Interprovincial Billing Out-Patient Rates
Effective for Visits on or After April 1, 2018

Service Code	Description	Rate ($)
01	Standard Out-patient Visit, including select discrete high cost diagnostic imaging procedures. Excludes specific services identified within other service codes. See note #7.	359
02	Day Care Surgery – includes high cost interventions of hyperbaric oxygen therapy, Video Capsule Endoscopy and cardiac catheterization (both the diagnostic imaging technical and the nursing clinical care components of this procedure). See note #8.	1,385
03	Hemodialysis	496
04	Computerized Tomography	786
05	Outpatient Laboratory and all other Diagnostic Imaging procedures not specifically listed elsewhere in this schedule of service codes. Includes general radiography, mammography, outpatient laboratory, and referred-in laboratory specimens except for those identified as High Cost Outpatient Laboratory Service Code 15. See note #9.	180
06	Chemotherapy drugs totaling less than $1,000: Bill a visit fee of $359 PLUS the actual acquisition cost of the drugs. No invoice is required. Use code 16 for drug costs totaling $1,000 or more. See note #10.	
07	Cyclosporine/Tacrolimus/AZT/Activase/Erythropoietin/Growth Hormone therapy visit: **$251 plus the actual drug costs**.	
08	Extracorporeal Shock Wave Lithotripsy (ESWL) - Lithotripsy for stones within the gallbladder are excluded.	1,399
11	Magnetic Resonance Imaging per day, including Radiologist services.	749
12	Radiotherapy Services.	435
13	Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/PCI with stents/endovascular coils: the invoiced price of the device (invoice required). In order to bill code 13 the device(s) cost must total $1,000 or more. Service code 13 is intended for the billing of the device cost only. Separate billing for code 01 or code 02 as applicable, is allowed. See note #11.	
15	High Cost Laboratory for laboratory services not specifically listed elsewhere in this schedule of service codes, and **above $180**: the rate provided in the host province's schedule of benefits for laboratory medicine applies; or in the absence of a scheduled rate, an amount that is negotiated between the provincial plans (Genetic screening is excluded).	
16	Chemotherapy drugs totaling $1,000 or greater: Bill a visit fee of $359 PLUS the actual acquisition cost of the drugs. Invoice is required. Prior approval must be obtained for drugs over $3,000. See notes 10 and 12.	

Rules of Application for Billing Out-Patient Services

1. Where applicable rates have been established based on an accumulation of costs reflective of the billing rule of one bill per patient per hospital per day.
2. All rates are composite charges that include non-invasive procedures and necessary diagnostic interpretations.
3. When two or more out-patient activities (service codes 01, 02 to 12, 15 and 16) are provided to the same patient on the same day at the same hospital, regardless of whether the patient was discharged and/or readmitted to the same hospital on the same day, only one out-patient activity can be billed by the hospital (i.e., the one activity with the highest rate).
4. An out-patient charge can be billed on the same day of in-patient admission or discharge from the same hospital, as long as the patient is not a registered in-patient at the hospital at the time of service.
5. If a patient receives out-patient services while admitted as an in-patient the hospital cannot bill for the out-patient services. In these instances the cost of the out-patient services are included in the in-patient per diem rates.
6. If a patient is registered at a hospital as an out-patient and leaves before being seen by a physician or receiving treatment, code 01 may be billed.
7. An out-patient is an individual who has been officially accepted by a hospital and receives one or more health services without being admitted as an inpatient; and whose person identifiable data is recorded in the registration or information system of the organization and to whom a unique identifier is assigned to record and track services.

   Select discrete high cost diagnostic imaging procedures include the following:

   • Nuclear medicine - diagnostic images and treatment procedures using radiopharmaceuticals. Includes single photon emission computed tomography (SPECT). Excludes nuclear medicine scans superimposed on images from modalities such as CT or MRI (e.g. SPECT/CT) which have their own service codes.

   • Fluoroscopy – an imaging technique to obtain real-time moving images of a patient through a fluoroscope, developed from the capture of external ionizing radiation on a fluorescent screen.

