Payment Schedule

For Insured Services by a Physician

April 1, 2026

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Saskatchewan

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LIST OF INSURED SERVICES, PROCEDURES AND VISITS

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INTRODUCTION

1. This Payment Schedule for Insured Services Provided by a Physician (the "Physician Payment Schedule") is effective for services provided on and after April 1, 2026. 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. Pursuant to *The Saskatchewan Medical Care Insurance Act (*the *"Act") s.s.* 14 (1):

    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 an Automated Claims Submission and 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 Physician Payment Schedule. Pursuant to *The Saskatchewan Medical Care Insurance Payment Regulations 1994* (2021), s.s. 6(1)(d):

    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 service code for the service rendered is listed in the Physician Payment Schedule, that service code must be used in claiming for the service, without substitution.

6. When a physician service is not listed in the Physician Payment Schedule, the physician should write to Medical Services Branch and request advice on the correct submission of the account:

    3475 Albert Street, Regina SK, S4S 6X6 or fax 306-798-0582

    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 Physician Payment Schedule may be authorized upon receipt of a written report.

   To request consideration of payment, please utilize the Customer Portal Query Claim function:

   - Select the Supplementary Claim Information option; and
   - Attach Required Documentation

   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 the following link:

New Fee Items/Tariffs - Saskatchewan Medical Association

OR copy and paste the following into your search bar:

https://www.sma.sk.ca/new-fee-items-tariffs/

SERVICES PROVIDED OUTSIDE SASKATCHEWAN

1. Services out-of-Saskatchewan – In-Canada Coverage

   a) Insured services not available in Saskatchewan should be sought in another province. It is important for you or your patient to contact the out-of-province provider **BEFORE** the service is received to confirm the service is eligible to be billed through the Inter-Provincial Billing Agreement (IRBA) otherwise the patient may be responsible for costs.

   b) **Most physician and hospital** services are billed through IRBA when provided within the **publicly funded** health care system. Services provided outside of the publicly funded health care system are not covered in the IRBA.

   c) Physician services in Quebec may be charged to the patient. Patients can submit a bill to the Ministry of Health for consideration of reimbursement at Saskatchewan rates.

   d) Services not fully covered under the IRBA, including some services in Quebec and services provided outside of the publicly funded health care system, may be considered for coverage in certain circumstances for specific conditions when a written request is submitted to the Ministry of Health. For coverage, **prior approval must be obtained BEFORE** the provision of services. A written prior approval request, including costs, must:
      - be received from a Saskatchewan specialist in the same field of practice as the required service;
      - describe the circumstances of the case, including why the service(s) are medically required and why it must be obtained outside of the province; and,
      - clearly describe the service(s) being requested, including whether it is available in Saskatchewan

2. Services out-of-Canada – Limited Coverage

   a) **Emergency** services, or services resulting from an unforeseen or unanticipated medical situation, are limited to payments at Saskatchewan rates. Prior approval is not required.

   b) **Non-emergency** services, or elective medical services deemed to be pre-arranged, are only considered for coverage in **exceptional** circumstances. **Prior approval must be obtained** from the Ministry of Health in writing **BEFORE** out-of-Canada services are obtained. Regulations **do not** permit reimbursement when prior approval is not obtained before services are provided. As such, to avoid misplaced coverage expectations, it is strongly recommended prior approval is obtained before a patient referral is made outside of Canada.

3. Services Unavailable in Canada – Prior Approval Coverage:

   When an insured service is unavailable in Canada, cost coverage may be considered in exceptional circumstances. **All** of the following conditions **must** be met:

   a) A Saskatchewan listed specialist, within whose field of practice the required service lies, submits a written application to the Ministry requesting consideration of coverage **BEFORE** out-of-Canada services are obtained.

   b) The application must state:
      - the patient's name, address and valid Health Services Number;
      - pertinent clinical details and diagnosis;
      - the specific and detailed nature of the service(s) required;
      - confirmation by the specialist that, to the best of their knowledge, the specific service(s) being requested is not obtainable within Canada; and,
      - where possible, the name and location of the physician who is to provide the service.

SERVICES PROVIDED OUTSIDE SASKATCHEWAN

Services Unavailable in Canada – Prior Approval Coverage – CONTINUED:

c) A coverage decision must be obtained in writing from the Medical Services Branch **BEFORE** the date of service. This decision is provided in writing to the requesting specialist, who is responsible for following up with the patient regarding the decision and the patient's plan for ongoing care.

All prior approval requests must be submitted to:

Director, Insured Services
Medical Services Branch, Ministry of Health
3475 Albert Street, Regina, SK S4S 6X6
Phone : 1-800-605-2965/Fax: 306-798-1124
Email: prss@health.gov.sk.ca

BILLING FOR SERVICES PROVIDED TO OUT-OF-PROVINCE BENEFICIARIES

1. With the exception of Quebec residents, Saskatchewan physicians providing insured services to any Canadian resident should submit their accounts electronically to Medical Services Branch, Ministry of Health, for processing at Saskatchewan rates.

2. Certain services may be excluded from Inter-Provincial Reciprocal Billing Agreement but may be insured by the beneficiary's home province. For clarification in these instances, it is suggested you forward a letter of inquiry to the beneficiary's provincial plan.

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 / All Inclusive** 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 (SHA) 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 nurse practitioner;
f) A specialist in obstetrics and gynecology, pediatrics, neonatology, anesthesia, radiology, psychiatry or pathology, by a midwife.

For the rare occasion when:

- the referring physician's billing number is not valid because the referring physician has not practised in Saskatchewan during the past two years; and
- the patient is not under the care of a new physician; and
- the physician/specialist's claim has been rejected with explanatory code 'ZL',

The consultant physician may use the following temporary referral number in place of the referring physician's number. The name of the referring physician must be documented as a comment in the claim and a record of the referral must be retained in the patient's clinical record. The temporary referral number will only be accepted two (2) times per patient per physician. Additional services will be considered in exceptional circumstances when accompanied by an explanation satisfactory to the Ministry of Health.

Once the patient is under the care of a new physician, it is the expectation that the consultant physician will provide the records related to the initial referral to the new physician and any further referrals or ongoing follow-up care will be billed using the new physician's 4-digit number.

9901 - Referral by retired/deceased/moved out-of-province physician

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 (SHA).

DEFINITIONS

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 their 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, 796A-797A, 793A.

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, they 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 their 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 their own physician number and name when billing. The Ministry of Health will make payment to the host clinic.

DEFINITIONS

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.

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/leasing of equipment and/or employment of staff, on request.

20. **Major Portion/ Major Part Thereof**

When submitting claims for services that state major portion or major part thereof, at least half of the minimum time stated in the code must have elapsed to be payable. For example, if the code states '15 minutes or major portion thereof', the minimum time that can be spent with the patient in order to submit a claim is 7.5 minutes.

When more than one unit is medically required, each unit except for the last one must be the full 15 minutes. The last unit must make up a major portion of the required time. For example, if the physician spent 53 minutes with the patient, three full 15-minute units have been spent, as well as, the major portion of 1 unit; therefore, a total of 4 units may be claimed. If the physician spends 50 minutes with the patient, only 3 units maybe claimed.

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.

Documentation requirements apply to both in-person and virtual care services.

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 (in-person and virtual):

- All listed service code criteria must be recorded.

Time-based Services (in-person and virtual):

- 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 time-based 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*.

- Unless otherwise specified: For time-based visits, the insured service is the time spent directly with the patient providing medically required care. For time-based procedures, the insured service is the time spent performing the medically required procedure.

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 the 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) a) 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 (6) months following the date of service to be eligible for payment under *The Saskatchewan 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 includes both in-person and virtual care services. 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 under the heading “Explanatory Codes”.

5. When a request is made for an explanation or an 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

The assessment rules regarding visit services are applicable to both in-person and virtual care 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.

ASSESSMENT RULES

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.

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 14 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 with a location of service "2" (inpatient).

Consultations

The assessment rules regarding consultation services are applicable to both in-person and virtual care services, unless otherwise stated under the heading "Virtual Care Services".

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 (except in the case of virtual care consultations where a physician examination is not required), review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring physician.

ASSESSMENT RULES

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 follow-up assessments, partial assessments or subsequent visits would be appropriate (either virtual or in-person).

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

Virtual Care Services

All existing assessment rules are applicable to virtual care service codes unless otherwise indicated below.

The provision of medical services via telephone and secure video are intended to align with existing policies and standards such as the College of Physicians and Surgeons of Saskatchewan's Virtual Care policy. This includes all other applicable policies and guidelines, which can be found here:

Policies Tab Landing Page (cps.sk.ca)

1. Virtual care is an interaction between patients and/or members of their circle of care, occurring remotely, using telephone or secure videoconferencing with the aim of facilitating or maximizing the quality and effectiveness of patient care. Remotely, for the purpose of virtual care codes only, is defined as without physical contact and does not necessarily involve long distances (unless explicitly stated in each service description).

2. Virtual care service codes are EMR eligible where applicable (i.e. consistent with existing in-person visit service codes). The 875A service code (Limited virtual care visit) is not EMR eligible.

3. Virtual care service codes are billable by Saskatchewan licensed physicians when both the physician and Saskatchewan beneficiary are located in Saskatchewan at the time the virtual care service is provided. 875A (Limited virtual care visit) may be billed by Saskatchewan physicians and/or Saskatchewan virtual care only clinics that do not provide any in-person services.

    a) Virtual care only clinics are virtual care clinics that do not provide in-person physician services.

    b) The Limited virtual care visit service code is payable to physicians providing episodic care initiated by a patient via secure videoconferencing through a virtual care clinic that does not provide in-person physician services.

    c) The Limited virtual care visit service code recognizes that physicians working in virtual care only clinics may be providing a patient-initiated single encounter episodic visit.

4. Unless stated otherwise, virtual care services are not restricted by location within Saskatchewan, i.e., patient and physician may be located anywhere in Saskatchewan. Both the physician and patient must be located in Saskatchewan at the time the service is provided.

5. Virtual care services are not billable to out-of-province residents or reciprocally by out-of-province physicians. Physicians wishing to provide a virtual care service(s) to an out-of-province resident are advised to contact the resident's home province to confirm payment.

6. Virtual care services are not payable to physicians who are concurrently working under salary, service contract, APP or sessional arrangements (i.e. no duplication of payments). Physicians who are compensated by an alternate payment plan (APP), or directly by the Saskatchewan Health Authority (SHA) are permitted to "shadow bill" these services, but no payment will be eligible.

7. Virtual care services are payable to a maximum of 3,000 virtual care services per physician per calendar year (i.e. total sum of telephone and video visits, including limited virtual care visits (875A), cannot exceed 3,000 per physician per year, and the total number of limited virtual care visit services (875A) cannot exceed 1,500 per physician per year). Note: For time-based virtual care service codes, only the base service code will count towards the annual service count limit.

8. Virtual care services must be medically required and all time requirements are for direct physician-patient interaction in real time.

ASSESSMENT RULES

9. Virtual care services must be direct physician-to-patient contact in real time.

    a) Time spent on indirect or administrative tasks cannot be claimed.

    b) Virtual cares services are not payable for:
        - notification of normal test results, or,
        - notification of office, referral or other appointments, or,
        - "triaging" of patients, or,
        - any other administrative tasks.

    c) For further clarity, the following time cannot be claimed via virtual care service codes:

        - Telephone calls to/from patients in an acute care setting;
        - phone calls to request/obtain sick notes;
        - form completions and other third-party requests;
        - phone calls to obtain or provide updates on behalf of the patient related to referrals/tests/procedures;
        - for consultations with other providers (physicians, allied health care professionals) on behalf/request of the patient.

10. When a medically required assessment is provided on behalf of a patient to the patient's parent/caregiver, communication regarding diagnosis, treatment and follow-up is considered part of the assessment that is to be billed under the HSN of the patient.

11. Unless indicated otherwise, virtual care services can be initiated by physician or patient. Service must be medically required and fulfil all the requirements of the virtual service code in order to be eligible for payment.

    Physician initiated check-in communication with patient is not eligible.

12. Virtual care services cannot be delegated by the physician to a non-physician.

13. Unless indicated otherwise, virtual care services which are payable when provided by a physician is also payable in certain instances when provided under the supervision of a physician. See criteria under the heading "Services Supervised by a Physician". Payments can be made to the physician when 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; and,

    b) the supervising physician is able to intervene promptly if necessary. Billings must include the comment: "supervision of medical learner".

14. Multiple virtual care services (telephone or video) cannot be billed by the same physician or a physician from the same clinic, for the same patient on the same day.

    If, due to extenuating circumstances, more than one virtual care service is medically required (e.g., a change in medical condition requiring reassessment), payment will be considered when a physician provides details. As per standard visit rules under the heading "Visit Services" item (2).

    a) 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.

ASSESSMENT RULES

b) Explanatory Code 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.

15. Services requiring physical in-person examination are not eligible for payment under virtual care codes. If during the course of a virtual visit it becomes apparent that an in-person visit is necessary, only the higher in-person service code is payable.

16. Unless indicated otherwise, no billings for any combination of in-person or virtual care service codes may exceed the individual service code billing limits/maximum units listed.

17. Unless indicated otherwise, virtual care services are not eligible for any premiums or surcharges.

18. Virtual care services may not be claimed for services payable under Monitoring Anticoagulant Therapy (763A), Monitoring Diabetic Patients on Insulin (764A-768A), Monitoring Home Parenteral Antimicrobial Intravenous Therapy (770A), monthly stipend for Overseeing Hepatitis C Treatment (57B), monthly stipend for Overseeing Methadone/Suboxone Management (60B-62B), or Special Care Home Management (627A/628A).

19. Secure videoconferencing must be provided on a secure platform that is compliant with The Health Information Privacy Act. The Saskatchewan EMR Program has released a Virtual Care Quick Start Guide to support physicians in providing virtual consultations during the COVID-19 pandemic. Please visit https://www.emr.sma.sk.ca/pages/virtual_care.html for more information.

20. Physicians are responsible to ensure appropriate documentation (that must include start and stop times for time-based codes) as per “Documentation Requirements for the Purposes of Billing.”

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, inpatient or outpatient, 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;

ASSESSMENT RULES

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 (i.e. “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 (both in-person and virtual)	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.

Note: A visit service can be both an in-person or virtual care service.

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:

1. A person during the period of registration on the educational register of the College of Physicians and Surgeons of Saskatchewan 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;

2. 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;

3. 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:

    a) a laboratory service (V section codes);
    b) the technical component of a diagnostic X-ray or diagnostic ultrasound procedure (W & X section codes);
    c) the technical component of a diagnostic procedure involving a tracing [including, but not limited to, ECGs (30D), spirometries (601D, 611D, etc.), echocardiograms (322A, 522A, etc.), etc.];
    d) an intramuscular, intradermal, or subcutaneous injection (including, but not limited to 110A, 113A, 161A, etc.);
    e) a specimen collection (204A, 205A, 206A);
    f) Repetitive Transcranial Magnetic Stimulation (TMS) (43E), technical component.

4. 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);

5. 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 (6) months following the date of service to be eligible for payment under *The Saskatchewan Medical Care Insurance Act.*

The six months' time limit may be extended to twelve (12) 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 five (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 Saskatchewan Medical Care Insurance Act* requires that they be provided with an itemized statement within six (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:

- patient's name in full;
- patient's Health Services Number (HSN);
- patient's month and year of birth, and sex;
- location of service: office, hospital inpatient, hospital outpatient, home, other;
- three-digit ICD diagnostic code;
- where service is provided in Saskatchewan, service code corresponding to procedure or treatment performed;
- 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;
- 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;
- amount charged for each service provided;
- additional remarks if nature of service was unusual;
- name and signature (not required if claim is submitted by computer) of person providing service;
- 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 their 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 provide a forwarding address to 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 their itemized account to the Ministry of Health.

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

The Saskatchewan Medical Care Insurance Act states, in part, that:

….t*he 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

Location of Service Indicators

The following numeric and alphanumeric indicators should be included on the claim to indicate the location and time the service was provided. For more information, please see:

- "Out-of-Hours Premiums" – Section A
- "After-Hours Clinic Premium for General Practitioners" – Section A

Non-premium location (7:00 a.m. – 7:00 p.m. weekdays)
1 – Office

Non-premium locations (7:00 a.m. – 5:00 p.m. weekdays)
2 -- Hospital inpatient
3 -- Hospital outpatient
4 -- Home
5 -- Other
6 -- Location not indicated
9 -- Emergency Room Physicians

After-Hours Clinic Premium (10%) for General Practitioners (7:00 p.m. to 7:00 a.m. weekdays, all day weekend and STAT holidays) – See Section A for more details ("After Hours Clinic Premium for General Practitioners")
F -- Office

Premium (50%) locations (5:00 p.m. – midnight weekdays; 7:00 a.m. – midnight weekends and STAT holidays)
B -- Inpatient
C -- Outpatient
D -- Home
E -- Other

Premium (100%) locations (Midnight to 7:00 a.m.)
K -- Inpatient
M -- Outpatient
P -- Home
T -- Other

Example: Inpatient service on Saturday at 7 p.m. would be indicator "B" (50%).
Example: Home service on Wednesday at 3 p.m. 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.

GENERAL INFORMATION

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.

Patient Identification

A plastic Health Services Card is issued to identify registered beneficiaries of *The Saskatchewan Medical Care Insurance Act*.

The card shows a Saskatchewan resident's lifetime 9-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 timely 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, residents in Saskatchewan, must be registered for coverage.

For newborns where the mother is a Saskatchewan resident, submit claim under newborn's own HSN. Please verify that coverage is active in Person Health Registration System (PHRS) prior to submission. If inactive, please contact mother or guardian. If the mother is an out of province (OOP) resident, submit the claim under the mother's OOP HSN and the newborn's identification data. The mother's name should be indicated in the comments record.

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 (WCB)**

   The Ministry of Health does not insure services required as a result of workplace injuries. 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. **Department of Veterans' Affairs (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 (SGI) - 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*, SGI 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, 796A-797A).

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) including, but not limited to:

Attendance at camps (i.e. YMCA, YWCA)	Motor vehicle or other licence (i.e. SGI Commercial Drivers' License)
Autopsies	Parking permits
Certification or decertification for mental incompetence	Participation in sports
Daycare/childcare facility	Passport or visa
Employment	Sick notes for any purpose
Employment Insurance Program	University, vocational (i.e. police service, RCMP) or private school entrance
Insurance purposes	Vehicle seat belt exemption
Judicial 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 provide medical services. Also see the College of Physicians and Surgeons of Saskatchewan's guidelines "Establishing a 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.

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 an assessment of an account and/or would like to report and request a review or correction of an account, the physician must write to Medical Services Branch as follows:

1. (a) **For general reassessments and/or corrections to accounts:**

Login to your Customer Portal account, select "Claims Query" and select type "Supplementary Claim
Information" with the description "Request for general reassessment (Claims Supervisor)".

Please refer to the training webpage for Claims Portal Claims Query details and instructions on how to process the steps required in Customer Portal which can be found here:

Training webpage:
https://www.ehealthsask.ca/services/CustomerPortal/Pages/Training.aspx

Claims Query:
https://www.ehealthsask.ca/services/CustomerPortal/Documents/Customer%20Portal%20Claim%20Query.pdf

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(b) **For audit reassessments:**

For services recovered under explanatory codes in the "Routine Audit and Recovery" Section (all explanatory codes starting with "R", i.e. RA, RB, RC)

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:	**By Fax:**	**By Email:**
3475 Albert Street Regina, SK S4S 6X6	306-787-3761	MSBPaymentsandAudit@health.gov.sk.ca

Request for Information and Response forms can be found at this link under the heading "Forms":

FORM - Request for Information and Response.pdf

ASSESSMENT OF ACCOUNTS

2. If dissatisfied with a general decision or an audit decision completed under steps (1) (a) or (1) (b), a further review may be requested by:

   Login to your Customer Portal account, select "Claims Query" and select type "Supplementary Claim Information" with the description "Request for Medical Consultant review".

   Please refer to the training webpage for Claims Portal Claims Query details and instructions on how to process the steps required in Customer Portal which can be found here:

   The Claims Query related documents are named: "Customer Portal Claim Query" and "Query Claim Updated Features"

   These 2 documents can be found on the 'Training and Education' site at the following link: https://www.ehealthsask.ca/services/CustomerPortal/Pages/Training.aspx

   In order for a request by a Medical Consultant to be considered, a detailed letter directly from the physician must be submitted that includes:

   a) **A list of all declined/disputed services for which the physician is requesting further review; and**
   b) **What specifically is being disputed; and**
   c) **Rationale for the appeal; and**
   d) **All corresponding medical records (including any relevant/applicable referral letters and/or pathology reports).**

   The request will not be considered in the absence of the required information. Appeals must be submitted within 60 days of the date of the reassessment under steps (1) (a) or (1) (b).

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

   Login to your Customer Portal account, select "Claims Query" and select type "Supplementary Claim Information" with the description "Request for Medical Assessment Board review".

   Please refer to the training webpage for Claims Portal Claims Query details and instructions on how to process the steps required in Customer Portal which can be found here:

   The Claims Query related documents are named: "Customer Portal Claim Query" and "Query Claim Updated Features"

   These 2 documents can be found on the 'Training and Education' site at the following link: https://www.ehealthsask.ca/services/CustomerPortal/Pages/Training.aspx

VERIFICATION PROGRAM

Accounts paid by the Ministry of Health to either physicians or patients are subject to verification. This does not imply criticism of persons providing or receiving services, but assists the government in maintaining an efficient public program. It also serves to confirm that payments are recorded, billed and paid correctly.

1. Routine Verification

Verification letters are sent to Saskatchewan beneficiaries (patients) 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; and/or

Where a beneficiary indicates disagreement with details in the verification letter, 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 (local)
1-800-667-7523 (toll free)
Fax: 306-798-0582

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

2. Physician Claim Inquiries

Phone: 1-800-605-2965

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 general reassessment; reporting incorrectly billed and paid services; and
f) Billing education, online billing course.

3. Processing Support

Phone: 1-800-605-2965

a) Inquiries regarding accounts submitted more than six months after the date of service;
b) Inquiries regarding unsuccessful internet claims submission or issues with submissions;
c) Specifications for the internet claims submission;
d) Patient information file download;
e) Diagnostic code and service code files;
f) General handling or processing of submissions;
g) Identity problems on returned claims; and
h) Handling of explanatory codes: AA – AR, CM, CN, CZ, YA-YS, ZA – ZS (except ZR).

4. Physician Billing Education

Phone: 1-800-605-2965

a) Inquiries regarding the Medical Services Branch Online Billing Course.
b) Inquiries regarding billing education support.
c) Physician entitlement inquiries.
d) Billing Information Sheets and MSB Claims Processing Calendar.

B. MEDICAL CONSULTANTS

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; and
f) Services not available in Saskatchewan or Canada – out-of-country coverage.

INFORMATION SOURCES

C. FINANCIAL SERVICES

Phone: 1-800-605-2965
Fax: 306-787-3761
Email: AccountingUnitMSB@health.gov.sk.ca

a) Inquiries regarding payment information or the deposit advice.
b) Direct bank deposit information.
c) 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

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D. PHYSICIAN REGISTRY & SUPPORT SERVICES (PRSS)

Phone: 1-800-605-2965
Fax: 306-798-1124
Email: prss@health.gov.sk.ca

a) New physician registration;
b) 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.
c) Medical Statements; and
d) Agreement for physicians to receive payment directly from the Ministry of Health.

E. POLICY, GOVERNANCE & AUDIT (PGA)

Phone: 306-787-0496 / 306-787-7647
Fax: 306-787-3761
Email: MSBPaymentsandAudit@health.gov.sk.ca

a) Responsible for all practitioner (physician, optometrist, dentist) professional review matters related to billing;
b) Routine practitioner audits;
c) Verification of accounts – beneficiaries (patients) and practitioners.

Submission of information should be submitted on an Audit Request for Information and Response Form and other audit related information can be found at the following link:
FORM - Request for Information and Response.pdf

d) Joint Medical Professional Review Committee (JMPRC) inquiries can be directed to: JMPRC@health.gov.sk.ca or billing information sheets can be accessed at the following link: https://www.ehealthsask.ca/services/resources/establish-operate-practice/Documents/JMPRC-Billing-Info.pdf

INFORMATION SOURCES

F. eHEALTH SASKATCHEWAN

Phone: 306-337-0600 (local)
1-888-316-7446 (toll free)
Fax: 306-781-8480
Email: ServiceDesk@eHealthsask.ca

G. FEE-FOR-SERVICE & STATISTICS

Phone: 306-787-7600
Fax: 306-787-3761
Email: MSBDataRequests@health.gov.sk.ca
Mail: Medical Services Branch
Fee-for-Service and Statistics
3475 Albert Street REGINA SK S4S 6X6

Physician profiles represent a summary of services for which the Ministry of Health has made payment to a physician and a comparison to the group average for physicians in the same type of practice. The Medical Services Branch prepares practitioner profiles on a fiscal year and quarterly basis. The fiscal year begins April 1 and ends March 31 of the following year.

a) **Quarterly** fiscal profiles are available on the following basis:

FIRST	--	April to June, inclusive
SECOND	--	July to September, inclusive
THIRD	--	October to December, inclusive
FOURTH	--	January to March, inclusive

b) **Annual fiscal profiles** are available and cover a twelve (12) month period from April of one year to March of the following year (April 1 to March 31). Annual profiles based on the calendar year are not available.

c) **Profile Costs** (GST included in costs) are as follows:

Complete profile set	**$40.00 ($30.00 if ordered prior to June)**
Annual profile	**$20.00**
Individual quarterly profiles	**$5.00 per quarter**

- A complete set of profiles (four quarterly and an annual) may be obtained for a fee of $30.00 if **ordered and prepaid prior to June 1 of the requested year.**
- For requests received after June 1, the regular rates of $5.00 per quarter and $20.00 for an annual will apply.
- In the interest of confidentiality, physician profiles will only be provided with a signed written request by the physician
- When ordering, a cheque for the amount payable should accompany the form.
- Cheques should be made payable to the MINISTER OF FINANCE.
- Requests can be mailed, faxed or emailed per the contact information listed above.
- The Physician Profile Request form can be found online at the following link:

REQUEST FOR INCOME STATEMENT or https://www.ehealthsask.ca/services/resources/establish-operate-practice/Documents/Request%20for%20Income%20Statement%20Form.pdf

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.

Visual examples of Insured Health Services Plan Cards for Reciprocal Billing can be found at the following link:https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx

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 gallbladder 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" – including but not limited to: employers, educational facilities, insurance companies, daycares, sports organizations, motor vehicle or other licensing bodies, etc.
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 (virtual care) 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 - the Health Services Number for this patient is incorrect. Please recheck the Health Services Card and verify your claim details in the Person Health Registration System (PHRS). If appropriate, correct your claim details and resubmit through your vendor system.

AC Incorrect sex indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the sex shown in the Person Health Registration System (PHRS) for future claim submissions.

AD Incorrect Health Services Number indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the number shown in the Person Health Registration System (PHRS) for future claims.

AE Incorrect date of birth indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the birth date shown in the Person Health Registration System (PHRS) for future claims.

AF Incorrect first name and/or last name indicated on claim - Medical Services Branch (MSB) has processed this claim. Please use the first name and/or last name shown in the Person Health Registration System for future claim submissions.

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 eHealth Registries at 1-800-667-7551 in order to have the newborn registered. If appropriate, correct your claim details and resubmit through your vendor system.

AH Please review this claim. Our records indicate that the beneficiary registered under this number died prior to the date of service.

AI This service code requires a comment with additional details for assessment to occur. Please refer to the payment schedule to include the required information and resubmit through your vendor system.

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) ICD code must be Z56;
6) Location of Service must be 3; or
7) An incorrect service code, day of the week or amount has been used.

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 eHealth Registries at 1-800-667-7551 or 306-787-3251 to have their coverage updated.

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, they should immediately contact eHealth Registries, by phone at 1-800-667-7551 or 306-787-3251, 2130 11th Avenue, Regina, S4P 0J5, in order to have coverage updated. If the patient's coverage is updated as per the Person Health Registration System (PHRS), please resubmit the rejected claim through your vendor system.

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 service code are not compatible. If appropriate, correct your claim details and resubmit through your vendor system.

AU To assist in the assessment of this claim, a copy of the operative report, medical record or a descriptive letter is required.
PLEASE NOTE: If an operative report is being submitted, it must contain surgical start & end times.
Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

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. Please verify. If appropriate, correct your claim details and resubmit through your vendor system OR submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information to support this unique billing scenario.

AX A Medical Consultant has reviewed this claim. The circumstances described are not considered sufficient to warrant additional payment. If there are further relevant details, please submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

AY Assessed by a Medical Consultant.

AZ
1) Please refer to correspondence sent to the physician or clinic. If you have questions, please contact the Business Support Desk at 1-800-605-2965; or
2) This code may have been rejected as a procedure that is “normally only performed once” (ie: total bilateral thyroidectomy) or only repeated after a reasonable interval (ie: delivery), please verify service code submitted for accuracy. If appropriate, correct your claim details and resubmit through your vendor system OR submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information to support this unique billing scenario.

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. Use Query Claims in Customer Portal to review this patient's claim history. To search, use the patients HSN, Province, your Billing and Group Number to display all claims processed and their status. This will display your claim history (paid, pended or rejected) and locate any/all duplicate submissions.

BB Possible duplication of a payment for a similar service. If no duplication, submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

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. If appropriate, submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

BD The beneficiary has been paid for a similar service provided on the same day.

BE This Payment Schedule service code and/or diagnostic code applies to a specific age and/or sex.

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) Payment Schedule listed rate in effect for the date of service based on your specialty.
2) The referred rate because a valid referring physician was provided.
3) The unreferred rate because of one of the following:
    a) The 4-digit referring doctor is not valid;
    b) We could find no record of the "referring physician" being licensed to practice; or
    c) 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 unreferred, using appropriate code and fee.

BK Your claim for service(s) has been assessed based on the service code requirements for billing and related assessment rules as indicated in the Payment Schedule.

BL

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 procedure. If done bilaterally or on both sides – please re-submit using the Bilateral Indicator per the Bilateral Indicator Billing Information Sheet.

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;
3) information received on Claims Query; OR
4) your request for recovery of this claim through Query Claims – Physician Requested Recovery

BQ The service code and/or amount submitted are incorrect. Please review and resubmit.

BR Blank or 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, 627A-629A, 680A, 681A, 708A-710A, 714A-718A, 725A-727A, 753A, 770A, 20B, 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, 13I, 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, 796A, 797A).
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; 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 Premium or non-premium payment based on the appropriate service code and amount listed for the date and times provided.

BW Billed more than listed payment - appropriate payment for the date of service has been approved.

BY This is a time-based service; however, no start or stop times were provided on the claim. Please resubmit your claim through your vendor system indicating the start and stop times for this service.

The Ministry of Health
Explanatory Codes For Physicians

BZ Payment is based on the amount payable to a Saskatchewan physician in the same specialty providing the same or similar service.

B1 This is a time-based service:

1) The service code descriptor states "major part thereof" or "major portion thereof" and the major portion/part of the time component stated in the code has not been met; therefore, the additional time units are not payable. Re: Definitions: Major Portion/ Major Part Thereof.
2) Start and Stop times provided do not correspond to the number of units billed.

If appropriate, correct your claim details and resubmit through your vendor system.

B2 This is a time-based service with a base and add component. The start and stop times provided have been entered incorrectly:

1) The start time of the add code must be the same as the stop time of the base code.
2) The total number of minutes for the base code must be equal to the maximum number of minutes eligible without the add code.

If appropriate, correct your claim details and resubmit through your vendor system.
For more information on correct billing, please refer to the 'Time-Based Codes' Billing Information Sheet.

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.

The Ministry of Health
Explanatory Codes For Physicians

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.

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; or

Based on an undertaking or license restriction imposed by the College of Physicians and Surgeons of Saskatchewan, this service is not payable to this physician.

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 Your claim has been rejected for payment and no further action is required. Per The College of Physicians and Surgeons of Saskatchewan's Bylaws (7.1) and Code of Ethics item (7), physicians must:

Limit treatment of yourself, your immediate family, or anyone with whom you have a similarly close relationship to minor or emergency interventions and only when another physician is not readily available; there should be no fee for such treatment.

Medical Services Branch routinely reviews services billed by physicians on family members (as registered in the same family unit by Health Registries) or themselves. In certain circumstances, as deemed necessary by MSB officials, this information is forwarded to the College of Physicians and Surgeons for further investigation.

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 indicating "D" in the claim type field to indicate not DVA responsibility.

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.

CL In-hospital services for which payment may be funded by the Ministry of Health.

The Ministry of Health
Explanatory Codes For Physicians

CM Claims received more than six months after the date of service. A resubmitted claim must be returned within 1 month. Resubmitted claims must include original claim number and the date of the original submission. If factors beyond your control prevented submission within 6 months, the following details must be received in writing addressed to the Manager, Claims Unit. Submit the required information through Customer Portal using Query Claims - Supplementary Claim Information - Request for extension of time limit (Explanatory codes CM-CN):

Please include:

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.

CP Our latest information from the College of Physicians and Surgeons of Saskatchewan indicates that you are registered in Saskatchewan as a General Practitioner.

CQ Quebec does not participate in the Inter-Provincial Reciprocal Billing Agreement for physician services. Please bill the patient directly.

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 indicating "W" in claim type field to indicate not WCB responsibility and a comment indicating the date submitted to and rejected by WCB.

CY This service not usually billed by a physician in your specialty.

CZ The 20A and other associated visits, laboratory services, 131A, 204A, 205A, 206A, 30D, 31D, 32D and 815A-839A can be on the same claim number and should be submitted with a diagnostic code of Z90 (Examination-Third Party Request from the Ministry of Social Services). Also a diagnostic code of Z90 should only be used in conjunction with a claim containing a service code of 20A. If appropriate, amend your claim details and resubmit through your vendor system.

