 42 | L |
| 170K | Extracranial anastomosis for facial nerve lesion -- hypoglossal accessory, etc. | \$422.10 | \$380.30 | 42 | L |

SECTION K – Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| 171K | Radiofrequency spinal rhizotomy | \$183.80 | \$165.45 | 0 | L |
| 172K | Facial nerve - microsurgical graft – neurosurgeon | \$422.10 | \$380.30 | 42 | L |
| 173K | Facial nerve - microsurgical graft -- general surgeon | \$306.90 | \$276.30 | 42 | L |
| 174K | Selective dorsal rhizotomy for spasticity | \$1,157.10 | \$1,040.90 | 42 | M |
| 175K | DREZ procedure for intractable pain | \$825.80 | \$743.20 | 42 | M |
| Vegetative Nervous System | | | | | |
| 180K | Cervical sympathectomy – unilateral | \$309.90 | \$278.30 | 42 | M |
| 181K | Cervical sympathectomy – bilateral | \$427.20 | \$384.40 | 42 | M |
| 182K | Cervico-thoracic sympathectomy – unilateral | \$392.50 | \$353.30 | 42 | H |
| 183K | Cervico-thoracic sympathectomy – bilateral | \$512.80 | \$461.50 | 42 | H |
| 184K | Lumbar sympathectomy – unilateral | \$336.40 | \$302.80 | 42 | M |
| 185K | Lumbar sympathectomy – bilateral | \$407.80 | \$367.00 | 42 | M |
| Exposures for Neurosurgery | | | | | |
| 210K | Trans-abdominal exposure of lumbar and lower thoracic spine for neurosurgical procedure | \$459.80 | \$413.80 | 42 | M |
| 211K | Trans-thoracic exposure of lower cervical or thoracic spine for neurosurgical procedure | \$425.00 | \$382.55 | 42 | M |
| 212K | Trans-sphenoidal exposure of pituitary for hypophysectomy | \$917.60 | \$825.80 | 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. | | | | | |
| <u>Example:</u> | | | | | |
| a) If procedure is 3.5 hours in entirety and opening and closure combined takes 1 hour | | | | | |
| b) Standby is then 2.5 hours | | | | | |
| c) Total billing would be the appropriate K code (210K, 211K, or 212K) and ten 15 minute units of 50J. | | | | | |
| d) Codes 210K to 212K are exempt from the multiple surgery rules | | | | | |
| Deep Brain Electrode For Movement Disorders | | | | | |
| 235K | Installation of deep brain electrode | \$2,000.00 | \$1,799.90 | 42 | H |
| 236K | -- add - micro-electrode recording and stimulation | \$509.80 | \$458.80 | 42 | H |
| 237K | -- add - internalization of deep brain electrode using single channel IPG | \$254.90 | \$229.40 | 42 | H |
| 238K | -- add - internalization of deep brain implant using dual channel IPG or pulse Generator | \$407.80 | \$367.00 | 42 | H |
| Neuromodulation Clinic Services | | | | | |
| <ul style="list-style-type: none"> • Clinic supervision, patient monitoring and adjustment of stimulation parameters, drug dose and/or drug mix. • Includes advice to the patient, either directly or indirectly through the neuromodulation nurse. • Visit fee payable if patient reviewed for a condition unrelated to neuromodulation device function) | | | | | |
| 278K | Patient not seen | \$29.40 | \$26.40 | | |
| 279K | Patient seen | \$43.40 | \$39.00 | 0 | |

SECTION K– Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| SPINE SURGERY | | | | | |
| Anterior Decompression – Cervical | | | | | |
| 500K | Odontoidectomy | \$1,682.20 | \$1,514.00 | 42 | H |
| 501K | Odontoidectomy -- exposure by separate surgeon | \$1,297.80 | \$1,168.00 | 42 | H |
| 502K | Odontoidectomy -- exposure by primary surgeon – add | \$392.50 | \$353.30 | 42 | |
| 503K | Discectomy -- 1 level | \$1,088.80 | \$979.90 | 42 | M |
| 504K | Discectomy -- each additional level – add | \$302.80 | \$272.50 | 42 | |
| 505K | Vertebrectomy -- includes adjacent discs | \$1,701.50 | \$1,531.40 | 42 | H |
| 506K | Vertebrectomy -- each additional level -- add -- maximum of 3 | \$293.60 | \$264.30 | 42 | |
| 507K | Artificial discs -- includes discectomy and fusion | \$2,039.00 | \$1,835.10 | 42 | H |
| 508K | Artificial discs -- additional level -- add -- maximum of 1 | \$1,529.30 | \$1,376.30 | 42 | |
| Fee codes 507K & 508K are not billable with any other cervical decompression, fusion or instrumentation | | | | | |
| Anterior Decompression – Thoracic | | | | | |
| 514K | Discectomy | \$1,019.50 | \$917.60 | 42 | M |
| 714K | Discectomy -- each additional level – add | \$288.50 | \$259.70 | 42 | M |
| 515K | Vertebrectomy – includes adjacent discs | \$1,712.80 | \$1,541.50 | 42 | H |
| 516K | Vertebrectomy -- each additional level -- add -- maximum of 3 | \$254.90 | \$229.40 | 42 | |
| 517K | Exposure by primary surgeon | \$448.60 | \$403.70 | 42 | M |
| Anterior Decompression – Lumbar | | | | | |
| 523K | Discectomy | \$1,036.80 | \$933.10 | 42 | M |
| 723K | Discectomy -- each additional level -- add | \$288.50 | \$259.70 | 42 | M |
| 524K | Vertebrectomy -- includes adjacent discs | \$1,660.80 | \$1,494.70 | 42 | H |
| 525K | Vertebrectomy -- each additional level -- add -- maximum of 2 | \$254.90 | \$229.40 | 42 | |
| 526K | Artificial disc -- includes discectomy and fusion | \$2,039.00 | \$1,835.10 | 42 | H |
| 527K | Artificial disc -- additional level -- add -- maximum of 1 | \$1,529.30 | \$1,376.30 | 42 | |
| 528K | Exposure by primary surgeon | \$305.90 | \$275.30 | 42 | M |
| Posterior Decompression – Cervical and Thoracic | | | | | |
| Laminectomy, Laminotomy, Foraminotomy | | | | | |
| 534K | -- unilateral | \$881.90 | \$793.70 | 42 | M |
| 535K | -- bilateral | \$1,037.90 | \$934.10 | 42 | M |
| 536K | -- each additional level -- add -- maximum of 4 | \$229.40 | \$205.90 | 42 | |
| 537K | -- discectomy – add | \$310.90 | \$279.90 | 42 | |
| 538K | -- foramen magnum – add | \$518.90 | \$467.00 | 42 | |
| 539K | Laminoplasty - includes strut and fixation | \$1,348.80 | \$1,213.90 | 42 | M |
| 540K | Laminoplasty - each additional level -- add -- maximum of 5 | \$310.90 | \$279.90 | 42 | M |

SECTION K– Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| Posterior Decompression – Lumbar | | | | | |
| Laminectomy, Laminotomy, Foraminotomy | | | | | |
| 546K | -- unilateral | \$937.90 | \$844.10 | 42 | M |
| 547K | -- bilateral | \$1,172.40 | \$1,055.20 | 42 | M |
| 548K | -- each additional level -- add -- maximum of 5 | \$264.10 | \$237.60 | 42 | |
| 549k | -- discectomy – add | \$293.60 | \$264.30 | 42 | |
| 550K | Pedicle subtraction osteotomy -- above lumbar 2 | \$815.60 | \$734.00 | 42 | M |
| 551K | Pedicle subtraction osteotomy -- below or at lumbar 2 | \$611.70 | \$550.50 | 42 | M |
| For the purpose of fusion and instrumentation, a level is defined as two vertebral bodies with an intervening disc space | | | | | |
| Anterior fusion - cervical, thoracic, lumbar - Degenerative, tumor, trauma, or infective conditions | | | | | |
| 557K | Anterior fusion -- first level fused | \$528.10 | \$475.30 | 42 | M |
| 558K | Anterior fusion -- each additional level -- add -- maximum of 4 | \$176.40 | \$158.70 | 42 | M |
| Posterior fusion – cervical, thoracic, lumbar - Degenerative, tumor, trauma, or infective conditions | | | | | |
| 564K | Posterior fusion -- first level fused | \$469.00 | \$422.10 | 42 | M |
| 565K | Posterior fusion -- each additional level -- add -- maximum of 5 | \$104.00 | \$93.60 | 42 | M |
| 566K | Autologous bone graft harvest from distant site | \$356.80 | \$321.10 | 42 | M |
| 567K | Preparation of allograft – not including premade grafts | \$254.90 | \$229.40 | 42 | M |
| Instrumentation – anterior | | | | | |
| 573K | Cervical | \$469.00 | \$422.10 | 42 | M |
| 574K | Cervical -- each additional level -- add -- maximum of 3 | \$117.20 | \$105.50 | 42 | M |
| 575K | Odontoid screw | \$1,521.10 | \$1,369.00 | 42 | H |
| May claim fracture decompression in addition, not fusion | | | | | |
| 576K | Thoracic & Lumbar | \$611.70 | \$550.50 | 42 | H |
| 577K | Thoracic & Lumbar -- each additional level -- add -- maximum of 3 | \$102.00 | \$91.80 | 42 | M |
| Instrumentation – posterior | | | | | |
| 583K | Cervical 1-2 screw fixation | \$1,289.70 | \$1,160.70 | 42 | M |
| 584K | Cervical 1-2 screw fixation -- if occiput included – add | \$586.20 | \$527.60 | 42 | |
| 585K | Cervical 1-2 screw fixation -- each additional level below cervical 2, add – max of 8 | \$234.50 | \$211.00 | 42 | |
| 586K | Cervical 1-2 wiring | \$576.00 | \$518.40 | 42 | M |
| 587K | Cervical 1-2 wiring -- if occiput included – add | \$509.80 | \$458.80 | 42 | |
| 588K | Cervical 1-2 wiring -- each additional level below C2 -- add – max of 8 | \$203.90 | \$183.50 | 42 | |
| 589K | Cervical 1-2 wiring -- hook or wire construct added to another procedure | \$254.90 | \$229.40 | 42 | |

SECTION K– Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|--------------------------------------|--|--------------------------------|----------------------|-------|------|
| Instrumentation – Below C2 | | | | | |
| 590K | 1 st level | \$937.90 | \$844.10 | 42 | M |
| 591K | -- each additional level -- add -- maximum of 8 | \$203.90 | \$183.50 | 42 | |
| 592K | -- each additional level beyond 8 - add -- maximum of 5 | \$102.00 | \$91.80 | 42 | |
| 593K | Iliac screws – add | \$254.90 | \$229.40 | 42 | |
| 594K | -- crossing cervicothoracic junction – add | \$203.90 | \$183.50 | 42 | |
| 600K | Instrumentation removal – anterior or posterior – per 15 minutes Billable with other procedures | \$93.80 | \$89.40 | 42 | M |
| Fractures | | | | | |
| 606K | Decompression and/or reduction of fracture -- cannot be billed with other decompression codes, instrumentation and fusion may also be billed | \$815.60 | \$734.00 | 0 | |
| 607K | Halo ring application | \$458.80 | \$412.90 | 0 | |
| 608K | Closed reduction and traction | \$351.70 | \$316.60 | 0 | |
| 609K | Halo Jacket | \$176.40 | \$158.70 | 0 | |
| 610K | Thoracolumbar bracing -- billable only when the physician personally applies the brace | \$234.50 | \$211.00 | 0 | |
| Tumour / Infection / Vascular | | | | | |
| 616K | Major decompression code -- add | 30% of Decompression | | | |
| 617K | Excision of mass without decompression | \$260.00 | \$234.00 | 42 | M |
| 618K | Excision of mass with nerve root decompression -- see posterior decompression -- add 30% | 30% of Posterior Decompression | | | |
| 619K | Removal intradural/extramedullary tumour -- cannot be claimed with other decompression codes | \$1,759.70 | \$1,583.70 | 42 | H |
| 620K | Removal intradural/intramedullary tumour -- cannot be claimed with other decompression codes | \$2,075.70 | \$1,868.10 | 42 | H |
| 621K | Excision of intradural vascular malformation -- cannot be claimed with other decompression codes | \$1,784.10 | \$1,605.70 | 42 | H |
| 622K | Interruption of spinal dural AV fistula -- cannot be claimed with other decompression codes | \$1,325.40 | \$1,192.80 | 42 | H |
| 623K | Percutaneous vertebral biopsy | \$176.40 | \$158.70 | 42 | M |
| 624K | Open vertebral biopsy | \$254.90 | \$229.40 | 42 | M |
| Pain | | | | | |
| 630K | Implantation of a single quadripolar electrode | \$879.80 | \$791.80 | 42 | M |
| 631K | -- additional quadripolar electrode - maximum of 1 additional | \$351.70 | \$316.60 | 42 | |
| 632K | Implantation of a single quadripolar electrode - if surgery in same area as a previous surgery | \$1,035.80 | \$932.20 | 42 | M |
| 633K | -- additional quadripolar electrode -- if surgery in same areas as previous surgery - maximum of 1 additional electrode | \$374.20 | \$336.70 | 42 | |
| 634K | Implantation of octopolar electrode | \$937.90 | \$844.10 | 42 | M |
| 635K | -- additional octopolar electrode -- maximum of 1 additional | \$351.70 | \$316.60 | 42 | |
| 636K | If laminectomy required for electrode insertion – 8 contacts | \$881.90 | \$793.70 | 42 | M |
| 637K | If laminectomy required for electrode insertion – 16 contacts | \$1,256.00 | \$1,130.40 | 42 | M |

Payment Schedule for Insured Services Provided by a Physician

SECTION K– Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|----------------------|--|------------|-----------------------------|-------|------|
| 638K | Internalization of stimulation system -- non-rechargeable | \$293.60 | \$264.30 | 42 | M |
| 639K | Internalization of stimulation system -- rechargeable | \$410.90 | \$369.80 | 42 | M |
| 640K | Removal of stimulating electrode | \$234.50 | \$211.00 | 42 | M |
| 641K | Adjustment of stimulating electrodes | \$465.90 | \$419.30 | 42 | M |
| 642K | Programming of pump | \$117.20 | \$105.50 | 42 | |
| 643K | Programming of pulse generator | \$117.20 | \$105.50 | 42 | |
| 644K | Myelotomy for pain -- open or percutaneous -- cannot be claimed with other decompression codes | \$1,019.50 | \$917.60 | 42 | H |
| 645K | Pain pump implantation | \$879.80 | \$791.80 | 42 | M |
| 646K | Dorsal root entry zone lesioning or percutaneous CT guided cordotomy | \$1,121.50 | \$1,009.30 | 42 | H |
| 647K | Repair or replacement of blocked intrathecal catheter | \$528.10 | \$475.30 | 42 | M |
| 648K | Reanchoring a flipping pump | \$351.70 | \$316.60 | 42 | M |
| 649K | Replacement of pain pump | \$469.00 | \$422.10 | 42 | M |
| 650K | Removal of pain pump and catheters | \$351.70 | \$316.60 | 42 | M |
| 651K | Replacement of Pulse generator – rechargeable | \$410.90 | \$369.80 | 42 | M |
| 652K | Replacement of Pulse generator – non rechargeable | \$293.60 | \$264.30 | 42 | M |
| Miscellaneous | | | | | |
| 658K | Vertebroplasty | \$620.30 | \$558.65 | 42 | M |
| 659K | -- each additional level – add (maximum of 3 additional levels) | \$208.80 | \$187.90 | 42 | |
| 660K | -- in addition to another spinal procedure | \$230.40 | \$207.40 | 42 | |
| 661K | Kyphoplasty | \$937.90 | \$844.10 | 42 | M |
| 662K | -- each additional level – add (maximum of 1 additional level) | \$586.20 | \$527.60 | 42 | |
| 663K | -- in addition to another spinal procedure | \$305.90 | \$275.30 | 42 | |
| 664K | Spinal duraplasty | \$288.50 | \$259.70 | 42 | M |
| 665K | Syringosubarachnoid shunt | \$917.60 | \$825.80 | 42 | H |
| 666K | Syringopleural or syringoperitoneal shunt | \$1,121.50 | \$1,009.30 | 42 | H |
| 667K | Management of intradural congenital lesion -- includes diastematomyelia, tethered cord, lipoma | \$1,141.80 | \$1,027.70 | 42 | H |
| 668K | Intradural rhizotomy | \$1,121.50 | \$1,009.30 | 42 | H |
| 669K | Meningocele repair | \$746.30 | \$671.60 | 42 | M |
| 670K | Myelomeningocele repair | \$997.10 | \$897.40 | 42 | M |
| 671K | Myelomeningocele repair -- if plastic surgeon performs closure | \$509.80 | \$458.80 | 42 | M |
| 677K | Acute spinal cord injury (ASIA A, B, or C less than 6 weeks) | | 15% of surgery | | |
| 331K | Team Spinal Surgery | | 50% of First Surgeons Claim | | |
| | a) Where procedure requires the presence of two spine surgeons working in equal capacity | | | | |
| | b) Not for routine assisting | | | | |
| | c) Billable by all neurosurgeons and orthopedic surgeons | | | | |
| 678K | Monitoring | \$300.00 | \$270.00 | 42 | |

Payment Schedule for Insured Services Provided by a Physician

- a) Electromyogram (EMG)
- b) Motor Evoked Potentials (MEP)
- c) Somatosensory Evoked Potentials (SSEP)

SECTION K– Neurosurgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 679K | Spine surgery supplement for patients with a Body Mass Index (Weight [kg]/Height [m] 2) greater than 40 | \$171.30 | \$171.30 | | |
| | a) Maximum of one 679K supplement per patient per day. | | | | |
| | b) Supplement 679K may be billed by spine surgeons with all K Section spine procedures done in the operating room. | | | | |
| 680K | Spinal stereotaxy for tumor, trauma, revision, pediatric | \$586.20 | \$527.60 | 42 | M |
| 681K | Revision surgery – add | | 30% of decompression | | |
| 682K | Revision surgery – add | | 30% of fusion | | |

SECTION L – General Surgery

Specialist in General Surgery

Referred Not Referred

Visits

| | | | |
|-----|---|-----------|----------|
| 5L | <p>Initial assessment -- of a specific condition includes:</p> <ul style="list-style-type: none"> a) pertinent family history; b) patient history, history of presenting complaint; 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. | \$58.10* | \$46.50* |
| 7L | <p>Follow-up assessment -- includes:</p> <ul style="list-style-type: none"> a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and, g) record of service provided. | \$35.70* | \$35.70* |
| 9L | <p>General, thoracic and vascular surgery consultation – includes:</p> <ul style="list-style-type: none"> a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; d) written submission of the consultant's opinion, and e) recommendations to the referring doctor. | \$115.00* | |
| 10L | <p>Cardiac surgery consultation (only payable to physicians with approved training in cardiac surgery) – includes:</p> <ul style="list-style-type: none"> a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; and, d) written submission of the consultant's opinion and recommendations to the referring doctor. | \$149.90* | |
| 11L | <p>Repeat consultation</p> <p>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.</p> <p>* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.</p> | \$55.10* | |
| 13L | <p>Written advice to referring physician on the management of a case based upon review of diagnostic imaging (payable once per case only)</p> <p>@ Payment approved for a physician with training and expertise in this section.</p> | \$29.20@ | \$20.90@ |

SECTION L – General Surgery

Specialist in General Surgery

| | |
|----------|-----------------|
| Referred | Not Referred |
|----------|-----------------|

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25L | -- 1-10 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 26L | -- 11-20 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 27L | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28L | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| 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 | | | | | |
| Head and Neck | | | | | |
| 30L | Maxilla -- partial resection | \$580.00 | \$522.00 | | |
| 31L | Maxilla -- total resection | \$797.20 | \$716.70 | 42 | M |
| 32L | V-excision lip -- less than 1/3 | \$143.40 | \$143.40 | 42 | L |
| 33L | Mandible -- one side at ramus excision | \$533.20 | \$479.90 | 42 | M |
| 35L | Mandible -- segmental resection | \$428.00 | \$385.20 | 42 | M |
| Tongue | | | | | |
| Repair of laceration or excision of benign tumour of tongue | | | | | |
| 45L | -- local anesthetic | \$53.40 | \$53.40 | 10 | |
| 46L | -- under general anesthetic or IV sedation (includes post-op | \$84.10 | \$84.10 | 10 | M |
| Frenectomy -- See 139T | | | | | |
| 47L | Glossectomy -- partial | \$374.60 | \$337.15 | 42 | M |
| 48L | Glossectomy -- hemi | \$429.20 | \$386.30 | 42 | M |
| 49L | Glossectomy -- total | \$595.40 | \$535.80 | 42 | M |
| 50L | Excision carotid body tumor | \$635.10 | \$571.60 | 42 | H |
| 51L | Excision carotid body tumor -- with bypass or arterial graft | \$758.50 | \$682.00 | 42 | H |
| 52L | Scalenotomy | \$251.80 | \$226.30 | 42 | L |
| 53L | Scalenotomy -- with cervical rib resection | \$452.70 | \$406.80 | 42 | M |
| 54L | Brachial cyst -- excision | \$444.70 | \$400.25 | 42 | M |
| 55L | Thyroglossal cyst or sinus or brachial sinus -- excision | \$528.30 | \$475.55 | 42 | M |
| 56L | Torticollis -- tenotomy | \$240.60 | \$216.10 | 42 | L |
| 57L | Torticollis -- resection of a tumor or wide fasciectomy | \$402.70 | \$362.40 | 42 | L |
| 58L | Cystic hygroma excision | \$818.10 | \$736.35 | 42 | H |
| 59L | Excision of congenital defects, angular or midline dermoids, brachial remnants, etc | \$251.80 | \$226.30 | 42 | M |
| Salivary Glands | | | | | |
| 60L | Submandibular or parotid stone removal | \$42.60 | \$42.60 | 10 | |
| 61L | Submandibular duct stone -- operative removal | \$149.90 | \$149.90 | 10 | M |
| 62L | Parotid duct stone -- operative removal | \$288.50 | \$288.50 | 42 | M |
| 63L | Local excision of parotid tumor and portion of gland without nerve dissection | \$480.30 | \$432.25 | 42 | M |
| 64L | Full excision of superficial lobe of parotid with nerve dissection | \$1,017.10 | \$915.40 | 42 | M |
| 65L | Total parotidectomy | \$1,187.50 | \$1,068.75 | 42 | M |
| 66L | Sublingual gland excision | \$184.50 | \$184.50 | 42 | L |
| 67L | Submandibular salivary gland excision | \$420.60 | \$378.60 | 42 | M |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| Thyroid | | | | | |
| 68L | Aspiration of thyroid gland | \$30.20 | \$30.20 | D | |
| 69L | Needle biopsy of thyroid gland | \$61.60 | \$61.60 | D | |
| 70L | Thyroidectomy -- partial -- unilateral | \$708.10 | \$637.35 | 42 | M |
| 71L | Thyroidectomy -- partial -- bilateral | \$806.70 | \$726.05 | 42 | M |
| 77L | Thyroidectomy -- total -- unilateral | \$845.50 | \$741.40 | 42 | M |
| 72L | Thyroidectomy -- total-- bilateral | \$1,187.50 | \$1,068.75 | 42 | M |
| 78L | Thyroidectomy -- recurrent | \$966.80 | \$870.10 | 42 | M |
| In instances of combined total and partial thyroidectomy, the maximum benefit paid will be at the rate of 72L for total bilateral thyroidectomy. | | | | | |
| Parathyroid | | | | | |
| 75L | Parathyroidectomy -- adenoma or hyperplasia | \$875.60 | \$788.10 | 42 | M |
| 76L | Parathyroidectomy -- with mediastinal exploration | \$1,004.20 | \$903.70 | 42 | H |
| 775L | Parathyroid, reimplantation, add to 72L, 75L or 76L | \$126.60 | \$113.90 | 42 | H |
| Breast | | | | | |
| For augmentation or reduction mammoplasty, prosthesis and nipple surgery see items 350N to 431N. | | | | | |
| 79L | Breast cyst aspiration -- each to a maximum of 4 | \$21.40 | \$21.40 | D | |
| 679L | Tru-cut needle biopsy of breast | \$42.50 | \$42.50 | D | |
| 80L | Abscess -- single or multilocular -- general anesthetic | \$173.60 | \$173.60 | 42 | L |
| 82L | Segmental resection | \$253.80 | \$228.40 | 42 | L |
| 83L | Excision of tumor or biopsy | \$202.50 | \$182.35 | 10 | L |
| 86L | Excision of non-palpable breast lesion using wire localization | \$365.80 | \$329.20 | 10 | L |
| 84L | Simple mastectomy | \$511.90 | \$460.70 | 42 | |
| 85L | Modified radical mastectomy | \$955.80 | \$860.25 | 42 | M |
| 87L | Radical mastectomy | \$1,039.00 | \$935.05 | 42 | M |
| 88L | Radical mastectomy -- with skin graft | \$1,034.80 | \$931.80 | 42 | M |
| 89L | Subcutaneous mastectomy with preservation of nipple& areola | \$556.70 | \$500.95 | 42 | L |
| Thorax | | | | | |
| 90L | Mediastinoscopy -- without biopsy | \$200.80 | \$180.80 | D | M |
| 689L | Mediastinoscopy -- with biopsy | \$320.10 | \$288.10 | 10 | M |
| 690L | Mediastinotomy | \$132.50 | \$119.30 | 42 | M |
| 91L | Funnel chest repair | \$684.00 | \$615.65 | 42 | M |
| 92L | Thoracotomy -- with or without biopsy - not paid in addition to thoracic surgery | \$453.70 | \$408.30 | 42 | H |
| Trans-thoracic exposure of lower cervical or thoracic spine for neurosurgical procedure -- see section K | | | | | |
| 93L | Thoracotomy for cardiac arrest -- referred | \$389.60 | \$350.70 | 42 | H |
| 94L | Sternal wound dehiscence, closure -- service exempt from repeat surgical rule | \$198.80 | \$198.80 | 42 | M |

Payment Schedule for Insured Services Provided by a Physician

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| 95L | Closed drainage of chest | \$185.50 | \$185.50 | 0 | L |
| 96L | Open drainage of chest with rib resection | \$276.30 | \$248.70 | 0 | M |
| 97L | Intrapleural adhesions -- endoscopic resection | \$231.40 | \$208.30 | 42 | M |
| 98L | Poudrage of chest | \$253.90 | \$228.50 | 42 | M |
| 99L | Decortication lung | \$903.30 | \$812.90 | 42 | H |
| 100L | Lobectomy -- lung -- total or segmental | \$1,020.50 | \$918.50 | 42 | H |
| 101L | Lobectomy -- lung -- wedge resection - one | \$801.30 | \$721.20 | 42 | H |
| 103L | Lobectomy -- lung -- each additional to a maximum of 3, add | \$105.00 | \$94.50 | 42 | H |
| 600L | Sleeve lobectomy | \$1,152.00 | \$1,036.80 | 42 | H |
| 102L | Pneumonectomy | \$1,063.30 | \$957.00 | 42 | H |
| 602L | Sleeve pneumonectomy | \$1,146.90 | \$1,031.70 | 42 | H |
| 106L | Biopsy of lung -- open | \$477.10 | \$429.40 | 42 | H |
| 108L | Drainage lung abscess -- one stage | \$495.40 | \$445.90 | 42 | H |
| 109L | Drainage lung abscess -- two stages | \$511.80 | \$460.80 | 42 | H |
| 110L | Resection first rib | \$472.00 | \$424.80 | 42 | M |
| 111L | Thoracoplasty -- without first rib | \$618.80 | \$557.00 | 42 | M |
| 112L | Thoracoplasty -- with first rib | \$637.20 | \$573.50 | 42 | M |
| 114L | Mediastinal tumor (includes thymectomy) -- removal | \$788.10 | \$709.60 | 42 | H |
| 115L | Mediastinal tumor (includes thymectomy) -- radical excision | \$1,026.60 | \$923.70 | 42 | H |
| | Heart -- Closed Operations | | | | |
| 116L | Exploratory cardiotomy - not paid in addition to thoracic surgery | \$519.90 | \$468.00 | 42 | H |
| 117L | Insertion of cardiac pacemaker via thoracotomy | \$473.00 | \$425.10 | 42 | H |
| | Implantation of transvenous pacemaker or AV sequential pacemaker (includes programming) | | | | |
| 120L | -- permanent ventricular (one lead) | \$438.40 | \$394.50 | 42 | L |
| 820L | -- permanent AV sequential (two lead), add | \$127.40 | \$114.70 | 42 | L |
| 121L | -- temporary | \$161.10 | \$145.00 | 0 | L |
| 821L | Permanent pacemaker lead repositioning | \$305.90 | \$275.30 | 42 | L |
| | Pacemaker Clinic Services -- see Section D | | | | |
| 122L | Replacement of pacemaker power pack -- service exempt from repeat surgical rule | \$239.60 | \$215.60 | 42 | L |
| 622L | Reinsertion or repositioning of temporary pacemaker | \$60.20 | \$54.10 | 0 | H |

Payment Schedule for Insured Services Provided by a Physician

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| Pericardiectomy | | | | | |
| 123L | Full pericardiectomy | \$917.60 | \$825.80 | 42 | H |
| 623L | Partial pericardiectomy -- minimum of 20 minutes | \$250.00 | \$225.00 | 42 | H |
| 124L | Patent ductus arteriosus -- ligation or division | \$615.00 | \$553.00 | 42 | H |
| 125L | Excision/exclusion of left atrial appendage | \$203.90 | \$183.50 | 42 | H |
| 126L | Mitral valvuloplasty -- closed | \$728.90 | \$656.60 | 42 | H |
| 128L | Cardiac wound repair | \$553.60 | \$497.50 | 42 | H |
| 129L | Pericardial window | \$383.30 | \$344.60 | 42 | H |
| 130L | Operative implantation of intra-aortic balloon pump | \$244.70 | \$220.20 | 0 | H |
| 131L | Operative removal of intra-aortic balloon pump | \$73.60 | \$66.30 | 0 | H |
| 132L | Percutaneous intra-aortic balloon pump -- insertion (includes removal) | \$167.20 | \$150.50 | 0 | H |
| 135L | Thoracotomy for post-operative hemorrhage -- service exempt from repeat surgical rule | \$343.60 | \$308.90 | 42 | H |
| Procedures With Cardio-Pulmonary Bypass | | | | | |
| 138L | Aorto-coronary bypass with tissue stabilizing device | \$546.50 | \$492.40 | 42 | H |
| 161L | Extracorporeal bypass | \$546.50 | \$492.40 | 42 | H |
| 141L | Pulmonary embolectomy | \$903.30 | \$813.60 | 42 | H |
| 142L | ASD, secundum | \$984.80 | \$885.90 | 42 | H |
| 143L | ASD, primum | \$966.00 | \$869.00 | 42 | H |
| 145L | VSD, direct closure or patch | \$924.70 | \$832.90 | 42 | H |
| 148L | Total anomalous pulmonary venous return | \$880.00 | \$791.90 | 42 | H |
| 149L | Aortic valve replacement | \$1,988.00 | \$1,789.20 | 42 | H |
| 150L | Mitral valve replacement (100% - 1st valve; 75% - each subsequent valve) | \$1,960.00 | \$1,763.90 | 42 | H |
| 151L | Mitral valvuloplasty -- direct vision | \$1,159.20 | \$1,042.90 | 42 | H |
| 152L | Aortic valvuloplasty -- direct vision | \$1,204.00 | \$1,083.70 | 42 | H |
| 652L | Bental procedure (modified) - includes 149L, 188L, 189L(x2) & 161L | \$3,313.40 | \$2,982.00 | 42 | H |
| 653L | Amplatzer device closure of atrial septal defect (does not include angiography if required) | \$847.20 | \$762.50 | 42 | H |
| 153L | Aorta-coronary bypass graft - single | \$1,380.00 | \$1,242.05 | 42 | H |
| 154L | Aorta-coronary bypass graft - for each additional | \$277.20 | \$249.80 | 42 | H |
| 155L | Aorta-coronary bypass graft - each coronary endarterectomy, add | \$267.10 | \$239.60 | 42 | H |
| 755L | Coronary patch angioplasty greater than 3 cm in length - add (includes endarterectomy) | \$387.40 | \$348.70 | | |
| 654L | Use of internal mammary artery for bypass graft, add | \$178.40 | \$160.60 | 42 | |
| 655L | Use of radial artery for bypass graft, add | \$183.50 | \$165.20 | 42 | |
| 156L | Excision of ventricular aneurysm | \$922.60 | \$830.90 | 42 | H |
| 157L | Procuring heart/heart valves for transplant | \$287.50 | \$258.70 | 0 | M |
| 760L | Implantation of cardiodefibrillator device (ICD) any method | \$815.60 | \$734.00 | 42 | H |
| 761L | Radiofrequency ablation of atrial fibrillation - add | \$509.80 | \$458.80 | 42 | H |
| 762L | Implantation of bi-ventricular dual chamber pacing device -- add | \$305.90 | \$275.30 | 42 | H |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| Veins | | | | | |
| Portacath, Infusaport, Hemo-Cath, Hickman-Broviac for chemotherapy or long-term TPN | | | | | |
| 657L | -- insertion | \$241.20 | \$217.15 | 10 | |
| 658L | -- remove and replace | \$347.70 | \$312.90 | 10 | |
| 659L | -- remove or revise, same site | \$144.10 | \$144.10 | 0 | |
| 730L | Intravascular thrombolysis attendance and standby | \$470.00 | \$423.00 | 10 | L |
| 158L | Transvenous insertion of intra atrial pediatric feeding catheter | \$79.20 | \$70.95 | 0 | L |
| 160L | IV cutdown | \$36.10 | \$36.10 | 0 | L |
| 182L | Ligation or plication of iliac or inferior vena cava | \$533.20 | \$479.90 | 42 | H |
| 183L | Ligation of femoral vein | \$267.10 | \$240.40 | 42 | M |
| 162L | Venous shunt -- portocaval, splenorenal, mesocaval | \$866.60 | \$779.90 | 42 | H |
| 166L | Venous thrombectomy -- trunk | \$538.30 | \$484.50 | 42 | H |
| 459L | Venous thrombectomy -- vena cava -- tumor thrombus | \$905.10 | \$814.60 | 42 | H |
| 167L | Venous thrombectomy -- extremity - deep vein | \$414.90 | \$373.10 | 42 | M |
| Repair of Wounds* | | | | | |
| 175L | Major artery or vein -- trunk -- suture | \$634.10 | \$570.90 | 42 | H |
| 176L | Major artery or vein -- trunk -- graft | \$1,053.10 | \$947.80 | 42 | H |
| 177L | Major artery -- extremity or neck -- suture | \$437.40 | \$393.60 | 42 | M |
| 178L | Major artery -- extremity or neck -- graft | \$675.00 | \$607.50 | 42 | M |
| 179L | Major vein -- extremity or neck -- suture | \$265.80 | \$239.20 | 42 | L |
| 180L | Major vein -- extremity or neck -- graft | \$486.30 | \$437.70 | 42 | L |
| | a) *If saphenous vein graft - add 769L. | | | | |
| | b) 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 | \$665.00 | \$598.45 | 42 | H |
| 282L | Revascularization -- arterial -- with vein graft | \$765.00 | \$688.55 | 42 | H |
| 283L | Revascularization -- venous | \$662.70 | \$596.40 | 42 | H |
| 284L | Revascularization -- venous -- with vein graft | \$764.60 | \$688.20 | 42 | H |
| | a) Codes 281L to 284L only apply when provided by a recognized microvascular unit. | | | | |
| | b) Each individual code is payable once per anatomical site at 100%. | | | | |
| | c) The 75% rule will apply for amputation where all attempts to revascularize fail. | | | | |