   • Ultrasound - the production of a visual record of body tissues by means of high frequency sound waves.

   • Interventional/Angiography Studies - the use of radiant energy from x-ray equipment during interventional and angiography studies. These radiographic techniques use minimally invasive methods and imaging guidance to perform studies that replace conventional surgery such as diagnostic arteriography, renal and peripheral vascular interventions, biliary, venous access procedures and embolization.

8. A day care surgery patient is one who has been pre-booked and registered to receive services from a functional centre that is equipped and staffed to provide day surgery (e.g. an operating room, an endoscopy suite, a cardiac catheterization lab).

9. For the referred-in laboratory specimen this is a composite fee for all specimens in relation to one patient referred to an institution for laboratory tests but where the patient is not present.

   General radiography refers to the use of radiant energy from x-ray equipment for general diagnostic purposes. Mammography involves taking an x-ray of breast tissue for screening and/or diagnostic purposes

10. Chemotherapy drugs are all drugs used to treat cancer including monoclonal antibodies, tyrosine kinase inhibitors, angiogenesis inhibitors etc.

11. Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/stents/endovascular coils:
Cardiac pacemakers and/or defibrillators (any type)

Refers to cardiac devices. Does not include temporary pacemakers or artificial heart.

CCI codes:
Percutaneous transluminal (transvenous) approach or approach NOS:
- 1.HZ.53.GR-NM single chamber rate responsive pacemaker
- 1.HZ.53.GR-NK dual chamber rate responsive pacemaker
- 1.HZ.53.GR-NL fixed rate pacemaker
- 1.HZ.53.GR-FS cardioverter/defibrillator
- 1.HZ.53.GR-FR cardiac resynchronization therapy pacemaker
- 1.HZ.53.GR-FU cardiac resynchronization therapy defibrillator

Percutaneous approach (to tunnel subcutaneously):
- 1.HZ.53.HA-FS cardioverter/defibrillator

Open (thoracotomy) approach:
- 1.HZ.53.LA-NM single chamber rate responsive pacemaker
- 1.HZ.53.LA-NK dual chamber rate responsive pacemaker
- 1.HZ.53.LA-NL fixed rate pacemaker
- 1.HZ.53.LA-FS cardioverter/defibrillator
- 1.HZ.53.LA-FR cardiac resynchronization therapy pacemaker
- 1.HZ.53.LA-FU cardiac resynchronization therapy defibrillator

Open Subxiphoid approach:
- 1.HZ.53.QA-NM single chamber rate responsive pacemaker
- 1.HZ.53.QA-NK dual chamber rate responsive pacemaker
- 1.HZ.53.QA-NL fixed rate pacemaker

Combined open (thoracotomy) approach and percutaneous transluminal (transvenous) approach:
- 1.HZ.53.SY-FS cardioverter/defibrillator
- 1.HZ.53.SY-FR cardiac resynchronization therapy pacemaker
- 1.HZ.53.SY-FU cardiac resynchronization therapy defibrillator

Cochlear Implants:

CCI codes:
- 1.DM.53.LA-LK Implantation of internal device, cochlea, of single channel cochlear implant
- 1.DM.53.LA-LL Implantation of internal device, cochlea, of multi-channel cochlear implant
Category does not include reposition of an existing, previously placed implant (1.DM.54.^^)

PCI (Percutaneous Coronary Intervention) with Stents (including drug eluting stents):

CCI codes:
- 1.IJ.50.GQ-NR Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using (endovascular) stent only
- 1.IJ.50.GQ-OA Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using balloon or cutting balloon dilator with (endovascular) stent-
1.IJ.50.GQ-OB Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using laser (and balloon) dilator with (endovascular) stent
- 1.IJ.50.GQ-OE Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using ultrasound (and balloon) dilator with (endovascular) stent
- 1.IJ.50.GU-OA Dilation, coronary arteries percutaneous transluminal approach with

thrombectomy using balloon or cutting balloon dilator with (endovascular) stent
- 1.IJ.50.GU-OB Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using laser (and balloon) dilator with (endovascular) stent
- 1.IJ.50.GU-OE Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using ultrasound (and balloon) dilator with (endovascular) stent
- 1.IJ.50.GT-OA Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using balloon or cutting balloon dilator with (endovascular) stent
- 1.IJ.50.GT-OB Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using laser (and balloon) dilator with (endovascular) stent
- 1.IJ.50.GT-OE Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using ultrasound (and balloon) dilator with (endovascular) stent

Stent Grafts:

Stent graft procedure is a procedure that uses percutaneous transluminal approach and (endovascular) stent with synthetic graft. EVAR related CCI codes are excluded from this procedure group.