The Ministry of Health
Explanatory Codes For Physicians

VISITS

DA Only one visit type service is approved by the system during a single patient contact. If there were 2 separate patient contacts, please add a comment to your claim through Customer Portal using Query Claims – Supplementary Claim Information including the reason and start and stop times of both visits on the same day in the comment field.

DB Please clarify the second visit on the same day by the same physician or the same specialty and clinic.

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, 206B, and 207B are only payable once per patient every 90 days; we have adjusted your payment to a similar visit 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 appropriate, correct your claim details and resubmit through your vendor system OR submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information to support this unique billing scenario.

DM 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.

If appropriate, correct your claim details and resubmit through your vendor system OR submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information to support this unique billing scenario.

The Ministry of Health
Explanatory Codes For Physicians

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, 935A, 936A, 335H to 339H and most 400H-424H services -- include all services provided during this time. Payment based on your description of services.

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.

If appropriate, correct your claim details and resubmit through your vendor system OR submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information to support this unique billing scenario.

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.
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. Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

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.

The Ministry of Health
Explanatory Codes For Physicians

EJ Claims paid for virtual care services have reached the maximum billable in a calendar year.

EL In person or virtual consultation converted to an in person or virtual partial/follow-up assessment. Re: Assessment Rules - "Consultations", #6 (b) and (d) and #7.

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.

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 have been admitted by a specialist or a GP Hospitalist from an approved site; please resubmit with the name of the admitting specialist or GP Hospitalist.
4) 52/53B is not payable based on other service code criteria listed in the Payment Schedule.

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.

The Ministry of Health
Explanatory Codes For Physicians

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.

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.

FJ This procedure is not payable as it is billed with another procedure that is:
- all inclusive or
- composite or
- billable when only procedure done.

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.

The Ministry of Health
Explanatory Codes For Physicians

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 Physician 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.

Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

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). Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

GC This claim is being reviewed by a Medical Consultant; please provide a copy of the medical record/operative report within 90 days. Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

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.

The Ministry of Health
Explanatory Codes For Physicians

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).

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

HQ Approved only for services provided in a designated Pain Clinic by a recognized specialist in anesthesia or other physician with training approved by the SMA Tariff Committee.

SURGICAL ASSISTANCE

JA Payment for assistance is not approved for this procedure unless special circumstances satisfactory to the Ministry of Health are described. Re: Section "J", item 2. Please send a copy of the Operative Report and the Case Record. Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

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 This claim is rejected as the surgery claim has not been received or the surgery submitted is not eligible for the type of assist billed. Please contact the surgeon.

1) When confirmed that surgery is submitted by the surgeon and Assist remains unpaid, please submit a Claims Query with a comment – Surgeon submitted the claim for procedure.
2) If surgery is not eligible for the type of assist billed, please resubmit a new claim.
3) Verify the date of service billed. If correct, provide the Operative report and case record, through Query claims, Supplementary claim information, for your claim to be reviewed. If incorrect, resubmit the claim with the correct date of service.

The Ministry of Health
Explanatory Codes For Physicians

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:

a) The service was not provided between 8:00 and 5:00 pm Monday to Friday;
b) The service was billed with a premium location (B, K, M, C);
c) The service was billed with a surcharge (815A-839A);
d) The physician was not eligible to bill this service because they do not earn less than 50% of their income through surgical assisting;
e) 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

JN Considered an inclusion within the payment for a more major procedure.

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.

The Ministry of Health
Explanatory Codes For Physicians

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.

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 This service is only payable for malignancy. Please submit additional information which supports the claim through the Customer Portal using Query Claims - Supplementary Claim Information.

KV This service is not payable unless necessary criteria of the code is documented on the claim. Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

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. 46P, 10 or 42 day procedures). Please resubmit through your vendor system with date of procedure, type of procedure and, if done out of province, the location (i.e. city/town) where the procedure was provided.

The Ministry of Health
Explanatory Codes For Physicians

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.

If appropriate, correct your claim details and resubmit through your vendor system.

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.

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.

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.

MF Payment for the previously attempted reduction is reduced by 50%.
1) "Fractures", item 3(b)
2) "Dislocations", item 2.

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).

The Ministry of Health
Explanatory Codes For Physicians

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).

50P and 250P cannot be billed for administering or prescribing pharmaceutical abortion agents such as mifepristone and misoprostol. See service code 150B and 351P for the administration and medical management of pharmaceutical abortion agents.

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).

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. Submit the required additional information through Customer Portal using Query Claims - Supplementary Claim Information.

PU Continuous personal attendance is not paid with a delivery.

INCORRECT FEES

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 Please review and resubmit when appropriate:

a) This service code applies to a specific day and/or time; or
b) 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); or
c) 701A is only billable on a Saturday or Sunday.

Resubmit with the correct date of service.

QE This service code must be billed in conjunction with a base code. Please review the Payment Schedule and code descriptor. Resubmit your amended claim in the next billing cycle.

The Ministry of Health
Explanatory Codes For Physicians

ROUTINE AUDIT & RECOVERY

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

Ministry officials expect that the records submitted for review are complete, legible and support the service(s) billed according to the "Documentation Requirements for the Purpose of Billing", as adjudication is based on the records received by MSB.

This includes supporting documentation regarding any applicable charges pertaining to time of day, location of service, start and stop times, etc.

All relevant documentation to support the code(s) as billed should be submitted for review at once within 30 days of the request in order to prevent delays in the completion of routine audits. If additional information has been formally requested by Audit, it is expected that the supporting documentation is submitted for review as soon as possible to avoid further delay.

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. Please refer to the "Routine Audit and Recovery" preamble in the current Physician Payment Schedule for further information.

RB This adjustment for repayment *or* recovery 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/recovered as it is currently under review as a part of a routine audit. Policy, Governance and Audit (PGA) will adjudicate this claim and make the appropriate adjustment, if warranted. Do not resubmit electronically. For inquiries related to this audit, contact PGA.

RD This service appears to have been pre-planned/pre-arranged. If the claim was billed with a surcharge (815A-839A or 721A), within 30 days please provide the medical record that supports:

a) the time of day that the service was provided;
b) the physician's location when they were called out; and
c) the reason for the special call.

The Ministry of Health
Explanatory Codes For Physicians

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, including documentation that supports the location of service billed and time that the service was provided. If the documentation submitted for review does not support the location of service provided, payment will be made with a non-premium location of service.

RF A special call/surcharge (815A to 839A) was billed. Within 30 days, please provide:

a) the time of day that the service was provided; and
b) the physician's location when they were called out; and
c) 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 Policy Governance and Audit (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, 161A, etc.), please resubmit as the appropriate injection code.

If the partial assessment (5B) was medically required and meets all of 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.

The Ministry of Health
Explanatory Codes For Physicians

RJ The Ministry of Health performs post-JMPRC 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-JMPRC 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.

RK The Ministry of Health performs post-JMPRC 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-JMPRC 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.

RM Monthly stipend codes (60B, 61B, 62B) are restricted to physicians who have been approved by the College of Physicians and Surgeons of Saskatchewan to prescribe either methadone or buprenorphine/naloxone (Suboxone) for addiction and are actively supervising the patient's continuing use of methadone or buprenorphine/naloxone (Suboxone), within the provincial methadone program, based on your prescribing authority status.

a) These codes are not billable for the management of patients with "pain"; and/or
b) These codes are not billable if the physician does not have current approval from the College of Physicians and Surgeons of Saskatchewan to prescribe these medications for addiction.

The Ministry of Health
Explanatory Codes For Physicians

RN This service is being recovered as the result of a routine audit pertaining to the billing of a Special Care Management service code (627A, 628A). Within 30 days, please submit the name and full address of the Special Care Home or facility, in addition to the corresponding record(s). See PGA contact information in preamble.

RO This service is being recovered as it appears to be cosmetic in nature. Cosmetic treatments and therapies (a service to enhance appearance without being medically necessary) are not insured services. This includes any consultations or assessments provided for the provision of assessing the suitability or options for a cosmetic treatment or therapy. Physicians should not use the presence of a "medical" element (ie: acne, medical refill) as justification to bill the publicly funded system when uninsured (cosmetic) services are the main motivation of the patient.

Per *The Medical Care Insurance Beneficiary and Administrative Regulations*, section 10, subsection (i) and (e):

> *For the purposes of section 15 of the Act, the following services are uninsured services:*
>
> *(e) plastic or other surgery for cosmetic purposes;*
> *(i) any service that is provided in conjunction with another service that is an uninsured service.*

RP The service code(s) submitted does not appear consistent with the condition or diagnosis as described. If it was not the correct code, please resubmit the correct code with a comment on the claim. We do not require a report unless the initial code submitted was the intended service code; if so, within 30 days, please submit documents to support your billing to PGA; please see the preamble for contact information.

RQ Diagnostic testing must only be ordered and performed when medically required and clinically indicated.

If there was a medical necessity for this testing, within 30 days, please provide an explanation regarding the clinical indication and medical necessity of the test(s) and submit the requested information to PGA; please see the preamble for contact information.

RR This service is being recovered as the result of a routine audit pertaining to the billing of a service that requires a referral, such as a consultation service or a diagnostic ultrasound/x-ray-, etc. We require a copy of the requisition/referral, as well as documentation that supports the service billed, such as the consultation letter or radiology report, etc. Within 30 days, please submit the requested information to PGA; please see the preamble for contact information.

The Ministry of Health
Explanatory Codes For Physicians

RS This service is being recovered as it appears to be billed in conjunction with a service that is not insured by the Ministry of Health. The service(s) for which your claim has been billed in conjunction with has been reviewed through routine audit and determined to be an uninsured service.

For surgery and procedures not insured by the publically funded system, the anesthetic and assistants' fees also are not insured.

Per *The Medical Care Insurance Beneficiary and Administrative Regulations*, section 10, subsection (i):

> *For the purposes of section 15 of the Act, the following services are uninsured services:*
>
> *(i) any service that is provided in conjunction with another service that is an uninsured service*.

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.

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.

RW This claim for routine house call surcharge(s) (615A, 915A) has been declined as it appears to be billed for non-medically required circumstances.

This code cannot be used for travelling to see patients in their home (such as private or group) for convenience, courtesy, or preference by the patient or the physician when no medical necessity for the travel exists. If there was a medically required reason for the physician to travel to the patient's home, within 30 days, please provide an explanation and submit to PGA; please see the preamble for contact information.

RX Services not performed by the physician personally:

a) This service appears to have been performed by someone other than the physician. Therefore, no payment is eligible – see "Services Supervised by a Physician"; or

b) It cannot be determined who performed this service; please submit an explanation and/or a copy of the supporting documentation which demonstrates who performed the service and submit to PGA; please see the preamble for contact information.

RY This service has been recovered, converted or adjusted based on the start and stop times submitted on the claim or contained in the medical record.

The Ministry of Health
Explanatory Codes For Physicians

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.

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

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.

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

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

The Ministry of Health
Explanatory Codes For Physicians

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

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

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.

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 Hospital days span split into 2 or more lines as there has been a change in specialty or entitlement.

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, they 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 their practice.

YT Please resubmit the claim indicating the hospital admission and discharge dates.

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. If appropriate, correct your claim details and resubmit through your vendor system.

ZD Please verify the following:
1) Date(s) of service;
2) Date of birth; AND/OR
3) A claim that spans over multiple months for non-hospital care services must be separated per calendar month.

If appropriate, correct your claim details and resubmit through your vendor system.

ZF This clinic/physician is not eligible to submit for services on the indicated dates of service.

The Ministry of Health
Explanatory Codes For Physicians

ZG Please verify your locations of service (LOS) on this claim. If this is for the same patient contact, you cannot submit multiple locations for premium eligible services that spans different LOS (i.e. non-premium/premium or 50% /100% premium). Please resubmit through your vendor system with the LOS appropriate for when the service started for that patient contact. If separate patient contacts, please split claim.

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, or for code 14B the billing physician specialty is not a GP with entitlement and/or the referring practitioner is not a nurse practitioner. Please check the referring physician name and number.

On occasion, the referring doctor's 4-digit number is not valid because the referring physician has not practised in Saskatchewan during the past two years. For these rare instances, resubmitting the claim using the temporary referral number 9901 may be appropriate. See 'Referral' in the 'Definitions' section of Payment Schedule for submission criteria. If appropriate, amend your claim details and resubmit through your vendor system.

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.
If appropriate, correct your claim details and resubmit through your vendor system.

ZN The Ministry of Health has received multiple claims from the same physician/same clinic for the same service code with the same date of service under the same HSN. One of the claim(s) is either pending (no further action on your part) or rejected (refer to the explanatory code provided). Please do not resubmit. Use Query Claims in Customer Portal to review this patient's claim history. To search, use the patients HSN, Province, your Billing and Group Number to display all claims processed and their status. This will display your claim history (paid, pended or rejected) and locate any/all duplicate submissions.

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 location of service submitted does not correspond to the service code, date of service and/or times indicated on the claim. (See "Out-of-Hours Premiums" or "After-Hours-Clinic Premium For General Practitioners" in Section A of this Payment Schedule). If appropriate, correct your claim details and resubmit through your vendor system.

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.

ZZ Exceeds maximum billable. The temporary referral number is payable two (2) times per patient per physician. Please submit an explanation for exceeding this limit through Customer Portal using Query Claims - Supplementary Claim Information.

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S E C T I O N 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 patient's 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. All calls must be recorded on the patient's file chart, including the name of the SGI representative.	$30.00	$30.00
71A	Written letter or 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. • All reports must be retained in the patients file. • SGI Requested Seizure Follow-up forms are also billable under 71A.	$55.00	$55.00
74A	Examination and Report requested by the SGI Driver Medical Review Unit requesting the physician's assessment of the patient's ability to operate a motor vehicle. The following forms are billable under this code only: • SGI Requested Driver's License Medical Report • Cognitive Assessment Report • Driver's Psychiatric Examination Report (specialists only) • Report of Visual Functions (ophthalmologists only)	$140.00	$75.00

S E C T I O N A – General Services

		Specialist	General Practitioner
20A	Report requested by the Ministry of Social Services to determine employability, rehabilitation potential, Level of care, or other specified reason. The 20A and other associated visits and laboratory codes should be submitted with a diagnostic code of Z90 (Examination-Third Party Request from the Ministry of Social Services).	$34.65	$34.65
37A	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	$64.30	$57.90
39A	**Rape victim** (suspected or actual) – includes: a) medical history; b) examination; c) counselling; d) all medical documentation; and, e) initial treatment.	$476.10	$476.10
40A	**Child abuse victim** (suspected or actual) – includes: 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	**FASD assessment and diagnosis** - per 15 minutes or major portion, max of 12 units per patient (3 hours)	$45.85@	$45.85@

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:
   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:
   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.

S E C T I O N A – General Services

		Specialist	General Practitioner
56A	**Report requested by Cancer Agency or Cancer Screening Program** The following are covered under this fee code: 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	$14.85	$14.85
60A	**Required physician reporting forms** The following form is covered under this fee code: Physician Reporting Form for West Nile Cases -- must be billed with diagnostic code 066	$14.50	$14.50
	Third party counselling for the provision of Medical Assistance in Dying (MAID) services provided by a willing practitioner 1. Billable on a third party basis when a family member, caregiver, relative, friend, spouse, etc is counselled because of the patient's request for Medical Assistance in Dying (MAID) services. 2. Third party counselling is billable to a maximum of 3 hours per day per patient. More than 3 hours is billable by report with a comment on the electronic claim with the total duration of time spent. 3. Third party counselling claims should be submitted in the name of the patient requesting MAID services (not the family member, relative, caregiver, etc). 4. Diagnosis must be Z37 (third party counselling, MAID). 5. May be billed by any physician. 6. Surcharges are not payable (815A-839A). 7. Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.		
80A	Third Party Counselling – first 15 minutes, includes a) History review; b) Counselling; c) Educational dialogue; d) Intervention; e) Record of service provided; f) Time spent counselling.	$56.20	$56.20
81A	Third Party Counselling – next 15 minutes or major portion thereof	$47.55	$47.55

S E C T I O N A – General Services

		Specialist	General Practitioner
	Exception Drug Status		
153A	**Multiple Sclerosis** Payment for the completion and submission of the initial and renewal documentation required by the Saskatchewan Drug Program (SDP) to determine eligibility for Exception Drug Status (EDS) in the treatment of multiple sclerosis. a) Only one fee is payable every twenty-four (24) 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 Exception Drug Status (EDS) in the treatment of Alzheimer's disease. a) Follow-up status reports required by the SDP 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 Exception 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
	Specified Forms		
753A	Physician completion and submission of an application filed with the court under *The Mandatory Testing and Disclosure (Bodily Substances) Act* -- by report	$17.60	$17.60
909A	Initiating protocol for the discontinuance of life-support systems following certification of brain death	$34.00	$34.00

S E C T I O N A – General Services

		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.				
100A	Collection of blood from donor for transfusion	$18.40	$18.40	0	
101A	Phlebotomy for therapeutic reason e.g. polycythemia	$18.40	$18.40	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.	$51.25	$51.25	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	$22.00	$22.00	0	
111A	Injections a) medication extra b) not for injection into IV tubing nor for initiation of IV c) direct intravenous injection of medication	$22.00	$22.00	0	
112A	Injections a) medication extra -- arterial puncture	$22.00	$22.00	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	$18.00	$18.00		
114A	IVP/IVC injection when performed in the absence of a radiologist	$16.30	$16.30	D	
115A	Aspiration and/or injection of ganglion	$31.00	$31.00	0	
116A	Insertion of subcutaneous contraceptive implant	$56.10	$56.10	0	L
117A	Removal of subcutaneous contraceptive implant	$70.00	$70.00	0	L
120A	Bladder catheterization -- urethral	$16.50	$16.50	0	
121A	Bladder catheterization -- other than urethral	$11.55	$11.55	0	
122A	Peritoneal lavage	$105.00	$105.00	D	
123A	Insertion of IUD	$56.10	$56.10	0	
104A	Removal of intrauterine device (IUD) Note: If attempt at removal of IUD is unsuccessful, only the visit service is payable.	$27.50	$27.50	0	
105A	Removal of intrauterine device (IUD) when string is not visible and requires the use of sterile instruments for intrauterine manipulation (e.g. IUD retrieval hook, grasper, or curette).	$44.00	$44.00	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)	$172.70	$172.70	0	
127A	Lumbar puncture	$69.20	$69.20	D	L
128A	Gastric lavage	$17.80	$17.80	0	
129A	Percutaneous manipulations of gallstone(s)	$277.00	$277.00	10	L
131A	Submission of Papanicolau smear (females only)	$22.00	$22.00	D	
118A	Pessary Visit -- Initial fitting or review (no tray service)	$50.00	$50.00	0	L

	S E C T I O N A – General Services	Specialist	General Practitioner	Class	Anes
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	
134A	Insertion of central venous catheter	$67.65	$67.65	D	L
135A	Insertion of central venous catheter in infant	$136.40	$136.40	D	L
136A	Insertion of central venous catheter in infant -- under general anesthesia or IV sedation (includes post-op recovery)	$164.20	$164.20	D	L
137A	Percutaneous intravenous central catheter (PICC), composite fee a) Includes vascular access, placement, removal, venography, fluoroscopy and ultrasound. b) Billable when performed by a specialist in pediatrics, general surgery, anesthesia or internal medicine.	$244.00	$219.60	0	L
140A	Insertion of arterial line for measurement of systemic pressures -- unilateral or bilateral -- adult	$43.55	$43.55	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	$3.40	$3.40	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	$22.00	$22.00		
162A	Vaccination and reading	$20.00	$20.00	0	
	Allergy Diagnosis (Testing)				
170A	Scratch test (inhalant/ingestant) - each -- max 35 units per year	$3.40	$3.40	D	
171A	Patch test (contact dermatoses) - each -- max 50 units per year	$6.20	$6.20	D	
172A	Intradermal test - each -- max 20 units per year	$7.80	$7.80	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	$8.40	$8.40	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)	$43.00	$38.80	D	
	Total Parenteral Nutrition 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		

S E C T I O N A – General Services

		Specialist	General Practitioner	Class

Botox Injections

1. Botox is not insured for cosmetic purposes, or 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
   - General Surgeons
   - Gynecologists
   - Internists
   - Neurologists
   - Ophthalmologists
   - Otolaryngologists
   - Orthopedic Surgeons
   - Physiatrists
   - Plastic Surgeons
   - Urologists
   - 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	$277.00	$249.25@	42
194A	Multiple muscle – unilateral	$247.50	$222.75@	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 – per side - left or right armpit, bill units	$115.20	$103.70@	42
	a) To initiate billing, two physicians must have diagnosed the patient with hyperhidrosis (e.g. referring physician and consultant, or two family physicians with the second physician confirming the diagnosis)			
	b) Botox injections are indicated in those cases of hyperhidrosis where conservative measures (e.g. aluminum chloride, iontophoresis, or systemic medications) fail to resolve the problem or where the symptoms of hyperhidrosis are severe enough to give rise to emotional and social, as well as functional problems that impact the patient’s quality of life.			
	c) The treatment includes pre-injection assessment, nerve blocks/local anesthetic, subsequent visits and any further injections within 12 (twelve) weeks.			
199A	Botox injection of detrusor muscle via cystoscopy for neurogenic or non-neurogenic overactive bladder.	$189.60	$170.70	42

S E C T I O N A – General Services

		Specialist	General Practitioner

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;
b) multiple systems major trauma;
c) cardio respiratory failure;
d) resuscitation of newborn;
e) severe shock; and,
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;
b) blood gases;
c) cardioversion;
d) cutdowns;
e) CVP lines;
f) defibrillation;
g) endotracheal intubation;
h) intravenous lines;
i) nasogastric tubes;
j) pharmacological agents;
k) pressure infusion sets;
l) tracheal toilet; and,
m) urinary catheters.

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	$123.20	$123.20
221A	-- second 15 minutes	$61.60	$61.60
222A	-- after first 30 minutes -- per 15 minutes or major portion thereof	$56.10	$56.10
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	$56.10	$56.10

S E C T I O N 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	$61.60	$61.60
225A	-- after first 15 minutes -- per 15 minutes or major portion thereof	$56.10	$56.10
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	$56.10	$56.10

S E C T I O N A – General Services

		Specialist	General Practitioner	Class	Anes
	Specimen collection and referral To be sent for a special test:				
204A	Urine Collection and referral of specimen(s)	$7.50	$7.50	D	
205A	Blood Collection and referral of specimen(s)	$7.50	$7.50	D	
206A	Other Collection and referral of specimen(s)	$7.50	$7.50	D	
207A	Bone Marrow -- aspiration	$53.55	$53.55	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	$21.55		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 A codes (Angiography procedures for radiologists - use Section X codes)				
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	$22.45	$22.45	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	$78.55	$78.55	D	H

S E C T I ON 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		$381.25		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	$271.00		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	$509.80		10	
333A	Transluminal angioplasty --	pulmonary valve or artery where followed by corrective surgery within 24 hours	$254.90		10	
334A	Transluminal angioplasty --	aorta or aortic valve	$494.90*		0	
336A	Transluminal angioplasty --	subclavian artery	$270.35		0	H
337A	Stent placement following angioplasty of peripheral, renal or subclavian vessels – add to appropriate angioplasty code – each vessel – bill units		$78.20		0	H
338A	Selective Catheter Embolization		$270.35		0	M
493A	Transcatheter closure of ductus arteriosus		$560.80*		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		$330.00		0	L
407A	Manipulation of peritoneal dialysis catheter		$64.40	$64.40		
460A	Non-palpable breast lesion - needle localization provided by surgeon -- bill units		$76.65	$76.65	D	L
412A	Percutaneous fallopian tube cannulation and dilatation -- with selective salpingography, unilateral or bilateral		$143.75	$143.75	10	L
463A	Injection of a sinus tract		$61.85		D	L
403A	Percutaneous intra-abdominal drainage		$192.10		0	L
462A	Sialography		$76.80	$76.80	D	L
661A	Percutaneous insertion of pleural catheter for closed chest drainage -- bill units		$112.00	$112.00	0	L

S E C T I ON A – General Services

Specialist Class Anes

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 they 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, 2025	321A	Interpretation of M Mode & 2D echo
May 15, 2025	521A	Interpretation of M Mode & 2D echo
July 12, 2025	533A	Interpretation of M Mode, 2D & Doppler echo
February 2, 2026	530A & 531A	Technical & interpretation of M Mode & 2D echo
March 6, 2026	No fee payable	Interpretation of M Mode & 2D echo
May 4, 2026	321A	Interpretation of M Mode & 2D echo (start of new series)

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

320A	-- technical	- first		$55.00#	D	
520A	-- technical	- second		$55.00#	D	
530A	-- technical	- third and fourth, each		$55.00#	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	$80.00#	D	
522A	-- technical	- second	- 17 years of age and older	$80.00#	D	
532A	-- technical	- third and fourth, each	- 17 years of age and older	$80.00#	D	
556A	-- technical		- under 17 years	$80.00#	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			$80.00#	D	
536A	-- interpretation			$110.10#	D	

S E C T I ON 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

S E C T I ON A – General Services

		Specialist	General Practitioner
	Geriatric Assessment Unit		
600A	Payment for assessment of patients attending Geriatric Assessment/Rehab Unit	$13.30	$13.30

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	$65.45	$65.45
681A	Group counselling -- additional complete 15-minute units (to a maximum of 3 units)	$65.45	$65.45
	House Call Surcharges		
615A	House Call Surcharge -- not specially called	$26.60	$26.60
915A	House Call Surcharge -- home care of cancer patient registered by the Saskatchewan Cancer Agency	$36.85	$36.85

The intent of payment under surcharge codes 615A and 915A is for a visit to a patient at home (not special care 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.

S E C T I O N A – General Services

Special Care Home Management (SCHM) - 627A, 628A, 629A

The routine continuous management (both indirect and direct) of patients in special care homes. Maximum of one (1) payment by any physician every 14 days for either indirect care or direct care.

To facilitate appropriate payments: When direct care is billed in addition to and following indirect care in the same 14-day period, indirect care is paid and direct care (628A) converts to 629A – Special Care Home Management Conversion.

For the purpose of Special Care Home Management, non-urgent patient care excludes special calls (i.e. urgent/emergent). Where a physician visits a patient on a special call basis, payment will be at the special call rates depending upon the time of day. 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).

As per best practice, special care home management is expected to include at least one direct patient care visit per year.

To initiate billing of these codes:

1. The physician's first SCHM fee claims for the patient must include the comment: "will be providing continuous care".
2. Subsequent (after 14 days) SCHM fee claims must be consecutive and continuous for the same patient by the same physician or clinic and will not require a comment.
3. If a different physician (from a different clinic) is temporarily providing management of special care home patients on behalf of the most responsible physician, and claiming SCHM fee codes for those patients, the claim(s) must include the comment: "Covering for Dr. first name; last name". If a different physician (from the same clinic) is temporarily providing management of special care home patients on behalf of the most responsible physician, and claiming SCHM fee codes for those patients, the claim(s) do not require an additional comment.

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:

The Facility Designation Regulations: https://publications.saskatchewan.ca/#/products/11559

The Personal Care Homes Act: https://publications.saskatchewan.ca/#/products/802

S E C T I O N A – General Services

		Specialist	General Practitioner
627A	**Indirect Patient Care for Special Care Home Patients**	$36.45	$36.45

This fee is for the bi-weekly continuous management of non-urgent indirect patient care to evaluate the patient's condition and to provide advice as necessary to the nursing/facility staff concerning the routine management of the patient.

For the purposes of billing 627A, a facility visit is not required. The expectation is that indirect patient care is provided during regular business hours (i.e. excluding evenings, weekends and statutory holidays)

This service includes all necessary non-acute indirect patient care:

a) Medication refills;
b) Routine ordering and/or reviewing test results;
c) Routine advice to family members/caregivers;
d) Monitoring Anticoagulant Therapy (763A);
e) All discussions with the staff of the facility related to the patient's care; and
f) All telephone calls to/from the staff of the facility, patient's relative(s) or patient's representative related to the patient's routine care.

NOTE: Does not include Telephone Calls/Facsimile/Email on behalf of a Palliative patient—793A billable in addition to 627A).

The fee is only payable for weeks in which continuous management of indirect patient care has been provided (i.e., the physician is the most responsible physician)

628A	**Direct Patient Care for Special Care Home Patients**	$91.40	$91.40

This fee is for a non-urgent medically necessary visit to evaluate the patient's condition and to provide advice as necessary to the patient and/or the nursing/facility staff concerning the routine management of the patient

1. A face-to-face patient/physician encounter must be made and must include:
   a) Relevant functional enquiry;
   b) Assessment;
   c) Physical examination (if indicated);
   d) Necessary treatment;
   e) Advice to the nursing/facility staff; and
   f) Record of service provided.

2. This service also includes all necessary non-urgent indirect patient care:
   a) Medication refills;
   b) Routine ordering and/or reviewing test results;
   c) Routine advice to family members/caregivers;
   d) Monitoring Anticoagulant Therapy (763A)
   e) Medication reviews;
   f) All discussions with the staff of the facility related to the patient's care; and
   g) All telephone calls to/from the staff of the facility, patient's relative(s) or patient's representative.

NOTE: Does not include Telephone Calls/Facsimile/Email on behalf of a Palliative Patient—793A billable in addition to 628A.

The fee is only payable for weeks in which direct patient care has been provided.

S E C T I O N A – General Services

		Specialist	General Practitioner
629A	**Special Care Home Management (SCHM) Conversion – <u>FOR MSB USE ONLY</u>**	$54.95	$54.95

There may be instances when direct care is provided following indirect care within the same 14-day billing period. Ideally, only direct care will be billed (as direct care includes indirect care). However, there may be instances when both indirect and direct care fee codes are submitted to MSB in the same 14-day billing period. In these instances, for the purposes of payment only:

1. The indirect patient care code will remain as billed to signal the beginning of the 14-day billing period;

2. The direct patient care code will automatically convert to 629A – Special Care Home Management Conversion and pay $54.95 – the difference between Direct and Indirect care.

S E C T I O N 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 they are already in the building.** Surcharges may apply to a service at: the patient's home;
   a) hospital out-patient or emergency department;
   b) Special care home;
   c) physician's office when the physician is called back from some other place;
   d) 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) For any service that is prearranged or prescheduled, including situations where the physician is notified by staff, patients, or any third party that the patient has arrived for a prescheduled service;
   b) Where by prior arrangement, a patient may go to the out-patient department of a hospital, in lieu of an office visit;
   c) Special call initiated by the physician (except the house call surcharges 615A or 915A);
   d) With another surcharge: 615A, 700A, 701A, 721A, 815A, 816A, 817A, 818A, 819A, 836A, 837A, 838A, 839A, or 915A.
   e) With codes 41A, 80A, 81A, 153A-155A, 184A, 190A-199A, 600A, 627A-629A, 680A, 681A, 708A-718A, 725A, 726A, 727A, 753A, 761A-769A, 790A-795A, 796A-797A, 770A, 20B, 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, 13I, 80J, 81J, 278K, 279K, 31M, 260P and 300T. These codes include all services rendered as well as any travel;
   f) With hospital day care items, e.g. 25 to 28 section B to T, 35B;
   g) With emergency medicine visits (73B & 85B);
   h) SGI Medical Driver Fitness and Review (codes 70A to 74A);
   i) 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.

S E C T I O N A – General Services

		Specialist	General Practitioner
700A	**Statutory Holiday Hospital Care Surcharge** 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.	$12.10	$12.10
701A	**Saturday and Sunday Hospital Care Surcharge** 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.	$12.10	$12.10
721A	**Emergency Surcharge** -- day or night -- any day – see preamble 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.	$97.70	$97.70
	Hospital Discharge		
725A	Hospital discharge & documentation: 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.	$19.50	$19.50

Surcharges – Special Calls – please see preamble on previous page

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 only	8:00 a.m. to 5:00 p.m.	$46.85	$46.85
817A	Surcharge --	first patient seen	5:00 p.m. to 12:00 a.m. (Mon - Thur)	$68.65	$68.65
837A	Surcharge --	each additional patient seen	5:00 p.m. to 12:00 a.m. (Mon - Thur)	$33.90	$33.90
819A	Surcharge --	first patient seen	12:00 a.m. to 8:00 a.m.	$159.70	$159.70
839A	Surcharge --	each additional patient seen	12:00 a.m. to 8:00 a.m.	$46.00	$46.00
	Weekends and Statutory Holiday				
816A	Surcharge --	first patient seen	8:00 a.m. to 5:00 p.m.	$61.95	$61.95
836A	Surcharge --	each additional patient seen	8:00 a.m. to 5:00 p.m.	$30.90	$30.90
818A	Surcharge --	first patient seen	5:00 p.m. to Midnight (Fri - Sun)	$83.60	$83.60
838A	Surcharge --	each additional patient seen	5:00 p.m. to Midnight (Fri - Sun)	$41.60	$41.60
819A	Surcharge --	first patient seen	12:00 a.m. to 8:00 a.m.	$159.70	$159.70
839A	Surcharge --	each additional patient seen	12:00 a.m. to 8:00 a.m.	$46.00	$46.00

S E C T I O N 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 anesthetist.
- This supplement excludes ECGS (30D, 31D, 32D).
- You are required to submit the following codes to obtain the weight supplement:

893A Patients greater than 30 days of age, less than 91 days and less than 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:

   <u>For patients less than 3 kg - 50% to a max of $1500</u>
   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%).

   <u>For patients greater than 3 kg and less than 6 kg - 25% to a max of $1500</u>
   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. <u>For patients greater than one year of age and less than 6 kg</u> in weight will be given consideration by report.
   a) Please submit separately to the Medical Consultant.

S E C T I O N 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 they provide 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, 13E 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, 12E, 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.

S E C T I O N A – General Services

Out-of-Hours Premiums

1. The out-of-hours premium provides the physician with increased compensation when they perform 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, i.e. 627A-629A;
   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, 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, 796A-797A, 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, 580N, 580P, 581P, 400R, 500R, 580R, 15S, 16S.

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;

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.