Payment Schedule for Insured Services Provided by a Physician

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| Renal | | | | | |
| 660L | Hemodialysis -- cutdown artery and vein | \$42.60 | \$38.30 | 0 | |
| 661L | Schribner or similar shunt -- initial or repeat | \$184.50 | \$166.20 | 42 | |
| 662L | A/V fistula for dialysis | \$357.70 | \$321.90 | 42 | |
| 663L | Arterial venous fistula with graft -- prosthetic or venous (includes harvesting of vein) | \$546.80 | \$492.05 | 42 | |
| 666L | Ligation of fistula | \$205.60 | \$185.05 | 0 | |
| Peritoneal Dialysis | | | | | |
| 667L | Chronic dialysis catheter -- insertion | \$232.30 | \$232.30 | 0 | |
| 669L | Chronic dialysis catheter -- removal | \$152.70 | \$152.70 | 0 | |
| 670L | Acute dialysis catheter insertion includes first 24 hours of dialysis | \$78.50 | \$70.30 | 0 | |
| 671L | Externalization of buried chronic peritoneal dialysis catheter | \$122.30 | \$110.10 | 0 | |
| Arteries | | | | | |
| 159L | Biopsy of artery | \$146.50 | \$146.50 | 10 | L |
| 181L | Ligation of carotid artery | \$265.10 | \$238.60 | 42 | H |
| 184L | Exploration of peripheral artery | \$190.40 | \$171.40 | 42 | M |
| Bypass Graft (Occlusive Disease or Aneurysm) | | | | | |
| | a) 769L paid in addition for harvesting of long saphenous | | | | |
| | b) 770L paid if in situ saphenous vein preparation | | | | |
| 769L | Harvesting long saphenous vein for use in peripheral vascular surgery, add | \$141.80 | \$127.60 | 42 | |
| 770L | In situ saphenous vein preparation, add | \$278.30 | \$250.50 | 42 | |
| Bifurcation Grafts -- Includes thromboendarterectomy and/or embolectomy | | | | | |
| 568L | Aorto-iliac - unilateral or bilateral | \$1,443.00 | \$1,298.65 | 42 | H |
| 668L | Aorto-unifemoral | \$1,376.30 | \$1,238.70 | 42 | H |
| 768L | Aorto-bifemoral | \$1,500.60 | \$1,350.50 | 42 | H |
| 460L | Juxta-renal aorto-bifemoral | \$1,962.50 | \$1,766.30 | 42 | H |
| 461L | Ilio-femoral obturator | \$999.10 | \$899.20 | 42 | H |
| 191L | Ruptured aortic aneurysm (add to surgical procedure) | \$326.20 | \$293.60 | 42 | H |
| Peripheral Artery | | | | | |
| 169L | Femoro-popliteal | \$770.80 | \$693.80 | 42 | H |
| 462L | Femoro-tibial or peroneal | \$1,010.40 | \$909.40 | 42 | H |
| 463L | Femoro-pedal | \$1,144.90 | \$1,030.40 | 42 | H |
| 464L | Axillo - axillary, axillo-femoral; carotid-subclavian; cross femoral; ilio-femoral; subclavian-subclavian; other arteries of neck or extremities | \$871.50 | \$784.40 | 42 | H |
| Thoracic or Abdominal Aorta | | | | | |
| 188L | Aorto-carotid; aorto-axillary; aorto-coeliac; aorto-superior mesenteric; aorto-innominate; renal; thoracic or abdominal aorta | \$1,361.00 | \$1,224.90 | 42 | H |
| 189L | Reimplantation of each major branch, add | \$195.60 | \$176.10 | 42 | H |
| 174L | Intra-operative arteriogram, add | \$53.70 | \$53.70 | D | |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| Bypass graft with thromboendarterectomy | | | | | |
| | a) A thromboendarterectomy at site of a regular arterial bypass is included in the composite fee. | | | | |
| | b) 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 | \$1,946.60 | \$1,751.95 | 42 | H |
| 791L | Aorto femoral -- bilateral with thromboendarterectomy of profunda femoris | \$2,074.70 | \$1,867.20 | 42 | H |
| 465L | Profundoplasty -- (sole procedure) | \$762.60 | \$686.30 | 42 | H |
| | 1. Profundoplasty up to the first major branch is included in the fee for bypass procedure. | | | | |
| | 2. If a bypass graft is accompanied by a profundoplasty extending beyond the first major branch of the profundofemoris artery, add 466L to the bypass fee. | | | | |
| | 3. If the repair extends beyond the second major branch, add 467L. | | | | |
| | 4. Payment for profundoplasty includes thromboendarterectomy. | | | | |
| | 5. Claim 465L if a profundoplasty is done alone. | | | | |
| 466L | Profundoplasty beyond first major branch, add | \$412.20 | \$370.95 | 42 | H |
| 467L | Profundoplasty beyond second major branch, add | \$513.90 | \$462.50 | 42 | H |
| 163L | Arteriotomy with Embolectomy -- trunk | \$708.10 | \$637.35 | 42 | M |
| 164L | Arteriotomy with Embolectomy -- neck | \$547.50 | \$492.40 | 42 | H |
| 165L | Arteriotomy with Embolectomy -- extremity | \$538.80 | \$484.90 | 42 | M |
| 468L | Arteriotomy with Embolectomy -- visceral | \$865.60 | \$779.00 | 42 | H |
| Thromboendarterectomy (Independent Procedure) | | | | | |
| 469L | Femoral --unilateral | \$811.50 | \$730.40 | 42 | M |
| 470L | Iliac; carotid; renal; subclavian; superior mesenteric; vertebral | \$906.50 | \$815.85 | 42 | H |
| 471L | Aorta innominate | \$1,293.70 | \$1,164.30 | 42 | H |
| 472L | Aorto-iliac -- unilateral or bilateral; aorto ilio-femoral – unilateral | \$1,359.00 | \$1,222.40 | 42 | H |
| 473L | Aorto ilio-femoral -- bilateral | \$1,553.70 | \$1,398.30 | 42 | H |
| 474L | Carotid endarterectomy with patch angioplasty greater than 3 cm - add | \$365.80 | \$329.20 | 42 | H |
| 920L | Vascular Re-do Procedure -- add to 163L, 164L, 165L, 169L, 188L, 460L, 461L, 462L, 463L, 464L, 465L, 468L, 469L, 470L, 471L, 472L, 473L, 568L, 668L, 768L, 790L, 791L | \$205.60 | \$185.05 | 42 | H |
| 192L | Excision AV fistula -- extremity | \$463.90 | \$417.00 | 42 | L |
| 193L | Excision AV fistula -- trunk | \$812.50 | \$731.00 | 42 | M |
| Varicose Veins | | | | | |
| 200L | Saphenous axis -- section and ligation -- unilateral | \$214.80 | \$214.80 | 42 | L |
| 201L | Saphenous axis -- section and ligation -- bilateral | \$404.70 | \$404.70 | 42 | L |

Payment Schedule for Insured Services Provided by a Physician

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| | Ligation of multiple veins, with or without long saphenous stripping, with saphenous axis ligation | | | | |
| 209L | -- unilateral | \$379.30 | \$379.30 | 42 | L |
| 210L | -- bilateral | \$735.90 | \$735.90 | 42 | L |
| 211L | Multiple ligation of all veins (unilateral or bilateral) done in a session - each -- maximum - 10 veins | \$37.10 | \$33.35 | 10 | L |
| 212L | Endovenous Laser Therapy 1. Excludes transcutaneous laser treatment of spider veins 2. 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 | \$401.90 | \$361.75 | 42 | |
| | Ligation and dissection short saphenous vein at saphenopopliteal junction | | | | |
| 213L | -- unilateral | \$180.80 | \$180.80 | 42 | L |
| 214L | -- bilateral | \$266.10 | \$266.10 | 42 | L |
| 215L | Subfascial ligation of one incompetent communicating vein | \$38.90 | \$38.90 | 0 | L |
| 216L | Follow-up operation to 209L or 210L -- unilateral | \$150.00 | \$150.00 | 42 | L |
| 217L | Subfascial ligation -- complete (Linton) | \$437.80 | \$394.65 | 42 | L |
| | Injection of spider veins is uninsured | | | | |
| 218L | Injection of symptomatic varicose veins -- first vein | \$22.90 | \$22.90 | 0 | L |
| 618L | Injection of symptomatic varicose veins -- each additional vein (one leg maximum 15, both legs max 25) | \$17.00 | \$17.00 | 0 | L |
| 219L | Stripping and ligation of short saphenous vein | \$303.80 | \$303.80 | 42 | L |
| | Abdomen | | | | |
| | Transabdominal exposure of lumbar and lower thoracic spine for neurosurgical procedure -- see section K. | | | | |
| 220L | Laparotomy -- diagnostic - including removal of foreign body, such as IUCD, not paid in addition to abdominal surgery | \$482.40 | \$482.40 | 42 | M |
| 531L | Laparotomy -- extended - including gland and liver biopsies | \$696.80 | \$627.15 | 42 | M |
| 532L | Laparotomy -- staged - for Hodgkins Disease - including biopsies and splenectomy | \$1,505.80 | | 42 | H |
| 533L | Laparotomy -- for acute trauma - by report | \$714.30 | \$642.85 | 42 | M |
| 534L | Laparotomy -- with repair of bowel -- single, add | \$257.40 | \$231.65 | 42 | M |
| 535L | Laparotomy -- with repair of bowel -- multiple and/or resection, add | \$407.90 | \$367.20 | 42 | M |
| 536L | Laparotomy -- with splenectomy or repair, add | \$445.00 | \$400.55 | 42 | H |
| 537L | Laparotomy -- with lacerated liver, add | \$367.00 | \$330.30 | 42 | H |
| 538L | Laparotomy -- with repair of diaphragm, add | \$219.00 | \$197.00 | 42 | M |
| 539L | Laparotomy -- insertion of tubes and post-operative continuous peritoneal lavage, add | \$167.60 | \$150.85 | 42 | M |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 221L | Staging and/or diagnostic peritoneoscopy -- with or without biopsy | \$176.80 | \$159.05 | D | M |
| | 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 should not be submitted by report (manually) unless requested by MSB. | | | | |
| | 5. Claim must indicate whether the service was for diagnostic or staging purposes. | | | | |
| 222L | Abdominal wound dehiscence – exempt from repeat surgical rule | \$291.80 | \$291.80 | 42 | M |
| 224L | Sub-phrenic abscess -- incision and drainage | \$761.60 | \$685.50 | 42 | M |
| | – When performed as an independent procedure. | | | | |
| | – Not billable in addition to other abdominal surgery. | | | | |
| 225L | Abdominal or pelvic abscess -- incision and drainage | \$437.80 | \$437.80 | 42 | M |
| 226L | Transrectal drainage of pelvic abscess | \$219.00 | \$219.00 | 42 | L |
| 227L | Incision and drainage of supra-levator, pelvi-rectal or retro-rectal abscess | \$270.30 | \$243.30 | 42 | L |
| 228L | Incision and drainage of ischio-rectal abscess | \$241.50 | \$241.50 | 42 | L |
| 229L | Incision and drainage of perianal abscess | \$186.30 | \$186.30 | 10 | L |
| 232L | Debulking of intra-thoracic or intra-abdominal tumor when primary procedure | \$495.60 | \$446.05 | 42 | H |
| 233L | Intraoperative Surgical Intervention | \$290.90 | \$261.85 | 42 | M |
| | 1. To be paid to the surgeon when he is 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). | | | | |
| | 2. This service is paid as a flat fee. | | | | |
| | 3. Consultation is not paid in addition. | | | | |
| | 4. 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 | \$816.10 | \$734.50 | 42 | M |
| 241L | Fundoplication and/or hiatus hernia repair | \$801.70 | \$721.55 | 42 | M |
| 248L | Esophagogastric fundoplasty (Nissen) with gastroplasty (Collis) | \$1,200.00 | \$1,080 | 42 | H |
| 242L | Epigastric hernia | \$330.00 | \$330.00 | 42 | L |
| 243L | Reduction of hernia | \$33.60 | \$33.60 | 0 | L |
| 244L | Reduction of hernia -- with Anesthetic | \$47.20 | \$47.20 | 0 | L |
| 245L | Incisional ventral hernia | \$573.60 | \$573.60 | 42 | L |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 246L | Complex incisional hernia with inlay mesh (retrorectus or intraperitoneal) | \$925.00 | \$832.45 | 42 | H |
| | 1. Billable when hernia is repaired with Inlay mesh <u>AND</u> | | | | |
| | 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; <u>AND</u> | | | | |
| | 3. Surgery is a minimum duration of 2.5 hours. | | | | |
| | 4. Physician must indicate on the <u>electronic</u> claim which 2 components are present and the total duration of time. Do not send manually “by report” unless requested by MSB. Physician may state “component 2 a) and c)” etc, if there is not enough room on the comment line. | | | | |
| | 5. If all billing criteria are not met, the code will be converted to “incisional ventral hernia” (245L). | | | | |
| 247L | Paraesophageal hernia repair | \$1,027.80 | \$925.05 | 42 | H |
| | Umbilical Hernia | | | | |
| | Not paid in addition to other laparoscopic abdominal surgery | | | | |
| 251L | Umbilical hernia -- child | \$352.50 | \$352.50 | 42 | L |
| 252L | Umbilical hernia -- adult | \$380.20 | \$380.20 | 42 | L |
| 253L | Umbilical hernia -- incarcerated or recurrent, child or adult | \$496.50 | \$446.90 | 42 | M |
| 255L | Omphalocele -- one stage | \$388.40 | \$349.70 | 42 | H |
| 256L | Omphalocele -- staged -- each stage | \$422.40 | \$380.25 | 42 | H |
| 258L | Patent urachus -- includes excision of urachal cyst or sinus | \$397.70 | \$358.00 | 42 | M |
| 260L | Inguinal or femoral herniorrhaphy | \$426.50 | \$426.50 | 42 | L |
| 261L | Inguinal or femoral herniorrhaphy -- incarcerated, strangulated or recurrent | \$498.50 | \$448.60 | 42 | M |
| | Herniotomy with orchidopexy, only the larger fee is paid | | | | |
| 262L | Simple herniotomy -- unilateral | \$381.90 | \$381.90 | 42 | L |
| 263L | Simple herniotomy -- bilateral -- includes unilateral herniotomy with negative contralateral exploration, open or by laparoscopy | \$521.10 | \$521.10 | 42 | L |
| 264L | Spigelian hernia | \$444.00 | \$399.65 | 42 | L |
| 265L | Lumbar hernia | \$468.00 | \$421.20 | 42 | L |
| 266L | Obturator hernia | \$464.50 | \$418.05 | 42 | L |
| 267L | Patent vitello-intestinal duct or excision Meckel's diverticulum -- includes excision of omphalomesenteric duct fistula, cyst or sinus | \$554.50 | \$499.10 | 42 | M |
| | Biliary Tract | | | | |
| 271L | Cholecystostomy | \$437.80 | \$394.05 | 42 | M |
| 272L | Choledochostomy with or without cholecystectomy/choledochoscopy | \$845.90 | \$761.30 | 42 | M |
| 273L | Cholecysto-enterostomy | \$629.00 | \$566.10 | 42 | M |

Payment Schedule for Insured Services Provided by a Physician

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------------------------------|--|------------|----------------------|-------|------|
| 274L | Choledocho-enterostomy or transduodenal sphincterotomy | \$860.20 | \$774.20 | 42 | M |
| 674L | Choledochojejunostomy with Roux-en-Y | \$1,181.90 | | 42 | M |
| 275L | Repair stricture common bile duct | \$1,332.10 | \$1,198.80 | 42 | M |
| 276L | Cholecystectomy -- without operative cholangiography | \$616.70 | \$555.00 | 42 | M |
| 277L | Cholecystectomy -- with cholangiogram | \$689.70 | \$620.75 | 42 | M |
| 278L | Biliary atresia -- exploration with cholangiogram -- not paid with portoenterostomy -- with liver biopsy add 416L at 75% | \$648.40 | \$584.20 | 42 | M |
| 279L | Hepatico-enterostomy -- includes portoenterostomy (Kasai procedure) for biliary atresia | \$1,691.70 | \$1,522.55 | 42 | H |
| Esophagus and Stomach | | | | | |
| 292L | Esophagomyotomy (Heller) | \$1,015.50 | \$913.90 | 42 | H |
| 293L | Congenital tracheo-esophageal fistula -- with or without esophageal atresia repair -- includes esophageal atresia repair without TEF and cervical repair of congenital TEF | \$1,012.40 | \$911.10 | 42 | H |
| 294L | Esophageal diverticulum -- transthoracic repair | \$688.20 | \$619.30 | 42 | H |
| 295L | Pharyngo-oesophageal diverticulum -- repair | \$593.30 | \$534.00 | 42 | M |
| 296L | Ruptured oesophagus -- transthoracic repair | \$656.60 | \$590.90 | 42 | H |
| 297L | Ruptured oesophagus -- transcervical repair | \$470.00 | \$423.00 | 42 | M |
| 298L | Esophagogastrostomy or esophagojejunostomy | \$1,011.30 | \$910.20 | 42 | M |
| 299L | Esophagectomy or esophagogastrectomy -- with or without pyloroplasty | \$1,446.70 | \$1,302.00 | 42 | H |
| 320L | Esophagectomy or esophagogastrectomy -- with replacement | \$1,890.60 | \$1,701.55 | 42 | H |
| 300L | Total esophagectomy with cervical fistula and gastrostomy | \$1,016.40 | \$914.50 | 42 | H |
| 301L | Replacement of oesophagus by transplant | \$1,257.00 | \$1,131.60 | 42 | H |
| 302L | Vagotomy -- truncal or selective -- abdominal or thoracic | \$584.20 | \$525.80 | 42 | H |
| 321L | Highly selective vagotomy -- with or without pyloroplasty | \$723.80 | \$651.50 | 42 | M |
| 303L | Gastrectomy -- with or without splenectomy -- partial | \$999.10 | \$899.20 | 42 | H |
| 304L | Gastrectomy -- with or without splenectomy -- partial with vagotomy | \$1,015.50 | \$913.90 | 42 | H |
| 305L | Gastrectomy -- with or without splenectomy -- total | \$1,606.50 | \$1,445.80 | 42 | H |
| 306L | Pyloroplasty | \$554.00 | \$498.65 | 42 | M |
| 607L | Pyloroplasty -- with oversewing of bleeding ulcer, add | \$146.00 | \$131.40 | 42 | M |
| 308L | Gastro-enterostomy | \$571.40 | \$514.35 | 42 | M |
| 309L | Gastro-enterostomy -- with vagotomy | \$802.30 | \$722.10 | 42 | M |
| 310L | Gastrotomy -- with or without removal of foreign body or tumor | \$473.90 | \$426.50 | 42 | M |
| 311L | Gastrostomy -- simple | \$455.20 | \$409.65 | 42 | M |
| 312L | Gastrostomy -- with living tube | \$589.00 | \$530.10 | 42 | M |
| 313L | Decompression gastrostomy -- in conjunction with other abdominal surgery, add | \$100.00 | \$100.00 | 42 | M |
| 314L | Rammstedt pyloromyotomy | \$490.30 | \$441.30 | 42 | M |
| 315L | Perforated ulcer -- repair | \$571.40 | \$571.40 | 42 | M |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| 317L | Resection of anastomotic ulcer | \$1,076.10 | \$968.55 | 42 | M |
| 318L | Repair duodenal tear | \$589.00 | \$530.10 | 42 | M |
| 319L | Traumatic duodenal fistula | \$813.00 | \$731.75 | 42 | M |
| 327L | Laparoscopic Roux-en-Y bypass | \$1,567.40 | \$1,387.55 | 42 | H |
| 328L | Laparoscopic sleeve gastrectomy | \$1,027.80 | \$925.05 | 42 | H |
| Small Bowel | | | | | |
| 330L | Perforated small bowel repair | \$624.90 | \$619.90 | 42 | M |
| 331L | Small bowel obstruction -- without resection | \$641.30 | \$641.30 | 42 | M |
| 332L | Small bowel resection | \$801.70 | \$721.55 | 42 | M |
| 333L | Appendectomy -- not paid in addition to abdominal surgery, except where clinically indicated and billed by report | \$418.30 | \$418.30 | 42 | M |
| 334L | Entero-enterostomy | \$761.60 | \$685.50 | 42 | M |
| 335L | Enterotomy for foreign body or tumor | \$613.50 | \$552.20 | 42 | M |
| 336L | Ileostomy revision – minor, service exempt from repeat surgical rule | \$388.10 | \$349.30 | 42 | L |
| 337L | Ileostomy revision – major, service exempt from repeat surgical rule | \$511.90 | \$460.70 | 42 | M |
| 338L | Feeding jejunostomy | \$512.90 | \$461.70 | 42 | M |
| 638L | Tube jejunostomy when performed with other surgery | \$256.00 | \$230.40 | 42 | |
| 339L | Continent ileostomy (Koch's) -- independent procedure | \$1,118.30 | \$1,006.50 | 42 | M |
| 340L | Enterostomy or cecostomy, service exempt from repeat surgical rule | \$536.50 | \$536.50 | 42 | M |
| 639L | Closure of loop or double barrelled ileostomy, service exempt from repeat surgical rule | \$541.60 | \$487.35 | 42 | M |
| Bowel Obstruction - Infant -- excluding intussusception | | | | | |
| 631L | -- without resection - includes Ladd's procedure for malrotation and/or correction of volvulus | \$680.00 | \$611.70 | 42 | M |
| 632L | -- with resection - includes duodenal, atresia repair, repair of jejunoileal atresia (single atresia) | \$889.00 | \$800.30 | 42 | M |
| Large Bowel, Rectum and Anus | | | | | |
| 342L | Colectomy -- hemi or segmental | \$1,035.00 | \$931.55 | 42 | H |
| 442L | Hartmann's procedure | \$1,040.10 | \$936.15 | 42 | H |
| 343L | Total colectomy with or without ileostomy | \$1,299.10 | \$1,169.25 | 42 | H |
| 344L | Total colectomy and proctectomy | \$2,029.90 | \$1,826.95 | 42 | H |
| 644L | Continent ileostomy (Koch's) -- with 343L or 344L, add | \$583.80 | \$525.45 | 42 | H |
| 645L | Total colectomy with mucosal proctectomy and ileo-pouch with ileo-anal anastomosis and loop ileostomy | \$2,375.20 | \$2,137.60 | 42 | M |
| 345L | Ileorectal anastomosis | \$780.10 | \$702.05 | 42 | M |
| 346L | Proctectomy | \$584.20 | \$525.80 | 42 | M |
| 347L | Colostomy -- service exempt from repeat surgical rule | \$541.60 | \$487.35 | 42 | M |
| 348L | Closure of loop or double barrelled colostomy -- service exempt from repeat surgical rule | \$541.60 | \$487.35 | 42 | M |
| 548L | Colonic reanastomosis following Hartmann's procedure | \$1,040.10 | \$936.15 | 42 | M |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 349L | Colostomy revision – minor, service exempt from repeat surgical rule | \$331.70 | \$298.55 | 42 | L |
| 350L | Colostomy revision – major, service exempt from repeat surgical rule | \$448.10 | \$403.35 | 42 | M |
| 365L | Massive rectal prolapse -- perineal repair | \$511.90 | \$460.70 | 42 | L |
| 366L | Massive rectal prolapse -- abdominal repair | \$728.70 | \$655.80 | 42 | M |
| 367L | Massive rectal prolapse -- with sigmoid resection | \$918.80 | \$826.95 | 42 | H |
| 368L | Massive rectal prolapse -- abdominal-perineal repair | \$1,038.90 | \$935.00 | 42 | M |
| 369L | Insertion of ring or wire for rectal prolapse | \$303.80 | \$273.40 | 42 | L |
| 373L | Closure of rectovesical or rectourethral fistula | \$701.00 | \$630.95 | 42 | M |
| 374L | Closure of rectovesical or rectourethral fistula with colostomy | \$769.70 | \$692.80 | 42 | M |
| 377L | Banding of hemorrhoids -- each -- maximum 3 | \$49.30 | \$49.30 | 10 | L |
| 378L | Hemorrhoid -- injection | \$23.40 | \$23.40 | 0 | L |
| 379L | Hemorrhoid -- incision or excision external thrombosed | \$62.60 | \$62.60 | 10 | L |
| 380L | Polyp -- anal -- excision | \$110.00 | \$110.00 | 10 | L |
| 381L | Hemorrhoidectomy | \$352.50 | \$352.50 | 42 | L |
| 383L | Low imperforate anus repair | \$688.60 | \$619.70 | 42 | M |
| 384L | High imperforate anus repair - by any method includes division of vaginal, urethral or bladder fistula | \$877.80 | \$790.40 | 42 | M |
| 386L | Rectal polyp or tumor -- excision or fulguration -- under anesthetic | \$146.00 | \$146.00 | 42 | L |
| 387L | Transanal excision of giant villous adenoma of rectum | \$471.80 | \$424.60 | 42 | M |
| 388L | Deep transrectal or perirectal biopsy for Hirschsprung's disease | \$128.50 | \$115.60 | 10 | L |
| 371L | Transanal endoscopic microsurgery (TEM), resection of rectal tumor | \$853.00@ | \$767.70@ | 42 | M |
| | <p>@ Entitlement to bill 371L is limited to physicians with advanced fellowship training in colorectal surgery or surgical oncology, as approved by the Saskatchewan Medical Association Tariff Committee.</p> <p>For the purposes of billing, 371L is billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".</p> | | | | |
| 389L | Excision sacro-coccygeal teratoma | \$728.70 | \$655.80 | 42 | M |
| 391L | Pilonidal -- cyst or sinus -- excision or marsupialization | \$388.50 | \$388.50 | 42 | L |
| 394L | Major anal sphincter repair for stricture or incontinence | \$590.00 | \$531.00 | 42 | M |
| 396L | Fissure-in-ano -- incision or excision and/or subcutaneous sphincterotomy | \$248.00 | \$248.00 | 42 | L |
| 397L | Fistula-in-ano -- excision -- superficial | \$318.60 | \$318.60 | 42 | L |
| 398L | Fistula-in-ano -- excision -- deep involving sphincter | \$490.30 | \$490.30 | 42 | L |
| 399L | Fistula-in-ano -- excision -- high | \$589.00 | \$530.10 | 42 | L |
| 562L | Fissure/fistula-in-ano -- cleansed and obliterated with Tiseel | \$212.70 | \$212.70 | 10 | L |
| 400L | Anal dilatation - manual or by balloon | \$58.10 | \$58.10 | 0 | L |
| | <p>a) Under anesthetic or IV sedation;</p> <p>b) Includes post-op recovery; and</p> <p>c) Not to be billed with other anorectal surgery such as hemorrhoidectomy, fissure codes etc.</p> | | | | |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| | Includes any type of pull-through procedure for Hirschsprung's disease | | | | |
| 352L | Abdomino-perineal resection -- one team -- surgeon | \$1,551.90 | \$1,396.75 | 42 | H |
| 353L | Abdomino-perineal resection -- two team -- abdominal surgeon | \$1,385.40 | \$1,246.90 | 42 | H |
| 354L | Abdomino-perineal resection -- two team -- perineal surgeon | \$528.30 | \$475.45 | 42 | H |
| 355L | Proctosigmoidectomy | \$1,181.90 | \$1,063.75 | 42 | H |
| 356L | Colotomy -- for foreign body | \$666.00 | \$599.45 | 42 | M |
| 357L | Colotomy -- for tumor | \$731.80 | \$658.60 | 42 | M |
| 358L | Anterior resection -- <u>without</u> total mesorectal excision | \$1,196.30 | \$1,076.65 | 42 | H |
| 359L | Posterior resection | \$1,209.10 | \$1,088.20 | 42 | H |
| 370L | Low anterior resection – <u>with</u> total mesorectal excision (TME) | \$1,510.00 | \$1,359.00 | 42 | H |
| | Liver, Spleen, Adrenals | | | | |
| 413L | Liver -- rupture -- repair | \$753.30 | \$677.95 | 42 | H |
| 414L | Liver -- abscess -- incision and drainage | \$624.90 | \$562.40 | 42 | M |
| 415L | Liver -- needle biopsy | \$93.80 | \$84.45 | D | L |
| 416L | Liver -- open biopsy | \$463.50 | \$417.15 | 42 | M |
| 417L | Liver -- hemi-hepatectomy | \$1,691.70 | \$1,522.55 | 42 | H |
| 418L | Liver -- segment hepatectomy | \$930.10 | \$837.15 | 42 | H |
| | Pancreas / Spleen | | | | |
| 419L | Pancreatectomy -- partial | \$919.90 | \$827.85 | 42 | H |
| 420L | Pancreatectomy -- partial with duodenectomy or total with or without duodenectomy | \$3,000.00 | \$2,700.00 | 42 | H |
| 421L | Pancreatic pseudocyst marsupialization or adenoma excision | \$900.90 | \$810.80 | 42 | M |
| 620L | Pancreatic abscess drainage | \$656.80 | \$591.05 | 42 | M |
| 621L | Pancreatico-enterostomy with Roux-en-Y | \$1,404.90 | \$1,264.40 | 42 | M |
| 422L | Splenectomy -- abdominal or repair | \$801.70 | \$721.55 | 42 | M |
| 423L | Splenectomy -- thoraco-abdominal | \$795.20 | \$715.70 | 42 | M |
| 426L | Adrenalectomy -- unilateral | \$891.40 | \$802.30 | 42 | H |
| 428L | Extra-adrenal phaeochromocytoma or other retroperitoneal tumor | \$1,130.10 | \$1,017.10 | 42 | H |
| | Lymph Nodes | | | | |
| 430L | Biopsy -- superficial node | \$180.00 | \$180.00 | 10 | L |
| 431L | Biopsy -- deep node -- beneath deep fascia | \$300.00 | \$300.00 | 10 | L |
| 432L | Biopsy -- scalene node | \$213.50 | \$192.15 | 10 | L |
| 433L | Biopsy -- mediastinal | \$303.80 | \$273.40 | 10 | M |
| 434L | Suprahyoid block dissection | \$624.60 | \$562.20 | 42 | M |
| 635L | Sentinel lymph node biopsy -- with malignant melanoma and breast cancer surgery | \$521.10 | \$469.00 | 42 | M |
| 73L | Central neck dissection -- thyroid cancer – add to 72L | \$287.80 | \$258.95 | 42 | M |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|---|--|------------|----------------------|-------|------|
| 435L | Complete block dissection -- neck | \$1,138.40 | \$1,024.60 | 42 | H |
| 436L | Complete block dissection -- axilla | \$687.50 | \$618.75 | 42 | M |
| 437L | Complete block dissection -- groin-wide inguinal | \$759.50 | \$683.60 | 42 | M |
| 438L | Complete block dissection -- groin-deep with common iliac dissection | \$1,066.80 | \$960.15 | 42 | M |
| 439L | Complete block dissection -- retroperitoneal including pelvic, aortic and renal | \$1,249.30 | \$1,124.40 | 42 | H |
| 440L | Scalene fat pad dissection | \$335.90 | \$302.25 | 42 | L |
| <u>Integumentary System</u> | | | | | |
| 840L | Biopsy of palpable superficial lesion -- unless otherwise listed -- by fine needle biopsy or aspiration | \$21.10 | \$21.10 | D | L |
| 841L | Biopsy of palpable superficial lesion -- unless otherwise listed -- by core needle biopsy | \$41.40 | \$41.40 | D | L |
| 849L | Aspiration of hematoma or cyst | \$21.10 | \$21.10 | 0 | L |
| 850L | Incision and drainage of abscess, etc. | \$53.00 | \$53.00 | 10 | L |
| 851L | Abscess -- multilocular | \$65.50 | \$65.50 | 10 | L |
| 852L | Carbuncle, deep (beneath deep fascia) or pilonidal cyst abscess -- unroofing under general anesthetic | \$93.60 | \$93.60 | 10 | L |
| 853L | Intramuscular abscess | By Report | | 10 | L |
| 854L | Muscle biopsy (general practitioners – billable “by report” only) | \$117.20 | \$117.20 | 10 | L |
| Ablation of actinic keratosis, pyogenic granuloma, keratoacanthoma, or bleeding lesions by electrocautery, chemical cautery, cryotherapy, laser and/or curettage. | | | | | |
| 603L | -- 1st lesion | \$25.00 | \$25.00 | 10 | L |
| 604L | -- 2nd to 7th lesion -- each -- max 6 units | \$9.50 | \$9.50 | 10 | L |
| 605L | -- 8th lesion and over, each | \$3.80 | \$3.80 | 10 | L |
| Ablation of seborrheic keratoses, molluscum contagiosum, skin tags and warts are uninsured. | | | | | |
| Laser ablation of actinic keratosis, pyogenic granuloma, keratoacanthoma, plantar warts, or bleeding lesions under local anesthesia -- laser owned by physician | | | | | |
| 610L | -- first 15 minute session | \$68.50 | \$68.50 | 10 | L |
| 611L | -- each subsequent 15 minutes (max of 2 additional units), add - bill units | \$34.30 | \$34.30 | 10 | L |
| Pulsed dye tuned laser ablation of facial portwine stains is insured under the age of 18. Pre-authorization required for other symptomatic or bleeding cutaneous angiomas | | | | | |
| 780L | Professional - laser owned by physician, per 15 minute session or major part thereof | \$45.00 | \$45.00 | 0 | L |
| 781L | -- for each unit used (ie 5 pulses), add -- bill units (Note: Billings also to be made in units; 1 unit = 5 pulses) | \$7.50 | \$7.50 | 0 | L |

SECTION L – General Surgery

| | Specialist | General Practitioner | Class | Anes |
|--|------------|----------------------|-------|------|
|--|------------|----------------------|-------|------|

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 | \$53.00 | \$53.00 | 10 | L |
| 858L | -- 2nd to 7th -- each -- max 6 units | \$26.30 | \$26.30 | 10 | L |
| 859L | -- 8th and over, each | \$17.60 | \$17.60 | 10 | L |

Over 1 cm. diameter -- face, palm of hand or fingers, sole of foot or toes

| | | | | | |
|------|--------------------------------------|---------|---------|----|---|
| 860L | -- 1st lesion | \$82.00 | \$82.00 | 10 | L |
| 861L | -- 2nd to 7th -- each -- max 6 units | \$42.30 | \$42.30 | 10 | L |
| 862L | -- 8th and over, each | \$28.00 | \$28.00 | 10 | L |

Over 1 cm. diameter -- other areas, including scalp

| | | | | | |
|------|--------------------------------------|---------|---------|----|---|
| 863L | -- 1st lesion | \$64.00 | \$64.00 | 10 | L |
| 864L | -- 2nd to 7th -- each -- max 6 units | \$30.70 | \$30.70 | 10 | L |
| 865L | -- 8th and over, each | \$17.70 | \$17.70 | 10 | L |

| | | | | | |
|------|--|---------|---------|----|---|
| 866L | Sebaceous cyst or intradermal cyst (any area) -- excision and suture closure | \$73.60 | \$73.60 | 10 | L |
|------|--|---------|---------|----|---|

Lipoma or subcutaneous tumor

1. Lipomas etc. are insured only when medically necessary (i.e. initial biopsy and / or causing symptoms in functional area)
2. Maximum 4 services

| | | | | | |
|------|---|-------------|----------|----|---|
| 867L | Lipoma or subcutaneous tumor -- excision -- up to 5 cm. | \$71.90 | \$71.90 | 10 | L |
| 868L | Lipoma or subcutaneous tumor -- excision -- over 5 cm. up to 10 cm. | \$119.30 | \$119.30 | 42 | L |
| 869L | Lipoma or subcutaneous tumor -- excision -- larger than 10 cm. | \$240.70 | \$240.70 | 42 | L |
| 870L | Lipoma or other benign tumor beneath deep fascia | \$359.90 | \$323.90 | 42 | L |
| 871L | Malignant tumor | By Report | | 42 | M |
| 971L | Resection of sarcoma (non-retroperitoneal) | By Report @ | | 42 | M |

@ Entitlement to bill 971L is limited to physicians with advanced fellowship training in surgical oncology or other proof of expertise in surgical oncology as approved by the Saskatchewan Medical Association Tariff Committee.

For the purposes of billing, 971L is billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

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.