CCI codes:
- 1IA80GQNRN, 1IB80GQNRN, 1IC80GQNRN, 1IM80GQNRN, 1JE80GQNRN,
- 1J K80GQNRN, 1KE80GQNRN, 1KG56GQNRN, 1KG80GQNRN, 1KT80GQNRN

Endovascular Coiling:

Endovascular coiling or endovascular embolization, is a surgical treatment for cerebral aneurysms. This is intended to prevent rupture in unruptured aneurysms, and rebleeding in ruptured aneurysms. The treatment uses detachable coils made of platinum that are inserted into the aneurysm using the microcatheter.

CCI codes
- 1JW51GPGE Occlusion, intracranial vessels percutaneous transluminal approach using [detachable] coils

12. Claims submitted with Code 16 must be accompanied by a hospital invoice that must identify the patient (name, health number, date of administration) and the cost of the drugs used in the visit. Prior approval **must be obtained** for chemotherapy drugs with a cost greater than $3,000. Hospitals should be informed that treatment should not take place until prior approval has been obtained. Hospitals should follow usual prior approval processes to request prior approval from the home Ministry.

    Only one prior approval request is needed for patients that require multiple visits. Hospitals should indicate on the prior-approval request that repeat visits are required.

    In emergency situations, where prior approval cannot be obtained in a timely manner, chemotherapy drugs can be reciprocally billed without prior approval. The host province must notify the home province in writing and provide a rationale as to why prior-approval could not be requested, an adjustment can be requested if no rationale is provided.

How to bill for chemotherapy drugs (codes 06 and 16):

	Scenario 1		Scenario 2		Scenario 3	
	Drug	Cost ($)	Drug	Cost ($)	Drug	Cost ($)
Examples:						
Chemo drugs provided to the patient:						
August 14, 2018	Fluorouracil	14.22	Fluorouracil	14.22	Fluorouracil	14.22
August 14, 2018	Trastuzumab	2,968.00	Trastuzumab	2,968.00	Cyclophosphamide	45.10
August 14, 2018	--	--	Epirubicin	93.39	Epirubicin	93.39
STEP 1 - Determining service code, invoice and prior approval requirements						
Total drug costs used to determine: what code to bill, if an invoice is required and if prior approval is required:		2,982.22		3,075.61		152.71
Billing code used (code 06 under $1,000 or code 16 if $1,000 or over)		16		16		06
Invoice required (total is $1,000 or more)		YES		YES		NO
Prior approval required (total is over $3,000) *		NO		YES		NO
STEP 2 - Determining the amount to claim						
Visit Amount (out-patient code 01)		359.00		359.00		359.00
Total Cost Claimed (total drugs + visit amount)		3,341.22		3,434.61		511.71

Prior-approval requests and invoices should never include the number of units (vials, tablets, dosage, etc.).

How to bill for laboratory services:

Scenarios	Cost = or < $180	Cost > $180
A. Referred in specimen	Code 05	Code 15
B. Patient presents at lab with referral from outside the hospital	Code 05	Code 15
C. Patient seen at emergency/outpatient department and presents at lab on the same day	Code 01	Bill code 01 if the laboratory service cost $359 or less. Bill code 15 if the laboratory service cost more than $359. Only one service code can be billed (see rule 3).
D. Patient seen at emergency/outpatient department and presents at lab on a different day	Code 01 for emergency department visit and code 05 for lab	Code 01 for emergency department visit and code 15 for lab