S E C T I O N A – General Services

After-Hours-Clinic Premium For General Practitioners

1. The after-hours-clinic premium provides the physician with increased compensation when they perform 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 only.
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; i.e. 627A-629A;
   e) lab services;
   f) services always done in the hospital, e.g. 184A, 600A, 725A, 726A, 727A, 732A, 734A, 121D, 123D, 124D, 128D, 129D, 132D, 278D, 279D, 281D-291D, 400H-424H, 540H, 545H, 580H, 585H, 80J, 81J, 278K, 279K, 679K, 580L, 180M, 383M, 580N, 333P, 580P, 581P, 400R, 500R, 580R;
   g) SGI services (70A, 71A, 74A); and
   h) other services, e.g. 763A, 764A, 765A, 766A, 767A, 768A, 57B, 60B, 61B, 62B, 130D, 131D, 43E.
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 Ministry of 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 Medical Services Branch, 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.

S E C T I O N 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.

S E C T I O N 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 SHA 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
		5 p.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

City / Town	Postal Code (s)	Dummy HSN	City / Town	Postal Code (s)	Dummy HSN
Arcola/Carlyle	S0C 0G0/S0C 0R0	000091448	Outlook	S0L 2N0	000091367
Assiniboia	S0H 0B0	000091014	Oxbow	S0C 2B0	000091456
Biggar	S0K 0M0	000091022	Radville	S0C 2G0	000091464
Esterhazy	S0A 0X0	000091030	Redvers	S0C 2H0	000091499
Fort Qu'Appelle	S0G 1S0	000091057	Rosetown	S0L 2V0 or S0L 3P0	000091235
Gravelbourg	S0H 1X0	000091421	Rosthern	S0K 3R0	000091243
Hudson Bay	S0E 0Y0	000091065	Shellbrook	S0J 2E0	000091251
Kamsack	S0A 1S0	000091081	Tisdale	S0E 1T0	000091286
Kelvington	S0A 1W0	000091413	Turtleford	S0M 2Y0	000091405
Kipling	S0G 2S0	000091383	Unity, Wilkie	S0K 4W0 or S0K 4L0	000091332
La Loche	S0M 1G0	000091111	Wadena	S0A 4J0	000091430
Lloydminster	S9V or T9V (Alta.)	000091146	Watrous	S0K 4T0	000091472
Maple Creek	S0N 1N0	000091359	Wynyard	S0A 4T0	000091375
Melville	S0A 2P0	000091170			

S E C T I O N 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 SHA plan. This plan may include concurrent coverage of more than one community or more than one facility.

2. It is expected that the SHA, 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

City / Town	Postal Code (s)	Dummy HSN
Black Lake	S0J 0H0	000092614
Broadview	S0G 0K0	000092045
Davidson	S0G 1A0	000092142
Herbert	S0H 2A0	000092231
Ile a la Crosse	S0M 1C0	000092258

City / Town	Postal Code (s)	Dummy HSN
Indian Head	S0G 2K0	000092274
Kerrobert	S0L 1R0	000092290
Lanigan	S0K 2M0	000092347
Leader	S0N 1H0	000092355
Porcupine Plain	S0E 1H0	000092509
Wolseley	S0G 5H0	000092703

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 (SHA) 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 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

Facility	Postal Code(s)	Dummy HSN
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

S E C T I O N A – General Services

		Specialist	General Practitioner
	Telemedicine Supplement with Direct Interactive Video Link with the Patient		
	Payment is limited to Medical Services Branch (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 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).	$12.50	$12.50
729A	**Telemedicine Technical Standby** -- for each 15 minutes, or major portion thereof, max 30 minutes 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.	$34.55	$34.55
728A	**General Practitioner Assistant** -- for each 15 minutes, or major portion thereof, more than 2 units require an explanation 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.		$31.40
	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	$57.65@	$57.65@
727A	Video case conference -- subsequent 15 minutes, or major portion	$39.60@	$39.60@

S E C T I O N 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) 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.	$27.50	$27.50
	Monitoring Anticoagulant Therapy		
763A	Monitoring anticoagulant therapy by telephone, per month – 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.	$25.20	$25.20
	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.		
764A	Patients with type 2 diabetes on insulin – per month	$27.50	$27.50
765A	Patients with type 1 diabetes on insulin – per month	$51.05	$51.05
766A	Patients with type 1 diabetes on insulin pump – first 12 months	$78.00	$78.00
767A	Patients with type 1 diabetes on insulin pump – after 12 months	$51.00	$51.00
768A	Pregnant patients with diabetes (type 1 or 2) on insulin -- includes gestational diabetes – per month	$76.45	$76.45

S E C T I O N A – General Services

		Specialist	General Practitioner

Remote Consultation Between Physicians

769A **Major Telephone Assessment** -- includes: $55.55 $55.55@

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.

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.

762A **Minor Telephone Assessment** -- includes: $27.50 $27.50@

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.

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.

@ General practitioners approved to provide coverage under the Specialist Emergency Coverage Program may be entitled to bill 762A and 769A.

770A **Monitoring Home Parenteral Antimicrobial Intravenous Therapy – by telephone** $27.35

1. Payable for management of antimicrobial agents prescribed for administration at home through parenteral home intravenous programs.
2. Only payable to specialists recognized by the College of Physicians and Surgeons of Saskatchewan as being Infectious Disease specialists (both adult and pediatric).
3. Payable once per calendar week per patient; ie: only one physician is able to bill on the same patient per week.
4. This service is not eligible for premiums or surcharges.
5. This payment stops when the active treatment protocol ends.
6. Includes:
   a) monitoring the condition of a patient regarding antimicrobial therapy;
   b) ordering blood tests;
   c) interpreting the results;
   d) inquiry into possible complications; and,
   e) adjusting the dosage of the antimicrobial therapy.
7. Visit services for each patient contact would be paid per usual.
8. A record of the information and the physician's advice must be included in the patient's chart.

S E C T I O N A – General Services

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:
   - Ambulance Paramedics
   - Home Care Coordinators
   - Mental health workers
   - Occupational Therapists
   - Pharmacists
   - Physiotherapists
   - Private care home shift supervisor
   - Psychiatric Nurses
   - Psychologists
   - Public health nurses
   - Registered/licensed practical nurses
   - Respiratory Therapists
   - School Teachers/counsellors
   - Social Workers
   - VON
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, 796A, 797A, 794A and 795A is payable per day.
13. If other services are provided on the same day codes 790A/791A/796A/797A 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 Special Care Home Patients

790A	Facsimile/email -	Not payable in addition to any other payment for the same date of service	$16.05	$16.05
796A	Telephone -	Not payable in addition to any other payment for the same date of service	$22.00	$22.00

On Behalf of All Other Patients

791A	Facsimile/email -	Not payable in addition to any other payment for the same date of service	$16.05	$16.05
797A	Telephone -	Not payable in addition to any other payment for the same date of service	$22.00	$22.00

S E C T I O N A – General Services

		Specialist	General 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, 796A, 797A, 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).

793A	Telephone calls/facsimile/email on behalf of palliative per patient -- bill units – max 3.	$22.00	$22.00

S E C T I O N A – General Services

			Specialist	General 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, 796A, 797A, 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	$6.05	$6.05
795A	Prescription renewal fax/email -	Not payable in addition to any other payment for the same date of service	$5.50	$5.50

S E C T I O N A – General Services

		Specialist	General Practitioner
	Virtual Care Services Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
875A	**Limited virtual care visit (patient to physician) provided via secure videoconference.** Maximum one per patient, per day. Cannot be billed with any additional service codes, virtual or in-person, by the same physician on the same day. Includes: a) history review; b) history of presenting complaint c) functional enquiry; d) assessment; e) diagnosis; f) necessary treatment; g) advice to the patient; and h) record of service provided. This service must be initiated by the patient. Limited virtual care visit service code is payable to physicians (General Practitioner or Specialist) providing episodic care initiated by a patient via a virtual care clinic that does not provide in-person physician services. This service code is not payable for services performed by a medical learner under the supervision of a physician. Physicians providing services via a virtual care only clinic must use this service code and must deliver the service via secure video conference. For further clarity, 875A is not payable for virtual care services provided via telephone.	$26.50	$26.50

S E C T I O N 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	$49.85	$44.90

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.

926A	Outbound journey with patient only – per 15 minutes or major portion thereof (bill units)	$54.00	$48.60
927A	Homeward or return journey with or without patient – per 15 minutes or major portion thereof (bill units)	$35.00	$31.50
928A	Standby at destination while patient is transferred to receiving physician (max 4 units) - per 15 minutes or major portion thereof (bill units)	$40.00	$40.00

S E C T I O N 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	$44.00

S E C T I O N A – General Services

		Specialist	General Practitioner

Hyperbaric Oxygen Therapy

The administration and supervision (direct continuous and indirect non-continuous) of hyperbaric oxygen therapy including assessment, examination, ongoing monitoring of the patient's condition, and intervention, as appropriate.

1. Billable only when provided in an MSB-approved facility.

2. Billable only for the treatment of those clinical conditions recognized and approved by Health Canada.

3. HBOT is only eligible for payment for idiopathic sudden sensorineural hearing loss when the following conditions are met:
   a) The patient is treated concurrently with corticosteroid unless corticosteroids are contraindicated; and
   b) The treatment is initiated within 14 days of a diagnosis of ISSHL that is made or confirmed by an Otolaryngologist.
4. Visit services billed in conjunction at the same patient contact must be medically required and fulfill all requirements as indicated in the Payment Schedule. Visit services are not to be billed in addition to 935A when only pre- and/or post-assessment and exam services are provided - these services are included in 935A fee

935A	**Hyperbaric Oxygen Therapy – Continuous Attendance --first 15 minutes**	$79.20	$79.20

First 15 minutes of direct continuous attendance and monitoring of a patient in the hyperbaric unit.

1. This fee is inclusive of all pre- and post-assessment and exam services (review of history, medications, treatment plan, contraindications, review of side effects and signed consent).
2. No other service can be provided or billed in this interval

936A	**Hyperbaric Oxygen Therapy – Continuous Attendance --subsequent 15 minutes or major portion thereof** -- bill units, maximum 11 units per session.	$39.60	$39.60

Per 15 minutes (or major portion thereof) of direct continuous attendance and monitoring of a patient in the hyperbaric unit.

1. No other service can be provided or billed in this interval.

937A	**Hyperbaric Oxygen Therapy – Non-Continuous Indirect Supervision**	$39.60	$39.60

Non-continuous indirect supervision of a patient in the hyperbaric unit. Physician must be on site and able to intervene promptly, as necessary.

1. Billable once per patient, per session.

2. Not payable if physician is receiving compensation by another program or funding source for providing on-site coverage during the same time and date at the same facility.

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S E C T I O N 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, 14B, 15B, 20B, 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 ----- 20%
   b) for patients 65 to 74 years of age ----- 30%
   c) for patients 75 to 84 years of age ----- 40%
   d) for patients 85 years of age and older ----- 45%

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

3B **Complete assessment--includes:** $88.05*

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

4B **Well baby care in office** -- refers to the periodic office visits during the first year of life of a healthy infant and includes: $45.80*

a) the necessary weights and measurements;
b) examination;
c) instruction to the parent regarding health care; and,
d) record of service provided.

5B **Partial assessment or subsequent visit -- includes:** $44.10*

a) history review;
b) history of presenting complaint;
c) functional enquiry;
d) examination of affected part(s) or system(s);
e) assessment;
f) diagnosis;
g) necessary treatment;
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.

S E C T I O N B – General Practice

General Practitioner

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

55B **Partial assessment or subsequent visit involving a specialist referral -- includes:** $44.10*

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

8B **Prenatal visit after the first visit for maternity care or post-natal office visit --** This service is only eligible for payment when all relevant clinical details of the visit are documented in a Saskatchewan approved prenatal form. $47.50

9B **Consultation** – includes: $92.50*

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

11B **Repeat Consultation** $48.30*

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 service code 5B “partial assessment” is appropriate.

S E C T I O N B – General Practice

General Practitioner

14B **Specialized assessment and written report involving a nurse practitioner referral – includes:** $92.50*@

a) all visits necessary;
b) pertinent history and examination;
c) review of laboratory and/or other data;
d) advice to patient;
e) written report with recommendations to the referring nurse practitioner; and,
f) record of service provided.

Note: 14B is not billable on patients who are on the physician's roster or if the physician is already the MRP for the patient at the time of referral.

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

@ Payment approved for physicians with additional post-graduate training/qualifications listed under their College of Physicians and Surgeons of Saskatchewan profile, for eligible NP-referred specialized assessments relevant to the physician's requisite education.

Eligible NP-referred specialized assessment services for physicians with approved training/qualifications in:

- GP-Anesthesia
- GP-Obstetrics
- GP-General Surgery
- Allergy
- Sports Medicine
- Addictions Medicine
- Dermatology
- Palliative Care
- Pediatric psychiatry: GPs with entitlement to bill Advanced Primary Health Care for Pediatric Patients – Psychiatric Care (163B/164B)
- Chronic Pain: GPs with entitlement to bill Pain Clinic Codes (201H-205H)

Physicians with additional post-graduate training or qualification in the abovementioned categories not listed on their CPSS profile who are providing (or intend to provide) eligible referred specialized services may submit an application form with their credentials to the SMA Tariff Committee for consideration to be approved by MSB & the SMA for entitlement to bill 14B.

For the purposes of billing, 14B is billable on the date that the approval is granted to the physician by MSB & the SMA.

15B Pre-operative assessment --includes: $79.60*

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.

S E C T I O N B – General Practice

General Practitioner

20B	**Medical management of sexually transmitted and blood-borne infections (STBBI)**	$61.60

1) Visit service for laboratory confirmed or suspected clinical case of one or more STBBIs – **must include:**
   a) Patient examination and assessment;
   b) Ordering, reviewing, and/or follow-up of laboratory tests;
   c) Diagnosis and necessary treatment including any necessary prescription(s);
   d) Patient education and/or counselling regarding STBBI care & prevention;
   e) Completion of prescribed STBBI Public Health Reporting form(s); and
   f) Record of service provided.
2) Per "Documentation Requirements for the Purposes of Billing", the documentation must demonstrate that all of the above components were performed.
3) Only payable once per patient, per case even if more than one STBBI is being assessed, treated, and reported during the same visit and/or additional information is added to the reporting form(s) at a later date.
4) This code cannot be billed if the only service provided is the completion of the STBBI reporting form.
5) Visit services are not billable in addition.
6) Surcharges (815A-839A) are not payable.

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 codes 627A-629A – Special Care Home Management.

25B	-- 1-10 days	-- per day -- bill units (max 10)	$64.00
26B	-- 11-20 days	-- per day -- bill units (max 10)	$64.00
27B	-- 21-30 days	-- per day -- bill units (max 10)	$64.00
28B	-- 31 days and thereafter	-- per day -- bill units (max 99)	$64.00

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 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)	$80.20

S E C T I O N B – General Practice

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: a) history review; b) counselling,; c) educational dialogue; d) intervention; e) record of service provided, and; f) time spent counselling.	$56.20
41B	Counselling -- next 15 minutes or major portion thereof	$47.55

S E C T I O N B – General Practice

General Practitioner

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.

42B	-- per conference (not patient)	-- first 30 minutes or part thereof	$108.15
43B	-- per home care conference (not patient)	-- first 30 minutes or part thereof	$108.15
44B	-- add to 42B or 43B	-- for each additional 15 minutes or part thereof	$54.05

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, or a General Practitioner (GP) Hospitalist from an approved site, 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.
6. An approved GP Hospitalist site is a hospital with at least one permanent GP hospitalist rota.
7. Supportive care is not billable by the family physician if they are the physician who admits the patient to hospital.
8. This service is only payable if the 4-digit number of the physician who admitted the patient is indicated in the referring doctor field.

52B	Supportive care, initial visit -- to be billed once per admission - otherwise use 53B	$50.15
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)	$50.15

S E C T I O N B – General Practice

General Practitioner

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".

57B	Hepatitis C - Monthly Stipend for Overseeing Treatment -- each month		$52.25@

Monthly stipend for Overseeing Methadone/Suboxone Management – Addiction patients only

60B	First 3 months	-- per patient (lifetime maximum)	$75.00
61B	Second 3 months	-- per patient (lifetime maximum)	$60.00
62B	Thereafter	-- per patient	$50.00

1. No restarts in the payment program; if the patient leaves the program and then at a later date re-enters the program, their payment would resume at the same level as when they 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 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 and/or Suboxone <u>for addiction</u>; 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/Suboxone.

63B	**Psychiatric Examination**	$110.25

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.

S E C T I O N B – General Practice

General Practitioner

150B **Medical Management of Termination of Early Pregnancy** – includes 5 days of ongoing medical management of the patient by the same physician or another physician in the same clinic, including any or all of the following: $174.10

a) Patient examination, assessment, visits, consultation, communication, and/or counselling;
b) Administration of the requisite medication regimen (the included 5 days of ongoing medical management entails management services provided on day of initial consultation and 4 days following);
c) Ordering, reviewing and follow-up of laboratory tests;
d) All communication with other physicians or allied health care personnel (verbal and written) related to the medical management of the patient; and,
e) Billable once per patient per discrete pregnancy by any physician.

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.

4. 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.

5. Time Spent with Patient:
   a) The CDM fee includes a patient visit that **involves at least 15 minutes of physician time**.
   b) Visits in excess of one every 90 days, or visits involving less than 15 minutes of physician time, should be billed using appropriate visit codes (e.g. code 5B).
   c) Start and stop times must be included on the claim and documented in the medical record.

6. 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.
   c) Start and stop times must be included on the claim and documented in the medical record.

S E C T I O N B – General Practice

					General Practitioner
64B	**Chronic Disease Management -- base fee**				$40.05
	Add one or more of the following fees for chronic condition(s) assessed during the visit:				
65B	**Diabetes mellitus**	**-- add**	- billable for diagnostic codes:	250	$40.05
66B	**Coronary artery disease**	**-- add**	- billable for diagnostic codes:	410-414 inclusive	$40.05
67B	**Heart failure**	**-- add**	- billable for diagnostic codes:	425, 428, 429	$40.05
68B	**COPD**	**-- add**	- billable for diagnostic codes:	490, 491, 492, 496, 518, 519	$40.05

For the purposes of entering times on the claim:
The start and stop times for the total physician time spent with the patient for the CDM visit should be entered under the 64B code and must be a minimum of 15 minutes. For more information, see the 'Time-based Services' billing information sheet.

Examples:

a) 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.
b) If a physician sees a patient with more than one chronic disease such as diabetes and coronary artery disease, they would bill fee 64B, 65B and 66B with the completion of a both flow sheets after 20 minutes of physician time.

S E C T I O N B – General Practice

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 **Complete assessment --** includes: $88.00*

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.

85B **Partial assessment or subsequent visit --**includes: $44.10*

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

* 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.

200B Spinal pathway $15.35

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.

S E C T I O N B – General Practice

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 (1) 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. Start and stop times must be included on the claim and documented in the medical record.

205B **Chronic Pain Management - Initial Assessment** $225.00@

Chronic Pain Management

Entitlement Criteria: Chronic Pain Management initial and follow-up pain assessments (205B, 206B) are payable to general practitioners who have applied to and have been granted approval from the Saskatchewan Medical Association Tariff Committee.

Approval will be based upon a combination of the following criteria: proof of expertise in chronic pain management (examples of proof must include 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. Start and stop times must be included on the claim and documented in the medical record.

206B **Chronic Pain Management – Follow-up Assessment** $75.00@

HIV/AIDS – Primary Care Management

HIV/AIDS management is payable to general practitioners responsible for the primary care of patients with a diagnosis of HIV/AIDS once per patient every 90 days for the following:

a) Review of medication and/or antiviral therapy; and
b) Review and/or ordering of diagnostic and/or screening tests, such as lab work, (ie: CD4 counts, viral loads), tuberculosis, vaccinations, chest x-rays, hepatitis screening, etc; and
c) Completion of approved flow sheets/templates with care consistent with approved guidelines; and
d) Assessment of vital signs, weight, and body mass index (BMI), noting any abnormalities and/or changes in general appearance, body habitus, physical well-being, frailty, and mobility; and
e) Review of current and past medical history, any relevant changes in social or family history, current functional inquiry and review of systems; and
f) Review and management of any relevant underlying co-morbid conditions; and
g) Review and evaluation of any substance or alcohol use; and
h) Review of any psychosocial implications or factors; and
i) Patient education and/or counselling regarding HIV/AIDS care.

- Visits in excess of quarterly (90-day) limits would be billed using other applicable fee codes (ie: partial assessment (5B)) when all criteria of those codes are met;
- Per "Documentation Requirements for the Purposes of Billing", the documentation must demonstrate that all of the above components were performed;
- No time-of-day premiums are eligible except in-office premium "F"; and
- No surcharges/special calls are billable, as this is considered a prearranged service.

207B	HIV/AIDS – Primary Care Management	$81.50

Advanced Primary Health Care for Pediatric Patients – Psychiatric Care

Billable time includes history taking, diagnostic formulation according to Child Psychiatry Principles and appropriate psychopharmacology, counselling and record keeping. It may include collection and review of data from collateral sources (ie: parents/caregivers, significant relatives, social workers, teachers, and allied health care professionals -- see "Definitions" section).

Note: Start and stop times must be included on the claim and documented in the medical record.

163B	**Advanced Primary Health Care for Pediatric Patients – Psychiatric Care, first 15 minutes** – must be 15 minutes of direct patient care.	$60.30@
164B	**Advanced Primary Health Care for Pediatric Patients – Psychiatric Care, each subsequent 15 minutes (or major portion thereof)** – max 2 units billable – may be direct or indirect patient care which includes collection, review and any discussion related to collateral history from a person who has close knowledge of a patient under the care of or treatment by the physician. May be done either in-person or by telephone, facsimile, email or other electronic means.	$60.30@

@ Physicians with training approved by the Saskatchewan Medical Association Tariff Committee. For the purposes of billing, 163B and 164B are billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

S E C T I O N B – General Practice

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

805B **Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference**-- includes: $39.70

a) history review;
b) history of presenting complaint;
c) functional enquiry;
d) assessment;
e) diagnosis;
f) necessary treatment;
g) advice to the patient; and
h) record of service provided.

Use 855B instead of 805B for a virtual visit where a specialist referral is made and continue using 805B for virtual visits where a specialist referral is not made

855B **Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference, involving a specialist referral** - includes: $39.70

a) history review;
b) history of presenting complaint;
c) functional enquiry;
d) assessment;
e) diagnosis;
f) necessary treatment;
g) advice to the patient; and
h) record of service provided.

809B **Virtual consultation provided via telephone or secure videoconference**-- includes: $83.25

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

811B **Repeat virtual consultation provided via telephone or secure videoconference:** $43.50

A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '805B' "Virtual partial assessment or subsequent virtual visit" is appropriate.

Virtual Counselling

1. Virtual counselling is where the physician engages with the patient on an individual basis, via telephone or secure videoconference, 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. Virtual 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. Payment for this service implies that it is a discrete service provided by the physician personally.
4. It is not a substitute for a virtual visit involving a partial examination or assessment.
5. This code is not to be used simply because a virtual assessment and/or treatment took 15 minutes or longer, such as in the case of multiple complaints.
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.

Virtual Third-Party Counselling

1. It is payable on a third-party basis when a family member is counselled via telephone or secure videoconference because of the patient's serious and complex problem.
2. It is not payable for routine briefing or advice to relatives, which is considered part of the visit service fee.
3. Third-party counselling must be provided at a booked separate appointment.
4. Third-party counselling claims are subject to a maximum of 30 minutes and should be submitted in the counselled individual's name.
5. Diagnosis must be confirmed or the diagnostic code Z84 must be indicated.
6. May be billed by any physician.

Third party counselling for the provision of Medical Assistance in Dying (MAID) services provided by a willing practitioner:

1. 840B is billable on a third-party basis when a family member, caregiver, relative, friend, spouse, etc. is counselled via telephone or secure videoconference because of the patient's request for Medical Assistance in Dying (MAID) services.
2. Third-party counselling for the provision of MAID claims should be submitted in the name of the patient requesting MAID services (not the family member, relative, caregiver, etc).
3. Diagnosis must be Z37 (third party counselling, MAID).

840B **Virtual counselling provided via telephone or secure videoconference** – first 15 minutes, includes: $50.60

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

841B **Virtual counselling provided via telephone or secure videoconference** – next 15 minutes or major portion thereof. $42.80

841B is to a maximum of 7 additional units (105 minutes), unless stipulated otherwise i.e., third party counselling is payable to a maximum of 1 additional unit (15 minutes).

For clarity: The combination of 840B and 841B is payable to a maximum of 120 minutes total; i.e., 840B + 841B x 7. For third party counselling, the two service codes are payable to a maximum of 30 minutes total; i.e., 840B + 841B x 1.

S E C T I O N B – General Practice

Virtual Chronic Disease Management

1. Virtual Chronic Disease Management (VCDM) fees are designed as an adjunct to the use of accepted clinical care pathways to optimize the patient management and the provision of in-person chronic disease management.

   a) For the physician's first VCDM billing to be payable, the physician must have seen the patient in-person, submitted a CDM fee claim for the patient with the comment: "will be providing ongoing care to the patient".

   b) VCDM does not satisfy the following Quality Improvement Payment criteria:

      Physicians must have billed at least one CDM base fee code (64B) for the patient within the 12-month period.

2. VCDM fees are billable only for patients with a confirmed diagnosis of diabetes mellitus, coronary artery disease (CAD), heart failure or chronic obstructive pulmonary disease (COPD) who require ongoing longitudinal care management of these diseases that may be safely and effectively provided via telephone of secure video technology.

3. Frequency:

   a) VCDM fees are billable only once per patient, every 90 days; a maximum of two virtual chronic disease management services per patient, per year are payable and must be preceded by at least one (1) in-person CDM visit.

   b) To initiate billing of the VCDM service code, the physician's first CDM fee claim for the patient must be in-person and include the comment: "will be providing ongoing care to the patient".

   c) Subsequent (after 90 days) VCDM and CDM fee claims must be consecutive and continuous for the same patient by the same physician or clinic and will not require a comment.

   d) One chronic disease management service (either VCDM or CDM) fee is billable per patient, every 90 days; a maximum of four chronic disease management services (i.e., combination of VCDM—not to exceed maximum stipulated in (a) above—or in-person CDM services per patient, per year are payable.

4. Time Spent With Patient:

   a) The VCDM fee includes a patient visit that **involves at least 15 minutes of direct physician to patient interaction in real-time** consistent with approved guidelines, but does not require a CDM flowsheet.

   b) Virtual chronic disease management visits in excess of one every 90 days, or virtual visits involving less than 15 minutes of physician to patient interaction in real-time, should be billed using appropriate virtual care visit codes (e.g. 805B).

   c) Start and stop times must be included on the claim and documented in the medical record.

5. More Than One Condition:

   a) If the patient has more than one of these conditions, they will be dealt with at the same virtual visit.

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.

8. Not billable with any additional service codes by the same physician on the same day.

S E C T I O N B – General Practice

		General Practitioner
864B	**Virtual Chronic Disease Management (VCDM) provided via telephone or secure videoconference --** When medically required, VCDM service includes, but is not limited to (i.e., this is not an exhaustive list): a) Review of medications and discussions about any side effects/adherence issues; b) Contraception or preconception planning in women with diabetes; c) Lifestyle, nutrition, diet and physical activity review; d) Discussion of any significant changes to medications or other management; e) Therapy adherence/comment; f) Patient goals/self-management; advanced care planning/health care directive. **Note:** Start and stop times must be included on the claim and documented in the medical record.	$50.60

S E C T I O N C – Pediatrics

		Specialist in Pediatrics	
		Referred	Not Referred
	Visits		
3C	**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.	$124.00*	$111.60*
4C	**Well baby care in office** -- refers to the periodic office visits during the first year of life of a healthy infant and includes: a) the necessary weights and measurements; b) examination; c) instruction to the parent regarding health care; and, d) record of service provided.	$46.50*	$41.85*
5C	**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.	$80.90*	$72.80*
9C	**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.	$185.45*	
11C	**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 service code 5C "partial assessment or subsequent review" is appropriate.	$78.00*	

S E C T I O N C – Pediatrics

		Specialist in Pediatrics	
		Referred	Not Referred

Extended/Complex Pediatric Consultation - for complex behavioural, neurodevelopmental, and/or psychiatric conditions in a child age 17 and under – includes:

a) physical exam;
b) review of history/lab/x-ray;
c) collection and review of data from collateral sources (parents, social workers, teachers, speech pathologists, allied health professionals, etc);
d) counseling of patient and/or family;
e) generation of referrals to other support agencies; and
f) preparation of report.

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.

12C	**Extended/Complex Pediatric Consultation -** per complete 45-minute time-period spent directly with the patient	$223.50*	
13C	**Extended/Complex Pediatric Consultation -** for each additional 15 minutes, or major portion thereof, spent directly with the patient – bill units (max 9)	$60.60*	
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.	$130.25*	$117.10*

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 <u>at least 15 minutes physician time</u> and the following <u>eligible conditions</u>:

- 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)

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

S E C T I O N C – Pediatrics

			Specialist in Pediatrics Referred	Specialist in Pediatrics Not 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;
b) Counselling;
c) Educational dialogue;
d) Intervention and/or treatment;
e) Record of service provided, and;
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 counseling 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		$60.50	$60.50
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)		$60.50	$60.50

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 codes 627A-629A – Special Care Home Management.

25C	-- 1-10 days	-- per day -- bill units (max 10)	$36.25	$36.25
26C	-- 11-20 days	-- per day -- bill units (max 10)	$36.25	$36.25
27C	-- 21-30 days	-- per day -- bill units (max 10)	$36.25	$36.25
28C	-- 31 days and thereafter	-- per day -- bill units (max 99)	$36.25	$36.25

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

S E C T I O N C – Pediatrics

		Specialist in Pediatrics	
		Referred	Not Referred
	Virtual Care Services Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
805C	**Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference**-- includes: a) history review; b) history of presenting complaint; c) functional enquiry; d) assessment; e) diagnosis; f) necessary treatment; g) advice to the patient; and h) record of service provided.	$72.80	$65.50
809C	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$166.90	
811C	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '805C' "Virtual partial assessment or subsequent virtual visit" is appropriate.	$70.20	

S E C T I O N C – Pediatrics

		Specialist in Pediatrics	
		Referred	Not Referred

Virtual Pediatric Counselling

Virtual pediatric counselling is where the pediatrician engages, via telephone or secure videoconference, with the patient and/or relatives/caregivers where the goal is to become aware of the child's problem and/or to provide comprehensive advice related to the modalities for prevention and/or treatment due to the seriousness and complexity of the issue – includes:

a) history review;
b) counselling;
c) educational dialogue;
d) intervention and/or treatment;
e) record of service provided; and
f) time spent counselling.

1. Stop and start times must be included on the claim and in the patient record.
2. It is not payable for routine virtual briefing or advice to relatives/caregivers, which is considered part of the visit service fee (i.e., 805C, 809C, etc).
3. It is not a substitute for a visit involving a virtual partial assessment (805C).
4. This code is not to be used because a virtual assessment (805C, 809C) and/or treatment took 15 minutes or longer, such as in the case of multiple complaints.
5. Maximum of 2 (in-person or virtual) per child per physician per year.
6. Third party counseling 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.

815C	**Virtual Pediatric counselling provided via telephone or secure videoconference** – per first complete 15-minute time-period for time spent virtually with the child and/or relatives/caregivers counselling	$54.45	$54.45
816C	**Virtual Pediatric counselling provided via telephone or secure videoconference** - for each additional 15-minute time-period, or major portion thereof, for time spent virtually with the patient and/or relatives/caregivers counselling – bill units (max 3)	$54.45	$54.45

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S E C T I O N 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	$45.00	$40.50	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 coarcation 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	Angiocardiography -- right and/or left side	$152.90		D	H
150C	Fetal echocardiogram and fetal rhythm	$156.00		D	H

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S E C T I O N 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.	$110.40*	$88.25*
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.	$103.00*	$71.10*
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.	$202.60*	
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.	$106.00*	

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

S E C T I O N D – Internal Medicine

		Specialist in Internal Medicine	
		Referred	Not referred

Comprehensive Geriatric Consultation – For patients 65 years and older. Consultation must include the following six components:

1. **Medical**: Includes but is not limited to a complete history, physical examination, a problem list, comorbidity conditions and disease severity, nutritional status, and review of medication, laboratory and/or other data.

2. **Functional:** Includes but is not limited to a review of basic and instrumental activities of daily living, activity and exercise status, gait, balance and risk of falls.

3. **Cognitive/psychological:** Includes but is not limited to review of mental status, cognitive assessment and mood/depression. Must include any testing (i.e. MMSE, MiniCog, ACE, Geriatric Depression Scale) when clinically appropriate.

4. **Social:** Includes but is not limited to a review of formal and informal support needs and assets, care resource eligibility and a financial assessment.

5. **Environmental:** Includes but is not limited to a review of current living situation, home safety and transportation.

6. **Recommendation:** Written submission of the consultant's opinion and recommendations to the referring doctor.

Note: Start and stop times must be included on the claim and documented in the medical record.

12D	**Comprehensive geriatric consultation** – 65 years and older. Minimum 90 minutes of direct in-person patient care. Maximum of 1 per patient by any physician per 12-month period.	$350.00@
13D	**Extended comprehensive geriatric consultation** – add on to 12D, max 6 units. Each complete 15-minute period or major portion thereof of direct in-person patient care.	$50.00@

@ Entitlement is limited to certified geriatricians or internal medicine specialists with appropriate training in geriatric medicine as approved by the Saskatchewan Medical Association Tariff Committee.

S E C T I O N D – Internal Medicine

		Specialist in Internal Medicine	
		Referred	Not referred
14D	**Complex partial assessment or subsequent visit** for eligible conditions -- 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. **Note:** Start and stop times must be included on the claim and documented in the medical record. For patient visits that involve at least 15 minutes of 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, tracheostomy, CPAP, oxygen dependent).	$139.10*	$125.30*

S E C T I O N D – Internal Medicine

			Specialist in Internal 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 codes 627A-629A – Special Care Home Management.