Payment Schedule for Insured Services Provided by a Physician

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| Removal of Foreign Body -- without anesthesia bill as a visit | | | | | |
| 872L | Removal of Foreign Body -- under local anesthesia | \$89.70 | \$89.70 | 10 | L |
| 873L | Removal of Foreign Body -- under general anesthesia or IV sedation (includes post-op recovery) | \$119.30 | \$119.30 | 10 | L |
| 874L | Removal of Foreign Body -- complicated | By Report | | 42 | L |
| 974L | Removal of deep metallic foreign body under x-ray or fluoroscopic guidance | \$153.80 | \$153.80 | 10 | L |
| Plantar Warts – venereal warts – see codes 420R to 422R | | | | | |
| Plantar warts -- Excision or fulguration plus curettage | | | | | |
| 875L | -- 1st wart | \$28.60 | \$28.60 | 10 | L |
| 876L | -- each additional wart (maximum of 4) -- bill units | \$9.60 | \$9.60 | 10 | L |
| Plantar warts -- treatment by cryotherapy, laser, cautery or chemical ablation | | | | | |
| 877L | -- 1st wart | \$14.20 | \$14.20 | 10 | L |
| 878L | -- 2nd to 7th wart, each (maximum of 6 units for this code) | \$5.50 | \$5.50 | 10 | L |
| 879L | -- 8th wart and over, each | \$1.50 | \$1.50 | 10 | L |
| Removal of fingernail or toenail | | | | | |
| 880L | Simple avulsion or wedge excision | \$57.30 | \$57.30 | 10 | L |
| 881L | Radical excision of nail bed or hemiphalangectomy | \$145.40 | \$145.40 | 10 | L |
| 882L | Wedge resection with phenol or cautery or cryo ablation | \$100.20 | \$100.20 | 10 | L |
| 883L | Trimming of toenails, corns or calluses where <u>medically necessary</u> -- maximum of 1 per day | \$25.00 | \$25.00 | 0 | L |
| 884L | Soft tissue nail-fold excision for ingrown toenails -- Vandenbos surgery | \$122.30 | \$122.30 | 10 | L |
| Lacerations | | | | | |
| 1. Repair of lacerations where approximation of wound edges needs to be achieved and maintained | | | | | |
| 2. Laceration repair is categorized below by body location. | | | | | |
| 3. When claiming 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 codes(s). | | | | | |
| 4. 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. | \$56.40 | \$56.40 | 10 | L |
| 891L | -- each additional 2.5 cm -- bill units | \$28.00 | \$28.00 | 10 | L |
| (B) Other areas, including scalp | | | | | |
| 894L | -- up to 2.5 cm. | \$37.50 | \$37.50 | 10 | L |
| 895L | -- each additional 2.5 cm -- bill units | \$18.80 | \$18.80 | 10 | L |
| 896L | -- complicated | By Report | | 42 | L |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| 897L | Tray service -- only for office procedures which require: a) Sutures or staples (not billable for tissue glue or Steri-Strips); b) The use of sterilized instruments and are performed under local anesthetic; example: excision of skin lesions with suture closure; biopsies requiring local anesthesia and suture closure; wedge resection of toenails; vasectomy; sigmoidoscopy; or endometrial biopsies. <u>Payable with the following office procedures:</u> 117A; 100F (with sutures), 102F (with sutures); 45L, 159L, 430L, 449L, 450L, 854L, 857L, 860L, 863L, 866L, 867L, 868L, 869L, 872L, 880L, 881L, 882L, 890L (with sutures or staples), 894L (with sutures or staples), 380N, 382N, 684N, 685N; 31P, 39P; 59R, 190R; 72S, 89S or 100S. | \$25.50 | \$25.50 | | |
| 899L | Minor tray service – only for office procedures which require two of the following: a) Suturing, b) the use of sterilized instruments; or, c) performed under local anesthetic. <u>Payable with the following office procedures:</u> a) 116A, 123A; 100F (without sutures), 102F (without sutures), 888F; 94H, 158H; 379L, 850L, 884L; 380M, 381M, 382M; 108P; 63S, 91S, 92S, 250S; and, 88T. | \$11.50 | \$11.50 | | |
| 898L | Removal of sutures and/or staples from lacerations or surgical incisions of any length by any physician | \$17.80 | \$17.80 | 0 | |
| 700L | Surgical debridement; excision of damaged, necrotic or otherwise non-viable tissue 1. Payment will include payment for office tray service where applicable. 2. This item is not paid in addition to laceration suture see code 896L; nor to burns. 3. <u>For a claim to be processed, the physician must provide details of:</u> a) the patients clinical condition; b) the treatment or procedure provided; c) time when the debridement started and was completed. | By Report | | 10 | |
| 720L | Penetrating wound (e.g. gunshot or stab wound) -- of chest | By Report | | 42 | H |
| 721L | Penetrating wound (e.g. gunshot or stab wound) -- of abdomen | By Report | | 42 | M |
| 725L | Internalization of Epidural Catheter -- tunnelling | \$237.40 | \$213.60 | 10 | L |
| 726L | Internalization of Epidural Catheter -- establishment and connection of catheter | \$109.10 | \$98.20 | 0 | L |
| | Burns 1. Emergency treatment (e.g. as out-patient) 2. Bill as 5B or 918A 3. Also see Section N | | | | |

SECTION L – General Surgery

| | | Specialist | General Practitioner | Class | Anes |
|---|--|------------|----------------------|-------|------|
| BMI Supplement | | | | | |
| 580L | General surgery supplement for patients with a Body Mass Index (Weight [kg]/Height [m] 2) greater than 40 | \$58.70 | \$58.70 | | |
| | <ol style="list-style-type: none"> 1. Maximum of one 580L supplement per patient per day. 2. Supplement 580L may be billed by all physicians with all Section L procedures done in the operating room. 3. Bariatric surgery fee code 327L is exempt from this supplement. | | | | |
| <u>Vascular Laboratory</u> | | | | | |
| Applicable 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 | \$12.70 | \$12.70 | D | |
| 751L | Reactive hyperemia with sequential pressures | \$12.60 | \$12.60 | D | |
| 752L | Vasospastic assessment -- to include digital pressures and/or plethysmography, cold and hot stress responses and/or multiple extremity wave form analysis | \$12.60 | \$12.60 | D | |
| 753L | Sympathetic tone response -- to include resting arterial assessment plus plethysmography and/or impedance monitoring and/or digital wave forms, response to Valsalva manoeuvres or other stimuli | \$12.60 | \$12.60 | D | |
| 756L | Digital index assessment (finger or toe), PPG wave forms, pulse volume recordings (not including resting arterial ankle brachial indexes). | \$12.70 | \$12.70 | D | |
| Peripheral Venous | | | | | |
| 754L | Laboratory assessment for interpretation of peripheral venous system | \$12.70 | \$12.70 | D | |

SECTION L – General Surgery

Specialist General Practitioner Class Anes

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 | Esophagoscopy -- base | \$85.50 | \$85.50 | D | L |
| 403L | -- Bleeding varices management (banding, sclerotherapy, glue, endoloops, hemoclips or other) -- any combination -- add | \$125.10 | \$125.10 | D | |
| 404L | -- Removal of benign tumor -- add | \$61.80 | \$61.80 | D | |
| | Dilatations via endoscope | | | D | |
| 405L | -- by means of pneumatic bag or balloon -- with or without thread or wire guidance -- add | \$124.10 | \$124.10 | D | |
| 406L | -- by means of sound or bougie -- add | \$63.10 | \$63.10 | D | |
| 407L | -- stenting with or without dilatation -- add | \$128.30 | \$128.30 | D | |
| 408L | Gastroduodenoscopy -- base includes esophagoscopy | \$130.80 | \$130.80 | D | L |
| 409L | Management of bleeding (varices, ulcers, GAVE Banding, sclerotherapy, glue, endoloop, hemoclips or other) -- any combination of above -- add | \$128.30 | \$128.30 | D | |
| 410L | Nasojejunoscopy tube placement -- add | \$63.10 | \$63.10 | D | |
| 411L | Extended enteroscopy -- add | \$126.60 | \$126.60 | D | |
| 412L | Dilatation of pylorus -- add | \$61.80 | \$61.80 | 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). | \$110.00 | \$110.00 | D | |
| 499L | Radiofrequency ablation for Barrett's esophagus -- add | \$212.10 | \$212.10 | D | L |
| 590L | Placement of gastric or duodenal self-expanding metal stent - add | \$183.10 | \$183.10 | D | L |
| | Endoscopic Ultrasound | | | | |
| 490L | Upper endoscopic ultrasound -- base | \$265.10 | \$265.10 | D | L |
| 492L | Lower endoscopic ultrasound -- base | \$159.00 | \$159.00 | D | L |
| 495L | Fine needle aspiration biopsy -- one or more -- add | \$53.00 | \$53.00 | D | L |
| 496L | Injection of one or more metastases, nodes, masses or celiac plexus - - add | \$162.20 | \$162.20 | D | L |
| 497L | Drainage of pseudo cyst, one or more -- add | \$212.10 | \$212.10 | D | L |

SECTION L – General Surgery

| | Specialist | General Practitioner | Class | Anes |
|--|------------|----------------------|-------|------|
| Percutaneous gastrostomy under gastroscopic control - by two physicians | | | | |
| Endoscopic gastrostomy or jejunostomy | | | | |
| 443L -- 1st physician | \$189.40 | \$189.40 | 0 | L |
| 444L -- 2nd physician | \$126.60 | \$126.60 | 0 | L |
| Endoscopic gastrostomy and jejunostomy same day | | | | |
| 445L -- 1st physician | \$278.60 | \$278.60 | 0 | L |
| 446L -- 2nd physician | \$184.50 | \$184.50 | 0 | L |
| 498L Endoanal Ultrasound | \$125.50 | \$125.50 | D | L |
| PEG tube change | | | | |
| 447L External approach PEG tube removal -- external via gastroscope | \$25.20 | \$25.20 | D | L |
| 448L Colonoscopy -- base | \$203.00 | \$203.00 | D | L |
| 449L Sigmoidoscopy -- flexible -- base code | \$70.40 | \$70.40 | D | L |
| 450L Sigmoidoscopy -- rigid -- base code | \$35.40 | \$35.40 | D | L |
| 453L Ileoscopy/jejunoscopy when done through ileostomy-- base code | \$70.40 | \$70.40 | D | L |
| (Considered an inclusion when performed same day as 448L or 408L) | | | | |
| Gastrointestinal Endoscopic Interventions biopsy included in base code except: | | | | |
| 480L -- for inflammatory bowel disease - 10 or more specimens - add | \$62.30 | \$62.30 | D | |
| 481L -- Barrett's esophagus - 4 or more specimens - add | \$31.50 | \$31.50 | D | |
| Polypectomy (any GI site) -- by loop, electrocautery, submucosal injection, etc. | | | | |
| 482L -- 1st polyp -- add | \$63.10 | \$63.10 | D | |
| 483L -- 2nd to 5th polyp, each (maximum of 5 total) -- add | \$47.90 | \$47.90 | D | |
| 484L Sclerotherapy by any thermal means (eg heater or bicaprobe) or any injectable method (eg. Adrenalin, sclerosing solution) or by gluing -- add | \$61.80 | \$61.80 | D | |
| 485L Dilatations -- all GI dilatations other than esophageal, add | \$61.40 | \$61.40 | D | |
| 486L Tattoo -- any GI site -- add -- bill units | \$31.50 | \$31.50 | D | |
| 487L Botox -- any GI or bronchial site -- add | \$62.70 | \$62.70 | D | |
| 488L Foreign body removal -- any GI site -- add | \$63.10 | \$63.10 | | |
| 500L Endoscopic Retrograde Cholangiopancreatography -- base | \$242.80 | \$242.80 | D | |
| a) includes routine sweeps of common duct | | | | |
| b) maximum procedural billing per base code same day \$571.00 | | | | |
| 501L -- plus papillotomy /sphincterotomy - add | \$92.90 | \$92.90 | D | |
| -- with removal of common duct stones and sludge | | | | |
| 502L -- 1 to 4 stones and/or sludge -- add | \$61.80 | \$61.80 | D | |
| 503L -- with removal of 5 or more stones -- includes 1 to 4 stones add | \$124.10 | \$124.10 | D | |
| 504L -- with mechanical lithotripsy -- add | \$61.80 | \$61.80 | D | |
| 505L -- with brush cytology -- add | \$30.90 | \$30.90 | D | |

SECTION L – General Surgery

| | Specialist | General Practitioner | Class | Anes |
|--|------------|----------------------|-------|------|
| 506L | | | | |
| With biliary or pancreatic duct balloon dilatations | | | | |
| -- 1st -- add | \$61.80 | \$61.80 | D | |
| 507L | | | | |
| -- 2nd -- add | \$30.90 | \$30.90 | D | |
| With stentings (any type of stent) - stent insertion | | | | |
| 508L | | | | |
| -- 1st -- add | \$61.80 | \$61.80 | D | |
| 509L | | | | |
| -- 2nd -- add | \$30.90 | \$30.90 | D | |
| 510L | | | | |
| -- stent removal -- one or more add | \$30.90 | \$30.90 | D | |
| 511L | | | | |
| -- stent removal and replacement -- add | \$61.80 | \$61.80 | D | |
| 513L | | | | |
| -- with nasobiliary tube placement -- add | \$59.30 | \$59.30 | D | |
| 514L | | | | |
| With cholangioscopy / pancreatoscopy -- add | \$121.40 | \$121.40 | D | |
| 520L | | | | |
| Bronchoscopy Base -- unilateral or bilateral with or without biopsy | \$126.60 | \$126.60 | D | L |
| 521L | | | | |
| -- with fluoroscopy -- add | \$60.50 | \$60.50 | D | |
| 522L | | | | |
| -- with tracheobronchial toilet -- add | \$63.10 | \$63.10 | D | |
| 523L | | | | |
| -- with removal of benign tumor -- add | \$55.00 | \$55.00 | D | |
| 524L | | | | |
| -- with endobronchial malignant tumor debulking -- add | \$260.00 | \$260.00 | D | |
| 525L | | | | |
| -- with tracheo oesophageal fistula creation -- add | \$55.90 | \$55.90 | D | |
| 526L | | | | |
| -- with removal of foreign body (rigid or flexscope) -- add | \$184.50 | \$184.50 | D | |
| 515L | | | | |
| Endobronchial Ultrasound Base -- includes bronchoscopy | \$270.40 | \$270.40 | D | |
| 516L | | | | |
| Transbronchial needle aspiration | \$54.00 | \$54.00 | D | |
| -- add to 515L | | | | |
| -- maximum of 3 lesions or stations | | | | |
| 452L | | | | |
| Video Capsule Endoscopy | \$54.30 | \$54.30 | D | |
| -- 15 minute units | | | | |
| -- maximum of 10 units | | | | |
| Balloon Endoscopies | | | | |
| 527L | | | | |
| Antegrade Double Balloon Enteroscopy | \$275.70 | \$275.70 | D | L |
| 627L | | | | |
| Antegrade Single Balloon Enteroscopy | \$275.70 | \$275.70 | D | L |
| 528L | | | | |
| Retrograde Double Balloon Enteroscopy | \$347.80 | \$347.80 | D | L |
| 628L | | | | |
| Retrograde Single Balloon Enteroscopy | \$347.80 | \$347.80 | D | L |
| 529L | | | | |
| Double Balloon Colonoscopy | \$304.30 | \$304.30 | D | L |
| 530L | | | | |
| Double Balloon Endoscopic Retrograde Cholangiopancreatography | \$347.80 | \$347.80 | D | L |

SECTION M – Orthopedic Surgery

Specialist in Orthopedic
Surgery
Not
Referred Referred

| | | Referred | Not Referred |
|-----|---|----------|--------------|
| 5M | <p>Initial assessment -- of a specific condition includes:</p> <p>a) pertinent family history; f) diagnosis;</p> <p>b) patient history; g) assessment;</p> <p>c) history of presenting complaint; h) necessary treatment;</p> <p>d) functional enquiry; i) advice to the patient; and,</p> <p>e) examination of affected part(s) or j) record of service provided. system(s);</p> | \$48.00* | \$38.45* |
| 7M | <p>Follow-up assessment -- includes:</p> <p>a) history review; e) necessary treatment;</p> <p>b) functional enquiry; f) advice to the patient; and,</p> <p>c) examination; g) record of service provided.</p> <p>d) reassessment;</p> | \$43.70* | \$43.70* |
| 9M | <p>Consultation – includes:</p> <p>a) all visits necessary;</p> <p>b) history and examination;</p> <p>c) review of laboratory and/or other data;</p> <p>d) written submission of the consultant's opinion, and</p> <p>e) recommendations to the referring doctor</p> | \$96.60* | |
| 10M | Consultation for patients referred for back pain only | \$79.50* | |
| 11M | <p>Repeat consultation</p> <p>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.</p> <p>* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.</p> | \$37.20* | |
| 13M | <p>Written advice to referring physician on the management of a case based upon review of x-rays by Orthopedic Surgeon (payable once per case)</p> <p>@ Payment approved for a physician with training and expertise in this section</p> | \$51.00 | \$40.80@ |

SECTION M – Orthopedic Surgery

Specialist in Orthopedic
Surgery
Not
Referred Referred

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician.

An assessment or consultation may not be billed when hospital care is transferred to another physician. Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25M | -- 1-10 days | -- per day -- bill units (max 10) | \$31.40 | \$31.40 |
| 26M | -- 11-20 days | -- per day -- bill units (max 10) | \$31.40 | \$31.40 |
| 27M | -- 21-30 days | -- per day -- bill units (max 10) | \$31.40 | \$31.40 |
| 28M | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$31.40 | \$31.40 |

SECTION M – Orthopedic Surgery

Specialist General Practitioner Class Anes

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.

Classification of Bones for Payment Purposes

| | Long | Short | Major | Minor | Large | Small |
|--------------------|------|-------|-------|-------|-------|-------|
| Clavicle | X | | X | | X | |
| Humerus | X | | X | | X | |
| Radius | X | | X | | X | |
| Ulna | X | | X | | X | |
| Femur | X | | X | | X | |
| Tibia | X | | X | | X | |
| Fibula | X | | X | | X | |
| Patella | | | X | | X | |
| Mandible | | | X | | X | |
| Facial Bones | | | X | | X | |
| Scapula | | | X | | X | |
| Pelvis | | | X | | X | |
| Vertebra | | | X | | X | |
| Os Calcis | | | X | | X | |
| Talus | | | X | | X | |
| Other Tarsal Bones | | | | X | | X |
| Carpal Bones | | | | X | | X |
| Metacarpals | | X | | X | | X |
| Metatarsals | | X | | X | | X |
| Phalanges | | X | | X | | X |

| | | | | | |
|-----|--|----------|----------|----|---|
| 30M | Incision of deep soft tissue, abscess from osteomyelitis - by report | \$450.00 | \$450.00 | 42 | L |
| 31M | Removal of percutaneous pins/wires in office or outpatient setting | \$35.70 | \$35.70 | 0 | |

Internal Fixation Removal

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

| | | | | | |
|-----|---|----------|----------|----|---|
| 32M | Operative removal of metal bone fixation device(s), any number of screws, nails or wires per operative site | \$100.00 | \$100.00 | 10 | L |
| 33M | -- plate (including screws, intramedullary nail) | \$331.30 | \$331.30 | 10 | L |

Osteotomy – with or without internal fixation

| | | | | | |
|-----|--|----------|----------|----|---|
| 40M | Clavicle | \$535.20 | \$482.20 | 42 | L |
| 44M | Humerus or ulna or radius | \$535.20 | \$481.20 | 42 | L |
| 48M | Radius and ulna | \$535.20 | \$481.20 | 42 | L |
| 49M | Femur – neck or supracondylar | \$535.20 | \$481.20 | 42 | M |
| 50M | Femur -- trochanteric or subtrochanteric | \$535.20 | \$481.20 | 42 | M |
| 56M | Tibia and Fibula | \$535.20 | \$481.20 | 42 | M |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| Osteotomy – with or without internal fixation | | | | | |
| 64M | Femur, supracondylar and tibia and fibular | \$509.80 | \$458.80 | 42 | M |
| 60M | Metacarpal, metatarsal or phalanx—one | \$400.00 | \$360.00 | 42 | L |
| 68M | Os calcis (Dwyer or wedge tarsectomy) | \$535.20 | \$481.70 | 42 | L |
| Excision | | | | | |
| 81M | Biopsy bone | \$305.90 | \$275.30 | 42 | L |
| 107M | Radio-ulnar synostosis | \$968.50 | \$871.70 | 42 | L |
| 90M | Coccygectomy | \$407.80 | \$367.00 | 42 | L |
| 93M | Excision of bone cyst, chondroma, exostosis - large bone | \$356.80 | \$321.10 | 42 | L |
| 94M | Excision of bone cyst, chondroma, exostosis - large bone - with bone graft | \$356.80 | \$321.10 | 42 | L |
| 95M | Excision of bone cyst, chondroma, exostosis - small bone | \$356.80 | \$321.10 | 42 | L |
| 96M | Excision of bone cyst, chondroma, exostosis - small bone - with bone graft | \$356.80 | \$321.10 | 42 | L |
| 98M | Partial ostectomy, excision of distal end of ulna or radius | \$254.90 | \$229.40 | 42 | L |
| 100M | Saucerization and/or sequestrectomy -- large bone | \$331.30 | \$298.20 | 42 | L |
| 101M | Saucerization and/or sequestrectomy -- small bone | \$331.30 | \$298.10 | 42 | L |
| 103M | Radical resection of bone for tumor with bone graft -- major bone | \$1,121.50 | \$1,009.30 | 42 | M |
| 104M | Radical resection of bone for tumor with bone graft -- minor bone | \$1,121.50 | \$1,009.30 | 42 | M |
| 83M | Claviclectomy – partial | \$183.50 | \$165.20 | 42 | L |
| 84M | Claviclectomy – total | \$764.60 | \$688.20 | 42 | L |
| 86M | Excision of head of radius | \$356.80 | \$321.10 | 42 | L |
| 88M | Carpectomy | \$400.00 | \$360.00 | 42 | L |
| 89M | Carpectomy -- each additional (same field only) -- bill units | \$305.90 | \$275.30 | 42 | L |
| 87M | Metacarpectomy or metatarsectomy | \$356.80 | \$321.10 | 42 | L |
| 102M | Excision of head of femur | \$330.30 | \$297.70 | 42 | M |
| 91M | Patellectomy – partial | \$222.30 | \$199.80 | 42 | L |
| 92M | Patellectomy – total | \$662.70 | \$596.40 | 42 | L |
| 97M | Shaving of patella – when only procedure done | \$215.10 | \$193.70 | 42 | L |
| 85M | Astagalectomy | \$400.00 | \$360.60 | 42 | L |
| 79M | Excision of 4 metatarsal heads (Hoffman) | \$331.30 | \$298.20 | 42 | L |
| Introduction | | | | | |
| 110M | Insertion of Kirschner wire or metal pins for traction or cast fixation | \$152.90 | \$152.90 | 0 | L |
| 111M | Application of calliper or tongs | \$152.90 | \$152.90 | 0 | L |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| Repair | | | | | |
| 120M | Osteoplasty -- shortening of bone -- femur, tibia or humerus | \$458.80 | \$412.90 | 42 | M |
| 121M | Osteoplasty -- shortening of bone -- radius or ulna | \$305.90 | \$275.75 | 42 | L |
| 122M | Osteoplasty -- shortening of bone -- both radius and ulna | \$713.70 | \$642.30 | 42 | L |
| 123M | Osteoplasty -- shortening of bone -- other bones | \$305.90 | \$275.30 | 42 | L |
| 124M | Osteoplasty -- lengthening of bone -- major | \$764.60 | \$688.20 | 42 | M |
| 125M | Osteoplasty -- lengthening of bone -- minor (hand or foot) | \$500.00 | \$450.00 | 42 | L |
| 126M | Acromioplasty includes excision of distal clavicle | \$350.00 | \$315.05 | 42 | L |
| 150M | Scapulopexy | \$917.60 | \$825.80 | 42 | M |
| Epiphyseal-diaphyseal fusion, epiphyseal arrest or epiphysiodesis | | | | | |
| 152M | -- femur or tibia and fibula | \$458.80 | \$412.90 | 42 | L |
| 154M | -- combined (femur, tibial and fibular) epiphyseal arrest | \$611.70 | \$550.50 | 42 | L |
| 155M | -- combined (upper and lower tibial and fibular) epiphyseal arrest | \$611.70 | \$550.50 | 42 | L |
| BMI Supplement | | | | | |
| 180M | Orthopedic surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height [m] 2) greater than 40 | \$168.20 | | | |
| | 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". | | | | |

SECTION M – Orthopedic Surgery

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).
- 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 payment schedule

3. Reduction

- a) Payment includes all manipulations and re-manipulations to achieve and maintain satisfactory reduction during the designated post-operative period.
- b) 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.
- c) Payment may be made to a physician who provides emergency care to a patient with a fracture before referral to a specialist.
- d) 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 paid 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%.

4. Open reduction:

- a) 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%.
- b) when a payment for open reduction is not listed, the listing for a closed reduction may be raised by 50%.
- c) Intramedullary fixation (closed or open) is payable at the same rate as open reduction.

5. Multiple fractures:

- a) 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
 - i. a composite payment is listed for the multiple fractures, or
 - ii. a specific payment is listed for the "additional" procedures, or
 - iii. a specific assessment rule applies for the type and locale of the fractures.

SECTION M – Orthopedic Surgery

FRACTURES

- b) 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 Anesthetic may be paid at 100% of the listing unless specified otherwise.
- 6. 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.
- 7. Payment for open treatment of a fracture which remains ununited after the designated post-operative period is based on 150% of the Payment Schedule item for primary open reduction
- 8. **Fracture and Dislocation**
 - a) Only the greater listed amount is paid when a Fracture and Dislocation are billed for the same day, same site.
 - b) Unless otherwise indicated, the rules for Fractures and Dislocations apply:
 - on the same day -- to the same physician or another physician in the same specialty and clinic (or part of the surgical team);
 - 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.

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| Bone graft | | | | | |
| 133M | Use of bone graft a) autogenous bone from different site; b) add 50% of the amount payable for the procedure done; and c) cannot be billed for spine surgery cases; | | | | |
| 134M | Bone bank a) add 25%; and b) cannot be billed for spine surgery cases. | | | | |
| 135M | Harvesting of bone graft for use by oral surgeon | \$600.00 | \$540.10 | 42 | L |
| 136M | Extensive harvesting of cadaver bone for bone bank | \$917.60 | \$825.80 | 42 | |
| Trunk | | | | | |
| 166M | Sacrum -- operative management | \$163.10 | \$146.80 | 42 | L |
| 173M | Clavicle -- open reduction | \$433.30 | \$390.00 | 42 | L |
| 174M | Scapula -- closed reduction | \$125.00 | \$125.00 | 42 | L |
| 177M | Scapula -- open reduction | \$764.60 | \$688.20 | 42 | L |
| 179M | Sternum -- open reduction | \$138.70 | \$124.40 | 42 | L |
| Pelvis (Ilium, Ischium, Pubis) | | | | | |
| 192M | Pelvis -- fracture -- one or more bones -- open reduction | \$1,019.50 | \$917.60 | 42 | M |
| 193M | Pelvis -- fracture -- unstable -- closed reduction with external fixation | \$560.70 | \$504.70 | 42 | M |
| Acetabulum -- with or without other fractures of pelvis | | | | | |
| 195M | Acetabulum -- central -- with displacement | \$251.80 | \$226.30 | 42 | L |
| 196M | Acetabulum -- open reduction | \$1,274.40 | \$1,146.90 | 42 | M |
| Upper Extremity | | | | | |
| 201M | Humerus -- surgical neck or epiphyseal separation -- closed reduction | \$150.00 | \$150.00 | 42 | L |
| 203M | Humerus -- surgical neck or epiphyseal separation -- open reduction | \$535.20 | \$482.20 | 42 | L |
| 204M | Humerus -- shaft -- closed reduction | \$178.40 | \$178.40 | 42 | L |
| 206M | Humerus -- shaft -- open reduction | \$535.20 | \$482.20 | 42 | L |
| 210M | Humerus -- shaft -- reduction with external fixation device | \$356.80 | \$321.10 | 42 | L |
| 207M | Elbow -- epicondyle only -- closed reduction | \$134.60 | \$134.60 | 42 | L |
| 208M | Elbow -- epicondyle only -- open reduction | \$356.80 | \$321.10 | 42 | L |
| Distal end of humerus, proximal end of radius or ulna, condyle -- one or more bones | | | | | |
| 209M | -- closed reduction | \$150.00 | \$150.00 | 42 | L |
| 212M | -- open reduction | \$535.20 | \$482.20 | 42 | L |
| 214M | Supracondylar -- displaced -- closed reduction by manipulation or traction | \$188.60 | \$170.30 | 42 | L |
| 218M | Olecranon -- open reduction | \$305.90 | \$275.30 | 42 | L |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 220M | Radius -- head -- closed reduction | \$203.90 | \$203.90 | 42 | L |
| 222M | Radius -- head -- open reduction | \$356.80 | \$321.10 | 42 | L |
| 225M | Radius -- shaft -- closed reduction | \$150.00 | \$150.00 | 42 | L |
| 229M | Radius -- shaft -- open reduction | \$331.30 | \$331.30 | 42 | L |
| 233M | Radius -- distal end -- closed -- Colles' including ulnar styloid reduction | \$203.90 | \$203.90 | 42 | L |
| 235M | Radius -- distal end (Colles' including ulnar styloid) -- open reduction | \$458.80 | \$458.80 | 42 | L |
| 237M | Colles -- reduction with external fixation device | \$280.40 | \$280.40 | 42 | L |
| 240M | Ulna -- shaft-- closed reduction | \$125.00 | \$125.00 | 42 | L |
| 243M | Ulna -- shaft-- open reduction | \$305.90 | \$305.90 | 42 | L |
| 244M | Ulna -- Monteggia fracture – dislocation | \$331.30 | \$297.70 | 42 | L |
| 247M | Radius and Ulna (excluding Colle's) -- closed reduction | \$229.40 | \$229.40 | 42 | L |
| 249M | Radius and Ulna (excluding Colle's) -- open reduction | \$535.20 | \$535.20 | 42 | L |
| 250M | Radius and Ulna (excluding Colle's) -- reduction with external fixation device | \$367.00 | \$367.00 | 42 | L |
| 251M | Carpal bone -- closed reduction | \$125.00 | \$125.00 | 42 | L |
| 252M | Carpal bone -- open reduction | \$535.20 | \$535.20 | 42 | L |
| 253M | Carpal bone -- reduction with external fixation device | \$382.30 | \$382.30 | 42 | L |
| 255M | Metacarpal -- closed reduction | \$203.90 | \$203.90 | 42 | L |
| 257M | Metacarpal -- open reduction | \$356.80 | \$321.10 | 42 | L |
| 256M | Reduction of Bennett's fracture by internal fixation | \$356.80 | \$356.80 | 42 | L |
| 260M | Phalanx -- finger or thumb -- closed reduction | \$203.90 | \$203.90 | 42 | L |
| 262M | Phalanx -- finger or thumb -- open reduction | \$356.80 | \$356.80 | 42 | L |
| | Lower Extremity | | | | |
| 291M | Femur -- neck -- internal fixation | \$720.00 | \$647.95 | 42 | M |
| 295M | Intertrochanteric -- internal fixation | \$720.00 | \$647.95 | 42 | M |
| 296M | Slipped epiphysis -- closed reduction | \$381.30 | \$343.60 | 42 | L |
| 297M | Slipped epiphysis -- open reduction – acute | \$720.00 | \$647.95 | 42 | M |
| 298M | Slipped epiphysis -- reconstructive later | \$764.60 | \$688.20 | 42 | M |
| 299M | Shaft -- including supracondylar -- closed reduction | \$281.40 | \$281.40 | 42 | L |
| 303M | Shaft -- including supracondylar -- open reduction | \$713.70 | \$642.30 | 42 | M |
| 305M | Patella -- immobilization only | \$171.30 | \$171.30 | 42 | L |
| 307M | Patella -- open reduction or excision -- complete or partial | \$356.80 | \$321.10 | 42 | L |
| 310M | Tibia -- shaft -- closed reduction -- includes fibular shaft | \$230.00 | \$230.00 | 42 | L |
| 312M | Tibia -- shaft -- open reduction -- includes fibular shaft | \$509.80 | \$509.80 | 42 | M |
| 314M | Tibia -- plateau -- closed reduction | \$200.00 | \$179.70 | 42 | L |
| 315M | Tibia -- plateau -- open reduction | \$611.70 | \$550.50 | 42 | M |
| 316M | Tibia -- malleolus -- closed reduction | \$150.00 | \$150.00 | 42 | L |
| 317M | Tibia -- malleolus -- open reduction | \$331.30 | \$298.70 | 42 | L |

Payment Schedule for Insured Services Provided by a Physician

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 318M | Fibula -- shaft -- closed reduction | \$152.90 | \$152.90 | 42 | L |
| 319M | Fibula -- shaft -- open reduction | \$331.30 | \$298.70 | 42 | L |
| 320M | Fibula -- malleolus -- closed reduction | \$125.00 | \$125.00 | 42 | L |
| 321M | Fibula -- malleolus -- open reduction | \$331.30 | \$297.70 | 42 | L |
| 330M | Tibia and Fibula -- reduction with external fixation device | \$484.30 | \$484.30 | 42 | L |
| 323M | Ankle -- bimalleolar (including Potts) -- closed reduction | \$152.90 | \$152.90 | 42 | L |
| 325M | Ankle -- bimalleolar (including Potts) -- open reduction | \$458.80 | \$412.90 | 42 | L |
| 340M | Ankle -- bimalleolar (including Potts) -- reduction with external fixation device | \$484.30 | \$435.30 | 42 | L |
| 326M | Ankle -- trimalleolar -- closed reduction | \$152.90 | \$152.90 | 42 | L |
| 328M | Ankle -- trimalleolar -- open reduction | \$535.20 | \$481.70 | 42 | L |
| 341M | Ankle -- trimalleolar -- reduction with external fixation device | \$484.30 | \$435.30 | 42 | L |
| 329M | Tarsal -- (except astragalus and os calcis) -- closed reduction | \$152.90 | \$152.90 | 42 | L |
| 331M | Tarsal -- (except astragalus and os calcis) -- open reduction | \$458.80 | \$412.90 | 42 | L |
| 332M | Astragalus -- closed reduction | \$152.90 | \$152.90 | 42 | |
| 334M | Astragalus -- open reduction | \$535.20 | \$535.20 | 42 | L |
| 335M | Os calcis -- closed reduction | \$152.90 | \$152.90 | 42 | L |
| 337M | Os calcis -- open reduction | \$535.20 | \$481.70 | 42 | L |
| 338M | Os calcis -- skeletal pinning with external fixation | \$382.30 | \$344.60 | 42 | L |
| 339M | Metatarsal -- closed reduction | \$125.00 | \$125.00 | 42 | L |
| 343M | Metatarsal -- open reduction | \$254.90 | \$229.40 | 42 | L |
| 345M | Phalanx -- closed reduction | \$152.90 | \$152.90 | 42 | L |
| 348M | Phalanx -- open reduction | \$254.90 | \$254.90 | 42 | L |
| | Treatment of ununited fractures by bone stimulator | | | | |
| | Total care – not payable for stress fractures | | | | |
| 350M | External application (Bi-Osteogen) | \$50.00 | \$50.00 | | L |
| 351M | Percutaneous insertion | \$371.10 | \$371.10* | | L |
| 352M | Operation Implantation | | | | |
| | a) add 100% of benefit rate for open reduction (50% for ununited fracture; 50% for operative implantation) | | | | |
| | b) with bone bank graft -- add 25% of benefit rate of open reduction, under code 134M | | | | |
| | c) with autogenous bone graft -- add 50% of benefit rate of open reduction, under code 133M | | | | |

Payment Schedule for Insured Services Provided by a Physician

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| | <u>Joints</u> | | | | |
| 359M | Arthroscopy | \$178.40 | \$160.10 | D | L |
| 500M | Manipulation of any peripheral joint under general anesthesia -- (includes shoulder or hip) | \$38.00 | \$38.00 | 0 | L |
| | <u>Incision</u> | | | | |
| | Arthrotomy or capsulotomy with exploration, drainage or removal of loose body, e.g. osteochondritis or foreign body | | | | |
| 360M | Shoulder | \$484.30 | \$436.30 | 42 | L |
| 361M | Elbow | \$484.30 | \$436.30 | 42 | L |
| 362M | Wrist | \$484.30 | \$436.30 | 42 | L |
| 363M | Other joints of upper extremity | \$484.30 | \$435.80 | 42 | L |
| 364M | Hip | \$484.30 | \$436.30 | 42 | L |
| 365M | Knee | \$484.30 | \$436.30 | 42 | L |
| 366M | Ankle | \$484.30 | \$436.30 | 42 | L |
| 367M | Other joints of lower extremity | \$484.30 | \$435.80 | 42 | L |
| 379M | Sesamoid bone – excision – one or more – unilateral | \$125.00 | \$125.00 | 42 | L |
| | <u>Arthrocentesis</u> – puncture for aspiration of joint and/or injection of medication | | | | |
| 380M | Arthrocentesis – hip | \$29.20 | \$29.20 | 0 | L |
| 381M | Arthrocentesis – shoulder, elbow, knee | \$25.00 | \$25.00 | 0 | L |
| 382M | Arthrocentesis – others | \$25.50 | \$25.50 | 0 | L |
| | <u>Excision</u> | | | | |
| | Arthrectomy – Excision of joint | | | | |
| 390M | Punch biopsy of synovial membrane | \$37.90 | \$34.20 | D | L |
| 391M | Temporomandibular joint – meniscectomy | \$274.20 | \$246.80 | 42 | L |
| 392M | Temporomandibular joint – condylectomy | \$253.90 | \$228.40 | 42 | L |
| 384M | Chemonucleolysis of intervertebral disc | \$256.90 | \$231.40 | 42 | L |
| 385M | Percutaneous automated discectomy | \$314.00 | \$282.40 | 42 | L |
| 398M | Excision of neural arch and nerve exploration for spondylolisthesis | \$406.80 | \$366.00 | 42 | L |
| | Major meniscal tears & extensive articular debridement are each paid | | | | |
| 399M | Meniscectomy – knee | \$294.60 | \$265.10 | 42 | L |
| 397M | Meniscus repair | \$356.80 | \$321.10 | 42 | L |
| | The fee for open or arthroscopic meniscectomy or meniscus repair includes limited trimming of chondromalacia, plica and minor tears of other meniscus. | | | | |
| 840M | Debridement of Shoulder Joint -- Arthroscopic a) Major debridement should take more than 20 minutes. b) Minor debridement, taking less than 20 minutes is included in arthroscopy code 359M) | \$346.60 | \$312.00 | 42 | L |
| 841M | Debridement of Knee Joint -- Arthroscopic a) Major debridement should take more than 20 minutes. b) Minor debridement, taking less than 20 minutes is included in arthroscopy code 359M) | \$294.60 | \$265.10 | 42 | L |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| Synovectomy -- not paid in addition to major joint surgery | | | | | |
| 400M | Synovectomy -- elbow | \$475.00 | \$427.90 | 42 | L |
| 401M | Synovectomy -- wrist | \$458.80 | \$412.90 | 42 | L |
| 402M | Synovectomy -- finger -- MP joint – one | \$356.80 | \$321.10 | 42 | L |
| 404M | Synovectomy -- finger -- IP joint | \$305.90 | \$275.30 | 42 | L |
| 406M | Synovectomy -- thumb -- MP joint | \$356.80 | \$321.10 | 42 | L |
| 407M | Synovectomy -- thumb -- IP joint | \$305.90 | \$275.30 | 42 | L |
| 408M | Synovectomy -- toe – one | \$305.90 | \$275.30 | 42 | L |
| 410M | Synovectomy -- hip | \$399.60 | \$359.90 | 42 | L |
| 411M | Synovectomy -- knee | \$356.80 | \$321.10 | 42 | L |
| 412M | Synovectomy -- ankle | \$356.80 | \$321.10 | 42 | L |
| 413M | Synovectomy -- foot | \$356.80 | \$321.10 | 42 | L |
| | (Excision of ganglion see 671M) | | | | |
| Arthroplasty | | | | | |
| | 1. Plastic or reconstructive operation on joint, any type includes reconstruction of ligaments, etc. | | | | |
| | 2. The reduction of a dislocated hip within the post-operative period is included in the payment for the arthroplasty. | | | | |
| | 3. For a two stage revision of a total hip replacement, payment is made on the basis of 435M for the first stage and 885M for the second stage. | | | | |
| | 4. Synovectomy is an inclusion within the payment for major joint surgery. | | | | |
| 430M | Shoulder arthroplasty | \$484.30 | \$435.80 | 42 | M |
| 446M | Total shoulder replacement | \$815.60 | \$734.00 | 42 | M |
| 846M | Total shoulder replacement –revision | \$1,529.30 | \$1,376.30 | 42 | M |
| 431M | Elbow arthroplasty | \$484.30 | \$436.30 | 42 | L |
| 442M | Total elbow replacement | \$968.50 | \$871.70 | 42 | L |
| 842M | Total elbow replacement – revision | \$1,937.10 | \$1,743.30 | 42 | L |
| 432M | Wrist arthroplasty | \$611.70 | \$550.50 | 42 | L |
| 448M | Total wrist replacement | \$968.50 | \$871.70 | 42 | L |
| 848M | Total wrist replacement – revision | \$1,937.10 | \$1,743.30 | 42 | L |
| 433M | Finger arthroplasty - one joint | \$356.80 | \$321.10 | 42 | L |
| 434M | Finger arthroplasty - one joint - with prosthesis | \$200.80 | \$180.50 | 42 | L |
| 834M | Finger arthroplasty - one joint - with prosthesis – revision | \$401.70 | \$360.90 | 42 | L |
| 634M | -- with extensor tendon transfer | \$300.80 | \$271.20 | 42 | L |
| 435M | Hip arthroplasty | \$535.20 | \$482.20 | 42 | M |
| 835M | Hip arthroplasty – revision | \$1,070.50 | \$964.40 | 42 | M |
| 445M | Total hip replacement or reconstructive arthroplasty | \$815.60 | \$734.00 | 42 | M |
| 845M | -- with extensive acetabular reconstruction with bone graft – add | \$200.00 | \$179.85 | 42 | M |
| 885M | Total hip replacement or reconstructive arthroplasty – revision | \$1,529.30 | \$1,376.30 | 42 | M |

Payment Schedule for Insured Services Provided by a Physician

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| 436M | Knee arthroplasty | \$484.30 | \$435.80 | 42 | M |
| 444M | Total knee arthroplasty includes unicompartmental knee and patellar replacement | \$815.60 | \$734.00 | 42 | M |
| 844M | Total knee arthroplasty includes unicompartmental knee and patellar replacement – revision | \$1,529.30 | \$1,376.30 | 42 | M |
| 437M | Ankle | \$484.30 | \$435.80 | 42 | L |
| 449M | Total ankle replacement | \$968.50 | \$871.70 | 42 | L |
| 849M | Total ankle replacement – revision | \$1,529.30 | \$1,376.30 | 42 | L |
| 438M | Toe – one joint (except great toe) | \$356.80 | \$321.10 | 42 | L |
| 439M | Metatarsophalangeal joint -- first -- bunion operation – unilateral | \$178.40 | \$161.10 | 42 | L |
| 441M | Bunionectomy with metatarsal osteotomy – unilateral | \$407.80 | \$367.00 | 42 | L |
| 460M | Hallux rigidus – repair | \$407.80 | \$367.00 | 42 | L |
| | Arthrodesis | | | | |
| 450M | Arthrodesis - shoulder | \$1,121.50 | \$1,009.30 | 42 | M |
| 451M | Arthrodesis - elbow | \$764.60 | \$688.20 | 42 | L |
| 452M | Arthrodesis - wrist | \$764.60 | \$688.20 | 42 | L |
| 453M | Arthrodesis - finger or thumb - one joint | \$356.80 | \$321.10 | 42 | L |
| 853M | Arthrodesis - finger or thumb - one joint - with autogenous bone graft (includes harvesting) | \$560.70 | \$504.70 | 42 | L |
| 454M | Arthrodesis - hip | \$1,121.50 | \$1,009.30 | 42 | M |
| 455M | Arthrodesis - knee | \$1,121.50 | \$1,009.30 | 42 | M |
| 456M | Arthrodesis - ankle | \$764.60 | \$688.20 | 42 | L |
| 464M | Arthrodesis – triple - unilateral | \$815.60 | \$734.00 | 42 | L |
| 462M | Arthrodesis -- tarsal joints -- one or more | \$407.80 | \$367.00 | 42 | L |
| 463M | Arthrodesis -- other joints -- lower extremity | \$407.80 | \$367.00 | 42 | L |
| 467M | Arthrodesis – triple - with tendon transplantation, add | \$305.90 | \$275.30 | 42 | L |
| | Hammer and claw toe -- repair includes excision, arthrodesis and arthroplasty of IP joints; capsulotomy of MTP joint; all tenotomies, tendon lengthening and transfers | | | | |
| 457M | Hammer and claw toe -- one toe (except great toe) | \$178.40 | \$178.40 | 42 | L |
| 459M | Hammer and claw toe -- great toe -- interphalangeal joint | \$356.80 | \$321.10 | 42 | L |
| 468M | Flat foot plasty or Grice | \$764.60 | \$688.20 | 42 | L |
| 469M | Stabilization of joints by bone block | \$356.80 | \$321.10 | 42 | L |
| | Club Foot | | | | |
| 520M | Clubfoot | \$1,019.50 | \$917.60 | 42 | M |
| | a) Extensive posterior release | | | | |
| | b) Includes Achilles tendon lengthening, flexor hallucis longus lengthening, capsulotomy of the ankle and subtalar joints | | | | |
| 521M | Clubfoot | \$502.60 | \$452.70 | 42 | M |
| | a) Complete extensive postero-medial release | | | | |
| | b) Includes code 520M | | | | |
| | Club foot -- non operative management -- Fee For Service | | | | |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|-----------------------|---|------------|----------------------|-------|------|
| Reconstruction | | | | | |
| 370M | Knee anterior cruciate ligament reconstruction, repair or reattachment of bony avulsion | \$535.20 | \$482.20 | 42 | M |
| 371M | Knee posterior cruciate ligament reconstruction, repair or reattachment of bony avulsion | \$535.20 | \$482.20 | 42 | M |
| 372M | Knee posterior cruciate ligament reconstruction with allograft or autograft | \$803.40 | \$722.80 | 42 | M |
| 373M | Knee medial collateral ligament reconstruction with allograft or autograft | \$535.20 | \$482.20 | 42 | M |
| 374M | Knee medial collateral ligament repair, reattachment or advancement | \$356.80 | \$321.10 | 42 | M |
| 375M | Knee lateral collateral ligament and/or posterolateral corner -- reconstruction with autograft or allograft | \$917.60 | \$825.80 | 42 | M |
| 376M | Knee lateral collateral ligament and/or posterolateral corner -- repair, reattachment or advancement | \$535.20 | \$482.20 | 42 | M |
| 470M | Sacroiliac fusion | \$611.70 | \$550.50 | 42 | M |
| 486M | Ankle -- repair of ligament(s) | \$300.00 | \$269.65 | 42 | L |
| 487M | Ankle -- reconstruction of ligament(s) | \$433.30 | \$390.00 | 42 | L |
| 488M | Hand -- reconstruction of metacarpophalangeal or interphalangeal ligament(s) | \$356.80 | \$321.10 | 42 | L |
| 170M | Acetabular labral debridement or repair | \$885.90 | \$797.20 | 42 | M |
| 480M | Capsulorrhaphy -- shoulder | \$509.80 | \$458.80 | 42 | M |
| | a) Recurrent dislocation | | | | |
| | b) Suture or repair of joint capsule and ligaments | | | | |
| 489M | Acromioclavicular joint – repair | \$356.80 | \$321.10 | 42 | M |
| 490M | Acromioclavicular joint – reconstruction | \$611.70 | \$550.50 | 42 | L |

SECTION M – Orthopedic Surgery

Specialist General Practitioner Class Anes

Dislocations

The payment listed includes:

- a) all manipulations to achieve and maintain satisfactory reduction, and
- b) 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.