25D	-- 1-10 days	-- per day -- bill units (max 10)	$44.50	$44.50
26D	-- 11-20 days	-- per day -- bill units (max 10)	$38.00	$38.00
27D	-- 21-30 days	-- per day -- bill units (max 10)	$38.00	$38.00
28D	-- 31 days and thereafter	-- per day -- bill units (max 99)	$38.00	$38.00

S E C T I O N D – Internal Medicine

		Specialist in Internal Medicine	
		Referred	Not referred
	Virtual Care Services Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
805D	**Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference**-- includes: a) history review; b) history of presenting complaint; c) functional enquiry; d) assessment; e) diagnosis; f) necessary treatment; g) advice to the patient; and h) record of service provided.	$92.70	$64.00
809D	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$182.35	
811D	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '805D' "Virtual partial assessment or subsequent virtual visit" is appropriate.	$95.40	

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S E C T I O N D – Internal Medicine

		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.			
30D	Electrocardiogram or phonocardiogram -- technical	$9.20	$9.20	
31D	Electrocardiogram or phonocardiogram -- interpretation only	$9.70#	$9.70#	
	(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)			
32D	Electrocardiogram or phonocardiogram -- technical and interpretation	$18.90#	$18.90#	
	# Physicians listed by the College of Physicians and Surgeons of Saskatchewan as qualified			
35D	Tilt table test for syncope -- includes venous and/or arterial cannulation - provocative and/or blocking drugs -- physician in constant attendance	$191.75	$172.60	D
39D	Group exercise training sessions for cardiac or pulmonary rehabilitation patients in an approved facility - per patient	$16.60	$16.60	D
	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:			
62D	-- professional supervision and interpretation with physician in constant attendance -- in approved facility	$91.00	$81.95#	D
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

S E C T I O N 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	$45.60	$45.60#	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	$86.00		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	$111.10	$100.00	0	L
	For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician".				
50D	Electroencephalogram -- technical	$23.20	$20.90	D	
51D	Electroencephalogram -- interpretation	$32.00	$28.75	D	
59D	Electroclinical detailed interpretation of a set of seizures (Telemetry)	$352.70	$317.50	D	
	For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician".				
54D	Polysomnography -- technical component	$46.40		D	
55D	Polysomnography -- 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 is 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

S E C T I O N 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.				

S E C T I O N 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 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.	$20.00	$20.00	D
601D	Simple spirometry -- technical component a) If instruments owned by physician and staff conducting the test are employed by the physician.	$11.25	$11.25	

Repeat after bronchodilators

602D	Simple spirometry, repeat after bronchodilators -- professional component	$13.20	$13.20	D
603D	Simple spirometry, repeat after bronchodilators -- technical component a) If instrument owned by physician and staff conducting the test are employed by the physician.	$5.60	$5.60	

Full Spirometry

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

610D	Full spirometry -- professional component a) Interpretation only. b) There is a permanent record that includes a written interpretation by the physician or the study is not eligible for payment.	$29.70	$29.70@	D
611D	Full spirometry -- technical component a) If instrument owned by physician and staff conducting the test are employed by the physician.	$11.25	$11.25*	

Repeat after bronchodilators

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

@ 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.

S E C T I O N 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
	For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”.			
400D	Airways resistance or conductance by body box -- professional component	$13.00	$11.70	D
401D	Airways resistance or conductance by body box -- 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
	For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”.			
77D	Histamine-Methacholine test -- professional component (internist or pediatrician only)	$97.20		D
276D	Histamine-Methacholine test -- 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
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

S E C T I O N D – Internal Medicine

		Specialist	General Practitioner	Class
	Peritoneal dialysis			
130D	Supervision of 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

S E C T I O N 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 – heart, lung, liver, pancreas (for kidney transplant follow-up – use 308R)** 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).	$273.40	$246.05	

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S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Not Referred
	Visits		
5E	**Initial assessment** -- of a specific condition includes: a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) examination of affected part(s) and system(s); f) diagnosis; g) assessment; h) necessary treatment; i) advice to the patient; and j) record of service provided.	$232.40*	$185.85*
7E	**Follow-up assessment** -- includes: a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and g) record of service provided.	$79.05*	$66.35*
	Consultations (8E, 9E, 10E, 11E, 12E, 13E) -- include: 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.		
	Note: Start and stop times must be included on the claim and documented in the medical record. For the purposes of this requirement, 8E and 11E are not considered time-based codes. When the consultation criteria is not met, physician is to bill appropriate assessment code.		
8E	**Minor Consultation (Adult or child)** - When consultation involves less than 30 minutes of direct in-person patient care. For consultations involving 30 minutes or more of direct patient care, physician is to bill appropriate consultation code 9E or 10E.	$194.15*	
9E	**Adult consultation** – Minimum of 30 minutes of direct in-person patient care	$356.50*	
10E	**Child Consultation – 17 years of age and under** - Minimum of 30 minutes of direct in-person patient care	$391.55*	
11E	**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 service code 7E "follow-up assessment" is appropriate.	$156.10*	

S E C T I O N E – Psychiatry

			Specialist in Psychiatry	
			Referred	Not Referred
12E	**Extended adult consultation -- add on to 9E, max 8 units** a) payable when consultation (9E) exceeds 55 minutes of direct in-person patient care; b) each complete 15-minute period or major portion thereof of direct in-person patient care; and, c) Start and stop times must be included on the claim and documented in the medical record.		$96.55*	
13E	**Extended child consultation -- add on to 10E, max 8 units** a) payable when consultation (10E) exceeds 55 minutes of direct in-person patient care; b) each complete 15-minute period or major portion thereof of direct in-person patient care; and, c) Start and stop times must be included on the claim and documented in the medical record.		$106.20*	

* 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 codes 627A-629A – Special Care Home Management

25E	-- 1-10 days	-- per day -- bill units (max 10)	$42.20	$42.20
26E	-- 11-20 days	-- per day -- bill units (max 10)	$42.20	$42.20
27E	-- 21-30 days	-- per day -- bill units (max 10)	$42.20	$42.20
28E	-- 31 days and thereafter	-- per day -- bill units (max 99)	$42.20	$42.20

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Not Referred

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.

Note: This service is not intended for routine discussions with hospital or facility staff to discuss the patient's ongoing care and management.

31E	Psychiatric social interview a) each complete 15-minute period b) maximum of three units of 31E per person interviewed – bill units	$85.30	$76.80

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 times, and place.

142E	Case conference -- per conference (not patient) -- first 30 minutes or part thereof	$131.90	$105.45
144E	Case conference -- add to 142E for each additional 15 minutes or part thereof – bill units	$65.95	$52.60

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Unreferred/ By Entitlement
	Certification		
62E	Examination and certification of need for psychiatric examination pursuant to *The Mental Health Services Act* a) with completion of Form A	$128.30	See 63B
63E	Consultation, examination, patient history, admission to hospital and certification of mental ill health a) with completion of Form G	$323.95	$284.50**
64E	Consultation, examination and certification of mental ill health a) with completion of Form G b) second psychiatrist	$294.50	$258.60**
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	$129.55	$113.80**
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	$129.55	$116.60**
68E	Consultation, examination and recertification of mental ill health when previous certifying psychiatrist is unavailable	$294.50	$265.15**
	a) includes completion of Form G	BY REPORT	BY REPORT
70E	Completion of certification of mental ill health a) with issuance of Form G, H, H.3 or H.4.	$51.95	$45.60**
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	$51.95	$45.60**
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	$51.95	$46.75**
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	$287.20	$258.55**

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

S E C T I O N E – Psychiatry

		Specialist in Psychiatry Referred	Specialist in Psychiatry Unreferred/ By entitlement
	Psychotherapy		
	Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles by means of a professional relationship between a psychiatrist and a patient. Psychotherapy services include direct contact with a patient for the purpose of evaluation, diagnosis, physical and/or drug treatment, and/or the delivery of therapies sanctioned by the Royal College of Physicians and Surgeons. All services provided must be documented in the patient's health record.		
	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	$52.20	$46.85@
34E	Group Psychotherapy, each subsequent 30 minutes or major part thereof, per person, bill units	$26.05	$23.50@
	A maximum of 2 hours applies to a combination of 33E and 34E.		
	Family Psychotherapy 1. Billed in the name of the primary patient, indicating names of other members treated. 2. A session where concurrent psychotherapy is conducted with a patient and a family member(s), romantic partner, or caregiver 3. Each session is billable to a maximum of 2 hours per day by the same physician, or same specialty and clinic. 4. 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	-- minimum period of 30 minutes	$204.75	$179.70@
37E	-- each subsequent 15 minutes or major part thereof – bill units	$102.40	$89.90@
	Individual Psychotherapy 1. Payment for this service implies a planned series of sessions of at least 30 minutes duration. 2. Individual psychotherapy and psychiatric care cannot be claimed for the same patient on the same day by the same physician 3. Cannot be billed on more than one patient during the same time-period. 4. 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	$170.60	$149.80@
39E	-- each subsequent 15 minutes or major part thereof to a maximum of 6 – bill units	$85.30	$74.90@

@ 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 is billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

S E C T I O N E – Psychiatry

		Specialist in Psychiatry			
		Referred	Unreferred/ By entitlement	Class	Anes
42E	Electroshock therapy -- per treatment -- with anesthetist	$128.30	$128.30#	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". As per the "Documentation Requirements for the Purposes of Billing", a follow-up assessment billed in conjunction with 43E must be medically required, clinically indicated, and fulfill the criteria listed under the service code descriptor. Follow-up assessments must be personally performed by the physician (i.e. cannot be delegated). For physician bedside attendance during procedure use 918A.	$82.60	$74.30		
51E	Psychological testing -- complex	$72.35	$63.60#	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) Psychiatric Assessment Initial Questionnaire, University of Saskatchewan/Saskatchewan Health Authority or Maternal Mental Health Initial Questionnaire, University of Saskatchewan/Saskatchewan Health Authority
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.

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

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Unreferred/ 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) Psychiatric Counselling
f) Pertinent positives and/or changes in mental status;
g) Assessment and diagnosis; and/or
h) 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".

Individual psychotherapy and psychiatric care cannot be claimed for the same patient on the same day by the same physician.

Total eligible billing is 2 hours per patient per day.

100E	-- minimum of 15 minutes	$74.80	$65.70#
101E	-- each subsequent 15 minutes or major part thereof to a maximum of 7, bill units	$74.80	$65.70#

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".

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Unreferred/ 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) Psychiatric Counselling
f) Pertinent positives and/or changes in mental status;
g) Assessment and diagnosis; and
h) 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".

Individual psychotherapy and psychiatric care cannot be claimed for the same patient on the same day by the same physician.

Total eligible billing is 1.5 hours per patient per day.

110E	-- minimum of 15 minutes	$82.30	$72.30#
111E	-- each subsequent 15 minutes or major part thereof to a maximum of 5, bill units	$82.30	$72.30#

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".

S E C T I O N E – Psychiatry

		Specialist in Psychiatry Referred	Specialist in Psychiatry Not referred

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

807E **Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: $71.15 $59.75
- a) history review;
- b) history of presenting complaint;
- c) functional enquiry;
- d) reassessment;
- e) necessary treatment; and
- f) record of service provided.

Virtual consultations provided via telephone or secure videoconference (808E, 809E, 810E, 811E, 812E, 813E) -- includes:
a) all visits necessary;
b) history;
c) review of laboratory and/or other data;
d) written submission of the consultant's opinion; and
e) recommendations to the referring doctor.

Note: Start and stop times must be included on the claim and documented in the medical record. For the purposes of this requirement, 808E and 811E are not considered time-based codes. When the virtual consultation criteria is not met, physician is to bill appropriate virtual assessment code.

808E **Minor virtual consultation provided via telephone or secure videoconference (Adult or child)** – When virtual consultation involves less than 30 minutes of direct patient care. For virtual consultations involving 30 minutes or more of direct patient care, physician is to bill appropriate consultation code 809E or 810E. $174.75

809E **Adult virtual consultation provided via telephone or secure videoconference** – Minimum of 30 minutes of direct patient care $320.85

810E **Child virtual consultation provided via telephone or secure videoconference – 17 years of age and under** – Minimum of 30 minutes of direct patient care $352.40

811E **Repeat virtual consultation provided via telephone or secure videoconference:** $140.50
A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807E' "Virtual follow-up assessment" is appropriate.

812E **Extended adult virtual consultation -- add on to 809E, max 8 units** $86.90
a) payable when virtual consultation (809E) exceeds 55 minutes of direct patient care;
b) each complete 15-minute period or major portion thereof of direct patient care; and,
c) start and stop times must be included on the claim and documented in the medical record.

813E **Extended child virtual consultation -- add on to 810E, max 8 units** $95.60
a) payable when virtual consultation (810E) exceeds 55 minutes of direct patient care;
b) each complete 15-minute period or major portion thereof of direct patient care; and,
c) start and stop times must be included on the claim and documented in the medical record.

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Not referred

Virtual 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 via telephone or secure videoconference.
4. This service is not payable for a case conference.
5. Service code 831E 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.

831E	**Virtual psychiatric social interview provided via telephone or secure videoconference** a) each complete 15-minute period b) maximum of 3 units of 831E per person interviewed – bill units	$76.75	$69.05

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Unreferred/ By entitlement

Virtual Psychotherapy

Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles by means of a professional relationship between a psychiatrist and a patient. Psychotherapy services include direct contact with a patient for the purpose of evaluation, diagnosis, physical and/or drug treatment, and/or the delivery of therapies sanctioned by the Royal College of Physicians and Surgeons. All services provided must be documented in the patient's health record.

Virtual Family Psychotherapy

1. Billed in the name of head of family, indicating names of other members treated.
2. A session where concurrent psychotherapy is conducted with a patient and a family member(s), romantic partner, or caregiver.
3. Each session is billable to a maximum of 2 hours per day by the same physician, or same specialty and clinic.
4. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.

835E	-- minimum period of 30 minutes provided via telephone or secure videoconference	$184.30	$161.80@
837E	-- each subsequent 15 minutes or major portion thereof provided via telephone or secure videoconference – bill units	$92.15	$80.95@

Virtual Individual Psychotherapy

1. Payment for this service implies a planned series of at least 30 minutes duration
2. Virtual individual psychotherapy and virtual psychiatric care cannot be claimed for the same patient on the same day by the same physician.
3. Cannot be billed on more than one patient during the same time-period.
4. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.

838E	-- minimum period of 30 minutes provided via telephone or secure videoconference	$153.55	$134.85@
839E	-- each subsequent 15 minutes or major portion thereof provided via telephone or secure videoconference to a maximum of 6 – bill units	$76.75	$67.40@

@ Payment to General Practitioners and other physicians with training in psychotherapy with approval from the Saskatchewan Medical Association. For the purposes of billing, 835E-839E is billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Unreferred/ By entitlement

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

Virtual Psychiatric Care is defined as a single medical intervention or a series of medical interventions carried out by a psychiatrist involving an interview via telephone or secure video conference 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:

a) history review;
b) diagnostic evaluation;
c) therapeutic evaluation;
d) changes in therapy;
e) psychiatric counselling;
f) pertinent positives and/or changes in mental status;
g) assessment and diagnosis, and/or
h) 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".

Virtual individual psychotherapy and virtual psychiatric care cannot be claimed for the same patient on the same day by the same physician.

Total eligible billing is 2 hours per patient per day.

700E	-- minimum of 15 minutes provided via telephone or secure videoconference	$67.35	$59.15#
701E	-- each subsequent 15 minutes or major portion thereof provided via telephone or secure videoconference to a maximum of 7 -- bill units	$67.35	$59.15#

\# Payment approved for a physician who has been designated by the College of Physicians and Surgeons of Saskatchewan. For the purposes of billing, 700E, 701E are billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

S E C T I O N E – Psychiatry

		Specialist in Psychiatry	
		Referred	Unreferred/ By entitlement

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

Virtual Psychiatric Care is defined as a single medical intervention or a series of medical interventions carried out by a psychiatrist involving an interview via telephone or secure video conference with a patient in a 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) psychiatric counselling;
f) pertinent positives and/or changes in mental status;
g) assessment and diagnosis, and/or
h) 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".

Virtual individual psychotherapy and virtual psychiatric care cannot be claimed for the same patient on the same day by the same physician.

Total eligible billing is 1.5 hours per patient per day.

710E	-- minimum of 15 minutes provided via telephone or secure videoconference	$74.10	$65.10#
711E	-- each subsequent 15 minutes or major portion thereof provided via telephone or secure videoconference to a maximum of 5 -- bill units	$74.10	$65.10#

\# Payment approved for a physician who has been designated by the College of Physicians and Surgeons of Saskatchewan. For the purposes of billing, 710E, 711E are billable on the date that the approval is granted to the physician. See "Services Billable by Entitlement".

S E C T I O N F – Dermatology

		Specialist in Dermatology Referred	Specialist in Dermatology Not Referred
	Visits		
5F	**Initial assessment** -- of a specific condition 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.	$62.20*	$49.75*
7F	**Follow-up assessment** -- 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.	$45.30*	$43.60*
9F	**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.	$96.30*	
11F	**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 service code 7F "follow-up assessment" is appropriate.	$55.00*	

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

S E C T I O N F – Dermatology

		Specialist in Dermatology	
		Referred	Not Referred
14F	**Complex partial assessment or subsequent visit** For the ongoing management of any of the diseases listed below where the complexity of the condition requires the continuing management by a dermatology specialist, for patient visits that involve <u>at least 15 minutes physician time</u>, 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. 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. <u>Eligible conditions</u>: Complex systemic disease with skin manifestations for at least one (1) of the following: • Sarcoidosis; • Systemic lupus erythematosis; • Dermatomyositis; • Scleroderma; • Relapsing polychondritis; • Inflammatory bowel diseases (pyoderma gangranosum, Sweet's syndrome, erythema nodosum); • Porphyria; • Autoimmune blistering diseases (pemphigus, pempihoid, linear IgA); • Paraneoplastic syndrome involving skin; • Vasculitis (including Behcet's disease); or • Cutaneous lymphomas (including lymphomatoid papulosis). OR Chronic pruritus with or without skin manifestations (prurigo nodularis). OR Complex systemic drug reactions for at least one (1) 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 (1) 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.	$62.00*	$62.00*

S E C T I O N F – Dermatology

			Specialist in Dermatology	
			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 codes 627A-629A – Special Care Home Management.

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

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

807F **Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: $40.80 $39.25

a) history review;
b) history of presenting complaint;
c) functional enquiry;
d) assessment;
e) diagnosis;
f) necessary treatment;
g) advice to the patient; and
h) record of service provided.

809F **Virtual consultation provided via telephone or secure videoconference**-- includes: $86.65

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

811F **Repeat virtual consultation provided via telephone or secure videoconference:** $49.50

A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807F' "Virtual follow-up assessment" is appropriate.

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S E C T I O N 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	$15.85	$15.85	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	$10.50	$10.50	D
	Biopsy of skin or mucous membrane			
100F	Punch or shave biopsy -- 1st biopsy	$34.50	$34.50	D
101F	Punch or shave biopsy -- each additional biopsy (maximum of 4) – bill units	$20.00	$20.00	D
102F	Marginal (incisional) biopsy of skin or mucosa -- 1st biopsy	$55.00	$55.00	0
103F	Marginal (incisional) biopsy of skin or mucosa -- each additional biopsy (maximum of 4) – bill units	$32.40	$32.40	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	$16.00	$16.00	0
111F	Comedos, acne pustules, milia - drainage or removal -- 6 to 14	$33.00	$33.00	0
112F	Comedos, acne pustules, milia - drainage or removal -- 15 or more	$44.00	$44.00	0
120F	Intralesional injections by dermojet or similar means	$20.00	$20.00	0
	Note: See Section N under the heading "Surgery of Appearance" (Other Body Areas), item (2) regarding injection of keloids.			
	Only one of the codes below can be claimed per case (121F, 122F)			
121F	Intralesional injections by needle -- up to 5 injections	$34.00	$34.00	0
122F	Intralesional injections by needle -- 6 or more injections (maximum)	$45.10	$45.10	0
888F	Treatment of localized cutaneous malignancy by curettage & cautery -- any area	$102.00	$102.00	42
130F	Extra corporal photophoresis	$75.50	$75.50	0
131F	Serum autologous skin test	$37.80	$37.80	D

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S E C T I O N 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	**Genetic assessment** – includes: a) history of the presenting condition; b) genetic history of the patient and of the family; c) diagnosis; d) necessary treatment; e) examination of the affected part(s) or system(s)including any special techniques; f) advice to the patient; and, g) record of service provided.	$110.85*	$99.70*
7G	**Follow-up assessment** -- All Follow-ups, if a Visit -- Not Counselling -- may include: a) a review and update of the recorded genetic history; b) necessary examination; c) review of diagnostic findings; d) necessary treatment; e) advice to the patient; and f) record of service provided.	$74.85*	$67.45*
9G	**Consultation** – includes: a) all visits necessary; b) history and examination; c) review of the laboratory and/or other data; d) written submission of the consultant's opinion; and, e) recommendations to the referring doctor.	$214.55*	
11G	**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 service code 7G "follow-up assessment" is appropriate. * Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.	$103.35*	
13G	**Review of genetic information** a) Review of clinical information for patients seen exclusively by a genetic counsellor for the medical geneticist. b) Dictated letter generated from the visit must indicate medical geneticist involvement. c) Patient chart must include note that clinical information was reviewed by medical geneticist. d) Not payable if patient seen by geneticist within 30 days.	$64.40	$64.40

S E C T I O N 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 codes 627A-629A – Special Care Home Management.

25G	-- 1-10 days	-- per day -- bill units (max 10)	$39.15	$39.15
26G	-- 11-20 days	-- per day -- bill units (max 10)	$39.15	$39.15
27G	-- 21-30 days	-- per day -- bill units (max 10)	$39.15	$39.15
28G	-- 31 days and thereafter	-- per day -- bill units (max 99)	$39.15	$39.15

VIRTUAL CARE SERVICES

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

807G **Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: $67.35 $60.60

a) a review and update of the recorded genetic history;
b) review of diagnostic findings;
c) necessary treatment;
d) advice to the patient; and
e) record of service provided.

809G **Virtual consultation provided via telephone or secure videoconference**-- includes: $193.10

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

811G **Repeat virtual consultation provided via telephone or secure videoconference:** $93.00

A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807F' "Virtual follow-up assessment" is appropriate.

S E C T I O N 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	$38.35	$34.50	
	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	$98.05*	$88.15*	
39G	Counselling -- each additional 15 minutes or part thereof -- bill units	$48.85*	$44.05*	
	* 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	$91.10	$91.10	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.	$214.55		0

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S E C T I O N 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.

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S E C T I O N H – Anesthesia

Specialist in Anesthesia

Specialist

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** $154.00*

11H **Repeat Consultation** $79.00*

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. See Section A for details.

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

809H **Major virtual consultation provided via telephone or secure videoconference**-- includes: $138.60
a) all visits necessary;
b) history;
c) review of laboratory and/or other data;
d) written submission of the consultant's opinion; and
e) recommendations to the referring doctor.

S E C T I O N H – Anesthesia

				Specialist in Anesthesia	
				Specialist	General Practitioner
	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	$34.10	$34.10
501H	Low Complexity:	(Low)	-- Per 15 min	$52.40	$52.40
502H	Intermediate Complexity:	(Medium)	-- Start-up	$39.20	$39.20
503H	Intermediate Complexity:	(Medium)	-- Per 15 min	$60.15	$60.15
504H	High Complexity:	(High)	-- Start-up	$47.30	$47.30
505H	High Complexity:	(High)	-- Per 15 min	$68.30	$68.30
506H	Dental Procedures^		-- Start-up	$39.20	$39.20
507H	Dental Procedures^		-- Per 15 min	$60.15	$60.15

^ 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.)

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	$18.00	$18.00

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.

S E C T I O N H – Anesthesia

		Specialist in Anesthesia	
		Specialist	General Practitioner
585H	**Operative premium for complexity and risk** -- per 15 minutes	$34.15	$34.15

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:
   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 and 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.**	$34.15	$34.15

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: *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)*

545H	**Premium for anesthesia beginning before midnight (11:59 p.m.) & ending after 12:00 midnight**	$34.15	$34.15

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 anesthetist – 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 “B” resulting in the 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.)

S E C T I O N 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, vitroretinal 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.

S E C T I O N 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.

S E C T I O N 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.

S E C T I O N H - Anesthesia

		Specialist	General Practitioner	Class
80H	Intubation for the management of the airway or ventilation, not associated with anesthetic	$117.85	$106.05	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 – 158H)			
	If a visit service has been provided within the previous 30 days for the same or related condition by the same physician, a visit is not payable on the day of the procedure.			
	A visit service may be billable in addition to a pre-scheduled procedure if it is medically required (i.e., the patient presents with a new medical condition that warrants a medically necessary assessment, there is a medically significant change in the patient's existing medical condition/diagnosis, or a medically necessary reassessment or reevaluation of an ongoing condition is required at a specific clinical interval).			
	If a medically required reason for a visit exists at the time of the procedure, it must be appropriately documented and must meet all the billing requirements of the service code.			
	Visits are not billable for the routine preparation of a prescheduled procedure including obtaining informed consent, verification of site/indication, explanation of procedure, preparation of patient, or coordination of supplies, etc. These services are considered an inclusion in the procedure fee.			
	Note: Prolotherapy is not an insured service.			
94H	Facet Injection -- single	$96.75	$96.75	0
95H	Facet Injection -- each additional to a maximum of 5	$47.75	$47.75	0
	Note: 94H/95H is not billable for intramuscular, subcutaneous, or peripheral joint injection/aspiration, intrathecal injection, or tendon/bursa injection. For these services, please use appropriate injection codes: 110A, 115A, 380M-382M, 614M, 642M, etc.			
96H	Trigger Point -- single	$47.75	$47.75	0
97H	Trigger Point -- one additional	$22.75	$22.75	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.			
	Note: 96H/97H is not billable for joint injection/aspiration, intrathecal injection, or tendon/bursa injection. For these services, please use appropriate injection codes: 110A, 115A, 380M-382M, 614M, 642M, etc.			
	Peripheral or Paravertebral Nerves			
98H	Single	$98.80	$98.80	0
99H	-- each additional to a maximum of three additional units	$49.10	$49.10	0
	Note: 98H/99H is not billable for joint injection/aspiration, intrathecal injection, or tendon/bursa injection. For these services, please use appropriate injection codes: 110A, 115A, 380M-382M, 614M, 642M, etc.			
100H	With sclerosing agent -- single nerve, add	$36.15	$36.15	0
101H	-- each additional nerve to a maximum of three units, add	$26.75	$26.75	0

S E C T I O N H - Anesthesia

		Specialist	General Practitioner	Class
102H	Sciatic or obturator nerve	$125.45	$125.45	0
103H	Sciatic or obturator nerve -- with sclerosing agent	$163.60	$163.60	0
120H	Somatic plexus (e.g. brachial)	$139.70	$139.70	0
121H	Somatic plexus (e.g. brachial) -- with sclerosing agent	$164.85	$164.85	0
130H	Stellate ganglion	$144.45	$144.45	0
131H	Stellate ganglion -- with sclerosing agent	$164.85	$164.85	0
132H	Lumbar sympathetic chain	$144.45	$144.45	0
133H	Lumbar sympathetic chain -- with sclerosing agent	$167.65	$167.65	0
134H	Other ganglion/plexus (e.g. celiac)	$293.90	$293.90	0
135H	Other ganglion/plexus (e.g. celiac) -- with sclerosing agent	$308.95	$308.95	0
140H	Epidural -- lumbar or caudal	$232.65	$232.65	0
141H	Epidural -- lumbar or caudal -- with sclerosing agent	$245.45	$245.45	0
142H	Epidural -- cervical or thoracic	$216.75	$216.75	0
143H	Epidural -- cervical or thoracic -- with sclerosing agent	$245.45	$245.45	0
144H	Epidural blood patch	$229.25	$229.25	0
150H	Subarachnoid -- lumbar	$216.75	$216.75	0
151H	Subarachnoid -- lumbar -- with sclerosing agent	$327.25	$327.25	0
153H	Subarachnoid -- thoracic -- with sclerosing agent	$327.25	$327.25	0
158H	Injection of piriformis muscle	$87.35	$87.35	0
161H	X-ray control in connection with service codes 94H to 153H, add (X-ray charges extra)	$64.65	$64.65	0
220H	Therapeutic intravenous regional anesthesia	$154.45	$154.45	0
680H	Rhizotomy - sacroiliac (SI) joint (hospital location) - medial branch nerves of multiple facets and SI joints - includes all radiofrequency ablations of multiple target zones.	$560.00@		0

@ Billable by physicians approved by the Saskatchewan Medical Association Tariff Committee. For the purposes of billing, 680H is billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.

S E C T I O N H - Anesthesia

		Specialist	General Practitioner	Class
	PAIN MANAGEMENT			
	Acute Pain Management			
190H	Initiation of patient-controlled analgesia	$18.45	$18.45	
191H	Injection of intrathecal opiate for post-operative pain management	$15.00	$15.00	
192H	Insertion or reinsertion of continuous epidural catheter for acute pain control including initial infusion of analgesic agent -- for obstetrical cases see 600H	$63.55	$63.55	
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	$51.25	$51.25	
194H	Insertion or reinsertion of continuous catheter technique local anesthetic blockade (excluding epidural) for acute pain control including initial infusion of analgesic agent.	$72.75	$72.75	
195H	Injection of local anesthetic to establish a major plexus block to assist in post-operative pain management -- cannot be claimed for topical, local infiltration or peripheral nerve block	$62.85	$62.85	
	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.	$385.40	$385.40	
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.	$185.50	$185.50	
667H	Attendance during delivery (after the first hour covered under code 600H), per 15 minutes or portion thereof	$42.75	$42.75	
687H	Intra-operative Transoesophageal Echocardiography -- billable with other echocardiogram or Swan-Ganz by report only	$133.25	$133.25	

S E C T I O N 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.

Entitlement criteria: Pain Clinic Assessment codes are limited to recognized specialists in anesthesia or other physicians with training approved by the Saskatchewan Medical Association Tariff Committee and are only payable for pain clinic services provided in a designated pain clinic centre recognized by the Ministry of Health. For other physicians involved in the pain control process the appropriate assessment within their own specialty section applies.

Physicians must bill visit codes from their own section for consultations on hospitalized patients with acute or chronic pain not specifically admitted for pain clinic work-up.

The Initial Complete Assessment can be billed on an inpatient if the patient is admitted to the hospital as an alternative to the outpatient pain clinic in order to facilitate the work-up.

If an assessment has been provided within the previous 30 days for the same or related condition by the same physician, a visit is not payable on the day of the procedure.

Note: A subsequent assessment may be billable in addition to a prescheduled procedure if it is medically required (i.e., the patient presents with a new medical condition that warrants a medically necessary assessment, there is a medically significant change in the patient's existing medical condition/diagnosis, or a medically necessary reassessment or reevaluation of an ongoing condition is required at a specific clinical interval).

If a medically required reason for a visit exists at the time of the procedure, it must be appropriately documented and must meet all the billing requirements of the service code.

Subsequent assessments are not billable for the routine preparation of a prescheduled procedure including obtaining informed consent, verification of site/indication, explanation of procedure, preparation of patient, or coordination of supplies, etc. These services are considered an inclusion in the procedure fee.

201H	**Initial Complete Pain Clinic Assessment** – must include: a) pertinent family and patient history; b) pain history including review of previous therapies; c) functional enquiry; d) examination of all parts and systems necessary to diagnose and initiate treatment; e) advice to patient; f) written report to referring physician; and, g) record of service provided.	$245.40	$245.40@
203H	**Subsequent Pain Clinic Assessment** – must include: a) review of problem; b) reassessment of pain control and/or pain treatment; c) review of history and physical examination as necessary to maintain on-going treatment; d) necessary changes to on-going care if indicated; e) advice to patient; and, f) record of service provided.	$122.30	$122.30@

S E C T I O N H – Anesthesia

		Specialist	General Practitioner
805H	**Virtual Subsequent Pain Clinic Assessment provided via telephone or secure videoconference** – must include: a) review of problem; b) reassessment of pain control and/or pain treatment; c) review of history; d) necessary changes to on-going care if indicated; e) advice to patient; and f) record of service provided. @ Billable by physicians approved by the Saskatchewan Medical Association Tariff Committee who are providing pain clinic services in a designated pain clinic centre recognized by the Ministry of Health.	$110.05	$110.05@

S E C T I O N 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.

S E C T I O N 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) esophagogastroscopy (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.

S E C T I O N H - Anesthesia

			Specialist	General 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	$39.40	$39.40
336H	Day 2	per unit -- maximum of 5 units per day	$39.40	$39.40
337H	Days 3 to 7	per unit -- maximum of 3 units per day	$39.40	$39.40
338H	Days 8 to 30	per unit -- maximum of 2 units per day	$39.40	$39.40
339H	Days 31 & thereafter	per unit -- maximum of 1 unit per day	$39.40	$39.40

S E C T I O N 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	$352.00	$352.00
401H	Day 2	-- per diem	$179.00	$179.00
402H	Days 3 to 7	-- per diem	$179.00	$179.00
403H	Days 8 to 30	-- per diem	$90.00	$90.00
404H	Days 31 & thereafter	-- per diem	$30.70	$30.70

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	$148.80	$148.80
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	$40.00	$40.00

S E C T I O N 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	$577.50	$577.50
421H	Day 2	-- per diem	$265.00	$265.00
422H	Days 3 to 7	-- per diem	$265.00	$265.00
423H	Days 8 to 30	-- per diem	$130.00	$130.00
424H	Days 31 & thereafter	-- per diem	$68.45	$68.45

S E C T I O N 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	$95.00*	$75.95*
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	$89.30*	$61.50*
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	$180.55*	
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 service code 5I "partial assessment or subsequent visit" is appropriate.	$91.00*	

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

S E C T I O N I – Cardiology

			Specialist in Cardiology 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 codes 627A-629A – Special Care Home Management.

25I	-- 1-10 days	-- per day -- bill units (max 10)	$39.70	$39.70
26I	-- 11-20 days	-- per day -- bill units (max 10)	$39.70	$39.70
27I	-- 21-30 days	-- per day -- bill units (max 10)	$39.70	$39.70
28I	-- 31 days and thereafter	-- per day -- bill units (max 99)	$39.70	$39.70

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

805I	**Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference**-- includes: a) history review; b) history of presenting complaint; c) functional enquiry; d) diagnosis; e) assessment; f) necessary treatment; g) advice to the patient; and h) record of service provided.	$80.35	$55.35
809I	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$162.50	
811I	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '805I' "Virtual partial assessment or subsequent virtual visit" is appropriate.	$81.90	

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S E C T I O N 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 @ Payment approved for a physician with training and expertise in this section	$39.75	$31.75@		
	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

S E C T I O N J – Surgical Assisting

		Specialist	General 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	$180.75	$180.75
31J	-- for each additional 15 minutes, or major portion thereof	$48.60	$48.60

Surgical Assistant for Unscheduled Emergency Surgery

60J	-- first patient - up to 60 minutes	$243.35	$243.35
70J	-- each additional patient - up to 60 minutes	$201.80	$201.80
61J	-- for each additional 15 minutes, or major portion thereof	$48.60	$48.60

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	$197.85	$197.85
81J	-- for each additional 15 minutes, or major portion thereof	$53.15	$53.15

S E C T I O N J – Surgical Assisting

		Specialist	General Practitioner
40J	**Surgical Assistant Standby** 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. 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.	$35.60	$35.60
50J	**Specialist O/R Standby** 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.	$29.25	
332J	**Surgical assist** 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.	1/3 of First Surgeons Claim	
333J	**Surgical assist** a) Payment based upon first surgeon's assessed claim. b) @ Only general practitioners designated by the Saskatchewan Medical Association Tariff Committee are 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.	30% of First Surgeons Claim @	
334J	**Surgical assist -- second assistant** a) Payment based upon first surgeon's assessed claim. b) @ Only general practitioners designated by the Saskatchewan Medical Association Tariff Committee are eligible. c) For the purposes of billing, 334J 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.	30% of First Surgeons Claim @	

S E C T I O N 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, they 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
175K	DREZ procedures for intractable pain
253K	Microsurgical decompression of cranial nerves
100L, 101L	Thoracoscopic lung resection
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	Osophagogastrectomy
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 pheochromocytoma 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
548L	Colonic reanastomosis following Hartmann's procedure
645L	Total colectomy with mucosal proctectomy and ileo-pouch with ileo-anal anastomosis and loop ileostomy anastomosis and loop ileostomy
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

S E C T I O N 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, they 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

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S E C T I O N K – Neurosurgery

		Specialist in Neurosurgery Referred	Specialist in Neurosurgery Not Referred
	Visits		
5K	**Initial assessment** -- of a specific condition includes: 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; i) advice to the patient; and, j) record of service provided.	$96.00*	$76.85*
7K	**Follow-up assessment** -- includes: a) history review; b) reassessment; c) functional enquiry; d) examination; e) necessary treatment; f) advice to the patient; and, record of service provided.	$65.00*	$59.70*
8K	**Consultation -- spinal, complex** 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**	$181.50*	
9K	**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	$172.55*	
10K	**Consultation -- spinal, routine** 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	$113.20*	
11K	**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 service code 7K "follow-up assessment" is appropriate.	$77.00*	

* 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”.

S E C T I O N K – Neurosurgery

		Specialist in Neurosurgery	
		Referred	Not Referred
14K	**Follow-up visit, spinal, complex** 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 **	$75.00*	$67.50*
15K	**Follow-up visit, spinal, routine** – billable by all neurosurgeons and orthopedic surgeons	$50.00*	$45.00*

* 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”.

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 codes 627A-629A – Special Care Home Management.

25K	-- 1-10 days	-- per day -- bill units (max 10)	$45.50	$45.50
26K	-- 11-20 days	-- per day -- bill units (max 10)	$45.50	$45.50
27K	-- 21-30 days	-- per day -- bill units (max 10)	$45.50	$45.50
28K	-- 31 days and thereafter	-- per day -- bill units (max 99)	$45.50	$45.50

S E C T I O N K – Neurosurgery

		Specialist in Neurosurgery Referred	Specialist in Neurosurgery Not Referred
	Virtual Care Services Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
807K	**Virtual follow-up assessment visit provided via telephone or secure videoconference**-- includes: a) history review; b) reassessment; c) functional enquiry; d) necessary treatment; e) advice to the patient; and f) record of service provided.	$58.50	$53.75
809K	**Virtual consultation provided via telephone or secure videoconference** -- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$155.30	
810K	**Virtual consultation – spinal, routine, provided via telephone or secure videoconference**-- includes: a) history, 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.	$101.90	
811K	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807K' "Virtual follow-up assessment" is appropriate.	$69.30	
815K	**Virtual follow-up visit, spinal, routine provided via telephone or secure videoconference –** Billable by all neurosurgeons and orthopedic surgeons	$45.00	$40.50

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S E C T I O N 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	$250.00	$225.00	0	L
36K	Double blind morphine pain study	$110.10	$98.90	D	
	Intercranial Procedures – Non-traumatic				
50K	Operative management of brain abscess	$1,200.00	$1,080.00	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	$2,450.00	$2,205.00	42	H
58K	Cerebellar or cerebral arteriovenous malformation or aneurysm -- excision or obliteration	$3,000.00	$2,700.00	42	H
59K	Stereotactic procedures -- framed or frameless to obtain deep tumor biopsy, localization and guidance during craniotomy for tumor excision	$1,000.00	$900.00	42	H
60K	Cortical excision for epilepsy, hypophysectomy or excision of choroid plexus	$1,500.00	$1,350.00	42	H
61K	Intra-operative electrophysiological monitoring and/or stimulation -- add to any intracranial procedure	$300.00	$270.00	42	
62K	Excision of osteomyelitis of skull	$750.00	$675.00	42	M
63K	Excision of skull tumor	$600.00	$540.00	42	M
64K	Excision of skull tumor with immediate cranioplasty	$750.00	$675.00	42	M
65K	Extra-axial brain tumor (microdissection, CO2 laser, ultrasonic aspirator)	$3,150.00	$2,835.00	42	H
80K	Ventriculocisternostomy	$750.00	$675.00	42	M
81K	Repair of encephalocele	$900.00	$810.00	42	H
82K	Shunts for hydrocephalus -- any type	$1,350.00	$1,215.00	42	M
83K	Shunts for hydrocephalus -- revision during the same hospital admission as original procedure	$625.00	$562.50	42	M
84K	Shunts for hydrocephalus - revision – independent procedure upper end	$950.00	$855.00	42	M
85K	Shunts for hydrocephalus -- lower end	$600.00	$540.00	42	M
86K	Removal of ventriculo peritoneal shunt without simultaneous revision	$300.00	$270.00	42	L
90K	Craniectomy for craniostenosis -- single suture	$621.90	$559.70	42	M
91K	Craniectomy for craniostenosis -- multiple sutures	$980.00	$882.00	42	M

S E C T I O N 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	$1,500.00	$1,350.00	42	H
	Procedures for Traumatic Intracranial Lesions				
113K	Evacuation of hematoma -- via burr holes	$1,150.00	$1,035.00	42	M
114K	Evacuation of hematoma -- via craniotomy	$1,500.00	$1,350.00	42	H
116K	Elevation of simple depressed skull fracture	$702.50	$632.20	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	$900.00	$810.00	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	$540.00	$486.00	42	L
160K	Section or crushing of nerve	$127.50	$114.30	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	$496.75	$447.05	42	L
170K	Extracranial anastomosis for facial nerve lesion -- hypoglossal accessory, etc.	$422.10	$380.30	42	L

S E C T I O N K – Neurosurgery

		Specialist	General Practitioner	Class	Anes
171K	Radiofrequency spinal rhizotomy	$202.20	$182.00	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	$1,000.00	$899.95	42	M

NOTE: Standby time is billable as 50J for the period of time between the completion of opening and the start of the closure.

Example:

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	$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

a) Clinic supervision, patient monitoring and adjustment of stimulation parameters, drug dose and/or drug mix.
b) Includes advice to the patient, either directly or indirectly through the neuromodulation nurse.
c) 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	

S E C T I O N 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	$350.00	$315.00	42	
505K	Vertebrectomy -- includes adjacent discs	$1,701.50	$1,531.40	42	H
506K	Vertebrectomy -- each additional level -- add -- maximum of 3	$475.00	$427.50	42	
507K	Artificial discs -- includes discectomy and fusion	$1,924.60	$1,732.15	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	$994.05	$894.70	42	M
714K	Discectomy -- each additional level – add	$298.00	$268.20	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	$1,010.95	$909.80	42	M
723K	Discectomy -- each additional level -- add	$298.00	$268.25	42	M
524K	Vertebrectomy -- includes adjacent discs	$1,567.65	$1,410.85	42	H
525K	Vertebrectomy -- each additional level -- add -- maximum of 2	$254.90	$229.40	42	
526K	Artificial disc -- includes discectomy and fusion	$1,924.60	$1,732.15	42	H
527K	Artificial disc -- additional level -- add -- maximum of 1	$1,529.30	$1,376.30	42	
528K	Exposure by primary surgeon	$298.30	$268.45	42	M
	Posterior Decompression – Cervical and Thoracic				
	Laminectomy, Laminotomy, Foraminotomy				
534K	-- unilateral	$881.90	$793.70	42	M
535K	-- bilateral	$1,100.00	$990.00	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	$1,273.15	$1,145.80	42	M
540K	Laminoplasty - each additional level -- add -- maximum of 5	$309.90	$279.00	42	M

S E C T I O N 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	$270.00	$243.00	42	
549K	-- discectomy – add	$320.00	$288.00	42	
550K	Pedicle subtraction osteotomy -- above lumbar 2	$900.00	$810.00	42	M
551K	Pedicle subtraction osteotomy -- below or at lumbar 2	$750.00	$675.00	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	$336.80	$303.10	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	$221.35	$199.15	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	$203.90	$183.50	42	
589K	Cervical 1-2 wiring -- hook or wire construct added to another procedure	$254.90	$229.40	42	

S E C T I O N K– Neurosurgery

		Specialist	General Practitioner	Class	Anes
	Instrumentation – Below C2				
590K	1st 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 a) cannot be billed with other decompression codes; b) 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	$250.00	$225.00	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	$2,050.00	$1,845.00	42	H
620K	Removal intradural/intramedullary tumour -- cannot be claimed with other decompression codes	$2,280.00	$2,051.95	42	H
621K	Excision of intradural vascular malformation -- cannot be claimed with other decompression codes	$1,960.00	$1,764.00	42	H
622K	Interruption of spinal dural AV fistula -- cannot be claimed with other decompression codes	$1,455.00	$1,309.45	42	H
623K	Percutaneous vertebral biopsy	$176.40	$158.70	42	M
624K	Open vertebral biopsy	$300.00	$270.00	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

S E C T I O N 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	$409.90	$368.90	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	$287.45	$258.75	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	$1,300.00	$1,170.00	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	$1,200.00	$1,080.00	42	M
671K	Myelomeningocele repair -- if plastic surgeon performs closure	$615.00	$553.50	42	M
677K	Acute spinal cord injury (ASIA A, B, or C less than 6 weeks)		15% of surgery		
331K	Team Spinal Surgery		45% of First Surgeons Claim		

a) Where procedure requires the presence of two spine surgeons working in equal capacity;
b) Not for routine assisting; and
c) Billable by all neurosurgeons and orthopedic surgeons.

S E C T I O N K– Neurosurgery

		Specialist	General Practitioner	Class	Anes
678K	Monitoring a) Electromyogram (EMG) b) Motor Evoked Potentials (MEP) c) Somatosensory Evoked Potentials (SSEP)	$350.00	$315.00	42	
679K	Spine surgery supplement for patients with a Body Mass Index (Weight [kg]/Height [m] 2) greater than 40 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.	$260.00	$260.00		
680K	Spinal stereotaxy for tumor, trauma, revision, pediatric	$640.00	$576.00	42	M
681K	Revision surgery – add		30% of decompression		
682K	Revision surgery – add		30% of fusion		

S E C T I O N L – General Surgery

		Specialist in General Surgery	
		Referred	Not Referred
	Visits		
5L	**Initial assessment** -- of a specific condition includes: 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; i) advice to the patient; and, j) record of service provided.	$88.00*	$70.40*
7L	**Follow-up assessment** -- includes: a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and, g) record of service provided.	$56.00*	$56.00*
9L	**General, thoracic and vascular surgery 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.	$149.10*	
12L	**Extended general, thoracic and vascular surgery consultation** – add on to 9L, max 4 units: a) Payable when consultation (9L) exceeds 25 minutes of direct in-person patient care and b) is satisfied. For clarity, 12L is payable when a minimum of 32.5 minutes of direct in-person patient care is provided; b) Each complete 15-minute period or major portion thereof of direct in-person patient care; and, c) Start and stop times for total direct in-person patient care (both 9L and 12L) must be entered on the claim and documented in the patient medical record.	$52.20*	
10L	**Cardiac surgery consultation** (only payable to physicians with approved training in cardiac surgery) – 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.	$191.30*	
11L	**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 7L "follow-up assessment" is appropriate.	$81.00*	

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

S E C T I O N L – General Surgery

			Specialist in General Surgery	
			Referred	Not Referred
13L	Written advice to referring physician on the management of a case based upon review of diagnostic imaging (payable once per case only)		$32.80@	$23.50@

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

Hospital Care

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 codes 627A-629A – Special Care Home Management.

25L	-- 1-10 days	-- per day -- bill units (max 10)	$42.50	$42.50
26L	-- 11-20 days	-- per day -- bill units (max 10)	$42.50	$42.50
27L	-- 21-30 days	-- per day -- bill units (max 10)	$42.50	$42.50
28L	-- 31 days and thereafter	-- per day -- bill units (max 99)	$42.50	$42.50

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

807L	**Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: a) history review; b) functional enquiry; c) reassessment; d) necessary treatment; e) advice to the patient; and f) record of service provided.	$50.40	$50.40
809L	**Virtual general, thoracic and vascular surgery consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$134.20	

S E C T I O N L – General Surgery

		Specialist in General Surgery	
		Referred	Not Referred
810L	**Virtual cardiac surgery consultation provided via telephone or secure videoconference (only payable to physicians with approved training in cardiac surgery)** – includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and, e) recommendations to the referring doctor.	$172.15	
811L	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807L' "Virtual follow-up assessment" is appropriate.	$72.90	

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S E C T I O N 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	$689.00	$620.10		
31L	Maxilla -- total resection	$947.10	$851.45	42	M
32L	V-excision lip -- less than 1/3	$173.50	$173.50	42	L
33L	Mandible -- one side at ramus excision	$800.00	$720.00	42	M
35L	Mandible -- segmental resection	$660.00	$594.00	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 recovery)	$84.10	$84.10	10	M
	Frenectomy -- See 139T				
47L	Glossectomy -- partial	$400.00	$360.00	42	M
48L	Glossectomy -- hemi	$500.00	$450.00	42	M
49L	Glossectomy -- total	$800.00	$720.00	42	M
50L	Excision carotid body tumor	$698.60	$628.75	42	H
51L	Excision carotid body tumor -- with bypass or arterial graft	$834.35	$750.20	42	H
52L	Scalenotomy	$251.80	$226.30	42	L
53L	Scalenotomy -- with cervical rib resection	$475.35	$427.15	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	$550.00	$495.00	42	M
64L	Full excision of superficial lobe of parotid with nerve dissection	$1,017.10	$915.40	42	M
65L	Total parotidectomy	$1,282.50	$1,154.25	42	M
66L	Sublingual gland excision	$350.00	$350.00	42	L
67L	Submandibular salivary gland excision	$420.60	$378.60	42	M

	S E C T I O N L – General Surgery	Specialist	General Practitioner	Class	Anes
	Thyroid				
68L	Aspiration of thyroid gland	$32.60	$32.60	D	
69L	Needle biopsy of thyroid gland	$67.75	$67.75	D	
70L	Thyroidectomy -- partial -- unilateral	$778.90	$701.10	42	M
71L	Thyroidectomy -- partial -- bilateral	$806.70	$726.05	42	M
77L	Thyroidectomy -- total -- unilateral	$933.00	$839.70	42	M
72L	Thyroidectomy -- total-- bilateral	$1,306.25	$1,175.65	42	M
78L	Thyroidectomy -- recurrent	$1,200.00	$1,080.00	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	$963.15	$866.90	42	M
76L	Parathyroidectomy -- with mediastinal exploration	$1,104.60	$994.05	42	H
775L	Parathyroid, reimplantation, add to 72L, 75L or 76L	$139.25	$125.30	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	$25.00	$25.00	D	
679L	Tru-cut needle biopsy of breast	$46.75	$46.75	D	
80L	Breast abscess -- single or multilocular -- general anesthetic	$199.65	$199.65	42	L
82L	Segmental resection	$346.00	$311.35	42	L
83L	Breast excision of tumor or biopsy	$320.30	$288.45	10	L
86L	Excision of non-palpable breast lesion using wire localization	$457.25	$411.50	10	L
84L	Simple mastectomy	$625.00	$562.50	42	
85L	Modified radical mastectomy	$1,194.75	$1,075.30	42	M
87L	Radical mastectomy	$1,298.75	$1,168.80	42	M
88L	Radical mastectomy -- with skin graft	$1,293.50	$1,164.75	42	M
89L	Subcutaneous mastectomy with preservation of nipple & areola	$695.90	$626.20	42	L
	Thorax				
90L	Mediastinoscopy -- without biopsy	$210.85	$189.85	D	M
689L	Mediastinoscopy -- with biopsy	$320.10	$288.10	10	M
690L	Mediastinotomy	$132.50	$119.30	42	M
91L	Funnel chest repair	$718.20	$646.45	42	M
92L	Thoracotomy -- with or without biopsy - not paid in addition to thoracic surgery	$476.40	$428.70	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	$208.75	$208.75	42	M

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
	Indwelling tunnelled pleural catheter 1. For management of chronic pleural effusion in patients with advanced or chronic malignancy requiring an indwelling tunnelled pleural catheter for long-term drainage. 2. Includes image guidance and interpretation. 3. Not payable for the adjustment of a previously inserted indwelling pleural catheter. Only the appropriate visit code applies. 4. Not billable in the acute short-term management of pneumothorax or pleural effusion. Use 95L.				
104L	-- insertion of indwelling pleural catheter	$209.00@	$209.00@	0	L
105L	-- removal of indwelling pleural catheter	$77.45@	$77.45@	0	L
@	Entitlement is limited to Respirologists and Thoracic surgeons only. Other specialists with appropriate training may apply to the Saskatchewan Medical Association Tariff Committee for entitlement				
95L	Closed drainage of chest	$185.50	$185.50	0	L
96L	Open drainage of chest with rib resection	$250.00	$225.05	0	M
97L	Intrapleural adhesions -- endoscopic resection	$231.40	$208.30	42	M
98L	Poudrage of chest	$266.60	$239.95	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	$1,116.45	$1,004.85	42	H
602L	Sleeve pneumonectomy	$1,261.60	$1,134.85	42	H
106L	Biopsy of lung -- open	$477.10	$429.40	42	H
108L	Drainage lung abscess -- one stage	$488.25	$439.50	42	H
109L	Drainage lung abscess -- two stages	$547.40	$492.85	42	H
110L	Resection first rib	$495.60	$446.05	42	M
111L	Thoracoplasty -- without first rib	$649.75	$584.85	42	M
112L	Thoracoplasty -- with first rib	$669.05	$602.15	42	M
114L	Mediastinal tumor (includes thymectomy) -- removal	$798.00	$718.50	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

	S E C T I O N L – General Surgery	Specialist	General Practitioner	Class	Anes
	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
	Pericardiectomy				
123L	Full pericardiectomy	$917.60	$825.80	42	H
623L	Partial pericardiectomy -- minimum of 20 minutes	$275.00	$247.50	42	H
124L	Patent ductus arteriosus -- ligation or division	$615.00	$553.00	42	H
125L	Excision/exclusion of left atrial appendage	$247.00	$222.30	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	$600.00	$540.00	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	$2,000.00	$1,800.00	42	H
150L	Mitral valve replacement (100% - 1st valve; 75% - each subsequent valve)	$2,100.00	$1,889.90	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	$3,700.00	$3,329.95	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	$1,600.00	$1,440.00	42	H
154L	Aorta-coronary bypass graft - for each additional	$325.00	$293.10	42	H
155L	Aorta-coronary bypass graft - each coronary endarterectomy, add	$267.10	$239.60	42	H

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
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	$192.70	$173.45	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 cardiodefribillator 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
	Veins				
	Portacath, Infusaport, Hemo-Cath, Hickman-Broviac for chemotherapy or long-term TPN				
657L	-- insertion	$265.30	$238.85	10	
658L	-- remove and replace	$382.45	$344.20	10	
659L	-- remove or revise, same site	$144.10	$144.10	0	
730L	Intravascular thrombolysis attendance and standby	$539.90	$485.90	10	L
158L	Transvenous insertion of intra atrial pediatric feeding catheter	$79.20	$70.95	0	L
160L	IV cutdown	$39.70	$39.70	0	L
182L	Ligation or plication of iliac or inferior vena cava	$586.50	$527.90	42	H
183L	Ligation of femoral vein	$293.80	$264.45	42	M
162L	Venous shunt -- portocaval, splenorenal, mesocaval	$953.25	$857.90	42	H
166L	Venous thrombectomy -- trunk	$583.00	$524.75	42	H
459L	Venous thrombectomy -- vena cava -- tumor thrombus	$995.60	$896.05	42	H
167L	Venous thrombectomy -- extremity - deep vein	$456.40	$410.40	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	$481.15	$432.95	42	M
178L	Major artery -- extremity or neck -- graft	$742.50	$668.25	42	M
179L	Major vein -- extremity or neck -- suture	$292.40	$263.10	42	L
180L	Major vein -- extremity or neck -- graft	$534.95	$481.45	42	L

a) *If saphenous vein graft - add 769L.
b) Unlisted or unusually complicated -- by report

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
	Digital Vessel Revascularization Microvascular or loupe magnification revascularization of a digital vessel as part of a wound repair				
281L	Digital vessel - revascularization -- arterial	$731.50	$658.30	42	H
282L	Digital vessel - revascularization -- arterial -- with vein graft	$841.50	$757.40	42	H
283L	Digital vessel - revascularization -- venous	$728.95	$656.00	42	H
284L	Digital vessel - revascularization -- venous -- with vein graft	$841.05	$757.00	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%. The 75% rule will apply for amputation where all attempts to revascularize fail.				
	Renal				
660L	Hemodialysis -- cutdown artery and vein	$42.60	$38.30	0	
661L	Schribner or similar shunt -- initial or repeat	$202.95	$182.80	42	
662L	A/V fistula for dialysis	$393.45	$354.10	42	
663L	Arterial venous fistula with graft -- prosthetic or venous (includes harvesting of vein)	$601.50	$541.25	42	
666L	Ligation of fistula	$226.15	$203.55	0	
	Peritoneal Dialysis				
667L	Chronic dialysis catheter -- insertion	$255.55	$255.55	0	
669L	Chronic dialysis catheter -- removal	$167.95	$167.95	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	$134.55	$121.10	0	
	Arteries				
159L	Biopsy of artery	$146.50	$146.50	10	L
181L	Ligation of carotid artery	$291.60	$262.45	42	H
184L	Exploration of peripheral artery	$209.45	$188.55	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	$156.00	$140.35	42	
770L	In situ saphenous vein preparation, add	$306.15	$275.55	42	
	Bifurcation Grafts -- Includes thromboendarterectomy and/or embolectomy				
568L	Aorto-iliac - unilateral or bilateral	$1,587.30	$1,428.50	42	H
668L	Aorto-unifemoral	$1,513.95	$1,362.55	42	H
768L	Aorto-bifemoral	$1,650.65	$1,485.55	42	H
460L	Juxta-renal aorto-bifemoral	$2,158.75	$1,942.95	42	H
461L	Ilio-femoral obturator	$1,099.00	$989.10	42	H
191L	Ruptured aortic aneurysm (add to surgical procedure)	$358.80	$322.95	42	H

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
	Peripheral Artery				
169L	Femoro-popliteal	$847.90	$763.20	42	H
462L	Femoro-tibial or peroneal	$1,111.45	$1,000.35	42	H
463L	Femoro-pedal	$1,259.40	$1,133.45	42	H
464L	Axillo - axillary, axillo-femoral; carotid-subclavian; cross femoral; ilio-femoral; subclavian-subclavian; other arteries of neck or extremities	$958.65	$862.85	42	H
	Thoracic or Abdominal Aorta				
188L	Aorto-carotid; aorto-axillary; aorto-coeliac; aorto-superior mesenteric; aorto-innominate; renal; thoracic or abdominal aorta	$1,497.10	$1,347.40	42	H
189L	Reimplantation of each major branch, add	$215.15	$193.70	42	H
174L	Intra-operative arteriogram, add	$59.05	$59.05	D	
	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)	$838.85	$754.95	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	$453.40	$408.05	42	H
467L	Profundoplasty beyond second major branch, add	$565.30	$508.75	42	H
163L	Arteriotomy with Embolectomy -- trunk	$778.90	$701.10	42	M
164L	Arteriotomy with Embolectomy -- neck	$602.25	$541.65	42	H
165L	Arteriotomy with Embolectomy -- extremity	$592.70	$533.40	42	M
468L	Arteriotomy with Embolectomy -- visceral	$952.15	$856.90	42	H
	Thromboendarterectomy (Independent Procedure)				
469L	Femoral --unilateral	$892.65	$803.45	42	M
470L	Iliac; carotid; renal; subclavian; superior mesenteric; vertebral	$997.15	$897.45	42	H
471L	Aorta innominate	$1,423.05	$1,280.75	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	$1,709.05	$1,538.15	42	H
474L	Carotid endarterectomy with patch angioplasty greater than 3 cm - add	$402.40	$362.10	42	H

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
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	$226.15	$203.55	42	H
192L	Excision AV fistula -- extremity	$510.30	$458.70	42	L
193L	Excision AV fistula -- trunk	$893.75	$804.10	42	M
	Varicose Veins				
200L	Saphenous axis -- section and ligation -- unilateral	$236.30	$236.30	42	L
201L	Saphenous axis -- section and ligation -- bilateral	$445.15	$445.15	42	L
	Ligation of multiple veins, with or without long saphenous stripping, with saphenous axis ligation				
209L	-- unilateral	$436.20	$436.20	42	L
210L	-- bilateral	$809.50	$809.50	42	L
211L	Multiple ligation of all veins (unilateral or bilateral) done in a session -- each -- maximum - 10 veins	$40.80	$36.70	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	$442.10	$397.95	42	
	Ligation and dissection short saphenous vein at saphenopopliteal junction (213L-214L)				
213L	-- unilateral	$198.90	$198.90	42	L
214L	-- bilateral	$292.70	$292.70	42	L
215L	Subfascial ligation of one incompetent communicating vein	$42.80	$42.80	0	L
216L	Follow-up operation to 209L or 210L -- unilateral	$165.00	$165.00	42	L
217L	Subfascial ligation -- complete (Linton)	$481.60	$434.10	42	L
	Injection of spider veins is uninsured				
218L	Injection of symptomatic varicose veins -- first vein	$24.05	$24.05	0	L
618L	Injection of symptomatic varicose veins -- each additional vein (one leg maximum 15, both legs max 25)	$17.85	$17.85	0	L
219L	Stripping and ligation of short saphenous vein	$334.20	$334.20	42	L

S E C T I O N L – General Surgery

			Specialist	General Practitioner	Class	Anes
	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	$530.65	$530.65	42	M
531L	Laparotomy --	extended - including gland and liver biopsies	$766.50	$689.85	42	M
532L	Laparotomy --	staged - for Hodgkins Disease - including biopsies and splenectomy	$1,656.40		42	H
533L	Laparotomy --	for acute trauma - by report	$785.75	$707.15	42	M
534L	Laparotomy --	with repair of bowel -- single, add	$283.15	$254.80	42	M
535L	Laparotomy --	with repair of bowel -- multiple and/or resection, add	$448.70	$403.90	42	M
536L	Laparotomy --	with splenectomy or repair, add	$489.50	$440.60	42	H
537L	Laparotomy --	with lacerated liver, add	$403.70	$363.35	42	H
538L	Laparotomy --	with repair of diaphragm, add	$240.90	$216.70	42	M
539L	Laparotomy --	insertion of tubes and post-operative continuous peritoneal lavage, add	$184.35	$165.95	42	M
221L	Staging and/or diagnostic peritoneoscopy -- with or without biopsy 1. Peritoneoscopy is not payable with laparoscopic surgery unless it precedes the surgery as a diagnostic and/or staging procedure. 2. Diagnostic peritoneoscopies are billable when the diagnosis or condition is uncertain or unknown. 3. Staging peritoneoscopies are billable for the diagnosis/staging of malignancies to determine extent of disease and treatment options (i.e.: 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.		$250.00	$224.90	D	M
222L	Abdominal wound dehiscence – exempt from repeat surgical rule		$340.00	$340.00	42	M
224L	Sub-phrenic abscess -- incision and drainage – When performed as an independent procedure. – Not billable in addition to other abdominal surgery.		$799.70	$719.75	42	M
225L	Abdominal or pelvic abscess -- incision and drainage		$481.60	$481.60	42	M
226L	Transrectal drainage of pelvic abscess		$240.90	$240.90	42	L
227L	Incision and drainage of supra-levator, pelvi-rectal or retro-rectal abscess		$297.35	$267.65	42	L
228L	Incision and drainage of ischio-rectal abscess		$265.65	$265.65	42	L
229L	Incision and drainage of perianal abscess		$195.60	$195.60	10	L
232L	Debulking of intra-thoracic or intra-abdominal tumor when primary procedure		$545.15	$490.65	42	H

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
233L	**Intraoperative Surgical Intervention** 1. To be paid to the surgeon when they are 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.	$342.10	$307.90	42	M
	Hernia Repairs				
240L	Diaphragmatic hernia	$897.70	$807.95	42	M
241L	Fundoplication and/or hiatus hernia repair	$881.85	$793.70	42	M
248L	Esophagogastric fundoplasty (Nissen) with gastroplasty (Collis)	$1,320.00	$1,188.00	42	H
242L	Epigastric hernia	$363.00	$363.00	42	L
243L	Reduction of hernia	$36.95	$36.95	0	L
244L	Reduction of hernia -- with Anesthetic	$51.90	$51.90	0	L
245L	Incisional ventral hernia	$630.95	$630.95	42	L
246L	Complex incisional hernia with inlay mesh (retrorectus or intraperitoneal) 1. Billable when hernia is repaired with Inlay mesh AND 2. Two (2) of the following 3 components are present: a) Component separation; or b) Hernia width is more than 8 cm on preoperative CT; or c) Multiple fascial defects are seen on preoperative CT; AND 3. Surgery is a minimum duration of 2.5 hours. 4. Physician must indicate on the electronic claim which 2 components are present and the total duration of time. 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).	$1,156.25	$1,040.55	42	H
247L	Paraesophageal hernia repair	$1,151.15	$1,036.05	42	H
	Umbilical Hernia Not paid in addition to other laparoscopic abdominal surgery				
251L	Umbilical hernia -- child	$418.20	$418.20	42	L
252L	Umbilical hernia -- adult	$418.20	$418.20	42	L
253L	Umbilical hernia -- incarcerated or recurrent, child or adult	$546.15	$491.60	42	M
255L	Omphalocele -- one stage	$427.25	$384.65	42	H
256L	Omphalocele -- staged -- each stage	$464.65	$418.25	42	H
258L	Patent urachus -- includes excision of urachal cyst or sinus	$437.45	$393.80	42	M

	S E C T I O N L – General Surgery	Specialist	General Practitioner	Class	Anes
260L	Inguinal or femoral herniorrhaphy	$469.15	$469.15	42	L
261L	Inguinal or femoral herniorrhaphy -- incarcerated, strangulated or recurrent	$548.35	$493.45	42	M
	Herniotomy with orchidopexy, only the larger fee is paid				
262L	Simple herniotomy -- unilateral	$420.10	$420.10	42	L
263L	Simple herniotomy -- bilateral -- includes unilateral herniotomy with negative contralateral exploration, open or by laparoscopy	$573.20	$573.20	42	L
264L	Spigelian hernia	$510.60	$459.60	42	L
265L	Lumbar hernia	$514.80	$463.30	42	L
266L	Obturator hernia	$510.95	$459.85	42	L
267L	Patent vitello-intestinal duct or excision Meckel's diverticulum -- includes excision of omphalomesenteric duct fistula, cyst or sinus	$609.95	$549.00	42	M
	Biliary Tract				
271L	Cholecystostomy	$481.60	$433.45	42	M
272L	Choledochostomy with or without cholecystectomy/ choledochoscopy	$930.50	$837.45	42	M
273L	Cholecysto-enterostomy	$691.90	$622.70	42	M
274L	Choledocho-enterostomy or transduodenal sphincterotomy	$946.20	$851.60	42	M
674L	Choledochojejunostomy with Roux-en-Y	$1,418.30		42	M
275L	Repair stricture common bile duct	$1,598.50	$1,438.55	42	M
276L	Cholecystectomy -- without operative cholangiography	$709.20	$638.25	42	M
277L	Cholecystectomy -- with cholangiogram	$840.00	$756.00	42	M
278L	Biliary atresia -- exploration with cholangiogram -- not paid with portoenterostomy -- with liver biopsy add 416L at 75%	$713.25	$642.60	42	M
279L	Hepatico-enterostomy -- includes portoenterostomy (Kasai procedure) for biliary atresia	$2,030.05	$1,827.05	42	H
	Esophagus and Stomach				
292L	Esophagomyotomy (Heller)	$1,117.05	$1,005.30	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	$1,113.65	$1,002.20	42	H
294L	Esophageal diverticulum -- transthoracic repair	$757.00	$681.25	42	H
295L	Pharyngo-oesophageal diverticulum -- repair	$652.65	$587.40	42	M
296L	Ruptured oesophagus -- transthoracic repair	$722.25	$650.00	42	H
297L	Ruptured oesophagus -- transcervical repair	$568.70	$511.85	42	M
298L	Esophagogastrostomy or esophagojejunostomy	$1,112.45	$1,001.20	42	M
299L	Esophagectomy or esophagogastrectomy -- with or without pyloroplasty	$1,591.35	$1,432.20	42	H
320L	Esophagectomy or esophagogastrectomy -- with replacement	$1,985.15	$1,786.65	42	H
300L	Total esophagectomy with cervical fistula and gastrostomy	$1,118.05	$1,005.95	42	H
301L	Replacement of oesophagus by transplant	$1,382.70	$1,244.75	42	H