1. Subsequent attempts at reduction are subject to the rules within the preamble to "Fractures".
2. Payment for compound dislocations is based on 150% of the fee for closed reduction.
3. Only the greater listed amount is paid when a fracture & dislocation are billed for the same day, same site.

| | | | | | |
|------|--|------------|------------|----|---|
| 530M | Temporomandibular -- closed reduction with or without anesthesia | \$20.70 | \$20.70 | 10 | L |
| 537M | Clavicle -- sternoclavicular -- closed reduction | \$125.00 | \$125.00 | 10 | L |
| 539M | Clavicle -- sternoclavicular -- open reduction | \$450.00 | \$405.00 | 42 | L |
| 540M | Clavicle -- acromioclavicular -- closed reduction | \$200.00 | \$200.00 | 42 | L |
| 541M | Clavicle -- acromioclavicular -- open reduction | \$254.90 | \$229.40 | 42 | L |
| 542M | Shoulder (humerus) -- closed reduction | \$203.90 | \$203.90 | 42 | L |
| 543M | Shoulder (humerus) -- open reduction – fresh | \$198.80 | \$179.40 | 42 | L |
| 544M | Shoulder (humerus) – old | \$295.70 | \$266.10 | 42 | L |
| 545M | Elbow -- closed reduction | \$230.00 | \$207.00 | 42 | L |
| 547M | Elbow -- open reduction – fresh | \$254.90 | \$229.40 | 42 | L |
| 548M | Elbow -- open reduction – old | \$509.80 | \$458.80 | 42 | L |
| 546M | Radial head -- closed reduction (pulled elbow) | \$125.00 | \$125.00 | 0 | L |
| 549M | Wrist -- carpal -- one bone -- closed reduction | \$125.00 | \$125.00 | 10 | L |
| 551M | Wrist -- carpal-- one bone -- open reduction | \$254.90 | \$229.40 | 42 | L |
| 555M | Metacarpal-- closed reduction | \$125.00 | \$125.00 | 10 | L |
| 557M | Metacarpal-- open reduction | \$305.90 | \$275.30 | 42 | L |
| 558M | Metacarpophalangeal joint -- closed reduction | \$125.00 | \$125.00 | 10 | L |
| 560M | Metacarpophalangeal joint -- open reduction | \$280.40 | \$252.30 | 10 | L |
| 561M | Interphalangeal joint -- closed reduction | \$125.00 | \$125.00 | 42 | L |
| 562M | Interphalangeal joint -- open reduction | \$280.40 | \$252.30 | 42 | L |
| 568M | Hip (femur) -- closed reduction | \$254.90 | \$254.90 | 42 | L |
| 569M | Hip (femur) -- open reduction | \$509.80 | \$458.80 | 42 | M |
| 570M | Hip (femur) -- with fracture of posterior portion of acetabulum | \$662.70 | \$596.40 | 42 | M |
| | Hip -- congenital -- closed treatment -- Fee For Service | | | | |
| 573M | Hip (femur) -- congenital -- open reduction | \$764.60 | \$688.20 | 42 | M |
| 574M | Hip (femur) -- congenital -- with shelving | \$662.70 | \$596.40 | 42 | M |
| 575M | Pelvic osteotomy -- Salter, etc | \$1,121.50 | \$1,009.30 | 42 | M |
| 576M | Pelvic osteotomy -- with arthrotomy | \$516.90 | \$464.90 | 42 | M |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| 577M | Knee (tibia) -- closed reduction | \$125.00 | \$125.00 | 42 | L |
| 579M | Knee (tibia) -- open reduction | \$331.30 | \$298.20 | 42 | L |
| 580M | Patella -- closed reduction | \$125.00 | \$125.00 | 10 | L |
| 582M | Patella -- open reduction | \$148.80 | \$133.60 | 42 | L |
| 583M | Reconstruction for recurrent patellar dislocation -- lateral retinacular | \$203.90 | \$183.50 | 42 | L |
| 581M | Reconstruction for recurrent patellar dislocation -- soft tissue | \$713.70 | \$642.30 | 42 | L |
| 589M | Reconstruction for recurrent patellar dislocation -- bony realignment | \$351.70 | \$317.10 | 42 | L |
| 584M | Ankle -- closed reduction | \$203.90 | \$183.50 | 42 | L |
| 585M | Ankle -- open reduction | \$331.30 | \$298.20 | 42 | L |
| 586M | Ankle -- subastragalar -- closed reduction | \$203.90 | \$183.50 | 42 | L |
| 587M | Ankle -- subastragalar -- open reduction | \$331.30 | \$298.20 | 42 | L |
| 588M | Tarsal -- closed reduction | \$203.90 | \$203.90 | 42 | L |
| 590M | Tarsal -- open reduction | \$331.30 | \$298.20 | 42 | L |
| 591M | Metatarsal -- one bone-- closed reduction | \$125.00 | \$125.00 | 10 | L |
| 594M | Metatarsal -- one bone -- open reduction | \$254.90 | \$229.40 | 42 | L |
| 596M | Toe -- closed reduction | \$125.00 | \$125.00 | 10 | L |
| 598M | Toe -- open reduction | \$254.90 | \$254.90 | 42 | L |
| | Bursae | | | | |
| 610M | Incision & drainage of infected bursa | \$30.50 | \$30.50 | 10 | L |
| 611M | Removal of subdeltoid calcareous deposits | \$133.60 | \$120.30 | 42 | L |
| 612M | Removal of subtrochanteric calcareous deposits | \$133.60 | \$120.30 | 42 | L |
| | Removal of calcareous deposits -- other joints -- see Arthrotomy | | | | |
| 614M | Puncture for aspiration or needling with or without irrigation or injection of medication | \$15.20 | \$15.20 | 0 | L |
| 620M | Radical excision of bursae -- forearm, viz tenosynovitis, fungosa, Tbc., and other granulomas | \$246.70 | \$222.30 | 42 | L |
| 621M | Excision of bursa – olecranon | \$254.90 | \$254.90 | 42 | L |
| 622M | Excision of bursa – prepatellar | \$254.90 | \$254.90 | 42 | L |
| 623M | Excision of bursa – subacromial | \$178.40 | \$160.60 | 42 | L |
| 624M | Excision of bursa – ischial | \$197.80 | \$178.00 | 42 | L |
| | Muscles | | | | |
| 630M | Quadriceps plasty | \$458.80 | \$412.90 | 42 | L |
| 631M | Repair of ruptured limb muscle -- belly, origin, or insertion | \$193.70 | \$174.30 | 42 | L |
| | For lacerations – see 890L, 896L | | | | |

S E C T I O N M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| <u>Tendons, Tendon Sheaths and Fascia</u> | | | | | |
| Incision | | | | | |
| 640M | Drainage of tendon sheath -- one digit | \$203.90 | \$203.90 | 42 | L |
| 641M | Drainage of tendon sheath -- single palm and/or wrist, ulnar or radial bursa -- in hospital | \$254.90 | \$229.40 | 42 | L |
| 642M | Injection of tendon sheath | \$29.20 | \$29.20 | 0 | L |
| 643M | Incision of fibrous sheath of tendon for stenosing tenosynovitis | \$254.90 | \$229.40 | 42 | L |
| 644M | Division of iliotibial band -- open reduction | \$163.10 | \$146.80 | 42 | L |
| 645M | Ober-Yount fasciotomy, combine (or Souter procedure) with Spica cast, pins in tibia, wedging of casts, etc. – unilateral | \$846.20 | \$761.60 | 42 | L |
| 646M | Compartment Pressure Monitoring | \$76.50 | \$68.80 | D | L |
| Hip adductors | | | | | |
| 649M | Hip adductors -- unilateral – percutaneous | \$152.90 | \$137.60 | 42 | L |
| 650M | Hip adductors -- unilateral – open | \$382.30 | \$344.10 | 42 | L |
| 651M | Hip adductors -- bilateral – percutaneous | \$203.90 | \$183.50 | 42 | L |
| 652M | Hip adductors -- bilateral – open | \$458.80 | \$412.90 | 42 | L |
| 653M | Hip adductors -- unilateral - with peripheral obturator neurectomy | \$153.90 | \$138.70 | 42 | L |
| 655M | Intrapelvic obturator neurectomy – unilateral | \$180.50 | \$162.10 | 42 | L |
| 657M | Sever (or similar procedure) of shoulder for Erb's palsy | \$815.60 | \$734.00 | 42 | L |
| Excision | | | | | |
| 671M | Excision of lesion of tendon or fibrous sheath, or ganglion Radical excision of bursae, forearm viz. tenosynovitis, fungosa, Tbc., and other granulomas -- See 620M | \$254.90 | \$254.90 | 42 | L |
| 673M | Excision of Baker's cyst | \$305.90 | \$275.30 | 42 | L |
| 674M | Fasciotomy -- single -- palm or sole -- subcutaneous – blind | \$203.90 | \$183.50 | 42 | L |
| 677M | Fasciectomy -- open -- plantar—unilateral | \$356.80 | \$321.10 | 42 | L |
| 678M | Compartment syndrome release -- for trauma | \$356.80 | \$321.10 | 42 | L |
| Repair | | | | | |
| 680M | Tendon sheath reconstruction - insertion of silastic rod | \$331.30 | \$297.70 | 42 | L |
| 681M | Tendon sheath reconstruction - insertion of silastic rod - each additional | \$136.60 | \$123.40 | 42 | L |
| 780M | Repair boutonniere deformity | \$161.10 | \$144.80 | 42 | L |
| Repair or suture – extensor tendon | | | | | |
| 690M | Hand or foot -- distal to wrist or ankle -- single | \$280.40 | \$280.40 | 42 | L |
| 691M | -- each additional tendon -- foot -- bill units | \$152.90 | \$152.90 | 42 | L |
| 692M | -- each additional tendon -- hand -- bill units | \$280.40 | \$280.40 | 42 | L |
| 693M | Forearm or leg – single | \$254.90 | \$254.90 | 42 | L |
| 694M | -- each additional tendon -- leg -- bill units | \$28.00 | \$28.00 | 42 | L |
| 695M | -- each additional tendon – forearm -- bill units | \$254.90 | \$254.90 | 42 | L |
| 696M | Repair or suture -- flexor tendon -- single unless otherwise listed | \$407.80 | \$367.00 | 42 | L |
| 697M | Repair or suture -- flexor tendon -- each additional -- bill units | \$305.90 | \$305.90 | 42 | L |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| Transfer or transplant of tendon – single | | | | | |
| 698M | Distal to elbow, distal to knee | \$433.30 | \$390.00 | 42 | L |
| 700M | Distal to elbow, distal to knee -- each additional -- bill units | \$356.80 | \$321.10 | 42 | L |
| 701M | Elbow or shoulder, knee or hip | \$433.30 | \$390.00 | 42 | L |
| 702M | Elbow or shoulder, knee or hip -- each additional -- bill units | \$152.90 | \$137.60 | 42 | L |
| 781M | Free extensor tendon graft -- single | \$400.00 | \$360.00 | 42 | L |
| 782M | Free extensor tendon graft -- each additional -- bill units | \$209.00 | \$188.10 | 42 | L |
| 703M | Free flexor tendon graft -- single | \$535.20 | \$481.20 | 42 | L |
| 704M | Free flexor tendon graft -- each additional | \$203.90 | \$183.50 | 42 | L |
| 705M | Tenolysis -- single – flexor | \$356.80 | \$321.10 | 42 | L |
| 706M | Tenolysis -- each additional -- bill units | \$229.40 | \$206.40 | 42 | L |
| 725M | Tenolysis -- single – extensor | \$254.90 | \$229.40 | 42 | L |
| 726M | Tenolysis -- each additional -- bill units | \$203.90 | \$183.50 | 42 | L |
| 727M | Tenodesis | \$433.30 | \$433.30 | 42 | L |
| 707M | Lengthening or shortening tendon | \$305.90 | \$275.30 | 42 | L |
| 708M | Opponens transfer | \$407.80 | \$367.00 | 42 | L |
| 709M | Intrinsic transplant active or passive | \$255.90 | \$230.40 | 42 | L |
| 710M | Intrinsic release (Littler) or incision | \$254.90 | \$229.40 | 42 | L |
| 711M | Intrinsic release (Littler) or incision -- additional fingers -- bill units | \$152.90 | \$137.60 | 42 | L |
| 712M | Free fascial graft for reconstruction tendon pulley or repair bowstring tendon -- single | \$305.90 | \$275.30 | 42 | L |
| 714M | Abdominal fascial transplants – bilateral | \$285.50 | \$256.90 | 42 | L |
| 716M | Ruptured quadriceps tendon – repair | \$356.80 | \$321.10 | 42 | L |
| 481M | Ruptured patellar ligament – repair | \$450.00 | \$404.95 | 42 | L |
| 721M | Ruptured patellar ligament or Achilles tendon -- repair with fascial or tendon graft | \$450.00 | \$405.05 | 42 | L |
| 717M | Ruptured biceps tendon -- elbow – repair | \$356.80 | \$321.10 | 42 | L |
| 718M | Flexor-plasty – elbow | \$450.00 | \$404.95 | 42 | L |
| 719M | Repair ruptured supraspinatus tendon or musculotendinous shoulder cuff -- with or without acromioplasty | \$484.30 | \$435.30 | 42 | L |
| 722M | Tenotomy – percutaneous | \$254.90 | \$254.90 | 10 | L |
| 723M | Tenotomy – open | \$254.90 | \$254.90 | 10 | L |
| 724M | Tenotomy -- each additional of either 722M or 723M -- bill units | \$152.90 | \$152.90 | 10 | L |
| Extremities – Incision | | | | | |
| 731M | Drainage of single infected space of hand (lumbrical, hypothenar, thenar, middle palmar, etc.) with or without tendon sheath involvement | \$356.80 | \$321.10 | 42 | |
| 732M | Drainage of multiple infected spaces of hand with or without tendon sheath involvement | \$560.70 | \$504.70 | 42 | |

SECTION M – Orthopedic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|-------------------------------------|---|------------|----------------------|-------|------|
| Amputation – Upper Extremity | | | | | |
| 740M | Amputation - Interthoracoscapular | \$764.60 | \$688.20 | 42 | M |
| 741M | Amputation - Disarticulation of shoulder | \$764.60 | \$688.20 | 42 | M |
| 742M | Amputation - Arm through humerus | \$800.00 | \$720.05 | 42 | M |
| 743M | Amputation - Forearm, through radius and ulna | \$764.60 | \$688.20 | 42 | M |
| 745M | Amputation - Forearm, through radius and ulna -- with subsequent revision or reamputation | \$764.60 | \$688.20 | 42 | M |
| 746M | Amputation - Cineplasty -- complete procedure | \$292.60 | \$263.00 | 42 | M |
| 747M | Amputation - Disarticulation of wrist | \$764.60 | \$688.20 | 42 | M |
| 748M | Amputation - Hand, through metacarpal bones | \$764.60 | \$688.20 | 42 | M |
| 749M | Amputation - Metacarpal, with finger or thumb, one with split or Wolff graft, or skin-plasty and/or tenodesis with definitive resection palmar digital nerves | \$764.60 | \$688.20 | 42 | L |
| 750M | Amputation - Finger, any joint, or phalanx, one -- with split or Wolff graft, or skin-plasty and/or tenodesis, with definitive resection volar digital nerves | \$407.80 | \$407.80 | 10 | L |
| Amputation – Lower Extremity | | | | | |
| 760M | Amputation - Interpelviabdominal | \$665.70 | \$599.50 | 42 | H |
| 761M | Amputation - Disarticulation of hip | \$968.50 | \$871.70 | 42 | M |
| 762M | Amputation - Disarticulation of knee | \$589.30 | \$530.30 | 42 | M |
| 763M | Amputation - Thigh through femur, including supracondylar | \$599.50 | \$539.50 | 42 | M |
| 765M | Amputation - high through femur, including supracondylar -- Revision or reamputation | \$130.50 | \$117.40 | 42 | M |
| 766M | Amputation - Leg, through tibia and fibula | \$800.00 | \$720.05 | 42 | M |
| 768M | Amputation - Leg, through tibia and fibula - Revision or reamputation | \$132.50 | \$119.30 | 42 | M |
| 769M | Amputation - Ankle (Syme, Pirogoff) -- with skin-plasty and resection nerves | \$764.60 | \$688.20 | 42 | M |
| 770M | Amputation - Foot – transmetatarsal | \$800.00 | \$720.05 | 42 | M |
| 771M | Amputation - Midtarsal | \$764.60 | \$688.20 | 42 | M |
| 772M | Amputation - Metatarsal, with toe, split or Wolff graft or skin-plasty and/or tenodesis, with definitive resection digital nerves | \$407.80 | \$367.00 | 42 | L |
| 774M | Amputation - Toe, any joint or phalanx, one -- with split or Wolff graft, or skin -- plasty and/or tenodesis, with definitive resection digital nerves | \$305.90 | \$305.90 | 10 | L |

SECTION M – Orthopedic Surgery

Specialist General Practitioner Class

Plaster Casts

1. Service codes 800M to 822M are payable in conjunction with a consultation, complete assessment, or initial assessment service when the physician personally applies the cast.
2. Payment may be made for the reapplication of casts after the discharge of a hospital in patient but not on the day of surgery.
3. Finger or toe -- bill as a visit fee

| | | | | |
|------|---|----------|----------|----|
| 800M | Plaster casts -- forearm | \$46.60 | \$46.60 | 0 |
| 801M | Plaster casts -- elbow to fingers | \$46.60 | \$46.60 | 0 |
| 802M | Plaster casts -- hand or wrist | \$45.00 | \$45.00 | 0 |
| 803M | Plaster casts -- shoulder to hand | \$50.00 | \$50.00 | 0 |
| 804M | Plaster casts -- shoulder Spica | \$50.00 | \$50.00 | 0 |
| 805M | Plaster casts -- ankle (foot to midleg) | \$50.00 | \$50.00 | 0 |
| 806M | Plaster casts -- knee (foot to thigh) | \$50.00 | \$50.00 | 0 |
| 808M | Ambulatory leg cast | \$50.00 | \$50.00 | 0 |
| 809M | Molded plaster to leg | \$76.50 | \$76.50 | 0 |
| 810M | Spica -- unilateral (rib margin to toe) | \$535.20 | \$535.20 | 0 |
| 812M | Plaster casts -- body -- shoulder to hip | \$254.90 | \$229.40 | 0 |
| 813M | Plaster casts -- body -- including head | \$63.50 | \$63.50 | 0 |
| 814M | Unna boot | \$52.10 | \$52.10 | 0 |
| 815M | Wedging of cast | \$51.00 | \$51.00 | 0 |
| 820M | Risser, or similar, cast for scoliosis | \$535.20 | \$481.70 | 0 |
| 821M | Halo cast | \$164.10 | \$147.70 | 42 |
| 822M | Application of hinged brace on knee cast -- composite fee for brace and | \$57.20 | \$57.20 | 0 |
| 825M | Cast removal (when physician personally removes the cast) | \$15.30 | \$15.30 | 0 |

Bracing

- a) Billable only when the physician personally applies the brace
- b) Adjustments performed by the physician are billed as visits/assessments
- c) Billable by only one physician once per brace

| | | | | |
|------|---|----------|----------|---|
| 830M | Thoracolumbar brace for spine deformity | \$234.50 | \$211.00 | 0 |
|------|---|----------|----------|---|

SECTION N – Plastic Surgery

Specialist in Plastic Surgery

Referred Not Referred

Visits

5N **Initial assessment** -- of a specific condition includes: \$45.90* \$37.10*

| | |
|--|--------------------------------|
| a) pertinent family history; | f) diagnosis; |
| b) patient history; | g) assessment; |
| c) history of presenting complaint; | h) necessary treatment; |
| d) functional enquiry; | i) advice to the patient; and, |
| e) examination of affected part(s) or system(s); | j) record of service provided. |

7N **Follow-up assessment** -- includes: \$39.60* \$39.60*

| | |
|------------------------|--------------------------------|
| a) history review; | e) necessary treatment; |
| b) functional enquiry; | f) advice to the patient; and, |
| c) examination; | g) record of service provided. |
| d) reassessment; | |

9N **Consultation** – includes: \$89.70*

a) all visits necessary;

b) history and examination;

c) review of laboratory and/or other data;

d) written submission of the consultant's opinion, and

e) recommendations to the referring doctor.

11N **Repeat Consultation** \$45.90*

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.

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

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 \$45.90 \$36.70@

@ Payment approved for a physician with training and expertise in this section

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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. Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25N | -- 1-10 days | -- per day -- bill units (max 10) | \$31.00 | \$31.00 |
| 26N | -- 11-20 days | -- per day -- bill units (max 10) | \$30.50 | \$30.50 |
| 27N | -- 21-30 days | -- per day -- bill units (max 10) | \$30.50 | \$30.50 |
| 28N | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.50 | \$30.50 |

SECTION N – Plastic Surgery

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.

The surgeon is invited to communicate with Saskatchewan Health pre-operatively in situations where insurability may be in question.

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.
3. Repair of traumatic or disease induced hair loss is insured. Medical or 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.
8. 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 angiomas for individuals over the age of 18.

SECTION N – Plastic Surgery

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.

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.

Abdominal panniculectomy is only insured by prior approval with submission of pictures and a "Prior Approval Request Form" which can be found at <https://www.ehealthsask.ca/services/resources/Resources/Prior-Approval-Abdominal-Panniculectomy.pdf>

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.

SECTION N - Plastic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|-----|---|------------|----------------------|-------|------|
| 32N | Removal of interdental and/or intermaxillary wiring and/or arch bar | \$70.00 | \$70.00 | 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 | \$216.10 | | 10 | L |
| 103N | -- 26 to 103 sq. cm | \$500.00 | | 42 | L |
| 105N | -- 103 to 350 sq. cm | \$700.00 | | 42 | M |
| 107N | -- more than 350 sq cm | \$800.00 | | 42 | M |
| 109N | Finger -- split graft of skin – plasty | \$305.90 | | 42 | L |
| 111N | Mesh grafting - paid in addition to split thickness grafts when 2 or more carriers are meshed | \$103.00 | | 42 | L |

Full Thickness Grafts

| | | | | | |
|------|--|----------|--|----|---|
| 241N | Free graft, full thickness, facial (eyelids, canthi, alae of nose, ears) | \$400.00 | | 10 | L |
| 242N | Free graft, full thickness, other -- less than 5 sq. cm. | \$310.00 | | 10 | L |
| 243N | Free graft, full thickness, other -- over 5 sq. cm. and up to 10 sq. cm. | \$385.00 | | 42 | L |
| 244N | Free graft, full thickness, other -- more than 10 sq. cm. | \$460.00 | | 42 | L |
| 280N | Composite graft (full thickness of external ear) | \$270.20 | | 42 | L |

SECTION N - Plastic Surgery

Specialist General Practitioner Class Anes

Treatment of Soft Tissue Injury – grafts, burns, wounds

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 | \$40.00 | \$40.00 | 0 |
|------|--|---------|---------|---|

Surgical Debridement – under general anesthesia, including dressings

| | | | | | |
|------|---|---------|---------|---|---|
| 123N | -- initial 5% total body surface area (TBSA) | \$50.00 | \$50.00 | 0 | L |
| 125N | -- each additional 5% or major part thereof – add, bill units | \$40.00 | \$40.00 | 0 | L |

Escharotomy

| | | | | | |
|------|--|----------|----------|----|---|
| 130N | -- all body areas other than trunk, per escharotomy site | \$163.10 | \$146.80 | 42 | L |
| 132N | -- trunk, per escharotomy site | \$121.30 | \$109.10 | 42 | L |

SECTION N - Plastic Surgery

Specialist General Practitioner Class Anes

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 | \$118.30 | | 42 | L |
| 142N | -- 65 to 103 sq cm, any body area | \$234.50 | | 42 | L |
| 144N | -- Greater than 103 sq cm, any body area | \$316.00 | | 42 | L |

Wound Repair - Face

- Single or multiple

| | | | | | |
|------|---------------------------------------|----------|--|----|---|
| 382N | -- up to 5 cm | \$180.00 | | 10 | L |
| 383N | -- each additional 2.5 cm, bill units | \$105.00 | | 10 | L |

Wound Management

| | | | | | |
|------|--|----------|----------|--|---|
| 420N | Vacuum assisted wound management – when set-up completed by a physician - setup, initial | \$150.00 | \$150.00 | | L |
| 421N | Vacuum assisted wound management – when set-up completed by a physician - Follow-up (includes visit) | \$80.00 | \$71.95 | | |

Flaps or Tubes of Skin from a Distance

| | | | | | |
|------|--|------------|------------|----|---|
| 252N | Major stage(s) -- raising of large direct flap or tube pedicle with closure of donor area | \$269.10 | \$242.60 | 42 | L |
| 253N | Major stage(s) -- raising of large direct flap or tube pedicle and skin graft to donor area | \$395.60 | \$356.00 | 42 | L |
| 254N | Minor stage(s) -- transposition of pedicle -- intermediate transfer or sectioning of pedicle with direct closure | \$219.20 | \$197.80 | 42 | L |
| 255N | Minor stage(s) -- transposition of pedicle -- delay of pedicle | \$254.90 | \$229.40 | 42 | L |
| 256N | Muscle flap with skin graft | \$1,325.40 | \$1,192.80 | 42 | M |

Payment Schedule for Insured Services Provided by a Physician

SECTION N - Plastic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| 257N | Myocutaneous flaps with donor closure | \$1,225.00 | \$1,102.55 | 42 | M |
| 258N | Myocutaneous flaps with skin grafts to donor area | \$968.50 | \$871.70 | 42 | M |
| 250N | Fasciocutaneous flap -- greater than 19 sq. cm - with donor closure | \$1,020.00 | \$918.05 | 42 | M |
| 251N | Fasciocutaneous flap -- greater than 19 sq. cm - with skin graft to donor area | \$1,225.00 | \$1,102.55 | 42 | M |
| 361N | Neurovascular pedicle flap | \$340.00 | \$305.95 | 42 | M |
| 440N | Transverse rectus abdominis myocutaneous flap for breast reconstruction | \$1,223.40 | \$1,101.10 | 42 | M |
| Excision and/or Repair by Adjacent Tissue Transfer or Rearrangement i.e. Z-plasty, rotation flap, advanced flap, double pedicle flap, etc. | | | | | |
| 260N | Defect up to 6 sq. cm. -- trunk | \$200.00 | \$180.05 | 42 | L |
| 261N | Defect up to 6 sq. cm. -- scalp, arms, legs | \$220.00 | \$198.00 | 42 | L |
| 262N | Defect up to 6 sq. cm. -- forehead, cheeks, chin, mouth, neck, axilla, genitalia, feet, hands | \$260.00 | \$234.00 | 42 | L |
| 263N | Defect up to 6 sq. cm. -- eyelids, nose, ears, lips | \$310.00 | \$279.00 | 42 | L |
| 264N | Defect 7-19 sq. cm. -- trunk | \$275.00 | \$247.50 | 42 | L |
| 265N | Defect 7-19 sq. cm. -- scalp, arms, legs | \$300.00 | \$269.95 | 42 | L |
| 266N | Defect 7-19 sq. cm. -- forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands, feet | \$360.00 | \$324.00 | 42 | L |
| 267N | Defect 7-19 sq. cm. -- eyelids, ears, nose, lips | \$385.00 | \$346.55 | 42 | L |
| 268N | Defect more than 19 sq. cm. -- unusual or complicated, by report | \$510.00 | \$459.00 | 42 | L |
| 371N | Syndactyly -- release with flaps | \$335.00 | \$301.55 | 42 | L |
| 372N | Syndactyly -- release with flaps and skin grafts | \$510.00 | \$459.00 | 42 | L |
| 659N | Lymphedema excision -- major excision and grafting Minor excision -- use 260N -- 268N | By report | | 42 | M |
| Eyelids | | | | | |
| Full thickness excision and repair by advancement flaps | | | | | |
| 270N | -- up to 1/4 of eyelid margin | \$213.10 | \$191.70 | 42 | L |
| 271N | -- over 1/4 of eyelid margin | \$253.90 | \$228.40 | 42 | L |
| 272N | By transfer flaps of tarso conjunctiva from opposing eyelid | \$257.90 | \$232.40 | 42 | L |
| Transplantation of Tissues Other than Skin | | | | | |
| 281N | Mucous membrane graft | \$181.50 | \$163.10 | 42 | L |
| 283N | Fascia grafts for facial nerve paralysis | \$458.80 | \$412.90 | 42 | L |
| 285N | Slings for ptosis | \$307.90 | \$277.30 | 42 | L |
| 286N | Cartilage -- autogenous transplant | \$340.00 | \$306.15 | 42 | L |
| 287N | Bone -- autogenous transplant -- nose, chin, orbit, forehead | \$480.00 | \$431.90 | 42 | M |

Payment Schedule for Insured Services Provided by a Physician

SECTION N - Plastic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|---|--|------------|----------------------|-------|------|
| Abrasive Surgery | | | | | |
| Facial resurfacing -- total face for removal of scars, etc. | | | | | |
| 290N | Mechanical – primary | \$284.40 | \$255.90 | 42 | L |
| 291N | Mechanical – secondary | \$140.70 | \$126.40 | 42 | L |
| 292N | Regional, cheeks, chin, forehead or elsewhere -- any method including laser | \$90.70 | \$81.60 | 42 | L |
| Nose | | | | | |
| 300N | Rhinoplasty | \$458.80 | \$412.90 | 42 | M |
| 301N | Rhinoplasty with septoplasty or submucous resection | \$600.00 | \$540.60 | 42 | M |
| 305N | Bone graft with 300N and 301N – add | \$220.00 | \$198.20 | 42 | L |
| 302N | Rhinophyma -- removal by shaving | \$220.00 | \$198.20 | 42 | L |
| 303N | Silastic implant -- when only procedure | \$181.50 | \$163.10 | 42 | L |
| Ear | | | | | |
| 310N | Preauricular fistula | \$146.80 | \$132.50 | 42 | L |
| 311N | Protruding ears -- otoplasty – unilateral | \$300.00 | \$270.45 | 42 | L |
| 313N | Segmental ear resection | \$145.00 | \$130.25 | 42 | L |
| Cleft Lip and Cleft Palate | | | | | |
| 320N | Plastic repair of cleft lip -- primary – unilateral | \$765.00 | \$688.55 | 42 | M |
| 323N | Plastic repair of cleft lip -- secondary - by recreation of defect and closure | \$615.00 | \$553.45 | 42 | M |
| 325N | Repair of nasal deformity due to cleft lip | \$370.00 | \$332.90 | 42 | M |
| 326N | Plastic operation for cleft palate -- partial – primary | \$765.00 | \$688.55 | 42 | M |
| 327N | Plastic operation for cleft palate -- complete – primary | \$920.00 | \$827.95 | 42 | M |
| 328N | Plastic operation for cleft palate -- major revision – secondary | \$900.00 | \$810.05 | 42 | M |
| 329N | Palate -- pharyngoplasty | \$500.00 | \$450.00 | 42 | M |
| Lips, Cheeks and Jaw | | | | | |
| 330N | Vermilionectomy or gingivectomy | \$285.00 | \$256.95 | 42 | L |
| 331N | Transverse wedge excision, lip | \$205.00 | \$184.50 | 42 | L |
| 631N | Rectangular or square through and through resection of lower lip | \$356.80 | \$321.10 | 42 | L |
| 332N | Radical resection of lip -- 1/2 or more with primary reconstruction | \$383.30 | \$344.60 | 42 | M |
| 333N | Total reconstruction of lip | \$551.50 | \$496.50 | 42 | M |
| 634N | LeFort I osteotomy of maxilla | \$922.60 | \$830.90 | 42 | M |
| 635N | LeFort I osteotomy of maxilla -- with bone grafting | \$1,031.70 | \$928.80 | 42 | M |
| 336N | Excision of cyst of dental origin -- intraoral approach - under 1 cm | \$37.10 | \$33.40 | 42 | M |
| 337N | Excision of cyst of dental origin -- intraoral approach - 1-2.5 cm | \$120.30 | \$108.10 | 42 | M |
| 338N | Excision of cyst of dental origin -- intraoral approach - over 2.5 cm | \$214.10 | \$192.70 | 42 | M |
| 339N | Interposed bone-graft augmentation of atrophic mandible | \$710.60 | \$639.20 | 42 | M |

SECTION N - Plastic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--------------------------------------|--|------------|----------------------|-------|------|
| Fractures of the Facial Bones | | | | | |
| 340N | Nose -- intranasal reduction and splinting | \$255.00 | \$229.50 | 42 | M |
| 341N | Nose -- total refracture and fixation | \$256.90 | \$231.40 | 42 | M |
| 342N | Mandible -- interdental wiring (horizontal) | \$255.00 | \$229.50 | 42 | M |
| 343N | Mandible -- intermaxillary wiring including interdental wiring | \$615.00 | \$553.45 | 42 | M |
| 344N | Mandible -- open reduction of single fracture, excluding interdental or intermaxillary wiring | \$410.00 | \$369.00 | 42 | M |
| 345N | Mandible -- multiple compound or comminuted fractures excluding interdental or intermaxillary wiring | \$615.00 | \$553.45 | 42 | M |
| 346N | Maxilla -- displaced -- open reduction | \$615.00 | \$553.45 | 42 | M |
| 347N | Maxilla -- open reduction with antrostomy (Caldwell Luc/packing) | \$375.20 | \$337.50 | 42 | M |
| 348N | Malar bone and zygomatic arch open elevation or temporal approach (Gillies) | \$410.00 | \$369.00 | 42 | M |
| 349N | Complete facial smash with cranial facial separation, complicated, open reduction, multiple surgical approaches, internal fixation, wiring teeth, etc | By Report | | 42 | M |
| Trunk | | | | | |
| 350N | Mammoplasty reduction – unilateral | \$569.00 | \$502.20 | 42 | M |
| 352N | Breast augmentation -- prosthetic – unilateral | \$315.00 | \$284.10 | 42 | L |
| 400N | Subcutaneous tissue space expander -- implantation | \$569.00 | \$502.10 | 42 | L |
| 401N | Subcutaneous tissue space expander -- removal (including replacement by prosthesis) | \$569.00 | \$502.10 | 42 | L |
| 430N | Nipple reconstruction, post mastectomy | \$360.00 | \$324.00 | 42 | L |
| 431N | Repair of inverted nipple | \$180.00 | \$162.55 | 42 | L |
| 432N | Removal of single breast prosthesis | \$105.00 | \$94.50 | 42 | L |
| 433N | Removal of single breast prosthesis with capsulectomy and/or skin plasty | \$320.00 | \$288.00 | 42 | L |
| 354N | Abdominal panniculectomy – by prior approval – see criteria page 222, item (5) | \$715.00 | \$643.45 | 42 | L |
| 355N | Decubitus ulcer -- repair by excision of bursa and underlying bone with rotation flap -- total care | \$1,350.00 | \$1,214.95 | 42 | M |
| 360N | Removal of axillary sweat glands (unilateral) | \$245.00 | \$220.45 | 42 | L |
| Extremities | | | | | |
| 362N | Phalangization | \$253.90 | \$228.40 | 42 | L |
| 363N | Pollicization | \$473.00 | \$426.20 | 42 | M |
| 364N | Cross finger flap -- total care | \$280.40 | \$252.30 | 42 | L |
| 365N | Transposition of digit | \$262.00 | \$235.50 | 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. | \$255.00 | \$229.50 | 42 | L |
| 367N | Palmar fasciectomy for Dupuytren's contracture – primary | \$565.00 | \$508.55 | 42 | L |
| 368N | Dupuytren's contracture – recurrent | \$665.00 | \$598.45 | 42 | L |
| 369N | Thumb, MCP joint -- collateral ligament reconstruction, by local tissue rearrangement | \$356.00 | \$320.70 | 42 | L |
| 370N | Thumb, MCP joint -- collateral ligament reconstruction, using tendon graft | \$534.00 | \$481.45 | 42 | L |