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
302L	Vagotomy -- truncal or selective -- abdominal or thoracic	$642.60	$578.40	42	H
321L	Highly selective vagotomy -- with or without pyloroplasty	$796.20	$716.65	42	M
303L	Gastrectomy -- with or without splenectomy -- partial	$1,099.00	$989.10	42	H
304L	Gastrectomy -- with or without splenectomy -- partial with vagotomy	$1,117.05	$1,005.30	42	H
305L	Gastrectomy -- with or without splenectomy -- total	$1,767.15	$1,590.40	42	H
306L	Pyloroplasty	$581.70	$523.60	42	M
607L	Pyloroplasty -- with oversewing of bleeding ulcer, add	$153.30	$137.95	42	M
308L	Gastro-enterostomy	$660.00	$594.10	42	M
309L	Gastro-enterostomy -- with vagotomy	$882.55	$794.30	42	M
310L	Gastrotomy -- with or without removal of foreign body or tumor	$521.30	$469.15	42	M
311L	Gastrostomy -- simple	$550.75	$495.65	42	M
312L	Gastrostomy -- with living tube	$647.90	$583.10	42	M
313L	Decompression gastrostomy -- in conjunction with other abdominal surgery, add	$110.00	$110.00	42	M
314L	Rammstedt pyloromyotomy	$593.30	$534.00	42	M
315L	Perforated ulcer -- repair	$689.95	$689.95	42	M
317L	Resection of anastomotic ulcer	$1,183.70	$1,065.40	42	M
318L	Repair duodenal tear	$647.90	$583.10	42	M
319L	Traumatic duodenal fistula	$983.75	$885.40	42	M
327L	Laparoscopic Roux-en-Y bypass	$1,645.75	$1,456.95	42	H
328L	Laparoscopic sleeve gastrectomy	$1,079.20	$971.30	42	H
	Small Bowel				
330L	Perforated small bowel repair	$687.40	$687.40	42	M
331L	Small bowel obstruction -- without resection	$705.45	$705.45	42	M
332L	Small bowel resection	$881.85	$793.70	42	M
333L	Appendectomy -- not paid in addition to abdominal surgery, except where clinically indicated and billed by report	$481.05	$481.05	42	M
334L	Entero-enterostomy	$837.75	$754.05	42	M
335L	Enterotomy for foreign body or tumor	$674.85	$607.40	42	M
336L	Ileostomy revision – minor, service exempt from repeat surgical	$426.90	$384.25	42	L
337L	Ileostomy revision – major, service exempt from repeat surgical	$563.10	$506.75	42	M
338L	Feeding jejunostomy	$564.20	$507.85	42	M
638L	Tube jejunostomy when performed with other surgery	$281.60	$253.45	42	
339L	Continent ileostomy (Koch's) -- independent procedure	$1,341.95	$1,207.80	42	M
340L	Enterostomy or cecostomy, service exempt from repeat surgical rule	$617.00	$617.00	42	M
639L	Closure of loop or double barrelled ileostomy, service exempt from repeat surgical rule	$595.75	$536.10	42	M
	Bowel Obstruction - Infant -- excluding intussusception				
631L	-- without resection - includes Ladd's procedure for malrotation and/or correction of volvulus	$748.00	$672.85	42	M
632L	-- with resection - includes duodenal, atresia repair, repair of jejunoileal atresia (single atresia)	$977.90	$880.35	42	M

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
	Large Bowel, Rectum and Anus				
342L	Colectomy -- hemi or segmental	$1,190.25	$1,071.30	42	H
442L	Hartmann's procedure	$1,201.30	$1,081.25	42	H
343L	Total colectomy with or without ileostomy	$1,493.95	$1,344.65	42	H
344L	Total colectomy and proctectomy	$2,232.90	$2,009.65	42	H
644L	Continent ileostomy (Koch's) -- with 343L or 344L, add	$642.20	$578.00	42	H
645L	Total colectomy with mucosal proctectomy and ileo-pouch with ileo-anal anastomosis and loop ileostomy	$2,612.70	$2,351.35	42	M
345L	Ileorectal anastomosis	$936.10	$842.45	42	M
346L	Proctectomy	$642.60	$578.40	42	M
347L	Colostomy -- service exempt from repeat surgical rule	$649.90	$584.80	42	M
348L	Closure of loop or double barrelled colostomy -- service exempt from repeat surgical rule	$649.90	$584.80	42	M
548L	Colonic reanastomosis following Hartmann's procedure	$1,144.10	$1,029.75	42	M
349L	Colostomy revision – minor, service exempt from repeat surgical	$364.85	$328.40	42	L
350L	Colostomy revision – major, service exempt from repeat surgical	$492.90	$443.70	42	M
365L	Massive rectal prolapse -- perineal repair	$614.30	$552.85	42	L
366L	Massive rectal prolapse -- abdominal repair	$874.45	$786.95	42	M
367L	Massive rectal prolapse -- with sigmoid resection	$1,102.55	$992.35	42	H
368L	Massive rectal prolapse -- abdominal-perineal repair	$1,246.70	$1,122.00	42	M
369L	Insertion of ring or wire for rectal prolapse	$334.20	$300.75	42	L
373L	Closure of rectovesical or rectourethral fistula	$771.10	$694.05	42	M
374L	Closure of rectovesical or rectourethral fistula with colostomy	$846.65	$762.10	42	M
377L	Banding of hemorrhoids -- each -- maximum 3	$49.30	$49.30	10	L
378L	Hemorrhoid -- injection	$25.75	$25.75	0	L
379L	Hemorrhoid -- incision or excision external thrombosed	$72.45	$72.45	10	L
380L	Polyp -- anal -- excision	$121.00	$121.00	10	L
381L	Hemorrhoidectomy	$405.40	$405.40	42	L
383L	Low imperforate anus repair	$757.45	$681.65	42	M
384L	High imperforate anus repair - by any method includes division of vaginal, urethral or bladder fistula	$965.60	$869.45	42	M
386L	Rectal polyp or tumor -- excision or fulguration -- under anesthetic	$157.70	$157.70	42	L
387L	Transanal excision of giant villous adenoma of rectum	$519.00	$467.05	42	M
388L	Deep transrectal or perirectal biopsy for Hirschsprung's disease	$141.35	$127.15	10	L
371L	Transanal endoscopic microsurgery (TEM), resection of rectal	$938.30@	$844.45@	42	M

@ 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.

For the purposes of billing, 371L is billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”.

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
389L	Excision sacro-coccygeal teratoma	$801.55	$721.40	42	M
391L	Pilonidal -- cyst or sinus -- excision or marsupialization	$427.35	$427.35	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	$272.80	$272.80	42	L
397L	Fistula-in-ano -- excision -- superficial	$334.55	$334.55	42	L
398L	Fistula-in-ano -- excision -- deep involving sphincter	$549.15	$549.15	42	L
399L	Fistula-in-ano -- excision -- high	$659.70	$593.70	42	L
562L	Fissure/fistula-in-ano -- cleansed and obliterated with Tiseel	$233.95	$233.95	10	L
400L	Anal dilatation - manual or by balloon a) Under anesthetic or IV sedation; b) Includes post-op recovery; and c) Not to be billed with other anorectal surgery such as hemorrhoidectomy, fissure codes etc. Includes any type of pull-through procedure for Hirschsprung's disease.	$59.25	$59.25	0	L
352L	Abdomino-perineal resection -- one team -- surgeon	$1,862.30	$1,676.10	42	H
353L	Abdomino-perineal resection -- two team -- abdominal surgeon	$1,662.50	$1,496.30	42	H
354L	Abdomino-perineal resection -- two team -- perineal surgeon	$697.25	$627.50	42	H
355L	Proctosigmoidectomy	$1,359.20	$1,223.30	42	H
356L	Colotomy -- for foreign body	$732.60	$659.40	42	M
357L	Colotomy -- for tumor	$805.00	$724.45	42	M
358L	Anterior resection -- without total mesorectal excision	$1,375.75	$1,238.15	42	H
359L	Posterior resection	$1,209.10	$1,088.20	42	H
370L	Low anterior resection – with total mesorectal excision (TME)	$1,736.50	$1,562.85	42	H
	Liver, Spleen, Adrenals				
413L	Liver -- rupture -- repair	$828.65	$745.75	42	H
414L	Liver -- abscess -- incision and drainage	$749.90	$674.90	42	M
415L	Liver -- needle biopsy	$103.20	$92.90	D	L
416L	Liver -- open biopsy	$533.00	$479.70	42	M
417L	Liver -- hemi-hepatectomy	$2,030.05	$1,827.05	42	H
418L	Liver -- segment hepatectomy	$1,116.10	$1,004.60	42	H
	Pancreas / Spleen				
419L	Pancreatectomy -- partial	$1,103.90	$993.40	42	H
420L	Pancreatectomy -- partial with duodenectomy or total with or without duodenectomy	$3,300.00	$2,970.00	42	H
421L	Pancreatic pseudocyst marsupialization or adenoma excision	$1,081.10	$972.95	42	M
620L	Pancreatic abscess drainage	$788.15	$709.25	42	M
621L	Pancreatico-enterostomy with Roux-en-Y	$1,545.40	$1,390.85	42	M
422L	Splenectomy -- abdominal or repair	$881.85	$793.70	42	M
423L	Splenectomy -- thoraco-abdominal	$874.70	$787.25	42	M
426L	Adrenalectomy -- unilateral	$980.55	$882.55	42	H
428L	Extra-adrenal pheochromocytoma or other retroperitoneal tumor	$1,299.60	$1,169.65	42	H

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
	Lymph Nodes				
430L	Biopsy -- superficial node	$198.00	$198.00	10	L
431L	Biopsy -- deep node -- beneath deep fascia	$400.00	$400.00	10	L
432L	Biopsy -- scalene node	$234.85	$211.35	10	L
433L	Biopsy -- mediastinal	$303.80	$273.40	10	M
434L	Suprahyoid block dissection	$700.00	$630.05	42	M
635L	Sentinel lymph node biopsy -- with malignant melanoma and breast cancer surgery	$573.20	$515.90	42	M
73L	Central neck dissection -- thyroid cancer – add to 72L	$350.00	$314.90	42	M
435L	Complete block dissection -- neck	$1,200.00	$1,080.05	42	H
436L	Complete block dissection -- axilla	$825.00	$742.50	42	M
437L	Complete block dissection -- groin-wide inguinal	$911.40	$820.30	42	M
438L	Complete block dissection -- groin-deep with common iliac dissection	$1,280.15	$1,152.20	42	M
439L	Complete block dissection -- retroperitoneal including pelvic, aortic	$1,499.15	$1,349.30	42	H
440L	Scalene fat pad dissection	$369.50	$332.50	42	L
	Integumentary System				
840L	Biopsy of palpable superficial lesion -- unless otherwise listed -- by fine needle biopsy or aspiration	$23.20	$23.20	D	L
841L	Biopsy of palpable superficial lesion -- unless otherwise listed -- by core needle biopsy	$45.55	$45.55	D	L
849L	Integumentary system - aspiration of hematoma or cyst	$24.70	$24.70	0	L
850L	Integumentary system - incision and drainage of abscess, etc.	$60.90	$60.90	10	L
851L	Integumentary system - abscess -- multilocular	$72.05	$72.05	10	L
852L	Carbuncle, deep (beneath deep fascia) or pilonidal cyst abscess -- unroofing under general anesthetic	$102.95	$102.95	10	L
853L	Intramuscular abscess	By Report		10	L
854L	Muscle biopsy (general practitioners – billable “by report” only)	$131.25	$131.25	10	L
	Ablation of actinic keratosis, pyogenic granuloma, keratoacanthoma, or bleeding lesions by electrocautery, chemical cautery, cryotherapy, laser and/or curettage.				
603L	-- 1st lesion	$27.05	$27.05	10	L
604L	-- 2nd to 7th lesion -- each -- max 6 units	$9.90	$9.90	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	$71.90	$71.90	10	L
611L	-- each subsequent 15 minutes (max of 2 additional units), add - bill units	$36.00	$36.00	10	L

	S E C T I O N L – General Surgery	Specialist	General Practitioner	Class	Anes
	Pulsed dye tuned laser ablation of facial port wine stains is insured under the age of 18. Pre-authorization required for other symptomatic or bleeding cutaneous angiomata				
780L	Professional - laser owned by physician, per 15-minute session or major part thereof	$47.25	$47.25	0	L
781L	-- for each unit used (i.e. 5 pulses), add -- bill units	$7.50	$7.50	0	L
	(Note: Billings also to be made in units; 1 unit = 5 pulses)				

S E C T I O N 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 (i.e.: 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	$66.50	$66.50	10	L
858L	-- 2nd to 7th -- each -- max 6 units	$30.50	$30.50	10	L
859L	-- 8th and over, each	$19.80	$19.80	10	L
	Over 1 cm. diameter -- face, palm of hand or fingers, sole of foot or toes				
860L	-- 1st lesion	$92.70	$92.70	10	L
861L	-- 2nd to 7th -- each -- max 6 units	$45.85	$45.85	10	L
862L	-- 8th and over, each	$28.85	$28.85	10	L
	Over 1 cm. diameter -- other areas, including scalp				
863L	-- 1st lesion	$72.30	$72.30	10	L
864L	-- 2nd to 7th -- each -- max 6 units	$31.60	$31.60	10	L
865L	-- 8th and over, each	$20.00	$20.00	10	L
866L	Sebaceous cyst or intradermal cyst (any area) -- excision and suture closure	$75.80	$75.80	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.	$79.10	$79.10	10	L
868L	Lipoma or subcutaneous tumor -- excision -- over 5 cm. up to 10 cm.	$137.20	$137.20	42	L
869L	Lipoma or subcutaneous tumor -- excision -- larger than 10 cm.	$281.60	$281.60	42	L
870L	Lipoma or other benign tumor beneath deep fascia	$435.00	$391.50	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 <u>electronic</u> 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.				

	S E C T I O N 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	$98.70	$98.70	10	L
873L	Removal of Foreign Body -- under general anesthesia or IV sedation (includes post-op recovery)	$131.25	$131.25	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	$169.20	$169.20	10	L
	Plantar Warts – venereal warts – see codes 420R to 422R				
	Plantar warts -- Excision or fulguration plus curettage				
875L	-- 1st wart	$33.00	$33.00	10	L
876L	-- each additional wart (maximum of 4) -- bill units	$11.00	$11.00	10	L
	Plantar warts -- treatment by cryotherapy, laser, cautery or chemical ablation, or any other non-surgical means. Includes paring and/or debulking of the plantar wart prior to or subsequent to treatment of the wart, when required.				
877L	-- 1st wart	$20.00	$20.00	10	L
878L	-- 2nd to 7th wart, each (**maximum of 6 units for this code**)	$7.50	$7.50	10	L
879L	-- 8th wart and over, each	$2.05	$2.05	10	L
	Removal of fingernail or toenail				
880L	Simple avulsion or wedge excision	$63.00	$63.00	10	L
881L	Radical excision of nail bed or hemiphalangectomy	$152.50	$152.50	10	L
882L	Wedge resection with phenol or cautery or cryo ablation	$116.55	$116.55	10	L
883L	Trimming of toenails, corns or calluses where medically necessary -- maximum of 1 per day. Not billable for the paring and/or debulking of a wart prior to or subsequent to treatment of the wart.	$29.40	$29.40	0	L
884L	Soft tissue nail-fold excision for ingrown toenails -- Vandenbos surgery	$141.75	$141.75	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.	$67.80	$67.80	10	L
891L	-- each additional 2.5 cm -- bill units	$33.90	$33.90	10	L
	(B) **Other areas, including scalp**				
894L	-- up to 2.5 cm.	$45.20	$45.20	10	L
895L	-- each additional 2.5 cm – bill units	$22.60	$22.60	10	L
896L	-- complicated	By Report		42	L

S E C T I O N 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. Payable with the following office procedures: 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), 260N, 261N, 262N, 263N, 894L (with sutures or staples), 380N, 382N, 684N, 685N; 31P, 39P; 59R, 190R (skin closure with suture or staples); 72S, 89S or 100S.	$30.80	$30.80		
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. Payable with the following office procedures: a) 104A, 105A, 116A, 123A; 100F (without sutures), 102F (without sutures), 888F; 94H, 158H; 379L, 705L, 850L, 884L; 380M, 381M, 382M; 108P, 109P, 114P; 190R (skin closure without sutures); 63S, 91S, 92S, 250S; 88T and 138T.	$14.30	$14.30		
898L	Removal of sutures and/or staples from lacerations or surgical incisions (10- or 42-day procedures only) of any length by any physician.	$20.00	$20.00	0	

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
	Surgical Debridements				
700L	Surgical debridement; excision of damaged, necrotic or otherwise non-viable tissue		By Report	10	
	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) **For a claim to be processed, the physician must provide details of**:				
	a) The patient's clinical condition;				
	b) The treatment or procedure provided;				
	c) Time when the debridement started and was completed.				
	Surgical debridement; excision of damaged, necrotic or otherwise non-viable tissue (701L-703L)				
	1) Payable when debridement of necrotizing soft tissue infection or systemic sepsis, under general anesthesia, regional anesthesia or monitored care.				
	2) Payment approved for General Surgery and Urology only.				
	3) Services 701L, 702L and 703L are exempt from the repeat surgical rules.				
701L	Less than 65 sq. cm	$174.05		10	H
702L	65-100 sq. cm	$277.30		42	H
703L	Over 100 sq. cm	$453.00		42	H
705L	**Surgical Debridement of chronic skin ulcer or wound**	$88.00		10	L
	Payable for surgical debridement only. For services that exceed 30 minutes, physician is to bill 700L, by report. Payment approved for General Surgery and Urology only				

S E C T I O N L – General Surgery

		Specialist	General Practitioner	Class	Anes
	Split Thickness Skin Grafts 1) Payment approved for general surgeons with additional training and expertise in split thickness skin grafting. 2) Qualified physicians do not need to request approval to bill for these services prior to the service being billed and/or provided. No formal entitlement is required. 3) Physicians only need to provide documentation demonstrating their training if the Ministry of Health specifically requests it. 4) Not billable by Plastic Surgery, Otolaryngology, Ophthalmology, or Urology. Physicians from these specialities must use available N codes.				
710L	Defects up to 6 sq. cm. (neck, trunk, arms, legs) onlay type graft – meticulous operative fixation not required	$70.20		10	L
711L	Defects up to 6-65 sq. cm. (neck, trunk, arms, legs) onlay type graft – meticulous operative fixation not required	$118.30		42	M
712L	Defects up to 65-194 sq. cm. (neck, trunk, arms, legs) onlay type graft – meticulous operative fixation not required	$257.95		42	M
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	$261.15	$234.95	10	L
726L	Internalization of Epidural Catheter - establishment and connection of catheter	$120.00	$108.00	0	L
	Burns: Emergency treatment (e.g. as outpatient bill as 5B or 918A. Also, See section N.				
	BMI Supplement				
580L	General surgery supplement for patients with a Body Mass Index (Weight [kg]/Height [m] 2) greater than 40 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. 4. BMI supplements are not payable to the surgical assistant billing "J" section codes.	$75.00	$75.00		

	S E C T I O N L – General Surgery	Specialist	General Practitioner	Class	Anes
	Vascular Laboratory				
	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).	$13.35	$13.35	D	
	Peripheral Venous				
754L	Laboratory assessment for interpretation of peripheral venous system	$12.70	$12.70	D	

S E C T I O N 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	Nasojejunostomy 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	Endoscopic - fine needle aspiration biopsy -- one or more – add to 490L, 492L	$53.00	$53.00	D	L
496L	Endoscopic - injection of one or more metastases, nodes, masses or celiac plexus -- add to 490L, 492L	$162.20	$162.20	D	L
497L	Endoscopic - drainage of pseudo cyst, one or more -- add to 490L, 492L	$212.10	$212.10	D	L

	S E C T I O N L – General Surgery	Specialist	General Practitioner	Class
	Percutaneous gastrostomy under gastroscopic control - by two physicians			
	Endoscopic gastrostomy or jejunostomy			
443L	-- 1st physician	$189.40	$189.40	0
444L	-- 2nd physician	$126.60	$126.60	0
	Endoscopic gastrostomy and jejunostomy same day			
445L	-- 1st physician	$278.60	$278.60	0
446L	-- 2nd physician	$184.50	$184.50	0
498L	Endoanal Ultrasound	$125.50	$125.50	D
447L	PEG tube change - external approach PEG tube removal -- external via gastroscope	$25.20	$25.20	D
448L	Colonoscopy -- base	$203.00	$203.00	D
449L	Sigmoidoscopy -- flexible -- base code	$70.40	$70.40	D
450L	Sigmoidoscopy -- rigid -- base code	$35.40	$35.40	D
453L	Ileoscopy/jejunoscopy when done through ileostomy– base code	$70.40	$70.40	D
	(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	Polypectomy (any GI site) -- 1st polyp -- add	$63.10	$63.10	D
483L	Polypectomy (any GI site) -- 2nd to 5th polyp, each (maximum of 5 total) -- add	$47.90	$47.90	D
484L	Sclerotherapy by any thermal means (e.g. heater or bicapprobe) or any injectable method (e.g. 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 a) includes routine sweeps of common duct b) maximum procedural billing per base code same day $571.00	$242.80	$242.80	D
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

	S E C T I O N L – General Surgery	Specialist	General Practitioner	Class	Anes
	With biliary or pancreatic duct balloon dilatations				
506L	-- 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	
540L	-- with bronchial brushing --add	$65.10		D	
541L	-- with broncho-alveolar lavage for diagnosis of malignancy or diagnosis and/or treatment of infection and includes obtaining specimens suitable for differential cellular analysis --- add	$50.00		D	
542L	-- with dilation of stricture -- add	$44.55		D	
515L	Endobronchial Ultrasound Base -- includes bronchoscopy	$270.40	$270.40	D	
516L	Transbronchial needle aspiration -- add to 515L -- maximum of 3 lesions or stations	$54.00	$54.00	D	
452L	Video Capsule Endoscopy - 15-minute units -- maximum of 10 units	$54.30	$54.30	D	
	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

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S E C T I O N M – Orthopedic Surgery

		Specialist in Orthopedic Surgery	
		Referred	Not Referred
	Visit Services		
5M	**Initial assessment** -- of a specific condition includes: 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; i) advice to the patient; and, j) record of service provided.	$77.00*	$61.65*
7M	**Follow-up assessment** -- includes: a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and, g) record of service provided.	$57.00*	$57.00*
9M	**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.	$122.45*	
12M	**Extended Consultation** – add on to 9M, max 4 units: a) Payable when consultation (9M) exceeds 20 minutes of direct in-person patient care and b) is satisfied. For clarity, 12M is payable when a minimum of 27.5 minutes of direct in-person patient care is provided; b) Each complete 15-minute period or major portion thereof of direct in-person patient care; and, c) Start and stop times for total direct in-person patient care (both 9M and 12M) must be entered on the claim and documented in the patient medical record.	$42.85*	
10M	**Consultation for patients referred for back pain only**	$85.00*	
11M	**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 service code '7M' "follow-up assessment" is appropriate. * Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.	$65.00*	
13M	Written advice to referring physician on the management of a case based upon review of x-rays by Orthopedic Surgeon (payable once per case) @ Payment approved for a physician with training and expertise in this section	$57.70	$46.15@

S E C T I O N M – Orthopedic Surgery

			Specialist in Orthopedic 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 codes 627A-629A – Special Care Home Management.

25M	-- 1-10 days	-- per day -- bill units (max 10)	$32.35	$32.35
26M	-- 11-20 days	-- per day -- bill units (max 10)	$32.35	$32.35
27M	-- 21-30 days	-- per day -- bill units (max 10)	$32.35	$32.35
28M	-- 31 days and thereafter	-- per day -- bill units (max 99)	$32.35	$32.35

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

507M **Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: $51.30 $51.30

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

509M **Virtual consultation provided via telephone or secure videoconference**-- includes: $110.20

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

511M **Repeat virtual consultation provided via telephone or secure videoconference:** $58.50

A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '507M' "Virtual follow-up assessment" is appropriate.

S E C T I O N 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	$38.50	$38.50	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)	$400.00	$400.00	10	L

Osteotomy – with or without internal fixation

40M	Clavicle	$600.00	$540.55	42	L
44M	Humerus or ulna or radius	$600.00	$540.55	42	L
48M	Radius and ulna	$600.00	$540.55	42	L
49M	Femur – neck or supracondylar	$600.00	$540.55	42	M
50M	Femur -- trochanteric or subtrochanteric	$600.00	$540.55	42	M
56M	Tibia and Fibula	$600.00	$540.55	42	M

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
	Osteotomy – with or without internal fixation				
64M	Femur, supracondylar and tibia and fibular	$600.00	$539.95	42	M
60M	Metacarpal, metatarsal or phalanx—one	$475.00	$427.50	42	L
68M	Os calcis (Dwyer or wedge tarsectomy)	$600.00	$540.00	42	L
	Excision				
81M	Biopsy bone	$350.00	$314.95	42	L
107M	Radio-ulnar synostosis	$985.45	$887.00	42	L
90M	Coccygectomy	$414.90	$373.40	42	L
93M	Excision of bone cyst, chondroma, exostosis - large bone	$500.00	$450.00	42	L
94M	Excision of bone cyst, chondroma, exostosis - large bone - with bone graft	$500.00	$450.00	42	L
95M	Excision of bone cyst, chondroma, exostosis - small bone	$400.00	$360.00	42	L
96M	Excision of bone cyst, chondroma, exostosis - small bone - with bone graft	$400.00	$360.00	42	L
98M	Partial ostectomy, excision of distal end of ulna or radius	$300.00	$270.05	42	L
100M	Saucerization and/or sequestrectomy -- large bone	$475.00	$427.50	42	L
101M	Saucerization and/or sequestrectomy -- small bone	$350.00	$315.00	42	L
103M	Radical resection of bone for tumor with bone graft -- major bone	$1,250.00	$1,124.95	42	M
104M	Radical resection of bone for tumor with bone graft -- minor bone	$1,250.00	$1,124.95	42	M
83M	Claviculectomy – partial	$186.70	$168.10	42	L
84M	Claviculectomy – total	$778.00	$700.25	42	L
86M	Excision of head of radius	$384.65	$346.15	42	L
88M	Carpectomy	$407.00	$366.30	42	L
89M	Carpectomy -- each additional (same field only) -- bill units	$311.25	$280.10	42	L
87M	Metacarpectomy or metatarsectomy	$363.05	$326.75	42	L
102M	Excision of head of femur	$336.05	$302.90	42	M
91M	Patellectomy – partial	$226.20	$203.30	42	L
92M	Patellectomy – total	$674.30	$606.80	42	L
97M	Shaving of patella – when only procedure done	$218.90	$197.10	42	L
85M	Astagalectomy	$431.20	$388.75	42	L
79M	Excision of 4 metatarsal heads	$357.15	$321.45	42	L
	Introduction				
110M	Insertion of Kirschner wire or metal pins for traction or cast fixation	$144.30	$144.30	0	L
111M	Application of calliper or tongs	$144.30	$144.30	0	L

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
	Repair				
120M	Osteoplasty -- shortening of bone -- femur, tibia or humerus	$466.85	$420.15	42	M
121M	Osteoplasty -- shortening of bone -- radius or ulna	$311.25	$280.60	42	L
122M	Osteoplasty -- shortening of bone -- both radius and ulna	$726.20	$653.55	42	L
123M	Osteoplasty -- shortening of bone -- other bones	$311.25	$280.10	42	L
124M	Osteoplasty -- lengthening of bone – major	$800.00	$720.05	42	M
125M	Osteoplasty -- lengthening of bone -- minor (hand or foot)	$550.00	$495.05	42	L
126M	Acromioplasty includes excision of distal clavicle	$356.10	$320.55	42	L
150M	Scapulopexy	$933.65	$840.25	42	M
	Epiphyseal-diaphyseal fusion, epiphyseal arrest or epiphysiodesis				
152M	-- femur or tibia and fibula	$466.85	$420.15	42	L
154M	-- combined (femur, tibial and fibular) epiphyseal arrest	$659.40	$593.45	42	L
155M	-- combined (upper and lower tibial and fibular) epiphyseal arrest	$659.40	$593.45	42	L
	BMI Supplement				
180M	Orthopedic surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height [m] 2) greater than 40	$180.00			

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”.

S E C T I O N 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.

S E C T I O N M – Orthopedic Surgery

FRACTURES

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.

   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.

	S E C T I O N 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	$610.55	$549.55	42	L
136M	Extensive harvesting of cadaver bone for bone bank	$989.15	$890.20	42	
	Trunk				
166M	Sacrum -- operative management	$165.95	$149.35	42	L
173M	Clavicle -- open reduction	$575.00	$517.55	42	L
174M	Scapula -- closed reduction	$137.50	$137.50	42	L
177M	Scapula -- open reduction	$841.05	$757.00	42	L
179M	Sternum -- open reduction	$152.55	$136.85	42	L
	Pelvis (Ilium, Ischium, Pubis)				
192M	Pelvis -- fracture -- one or more bones -- open reduction	$1,150.00	$1,035.05	42	M
193M	Pelvis -- fracture -- unstable -- closed reduction with external fixation	$700.00	$630.10	42	M
	Acetabulum -- with or without other fractures of pelvis				
195M	Acetabulum -- central -- with displacement	$277.00	$248.95	42	L
196M	Acetabulum -- open reduction	$1,401.85	$1,261.60	42	M
	Upper Extremity				
201M	Humerus -- surgical neck or epiphyseal separation -- closed reduction	$175.00	$175.00	42	L
203M	Humerus -- surgical neck or epiphyseal separation -- open reduction	$600.00	$540.00	42	L
204M	Humerus -- shaft -- closed reduction	$185.25	$185.25	42	L
206M	Humerus -- shaft -- open reduction	$600.00	$540.00	42	L
210M	Humerus -- shaft -- reduction with external fixation device	$475.00	$427.45	42	L
207M	Elbow -- epicondyle only -- closed reduction	$139.75	$139.75	42	L
208M	Elbow -- epicondyle only -- open reduction	$440.00	$396.00	42	L
	Distal end of humerus, proximal end of radius or ulna, condyle -- one or more bones				
209M	-- closed reduction	$155.75	$155.75	42	L
212M	-- open reduction	$615.00	$553.50	42	L
214M	Supracondylar -- displaced -- closed reduction by manipulation or traction	$195.80	$176.85	42	L
218M	Olecranon -- open reduction	$336.50	$302.85	42	L

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
220M	Radius -- head -- closed reduction	$203.90	$203.90	42	L
222M	Radius -- head -- open reduction	$440.00	$396.00	42	L
225M	Radius -- shaft -- closed reduction	$155.75	$155.75	42	L
229M	Radius -- shaft -- open reduction	$440.00	$440.00	42	L
233M	Radius -- distal end -- closed -- Colles' including ulnar styloid reduction	$225.00	$225.00	42	L
235M	Radius -- distal end (Colles' including ulnar styloid) -- open reduction	$535.00	$535.00	42	L
237M	Colles -- reduction with external fixation device	$308.45	$308.45	42	L
240M	Ulna -- shaft-- closed reduction	$129.80	$129.80	42	L
243M	Ulna -- shaft-- open reduction	$440.00	$440.00	42	L
244M	Ulna -- Monteggia fracture – dislocation	$364.45	$327.45	42	L
247M	Radius and Ulna (excluding Colle's) -- closed reduction	$238.20	$238.20	42	L
249M	Radius and Ulna (excluding Colle's) -- open reduction	$600.00	$600.00	42	L
250M	Radius and Ulna (excluding Colle's) -- reduction with external fixation device	$500.00	$500.00	42	L
251M	Carpal bone -- closed reduction	$173.40	$173.40	42	L
252M	Carpal bone -- open reduction	$600.00	$600.00	42	L
253M	Carpal bone -- reduction with external fixation device	$420.55	$420.55	42	L
255M	Metacarpal -- closed reduction	$203.90	$203.90	42	L
257M	Metacarpal -- open reduction	$380.00	$342.00	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	$380.00	$380.00	42	L
	Lower Extremity				
291M	Femur -- neck -- internal fixation	$792.00	$712.75	42	M
295M	Intertrochanteric -- internal fixation	$792.00	$712.75	42	M
296M	Slipped epiphysis -- closed reduction	$419.45	$377.95	42	L
297M	Slipped epiphysis -- open reduction – acute	$792.00	$712.75	42	M
298M	Slipped epiphysis -- reconstructive later	$841.05	$757.00	42	M
299M	Shaft -- including supracondylar -- closed reduction	$292.15	$292.15	42	L
303M	Shaft -- including supracondylar -- open reduction	$792.00	$712.75	42	M
305M	Patella -- immobilization only	$174.30	$174.30	42	L
307M	Patella -- open reduction or excision -- complete or partial	$390.00	$350.95	42	L
310M	Tibia -- shaft -- closed reduction -- includes fibular shaft	$238.80	$238.80	42	L
312M	Tibia -- shaft -- open reduction -- includes fibular shaft	$600.00	$600.00	42	M
314M	Tibia -- plateau -- closed reduction	$207.70	$186.60	42	L
315M	Tibia -- plateau -- open reduction	$700.00	$630.00	42	M
316M	Tibia -- malleolus -- closed reduction	$155.75	$155.75	42	L
317M	Tibia -- malleolus -- open reduction	$375.00	$338.05	42	L

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
318M	Fibula -- shaft -- closed reduction	$158.75	$158.75	42	L
319M	Fibula -- shaft -- open reduction	$364.45	$328.55	42	L
320M	Fibula -- malleolus -- closed reduction	$129.80	$129.80	42	L
321M	Fibula -- malleolus -- open reduction	$450.00	$404.40	42	L
330M	Tibia and Fibula -- reduction with external fixation device	$550.00	$550.00	42	L
323M	Ankle -- bimalleolar (including Potts) -- closed reduction	$158.75	$158.75	42	L
325M	Ankle -- bimalleolar (including Potts) -- open reduction	$550.00	$495.00	42	L
340M	Ankle -- bimalleolar (including Potts) -- reduction with external fixation device	$532.75	$478.85	42	L
326M	Ankle -- trimalleolar -- closed reduction	$158.75	$158.75	42	L
328M	Ankle -- trimalleolar -- open reduction	$660.00	$594.00	42	L
341M	Ankle -- trimalleolar -- reduction with external fixation device	$550.00	$494.35	42	L
329M	Tarsal -- (except astragalus and os calcis) -- closed reduction	$158.75	$158.75	42	L
331M	Tarsal -- (except astragalus and os calcis) -- open reduction	$550.00	$495.00	42	L
332M	Astragalus -- closed reduction	$158.75	$158.75	42	
334M	Astragalus -- open reduction	$625.00	$625.00	42	L
335M	Os calcis -- closed reduction	$158.75	$158.75	42	L
337M	Os calcis -- open reduction	$625.00	$562.50	42	L
338M	Os calcis -- skeletal pinning with external fixation	$420.55	$379.05	42	L
339M	Metatarsal -- closed reduction	$129.80	$129.80	42	L
343M	Metatarsal -- open reduction	$295.00	$265.50	42	L
345M	Phalanx -- closed reduction	$158.75	$158.75	42	L
348M	Phalanx -- open reduction	$295.00	$295.00	42	L
	Treatment of ununited fractures by bone stimulator **Total care – not payable for stress fractures**				
350M	External application (Bi-Osteogen)	$47.20	$47.20		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

	S E C T I O N M – Orthopedic Surgery	Specialist	General Practitioner	Class	Anes
	Joints				
359M	Arthroscopy	$190.00	$170.55	D	L
500M	Manipulation of any peripheral joint under general anesthesia -- (includes shoulder or hip)	$45.00	$45.00	0	L
	Incision Arthrotomy or capsulotomy with exploration, drainage or removal of loose body, e.g. osteochondritis or foreign body				
360M	Shoulder	$525.00	$473.00	42	L
361M	Elbow	$525.00	$473.00	42	L
362M	Wrist	$525.00	$473.00	42	L
363M	Other joints of upper extremity	$525.00	$473.00	42	L
364M	Hip	$525.00	$473.00	42	L
365M	Knee	$525.00	$473.00	42	L
366M	Ankle	$525.00	$473.00	42	L
367M	Other joints of lower extremity	$525.00	$473.00	42	L
378M	ORIF or excision of accessory bone foot – includes repair or transfer of tendons and all procedures on the same joint through the same or extended incision by any physician	$437.35	$393.60	42	L
379M	Open reduction internal fixation or excision sesamoid of the 1st MTP joint	$448.35	$403.50	42	L
	Arthrocentesis – puncture for aspiration of joint and/or injection of medication				
380M	Arthrocentesis – hip	$32.10	$32.10	0	L
381M	Arthrocentesis – shoulder, elbow, knee	$25.45	$25.45	0	L
382M	Arthrocentesis – others	$25.95	$25.95	0	L
383M	Fluoroscopy-guided joint injection (hospital location) – one injection billable per joint – maximum 2 injections per patient contact. • Second joint injection paid at 75%. • Not billable with any other surgical procedure on the same patient, same day. • Not billable for ultrasound injections.	$107.80	$97.00	D	L
	Excision				
	Arthrectomy – Excision of joint				
390M	Punch biopsy of synovial membrane	$38.55	$34.75	D	L
391M	Temporomandibular joint – meniscectomy	$279.00	$251.10	42	L
392M	Temporomandibular joint – condylectomy	$253.90	$228.40	42	L
384M	Chemonucleolysis of intervertebral disc	$261.40	$235.45	42	L
385M	Percutaneous automated discectomy	$319.50	$287.35	42	L
398M	Excision of neural arch and nerve exploration for spondylolisthesis	$413.95	$372.45	42	L

	S E C T I O N M – Orthopedic Surgery	Specialist	General Practitioner	Class	Anes
	Major meniscal tears & extensive articular debridement are each paid				
399M	Meniscectomy – knee	$310.00	$278.90	42	L
397M	Meniscus repair	$375.00	$337.50	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)	$352.65	$317.45	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)	$299.75	$269.70	42	L
	Synovectomy -- not paid in addition to major joint surgery				
400M	Synovectomy -- elbow	$550.00	$495.50	42	L
401M	Synovectomy -- wrist	$500.00	$450.00	42	L
402M	Synovectomy -- finger -- MP joint – one	$384.65	$346.15	42	L
404M	Synovectomy -- finger -- IP joint	$329.75	$296.75	42	L
406M	Synovectomy -- thumb -- MP joint	$384.65	$346.15	42	L
407M	Synovectomy -- thumb -- IP joint	$329.75	$296.75	42	L
408M	Synovectomy -- toe – one	$311.25	$280.10	42	L
410M	Synovectomy -- hip	$406.60	$366.25	42	L
411M	Synovectomy -- knee	$363.05	$326.75	42	L
412M	Synovectomy -- ankle	$363.05	$326.75	42	L
413M	Synovectomy -- foot	$363.05	$326.75	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	$492.80	$443.45	42	M
446M	Total shoulder replacement	$838.20	$754.35	42	M
846M	Total shoulder replacement –revision	$1,556.10	$1,400.45	42	M
431M	Elbow arthroplasty	$492.80	$443.95	42	L
442M	Total elbow replacement	$995.30	$895.85	42	L
842M	Total elbow replacement – revision	$1,971.05	$1,773.85	42	L

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
432M	Wrist arthroplasty	$622.45	$560.20	42	L
448M	Total wrist replacement	$995.30	$895.85	42	L
848M	Total wrist replacement – revision	$1,971.05	$1,773.85	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	$433.05	$389.05	42	L
634M	-- with extensor tendon transfer	$300.80	$271.20	42	L
435M	Hip arthroplasty	$544.60	$490.65	42	M
835M	Hip arthroplasty – revision	$1,089.25	$981.30	42	M
445M	Total hip replacement or reconstructive arthroplasty	$838.20	$754.35	42	M
845M	-- with extensive acetabular reconstruction with bone graft – add	$200.00	$180.00	42	M
885M	Total hip replacement or reconstructive arthroplasty – revision	$1,556.10	$1,400.45	42	M
436M	Knee arthroplasty	$492.80	$443.45	42	M
444M	Total knee arthroplasty includes unicompartmental knee and patellar replacement	$838.20	$754.35	42	M
844M	Total knee arthroplasty includes unicompartmental knee and patellar replacement – revision	$1,556.10	$1,400.45	42	M
437M	Ankle arthroplasty	$522.10	$469.80	42	L
449M	Total ankle replacement	$1,227.05	$1014.35	42	L
849M	Total ankle replacement – revision	$1,556.10	$1,400.45	42	L
850M	Arthroplasty 1st MTP joint (hemi or total replacement with implant) – includes osteotomy and any other procedures on the 1st MTP joint through the same or extended incision by any physician.	$519.15	$467.25	42	L
851M	Arthroplasty of lesser MTP joint 2nd through 5th (hemi or total with implant) – includes osteotomy and any other procedures on the lesser MTP joints through the same or extended incision by any physician.	$519.15	$467.25	42	L
438M	Toe – one joint (except great toe)	$363.05	$326.75	42	L
439M	Metatarsophalangeal joint -- first -- bunion operation – unilateral	$192.30	$173.65	42	L
441M	Distal metatarsal osteotomy for bunion correction – includes tenotomy, arthrotomy of 1st MTP joint, all soft tissue realignment, and any other procedures on the same joint through the same or extended incision by any physician.	$519.15	$467.25	42	L
443M	Isolated first MTP debridement including arthrotomy, cheilectomy and soft tissue realignment. All inclusive of any combination of the three procedures performed on the same joint, through the same or extended incision by any physician.	$471.95	$424.75	42	L
460M	1st metatarsophalangeal (MTP) fusion – includes arthroplasty, cheilectomy, and all other procedures on the same joint through the same incision	$490.85	$441.80	42	L
475M	Proximal metatarsal osteotomy or 1st TMT fusion with distal lateral soft tissue release and medial capsular plication 1st MTP joint – includes arthroplasty, tenotomy, tendon transfers, and all procedures on the same joint through the same or extended incision by any physician.	$624.75	$562.30	42	L

	S E C T I O N M – Orthopedic Surgery	Specialist	General Practitioner	Class	Anes
	Arthrodesis				
450M	Arthrodesis - shoulder	$1,141.15	$1,027.00	42	M
451M	Arthrodesis - elbow	$800.00	$720.05	42	L
452M	Arthrodesis - wrist	$800.00	$720.05	42	L
453M	Arthrodesis - finger or thumb - one joint	$384.65	$346.15	42	L
853M	Arthrodesis - finger or thumb - one joint - with autogenous bone graft (includes harvesting)	$529.25	$476.40	42	L
454M	Arthrodesis - hip	$1,141.15	$1,027.00	42	M
455M	Arthrodesis - knee	$1,141.15	$1,027.00	42	M
456M	Arthrodesis – ankle – includes osteotomy, syndesmosis reconstruction and all other procedures on the same joint (ligaments, tendons) through same incision.	$874.65	$787.20	42	L
464M	Hindfoot Arthrodesis first joint (talocalcaneal, talonavicular, calcaneocuboid joints) – includes arthrotomy or capsulotomy with exploration, drainage or removal of loose body, e.g. osteochondritis or foreign body, soft tissue realignment, tendon lengthening and any other procedures on the same joint through the same or extended incision by any physician.	$920.30	$828.25	42	L
466M	Hindfoot Arthrodesis, each additional joint (max 2)	$212.35	$191.10	42	L
462M	Midfoot fusion (naviculocunieform (3 joints), intercunieform (2 joints), TMT (5 joints)) – first joint	$495.55	$446.00	42	L
465M	Midfoot fusion – each additional joint – bill units (maximum 4), add to 462M, 441M, 457M, 475M.	$141.60	$127.45	42	L
463M	Arthrodesis -- other joints -- lower extremity	$439.60	$395.65	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	**Lesser claw toe correction** -- single claw toe (2nd through 5th) - includes tendon transfers, tenotomies, IP joint fusion, osteotomies, capsulotomy MTP joint and any other procedures on the same toe through the same or extended incision by any physician.	$377.55	$339.80	42	L
458M	Lesser claw toe correction, each additional toe (max 4)	$141.60	$127.45	42	L
459M	1st interphalangeal joint (IP) joint fusion – includes excision, arthrodesis and arthroplasty of IP joint; capsulotomy of IP joint; all tenotomies, tendon lengthening and transfers and any other procedures on the same joint through the same or extended incision by any physician.	$490.85	$441.75	42	L
461M	Plantar plate reconstruction MTP Joint – includes arthrodesis of PIP/DIP joint of the same toe, osteotomy, all tenotomies, tendon lengthening and transfers, and any other procedures on the same joint through the same or extended incision by any physician.	$750.00	$675.00	42	M
468M	Flat foot plasty or Grice	$778.00	$700.25	42	L
469M	Stabilization of joints by bone block	$384.65	$346.15	42	L

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
	Clubfoot				
520M	Clubfoot a) Extensive posterior release b) Includes Achilles tendon lengthening, flexor hallucis longus lengthening, capsulotomy of the ankle and subtalar joints	$1,099.00	$989.15	42	M
521M	Clubfoot a) Complete extensive postero-medial release b) Includes code 520M	$541.80	$488.00	42	M
	Club foot -- non operative management -- Fee For Service				
	Reconstruction				
370M	Knee anterior cruciate ligament reconstruction, repair or reattachment of bony avulsion	$570.00	$513.55	42	M
371M	Knee posterior cruciate ligament reconstruction, repair or reattachment of bony avulsion	$570.00	$513.55	42	M
372M	Knee posterior cruciate ligament reconstruction with allograft or autograft	$817.50	$735.45	42	M
373M	Knee medial collateral ligament reconstruction with allograft or autograft	$570.00	$513.55	42	M
374M	Knee medial collateral ligament repair, reattachment or advancement	$375.00	$337.50	42	M
375M	Knee lateral collateral ligament and/or posterolateral corner -- reconstruction with autograft or allograft	$971.00	$873.85	42	M
376M	Knee lateral collateral ligament and/or posterolateral corner -- repair, reattachment or advancement	$566.40	$510.30	42	M
470M	Sacroiliac fusion	$622.45	$560.20	42	M
486M	Acute ankle ligament repair/reconstruction/reattachment of bony avulsion. Includes any other procedures on the same joint through the same or extended incision by any physician	$283.15	$254.50	42	L
487M	Ankle -- reconstruction of ligament(s) for chronic instability – includes arthroscopy, osteotomy, synovectomy, arthroplasty, arthrodesis, and all tendon repairs, transfers and lengthening and any other procedures on the same joint through the same or extended incision by any physician.	$519.15	$467.25	42	L
497M	Ankle Ligament Reconstruction with Allograft/Autograft – for failed ankle ligament reconstruction or severe tissue deficiency. Includes bone tunnels to reconstruct ligament; graft harvesting and tunneling; fixation with screws or interference device, and any other procedures on the same joint through the same or extended incision by any physician.	$900.00	$810.00	42	M
488M	Hand -- reconstruction of metacarpophalangeal or interphalangeal ligament(s)	$356.80	$321.10	42	L
170M	Acetabular labral debridement or repair	$1,000.00	$899.90	42	M

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
480M	Capsulorrhaphy -- shoulder a) Recurrent dislocation b) Suture or repair of joint capsule and ligaments	$535.00	$481.45	42	M
489M	Acromioclavicular joint – repair	$450.00	$405.00	42	M
490M	Acromioclavicular joint – reconstruction	$650.00	$585.00	42	L

S E C T I O N 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	$32.35	$32.35	10	L
537M	Clavicle -- sternoclavicular -- closed reduction	$134.75	$134.75	10	L
539M	Clavicle -- sternoclavicular -- open reduction	$550.00	$494.95	42	L
540M	Clavicle -- acromioclavicular -- closed reduction	$215.60	$215.60	42	L
541M	Clavicle -- acromioclavicular -- open reduction	$259.35	$233.45	42	L
542M	Shoulder (humerus) -- closed reduction	$231.75	$231.75	42	L
543M	Shoulder (humerus) -- open reduction – fresh	$214.30	$193.40	42	L
544M	Shoulder (humerus) – old	$318.75	$286.85	42	L
545M	Elbow -- closed reduction	$234.05	$210.65	42	L
547M	Elbow -- open reduction – fresh	$259.35	$233.45	42	L
548M	Elbow -- open reduction – old	$549.55	$494.60	42	L
546M	Radial head -- closed reduction (pulled elbow)	$150.00	$150.00	0	L
549M	Wrist -- carpal -- one bone -- closed reduction	$127.20	$127.20	10	L
551M	Wrist -- carpal-- one bone -- open reduction	$259.35	$233.45	42	L
555M	Metacarpal-- closed reduction	$127.20	$127.20	10	L
557M	Metacarpal-- open reduction	$329.75	$296.75	42	L
558M	Metacarpophalangeal joint -- closed reduction	$127.20	$127.20	10	L
560M	Metacarpophalangeal joint -- open reduction	$302.25	$272.00	10	L
561M	Interphalangeal joint -- closed reduction	$134.75	$134.75	42	L
562M	Interphalangeal joint -- open reduction	$302.25	$272.00	42	L
568M	Hip (femur) -- closed reduction	$259.35	$259.35	42	L
569M	Hip (femur) -- open reduction	$600.00	$539.95	42	M
570M	Hip (femur) -- with fracture of posterior portion of acetabulum	$674.30	$606.80	42	M
	Hip -- congenital -- closed treatment -- Fee For Service				
573M	Hip (femur) -- congenital -- open reduction	$824.25	$741.90	42	M
574M	Hip (femur) -- congenital -- with shelving	$714.40	$642.90	42	M
575M	Pelvic osteotomy -- Salter, etc	$1,141.15	$1,027.00	42	M
576M	Pelvic osteotomy -- with arthrotomy	$557.20	$501.15	42	M

	S E C T I O N M – Orthopedic Surgery	Specialist	General Practitioner	Class	Anes
577M	Knee (tibia) -- closed reduction	$155.00	$155.00	42	L
579M	Knee (tibia) -- open reduction	$337.10	$303.40	42	L
580M	Patella -- closed reduction	$155.00	$155.00	10	L
582M	Patella -- open reduction	$151.40	$135.95	42	L
583M	Reconstruction for recurrent patellar dislocation -- lateral retinacular release	$200.00	$180.00	42	L
581M	Reconstruction for recurrent patellar dislocation -- soft tissue realignment	$700.00	$630.00	42	L
589M	Reconstruction for recurrent patellar dislocation -- bony realignment including soft tissue realignment	$357.85	$322.65	42	L
584M	Ankle -- closed reduction	$220.00	$220.00	42	L
585M	Ankle -- open reduction	$337.10	$303.40	42	L
586M	Ankle -- subastragalar -- closed reduction	$220.00	$198.00	42	L
587M	Ankle -- subastragalar -- open reduction	$337.10	$303.40	42	L
588M	Tarsal -- closed reduction	$220.00	$220.00	42	L
590M	Tarsal -- open reduction	$337.10	$303.40	42	L
591M	Metatarsal -- one bone-- closed reduction	$127.20	$127.20	10	L
594M	Metatarsal -- one bone -- open reduction	$259.35	$233.45	42	L
596M	Toe -- closed reduction	$150.00	$150.00	10	L
598M	Toe -- open reduction	$300.00	$300.00	42	L
	Bursae				
610M	Incision & drainage of infected bursa	$45.00	$45.00	10	L
611M	Removal of subdeltoid calcareous deposits	$126.10	$113.55	42	L
612M	Removal of subtrochanteric calcareous deposits	$135.95	$122.40	42	L
	Removal of calcareous deposits -- other joints -- see Arthrotomy				
614M	Puncture for aspiration or needling with or without irrigation or injection of medication	$15.45	$15.45	0	L
620M	Radical excision of bursae -- forearm, viz tenosynovitis, fungosa, Tbc., and other granulomas	$260.00	$234.25	42	L
621M	Excision of bursa – olecranon	$259.35	$259.35	42	L
622M	Excision of bursa – prepatellar	$259.35	$259.35	42	L
623M	Excision of bursa – subacromial	$180.00	$162.00	42	L
624M	Excision of bursa – ischial	$213.25	$191.90	42	L
	Muscles				
630M	Quadriceps plasty	$466.85	$420.15	42	L
631M	Repair of ruptured limb muscle -- belly, origin, or insertion	$225.00	$202.50	42	L
	For lacerations – see 890L, 896L				

	S E C T I O N M – Orthopedic Surgery	Specialist	General Practitioner	Class	Anes
	Tendons, Tendon Sheaths and Fascia				
	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	$259.35	$233.45	42	L
642M	Injection of tendon sheath	$29.70	$29.70	0	L
643M	Incision of fibrous sheath of tendon for stenosing tenosynovitis	$270.00	$243.00	42	L
644M	Division of iliotibial band -- open reduction	$175.80	$158.25	42	L
645M	Ober-Yount fasciotomy, combine (or Souter procedure) with Spica cast, pins in tibia, wedging of casts, etc. – unilateral	$912.20	$821.00	42	L
647M	Stabilization of Chronically Subluxing Tendon (including all methods) - includes fibular groove deepening procedures (with or without suture anchors), tenotomies, synovectomy, and all other procedures on the same joint through the same or extended incision by any physician.	$525.00	$472.50	42	L
646M	Compartment Pressure Monitoring	$100.00	$90.00	D	L
	Hip adductors				
649M	Hip adductors -- unilateral – percutaneous	$164.85	$148.35	42	L
650M	Hip adductors -- unilateral – open	$412.10	$370.95	42	L
651M	Hip adductors -- bilateral – percutaneous	$219.80	$197.80	42	L
652M	Hip adductors -- bilateral – open	$494.60	$445.10	42	L
653M	Hip adductors -- unilateral - with peripheral obturator neurectomy	$165.90	$149.50	42	L
655M	Intrapelvic obturator neurectomy – unilateral	$194.60	$174.75	42	L
657M	Sever (or similar procedure) of shoulder for Erb's palsy	$879.20	$791.25	42	L
	Excision				
671M	Excision of lesion of tendon or fibrous sheath, or ganglion	$270.00	$270.00	42	L
	Radical excision of bursae, forearm viz. tenosynovitis, fungosa, Tbc., and other granulomas -- See 620M				
673M	Excision of Baker's cyst	$311.25	$280.10	42	L
674M	Fasciotomy -- single -- palm or sole -- subcutaneous – blind	$207.45	$186.70	42	L
677M	Fasciectomy -- open -- plantar—unilateral	$363.05	$326.75	42	L
678M	Compartment syndrome release -- for trauma	$450.00	$405.00	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	$274.80	$274.80	42	L
694M	-- each additional tendon -- leg -- bill units	$30.20	$30.20	42	L
695M	-- each additional tendon – forearm -- bill units	$254.90	$254.90	42	L

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
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
	Transfer or transplant of tendon – single				
698M	Distal to elbow, distal to knee	$409.00	$368.15	42	L
700M	Distal to elbow, distal to knee -- each additional -- bill units	$336.80	$303.10	42	L
701M	Elbow or shoulder, knee or hip	$440.90	$396.85	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	$505.20	$454.25	42	L
704M	Free flexor tendon graft -- each additional	$219.80	$197.80	42	L
705M	Tenolysis -- single – flexor	$363.05	$326.75	42	L
706M	Tenolysis -- each additional -- bill units	$229.40	$206.40	42	L
725M	Tenolysis -- single – extensor	$259.35	$233.45	42	L
726M	Tenolysis -- each additional -- bill units	$203.90	$183.50	42	L
727M	Tenodesis	$409.00	$409.00	42	L
707M	Lengthening or shortening tendon	$311.25	$280.10	42	L
708M	Opponens transfer	$439.60	$395.65	42	L
709M	Intrinsic transplant active or passive	$275.85	$248.35	42	L
710M	Intrinsic release (Littler) or incision	$254.90	$229.40	42	L
711M	Intrinsic release (Littler) or incision -- additional fingers -- bill units	$164.85	$148.35	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	$307.75	$276.95	42	L
716M	Ruptured quadriceps tendon – repair	$550.00	$494.95	42	L
481M	Ruptured patellar ligament – repair	$515.00	$463.45	42	L
721M	Ruptured patellar ligament or Achilles tendon -- repair with fascial or tendon graft	$560.00	$504.05	42	L
728M	Achilles Insertional Reconstruction with Bony Resection Calcaneus – includes reflection of Achilles insertion off calcaneus; excision of haglund exostosis; arthrodesis and arthroplasty of tarsal joints; capsulotomy/arthrotomy of calcaneal joints; all tenotomies, tendon lengthening and transfers; reattachment of Achilles with suture anchors, and all other procedures on the same joint through the same or extended incision by any physician. If procedure is done without bony resection, physicians are to submit billings using tenodesis (727M) - suture or screw anchor to bone.	$750.00	$675.00	42	M

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
717M	Ruptured biceps tendon -- elbow – repair	$550.00	$494.95	42	L
718M	Flexor-plasty – elbow	$500.00	$449.95	42	L
719M	Repair ruptured supraspinatus tendon or musculotendinous shoulder cuff -- with or without acromioplasty	$500.00	$449.40	42	L
722M	Tenotomy – percutaneous	$259.35	$259.35	10	L
723M	Tenotomy – open	$259.35	$259.35	10	L
724M	Tenotomy -- each additional of either 722M or 723M -- bill units	$144.30	$144.30	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	L
732M	Drainage of multiple infected spaces of hand with or without tendon sheath involvement	$560.70	$504.70	42	L
	Amputation – Upper Extremity				
740M	Amputation - Interthoracoscapular	$800.00	$720.05	42	M
741M	Amputation - Disarticulation of shoulder	$800.00	$720.05	42	M
742M	Amputation - Arm through humerus	$814.00	$732.65	42	M
743M	Amputation - Forearm, through radius and ulna	$778.00	$700.30	42	M
745M	Amputation - Forearm, through radius and ulna -- with subsequent revision or reamputation	$778.00	$700.25	42	M
746M	Amputation - Cineplasty -- complete procedure	$315.40	$283.50	42	M
747M	Amputation - Disarticulation of wrist	$778.00	$700.25	42	M
748M	Amputation - Hand, through metacarpal bones	$745.00	$670.55	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	$745.00	$670.55	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	$420.00	$420.00	10	L
	Amputation – Lower Extremity				
760M	Amputation - Interpelviabdominal	$717.60	$646.25	42	H
761M	Amputation - Disarticulation of hip	$1,044.05	$939.70	42	M
762M	Amputation - Disarticulation of knee	$599.50	$539.45	42	M
763M	Amputation - Thigh through femur, including supracondylar	$665.00	$598.40	42	M
765M	Amputation - high through femur, including supracondylar -- Revision or reamputation	$134.80	$121.40	42	M
766M	Amputation - Leg, through tibia and fibula	$814.00	$732.65	42	M
768M	Amputation - Leg, through tibia and fibula - Revision or reamputation	$134.80	$121.40	42	M
769M	Amputation - Ankle (Syme, Pirogoff) -- with skin-plasty and resection nerves	$814.00	$732.60	42	M

S E C T I O N M – Orthopedic Surgery

		Specialist	General Practitioner	Class	Anes
770M	Amputation - Foot – transmetatarsal	$814.00	$732.65	42	M
771M	Amputation - Midtarsal	$814.00	$732.65	42	M
772M	Amputation - Metatarsal, with toe, split or Wolff graft or skin-plasty and/or tenodesis, with definitive resection digital nerves	$414.90	$373.40	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	$311.25	$311.25	10	L

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	$47.45	$47.45	0	
801M	Plaster casts -- elbow to fingers	$47.45	$47.45	0	
802M	Plaster casts -- hand or wrist	$45.80	$45.80	0	
803M	Plaster casts -- shoulder to hand	$50.90	$50.90	0	
804M	Plaster casts -- shoulder Spica	$50.90	$50.90	0	
805M	Plaster casts -- ankle (foot to midleg)	$50.90	$50.90	0	
806M	Plaster casts -- knee (foot to thigh)	$50.90	$50.90	0	
808M	Ambulatory leg cast	$50.90	$50.90	0	
809M	Molded plaster to leg	$77.85	$77.85	0	
810M	Spica -- unilateral (rib margin to toe)	$544.60	$544.60	0	
812M	Plaster casts -- body -- shoulder to hip	$274.80	$247.30	0	
813M	Plaster casts -- body -- including head	$64.65	$64.65	0	
814M	Unna boot	$53.05	$53.05	0	
815M	Wedging of cast	$51.90	$51.90	0	
820M	Risser, or similar, cast for scoliosis	$544.60	$490.15	0	
821M	Halo cast	$167.00	$150.25	42	
822M	Application of hinged brace on knee cast -- composite fee for brace and	$58.20	$58.20	0	
825M	Cast removal (when physician personally removes the cast)	$15.60	$15.60	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	$238.60	$214.70	0	

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S E C T I O N N – Plastic Surgery

		Specialist in Plastic Surgery Referred	Specialist in Plastic Surgery Not Referred
	Visits		
5N	**Initial assessment** -- of a specific condition includes: 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; i) advice to the patient; and, j) record of service provided.	$60.00*	$48.50*
7N	**Follow-up assessment** -- includes: a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and, g) record of service provided.	$52.25*	$52.25*
9N	**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.	$104.85*	
12N	**Extended Consultation** – add on to 9N, max 4 units: a) Payable when a consultation (9N) exceeds 20 minutes of direct in-person patient care and b) is satisfied. For clarity, 12N is payable when a minimum of 27.5 minutes of direct in-person patient care is provided. b) Each complete 15-minute period or major portion thereof of direct in-person patient care; and, c) Start and stop times for total direct in-person patient care (both 9N and 12N) must be entered on the claim and documented in the patient medical record.	$36.70*	
11N	**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 service code 7N "follow-up assessment" is appropriate. * Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.	$60.00*	
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 @ Payment approved for a physician with training and expertise in this section	$52.00	$41.60@

S E C T I O N N – Plastic Surgery

			Specialist in Plastic 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 codes 627A-629A – Special Care Home Management.

25N	-- 1-10 days	-- per day -- bill units (max 10)	$39.50	$39.50
26N	-- 11-20 days	-- per day -- bill units (max 10)	$39.50	$39.50
27N	-- 21-30 days	-- per day -- bill units (max 10)	$39.50	$39.50
28N	-- 31 days and thereafter	-- per day -- bill units (max 99)	$39.50	$39.50

VIRTUAL CARE SERVICES

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

807N **Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: $47.05 $47.05

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

809N **Virtual consultation provided via telephone or secure videoconference**-- includes: $94.40

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

811N **Repeat virtual consultation provided via telephone or secure videoconference:** $54.00
A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807N' "Virtual follow-up assessment" is appropriate.

S E C T I O N 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.

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

S E C T I O N 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. The injection of keloids is only insured when symptomatic (pain, ulceration, etc.) or causing functional impairment.

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

4. Augmentation mammoplasty is insured for congenital or post-surgical amastia. If unilateral augmentation mammoplasty is done for the above reasons or if an oncoplastic reconstruction for breast cancer is performed, then a balancing operation such as augmentation, reduction, or mastopexy is insured for the opposite breast, when performed under the same anesthetic as the operation for the other 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).

5. 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.

6. 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/establish-operate-practice/Pages/Physicians.aspx

7. Spider vein (telangiectasia) treatment by injection, excision, thermal ablation, or laser therapy is not insured. Treatment of symptomatic varicose veins is insured.