SECTION N - Plastic Surgery

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| Skin - Miscellaneous | | | | | |
| 380N | Excision of lesion, benign -- facial on referral Benign -- non-facial (see Section L) | \$100.00 | \$90.00 | 10 | L |
| Codes 684N and 685N 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 | Excision of lesion, malignant , by wide excision and suture, non-facial | \$152.90 | \$137.60 | 10 | L |
| 685N | Excision of lesion, malignant, by wide excision and suture , facial (not including neck and scalp) | \$203.90 | \$183.50 | 10 | L |
| For excision of malignant skin lesions with skin graft or flap repair -- use appropriate codes | | | | | |
| 410N | Percutaneous inflation of tissue expander, first | \$22.40 | \$22.40 | 0 | L |
| 411N | Percutaneous inflation of tissue expander, each additional expander, per patient contact, same day – maximum of 3, bill units | \$11.20 | \$11.20 | 0 | L |
| Assessment Rules for Microvascular Surgery (500N-506N): | | | | | |
| 1. Codes apply only when provided by a recognized microvascular surgeon. | | | | | |
| 2. Codes 500N and 501N are payable only once per anatomical site. | | | | | |
| 3. Codes 503N to 506N are dependent on the necessary REQUIRED blood flow for adequate microvascular success. | | | | | |
| 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 at the same surgical time of the initial attempt; take-back surgeries performed at separate times for revascularization are paid at 75%. | | | | | |
| 5. The 75% rule would apply for amputation where all attempts to revascularize fail. | | | | | |
| 6. Code 502N is not payable with 500N or 501N. | | | | | |
| 500N | Preparation and harvesting of graft and closure of donor site | \$1,000.00 | \$899.95@ | 42 | H |
| 501N | Preparation of distant recipient site including repair of nerves, tendons, bones and skin | \$1,000.00 | \$899.95@ | 42 | H |
| 502N | Preparation of adjacent donor and recipient sites including repair of nerves, tendons, bones and skin | \$1,121.50 | \$1009.30@ | 42 | H |
| 503N | Revascularization -- arterial | \$650.00 | \$584.95@ | 42 | H |
| 504N | Revascularization -- arterial -- with vein graft | \$713.70 | \$642.30@ | 42 | H |
| 505N | Revascularization -- venous | \$650.00 | \$584.95@ | 42 | H |
| 506N | Revascularization -- venous -- with graft | \$750.00 | \$674.95@ | 42 | H |

@ Payment approved for a physician with training and expertise in this section

SECTION O – Physical Medicine

Specialist in Physical Medicine

| | | Referred | Not Referred |
|--|---|-----------|--------------|
| Visits | | | |
| 30 | Complete assessment -- includes: a) pertinent family history; b) patient history, history of presenting complaint; c) functional enquiry; d) examination of all parts and systems; e) diagnosis; f) assessment; g) necessary treatment; h) advice to the patient; and, i) record of service provided. | \$92.00* | \$73.55* |
| 50 | Partial assessment or subsequent visit -- includes: a) history review; b) history of presenting complaint; 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. | \$82.00* | \$65.60* |
| 90 | Consultation – includes: a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; d) written submission of the consultant's opinion, and e) recommendations to the referring doctor. | \$195.80* | |
| 110 | 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. | \$107.00* | |
| 140 | Hospital Inpatient Consultation – includes: a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; d) written submission of the consultant's opinion, and e) recommendations to the referring doctor | \$271.70* | |
| * Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied. | | | |
| Case Conference | | | |
| 1. Must be a formal scheduled session. | | | |
| 2. 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. | | | |
| 3. The physician should keep appropriate documentation of time and place | | | |
| 420 | -- per conference (not patient) -- first 30 minutes or part thereof | \$95.00 | \$95.00 |
| 440 | -- add to 420 for each additional 15 minutes or part thereof | \$47.00 | \$47.00 |

SECTION O – Physical Medicine

Specialist in Physical
Medicine

Referred Not
Referred

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 250 | -- 1-10 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 260 | -- 11-20 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 270 | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 280 | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION P – Obstetrics & Gynecology

Specialist in Gynecology &
Obstetrics

Referred Not Referred

Visits

| | | | |
|-----|---|----------|----------|
| 5P | <p>Initial assessment -- of a specific condition includes:</p> <p>a) pertinent family history; f) diagnosis;</p> <p>b) patient history; g) assessment;</p> <p>c) history of presenting complaint; h) necessary treatment;</p> <p>d) functional enquiry; i) advice to the patient; and,</p> <p>e) examination of affected part(s) j) record of service provided. or system(s)</p> | \$56.00* | \$44.75* |
| 7P | <p>Follow-up assessment -- includes:</p> <p>a) history review; e) necessary treatment;</p> <p>b) functional enquiry; f) advice to the patient; and,</p> <p>c) examination; g) record of service provided.</p> <p>d) reassessment;</p> | \$31.75* | \$31.75* |
| 8P | <p>Pre-natal visit subsequent to a first visit under 5P for maternity care or post-natal office visit</p> | \$31.75 | \$31.75 |
| 9P | <p>Consultation – includes:</p> <p>a) all visits necessary;</p> <p>b) history and examination;</p> <p>c) review of laboratory and/or other data;</p> <p>d) written submission of the consultant's opinion, and</p> <p>e) recommendations to the referring doctor</p> | \$86.00* | |
| 11P | <p>Repeat consultation</p> <p>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.</p> <p>* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.</p> | \$41.90* | |
| 13P | <p>Interpretation of telephonic fetal monitoring by consultant with immediate response, per patient</p> | \$35.70 | \$28.55@ |

@ Payment approved for a physician with training and expertise in this section.

SECTION P – Obstetrics & Gynecology

Specialist in Gynecology &
Obstetrics

Referred Not
Referred

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25P | -- 1-10 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 26P | -- 11-20 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 27P | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28P | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION P – Obstetrics & Gynecology

Obstetrics

1. Payment for pre-natal care and post-natal 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 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 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 for 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 cesarean 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 cesarean section if provided.

3. When the patient is referred for a cesarean 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 specialty and clinic or another physician in the same locale:
 - 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 in-filtration or regional anesthesia, and repair of episiotomy);
 - f) services for the control of hemorrhage 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 - see section A - General Services.
6. To support and encourage family physicians to remain or become involved in obstetrics, a bonus of 25% will be paid in each fiscal year (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 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.

SECTION P – Obstetrics & Gynecology

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 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. | \$591.30 | \$591.30 | | |
| | 1. 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., fetal distress, failure to progress, the attending physician finds it necessary to call a consultant to deliver the patient | | | | |
| | 2. Please indicate on the claim the name of the consultant to whom the case was referred. | | | | |
| | Vaginal delivery and post-natal care in hospital -- reference item 4 in preamble | | | | |
| 40P | Vaginal delivery and post-natal care in hospital - specialist | \$609.30 | | | |
| 41P | Vaginal delivery and post-natal care in hospital - general practitioner | | \$609.30 | | |
| 46P | Cesarean section** -- any type and post-operative care | \$635.00 | \$635.00 | | M |
| 246P | Cesarean section** -- intrapartum, add | \$94.50 | \$94.50 | | |
| | ** Tubal resection and/or ligation performed for sterilization at the time of Cesarean Section is payable under 135P at 75% | | | | |
| 241P | Delivery of stillborn (claim only where a fetus was a minimum of 500 grams and/or had reached 20 weeks gestation) | \$615.00 | \$615.00 | | |
| 44P | Multiple pregnancy -- each additional child | \$148.00 | \$148.00 | | |
| 45P | Intrauterine manual separation and removal of retained placenta | \$118.00 | \$118.00 | 0 | M |
| 47P | Chemical induction or augmentation of labour -- payable once per delivery, add | \$37.90 | \$37.90 | | |
| 48P | Ectopic gestation – removal | \$510.00 | \$510.00 | 42 | M |
| 248P | Ectopic gestation salpingorrhaphy, embryectomy and salpingorrhaphy | \$550.00 | \$495.00 | 42 | M |
| 49P | Occlusive suture of cervix in pregnancy | \$208.00 | \$187.20 | 10 | M |
| 269P | Removal of occlusive suture of cervix -- office procedure | \$24.80 | \$24.80 | 0 | |
| 279P | Removal of occlusive suture of cervix -- hospital procedure under anesthesia | \$104.00 | \$104.00 | 0 | L |

SECTION P – Obstetrics & Gynecology

Specialist General
Practitioner

Complications of Pregnancy

1. Two of these codes may be paid per patient per pregnancy to one or two physicians.
2. If a third or subsequent code is requested there should be an accompanying explanation.

| | | | |
|------|--|----------|----------|
| 200P | Breech presentation -- delivered vaginally – add | \$125.00 | \$112.50 |
| 201P | Face or brow presentation -- delivered vaginally – add | \$81.70 | \$73.50 |
| 202P | Transverse or occiput posterior -- forceps extraction or vacuum extraction (excludes outlet or elective forceps) – add | \$88.60 | \$79.85 |
| 203P | Prolonged rupture of membranes for over 24 hours – add | \$82.50 | \$74.25 |
| 204P | Abruptio placenta – add | \$82.50 | \$74.25 |
| 205P | Placenta previa – add | \$82.50 | \$74.25 |
| 206P | Vaginal delivery following previous Cesarean section – add | \$110.00 | \$99.00 |
| 207P | Pregnancy - severe hypertension in pregnancy requiring pharmacological therapy and monitoring – add | \$106.00 | \$95.40 |
| 208P | Pharmacological suppression of premature labour – add | \$82.00 | \$73.80 |
| 209P | Repair of significant cervical laceration – add | \$86.00 | \$77.35 |
| 210P | Previous stillbirth after 20 weeks – add | \$82.00 | \$73.80 |
| 211P | Cephalic version under ultrasound control without tocolysis – add | \$64.85 | \$58.35 |
| 212P | Cephalic version under ultrasound control with tocolysis – add | \$93.60 | \$84.20 |
| 213P | Diabetes requiring insulin antepartum – add | \$82.00 | \$73.80 |
| 214P | IUGR (birth weight < 5th percentile) – add | \$82.00 | \$73.80 |
| 215P | Pregnancy and heart disease (New York Heart Association Class 3 or 4) – add | \$84.20 | \$75.85 |
| 216P | Pregnancy and pre-existing hypertension (on antihypertensive therapy before pregnancy) – add | \$82.00 | \$73.80 |
| 217P | Pregnancy and antiphospholipid antibody syndrome – add | \$81.20 | \$73.10 |
| 218P | Pregnancy and significant medical disease (Not listed above) requiring active concurrent management -- by report | \$82.00 | \$73.80 |

Payment Schedule for Insured Services Provided by a Physician

SECTION P – Obstetrics & Gynecology

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| 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. | | | | | |
| 50P | Therapeutic abortion -- first trimester - surgical | \$177.50 | \$177.50 | 42 | L |
| 250P | Therapeutic abortion -- second trimester - surgical | \$230.00 | \$207.00 | 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. | | | | | |
| 350P | Dilation and curettage (D&C) for incomplete or missed abortion | \$177.30 | \$177.30 | 42 | L |
| 51P | Intrauterine fetal transfusion | \$266.10 | \$239.50 | 10 | |
| 52P | Repair of fourth degree tear following delivery | \$193.00 | \$173.65 | 42 | L |
| 54P | Repair of 3rd degree tear following delivery or secondary repair of episiotomy | \$95.50 | \$85.95 | 10 | L |
| Note: Repair of episiotomy is included in the delivery fee. | | | | | |
| 53P | Replacement of inverted uterus | \$187.60 | \$168.80 | 42 | L |
| 55P | Insertion of intrauterine pressure catheter | \$30.25 | \$30.25 | D | |
| 258P | Transvaginal fetal scalp blood sampling -- payable twice per pregnancy | \$63.00 | \$63.00 | D | |
| 57P | Amniotic tap -- trans-abdominal -- second trimester | \$86.70 | \$86.70 | D | |
| 58P | Amniotic tap -- trans-abdominal -- third trimester | \$62.90 | \$62.90 | D | |
| 59P | Fetoscopy -- including fetal blood sample, cell harvest or amniocentesis | \$163.60 | \$147.25 | D | |
| Non stress test – in office -- if equipment owned by physician | | | | | |
| 260P | Non stress test -- first fetus | \$37.60 | \$33.80 | D | |
| 261P | Non stress test -- second and subsequent per fetus in cases of multiple gestations | \$28.00 | \$25.25 | D | |
| Gynecology | | | | | |
| 30P | Vaginal sperm examination | \$20.20 | \$20.20 | D | |
| 338P | Sperm washing prior to insemination -- performed in physician's own office | \$36.70 | \$36.70 | 0 | |
| 31P | Tubal insufflation or hysterosalpingogram or sonohysterogram -- Rubins (bilateral) | \$53.20 | \$51.70 | D | L |
| 32P | Pelvic examination under anesthesia -- when only procedure done | \$68.25 | \$68.25 | D | L |
| 34P | Culdoscopy or laparoscopy* -- with or without biopsy | \$186.80 | \$168.05 | D | M |
| 35P | Culdoscopy or laparoscopy* -- with division of adhesions or cauterly for endometriosis with or without peritoneal lavage | \$253.00 | \$227.65 | 10 | M |
| * Laparoscopy not paid with laparoscopic surgery unless it precedes the surgery as a diagnostic procedure | | | | | |

Payment Schedule for Insured Services Provided by a Physician

SECTION P – Obstetrics & Gynecology

| | | Specialist | General Practitioner | Class | Anes |
|---------------|---|------------|----------------------|-------|------|
| 334P | Hysteroscopy, with or without D & C, with or without other intrauterine procedures @ with approved training | \$120.50 | \$108.45@ | D | L |
| 335P | Endometrial ablation | \$353.60 | \$318.20 | 42 | M |
| 336P | Excision of endometrial polyps and/or fibroids -- add to 334P or 335P only | \$70.80 | \$70.80 | 42 | L |
| 232P | Hysteroscopic division of uterine septum | \$295.20 | \$265.75 | 42 | L |
| 233P | Fallopian tube cannulation by hysteroscopy, unilateral or bilateral | \$226.30 | \$203.70 | 42 | L |
| 36P | Hydrotubation | \$33.70 | \$33.70 | 0 | L |
| 37P | Colposcopy -- not in office | \$32.80 | \$32.80 | D | L |
| 38P | Colposcopy -- with biopsy -- not in office | \$39.80 | \$39.80 | D | L |
| 438P | Colposcopy -- in office | \$39.60 | \$39.60 | D | |
| 439P | Colposcopy -- with biopsy - in office | \$46.60 | \$46.60 | D | |
| 39P | Endometrial tissue biopsy by aspiration | \$33.05 | \$33.05 | D | L |
| 314P | Menopausal gonadotropin therapy, add to appropriate visit fee -- initial set-up per treatment cycle | \$79.00 | \$71.05 | | |
| 315P | Menopausal gonadotropin therapy, add to appropriate visit fee -- subsequent injections | \$26.40 | \$23.75 | | |
| Vulva | | | | | |
| 60P | Hymenectomy (in hospital -- general Anesthetic) | \$81.20 | \$81.20 | 0 | L |
| 61P | Bartholin cyst -- incision | \$41.00 | \$41.00 | 10 | L |
| 78P | Bartholin cyst -- marsupialization | \$118.65 | \$118.65 | 42 | L |
| 62P | Bartholin cyst -- excision | \$150.00 | \$150.00 | 42 | L |
| 63P | Skene's glands -- cautery or excision | \$54.50 | \$54.50 | 10 | L |
| 65P | Urethra -- caruncle -- cautery | \$34.20 | \$34.20 | 0 | L |
| 66P | Urethra -- caruncle -- excision | \$118.30 | \$118.30 | 10 | L |
| 67P | Urethra -- caruncle -- diverticulum -- repair | \$237.80 | \$213.95 | 42 | L |
| 68P | Urethra -- caruncle -- prolapse -- repair | \$129.50 | \$116.50 | 42 | L |
| 69P | Correction of atresia of vulva | \$133.90 | \$120.55 | 42 | L |
| 70P | Vulvectomy | \$461.70 | \$415.50 | 42 | M |
| 71P | Vulvectomy -- with bilateral inguinal node excision | \$693.30 | \$623.90 | 42 | M |
| 72P | Vulvectomy -- with bilateral inguinal and pelvic node excision | \$827.80 | \$745.30 | 42 | M |
| 73P | Surgical denervation of vulva for pruritus vulvae | \$124.70 | \$112.25 | 42 | L |
| Vagina | | | | | |
| 80P | Dilatation of vagina under general anesthesia or IV sedation (includes post-op recovery) | \$53.00 | \$53.00 | 0 | L |
| 81P | Colpotomy | \$133.70 | \$133.70 | 42 | L |
| 82P | Fistula -- recto-vaginal -- repair | \$343.40 | \$309.00 | 42 | M |
| 83P | Fistula -- urethro-vaginal -- repair | \$339.10 | \$305.65 | 42 | M |
| 84P | Fistula -- vesico-vaginal -- repair | \$1,066.50 | \$959.85 | 42 | M |

SECTION P – Obstetrics & Gynecology

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 85P | Vaginal cysts -- inclusion – removal | \$82.00 | \$82.00 | 10 | L |
| 86P | Vaginal cysts -- congenital – removal | \$133.70 | \$120.40 | 42 | L |
| 87P | Vaginal atresia -- plastic reconstruction | \$342.20 | \$308.00 | 42 | L |
| 88P | Vaginectomy | \$663.70 | \$597.30 | 42 | M |
| 89P | Excision of vaginal septum | \$135.00 | \$121.55 | 10 | L |
| | Genital Prolapse | | | | |
| 90P | Colporrhaphy -- anterior or posterior | \$274.50 | \$274.50 | 42 | L |
| 91P | Colporrhaphy – repeat | \$295.20 | \$265.65 | 42 | L |
| 105P | Paravaginal repair (alternative to anterior repair) | \$287.00 | \$258.25 | 42 | L |
| 92P | Paravaginal repair -- anterior and posterior | \$361.00 | \$361.00 | 42 | L |
| 93P | Paravaginal repair -- repeat | \$381.00 | \$342.95 | 42 | L |
| 193P | Mesh augmented prolapse repair | \$277.60 | \$245.00 | 42 | L |
| 96P | Vaginal vault prolapse – repair | \$371.50 | \$334.35 | 42 | L |
| 97P | Enterocoele repair | \$316.50 | \$284.85 | 42 | L |
| 98P | LeFort operation | \$228.80 | \$205.95 | 42 | L |
| 99P | Manchester operation | \$278.30 | \$250.50 | 42 | L |
| 100P | Third degree laceration (old) repair | \$236.80 | \$213.15 | 42 | L |
| 101P | Urethra -- suspension procedure – initial | \$374.20 | \$336.70 | 42 | L |
| 103P | Urethra -- suspension procedure – repeat after 42 days | \$413.90 | \$372.50 | 42 | L |
| 102P | Urethra -- pubo vaginal sling | \$530.00 | \$477.00 | 42 | L |
| 104P | Abdominosacrocolpopexy | \$535.20 | \$481.70 | 42 | M |
| | Cervix and Uterus | | | | |
| 108P | Artificial insemination, per insemination | \$37.20 | \$37.20 | 0 | |
| 109P | Cryoconization or loop diathermy of cervix | \$81.50 | \$73.45 | 0 | L |
| 110P | Cervix -- biopsy with or without electro-cauterization | \$27.35 | \$27.35 | D | L |
| 111P | Cervix -- electro-cauterization | \$13.60 | \$13.60 | 0 | L |
| 112P | Cervix -- polyp -- removal -- with or without electro-cauterization | \$27.40 | \$27.40 | 0 | L |
| 113P | Cervix -- conization with D and C, with or without deep cautery, with or without polyp removal | \$193.00 | \$173.65 | 10 | L |
| 114P | Cervix -- biopsy – excision | \$37.05 | \$37.05 | 10 | L |
| 115P | Cervix -- repair or amputation | \$190.30 | \$171.25 | 42 | L |
| 116P | Removal of cervical stump – abdominal | \$264.40 | \$238.05 | 42 | M |
| 117P | Removal of cervical stump – vaginal | \$339.80 | \$305.75 | 42 | L |
| 118P | Dilatation and curettage | \$93.10 | \$93.10 | 0 | L |
| 228P | Insertion of brachytherapy stent/sleeve | \$203.90 | \$203.90 | 10 | L |
| 120P | Hysterotomy | \$366.00 | \$329.40 | 42 | M |

SECTION P – Obstetrics & Gynecology

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| | Hysterectomy – open -- not paid in addition to adnexal surgery | | | | |
| 122P | Hysterectomy -- subtotal | \$540.00 | \$486.10 | 42 | M |
| 123P | Hysterectomy -- total – abdominal | \$540.00 | \$486.10 | 42 | M |
| 124P | Hysterectomy -- total – vaginal | \$540.00 | \$486.10 | 42 | M |
| 125P | Hysterectomy -- total – Wertheim | \$980.00 | \$882.05 | 42 | H |
| | Hysterectomy -- laparoscopic or laparoscopic assisted -- not paid in addition to adnexal surgery | | | | |
| 126P | Hysterectomy -- subtotal or total -- includes 34P & 134P | \$672.00 | \$604.75 | 42 | M |
| 130P | Conservative surgery for endometriosis includes presacral neurectomy | \$381.10 | \$343.00 | 42 | M |
| 131P | Myomectomy by laparotomy, laparoscopy or hysteroscopy a) Single or multiple; b) Not paid in addition to adnexal surgery; and c) If done by hysteroscopy, then hysteroscopy and other intrauterine procedures are included. | \$381.10 | \$343.00 | 42 | M |
| 132P | Uteroplasty | \$495.50 | \$445.90 | 42 | M |
| 133P | Uterus – suspension | \$281.70 | \$253.55 | 42 | M |
| 134P | Salpingectomy and/or oophorectomy and/or ovarian cystectomy a) Unilateral or bilateral; and b) When second ovary requires cystectomy, the surgery on the contralateral side may be paid at 75% by report. | \$409.30 | \$409.30 | 42 | M |
| 135P | Tubal resection and/or ligation for sterilization a) Unilateral or bilateral; and b) Payable at 75 %, by report when performed as a second and unrelated procedure at the time of other gynecological surgery in which fertility would otherwise be preserved. | \$250.00 | \$250.00 | 42 | M |
| | Salpingostomy -- not paid in addition to other adnexal surgery | | | | |
| 236P | Salpingostomy – unilateral | \$410.00 | \$369.05 | 42 | M |
| 237P | Salpingostomy – bilateral | \$485.40 | \$436.85 | 42 | M |
| 238P | Salpingo-utero-ovario-lysis -- not paid in addition to other adnexal surgery, unilateral or bilateral | \$406.20 | \$365.65 | 42 | M |
| 138P | Broad ligament cyst enucleation - not paid in addition to other adnexal surgery | \$371.50 | \$334.35 | 42 | M |
| 139P | Ovarian suspension or neurectomy - not paid in addition to other adnexal surgery | \$280.40 | \$280.40 | 42 | M |
| 140P | Tubal ligation through laparoscope -- unilateral or bilateral | \$250.00 | \$250.00 | 42 | M |
| 141P | Hysteroscopic sterilization by tubal occlusion (Essure) | \$247.70 | \$222.90 | 42 | M |
| 142P | Omentectomy - when done in addition to 123P or 134P in cases of malignancy, add | \$102.00 | \$102.00 | 42 | M |
| 143P | Reconstruction of fallopian tubes following pathological occlusion - unilateral (second tube is payable at 75%) | \$504.30 | \$453.80 | 42 | M |

SECTION P – Obstetrics & Gynecology

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| 150P | Laser vaporization -- cervix -- full circumference | \$122.60 | \$110.35 | 10 | L |
| 151P | Laser vaporization -- intraepithelial neoplasia of vulva, vagina or cervical segment | \$101.50 | \$91.35 | 0 | L |
| 251P | Laser vaporization - extensive -- vulva and/or vagina and/or cervix 1. For laser therapy of venereal warts (time 30 minutes or less) use 422R. 2. Claim 150P and 422R for circumferential laser ablation of cervix for CIN plus removal of genital warts. 3. Claims for 251P for CIN and/or venereal warts (over 30 minutes) are payable at \$4.00 per minute. | By report | | 10 | L |
| 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. | \$60.00 | \$60.00 | | |
| 581P | Obstetrics and Gynecology supplement for patients with a body mass index, (weight[kg]/height[m] 2) greater than 50. | \$88.50 | \$88.50 | | |
| Obstetrics and Gynecology 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, 233P, 236P, 237P, 238P, 241P, 248P, 250P, 251P, 258P, 269P, 279P, 334P, 335P, 350P, 438P and 439P. | | | | | |
| a) Maximum of one (1) 580P or 581P supplement per patient per day. | | | | | |
| b) Codes 580P and 581P cannot be billed together. | | | | | |

SECTION Q – Neurology

Specialist in Neurosurgery

Referred Not Referred

Visits

3Q **Complete assessment** -- includes: \$80.30* \$64.20*

| | |
|--|--------------------------------|
| a) pertinent family history; | f) diagnosis; |
| b) patient history; | g) assessment; |
| c) history of presenting complaint; | h) necessary treatment; |
| d) functional enquiry; | i) advice to the patient; and, |
| e) examination of all parts & systems; | j) record of service provided. |

5Q **Partial assessment or subsequent visit** -- includes: \$77.30* \$53.30*

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

9Q **Consultation** – includes: \$160.70*

| |
|--|
| a) all visits necessary; |
| b) history and examination; |
| c) review of laboratory and/or other data; |
| d) written submission of the consultant's opinion, and |
| e) recommendations to the referring doctor. |

11Q **Repeat consultation** \$85.60*

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.

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25Q | -- 1-10 days | -- per day -- bill units (max 10) | \$32.00 | \$32.00 |
| 26Q | -- 11-20 days | -- per day -- bill units (max 10) | \$31.00 | \$31.00 |
| 27Q | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28Q | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION Q – Neurology

| | | Specialist | General Practitioner | Class |
|--|--|------------|----------------------|-------|
| 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. | | | | |
| 101Q | Manual muscle testing – complete | \$20.40 | \$18.40 | D |
| 102Q | Manual muscle testing – regional | \$8.00 | \$7.10 | D |
| 103Q | Major myoneural study - complete - 11 or more units* | \$76.50 | \$69.30 | D |
| 104Q | Minor myoneural study - 6 to 10 units* | \$51.00 | \$45.90 | D |
| 105Q | Limited study 1 to 5 units* | \$36.00 | \$32.35 | D |
| * 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 | \$15.30 | \$13.80 | D |
| 107Q | Repetitive nerve stimulation of 2 or more muscles | \$38.70 | \$34.90 | D |
| 108Q | Blink reflex bilateral stimulation of facial nerve with ipsilateral and contralateral recording of blink reflex | \$20.40 | \$18.40 | D |
| 109Q | Technical fee for physician performance of nerve conduction studies and/or EMG only. For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”. | \$32.00 | \$32.00 | D |
| 110Q | Complex study - add to appropriate procedure or technical code -- requires explanation (e.g. ICU neuromuscular assessment) | \$20.40 | \$20.40 | D |
| 120Q | Ischemic or Non-Ischemic forearm test -- professional component | \$152.90 | \$137.60 | D |
| Organ Donor Assessment | | | | |
| 140Q | Certification of brain death and organ donor assessment by specialist with appropriate training, following health authority protocols | \$148.40 | \$133.65 | |
| 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 | \$73.60 | \$66.25 | |

SECTION R – Urological Surgery

Specialist in Urological Surgery

Referred Not Referred

Visits

5R **Initial assessment** -- of a specific condition includes: \$55.40* \$44.30*

| | |
|--|--------------------------------|
| a) pertinent family history; | f) diagnosis; |
| b) patient history; | g) assessment; |
| c) history of presenting complaint | h) necessary treatment; |
| d) functional enquiry; | i) advice to the patient; and, |
| e) examination of affected part(s) or system(s); | j) record of service provided. |

7R **Follow-up assessment** -- includes: \$35.30* \$31.70*

| | |
|------------------------|--------------------------------|
| a) history review; | e) necessary treatment; |
| b) functional enquiry; | f) advice to the patient; and, |
| c) examination; | g) record of service provided. |
| d) reassessment; | |

9R **Consultation** – includes: \$82.90*

- a) all visits necessary;
- b) history and examination;
- c) review of laboratory and/or other data;
- d) written submission of the consultant's opinion, and
- e) recommendations to the referring doctor

11R **Repeat consultation** \$42.30*

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.

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25R | -- 1-10 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 26R | -- 11-20 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 27R | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28R | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION R – Urological Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 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 | \$42.40 | \$33.90@ | | |
| | @ Payment approved for a physician with training and expertise in this section | | | | |
| | 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. | | | | |
| 29R | Diagnostic bladder catheterization -- in office procedure | \$8.35 | \$8.35 | D | L |
| 30R | Cystoscopy | \$108.80 | \$97.90 | D | L |
| 31R | Cystoscopy -- with bilateral ureteral catheterization or retrograde pyelography | \$135.00 | \$121.55 | D | L |
| 33R | Cystoscopy -- split function renal study with interpretation | \$140.70 | \$126.40 | D | L |
| 38R | Cystoscopy -- voiding cystourethrogram in operating room, add | \$34.10 | \$34.10 | D | L |
| 35R | Seminal fluid analysis -- count, motility, morphology -- bill units | \$21.80 | \$21.80 | D | |
| 36R | Prostatic secretion (microscopic examination) | \$4.60 | \$4.20 | D | |
| 39R | Assessment of penile and/or testicular blood flow and/or varicocele, including measurement of penile blood pressure | \$14.70 | \$14.70 | D | |
| | Urodynamics Investigations For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | |
| 400R | Cystometrogram -- technical component | \$41.10 | \$41.10 | D | |
| 500R | Cystometrogram -- technical component using disposable catheter | \$71.75 | \$71.75 | D | |
| 401R | Cystometrogram -- professional component | \$61.75 | \$61.75 | D | |
| 402R | Electromyography -- technical component | \$38.80 | \$38.80 | D | |
| 403R | Electromyography -- professional component | \$95.60 | \$95.60 | D | |
| 404R | Urethral pressure profile -- technical component | \$41.25 | \$41.25 | D | |
| 405R | Urethral pressure profile -- professional component | \$61.75 | \$61.75 | D | |
| 406R | Uroflow -- technical component | \$13.50 | \$13.50 | D | |
| 407R | Uroflow -- professional component | \$27.70 | \$27.70 | D | |
| | Venereal warts -- either sex Electrocoagulation or chemocoagulation of venereal warts -- includes treatment with Podophyllin | | | | |
| 420R | Venereal warts -- initial | \$109.10 | \$109.10 | 0 | |
| 421R | Venereal warts -- repeat within 10 days | \$33.80 | \$33.80 | 0 | |
| 422R | Venereal warts -- operation -- in hospital | \$109.80 | \$109.80 | 10 | L |
| | Endoscopic | | | | |
| 40R | Fulguration or biopsy of bladder -- tumors and/or other lesions | \$173.70 | \$156.35 | 42 | L |
| 41R | Transurethral -- lithopexy | \$443.80 | \$399.35 | 42 | L |
| 42R | Transurethral -- removal of ureteral stone by manipulation | \$276.30 | \$248.70 | 42 | L |
| 43R | Periurethral injection of Teflon for incontinence -- includes cystoscopy | \$276.30 | \$248.70 | 10 | L |
| 44R | Bladder tumor resection | \$518.10 | \$466.25 | 42 | M |

SECTION R – Urological Surgery

| | | Specialist | General Practitioner | Class | Anes |
|-----|--|------------|----------------------|-------|------|
| 46R | Secondary hemorrhage -- endoscopic treatment -- exempt from repeat surgical rule | \$173.70 | \$156.35 | 42 | L |
| 47R | Bladder neck resection | \$411.40 | \$370.25 | 42 | L |
| 48R | Resection of ureterocele | \$173.70 | \$156.35 | 42 | L |
| 49R | Resection of posterior urethral valve | \$371.50 | \$334.35 | 42 | L |
| 50R | Ureteroscopy -- with or without biopsy (includes cystoscopy) | \$513.90 | \$462.45 | D | L |
| 51R | Ureteroscopy -- with removal of stone (includes cystoscopy) | \$687.60 | \$618.80 | 42 | |
| 52R | Ureteroscopy -- with ultrasonic disintegration add to 51R | \$87.60 | \$78.85 | 42 | |
| 53R | Uteroplasty -- endoscopic with balloon dilation of ureteric stricture with or without stent not billable with 51R | \$326.60 | \$293.95 | 0 | L |
| | Penis | | | | |
| 59R | Incisional biopsy of glans penis | \$74.50 | \$74.50 | 10 | L |
| 60R | Penis -- amputation | \$821.60 | \$739.45 | 42 | M |
| 61R | Penis -- amputation -- with excision (radical) of node | \$1,204.00 | \$1,083.70 | 42 | M |
| 62R | Penis -- partial amputation | \$687.60 | \$618.80 | 42 | M |
| 37R | Intra-penile vasoactive injection, each to a max of 2 units per day | \$13.90 | \$13.90 | 0 | |
| 71R | Intralesional Verapamil injection for Peyronie's plaque - Not billable in multiples, only one treatment/service is billable per patient contact | \$85.00 | \$76.50 | 10 | L |
| | Circumcision (routine circumcision is not insured) | | | | |
| 65R | Circumcision -- without anesthesia | \$118.20 | \$118.20 | 0 | |
| 66R | Circumcision -- under anesthesia -- child | \$266.90 | \$266.90 | 42 | L |
| 67R | Circumcision -- under anesthesia -- adult | \$266.90 | \$266.90 | 42 | L |
| 68R | Dorsal slit or preputial adhesiolysis under EMLA | \$135.00 | \$135.00 | 0 | L |
| | Urethra | | | | |
| 69R | Urethra -- meatotomy -- with plastic repair | \$95.10 | \$85.55 | 10 | L |
| 70R | Urethra -- dilation | \$68.50 | \$68.50 | 0 | L |
| 73R | Urethra -- surgical repair anterior urethral rupture | \$687.60 | \$618.80 | 42 | L |
| 74R | Urethra -- repair posterior -- primary repair including suprapubic cystotomy | \$911.40 | \$820.30 | 42 | M |
| 79R | Repeat repair of anterior or posterior urethral rupture or stricture (related to 73R or 74R) | \$894.10 | \$804.40 | 42 | L |
| 80R | Urethral stent for prostatic hypertrophy or stricture - includes cystoscopy | \$293.60 | \$264.30 | 42 | L |
| 75R | Urethrotomy | \$207.30 | \$186.55 | 42 | L |
| 76R | Removal of foreign body from urethra | \$185.30 | \$166.70 | 10 | L |
| 77R | Urethral diverticulectomy | \$548.40 | \$493.60 | 42 | L |
| 78R | Urethrocutaneous fistula -- repair | \$614.30 | \$552.90 | 42 | L |

SECTION R – Urological Surgery

| | | Specialist | General Practitioner | Class | Anes |
|-----------------|--|------------|----------------------|-------|------|
| Bladder | | | | | |
| 89R | Chemotherapeutic bladder irrigation for treatment of malignancy or of interstitial cystitis | \$68.50 | \$61.60 | 0 | L |
| 189R | Bladder hydrodistension for patients with interstitial cystitis or clinical presentation strongly suggestive of interstitial cystitis -- payable in addition to cystoscopy | \$68.50 | \$61.60 | 0 | L |
| 90R | Cystotomy -- with trochar | \$172.70 | \$172.70 | 10 | L |
| 91R | Cystotomy -- with removal of stone, foreign body, etc. | \$443.80 | \$399.35 | 42 | L |
| 92R | Cystotomy -- excision, electro-resection or fulguration of bladder tumor with or without radiation implants | \$306.90 | \$276.20 | 42 | L |
| 93R | Cystectomy -- partial | \$687.60 | \$618.80 | 42 | M |
| 94R | Cystectomy -- partial with ureteral reimplantation | \$968.10 | \$871.30 | 42 | M |
| 95R | Cystectomy -- total -- with ureterointestinal transplant | \$2,303.60 | \$2,073.35 | 42 | H |
| 96R | Cystectomy -- with ureteroileal conduit | \$3,433.00 | \$3,089.70 | 42 | H |
| 97R | Cystectomy -- with rectal bladder and colostomy | \$2,805.70 | \$2,525.30 | 42 | H |
| 100R | Diverticulectomy | \$825.80 | \$743.15 | 42 | M |
| 101R | Resection ureteral stump | \$493.00 | \$443.70 | 42 | L |
| 102R | Ileocystoplasty | \$2,059.80 | \$1,853.75 | 42 | H |
| 103R | Surgical repair of ruptured bladder | \$687.60 | \$618.80 | 42 | M |
| 104R | Ureterocutaneous anastomosis -- unilateral | \$391.50 | \$352.70 | 42 | M |
| 105R | Ureterocutaneous anastomosis -- bilateral | \$577.80 | \$520.20 | 42 | M |
| 106R | Ileal conduit | \$1,714.30 | \$1,542.85 | 42 | H |
| 109R | Bladder neck plasty | \$647.90 | \$583.10 | 42 | M |
| 110R | Insertion of artificial urinary sphincter | \$948.30 | \$853.45 | 42 | M |
| Prostate | | | | | |
| 120R | Prostate -- abscess -- incision | \$144.40 | \$144.40 | 42 | L |
| 121R | Prostate -- biopsy -- needle | \$89.20 | \$80.25 | D | L |
| 122R | Open perineal prostatic biopsy | \$562.80 | \$506.70 | 42 | L |
| 126R | Ultrasound guided prostate biopsy | \$135.60 | \$122.00 | D | L |
| 123R | Prostatectomy -- or laser ablation | \$687.60 | \$618.80 | 42 | M |
| 124R | Radical prostatectomy -- excludes exploration and biopsy of pelvic lymph nodes | \$2,059.80 | \$1,853.75 | 42 | H |
| 125R | Seminal vesiculectomy | \$933.20 | \$839.85 | 42 | M |

SECTION R – Urological Surgery

| | | Specialist | General Practitioner | Class | Anes |
|-----------------------------|---|------------|----------------------|-------|------|
| Kidney and Ureter | | | | | |
| 130R | Kidney -- rupture -- repair | \$1,171.10 | \$1,053.95 | 42 | H |
| 131R | Renal biopsy -- percutaneous -- unilateral | \$127.40 | \$114.70 | D | L |
| 133R | Renal biopsy -- open exposure | \$430.10 | \$387.20 | 42 | M |
| 134R | Perinephric abscess -- drainage | \$476.20 | \$428.55 | 42 | M |
| 135R | Exploration of kidney -- not paid in addition to renal surgery | \$647.90 | \$583.10 | 42 | M |
| 136R | Nephrectomy -- complete or partial | \$1,372.20 | \$1,234.95 | 42 | H |
| 138R | Nephrectomy -- thoraco-abdominal radical nephrectomy | \$1,645.30 | \$1,480.75 | 42 | H |
| 139R | Nephrolithotomy or nephrotomy, pyelolithotomy or pyelotomy | \$944.10 | \$849.65 | 42 | M |
| 140R | Nephropexy -- not paid in addition to renal surgery | \$286.70 | \$258.45 | 42 | M |
| 141R | Nephrostomy or pyelostomy and ureterostomy | \$687.60 | \$618.80 | 42 | M |
| 142R | Ileal substitution for ureter | \$1,400.80 | \$1,261.10 | 42 | H |
| 143R | Exploration ureter for lesion or trauma in conjunction with or for other surgeons | \$489.80 | \$440.85 | 42 | M |
| 144R | Plastic -- renal pelvis and/or ureter | \$1,235.00 | \$1,111.50 | 42 | M |
| 145R | Ureterolysis or pelviolysis | \$689.80 | \$620.80 | 42 | M |
| 146R | Ureterolithotomy -- upper 2/3 | \$663.00 | \$596.65 | 42 | M |
| 147R | Ureterolithotomy -- lower 1/3 | \$635.30 | \$571.85 | 42 | M |
| 158R | Ureterolithotomy -- following previous ureteral surgery | \$642.30 | \$578.10 | 42 | M |
| 148R | Resection of ureterovesical junction | \$493.00 | \$443.70 | 42 | M |
| 149R | Horseshoe symphysiotomy | \$616.80 | \$555.60 | 42 | M |
| 150R | Hypothermia to kidney, add | \$46.60 | \$46.60 | 42 | |
| 151R | Ureteroneocystostomy -- single | \$894.90 | \$805.40 | 42 | M |
| 152R | Ureteroneocystostomy -- bilateral | \$1,114.70 | \$1,003.20 | 42 | M |
| 153R | Repair of ureteral fistula | \$841.50 | \$757.30 | 42 | M |
| 154R | Intubated ureterotomy and/or ureterolysis | \$670.70 | \$603.60 | 42 | M |
| 155R | Renal cyst -- excision of -- single or multiple -- one kidney | \$687.60 | \$618.80 | 42 | M |
| 156R | Nephrostomy tube -- routine change | \$25.90 | \$25.90 | 0 | L |
| 157R | Nephrostomy tube -- emergency reinsertion | \$57.50 | \$51.75 | 0 | L |
| 258R | Ureteral stent -- placement -- unilateral | \$178.90 | \$161.05 | 10 | L |
| 259R | Ureteral stent -- replacement | \$178.90 | \$161.05 | 10 | L |
| 659R | Ureteral stent -- removal | \$132.90 | \$119.55 | 0 | L |
| Scrotum and Contents | | | | | |
| 160R | Open testicular biopsy | \$135.00 | \$121.55 | 0 | L |
| 161R | Epididymectomy -- unilateral | \$419.70 | \$377.70 | 42 | L |
| 162R | Hydrocele or epididymal cyst -- aspirate | \$33.80 | \$33.80 | 0 | L |
| 163R | Hydrocele or epididymal cyst -- surgical repair | \$288.90 | \$288.90 | 42 | L |
| 164R | Varicocele -- repair | \$341.20 | \$341.20 | 42 | L |
| 165R | Varicocele -- with exploration of inguinal canal | \$341.20 | \$341.20 | 42 | L |
| 166R | Orchidectomy -- unilateral | \$175.90 | \$175.90 | 42 | L |
| 167R | Orchidectomy -- bilateral | \$341.20 | \$341.20 | 42 | L |

SECTION R – Urological Surgery

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 168R | Retroperitoneal exploration for testicle | \$504.50 | \$454.10 | 42 | M |
| 169R | Orchidopexy -- unilateral -- Includes simple herniotomy -- herniorrhaphy paid in addition | \$614.30 | \$552.90 | 42 | L |
| 170R | Orchidolysis | \$46.50 | \$46.50 | 42 | L |
| 171R | Torsion -- testis or appendix testis with fixation of contralateral testis | \$559.90 | \$559.90 | 42 | L |
| 180R | Orchidectomy with excision at internal ring -- unilateral | \$341.20 | \$307.00 | 42 | L |
| 190R | Vasectomy -- unilateral or bilateral | \$275.00 | \$275.00 | 42 | L |
| 191R | Vasovasostomy limited to the treatment of post vasectomy pain syndrome -- unilateral | \$784.90 | \$706.45 | 42 | L |
| 192R | Epididymovasostomy -- unilateral | \$565.10 | \$508.65 | 42 | L |
| 193R | Insertion of testicular prosthesis -- independent procedure | \$559.90 | \$559.90 | 42 | L |
| 194R | Vasogram -- unilateral or bilateral -- in conjunction with open scrotal procedure -- add | \$61.10 | \$61.10 | D | L |
| 195R | Vasogram -- unilateral or bilateral -- independent procedure | \$56.00 | \$56.00 | D | L |
| | Intra-abdominal | | | | |
| 202R | Exploration and biopsy of pelvic lymph nodes | \$687.40 | \$618.65 | 42 | M |
| 203R | Pelvic lymphadenectomy | \$1,028.90 | \$926.05 | 42 | M |
| | Percutaneous Nephrolithotripsy | | | | |
| 251R | Dilatation of nephrostomy tract -- add | \$135.00 | \$121.55 | 0 | |
| 252R | Nephroscopy through nephrostomy tract -- add | \$173.70 | \$156.35 | D | |
| | Removal of calculi by basket, ultrasonic disintegration or electrohydraulic lithotripsy | | | | |
| 253R | -- small -- single | \$411.40 | \$370.25 | 42 | M |
| 254R | -- multiple | \$687.60 | \$618.80 | 42 | M |
| 255R | -- large -- (greater than 2 cm.) | \$961.80 | \$865.60 | 42 | M |
| 256R | Extracorporeal Shockwave Lithotripsy (ESWL) -- unilateral | \$526.40 | \$473.75 | 42 | M |
| 580R | BMI Supplement - Urology surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height [m] 2) greater than 40 | \$58.90 | | | |
| | 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. | | | | |
| | 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 R – Urological Surgery

Specialist General Practitioner Class Anes

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 the Urological or Vascular surgeons, or Internists;
- b) Anesthetic services.

Donor nephrectomy -- living donor or cadaver

| | | | | | |
|------|--|------------|--|----|---|
| 300R | One surgeon | \$1,567.40 | | 42 | M |
| 301R | Two surgeons -- first | \$669.80 | | 42 | M |
| 311R | Two surgeons -- second | \$608.60 | | 42 | M |
| 302R | Renal perfusion | \$163.50 | | 0 | |
| 303R | Renal implantation -- urology component | \$545.40 | | 42 | M |
| 304R | Renal implantation -- vascular component | \$1,143.90 | | 42 | H |
| 340R | Intra-operative biopsy of donor kidney -- add | \$52.40 | | D | |
| 305R | Renal implantation -- Internist services – total, includes 306R and 307R | \$3,297.10 | | 42 | |
| 306R | Internist services in donor kidney procurement in other than the transplant center | \$208.00 | | 0 | |
| 307R | Internist services in the provision of renal implant and follow-up services | \$3,333.80 | | 42 | |
| 308R | Follow-up of renal implant patient | \$270.40 | | | |

308R is payable for a visit to provide assessment and ongoing management of a patient's condition following a kidney transplant.

- 1. This service is payable to the physician designated as the most responsible physician for monitoring the post-transplant status of the patient.
- 2. Not payable in addition to other visit services or dialysis, or within 42 days of the previous 308R
- 3. Limited to six 308R services per patient per year (beginning April 1 of each year)
- 4. Not payable in the first 12 months following a transplant

| | | | | | |
|------|--|------------|----------|----|---|
| 356R | Hypospadias -- first stage repair | \$364.00 | \$327.60 | 42 | L |
| 357R | Hypospadias -- second stage (urethroplasty) | \$518.90 | \$467.00 | 42 | L |
| 657R | Single stage hypospadias repair | \$1,066.50 | \$959.85 | 42 | L |
| 358R | Single stage hypospadias repair -- urethral fistula repair | \$151.90 | \$136.60 | 42 | L |
| 359R | Epispadias | \$314.00 | \$282.40 | 42 | L |

SECTION S – Ophthalmology

Specialist in Ophthalmology

Referred Not Referred

| | | Referred | Not Referred |
|-----|---|-----------|--------------|
| | Visits | | |
| 5S | Initial assessment -- of a specific condition includes: a) pertinent family history; f) diagnosis; b) patient history; g) assessment; c) history of presenting complaint; h) necessary treatment; d) functional enquiry; i) advice to the patient; and, e) examination of affected part(s) or system(s); j) record of service provided. | \$66.30* | \$53.00* |
| 7S | Follow-up assessment -- includes: a) history review; e) necessary treatment; b) functional enquiry; f) advice to the patient; and, c) examination; g) record of service provided. d) reassessment; | \$41.00* | \$35.30* |
| 8S | Neuro-ophthalmology follow-up assessment -- includes: a) history review; f) advice to the patient; and, b) functional enquiry; g) record of the service provided. c) examination; h) only payable to physicians with approved training in neuro-ophthalmology. d) reassessment; e) necessary treatment; | \$47.00* | \$42.30* |
| 9S | Consultation – includes: a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; d) written submission of the consultant's opinion, and e) recommendations to the referring doctor. | \$84.40* | |
| 10S | Neuro-ophthalmology consultation – includes: a) all visits necessary; b) history and examination; c) review of laboratory and/or other data; and, d) written submission of the consultant's opinion, and; e) recommendations to the referring doctor. f) only payable to physicians with approved training in neuro-ophthalmology. | \$125.40* | |
| 11S | 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. | \$44.90* | |
| 12S | Low vision assessment - limited to 1 benefit per beneficiary per 12-month period * Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied. | \$133.60* | |
| 6S | Routine examination of eyes (reference Item A, page 254) | \$69.30 | \$52.70 |

SECTION 5 – Ophthalmology

Specialist in Ophthalmology

Referred Not Referred

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit.

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25S | -- 1-10 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 26S | -- 11-20 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 27S | -- 21-30 days | -- per day -- bill units (max 10) | \$30.00 | \$30.00 |
| 28S | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$30.00 | \$30.00 |

SECTION 5 – Ophthalmology

Ophthalmology

A. 6S -- Routine examination of eyes:

Eligibility: Beneficiaries under 18, social assistance recipients nominated to receive Supplementary Health Benefits and adult recipients of the Family Health Plan and the Saskatchewan Income Plan Supplement.

1. means an examination of the eyes that shall include:
 - a) case history
 - b) visual acuity
 - c) external examination
 - d) assessment of extraocular muscles
 - e) convergence testing
 - f) pupil response
 - g) accommodation
 - h) examination of cornea, lens, media, fundus
 - i) determination of refractive error or change
 - j) instruction, information and advice to the patient with respect to the status of his/her or their vision
 - k) and its future management
 - l) provision of the necessary prescription
2. is restricted in the payment of the listed specialist fee; only a specialist in Ophthalmology or the combined specialty of Ophthalmology and Otolaryngology receives payment at the specialist fee when treating a referred patient. In all other instances, the "Not Referred" listing is paid.
3. is approved only once within a period of 12 consecutive months for individuals under 18 and eligible beneficiaries over 64 and within a period of 24 months for eligible beneficiaries between 18 and 64, for the same physician or clinic, unless:
 - a) the beneficiary was referred by a physician for the refraction; or,
 - b) Saskatchewan Health approved the second refraction on the basis of the reported medical factors; or,
 - c) change in the degree of refractive error which necessitated the current refraction. (Current and previous refractive changes should be indicated on the claim form or on a comment record of direct input claim).
4. Payment eligibility for 6S Routine Examination of eyes is limited to specialist ophthalmologists and to those physicians who are granted special licensure under Section 30 of The Medical Profession Act to engage in practice limited to ophthalmology.
5. Those physicians who have completed a full program of post-graduate ophthalmology, who restrict their practise to that discipline and who currently receive payment for ophthalmology services continue to be eligible to bill code 6S.

- B.** Payment for retinal detachment includes payment for light coagulation if performed as an adjunct to surgery or within the designated post-operative period, by the same physician, a general practitioner in the same clinic, or a specialist in the same specialty and clinic

SECTION S – Ophthalmology

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| 32S | Tension -- measured with a tonometer – bilateral | \$12.50 | \$12.50 | D | |
| 332S | Diurnal tension curve – bilateral | \$73.40 | \$66.10 | D | |
| 33S | Gonioscopy – bilateral | \$12.50 | \$12.50 | D | |
| 534S | Formal orthoptic assessment interpretation | \$30.00 | \$27.05 | D | |
| 580S | Corneal pachymetry (repeat by report only) – bilateral | \$8.15 | \$8.15 | D | |
| 15S | Cycloplegic retinoscopy -- under 11 years age | \$30.00 | \$30.00 | D | |
| 535S | Orthoptic technical fee | \$30.00 | \$30.00 | D | |
| | a) Bilateral | | | | |
| | b) Add to 5S, 6S, 7S, 9S, 10S, 11S, 12S, 534S | | | | |
| | c) For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”. | | | | |
| 651S | Automated perimetry/specular microscopy/topography | \$13.50 | \$13.50 | D | |
| | a) Technical fee | | | | |
| | b) Bilateral | | | | |
| | c) Add to 34S, 35S, 36S, 650S, 671S | | | | |
| | d) 1 per patient visit | | | | |
| | e) For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”. | | | | |
| 579S | Screening visual fields (FDT or Similar) | \$2.00 | \$2.00 | D | |
| | a) Technical fee | | | | |
| | b) Bilateral | | | | |
| | c) Limit of 1 per visit | | | | |
| | d) Only payable with 34S | | | | |
| | e) For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”. | | | | |
| Optical Coherence Tomography (OCT), bilateral | | | | | |
| Not to be used for routine screening of patients and limit of one per year (professional and technical) when billed for monitoring glaucoma patients. For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”. | | | | | |
| 581S | -- professional | \$25.50 | \$22.90 | D | |
| 582S | -- technical | \$25.50 | \$25.50 | D | |
| 34S | Screening visual field including tangent screen, auto plot arc perimetry and frequency doubling screening – bilateral | \$8.20 | \$8.20 | D | |
| 35S | Central threshold visual field – bilateral | \$19.40 | \$19.40 | | |
| 36S | Central and peripheral visual field – bilateral | \$39.80 | \$39.80 | D | |
| 422S | Manual static and kinetic perimetry – bilateral | \$39.80 | \$39.80 | D | |
| 37S | Provocative tests for glaucoma – bilateral | \$12.20 | \$12.20 | D | |
| 39S | Fundus examination under general anesthetic-- unilateral or bilateral | \$175.40 | \$175.40 | D | L |
| 424S | Forced Duction Test -- local | \$26.80 | \$26.80 | D | |
| 425S | Forced Duction Test -- general | \$47.70 | \$47.70 | D | L |

SECTION S – Ophthalmology

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| | Fundus or Slit Lamp Photography, bilateral | | | | |
| | For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | |
| 652S | -- professional component | \$6.10 | \$6.10 | D | |
| 653S | -- technical component | \$6.10 | \$6.10 | D | |
| | Fluorescein Angiography | | | | |
| | For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | |
| | a) Apparatus owned by physician and injection by physician. | | | | |
| | b) Use 111A if IV injection only by the physician | | | | |
| 40S | -- technical component | \$35.00 | \$35.00 | D | |
| 41S | -- professional component | \$55.00 | \$55.00 | D | |
| 42S | Visually evoked occipital response interpretation | \$15.00 | \$15.00 | D | |
| 43S | Electroretinography interpretation | \$37.00 | \$37.00 | D | |
| 44S | Electro-oculography interpretation | \$37.00 | \$37.00 | D | |
| | Color vision assessment - F.M. 100 Hue Test or Pickford Anomaloscope | | | | |
| | For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | |
| 45S | -- technical component | \$8.20 | \$8.20 | D | |
| 46S | -- professional component | \$16.30 | \$16.30 | D | |
| 650S | Contact or non-contact specular microscopy of corneal endothelium, unilateral, bill units -- professional component | \$22.40 | \$22.40 | D | |
| 429S | Laser Inferometry | \$5.50 | \$5.50 | D | |
| 430S | Potential Acuity Meter | \$2.10 | \$2.10 | D | |
| 656S | Exophthalmometry | \$6.10 | \$6.10 | D | |
| 658S | Dark adaptation curve, both eyes -- professional component | \$20.20 | \$20.20 | D | |
| 661S | Hess or Lees test | \$20.40 | \$20.40 | D | |
| 664S | Indirect ophthalmoscopy with scleral depression for complete | \$18.40 | \$18.40 | D | |
| 680S | Infrared pupillography – bilateral | \$21.20@ | \$19.10@ | D | |
| 681S | Eye movement videography/photography – bilateral | \$21.20@ | \$19.10@ | D | |
| 682S | Quantification of relative afferent pupillary defect with neural density | \$21.20@ | \$19.10@ | D | |
| 683S | Diagnostic pupillary drop testing – bilateral | \$26.50@ | \$23.90@ | D | |

@ Codes 680S to 683S are only billable by physicians with approved neuro-ophthalmology training

SECTION S – Ophthalmology

Specialist General Practitioner Class Anes

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.

Eyelids

| | | | | | |
|-----|--------------------|---------|---------|---|---|
| 60S | Abscess – incision | \$22.70 | \$22.70 | 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 | \$122.30 | \$110.10 | 10 | L |
| 62S | Blepharoplasty -- excision of skin and/or muscle, unilateral, lower lid | \$122.30 | \$110.10 | 10 | L |
| 276S | Blepharoplasty -- with orbital fat excision or repositioning, unilateral, upper lid | \$254.90 | \$229.40 | 42 | L |
| 277S | Blepharoplasty -- with orbital fat excision or repositioning, unilateral, lower lid | \$236.50 | \$213.10 | 42 | L |
| 63S | Chalazion -- removal | \$61.20 | \$61.20 | 10 | L |
| 64S | Chalazion – removal -- under general anesthetic or IV sedation (includes post-op recovery) | \$122.30 | \$122.30 | 10 | L |
| 65S | Cauterization – lid | \$20.40 | \$20.40 | 0 | L |

Trichiasis

| | | | | | |
|------|---|---------|---------|----|---|
| 66S | Epilation – unilateral | \$22.40 | \$22.40 | 0 | L |
| 431S | Electrolysis or laser ablation – unilateral | \$30.60 | \$30.60 | 10 | L |
| 432S | Cryotherapy – unilateral | \$60.50 | \$54.40 | 10 | L |

SECTION S – Ophthalmology

| | | Specialist | General Practitioner | Class | Anes |
|--|--|------------|----------------------|-------|------|
| Districhiasis | | | | | |
| 436S | Permanent repair -- per lid | \$242.60 | \$218.40 | 42 | L |
| 67S | Ziegler puncture | \$26.50 | \$26.50 | 10 | L |
| 68S | Tarsorrhaphy -- temporary or reversal | \$66.30 | \$59.60 | 10 | L |
| 69S | Tarsorrhaphy -- permanent -- double adhesion | \$163.10 | \$146.80 | 42 | L |
| 80S | Ectropion -- surgical repair | \$326.20 | \$293.60 | 42 | L |
| 81S | Entropion -- surgical repair | \$326.20 | \$293.60 | 42 | L |
| 75S | Ptosis -- simple repair | \$407.80 | \$367.00 | 42 | L |
| 439S | Ptosis -- complicated repair with graded tarsomeuller resection, add | \$96.90 | \$87.20 | 42 | L |
| 440S | Ptosis -- with fascia lata sling – add | \$96.90 | \$87.20 | 42 | L |
| 441S | Ptosis -- with levator excision – add | \$96.90 | \$87.20 | 42 | L |
| 442S | Ptosis -- with aponeurosis reinsertion – add | \$96.90 | \$87.20 | 42 | L |
| | Blepharoplasty included in the fees for ptosis repair | | | | |
| Lid Lengthening | | | | | |
| 444S | Graded meullerectomy | \$362.90 | \$326.60 | 42 | L |
| 445S | Graded meullerectomy -- with levator recession, add | \$61.20 | \$55.10 | 42 | L |
| 446S | Graded meullerectomy -- with scleral graft, add | \$61.20 | \$55.10 | 42 | L |
| 70S | Eyelid or Conjunctival Tumor - Excision – without sutures Excision – repair with sutures (use 380N) | \$51.00 | \$51.00 | 10 | L |
| 77S | Full thickness excision of benign or malignant tumor with plastic repair using conjunctiva | \$183.50 | \$165.20 | 42 | L |
| Lid Laceration (upon referral to Ophthalmologist) | | | | | |
| 72S | Lid Laceration -- simple repair | \$61.20 | \$61.20 | 10 | L |
| 448S | Lid Laceration -- full thickness | \$152.90 | \$137.60 | 42 | L |
| 449S | Lid Laceration -- full thickness -- lid margin | \$183.50 | \$165.20 | 42 | L |
| 454S | Lid Laceration -- full thickness plus levator division | \$242.60 | \$218.40 | 42 | L |
| 73S | Lid Laceration -- repair of canaliculus -- old or recent | \$407.80 | \$367.00 | 42 | L |
| 450S | Lid Defect -- closure with rotation flap | \$242.60 | \$218.40 | 42 | L |
| 451S | Lid Defect -- closure with rotation flap plus cantholysis – add | \$61.20 | \$55.10 | 42 | L |
| 452S | Lid Defect -- closure with temporal flap and cantholysis – add | \$163.10 | \$146.80 | 42 | L |
| 453S | Lid Defect -- closure with free posterior lamellar graft – add | \$138.70 | \$125.40 | 42 | L |
| 455S | Upper or lower eyelid bridge flap -- first stage | \$535.20 | \$481.70 | 42 | L |
| 456S | Upper or lower eyelid bridge flap -- second stage | \$91.80 | \$82.60 | 42 | L |
| 457S | Free composite eyelid graft | \$463.90 | \$418.00 | 42 | L |
| 458S | Medial canthoplasty | \$305.90 | \$275.30 | 42 | L |
| 459S | Medial canthal tendon injury -- repair | \$242.60 | \$218.40 | 42 | L |
| 460S | Medial canthal tendon injury -- with boney fixation – add | \$91.80 | \$82.60 | 42 | L |
| 461S | Medial or lateral cantholysis | \$123.40 | \$111.00 | 42 | L |
| 462S | Lateral canthopexy – primary | \$242.60 | \$218.40 | 42 | L |

Payment Schedule for Insured Services Provided by a Physician

SECTION S – Ophthalmology

| | | Specialist | General Practitioner | Class | Anes |
|---|--|------------|----------------------|-------|------|
| Lacrimal Tract | | | | | |
| 50S | Duct Probing -- local anesthesia | \$20.40 | \$20.40 | 0 | |
| 51S | Duct Probing -- general anesthesia | \$122.30 | \$122.30 | 0 | |
| 52S | Duct probing and insertion of plastic tube or similar method, total care | \$167.20 | \$150.50 | 10 | L |
| 464S | Duct probing -- with turbinate fracture, add | \$25.50 | \$25.50 | 0 | L |
| 466S | Tube change or reinsertion -- local or general after 10 days | \$61.20 | \$55.10 | 0 | L |
| 54S | Dacryocystectomy | \$201.90 | \$182.50 | 42 | L |
| 55S | Dacryocystorhinostomy | \$535.20 | \$481.70 | 42 | M |
| 468S | Dacryocystorhinostomy -- with lacrimal bypass or canalicular reconstruction, add | \$73.40 | \$66.10 | 42 | L |
| 469S | "Three Snip" procedure on punctum | \$73.40 | \$66.10 | 10 | L |
| 470S | Canaliculotomy | \$36.70 | \$36.70 | 0 | L |
| 471S | Closure of punctum by cautery -- unilateral or bilateral | \$73.40 | \$66.10 | 0 | L |
| 472S | Drainage of lacrimal sac abscess | \$62.50 | \$62.50 | 0 | L |
| 573S | Punctal Plugs - per punctum -- bill units (max 2) | \$66.30 | \$59.60 | 10 | |
| Extraocular Muscles | | | | | |
| Recession, resection, myotomy, myectomy, oblique weakening or strengthening | | | | | |
| 130S | -- first muscle | \$454.70 | \$409.20 | 42 | M |
| 131S | -- second muscle -- either eye | \$339.50 | \$305.50 | 42 | M |
| 132S | -- any additional muscle (s) -- either eye | \$117.20 | \$105.50 | 42 | M |
| 133S | -- adjustable suture technique per muscle | \$254.90 | \$229.40 | 42 | M |
| 134S | -- two muscle transposition procedure | \$816.60 | \$735.00 | 42 | M |
| Corneal collagen cross-linking | | | | | |
| For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | | |
| 690S | -- professional fee | \$543.40 | \$489.10 | 42 | L |
| 691S | -- technical fee | \$509.80 | \$509.80 | | L |
| Conjunctiva – Cornea – Sclera | | | | | |
| 88S | Removal of corneal tattooing | \$69.40 | \$62.50 | 10 | L |
| 89S | Biopsy of conjunctiva | \$42.80 | \$42.80 | D | L |
| 90S | Foreign body or bodies -- removal -- unembedded | \$20.50 | \$20.50 | 0 | L |
| 91S | Foreign body or bodies -- removal -- embedded - local anesthesia | \$34.20 | \$30.80 | 0 | L |
| 106S | Foreign body or bodies -- removal -- general anesthesia | \$113.20 | \$101.80 | 10 | L |
| 671S | Corneal topography - interpretation fee (only for corneal pathology i.e. not billable for refractive surgical assessments) unilateral or bilateral | \$26.50 | \$23.90 | D | L |
| 92S | Keratotomy – superficial | \$367.00 | \$330.30 | 42 | L |
| 93S | Keratoplasty – lamellar | \$560.70 | \$504.70 | 42 | L |
| 94S | Keratoplasty – penetrating | \$1,014.40 | \$913.00 | 42 | M |
| 95S | Pterygium -- any method | \$305.90 | \$275.30 | 42 | L |
| 96S | Subconjunctival injection | \$15.30 | \$15.30 | 0 | L |
| 97S | Corneal ulcer -- cauterization -- initial or repeat | \$16.50 | \$16.50 | 0 | L |
| 98S | Relaxing corneal incisions following corneal transplantation (This code does not apply to radial keratotomy) | \$254.90 | \$229.40 | 42 | L |

SECTION S – Ophthalmology

| | Specialist | General Practitioner | Class | Anes | |
|---|--|----------------------|----------|------|---|
| Phototherapeutic keratectomy for anterior scarring, hereditary congenital dystrophy or recurrent erosion syndrome - requires prior approval | | | | | |
| For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician". | | | | | |
| 300S | -- professional component | \$367.00 | \$330.30 | 42 | L |
| 301S | -- technical component (physician owned equipment) | \$978.70 | \$978.70 | | 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) | \$66.30 | \$66.30 | 0 | |
| 99S | Conjunctival flap over ulcer or wound – simple | \$224.30 | \$201.90 | 42 | L |
| 107S | Conjunctival flap over ulcer or wound -- Gunderson or complicated | \$509.80 | \$458.80 | 42 | M |
| 100S | Wounds -- suture -- conjunctiva | \$122.30 | \$122.30 | 10 | L |
| 101S | Wounds -- suture -- corneal or sclera -- without complication | \$560.70 | \$504.70 | 42 | M |
| 102S | Wounds -- suture -- with prolapse by conjunctivoplasty | \$688.20 | \$619.30 | 42 | M |
| 103S | Retrobulbar injection of alcohol | \$61.20 | \$61.20 | 0 | L |
| 104S | Excision of corneal dermoid | \$305.90 | \$275.30 | 42 | L |
| 474S | EDTA removal of band keratopathy | \$249.80 | \$225.30 | 10 | L |
| 475S | Conjunctival resection for corneal melt | \$138.70 | \$125.40 | 0 | L |
| 476S | Cyanoacrylate for corneal melt | \$229.40 | \$206.40 | 0 | L |
| 522S | Re-operation through conjunctiva -- for glaucoma, strabismus and scleral buckling surgery, unilateral -- add to 160S, 130S, 131S, 132S, 133S, 169S -- bill units | \$102.00 | \$91.80 | 42 | M |
| 477S | Epikeratophakia | \$607.60 | \$547.50 | 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. | | | | | |
| 4) Not an insured service when done as cosmetic procedure. | | | | | |
| Iris | | | | | |
| 182S | Iridotomy -- laser per eye -- bill units | \$145.00 | \$130.50 | 10 | |
| 478S | Iridotomy – surgical | \$224.30 | \$201.90 | 42 | L |
| 163S | Iridectomy – surgical | \$224.30 | \$201.90 | 42 | L |
| 105S | Iridodialysis repair | \$254.90 | \$229.40 | 42 | |
| 164S | Irrigation -- anterior chamber, through corneal incision | \$224.30 | \$201.90 | 42 | L |
| 165S | Synechotomy -- anterior chamber, surgical | \$122.30 | \$110.10 | 42 | L |
| 187S | Synechotomy -- anterior chamber, laser | \$81.60 | \$73.40 | 10 | L |
| 166S | Paracentesis – aqueous | \$32.60 | \$29.40 | 0 | L |
| 167S | Paracentesis – vitreous | \$51.00 | \$45.90 | 0 | L |
| 186S | Photomydriasis | \$132.50 | \$119.30 | 10 | L |

Payment Schedule for Insured Services Provided by a Physician

SECTION S – Ophthalmology

| | | Specialist | General Practitioner | Class | Anes |
|--------------------------|--|------------|----------------------|-------|------|
| Glaucoma | | | | | |
| 180S | Laser trabeculectomy -- per eye -- bill units | \$165.00 | \$148.50 | 10 | |
| 159S | Cyclodiathermy, cycloelectrolysis or cyclocryotherapy | \$229.40 | \$206.40 | 42 | |
| 160S | Filtering Operation – standard | \$611.70 | \$550.50 | 42 | M |
| 520S | Filtering Operation -- with any seton device in the anterior chamber or through pars plana – add | \$265.10 | \$238.60 | 42 | |
| 521S | Filtering Operation -- with the use of anti-metabolite drugs – add | \$91.80 | \$82.60 | 42 | M |
| 190S | Cyclodialysis | \$91.80 | \$82.60 | 10 | L |
| 161S | Goniotomy and/or goniotomy puncture – unilateral | \$184.50 | \$166.10 | 42 | L |
| 162S | Goniotomy and/or goniotomy puncture – repeat | \$117.20 | \$105.50 | 42 | L |
| 480S | Post-op trabeculectomy - cutting of sutures | \$61.20 | \$55.10 | 0 | L |
| Lens | | | | | |
| 135S | Cataract -- complete treatment -- all forms, child or adult | \$311.50 | \$280.75 | 42 | L |
| 136S | Cataract -- Implantation of prosthetic intraocular lens -- add -- bill | \$86.00 | \$86.00 | 42 | L |
| 236S | Prosthetic Intraocular lens – repositioning | \$144.80 | \$130.30 | 0 | L |
| 336S | Prosthetic Intraocular lens – removal | \$132.50 | \$119.30 | 10 | L |
| 479S | Removal and replacement | \$397.60 | \$357.80 | 42 | L |
| 539S | Suture fixation of lens haptics to iris or scleral – add | \$600.00 | \$539.95 | 42 | L |
| 142S | Secondary implantation of lens prosthesis-- simple -- intact vitreous Complicated with vitrectomy, use vitrectomy codes | \$356.80 | \$321.10 | 42 | L |
| 139S | Crystalline Lens -- Removal of Dislocated -- anterior chamber | \$367.00 | \$330.30 | 42 | L |
| 137S | Capsulectomy | \$254.90 | \$229.40 | 42 | L |
| 138S | Capsulotomy or discission of secondary membranes (surgical) | \$152.90 | \$137.60 | 42 | L |
| 189S | Posterior capsulotomy (laser) | \$138.00 | \$124.15 | 10 | L |
| Complex Cataracts | | | | | |
| 673S | Pupil expansion device, insertion and removal, unilateral, bill units -- add to 135S,139S,142S, 226S, 236S, 220S, 230 | \$87.70 | \$78.90 | 42 | L |
| 674S | Capsular tension ring or segment insertion, unilateral, bill units -- add to 135S,139S,142S,226S,236S | \$87.70 | \$78.90 | 42 | L |
| 675S | Capsular staining by any method, unilateral, bill units -- add to 135S,139S,142S,226S,236S | \$25.50 | \$22.90 | 42 | L |
| Sclera | | | | | |
| 481S | Scleral Patch Graft | \$428.20 | \$385.40 | 42 | M |
| 482S | Noniatrogenic scleral dehiscence or rupture – repair | \$183.50 | \$165.20 | 42 | M |
| 483S | Tumor of ciliary body | By report | | 42 | M |
| 171S | Posterior sclerotomy with or without insufflation of anterior chamber | \$152.90 | \$137.60 | 10 | L |
| Orbit | | | | | |
| 108S | Harvesting of donor eyes -- one or both -- for corneal transplant | \$305.90 | \$275.30 | 0 | L |
| 109S | Exenteration | \$713.70 | \$642.30 | 42 | M |
| 110S | Abscess -- incision and drainage (general practitioners – billable “by report” only) | \$281.40 | \$253.20 | 42 | L |

Payment Schedule for Insured Services Provided by a Physician

| SECTION 5 – Ophthalmology | | Specialist | General Practitioner | Class | Anes |
|----------------------------------|---|------------|----------------------|-------|------|
| 111S | Enucleation | \$458.80 | \$412.90 | 42 | M |
| 112S | Enucleation -- with insertion of an integrated orbital ocular implant in scleral shell – add | \$122.30 | \$110.10 | 42 | M |
| 113S | Extruded implant - replace - secondary operation | \$290.60 | \$261.00 | 42 | L |
| 540S | Secondary drilling of integrated orbital implant | \$190.60 | \$171.60 | 42 | L |
| 313S | Dermal Fat Graft -- Immediate following enucleation | \$193.70 | \$174.30 | 42 | L |
| 485S | Dermal Fat Graft -- delayed replacement of extruded implant by graft | \$489.40 | \$440.40 | 42 | L |
| 78S | Fornix Restoration | \$356.80 | \$321.10 | 42 | L |
| 487S | Fornix Restoration -- with mucous membrane graft – add | \$123.40 | \$111.00 | 42 | L |
| 488S | Fornix Restoration -- with autogenous conjunctival transplant – add | \$112.10 | \$100.90 | 42 | L |
| 413S | Reversal of anophthalmic socket with secondary integrated implant | \$341.50 | \$307.40 | 42 | L |
| 114S | Excise anterior tumor | \$499.60 | \$449.60 | 42 | M |
| 489S | Excise posterior tumor | \$776.90 | \$698.40 | 42 | M |
| 490S | Biopsy anterior tumor | \$333.40 | \$300.00 | 10 | L |
| 491S | Biopsy posterior tumor | \$458.80 | \$412.90 | 10 | L |
| 292S | Exploration of orbital floor or medial wall for suspected blowout fracture | \$225.00 | \$202.55 | 42 | M |
| 293S | Repair of orbital blowout fracture (floor or medial wall) -- first wall | \$500.00 | \$450.00 | 42 | M |
| 294S | Repair of orbital blowout fracture (floor or medial wall) -- second wall, add - - by report | \$300.00 | \$270.00 | 42 | M |
| 119S | Lateral orbitotomy (Kronlein's procedure) or other decompression -- by report | \$968.50 | \$871.70 | 42 | M |
| | Retina | | | | |
| 170S | Retinal tear -- complete treatment by diathermy, cryosurgery or laser | \$244.70 | \$220.20 | 42 | L |
| 174S | Retinal tumor -- treatment by laser | \$397.60 | \$357.80 | 42 | L |
| 670S | Retinal photography -- interpretation fee – bilateral | \$26.50 | \$26.50 | D | |
| | Diabetic retinopathy or similar vascular abnormality, treatment by laser -- per eye | | | | |
| | Maximum benefit payable under codes 175S and 176S in any six consecutive month period per eye is 1 initial and 3 subsequent treatments. | | | | |
| 175S | -- initial treatment session | \$291.60 | \$262.40 | 42 | L |
| 176S | -- subsequent treatment -- per session | \$147.80 | \$133.00 | 0 | L |
| 177S | Retinal degeneration or detachment treatment by diathermy, cryosurgery, or laser with or without hole | \$242.60 | \$218.40 | 42 | L |
| 178S | Peripheral retinal diathermy, cryosurgery or photocoagulation | \$242.60 | \$218.40 | 42 | L |
| 169S | Scleral buckling for retinal detachment includes -- diathermy, cryo or laser (includes 232S) | \$790.10 | \$711.10 | 42 | M |
| 251S | Removal of scleral buckle hardware by different or same surgeon beyond post-op period | \$106.00 | \$95.40 | 10 | L |
| 275S | Retinopathy of prematurity (preterm infants) (by laser), unilateral | \$509.80 | \$458.80 | 42 | H |

SECTION S – Ophthalmology

| | | Specialist | General Practitioner | Class | Anes |
|---|---|------------|----------------------|-------|------|
| Macula | | | | | |
| 493S | Photocoagulation of choroidal neovascular membrane | \$242.60 | \$218.40 | 42 | L |
| 494S | Photocoagulation of choroidal neovascular membrane -- subsequent treatment | \$181.50 | \$163.30 | 42 | L |
| 495S | Focal Photocoagulation of significant diabetic macular edema | \$242.60 | \$218.40 | 42 | L |
| 496S | Focal Photocoagulation of significant diabetic macular edema -- subsequent treatment | \$183.50 | \$165.20 | 42 | L |
| | 1. Grid and focal therapy not paid together. | | | | |
| | 2. Maximum benefit payable under codes 493S to 496S in any six consecutive month period per eye is 1 initial and 3 subsequent treatments. | | | | |
| | 3. May be exceeded if extenuating circumstances (by report). | | | | |
| 497S | Photodynamic therapy (Visudyne) approved for cases of pathologic myopia or the classic form of age related macular degeneration in patients with predominantly subfoveal choroidal neovascularization and choroidal neurovascularization secondary to histoplasmosis – unilateral | \$348.70 | \$313.80 | 42 | L |
| Vitreous | | | | | |
| Anterior vitrectomy – planned | | | | | |
| 220S | -- with or without penetrating wound | \$285.50 | \$256.90 | 42 | M |
| 222S | -- with corneoscleral laceration repair, add | \$95.80 | \$85.60 | 42 | M |
| 223S | -- with uveal tissue prolapse and repair, add | \$71.90 | \$64.60 | 42 | M |
| 224S | -- with lensectomy, add | \$90.70 | \$81.70 | 42 | L |
| 136S | -- Implantation of prosthetic intraocular lens, add | \$86.00 | \$86.00 | 42 | L |
| Posterior vitrectomy -- planned (includes anterior vitrectomy) | | | | | |
| 230S | -- pars plana | \$723.80 | \$651.50 | 42 | M |
| 757S | -- with intravitreal injection of silicone oil, add | \$91.80 | \$82.60 | 42 | L |
| 232S | -- with endophotocoagulation, add | \$123.40 | \$123.40 | 42 | L |
| 224S | -- with lensectomy, add | \$90.70 | \$81.70 | 42 | L |
| 225S | -- with preretinal membrane peeling- add | \$242.60 | \$218.40 | 42 | L |
| 136S | -- Implantation of prosthetic intraocular lens, add | \$86.00 | \$86.00 | 42 | L |
| 325S | -- removal of dislocated crystalline lens or cataract from the vitreal cavity , add | \$367.00 | \$330.30 | 42 | L |
| 226S | Posterior vitrectomy with cataract extraction via separate anterior approach (includes lensectomy), add | \$332.40 | \$299.10 | 42 | M |
| 515S | Air/gas/fluid exchange, add | \$152.90 | \$137.60 | 42 | L |
| 516S | Air/gas/fluid exchange, repeat | \$91.80 | \$82.60 | 0 | L |
| 233S | Removal of foreign body from anterior chamber (magnetic or nonmagnetic), add | \$61.20 | \$55.10 | 42 | L |
| 234S | Removal of foreign body from posterior chamber (magnetic or nonmagnetic), add | \$123.40 | \$111.00 | 42 | M |
| 141S | Removal of foreign body from anterior or posterior chamber or vitreous without vitrectomy -- any method | \$305.90 | \$275.30 | 42 | M |

Payment Schedule for Insured Services Provided by a Physician

SECTION S – Ophthalmology

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 252S | Post-operative vitreous cavity washout by different surgeon or same surgeon beyond post-op period | \$112.10 | \$100.90 | 0 | L |
| 254S | Intraocular fluid/gas exchange -- independent procedure | \$182.50 | \$164.20 | 42 | L |
| 517S | Intraocular fluid/gas exchange – removal | \$123.40 | \$111.00 | 42 | L |
| 755S | Vitreous tap with intravitreal injection of antibiotic/steroids in the management of bacterial endophthalmitis | \$193.70 | \$174.30 | 0 | L |
| 756S | Intravitreal injection of drugs | \$102.00 | \$91.80 | 0 | L |
| 518S | Pneumatic retinopexy with cryotherapy | \$504.70 | \$454.20 | 42 | M |
| 285S | Dissection of vitreous bands or membranes with Yag laser -- anterior segment | \$172.30 | \$155.10 | 42 | |
| 286S | Dissection of vitreous bands or membranes with Yag laser -- posterior segment | \$362.90 | \$326.60 | 42 | |
| 625S | Amniotic membrane transplantation -- unilateral -- second eye same day paid at 75% | \$382.30 | \$344.10 | 42 | M |
| 181S | Laser Technical Components, per eye (unilateral) – laser owned and maintained by physician, bill units -- add to 170S, 174S, 175S, 176S, 177S, 178S, 180S, 182S, 186S,187S, 189S, 285S, 286S, 493S, 494S, 495S, 496S, 497S | \$30.00 | \$30.00 | D | |

For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”.

SECTION T – Otolaryngology

Specialist in Otolaryngology

Referred Not Referred

Visits

5T **Initial assessment** -- of a specific condition includes: \$53.00* \$42.40*

| | |
|-------------------------------------|--------------------------------|
| a) pertinent family history; | f) clinical examination of |
| b) patient history; | affected part(s) or system(s); |
| c) history of presenting complaint; | g) necessary treatment; |
| d) functional enquiry; | h) advice to the patient; and, |
| e) diagnosis-tentative or final; | i) record of service provided. |

7T **Follow-up assessment** -- includes: \$50.50* \$47.40*

| | |
|----------------------------------|------------------------------------|
| a) history review; | e) necessary treatment; |
| b) functional enquiry; | f) advice to the patient; and, |
| c) clinical examination; | g) record of the service provided. |
| d) diagnosis tentative or final; | |

9T **Consultation** – includes: \$87.00*

- a) all visits necessary;
- b) history and examination;
- c) review of laboratory and/or other data;
- d) written submission of the consultant's opinion, and
- e) recommendations to the referring doctor

11T **Repeat consultation** \$51.00*

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.

* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

Hospital Care – Payable on day of admission

Hospital care is billable by the physician responsible for inpatient care of patients admitted to hospital. 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.

Post-operative hospital care is included in the surgical fee and can only be paid if hospital care is provided by another physician for a condition unrelated to the surgery. Upon transfer of hospital care to another physician, billing of hospital care should be as if there was a continuation of care under the same physician. An assessment or consultation may not be billed when hospital care is transferred to another physician.

Hospital care 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 hospital care to cover in-hospital patients who are designated as long-term care. These patients are to be billed under code 626A - Routine Nursing Home Visit

| | | | | |
|-----|---------------------------|-----------------------------------|---------|---------|
| 25T | -- 1-10 days | -- per day -- bill units (max 10) | \$53.00 | \$53.00 |
| 26T | -- 11-20 days | -- per day -- bill units (max 10) | \$53.00 | \$53.00 |
| 27T | -- 21-30 days | -- per day -- bill units (max 10) | \$50.00 | \$50.00 |
| 28T | -- 31 days and thereafter | -- per day -- bill units (max 99) | \$50.00 | \$50.00 |

SECTION T – Otolaryngology

| | | Specialist | General Practitioner | Class | Anes |
|--|---|------------|----------------------|-------|------|
| 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. | | | | | |
| 430T | Screening audiogram -- not to be billed for Welch Allyn type audioscope | \$16.00 | \$16.00 | D | |
| Diagnostic pure tone audiogram in sound-proof room including thresholds and four frequencies | | | | | |
| 431T | -- air | \$16.00 | \$16.00 | D | |
| 432T | -- air and bone | \$16.00 | \$16.00 | D | |
| 433T | Speech reception threshold | \$2.00 | \$2.00 | D | |
| 434T | Discrimination score | \$4.00 | \$4.00 | D | |
| 435T | One or more of -- most comfortable level, speech detection threshold, Stenger test, ABLB or tone decay, total | \$4.00 | \$4.00 | D | |
| 537T | Impedance hearing testing (e.g. impedance tympanometry and/or acoustic reflexes) | \$1.05 | \$1.05 | D | |
| 438T | Reflex decay | \$4.00 | \$4.00 | D | |
| 439T | Conditioned play audiometry | \$15.00 | \$15.00 | D | |
| 440T | VRA requiring two testers | \$15.00 | \$15.00 | D | |
| 441T | TROCA requiring two testers | \$22.90 | \$22.90 | D | |
| 442T | Vestibular caloric test | \$5.80 | \$5.80 | D | |
| Electronystagmography including gaze, positional and caloric testing | | | | | |
| 443T | Electronystagmography -- test and interpretation | \$55.10 | \$55.10 | D | |
| 444T | Electronystagmography -- interpretation only | \$15.30 | \$15.30 | D | |
| 445T | Canalolith repositioning maneuver for benign paroxysmal positional vertigo | \$10.20 | \$9.20 | D | |
| Ear | | | | | |
| 51T | Catheter inflation | \$12.20 | \$12.20 | 0 | |
| 52T | Cerumen -- removal includes syringing -- simple (bilateral) -- not payable with a consultation | \$30.00 | \$30.00 | 0 | |
| 53T | Cerumen -- removal includes syringing -- impacted -- under injected local or general Anesthesia | \$50.00 | \$50.00 | 10 | L |
| 350T | Removal of cerumen under magnification (e.g. Hotchkiss otoscope or binocular microscope) -- bilateral | \$10.00 | \$10.00 | 0 | |
| 54T | Foreign body -- removal -- simple | \$20.40 | \$20.40 | 0 | L |
| 55T | Foreign body -- removal -- complicated -- under injected local or general anesthesia | \$77.50 | \$77.50 | 10 | L |
| 56T | Foreign body -- removal -- involving post-aural incision | \$254.90 | \$229.40 | 42 | L |
| 57T | Paracentesis of eardrum | \$51.00 | \$51.00 | 0 | L |
| 58T | Polyp -- removal -- simple | \$25.50 | \$25.50 | 10 | L |
| 59T | Polyp -- removal under local or general anesthesia | \$50.00 | \$50.00 | 10 | L |
| 61T | Labyrinthotomy | \$611.70 | \$550.50 | 42 | L |
| 62T | Endolymphatic sac surgery -- initial or revision | \$699.40 | \$699.40 | 42 | L |

SECTION T – Otolaryngology

| | | Specialist | General Practitioner | Class | Anes |
|------|---|------------|----------------------|-------|------|
| 70T | Mastoidectomy -- infant -- antrotomy | \$509.80 | \$458.80 | 42 | L |
| 71T | Mastoidectomy -- simple -- complete any age | \$509.80 | \$458.80 | 42 | L |
| 72T | Mastoidectomy -- radical -- classical – revision | \$509.80 | \$458.80 | 42 | L |
| 74T | Mastoidectomy -- revision -- same surgeon | \$509.80 | \$458.80 | 42 | L |
| 75T | Mastoidectomy -- revision -- different surgeon | \$509.80 | \$458.80 | 42 | L |
| 76T | Mastoidectomy -- revision - with musculoplasty, add to 72T, 74T, 75T, 87T | \$40.40 | \$36.30 | 42 | L |
| 77T | Review of radical mastoid cavity -- removal of cerumen and debris – unilateral | \$35.70 | \$35.70 | 0 | L |
| 78T | Post-aural fistula -- closing | \$100.00 | \$90.00 | 42 | L |
| 79T | Post-aural fistula -- with sliding or pedicle graft | \$100.00 | \$90.00 | 42 | L |
| 80T | Post-aural fistula -- stapedectomy with prosthesis (fenestration of the oval window | \$764.60 | \$688.20 | 42 | L |
| 81T | Stapes mobilization | \$305.90 | \$275.30 | 42 | L |
| 82T | Sinus thrombosis -- operative management with mastoidectomy | \$269.10 | \$242.20 | 42 | L |
| 83T | Tympanotomy, exploratory (internal) (not paid in addition to inner ear surgery) | \$152.90 | \$137.60 | 42 | L |
| 283T | Tympanotomy with ossicular chain reconstruction | \$407.80 | \$367.00 | 42 | L |
| 84T | Myringoplasty -- per canal approach only | \$158.00 | \$142.70 | 42 | L |
| 85T | Tympanoplasty -- with widening of external auditory canal and exploration of attic with or without antrotomy | \$407.80 | \$367.00 | 42 | L |
| 86T | Tympanoplasty -- with ossicular reconstruction | \$611.70 | \$550.50 | 42 | L |
| 87T | Tympanoplasty -- with radical mastoidectomy | \$917.60 | \$825.80 | 42 | L |
| 88T | Myringotomy with insertion of tube (total care) | \$78.50 | \$70.70 | 42 | L |
| 89T | Cochlear implant, unilateral, with or without mastoidectomy, includes posterior tympanotomy, free tissue harvest for cochleostomy obliteration and musculopiosteal temporalis muscle rotation flap | \$1,400.00 | \$1,260.00 | 42 | H |
| 100T | Percutaneous insertion of bone-anchored hearing aid, unilateral (all-inclusive code) | \$410.00 | \$369.00 | 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) | \$137.05 | \$137.05 | 42 | |
| | Nose | | | | |
| 90T | Antrum -- puncture and/or irrigation, unilateral, diagnostic or therapeutic | \$25.50 | \$25.50 | 0 | L |
| 92T | Anterior packing for epistaxis -- unilateral or bilateral | \$26.10 | \$26.10 | 0 | L |
| 93T | Post nasal packing -- unilateral or bilateral | \$71.40 | \$71.40 | 0 | L |
| 292T | Post nasal packing -- removal -- bilateral | \$25.50 | \$25.50 | 0 | L |
| 393T | Epistaxis, for anterior packing and post nasal packing -- unilateral or bilateral | \$203.90 | \$203.90 | 0 | L |

SECTION T – Otolaryngology

| | | Specialist | General Practitioner | Class | Anes |
|------|--|------------|----------------------|-------|------|
| 94T | Foreign body removal -- simple | \$29.20 | \$29.20 | 0 | L |
| 95T | Foreign body removal -- complicated -- general anesthetic | \$102.00 | \$102.00 | 10 | L |
| 96T | Polyp removal -- single -- in office | \$60.00 | \$60.00 | 10 | L |
| 296T | Polyp removal -- single -- in operating room | \$103.00 | \$103.00 | 10 | L |
| 97T | Polyp removal -- multiple -- unilateral -- in operating room | \$81.60 | \$73.40 | 10 | L |
| 98T | Polyp removal -- choanal | \$83.60 | \$75.20 | 10 | L |
| 99T | Polyp removal -- electrocoagulation - per treatment -- unilateral or bilateral -- maximum 4 treatments | \$13.70 | \$12.30 | 0 | L |
| 105T | Choanal atresia -- emergency treatment in newborn, transnasal procedure and insertion of tube | \$52.30 | \$47.10 | 0 | L |
| 106T | Choanal atresia -- repair -- anterior nasal approach -- unilateral | \$305.90 | \$275.30 | 42 | M |
| 107T | Choanal atresia -- repair -- transpalatal approach | \$509.80 | \$458.80 | 42 | M |
| 108T | Choanal atresia -- choanal dilation | \$23.00 | \$23.00 | 0 | L |
| 109T | Cauterization of nose -- general anesthetic | \$102.00 | \$102.00 | 0 | L |
| 110T | Septum cauterization -- chemical -- unilateral or bilateral | \$20.40 | \$20.40 | 0 | L |
| 111T | Septum cauterization -- electro-cautery or diathermy -- unilateral or bilateral | \$102.00 | \$102.00 | 0 | L |
| 112T | Submucous resection | \$305.00 | \$274.50 | 42 | L |
| 113T | Septoplasty -- utilizing transfixion incision with mobilization of cartilaginous septum | \$305.00 | \$274.50 | 42 | M |
| 114T | Septal dermoplasty -- septum only | \$305.00 | \$274.50 | 42 | L |
| 115T | Septal dermoplasty -- septum, floor and lateral wall | \$305.00 | \$274.50 | 42 | L |
| | Sinus -- unilateral operation | | | | |
| 116T | Sinus -- maxillary antrum -- radical (Caldwell-Luc, etc) | \$458.80 | \$412.90 | 42 | M |
| 117T | Sinus -- maxillary antrum -- radical with closure of oral fistula | \$450.00 | \$405.00 | 42 | M |
| 118T | Sinus -- maxillary antrum -- intranasal | \$120.00 | \$108.00 | 42 | M |
| 119T | Sinus -- ethmoidectomy -- external | \$509.80 | \$458.80 | 42 | M |
| 520T | Sinus -- ethmoidectomy -- intranasal -- anterior or complete | \$180.00 | \$162.00 | 42 | L |
| 122T | Sinus -- frontal -- external -- trephine | \$305.90 | \$275.30 | 42 | M |
| 123T | Sinus -- frontal -- obliteration. osteoplastic flap with fat or similar graft | \$509.80 | \$458.80 | 42 | M |
| 124T | Sinus -- frontal -- obliteration -- removal of anterior wall and floor | \$305.90 | \$275.30 | 42 | M |
| 125T | Sinus -- frontal -- including either ethmoid and/or sphenoid | \$360.00 | \$324.00 | 42 | M |
| 126T | Sinus -- frontal -- intranasal | \$180.00 | \$162.05 | 42 | M |
| 127T | Sinus -- sphenoid -- intranasal | \$180.00 | \$162.05 | 42 | M |
| | Transphenoidal exposure of pituitary for hypophysectomy see Section K | | | | |
| 128T | Transantral orbital decompression -- unilateral | \$509.80 | \$509.80 | 42 | M |
| 129T | Transantral orbital decompression -- bilateral | \$407.80 | \$407.80 | 42 | M |
| 130T | Turbinate -- cauterization -- cautery or diathermy -- unilateral or | \$61.20 | \$61.20 | 0 | L |
| 131T | Turbinate -- resection -- partial | \$75.00 | \$67.50 | 10 | M |
| 132T | Turbinate -- submucous resection of | \$75.00 | \$67.45 | 10 | M |
| 450T | Turbinate -- sinuscopy -- unilateral or bilateral | \$29.00 | \$26.10 | D | L |

SECTION T – Otolaryngology

| | | Specialist | General Practitioner | Class | Anes |
|-------------------------|--|------------|----------------------|-------|------|
| Throat and Mouth | | | | | |
| 138T | Frenectomy -- without anesthesia | \$43.80 | \$43.80 | 10 | L |
| 139T | Frenectomy -- under general anesthesia | \$102.00 | \$102.00 | 10 | M |
| 140T | Abscess - incision and drainage with scalpel -- peritonsillar or retropharyngeal | \$254.90 | \$254.90 | 10 | M |
| 142T | Adenoidectomy | \$254.90 | \$229.40 | 42 | M |
| 145T | Tonsillectomy with or without adenoidectomy | \$350.00 | \$350.00 | 42 | M |
| 147T | Post T & A hemorrhage -- surgical treatment | \$500.00 | \$500.00 | 42 | M |
| 165T | Endoscopic -- removal of foreign body from larynx | \$305.90 | \$275.30 | 42 | M |
| 173T | Laryngoscopy -- direct - diagnostic | \$35.00 | \$35.00 | D | L |
| 174T | Laryngoscopy -- direct - with biopsy | \$203.90 | \$183.50 | D | M |
| 175T | Laryngoscopy -- direct - with benign tumor removal or cord stripping | \$203.90 | \$183.50 | 42 | M |
| 275T | Laryngoscopy -- with microscope -- with biopsy or cord stripping | \$203.90 | \$183.50 | 42 | L |
| 171T | Intubation -- for laryngeal obstruction | \$305.90 | \$305.90 | 0 | M |
| 176T | Hypopharyngeal -- removal of foreign body | \$102.00 | \$102.00 | 0 | M |
| 177T | Tracheostomy | \$362.90 | \$326.60 | 42 | M |
| 178T | Complete change of tracheostomy tube or Blom Singer prosthesis | \$102.00 | \$102.00 | 0 | L |
| Miscellaneous | | | | | |
| 192T | Arytenoidopexy or arytenoidectomy | \$356.80 | \$321.10 | 42 | M |
| 193T | Total laryngectomy | \$1,223.40 | \$1,101.10 | 42 | H |
| 293T | Primary creation/insertion of voice prosthesis | \$102.00 | \$91.80 | 42 | H |
| 194T | Partial laryngectomy -- not laryngofissure | \$713.70 | \$642.30 | 42 | H |
| 195T | Laryngofissure | \$815.60 | \$734.00 | 42 | M |
| 196T | Anterior or lateral pharyngotomy | \$407.80 | \$367.00 | 42 | M |
| 197T | Total maxillectomy with or without orbital exenteration | \$596.40 | \$537.30 | 42 | M |
| 198T | Transoral cricopharyngeal myotomy | \$611.70 | \$550.50 | 42 | M |
| 199T | Transoral cricopharyngeal myotomy with another procedure, add | \$102.00 | \$91.80 | 42 | M |
| 200T | Tympanic neurectomy -- unilateral | \$179.40 | \$161.10 | 42 | M |
| 201T | Tympanic neurectomy -- bilateral | \$330.30 | \$297.70 | 42 | M |
| 300T | Laryngoscope or nasal sinuscope tray fee | | | | |
| | 1. For cleaning and maintaining endoscopic instruments. | \$12.20 | \$12.20 | | |
| | 2. Paid in addition to the following office procedures only: 173T, 174T, 175T, 450T | | | | |

SECTION V – Laboratory Medicine

Laboratory Services:

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 Ministry of Health are insured as defined in the lists:

| <u>Physician</u> | <u>Payment Approved For</u> |
|---|-----------------------------|
| Pathologist | Lists 1, 2, 3 |
| Physician with a registered Laboratory Technician | Lists 1, 2 |
| Other Physicians | List 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

Classification: Diagnostic

The following services are insured when provided by a physician or a person employed by the physician in a medical laboratory which holds a Category I licence issued pursuant to The Medical Laboratory Licensing Act:

| | | |
|-----|--|--------|
| 14V | Hemoglobin (Hgb) | \$4.40 |
| 15V | Hematocrit or packed cell volume (PCV) | \$3.60 |
| 31V | Blood sugar -- diagnostic stick -- whole blood | \$4.00 |
| 32V | Blood sugar -- serum -- machine read (when done on an Ames seralyzer or a similar machine) | \$4.70 |
| 59V | Urinalysis -- dipstick | \$4.00 |
| 60V | Urinalysis -- complete -- dipstick and microscopic | \$4.70 |
| 62V | Test for pregnancy -- any method | \$9.00 |
| 70V | Examination of slide for trichomas, yeast, scales - lab licence not required to perform this service | \$4.70 |
| 80V | Occult blood | \$4.70 |
| 90V | Microalbumin testing -- max one per year per patient (for diabetic patients with negative albumin only) urine dipstick | \$7.60 |

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

SECTION V – Laboratory Medicine

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 hemoglobin (Hgb), 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) | \$10.40 |
| 14V | Hemoglobin (Hgb) | \$4.40 |
| 15V | Hematocrit (HCT) or packed cell volume (PCV) | \$3.60 |
| 17V | Erythrocyte sedimentation rate (ESR) | \$3.60 |
| 18V | Smear with differential count | \$5.00 |
| 19V | White blood cell count (WBC) | \$3.10 |
| 904V | Automated or semi-automated hematology profile, counts and indices (includes Hgb, RBC, WBC, HCT, MCH, MCHC, and MCV, when performed) | \$9.10 |
| 27V | Blood urea nitrogen -- serum -- machine read (when done on an Ames serylizer or a similar machine) | \$3.20 |
| 29V | Blood urea nitrogen -- diagnostic stick -- whole blood | \$2.10 |
| 31V | Blood sugar -- diagnostic stick -- whole blood | \$4.00 |
| 32V | Blood sugar serum -- machine read (when done on an Ames serylizer or a similar machine) | \$4.70 |
| 33V | Blood glucose test or glucose tolerance test (including urine test), per unit | \$5.50 |
| 59V | Urinalysis -- dipstick | \$4.00 |
| 60V | Urinalysis -- complete -- dipstick and microscopic | \$4.70 |
| 62V | Test for pregnancy -- any method | \$9.00 |
| 70V | Examination of slide for tricomonas, yeast, scales -- lab licence not required to perform this service | \$4.70 |
| 80V | Occult blood | \$4.70 |
| 512V | Prothrombin -- Quick's one stage prothrombin time with control | \$5.70 |
| 627V | Spot test for mononucleosis | \$8.50 |
| 90V | Microalbumin testing --max one per year per patient (for diabetic patients with negative albumin only) urine dipstick | \$7.60 |

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

SECTION V – Laboratory Medicine

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 Laboratory Licensing Act.
 - a) A Category III laboratory is a laboratory outside of a hospital which is supervised by a pathologist.
 - b) A category IV laboratory is a satellite laboratory affiliated with a Category III laboratory whose manager is responsible for the satellite laboratory.
2. Payment includes both the technical and professional components unless otherwise specified.
3. Supervision by a pathologist means that he 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;
 - e) accept responsibility for the procedures used in the work of the laboratory; and
 - f) if the specialist is hospital-based, then his supervision of a non-hospital laboratory should be restricted to one such laboratory.
4. 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.

| | | |
|-----|--|---------|
| 65A | Pathologist Assessment includes: | \$28.10 |
| | a) all visits necessary; b) history and examination; c) review of laboratory and/or other data, d) written submission of the consultant's opinion and recommendations to the referring doctor; and, e) advise to the patient as required | |

Only payable to physician providing a surgical biopsy (standard assessment rules apply).

Specimen Collection and Referral

| | | |
|------|---|---------|
| 751V | Phlebotomy, venipuncture | \$24.20 |
| 752V | Phlebotomy, pediatric (0 to 6 years) | \$36.40 |
| 771V | Referral -- blood | \$12.30 |
| 770V | Referral -- urine | \$12.30 |
| 772V | Referral -- other | \$15.70 |
| 756V | Referral -- transfer of dangerous goods (TDG) - blood | \$38.20 |
| 757V | Referral -- transfer of dangerous goods (TDG) - urine | \$38.20 |
| 758V | Referral -- transfer of dangerous goods (TDG) - other | \$38.20 |

SECTION V – Laboratory Medicine

Specialist in Pathology

Chemistry

Blood Gases

| | | |
|------|--|---------|
| 111V | Blood gases (pH, pO2,pCO2, O2 saturation) | \$8.50 |
| 112V | Blood gas (pH only) | \$6.00 |
| 113V | Blood gas and metabolites - pH, pO2, pCO2, O2 saturation, sodium, potassium, chloride, glucose, lactate | \$12.40 |
| 114V | Blood gas and metabolites - pH, pO2,pCO2, O2 saturation, sodium, potassium, chloride, glucose, lactate and ionized calcium | \$13.40 |
| 118V | CoOximetry (any single test) | \$6.00 |
| 119V | CoOximetry (methemoglobin, carboxyhemoglobin, oxyhemoglobin) | \$7.60 |
| 120V | Blood gas, metabolites and CoOximetry (pH, pO2, pCO2, O2 saturation, sodium, potassium, chloride, glucose, lactate, ionized calcium, methemoglobin, carboxyhemoglobin, oxyhemoglobin, hemoglobin-arterial) | \$16.50 |
| 121V | Ionized calcium - whole blood | \$6.00 |
| 122V | Ionized calcium - serum | \$6.00 |

Routine

| | | |
|------|---|--------|
| 130V | Specimen may be serum/plasma/urine/fluids -- single analyte | \$6.00 |
| 131V | For each additional analyte performed on the same specimen from the following menu add: | \$0.80 |

| | | |
|----------------------------------|---|-----------------|
| Acetaminophen | Creatinine | Magnesium |
| Albumin | Creatinine Kinase (CK) | Potassium |
| Alanine Aminotransferase (ALT) | Creatinine Kinase-MB (CKMB) | Phosphate |
| Alkaline phosphatase (ALP) | Direct bilirubin | Salicylate |
| Ammonia | Ethanol | Sodium |
| Amylase | Gamma-glutamyl transpeptidase (GGT) | Total bilirubin |
| Aspartate Aminotransferase (AST) | Glucose | Total protein |
| Bicarbonate (TCO2) | HDL cholesterol | Triglyceride |
| Calcium | Iron + total iron binding capacity (TIBC) | Urea |
| Chloride | Lactate Dehydrogenase (LDH) | Uric acid |
| Cholesterol | | |

Urinalysis/Urine Testing

| | | |
|------|--|---------|
| 132V | Routine urinalysis includes -- bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrates, pH, protein, specific gravity & urobilinogen | \$7.10 |
| 133V | Urine microscopy | \$6.00 |
| 134V | Myoglobin urine | \$22.50 |
| 135V | Occult blood (stool/gastric) | \$6.00 |
| 136V | Osmolality urine/serum | \$20.50 |
| 137V | Ketones, reducing substances (urine/feces) | \$2.00 |
| 138V | 24-hour urine, creatinine clearance | \$17.00 |
| 139V | 24-hour urine, total protein | \$16.20 |

Urinalysis/Urine Testing

| | | |
|------|--|---------|
| 141V | Albumin/creatinine ratio | \$40.10 |
| 433V | Microalbumin - by automated method | \$16.60 |
| 140V | Pregnancy test – human chorionic gonadotropin (HCG) - urine or serum | \$23.40 |

SECTION V – Laboratory Medicine

Specialist in Pathology

| Chemistry - Immunology/Rheumatology | | |
|--|---|--------------------------------|
| 151V | Alpha 1 antitrypsin | \$16.60 |
| 152V | C3 | \$16.60 |
| 153V | C4 | \$16.60 |
| 162V | Ceruloplasmin | \$16.60 |
| 155V | C-reactive protein (CRP) | \$16.60 |
| 240V | Electrophoresis (serum) | \$40.10 |
| 156V | Electrophoresis creatine kinase (CK) | \$40.10 |
| 157V | Electrophoresis cerebrospinal fluid (CSF)/urine | \$50.30 |
| 158V | Immunoglobulin A (IgA) | \$16.60 |
| 159V | Immunoglobulin G (IgG) | \$16.60 |
| 161V | Immunoglobulin M (IgM) | \$16.60 |
| 163V | Immunofixation (serum/CSF/urine) | \$97.40 |
| 630V | Rheumatoid factor (RF) | \$16.60 |
| 166V | Transferrin | \$16.60 |
| 167V | Cryoglobulins | \$25.00 |
| Chemistry - Endocrinology and Therapeutic Drug Monitoring | | |
| 171V | For any single analyte ordered on the same specimen from the following group | \$11.10 |
| 172V | For each additional analyte ordered from the following group add: | \$3.60 |
| | - Alpha fetoprotein (AFP) | - Phenytoin |
| | - Carbamazepine | - Prolactin |
| | - Carcinoembryonic Antigen (CEA) | - Serum beta HCG, quantitative |
| | - Digoxin | - Theophylline |
| | - Ferritin | - Tobramycin |
| | - Follicle stimulating hormone (FSH) | - Troponin 1 |
| | - Gentamicin | - Valproic acid |
| | - Luteinizing hormone (LH) | - Vancomycin |
| | - Phenobarbital | |
| 173V | Estradiol | \$30.50 |
| 174V | Free T3 | \$8.30 |
| 175V | FreeT4 | \$8.30 |
| 270V | Thyroid-stimulating hormone (TSH) | \$8.30 |
| 271V | Thyroid-stimulating hormone (TSH) - (free T4 reflexed) | \$11.20 |
| 181V | Thyroid-stimulating hormone (TSH) - (free T4 & free T3 reflexed) | \$14.30 |
| 182V | Amikacin | \$13.90 |
| 183V | Cortisol | \$13.90 |
| 185V | Cyclosporine | \$19.40 |
| 186V | Methotrexate | \$13.90 |
| 187V | Prostate specific antigen (PSA) | \$11.10 |
| 188V | Secobarbital, phenytoin, amobarbital, butalbarbital, pentobarbital, phenobarbital (urine/serum) (when done as a panel of six) | \$54.40 |
| 189V | Tacrolimus | \$22.10 |
| 190V | Thiopental | \$41.50 |
| 203V | Toxicology screen (serum or urine) | \$96.10 |

SECTION V – Laboratory Medicine

Specialist in Pathology

Chemistry - Miscellaneous

| | | |
|------|--|----------|
| 204V | B2 microglobulin | \$13.90 |
| 205V | Bilirubin amniotic - B12/RBC folate - see hematology section | \$38.20 |
| 302V | Calculus analysis | \$30.50 |
| 142V | Carotene | \$69.40 |
| 206V | Chylomicrons (refridge & visual) | \$22.10 |
| 207V | Chymex | \$41.50 |
| 208V | Cryofibrinogen | \$41.50 |
| 168V | Cryoglobulin | \$25.00 |
| 209V | Ethanol, isopropanol, methanol (when done as a panel of 3) | \$44.30 |
| 210V | Ethylene glycol | \$44.30 |
| 211V | Fat globule (prep,stain,interp) | \$55.50 |
| 412V | Fecal fat assay | \$152.40 |
| 212V | Free erythrocyte protoporphyrin (FEP) assay | \$52.60 |
| 213V | Gastric analysis | \$16.50 |
| 214V | Glucose by glucose meter | \$7.10 |
| 215V | Haptoglobin | \$16.60 |
| 216V | Hemoglobin A1C - iron/iron binding/% saturation - see Hematology Section | \$12.00 |
| 249V | Lithium | \$11.20 |
| 217V | Lecithin-sphingomyelin (LS)/phosphatidylglycerol (PG) on amniotic fluid | \$138.30 |
| 338V | Melanin | \$27.60 |
| 202V | Methemalbumin | \$58.00 |
| 425V | Mucin | \$13.90 |
| 218V | pH - pH meter (fluid) | \$6.00 |
| 219V | Phenylalanine | \$41.50 |
| 221V | Plasma hemoglobin | \$41.50 |
| 349V | Porphobilinogen screen | \$25.00 |
| 222V | Porphyrin screen (feces/urine/serum) | \$27.60 |
| 224V | Prealbumin | \$16.60 |
| 225V | Pregnancy test - human chorionic gonadotropin (HCG) - serum | \$23.40 |
| 227V | Sweat chloride analysis (does not include specimen collection) | \$16.50 |
| 418V | Trypsin | \$30.50 |
| 229V | Xylose | \$22.10 |

Chemistry – Allergy

| | | |
|------|--|---------|
| 235V | Immunoglobulin E (IgE) | \$69.70 |
| 236V | Food mix screen | \$69.70 |
| 237V | Inhalant screen IgE | \$69.70 |
| 238V | For each additional specific allergen ordered with total Immunoglobulin E (IgE) or a screen, add | \$9.70 |
| 239V | For each allergen, if ordered individually - some common allergens are: dog dander, dust, milk, yellow hornet, honey bee, peanut | \$69.70 |

Hematology - Routine

| | | |
|------|--|---------|
| 422V | CBC 8 parameters + histograms, 3 or 5 part differential | \$12.70 |
| 423V | CBC 8 parameters or less (hemoglobin, HCT, RBC, WCB, MCV, MCH, MCHC + platelets) | \$7.60 |

SECTION V – Laboratory Medicine

Specialist in Pathology

| Miscellaneous | | |
|------------------------------------|--|----------|
| 251V | B12 | \$11.10 |
| 253V | Cell count and differential cerebrospinal fluid (CSF) | \$53.70 |
| 434V | Erythrocyte sedimentation rate | \$10.20 |
| 464V | Estimate - platelet/white blood cell (WBC) count | \$7.60 |
| 254V | Red blood cell (RBC) folate | \$27.60 |
| 180V | Iron, total iron binding capacity (TIBC) and % saturation | \$12.90 |
| 255V | Manual differential | \$28.10 |
| 257V | Manual hemoglobin (Hgb) | \$28.10 |
| 476V | Manual white blood cell (WBC) count | \$15.90 |
| 259V | Monotest | \$15.90 |
| 260V | Morphology | \$7.60 |
| 470V | Reticulocyte count | \$23.10 |
| 494V | Blood parasites (malarial & others) | \$56.30 |
| 261V | Bone marrow - assist, stain, differential, iron | \$235.70 |
| 262V | Bone marrow - for each additional 500 cells counted, add | \$50.80 |
| 263V | Bone marrow - for each additional slide stained | \$50.80 |
| 265V | Buffy coat preparation | \$40.90 |
| 481V | Cell count and differential | \$46.10 |
| 266V | Cytospin | \$17.90 |
| 267V | Eosinophil smear (sputum) | \$20.50 |
| 268V | Eosinophil smear (urines) | \$38.30 |
| 550V | Esterase, iron, peroxidase, sudan black, TRAP | \$51.30 |
| 274V | Fluid crystals | \$15.90 |
| 497V | Heinz bodies (direct) | \$38.30 |
| 346V | Hemoglobin (HGB) pigments (qualitative) | \$30.10 |
| 275V | Hemolysate preparation | \$43.60 |
| 276V | Iron stain hematology | \$12.70 |
| 277V | Leukocyte alkaline phosphatase score | \$92.70 |
| 278V | Hemosiderin – urine | \$15.90 |
| Hematology - Coagulation | | |
| 279V | Prothrombin time (PT)/INR & Activated Partial Thromboplastin Time (APTT) | \$11.50 |
| 280V | Prothrombin time (PT)/INR | \$10.20 |
| 281V | Activated Partial Thromboplastin Time (APTT) | \$10.20 |
| 282V | D-dimer – automated | \$93.80 |
| 283V | Factor assays (each) | \$67.20 |
| 506V | Fibrinogen | \$10.20 |
| Hematology - Flow Cytometry | | |
| 284V | CD4/CD8 | \$374.10 |
| 285V | CD34-peripheral blood | \$275.60 |
| 287V | CD34-apheresis | \$367.00 |

SECTION V – Laboratory Medicine

Specialist in Pathology

| Transfusion Medicine | | |
|-------------------------------|--|-----------|
| 560V | ABO & RH typing (group & type) | \$43.70 |
| 563V | Antibody screen | \$39.40 |
| 289V | Antibody panel | \$65.60 |
| 290V | Antibody panel -- each additional panel | \$65.60 |
| 291V | Antigen typing | \$39.40 |
| 600V | Direct antiglobulin test (Coombs & fractionation) | \$48.10 |
| 559V | Crossmatch (group & type, antibody screen & 2 units of packed cells) | \$96.10 |
| 293V | Crossmatch (group & type, antibody screen & 2 units of packed cells)- each additional unit of packed | \$17.40 |
| 295V | Human leukocyte antigen (HLA) typing (ABC/DR typing) | \$1219.30 |
| Microbiology – Routine | | |
| 297V | Blood culture and sensitivity (C&S) for bacteria &/or yeast - automated | \$44.60 |
| 690V | Blood culture and sensitivity (C&S) for bacteria &/or yeast - manual | \$79.80 |
| 299V | Cervix culture and sensitivity (C&S) | \$44.30 |
| 300V | Cerebrospinal fluid (CSF) culture and sensitivity (C&S) | \$68.10 |
| 301V | Dermatophyte culture | \$156.00 |
| 305V | Direct gram stain only | \$33.80 |
| 306V | Effluent culture | \$59.80 |
| 307V | Environmental culture | \$33.40 |
| 309V | Fluids culture and sensitivity (C&S) | \$86.70 |
| 311V | Fungal culture and sensitivity (C&S) | \$156.00 |
| 312V | Lower Respiratory CBS with gram stain | \$61.50 |
| 724V | Microscopic exam for Fungus | \$23.40 |
| 313V | Miscellaneous culture and sensitivity (C&S) | \$93.80 |
| 314V | Methicillin-resistant staphylococcus aureus (MRSA) culture | \$54.00 |
| 731V | Parasite examination - pinworm paddle | \$23.40 |
| 725V | Parasite examination - skin scrapings | \$47.00 |
| 317V | Parasite examination -- stool - full ova and parasites (O&P) workup | \$102.10 |
| 318V | Parasite examination -- stool - giardia/cryptosporidium screen | \$23.40 |
| 319V | Parasite examination -- trichomonas | \$23.40 |
| 729V | Parasite examination -- urine | \$49.50 |
| 321V | Pneumocystis examination | \$123.20 |
| 322V | Stool for culture and sensitivity (C&S) | \$53.00 |
| 323V | Stool for Clostridium difficile toxin | \$28.60 |
| 324V | Streptozyme screen | \$18.10 |
| 325V | Throat culture and sensitivity (C&S) | \$28.60 |
| 326V | Ureaplasma urealyticum testing | \$32.60 |
| 327V | Urethra culture and sensitivity (C&S) | \$44.30 |
| 329V | Urine culture and sensitivity (C&S) | \$26.10 |
| 331V | Vaginal or vaginal/rectal swab for group B strep | \$34.20 |
| 333V | Vaginal swab for bacterial vaginosis examination | \$33.80 |
| 334V | Vancomycin resistant enterococcus (VRE) screen | \$34.40 |

SECTION V – Laboratory Medicine

Specialist in Pathology

| | | |
|---|---|---|
| 335V | Wound culture - deep site | \$86.70 |
| 337V | Wound culture - surface site | \$70.70 |
| Microbiology – Tuberculosis (TB) | | |
| 344V | Bronchial washing tuberculosis (TB) culture | \$216.90 |
| 345V | Cerebrospinal fluid (CSF) tuberculosis (TB) culture | \$206.30 |
| 347V | Fluid tuberculosis (TB) culture | \$236.80 |
| 351V | Gastric washing tuberculosis (TB) culture | \$166.50 |
| 352V | Polymerase chain reactin (PCR) for mycobacterium tuberculosis (TB) | \$241.50 |
| 242V | Polymerase chain reactin (PCR) for mycobacteria species | \$241.50 |
| 722V | Smear only | \$96.10 |
| 354V | Sputum tuberculosis (TB) culture | \$236.80 |
| 355V | Stool tuberculosis (TB) smear | \$96.10 |
| 356V | Miscellaneous tuberculosis (TB) culture | \$206.30 |
| 357V | Tissue tuberculosis (TB) culture | \$236.80 |
| 358V | Urine tuberculosis (TB) culture | \$187.60 |
| Microbiology - Virology | | |
| 359V | Cytomegalovirus (CMV) antigenemia | \$423.30 |
| 360V | Cytomegalovirus (CMV) IgG | \$66.70 |
| Epstein-Barr virus (EBV) serology -- Epstein-Barr virus nuclear antigen (EBNA); Epstein-Barr viral-capsid antigen (VCA) IgM or IgG | | |
| 361V | -- if ordered individually. | \$59.30 |
| 363V | -- If added to an existing order ---add | \$22.30 |
| 368V | Epstein-Barr Virus (EBV) early antigen (EA) -- if ordered individually | \$147.70 |
| 369V | Epstein-Barr Virus (EBV) early antigen (EA) -- If added to an existing order ---add | \$111.40 |
| Hepatitis testing | | |
| 370V | -- single marker | \$74.10 |
| 371V | -- for each additional marker added to order -- add | \$37.00 |
| Includes the following list of markers: | | |
| | - Hepatitis A Antibody | - Hepatitis B Core immunoglobulin M (IgM) |
| | - Hepatitis A immunoglobulin G (IgG) | - Hepatitis B Surface Antibody |
| | - Hepatitis A immunoglobulin M (IgM) | - Hepatitis B Surface Antigen |
| | - Hepatitis B Core Antibody | - Hepatitis C Antibody |
| 373V | Herpes antibody | \$66.70 |
| 374V | Mycoplasma pneumonia antibodies | \$66.70 |
| 375V | Parvovirus serology (B19 - immunoglobulin G (IgG) and immunoglobulin M (IgM)) | \$163.00 |
| 376V | Rubella immunoglobulin G (IgG) antibody | \$59.30 |
| 377V | Rubella immunoglobulin M (IgM) antibody | \$51.90 |
| 379V | Toxoplasma immunoglobulin G (IgG) | \$51.90 |
| 383V | Toxoplasma immunoglobulin M (IgM) | \$51.90 |
| 384V | Varicella immunoglobulin G (IgG) antibody | \$66.70 |
| 385V | Chlamydia culture | \$141.90 |

SECTION V – Laboratory Medicine

Specialist in Pathology

| | | |
|---|--|----------|
| 386V | Respiratory specimen for viruses by direct fluorescent antibody tests | \$207.60 |
| 387V | Rotavirus antigen test | \$59.30 |
| 388V | Viral culture -- cerebrospinal fluid (CSF) | \$215.70 |
| 389V | Viral culture -- eye | \$224.00 |
| 390V | Viral culture -- genital | \$145.40 |
| 391V | Viral culture -- miscellaneous | \$335.30 |
| 392V | Viral culture -- respiratory | \$245.10 |
| 393V | Viral culture -- skin | \$262.60 |
| 394V | Viral culture -- stool | \$266.20 |
| 395V | Viral culture -- tissue | \$349.40 |
| 396V | Viral culture -- urine | \$206.30 |
| Microbiology dimethyl pimelimidate (DMP) | | |
| 398V | Chlamydia trachomatis polymerase chain reaction (PCR) | \$158.30 |
| 399V | Hepatitis C polymerase chain reaction (PCR) | \$348.30 |
| 400V | Herpes simplex virus polymerase chain reaction (PCR) | \$195.80 |
| 401V | Pertussis polymerase chain reaction (PCR) | \$189.90 |
| 402V | Varicella polymerase chain reaction (PCR) | \$124.30 |
| Cytology – Gynecologic | | |
| 403V | Cytology – gynecologic specimen -- 1 slide (Papanicolau) (PAP) | \$24.90 |
| 405V | Cytology – gynecologic specimen -- each additional slide (Papanicolau) (PAP) | \$8.40 |
| Cytology – Medical | | |
| 407V | Fine needle biopsy - CytoSpin handling -- 1 slide | \$289.60 |
| 409V | Fluid for cells -- 1 slide | \$116.10 |
| 411V | Sputum for cells -- 1 slide | \$110.20 |
| 413V | Urine for cells -- 1 slide | \$116.10 |
| 415V | Urine for cells -- each additional slide | \$26.30 |

SECTION W – Diagnostic Ultrasound

Classification: Diagnostic

Ultrasound is an insured service where:

1. it is provided outside a hospital and it is not provided to a hospital in-patient or a patient in the Emergency Department, and
2. it is provided by a physician who is listed by the College of Physicians and Surgeons of Saskatchewan as having qualified to receive payments and,
3. a hard copy of the diagnostic ultrasound examination(s) plus a written signed interpretation or report of that examination is retained by the physician providing the services, and
4. there is a 4-digit referring doctor number in the referring doctor field on the claim.
5. * For billing of technical components see “Definitions” (19) and “Services Supervised by a Physician”.

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

| | | Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|----------------------|---|-------------------------|-----------------------------|---|
| Head and Neck | | | | |
| 11W | Echoencephalography (midline and ventricular size) | \$30.85 | \$23.45 | \$54.30 |
| 12W | Thyroid | \$34.40 | \$22.20 | \$56.60 |
| 13W | Thyroid -- with 7.5 or 10 mhz transducer | \$67.30 | \$26.20 | \$93.50 |
| 16W | Biometry for measuring axial length - unilateral -- second eye not billable if done for comparison purposes | \$27.80 | \$20.40 | \$48.20 |
| 17W | Ophthalmic ultrasound for diagnostic examination of the posterior segment - unilateral -- second eye not billable if done for comparison purposes | \$26.50 | \$18.90 | \$45.40 |
| 72W | Parotid glands or similar | \$43.00 | \$29.00 | \$72.00 |
| Chest | | | | |
| 20W | Echocardiography, M-mode | \$47.40 | \$34.00 | \$81.40 |
| 21W | Ultrasonically-guided pericardiocentesis or thoracocentesis, bill units | \$47.10 | \$38.50 | \$85.60 |
| 22W | Chest -- for pleural effusion | \$40.80 | \$12.70 | \$53.50 |
| 23W | Breast -- for breast mass (per breast) -- bill units | \$47.60 | \$29.20 | \$76.80 |
| Abdomen | | | | |
| 30W | Kidneys, liver, pancreas, gall bladder, spleen, aorta and related structures | \$93.55 | \$52.65 | \$146.20 |
| 31W | Renal -- independent study only | \$55.80 | \$38.70 | \$94.50 |
| 32W | Ultrasonically guided biopsy or cyst aspiration | \$40.95 | \$28.45 | \$69.40 |
| 73W | Hypertrophic pyloric stenosis | \$57.15 | \$32.15 | \$89.30 |

SECTION W – Diagnostic Ultrasound

| | | |
|-------------------------|-----------------------------|---|
| Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|-------------------------|-----------------------------|---|

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.

* For billing of technical components see “Definitions” (19) and “Services Supervised by a Physician”.

First Trimester (0 to 13 weeks)

First trimester complete ultrasound must include image documentation of:

- 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); and
- Limited obstetrical ultrasounds.

| | | | | |
|------|----------------------------|---------|---------|----------|
| 401W | First trimester - Complete | \$87.15 | \$51.25 | \$138.40 |
|------|----------------------------|---------|---------|----------|

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 | Second trimester - Complete – singleton | \$87.15 | \$51.25 | \$138.40 |
| 412W | Second trimester - Complete – twins - not to be billed before 16 weeks | \$107.25 | \$64.75 | \$172.00 |
| 422W | Second trimester - Complete – triplets or greater - not to be billed before 16 weeks. | \$126.55 | \$84.45 | \$211.00 |

SECTION W – Diagnostic Ultrasound

| | | |
|-------------------------|-----------------------------|---|
| Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|-------------------------|-----------------------------|---|

Obstetrics

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 | Second trimester - Limited – singleton, twins or triplets or greater | \$44.60 | \$26.10 | \$70.70 |
|------|--|---------|---------|---------|

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 | Third trimester - Complete – singleton | \$87.15 | \$51.25 | \$138.40 |
| 413W | Third trimester - Complete – twins | \$107.25 | \$64.75 | \$172.00 |
| 423W | Third trimester - Complete – triplets or greater | \$126.55 | \$84.45 | \$211.00 |
| 433W | Third trimester - Limited – singleton, twins or triplets or greater | \$44.60 | \$26.10 | \$70.70 |
| 44W | Ultrasonically guided amniocentesis | \$43.65 | \$30.45 | \$74.10 |
| 46W | Biophysical profile of fetus (not to be billed before 28 weeks) – max of 1 per day | \$69.70 | \$40.40 | \$110.10 |
| 446W | Biophysical profile per additional multiple fetus (not to be billed before 28 weeks) | \$47.90 | \$30.70 | \$78.60 |
| 149W | Nuchal translucency screening | \$41.80@ | \$26.10@ | \$67.90@ |
| 150W | Nuchal translucency screening -- each additional fetus (add to 149W) | \$30.60@ | \$19.10@ | \$49.70@ |

- a) First trimester in an approved facility.
- b) One per pregnancy.
- c) Doppler flow studies (50W/51W) are not payable as a routine scan in addition to 149W/150W. It is only payable in specific medically required circumstances, such as evidence to suggest that the umbilical cord may be wrapped around the neck, a heart condition is present, etc.

@ Billable by physicians approved by the Saskatchewan Medical Association Tariff Committee. For the purposes of billing, 149W and 150W are billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.

SECTION W – Diagnostic Ultrasound

| | | Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|---------------------------|--|-------------------------|-----------------------------|---|
| Gynecology | | | | |
| 42W | Intrauterine contraceptive device (IUCD) localization | \$33.10 | \$23.40 | \$56.50 |
| 43W | Pelvis | \$76.00 | \$41.00 | \$117.00 |
| 45W | Transvaginal ultrasound study in addition to 43W, 401W-433W | \$35.65 | \$19.25 | \$54.90 |
| 49W | Transvaginal ultrasound study as an independent procedure – initial a) Serial studies for infertility are uninsured and not billable. b) Follicle tracking for insured services is payable as 49W for the first exam and 449W for subsequent exams within 22 days. | \$70.85 | \$38.15 | \$109.00 |
| 449W | Transvaginal ultrasound follicle tracking follow-up study -- subsequent exam within 22 days | \$40.70 | \$24.00 | \$64.70 |
| Doppler Studies | | | | |
| | 1. Doppler flow studies are not payable in the first trimester of pregnancy. | | | |
| | 2. Doppler flow studies are only payable when requested and performed for very specific clinical indications to assess the patency, vascularity or venous flow of the arteries/veins, etc. | | | |
| | 3. Doppler flow studies are not intended to be used as an “add-on” code in conjunction with any other ultrasound service to routinely assess the area of concern with color Doppler or otherwise. | | | |
| 50W | Flow studies including arterial or venous or fetal monitoring or shunt assessment, etc. | \$64.20 | \$28.80 | \$93.00 |
| 51W | Flow studies including arterial or venous or fetal monitoring or shunt assessment, etc. -- each additional fetus -- bill units | \$46.50 | \$21.20 | \$67.70 |
| 54W | Peripheral venous -- per limb-- -- bill units | \$111.80 | \$42.50 | \$154.30 |
| Prostate/Testicles | | | | |
| 60W | Transrectal ultrasound of prostate | \$60.10 | \$36.20 | \$96.30 |
| 62W | Testicles | \$53.15 | \$26.95 | \$80.10 |

SECTION W – Diagnostic Ultrasound

Technical Component Interpretation Component Technical & Interpretation Component

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.
3. * For billing of technical components see “Definitions” (19) and “Services Supervised by a Physician”.

| | | | | | |
|------|--|---|---------|---------|---------|
| 120W | Head and Neck -- excluding thyroid or parotid glands | | \$57.15 | \$32.15 | \$89.30 |
| 122W | Torso -- excluding axilla or groin | | \$57.15 | \$32.15 | \$89.30 |
| 124W | Back | | \$57.15 | \$32.15 | \$89.30 |
| 126W | Shoulder to elbow | - two units may be billed for bilateral | \$57.15 | \$32.15 | \$89.30 |
| 128W | Elbow to fingers | - two units may be billed for bilateral | \$57.15 | \$32.15 | \$89.30 |
| 130W | Axilla | - two units may be billed for bilateral | \$57.15 | \$32.15 | \$89.30 |
| 132W | Hip to knee | - two units may be billed for bilateral | \$57.15 | \$32.15 | \$89.30 |
| 134W | Knee to toes | - two units may be billed for bilateral | \$57.15 | \$32.15 | \$89.30 |
| 136W | Groin | - two units may be billed for bilateral | \$57.15 | \$32.15 | \$89.30 |

Joint Ultrasound

| | | | | | |
|------|--|---|---------|---------|----------|
| 200W | Spine | | \$77.70 | \$38.20 | \$115.90 |
| 202W | Neck | | \$77.70 | \$38.20 | \$115.90 |
| 204W | Complete shoulder or acromioclavicular joint | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |
| 206W | Elbow | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |
| 208W | Wrist | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |
| 210W | Hand -- fingers -- thumb | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |
| 212W | Hip | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |
| 214W | Knee | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |
| 216W | Ankle | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |
| 218W | Foot -- toes | - two units may be billed for bilateral | \$77.70 | \$38.20 | \$115.90 |

Additional units/scans done for comparison purposes are not billable.

SECTION X – Diagnostic Radiology

Specialist in Diagnostic Radiology

9X Special review of x-rays by Radiologist with written report to referring physician(s) - by report \$73.10#

Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.

Classification: Diagnostic

1. A diagnostic x-ray procedure is an insured service where it is entirely provided outside a hospital by a radiologist and there is a 4-digit referring doctor number in the referring doctor field on the claim.
2. Payment to a radiologist will be made only where he has performed the procedure personally or the technical component was performed by qualified staff for whom he assumes responsibility and provides daily supervision.
3. Payment 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.
4. Multiple Diagnostic Procedures -- are paid at 100% of the listed payment for each procedure both from Section X and Section A.

5. * For billing of technical components see "Definitions" (19) and "Services Supervised by a Physician".

| | | Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|------|--|-------------------------|-----------------------------|---|
| | Head | | | |
| 100X | Skull | \$30.80 | \$13.00 | \$43.80 |
| 101X | Nasal sinuses | \$30.00 | \$14.10 | \$44.10 |
| 102X | Mastoids | \$33.40 | \$16.70 | \$50.10 |
| 103X | Facial Bones and/or Zygoma | \$30.05 | \$14.85 | \$44.90 |
| 104X | Nasal bones | \$22.20 | \$7.60 | \$29.80 |
| 105X | Salivary duct | \$22.95 | \$13.65 | \$36.60 |
| 106X | Internal auditory meati | \$30.25 | \$11.25 | \$41.50 |
| 107X | Mandible | \$27.15 | \$10.45 | \$37.60 |
| 108X | Temporomandibular joints | \$30.00 | \$12.50 | \$42.50 |
| 109X | Eye -- without localization -- bill units | \$25.60 | \$12.00 | \$37.60 |
| 110X | Sella turcica | \$22.10 | \$11.00 | \$33.10 |
| | Teeth | | | |
| 120X | Pantomography - not insured for routine dental care | \$19.40 | \$13.00 | \$32.40 |
| 121X | Teeth -- isolated area -- bill units | \$6.70 | \$4.10 | \$10.80 |
| 122X | Teeth -- quarter set | \$10.20 | \$5.80 | \$16.00 |
| 123X | Teeth -- half set | \$13.35 | \$6.75 | \$20.10 |
| 124X | Teeth -- full set | \$19.20 | \$10.60 | \$29.80 |
| 125X | Eye -- Sweet (or equivalent) localization for foreign body in eye or orbit | \$35.95 | \$22.25 | \$58.20 |

Payment Schedule for Insured Services Provided by a Physician

SECTION X – Diagnostic Radiology

| | | | Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|-------------------------|--|----------------------------------|-------------------------|-----------------------------|---|
| Spine and Pelvis | | | | | |
| 130X | Cervical | | \$43.60 | \$16.20 | \$59.80 |
| 131X | Thoracic | | \$35.00 | \$13.00 | \$48.00 |
| 132X | Lumbar | | \$43.60 | \$16.20 | \$59.80 |
| 133X | Sacro-iliac joints | | \$21.90 | \$12.80 | \$34.70 |
| 134X | Sacrum and coccyx | | \$21.90 | \$12.80 | \$34.70 |
| 135X | Scoliosis survey (limited) | | \$20.05 | \$9.95 | \$30.00 |
| 136X | Oblique views of spine -- add - bill units | | \$16.70 | \$8.10 | \$24.80 |
| 137X | Lumbar spine with flexion and extension | | \$40.45 | \$18.85 | \$59.30 |
| 138X | Cervical spine with flexion and extension | | \$40.45 | \$18.85 | \$59.30 |
| 140X | Scoliosis survey -- full | | \$34.45 | \$18.85 | \$53.30 |
| 141X | Myelogram | | \$89.90 | \$51.00 | \$140.90 |
| 142X | Discogram | | \$89.80 | \$46.80 | \$136.60 |
| 143X | Pelvis | | \$23.25 | \$10.45 | \$33.70 |
| 144X | Pelvis and one or both hips | | \$40.45 | \$15.05 | \$55.50 |
| 145X | Smith-Peterson pinning | | \$70.60 | \$40.50 | \$111.10 |
| Thorax | | | | | |
| 150X | Chest | | \$33.85 | \$14.65 | \$48.50 |
| 151X | Thoracic inlet | | \$19.40 | \$9.10 | \$28.50 |
| 152X | Ribs | | \$25.25 | \$9.95 | \$35.20 |
| 153X | Clavicle | | \$22.20 | \$8.60 | \$30.80 |
| 154X | Sternum or sternoclavicular joints | | \$22.20 | \$9.10 | \$31.30 |
| 157X | Bronchogram (unilateral) | | \$44.30 | \$20.40 | \$64.70 |
| 158X | Chest films with fluoroscopy | | \$26.80 | \$17.30 | \$44.10 |
| 159X | Heart survey and/or cardiac pacemaker evaluation | | \$27.50 | \$10.70 | \$38.20 |
| Extremities | | | | | |
| 160X | Acromioclavicular joint | Two units billable for bilateral | \$22.20 | \$9.10 | \$31.30 |
| 161X | Shoulder | Two units billable for bilateral | \$23.95 | \$10.25 | \$34.20 |
| 361X | Shoulder -- 4 views – unilateral | Two units billable for bilateral | \$31.05 | \$10.95 | \$42.00 |
| 162X | Humerus | Two units billable for bilateral | \$22.20 | \$8.60 | \$30.80 |
| 163X | Elbow | Two units billable for bilateral | \$22.20 | \$8.60 | \$30.80 |
| 164X | Forearm -- radius and ulna | Two units billable for bilateral | \$22.20 | \$8.60 | \$30.80 |
| 165X | Wrist | Two units billable for bilateral | \$22.20 | \$8.60 | \$30.80 |
| 166X | Carpals | Two units billable for bilateral | \$22.20 | \$8.60 | \$30.80 |
| 167X | Hand | Two units billable for bilateral | \$27.55 | \$11.75 | \$39.30 |
| 168X | Scapula | Two units billable for bilateral | \$22.10 | \$9.40 | \$31.50 |
| 170X | Femur | Two units billable for bilateral | \$22.10 | \$9.40 | \$31.50 |
| 171X | Knee | Two units billable for bilateral | \$27.55 | \$11.75 | \$39.30 |
| 172X | Tibia and fibula | Two units billable for bilateral | \$22.10 | \$9.40 | \$31.50 |
| 173X | Ankle | Two units billable for bilateral | \$26.45 | \$11.35 | \$37.80 |
| 373X | Ankle -- specialty view -- (4 views) unilateral | Two units billable for bilateral | \$36.60 | \$12.30 | \$48.90 |

SECTION X – Diagnostic Radiology

| | | | Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|-----------------------|--|----------------------------------|-------------------------|-----------------------------|---|
| Extremities | | | | | |
| 174X | Tarsus | Two units billable for bilateral | \$26.45 | \$11.35 | \$37.80 |
| 175X | Forefoot | Two units billable for bilateral | \$22.10 | \$9.40 | \$31.50 |
| 176X | Os calcis | Two units billable for bilateral | \$22.10 | \$9.40 | \$31.50 |
| 190X | Single digit, same hand or foot | | \$20.90 | \$9.10 | \$30.00 |
| 191X | Digits, same hand or foot | | \$22.20 | \$9.10 | \$31.30 |
| 192X | Orthoroentgenograms | | \$21.40 | \$11.20 | \$32.60 |
| Bone Survey | | | | | |
| 193X | Bone survey | | \$60.20 | \$25.10 | \$85.30 |
| 194X | Joint survey | | \$58.80 | \$24.50 | \$83.30 |
| 195X | Wrist -- four views | Two units billable for bilateral | \$23.20 | \$12.30 | \$35.50 |
| 196X | Knee -- four views | Two units billable for bilateral | \$31.05 | \$13.85 | \$44.90 |
| 197X | Skeletal survey -- infant | | \$40.75 | \$18.25 | \$59.00 |
| Abdomen | | | | | |
| 200X | Single film of abdomen (KUB.) | | \$18.85 | \$9.15 | \$28.00 |
| 201X | Acute abdomen survey with erect and/or lateral views | | \$27.25 | \$15.85 | \$43.10 |
| 210X | Esophagus | | \$36.70 | \$16.10 | \$52.80 |
| 211X | GI Series | | \$68.10 | \$33.10 | \$101.20 |
| 212X | Small bowel study | | \$53.00 | \$20.40 | \$73.40 |
| 213X | Colon -- enema | | \$83.10 | \$36.40 | \$119.50 |
| 214X | Colon -- double contrast enema | | \$118.50 | \$46.20 | \$164.70 |
| 215X | Fluoroscopy for position of tube in abdomen | | \$14.70 | \$13.50 | \$28.20 |
| 216X | Hypotonic duodenography | | \$37.20 | \$21.80 | \$59.00 |
| 217X | Double contrast GI with glucagon | | \$61.20 | \$20.40 | \$81.60 |
| Biliary System | | | | | |
| 220X | Cholecystogram | | \$32.35 | \$14.65 | \$47.00 |
| 221X | Cholangiogram -- intravenous | | \$82.30 | \$31.20 | \$113.50 |
| 222X | Cholangiogram -- operative | | \$57.30 | \$25.30 | \$82.60 |
| 223X | Cholangiogram -- post-operative (T-tube) | | \$50.90 | \$24.00 | \$74.90 |
| 224X | Cholangiogram -- transhepatic, percutaneous | | \$86.10 | \$36.20 | \$122.30 |
| Urinary System | | | | | |
| 228X | Percutaneous renal cystography | | \$23.70 | \$8.40 | \$32.10 |
| 229X | Intravenous pyelogram (hypertensive survey) | | \$72.20 | \$19.60 | \$91.80 |
| 230X | Cystogram | | \$37.40 | \$13.70 | \$51.10 |
| 231X | Pyelogram -- intravenous | | \$93.80 | \$24.10 | \$117.90 |
| 232X | Pyelogram -- retrograde | | \$29.00 | \$7.50 | \$36.50 |
| 233X | IVP -- with voiding cystourethrogram | | \$78.70 | \$25.30 | \$104.00 |
| 234X | Voiding cystourethrogram | | \$72.80 | \$33.20 | \$106.00 |
| 235X | Drip infusion pyelogram | | \$86.10 | \$35.20 | \$121.30 |
| 239X | Urethrogram (retrograde) | | \$29.70 | \$12.30 | \$42.00 |

SECTION X – Diagnostic Radiology

| | | Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|--|--|-------------------------|-----------------------------|---|
| Obstetrics and Gynecology | | | | |
| 240X | Fetus -- scout film | \$15.60 | \$9.50 | \$25.10 |
| 241X | Fetus -- maturity and/or position | \$15.60 | \$9.50 | \$25.10 |
| 243X | Pelvimetry | \$27.30 | \$14.20 | \$41.50 |
| 244X | Utero-salpingogram | \$29.30 | \$15.70 | \$45.00 |
| 245X | Intrauterine blood transfusion | \$26.30 | \$14.20 | \$40.50 |
| Miscellaneous -- without contrast media | | | | |
| 300X | Diagnostic Mammography a) Unilateral. b) repeats within 42 days should be submitted "By report". c) Bill units when bilateral. 1. Screening mammography for women in the 50 to 69 age group is not insured under the Medical Care Insurance Program. Patients should be directed to the provincial Screening Program for Breast Cancer. 2. Where clinical factors determine the need for a mammography (all ages), the physician may refer to a private or public radiology facility. 3. Women <50, where a mammography is deemed necessary, would be supported under the diagnostic definition. | \$62.85 | \$40.25 | \$103.10 |
| 312X | Repeat mammography for radiological localization of non-palpable breast lesion -- bill units | \$97.30 | \$25.50 | \$122.80 |
| 301X | Soft tissues of the neck | \$21.20 | \$7.80 | \$29.00 |
| 302X | Laryngogram | \$37.60 | \$20.10 | \$57.70 |
| 303X | Planigraphy -- first cut | \$24.20 | \$9.70 | \$33.90 |
| 304X | Planigraphy -- each additional cut -- bill units | \$8.80 | \$5.10 | \$13.90 |
| 306X | Cinefluorograph or videotape | | \$15.80 | \$15.80 |
| 307X | Cardiac catheterization | \$33.00 | \$20.00 | \$53.00 |
| Miscellaneous -- with contrast media | | | | |
| 320X | Fistula or sinus tract | \$25.00 | \$8.90 | \$33.90 |
| 321X | Sialogram | \$54.20 | \$29.90 | \$84.10 |
| 322X | Arthrogram | \$64.80 | \$28.50 | \$93.30 |
| 323X | Lymphangiography - upper and lower extremities, including pelvis, chest and abdomen | \$53.00 | \$23.10 | \$76.10 |
| 324X | Dacryocystography | \$26.30 | \$13.70 | \$40.00 |
| 325X | Venogram | \$50.00 | \$22.40 | \$72.40 |
| 327X | Selective cavogram | \$52.90 | \$22.10 | \$75.00 |
| 328X | Azygography | \$52.90 | \$22.10 | \$75.00 |
| 329X | Ventriculogram or encephalogram | \$52.90 | \$22.10 | \$75.00 |
| 330X | Arteriography -- peripheral | \$52.90 | \$22.10 | \$75.00 |
| 331X | Arteriography -- cerebral | \$62.70 | \$29.10 | \$91.80 |

SECTION X – Diagnostic Radiology

| | | Technical Component* | Interpretation Component | Technical* & Interpretation Component |
|------|---|-------------------------|-----------------------------|---|
| 332X | Aortography -- aortic | \$52.90 | \$22.10 | \$75.00 |
| 333X | Aortography -- selective - coronary, renal, mesenteric, bronchial etc | \$52.90 | \$22.10 | \$75.00 |
| 334X | Cardiac angiography | \$62.70 | \$29.10 | \$91.80 |
| 335X | Portogram through umbilical vein | \$62.70 | \$29.10 | \$91.80 |
| 336X | Posterior fossa myelogram | \$70.40 | \$27.50 | \$97.90 |

SECTION X – Diagnostic Radiology

Specialist in Diagnostic Radiology

| | | Specialist | Class | Anes |
|------|--|------------|-------|------|
| 10X | <p>Consultation -- requires formal referral – includes:</p> <ul style="list-style-type: none"> a) all visits necessary; b) history and examination; c) review of radiology and/or other data; and, d) written submission of the consultant's opinion and recommendations to the referring doctor. <p>This code does not apply when the radiologist is only providing information to the patient and/or getting consent for a procedure.</p> <p># Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.</p> <p>Classification: Radiologist Clinical Procedures</p> <ol style="list-style-type: none"> 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% 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%. <p>Angiography</p> <ul style="list-style-type: none"> a) These codes are for use by Radiologists only. b) Cardiologists will find applicable angiography in the A Section. | \$62.70# | | |
| 501X | Vascular access -- for angiography purposes only – max of 2 units per case | \$62.70 | | H |
| 502X | Aortography -- for a dedicated Aortogram(s) only – max of 1 unit per case | \$64.20 | | H |
| 503X | Large vessel angiography -- for angiograms of the main cerebral and visceral trunks of the aorta, maximum of 3 units per case | \$73.10 | | H |
| 504X | Extremity angiogram -- for visualization of vascular structures in either arm or leg, maximum of 2 units per case -- one per extremity | \$68.90 | | H |
| | # 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. | | | |
| | Transluminal angioplasty | | | |
| 600X | Transluminal angioplasty -- peripheral | \$240.20 | 0 | H |
| 601X | Transluminal angioplasty -- renal | \$282.00 | 0 | H |
| 602X | Transluminal angioplasty -- subclavian artery | \$245.40 | 0 | H |
| 603X | Transluminal angioplasty -- aorta or aortic valve | \$438.60* | 0 | H |
| 604X | Stent placement following angioplasty of peripheral, renal or subclavian vessels – add to appropriate angioplasty code – each vessel – bill units | \$71.00 | 0 | H |
| | *Note: Post-angioplasty care for elective procedures is included in the payment for this procedure | | | |

SECTION X – Diagnostic Radiology

Specialist in Diagnostic Radiology

Specialist Class Anes

Radiology Clinical Procedures

1. Clinical procedures associated with diagnostic radiology may be charged in addition to the payments listed in Section X as codes 100X to 336X.
2. 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.

| | | | | |
|------|--|----------|---|---|
| 606X | Selective catheterization of renal vein by Seldinger technique or cut down, unilateral | \$75.20 | D | |
| 607X | Selective catheterization of renal vein by Seldinger technique or cut down, bilateral | \$108.60 | D | L |
| 608X | Selective catheter embolization | \$245.40 | 0 | M |
| 609X | Intravascular thrombolysis -- composite professional fee | \$490.80 | 0 | L |
| 610X | Intravascular thrombolysis -- composite professional fee -- repeats within 48 hours | \$245.40 | 0 | L |
| 612X | Selective transarterial catheterization with infusion | \$222.50 | 0 | L |
| 613X | Azygography | \$41.90 | D | L |
| 614X | Peripheral venography -- unilateral | \$69.40 | D | L |
| 615X | Cavography -- percutaneous or catheter | \$89.30 | D | L |
| 616X | Lymphangiography -- unilateral including pelvis, abdomen and chest | \$82.60 | D | L |
| 617X | Arthrography --each -- bill units | \$63.70 | D | L |
| 618X | Bronchogram – unilateral | \$52.50 | D | |
| 619X | Laryngogram | \$34.30 | D | |
| 620X | Myelography | \$99.50 | D | L |
| 621X | Discography -- one or more discs | \$54.30 | D | L |
| 622X | Sialography -- each -- bill units | \$68.10 | D | L |
| 623X | Injection of a sinus tract | \$54.80 | D | L |
| 624X | Reduction or attempted reduction of intussusception by barium enema | \$67.90 | 0 | L |
| 625X | Percutaneous cholangiography | \$135.70 | D | L |
| 626X | Percutaneous renal cystography | \$50.60 | D | |
| 627X | Percutaneous renal cystography -- with alcohol obliteration of renal cyst | \$81.40 | 0 | |
| 628X | Dacryocystography -- each -- bill units | \$54.30 | D | |
| 629X | Portogram through umbilical vein | \$41.90 | D | |
| 630X | Bronchial brushing | \$65.10 | D | |
| 631X | Pelvic venography | \$34.30 | D | L |
| 632X | Tube positioning for small bowel study | \$29.50 | D | L |
| 639X | Epidurography | \$60.70 | D | |
| 640X | Lumbar epidural venography | \$82.60 | D | |
| 641X | Ureteral stent placement via nephrostomy tract | \$138.40 | 0 | L |

SECTION X – Diagnostic Radiology

Specialist in Diagnostic Radiology

| | | Specialist | Class | Anes |
|---|---|------------|-------|------|
| Procedures under fluoroscopic, CT or ultrasonic guidance | | | | |
| 642X | Percutaneous intrathoracic biopsy | \$122.70 | D | L |
| 643X | Percutaneous intra-abdominal biopsy | \$122.70 | D | L |
| 644X | Percutaneous intra-abdominal drainage | \$183.80 | 0 | L |
| 645X | Percutaneous biliary drainage | \$287.20 | 0 | L |
| 646X | Change of drainage tube in relation to 644X, 645X, 647X, 650X, 651X | \$62.90 | 0 | |
| 647X | Percutaneous nephrostomy with nephrogram | \$313.30 | 0 | L |
| 648X | Manipulation of peritoneal dialysis catheter | \$58.50 | 0 | |
| 649X | Transjugular liver biopsy | \$240.20 | 0 | |
| 650X | Percutaneous gastrotomy | \$174.90 | 0 | L |
| 651X | Percutaneous jejunostomy | \$195.80 | 0 | L |
| 652X | Percutaneous insertion of vena cava filter | \$161.80 | 0 | |
| 653X | Fallopian tube cannulation and dilatation -- with selective salpingography, unilateral or bilateral | \$131.60 | 10 | L |
| 654X | Removal of intravascular foreign body – composite fee | \$235.00 | 0 | |
| 655X | Transjugular portosystemic shunts (TIPS) – composite fee | \$563.80 | 0 | |
| 656X | Non-palpable breast lesion -- needle localization – each, bill units | \$67.90 | D | L |
| 657X | Stereotactic mammographic guided breast biopsy – each, bill units | \$30.60 | D | L |
| 658X | Mammographic or ultrasound guided breast biopsy | \$151.40 | D | |
| | Fluoroscopic control of clinical procedures done by another physician -- per 1/4 hour or major part thereof | | | |
| | For billing of technical components see “Definitions” (19) and “Services Supervised by a Physician”. | | | |
| 659X | — technical component, bill units | \$9.40 | 0 | |
| 660X | — professional component, bill units | \$21.90 | 0 | |
| 661X | Percutaneous insertion of pleural catheter for closed chest drainage (includes 659X and 660X) – each, bill units | \$91.40 | 0 | L |
| 662X | Percutaneous intravenous central catheter (PICC) -- includes placement, removal venography and ultrasound – composite fee | \$220.30 | 0 | L |
| | Portacath, Infusaport, Hemo-Cath, Hickman-Broviac for chemotherapy or long-term TPN (PORT) | | | |
| 663X | -- insertion, composite fee | \$241.20 | 10 | L |
| 664X | -- remove and replace, composite fee | \$347.70 | 10 | L |
| 665X | -- remove or revise, same site, composite fee | \$144.10 | 0 | L |
| 670X | Tunnelled paracentesis drainage catheter -- insertion | \$231.80 | 0 | L |
| 671X | Tunnelled paracentesis drainage catheter -- removal | \$152.40 | 0 | L |
| 672X | Tunnelled pleural drainage catheter -- insertion | \$190.00 | 0 | L |
| 673X | Tunnelled pleural drainage catheter -- removal | \$70.40 | 0 | L |
| 680X | Rhizotomy - sacroiliac (SI) joint - medial branch nerves of multiple facets and SI joints - includes all ablations of multiple target zones | \$516.90 | 0 | L |
| 681X | Rhizotomy – spinal, radiofrequency | \$183.80 | 0 | L |

SECTION X – Diagnostic Radiology

Specialist in Diagnostic Radiology

| | | Specialist | Class | Anes |
|------|--|------------|-------|------|
| 682X | Percutaneous radiofrequency ablation of solid tumors using CT/ultrasound guidance -- first lesion | \$544.50 | 0 | L |
| 683X | Percutaneous radiofrequency ablation of solid tumors using CT/ultrasound guidance -- each additional lesion at the same patient contact (max of 3), bill units | \$296.00 | | L |
| | <ul style="list-style-type: none"> • 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. | | | |

SECTION Y – Therapeutic Radiology, Nuclear Medicine

Therapeutic Radiology services are not listed in this Schedule because in Saskatchewan these procedures are performed in facilities funded through other government programs.

Therapeutic Radiology or isotope procedure is an insured service, where:

- a) it is entirely provided outside a hospital; and
- b) it is provided by a qualified specialist in Therapeutic Radiology