S E C T I O N 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)

d) Grafting codes 100N to 111N, 241N to 244N and 280N are on referral to a plastic surgeon, otolaryngologist, ophthalmologist or urologist.

b) 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	$290.00	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	$300.00	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)	$440.00	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

S E C T I O N 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) Only billable for burn diagnosis (ICD diagnostic codes 940-949) c) Subsequent dressings and surgical debridements for severe burn patients per 5% body surface area up to a total of 100% body surface area d) 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				
	Burns - Surgical Debridement and/or Dressings - without anesthesia or under local anesthesia				
120N	-- per 5% total body surface area (TBSA), bill units	$50.00	$50.00	0	
	Burns - 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

S E C T I O N 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 <u>on referral to a plastic surgeon.</u>				
	<u>Body Areas:</u> 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	$200.00		42	L
142N	-- 65 to 103 sq cm, any body area	$405.00		42	L
144N	-- Greater than 103 sq cm, any body area	$635.00		42	L
	Wound Repair - Face • Single or multiple				
382N	-- up to 5 cm	$200.00		10	L
383N	-- each additional 2.5 cm, bill units	$145.00		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	$300.00	$270.45	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	$300.00	$270.70	42	L
255N	Minor stage(s) -- transposition of pedicle -- delay of pedicle	$300.00	$270.00	42	L
256N	Muscle flap with skin graft	$1,500.00	$1,350.00	42	M

S E C T I O N N - Plastic Surgery

			Specialist	General Practitioner	Class	Anes
257N	Myocutaneous flaps with donor closure		$1,400.00	$1,260.00	42	M
258N	Myocutaneous flaps with skin grafts to donor area		$1,500.00	$1,350.00	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		$524.00	$471.50	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, advancement flap, double pedicle flap, etc.					
	Documentation must include the reconstructive effort including flap design, tissue mobilization, and closure method to support billing of 260N-268N.					
	Note: The following codes (260-268N) are not billable for minor excisional or incisional biopsies (e.g., 102F, 857L), or for punch or shave biopsies (e.g., 100F).					
260N	Defect up to 6 sq. cm. --	trunk	$260.00	$234.00	42	L
261N	Defect up to 6 sq. cm. --	scalp, arms, legs	$265.00	$238.50	42	L
262N	Defect up to 6 sq. cm. --	forehead, cheeks, chin, mouth, neck, axilla, genitalia, feet, hands	$295.00	$265.50	42	L
263N	Defect up to 6 sq. cm. --	eyelids, nose, ears, lips	$350.00	$315.00	42	L
264N	Defect 7-19 sq. cm. --	trunk	$300.00	$270.00	42	L
265N	Defect 7-19 sq. cm. --	scalp, arms, legs	$335.00	$301.50	42	L
266N	Defect 7-19 sq. cm. --	forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands, feet	$390.00	$351.00	42	L
267N	Defect 7-19 sq. cm. --	eyelids, ears, nose, lips	$430.00	$387.00	42	L
268N	Defect more than 19 sq. cm. -- unusual or complicated, by report		$550.00	$495.00	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		By report		42	M
	For minor excision of lymphedema– use 260N – 268N					
	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		$360.00	$324.15	42	L
287N	Bone -- autogenous transplant -- nose, chin, orbit, forehead		$480.00	$431.90	42	M

S E C T I O N 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	$240.60	$216.10	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	$350.00	$315.50	42	L
313N	Segmental ear resection	$175.00	$157.20	42	L
	Cleft Lip and Cleft Palate				
320N	Plastic repair of cleft lip -- primary – unilateral	$790.00	$711.00	42	M
323N	Plastic repair of cleft lip -- secondary - by recreation of defect and closure	$790.00	$711.00	42	M
325N	Repair of nasal deformity due to cleft lip	$400.00	$360.00	42	M
326N	Plastic operation for cleft palate -- partial – primary	$765.00	$688.55	42	M
327N	Plastic operation for cleft palate -- complete – primary	$940.00	$846.00	42	M
328N	Plastic operation for cleft palate -- major revision – secondary	$960.00	$864.00	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	$400.00	$360.00	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	$40.00	$36.00	42	M
337N	Excision of cyst of dental origin -- intraoral approach - 1-2.5 cm	$131.00	$117.80	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
	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

S E C T I O N N - Plastic Surgery

		Specialist	General Practitioner	Class	Anes
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	$550.00	$495.00	42	M
345N	Mandible -- multiple compound or comminuted fractures excluding interdental or intermaxillary wiring	$685.00	$616.50	42	M
346N	Maxilla -- displaced -- open reduction	$715.00	$643.50	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	$800.00	$720.00	42	M
352N	Breast augmentation -- prosthetic – unilateral	$493.05	$444.70	42	L
395N	Oncoplastic reconstruction, breast – unilateral when performed at the same time as the lumpectomy or segmental resection for breast cancer. @ Payment approved for General Surgeons with advanced fellowship training in oncoplastic surgery as approved by the Saskatchewan Medical Association (SMA) Tariff Committee. For the purposes of billing, 395N is billable on the date that the approval is granted to the physician. See “Services Billable by Entitlement”	$650.00	$585.00@	42	M
396N	Balancing operation – contralateral breast. This fee is inclusive of all procedures on the contralateral side. Payable only when the ipsilateral breast has been operated on for congenital/post-surgical amastia or breast cancer.	$650.00	$573.70	42	M
400N	Subcutaneous tissue space expander -- implantation	$770.00	$679.50	42	L
401N	Subcutaneous tissue space expander -- removal (including replacement by prosthesis)	$735.00	$648.60	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	$197.85	$178.05	42	L
433N	Removal of single breast prosthesis with capsulectomy and/or skin plasty	$390.00	$351.00	42	L
354N	Abdominal panniculectomy – by prior approval – see criteria in Section N Preamble under Procedures, item (6)	$675.00	$607.45	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

	S E C T I O N N - Plastic Surgery	Specialist	General Practitioner	Class	Anes
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.	$225.00	$202.50	42	L
367N	Palmar fasciectomy for Dupuytren's contracture – primary	$565.00	$508.55	42	L
368N	Dupuytren's contracture – recurrent	$700.00	$629.95	42	L
369N	Thumb, MCP joint -- collateral ligament reconstruction, by local tissue rearrangement	$400.00	$360.00	42	L
370N	Thumb, MCP joint -- collateral ligament reconstruction, using tendon graft	$534.00	$481.45	42	L
	Skin - Miscellaneous				
380N	Excision of lesion, benign -- facial on referral	$106.00	$95.40	10	L
	Benign -- non-facial (see Section 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	$164.00	$147.60	10	L
685N	Excision of lesion, malignant, by wide excision and suture, facial (not including neck and scalp)	$200.00	$180.00	10	L
	For excision of malignant skin lesions with skin graft or flap repair -- use appropriate codes				
410N	Percutaneous inflation of tissue expander, first	$50.00	$50.00	0	L
411N	Percutaneous inflation of tissue expander, each additional expander, per patient contact, same day – maximum of 3, bill units	$20.00	$20.00	0	L

S E C T I O N N - Plastic Surgery

		Specialist	General Practitioner	Class	Anes

Assessment Rules for Microvascular Surgery (500N-506N):

1. Codes apply only when provided by a recognized microvascular surgeon.
2. Codes 500N and501N 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	$1,300.00	$1,169.95@	42	H
501N	Preparation of distant recipient site including repair of nerves, tendons, bones and skin	$1,300.00	$1,169.95@	42	H
502N	Preparation of adjacent donor and recipient sites including repair of nerves, tendons, bones and skin	$1,500.00	$1,349.95@	42	H
503N	Revascularization -- arterial	$900.00	$810.00@	42	H
504N	Revascularization -- arterial -- with vein graft	$1,100.00	$990.00@	42	H
505N	Revascularization -- venous	$900.00	$810.00@	42	H
506N	Revascularization -- venous -- with graft	$1,100.00	$990.00@	42	H

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

580N **BMI Supplement** – Plastic surgery supplement for patients with a Body Mass Index (BMI), (Weight [kg]/Height [m]2) greater than 40 — $65.00

1. Maximum of one (1) 580N supplement per patient per day;
2. Supplement 580N may be billed by plastic surgeons with all N Section procedures done in the operating room;
3. BMI supplements are not payable to the surgical assistant billing “J” section codes.

S E C T I O N O – Physical Medicine

		Specialist in Physical Medicine	
		Referred	Not Referred
	Visits		
3O	**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.	$135.00*	$107.90*
5O	**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.	$105.20*	$84.15*
9O	**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.	$214.25*	
11O	**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.	$140.00*	
14O	**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.	$280.00*	
	* 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.		
42O	-- per conference (not patient) -- first 30 minutes or part thereof	$104.05	$104.05
44O	-- add to 42O for each additional 15 minutes or part thereof	$52.05	$52.05

S E C T I O N 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 codes 627A-629A – Special Care Home Management.

25O	-- 1-10 days	-- per day -- bill units (max 10)	$33.50	$33.50
26O	-- 11-20 days	-- per day -- bill units (max 10)	$33.50	$33.50
27O	-- 21-30 days	-- per day -- bill units (max 10)	$33.50	$33.50
28O	-- 31 days and thereafter	-- per day -- bill units (max 99)	$33.50	$33.50

Virtual Care Services

Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.

805O	**Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference**-- includes: a) history review; b) history of presenting complaint; c) functional enquiry; d) assessment; e) diagnosis; f) necessary treatment; g) advice to the patient; and h) record of service provided.	$94.70	$75.80
809O	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; and d) written submission of the consultant's opinion; and e) recommendations to the referring doctor	$192.85	
811O	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '805O' "Virtual partial assessment or subsequent virtual visit" is appropriate.	$126.00	

S E C T I O N P – Obstetrics & Gynecology

		Specialist in Gynecology & Obstetrics	
		Referred	Not Referred
	Visits		
5P	**Initial assessment** -- of a specific condition includes: 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; i) advice to the patient; and, j) record of service provided.	$96.90*	$77.45*
7P	**Follow-up assessment** -- includes: a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and, g) record of service provided.	$70.25*	$70.25*
8P	**Pre-natal visit** after the first visit for maternity care or post-natal office visit. This service is only eligible for payment when all relevant clinical details of the visit are documented in a Saskatchewan approved prenatal form.	$58.00*	$58.00*
9P	**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.	$135.50*	
12P	**Extended consultation** – add on to 9P, max 4 units: a) Payable when consultation (9P) exceeds 25 minutes of direct in-person patient care and b) is satisfied. For clarity 12P is payable when a minimum of 32.5 minutes of direct in-person patient care is provided; b) Each complete 15-minute period or major portion thereof of direct in-person patient care; c) Start and stop times for total direct in-person patient care (both 9P and 12P) must be entered on the claim and documented in the patient medical record; d) Time spent on complications of pregnancy services (200P-218P) is not billable towards direct in-person patient care time; and, e) Maximum of one (1) extended consultation per pregnancy per physician.	$47.45*	
11P	**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 service 7P "follow-up assessment" is appropriate.	$80.25*	

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

S E C T I O N P – Obstetrics & Gynecology

			Specialist in Gynecology & Obstetrics	
			Referred	Not Referred
13P	Interpretation of telephonic fetal monitoring by consultant with immediate response, per patient.		$40.00	$32.00@

@ 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 codes 627A-629A – Special Care Home Management.

25P	-- 1-10 days	-- per day -- bill units (max 10)	$40.00	$40.00
26P	-- 11-20 days	-- per day -- bill units (max 10)	$40.00	$40.00
27P	-- 21-30 days	-- per day -- bill units (max 10)	$40.00	$40.00
28P	-- 31 days and thereafter	-- per day -- bill units (max 99)	$40.00	$40.00

S E C T I O N P – Obstetrics & Gynecology

		Specialist in Gynecology & Obstetrics	
		Referred	Not Referred
	VIRTUAL CARE SERVICES		
	Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
807P	**Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: a) history review; b) history of presenting complaint; c) functional enquiry; d) diagnosis; e) assessment; f) necessary treatment; g) advice to the patient; and h) record of service provided.	$63.25	$63.25
808P	**Virtual pre-natal visit** subsequent to a first in-person visit under 5P for maternity care or post-natal office visit	$52.20	$52.20
809P	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$121.95	
811P	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807P' "Virtual follow-up assessment" is appropriate.	$72.25	

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S E C T I O N 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 their 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 they have 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 their patient by cesarean section because the referring physician does not have surgical privileges, then they may bill under code 42P. They 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.

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S E C T I O N 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, during attendance/assistance of the delivery by the consultant, and including post-natal care in hospital when provided. 1. This service code is applicable only if a substantial amount of time is required by the most responsible/referring physician because: a) the referring physician attended to the patient during active labour and provided assessment of the progress of the labour, both initial and ongoing; and, b) during the course of labour because of urgent/emergent complications (i.e., fetal distress, failure to progress, cord prolapse, uncontrolled hemorrhage, placenta abruption, failed vacuum delivery, malpresentation, severe preeclampsia, eclampsia, HELLP syndrome), the attending physician finds it necessary to call a consultant to deliver the patient; and, c) the referring physician remains in attendance and assists the consultant with the delivery; or, d) the referring physician must transfer and accompanies the patient to another facility. For clarity, this service code is payable when the following criteria is all satisfied: (a), (b), (c); or (a), (b), (d). 2. Please indicate on the claim the name of the consultant to whom the case was referred. 3. This service is not payable if the patient is already under the care of an Obstetrician. If (i) the referral is necessary due to a documented urgent/emergent complication not listed above or (ii) where the referring physician does not remain in attendance to assist with the delivery but (a) and (b) are satisfied, the referring physician may write to Medical Services Branch for consideration of payment.	$688.00	$688.00		
	Deliveries Vaginal delivery and post-natal care in hospital -- see item 4 in preamble				
40P	Vaginal delivery and post-natal care in hospital - specialist	$714.00			
41P	Vaginal delivery and post-natal care in hospital - general practitioner		$704.50		
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)	$714.00	$714.00		
44P	Multiple pregnancy -- each additional child	$148.00	$148.00		

S E C T I O N P – Obstetrics & Gynecology

		Specialist	General Practitioner	Class	Anes
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	$550.00	$550.00	42	M
248P	Ectopic gestation salpingorrhaphy, embryectomy and salpingorrhaphy	$600.00	$540.00	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

S E C T I O N 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	$95.00	$85.45
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

S E C T I O N 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	$250.00	$250.00	42	L
250P	Therapeutic abortion -- second trimester - surgical	$338.25	$304.45	42	L
	Note: 50P and 250P cannot be billed for administering or prescribing pharmaceutical abortion agents such as mifepristone and misoprostol. See service code 150B for the administration and medical management of pharmaceutical abortion agents.				
	Administering or prescribing pharmaceutical abortion agents are an inclusion in the visit service.				
349P	Dilation and curettage (D&C) for management of acute or delayed postpartum hemorrhage 24 hours to 6 weeks post-delivery	$250.00	$250.00	42	L
350P	Dilation and curettage (D&C) for incomplete or missed abortion	$250.00	$250.00	42	L
351P	Management of second trimester therapeutic medical termination of pregnancy – in hospital 1. In-hospital medical management of a therapeutic, non-surgical termination of second trimester pregnancy (between 14 and 20 weeks' gestation) for fetal demise or significant fetal anomaly. 2. This service is intended to compensate for the administration, induction, and delivery of fetus/products of conception in a hospital setting. 3. Payment for this service is a composite fee for the in-hospital medical management and includes any cervical dilatation (i.e.: insertion of laminaria), administration of medication, assessments/evaluations, monitoring, counselling/advice provided during the hospital stay and management of delivery. 4. 351P is not billable when the only service provided is administering or prescribing pharmaceutical abortion agents such as mifepristone and misoprostol. See service code 150B for the administration and medical management of pharmaceutical abortion agents.	$287.60	$287.60		
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	

	S E C T I O N P – Obstetrics & Gynecology	Specialist	General Practitioner	Class	Anes
	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	$38.00	$38.00	0	
31P	Tubal insufflation or hysterosalpingogram or sonohysterogram – Rubin's (bilateral)	$80.00	$80.00	D	L
32P	Pelvic examination under anesthesia -- when only procedure done	$100.00	$100.00	D	L
34P	Culdoscopy or laparoscopy* -- with or without biopsy	$250.00	$224.90	D	M
35P	Laparoscopy Surgery* -- with divisions of adhesions for endometriosis or with treatment of endometriosis by either cauterization or CO2 laser vaporization. * Laparoscopy not paid with any laparoscopic surgery (i.e., not paid in addition to other surgical codes). For further clarity, diagnostic laparoscopy is payable as a standalone diagnostic procedure.	$450.00	$404.90	10	M
333P	Removal of intrauterine device (IUD) under general anesthesia or IV sedation – when only procedure done.	$150.60	$135.55	42	L
334P	Hysteroscopy -- with or without D & C, with or without other intrauterine procedures @ with approved training Note: 334P not payable for the insertion or removal of intrauterine device (IUD). See codes: 104A, 105A, 123A, 333P.	$250.00	$225.00@	D	L
335P	Endometrial ablation	$300.00	$270.00	42	M
336P	Excision of endometrial polyps and/or fibroids -- add to 334P or 335P only	$200.00	$200.00	42	L
232P	Hysteroscopic division of uterine septum	$350.00	$315.10	42	L
233P	Fallopian tube cannulation by hysteroscopy, unilateral or bilateral	$300.00	$270.00	42	L
234P	Hysteroscopic adhesiolysis for treatment of Asherman's Syndrome	$350.00	$315.10	42	L
235P	Hysteroscopic endometrial resection	$350.00	$315.10	42	M
36P	Hydrotubation	$50.00	$50.00	0	L
37P	Colposcopy -- not in office	$46.00	$46.00	D	L
38P	Colposcopy -- with biopsy -- not in office	$50.00	$50.00	D	L
438P	Colposcopy -- in office	$50.00	$50.00	D	
439P	Colposcopy -- with biopsy - in office	$54.00	$54.00	D	
39P	Endometrial tissue biopsy by aspiration	$59.00	$59.00	D	L
314P	Menopausal gonadotropin therapy, add to appropriate visit fee -- initial set-up per treatment cycle	$85.00	$76.45		
315P	Menopausal gonadotropin therapy, add to appropriate visit fee -- subsequent injections	$25.00	$22.50		

	S E C T I O N P – Obstetrics & Gynecology	Specialist	General Practitioner	Class	Anes
	Vulva				
60P	Hymenectomy (in hospital -- general Anesthetic)	$120.00	$120.00	0	L
61P	Bartholin cyst -- incision	$50.00	$50.00	10	L
78P	Bartholin cyst -- marsupialization	$175.00	$175.00	42	L
62P	Bartholin cyst -- excision	$300.00	$300.00	42	L
63P	Skene's glands -- cautery or excision	$150.00	$150.00	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	$550.00	$495.00	42	M
71P	Vulvectomy -- with bilateral inguinal node excision	$846.80	$762.05	42	M
72P	Vulvectomy -- with bilateral inguinal and pelvic node excision	$1,168.40	$1,051.95	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)	$100.00	$100.00	0	L
81P	Colpotomy	$150.00	$150.00	42	L
82P	Fistula -- recto-vaginal – repair	$1,000.00	$900.00	42	M
83P	Fistula -- urethro-vaginal – repair	$892.20	$804.25	42	M
84P	Fistula -- vesico-vaginal – repair	$1,066.50	$959.85	42	M
85P	Vaginal cysts -- inclusion – removal	$300.00	$300.00	10	L
86P	Vaginal cysts -- congenital – removal	$300.00	$270.15	42	L
87P	Vaginal atresia -- plastic reconstruction	$400.00	$360.00	42	L
88P	Vaginectomy	$650.00	$585.00	42	M
89P	Excision of vaginal septum	$300.00	$270.10	10	L
	Genital Prolapse				
90P	Colporrhaphy -- anterior or posterior	$300.00	$300.00	42	L
91P	Colporrhaphy – repeat	$450.00	$404.95	42	L
105P	Paravaginal repair (alternative to anterior repair)	$300.00	$269.95	42	L
92P	Paravaginal repair -- anterior and posterior	$300.00	$300.00	42	L
93P	Paravaginal repair -- repeat	$450.00	$405.05	42	L
193P	Mesh augmented prolapse repair	$300.00	$270.00	42	L
96P	Vaginal vault prolapse – repair	$450.00	$405.00	42	L
97P	Enterocele repair	$350.00	$315.00	42	L
98P	LeFort operation	$450.00	$405.05	42	L
99P	Manchester operation	$450.00	$405.05	42	L
100P	Third degree laceration (old) repair	$590.00	$531.10	42	L
101P	Urethra -- suspension procedure – initial	$400.00	$359.90	42	L
103P	Urethra -- suspension procedure – repeat after 42 days	$600.00	$540.00	42	L
102P	Urethra -- pubo vaginal sling	$550.00	$495.00	42	L
104P	Abdminosacrocolpopexy	$700.00	$630.00	42	M

	S E C T I O N P – Obstetrics & Gynecology	Specialist	General Practitioner	Class	Anes
	Cervix and Uterus				
108P	Artificial insemination, per insemination	$52.10	$52.10	0	
109P	Cryoconization or loop diathermy of cervix	$200.00	$180.25	0	L
110P	Cervix -- biopsy with or without electro-cauterization	$35.00	$35.00	D	L
111P	Cervix -- electro-cauterization	$15.00	$15.00	0	L
112P	Cervix -- polyp -- removal -- with or without electro-cauterization	$35.00	$35.00	0	L
113P	Cervix -- conization with D and C, with or without deep cautery, with or without polyp removal	$200.00	$179.95	10	L
114P	Cervix -- biopsy – excision	$35.00	$35.00	10	L
115P	Cervix -- repair or amputation	$200.00	$180.00	42	L
116P	Removal of cervical stump – abdominal	$630.00	$567.20	42	M
117P	Removal of cervical stump – vaginal	$630.00	$566.90	42	L
118P	Dilatation and curettage	$250.00	$250.00	0	L
228P	Insertion of brachytherapy stent/sleeve	$400.00	$400.00	10	L
120P	Hysterotomy	$450.00	$405.00	42	M
	Hysterectomy – open -- not paid in addition to adnexal surgery				
122P	Hysterectomy -- subtotal	$995.00	$895.65	42	M
123P	Hysterectomy -- total – abdominal	$1,100.00	$990.00	42	M
124P	Hysterectomy -- total – vaginal	$1,100.00	$990.00	42	M
125P	Hysterectomy -- total – Wertheim	$1,800.00	$1,620.00	42	H
	Hysterectomy -- laparoscopic or laparoscopic assisted -- not paid in addition to adnexal surgery				
126P	Hysterectomy -- subtotal or total -- includes 34P & 134P	$1,100.00	$990.00	42	M
130P	Surgical treatment of endometriosis by excision of lesion/lesions requiring at least 45 minutes of operating time to treat endometriosis, includes presacral neurectomy.	$593.85	$534.45	42	M
131P	Myomectomy by laparotomy or laparoscopy: a) Single or multiple; b) Not paid in addition to adnexal surgery; and, c) 131P is not payable for myomectomy by hysteroscopy; for this service, the following service codes may be appropriate: 334P, 336P	$905.45	$814.90	42	M
	Cervix and Uterus				
132P	Uteroplasty	$750.00	$675.00	42	M
133P	Uterus – suspension	$450.00	$405.05	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.	$500.00	$500.00	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.	$300.00	$300.00	42	M

S E C T I O N P – Obstetrics & Gynecology

		Specialist	General Practitioner	Class	Anes
	Salpingostomy -- not paid in addition to other adnexal surgery				
236P	Salpingostomy – unilateral	$410.00	$369.05	42	M
237P	Salpingostomy – bilateral	$510.00	$459.00	42	M
238P	Salpingo-utero-ovario-lysis -- not paid in addition to other adnexal surgery, unilateral or bilateral	$400.00	$360.10	42	M
138P	Broad ligament cyst enucleation - not paid in addition to other adnexal surgery	$400.00	$360.00	42	M
139P	Ovarian suspension or neurectomy - not paid in addition to other adnexal surgery	$300.00	$300.00	42	M
140P	Tubal ligation through laparoscope -- unilateral or bilateral	$300.00	$300.00	42	M
141P	Hysteroscopic sterilization by tubal occlusion (Essure)	$250.00	$225.00	42	M
142P	Omentectomy - when done in addition to 123P or 134P in cases of malignancy, add	$100.00	$100.00	42	M
143P	Reconstruction of fallopian tubes following pathological occlusion - unilateral (second tube is payable at 75%)	$550.00	$495.00	42	M
150P	Laser vaporization -- cervix -- full circumference	$150.00	$135.00	10	L
151P	Laser vaporization -- intraepithelial neoplasia of vulva, vagina or cervical segment	$150.00	$135.00	0	L
251P	Laser vaporization -- extensive -- vulva and/or vagina and/or cervix	By report		10	L

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.

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.	$149.00	$149.00		
581P	Obstetrics and Gynecology supplement for patients with a body mass index, (weight[kg]/height[m] 2) greater than 50.	$224.00	$224.00		

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, 234P, 235P, 236P, 237P, 238P, 241P, 248P, 250P, 251P, 258P, 269P, 279P, 333P, 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.

S E C T I O N Q – Neurology

		Specialist in Neurosurgery Referred	Not Referred
	Visits		
3Q	**Complete assessment** -- includes: a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) examination of all parts & systems; f) diagnosis; g) assessment; h) necessary treatment; i) advice to the patient; and, j) record of service provided.	$107.50*	$86.00*
5Q	**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.	$102.25*	$71.60*
9Q	**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.	$181.20*	
11Q	**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.	$105.00*	
	* 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 codes 627A-629A – Special Care Home Management.		
25Q	-- 1-10 days -- per day -- bill units (max 10)	$35.20	$35.20
26Q	-- 11-20 days -- per day -- bill units (max 10)	$35.20	$35.20
27Q	-- 21-30 days -- per day -- bill units (max 10)	$35.20	$35.20
28Q	-- 31 days and thereafter -- per day -- bill units (max 99)	$35.20	$35.20

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S E C T I O N Q – Neurology

		Specialist in Neurosurgery Referred	Not Referred
	VIRTUAL CARE SERVICES		
	Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
805Q	**Virtual partial assessment of subsequent virtual visit provided via telephone or secure videoconference**-- includes: a) history review; b) history of presenting complaint; c) functional enquiry; d) diagnosis; e) assessment; f) necessary treatment; g) advice to the patient; and h) record of service provided.	$92.05	$64.45
809Q	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$163.10	
811Q	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '805Q' "Virtual partial assessment or subsequent virtual visit" is appropriate.	$94.50	

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S E C T I O N 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	$22.00	$19.85	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	

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S E C T I O N R – Urological Surgery

		Specialist in Urological Surgery Referred	Not Referred
	Visits		
5R	**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.	$66.15*	$52.90*
7R	**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;	$50.00*	$44.90*
9R	**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	$120.00*	
11R	**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.	$60.00*	

* 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 codes 627A-629A – Special Care Home Management.

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

S E C T I O N R – Urological Surgery

		Specialist in Urological Surgery	
		Referred	Not Referred
	Virtual Care Services Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
807R	**Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: a) history review; b) functional enquiry; c) reassessment; d) necessary treatment; e) advice to the patient; and f) record of service provided.	$45.00	$40.40
809R	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$108.00	
811R	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807R' "Virtual follow-up assessment" is appropriate.	$54.00	

S E C T I O N 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	$16.50	$16.50	D	L
30R	Cystoscopy	$108.80	$97.90	D	L
31R	Cystoscopy -- with bilateral ureteral catheterization or retrograde pyelography	$150.00	$135.05	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	$80.00	$80.00	D	
402R	Electromyography -- technical component	$38.80	$38.80	D	
403R	Electromyography -- professional component	$120.00	$120.00	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

S E C T I O N 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	Ureteroplasty-- endoscopic with balloon dilation of ureteric stricture with or without stent not billable with 51R	$326.60	$293.95	0	L
	Penis				
	Penile Curvature Correction, composite Surgical correction of penis curvature for patients with Peyronie's Disease in the chronic phase or from congenital penile curvature. 1. Only one of the three procedures below billable per patient, on the same date. 2. Payable when all other appropriate treatment options have been exhausted and failed. 3. Billable when performed by a specialist with requisite subspecialty training in urology. 4. 30R (Cystoscopy) is billable in addition, by report only. This does not include documentation of urethral injury, which is considered an inclusion. 5. 63R (Insertion of penile prosthesis), when scheduled to be done in conjunction with one of the procedures below for the same patient, on the same date, is subject to prior approval by MSB Medical Consultant(s). 6. If 63R (Insertion of penile prosthesis) is done following a failed attempt of one of the procedures below for the same patient, on the same date, only 63R is billable.				
55R	Correction of penile curvature by grafting	$1,000.00		42	M
56R	Correction of penile curvature by intracorporeal destruction/incision	$450.00		42	M
57R	Correction of penile curvature by plication	$700.00		42	M
59R	Incisional biopsy of glans penis	$100.00	$100.00	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	
63R	Insertion of semi-rigid or self-contained inflatable penile prosthesis, composite, billable when: 1. Erectile dysfunction is a direct result of surgical injury, trauma or severe penile deformity (i.e.: ≥ 90 degrees curvature secondary to Peyronie's disease); and, 2. All other treatment options have been exhausted and failed.	$850.00		42	M

S E C T I O N R – Urological Surgery

		Specialist	General Practitioner	Class	Anes
71R	Intralesional Verapamil injection for Peyronie's plaque - Not billable in multiples, only one treatment/service is billable per patient contact	$100.00	$90.00	10	L
	Circumcision (routine circumcision is not insured)				
65R	Circumcision -- with local anesthesia injection	$129.00	$129.00	0	
66R	Circumcision -- under anesthesia administered by an anesthesiologist -- child	$266.90	$266.90	42	L
67R	Circumcision -- under anesthesia administered by an anesthesiologist -- adult	$288.90	$288.90	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	$90.00	$90.00	0	L
73R	Urethra -- surgical repair anterior urethral rupture	$1,000.00	$899.95	42	L
74R	Urethra -- repair posterior -- primary repair including suprapubic cystotomy	$911.40	$820.30	42	M
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
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
	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	$100.00	$89.95	0	L
90R	Cystotomy -- with trochar	$200.00	$200.00	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	$1,000.00	$899.95	42	M
94R	Cystectomy -- partial with ureteral reimplantation	$1,500.00	$1,350.00	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

S E C T I O N R – Urological Surgery

		Specialist	General Practitioner	Class	Anes
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	$1,000.00	$900.00	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	$800.00	$720.00	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
	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	$1,700.00	$1,530.00	42	H
138R	Nephrectomy -- thoraco-abdominal radical nephrectomy	$1,700.00	$1,530.00	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

S E C T I O N R – Urological Surgery

		Specialist	General Practitioner	Class	Anes
156R	Nephrostomy tube -- routine change	$30.00	$30.00	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	$200.00	$180.05	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	$315.00	$315.00	42	L
164R	Varicocele – repair	$450.00	$450.00	42	L
165R	Varicocele -- with exploration of inguinal canal	$341.20	$341.20	42	L
166R	Orchiectomy -- unilateral	$200.00	$200.00	42	L
167R	Orchiectomy -- bilateral	$350.00	$350.00	42	L
168R	Retroperitoneal exploration for testicle	$504.50	$454.10	42	M
169R	Orchiopexy -- unilateral -- Includes simple herniotomy -- herniorrhaphy paid in addition	$614.30	$552.90	42	L
170R	Orchiolysis	$46.50	$46.50	42	L
171R	Torsion -- testis or appendix testis with fixation of contralateral testis	$600.00	$600.00	42	L
180R	Orchiectomy with excision at internal ring -- unilateral	$400.00	$359.90	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	$1,000.00	$900.00	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

S E C T I O N R – Urological Surgery

		Specialist	General Practitioner	Class	Anes
580R	**BMI Supplement -** Urology surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height [m] 2) greater than 40 1. Maximum of one 580R supplement per patient per day. 2. Supplement 580R may be billed by urologists with all R Section procedures done in the operating room. 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.	$125.00			
	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 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.	$270.40			
356R	Hypospadias -- first stage repair	$425.00	$382.50	42	L
357R	Hypospadias -- second stage (urethroplasty)	$605.90	$545.30	42	L
657R	Single stage hypospadias repair	$1,200.00	$1,080.0	42	L
358R	Single stage hypospadias repair -- urethral fistula repair	$151.90	$136.60	42	L
359R	Epispadias	$314.00	$282.40	42	L

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S E C T I O N S – Ophthalmology

		Specialist in Ophthalmology Referred	Specialist in Ophthalmology Not Referred
	Visits		
5S	**Initial assessment** -- of a specific condition includes: 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; i) advice to the patient; and, j) record of service provided.	$70.00*	$56.00*
7S	**Follow-up assessment** -- includes: a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and, g) record of service provided.	$46.25*	$39.85*
8S	**Neuro-ophthalmology follow-up assessment** -- includes: a) history review; b) functional enquiry; c) examination; d) reassessment; e) necessary treatment; f) advice to the patient; and, g) record of the service provided. h) only payable to physicians with approved training in neuro-ophthalmology.	$70.00*	$63.00*
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.	$91.10*	
10S	**Neuro-ophthalmology 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. f) only payable to physicians with approved training in neuro-ophthalmology.	$175.00*	
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.	$56.00*	
12S	**Low vision assessment** - limited to 1 benefit per beneficiary per 12-month period	$200.00*	
	* Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.		
6S	**Routine examination of eyes** (reference Item A, page 306)	$70.00	$53.20

S E C T I O N S – Ophthalmology

			Specialist in Ophthalmology Referred	Specialist in Ophthalmology 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 codes 627A-629A – Special Care Home Management.			
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

S E C T I O N S – Ophthalmology

		Specialist in Ophthalmology Referred	Specialist in Ophthalmology Not Referred
	Virtual Care Services Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.		
807S	**Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: a) history review; b) functional enquiry; c) reassessment; d) necessary treatment; e) advice to the patient; and f) record of service provided.	$41.65	$35.90
808S	**Virtual neuro-ophthalmology follow-up assessment provided via telephone or secure videoconference** – includes: a) history review; b) functional enquiry; c) reassessment; d) necessary treatment; e) advice to the patient; and f) record of service provided. Note: 808S is only payable to physicians with approved training in neuro-ophthalmology.	$63.00	$56.70
809S	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.	$82.00	
811S	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807S" "Virtual follow-up assessment" is appropriate.	$50.40	

S E C T I O N S – 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 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

S E C T I O N 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	$24.00	$24.00	D	
534S	Formal orthoptic assessment interpretation	$40.00	$36.00	D	
580S	Corneal pachymetry (repeat by report only) – bilateral	$8.15	$8.15	D	
	Cycloplegic retinoscopy – maximum three (3) per year billable per physician				
15S	- bilateral – under 11 years age	$45.00	$45.00	D	
16S	- bilateral – Ages 11-17	$45.00	$45.00	D	
	Note: Eligibility is limited to beneficiaries aged 11 to 17, only in limited circumstances, such as cognitive function or physical disability, comment required.				
535S	Orthopic technical fee 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”.	$30.00	$30.00	D	
651S	Automated perimetry/specular microscopy/topography a) Technical fee b) Bilateral c) Add to 34S, 35S, 36S, 650S, 671S d) 1 per patient visit e) For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”.	$13.50	$13.50	D	
579S	Screening visual fields (FDT or Similar) 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”.	$4.00	$4.00	D	
	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	Optical Coherence Tomography -- professional	$25.50	$22.90	D	
582S	Optical Coherence Tomography -- technical	$25.50	$25.50	D	
34S	Screening visual field including tangent screen, auto plot arc perimetry and frequency doubling screening – bilateral	$9.00	$9.00	D	
35S	Central threshold visual field – bilateral	$19.90	$19.90		
36S	Central and peripheral visual field – bilateral	$40.80	$40.80	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	$263.10	$263.10	D	L
424S	Forced Duction Test -- local	$53.60	$53.60	D	
425S	Forced Duction Test -- general	$95.40	$95.40	D	L

S E C T I O N S – Ophthalmology

		Specialist	General Practitioner	Class	Anes
	For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician"				
652S	Fundus or Slit Lamp Photography, bilateral -- professional component	$6.10	$6.10	D	
653S	Fundus or Slit Lamp Photography, bilateral -- technical component	$6.10	$6.10	D	
	Fluorescein Angiography a) Apparatus owned by physician and injection by physician. b) Use 111A if IV injection only by the physician				
40S	Fluorescein Angiography -- technical component	$35.00	$35.00	D	
41S	Fluorescein Angiography -- 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	
45S	Color vision assessment - F.M. 100 Hue Test or Pickford Anomaloscope -- technical component	$10.20	$10.20	D	
46S	Color vision assessment - F.M. 100 Hue Test or Pickford Anomaloscope -- professional component	$17.10	$17.10	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	$40.80	$40.80	D	
664S	Indirect ophthalmoscopy with scleral depression for complete examination of fundus and diagraming -- unilateral or bilateral	$18.40	$18.40	D	
680S	Infrared pupillography – bilateral	$31.80@	$28.65@	D	
681S	Eye movement videography/photography – bilateral	$31.80@	$28.65@	D	
682S	Quantification of relative afferent pupillary defect with neural density filters – bilateral	$31.80@	$28.65@	D	
683S	Diagnostic pupillary drop testing – bilateral	$39.75@	$35.80@	D	

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

S E C T I O N 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	$23.85	$23.85	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	$76.50	$76.50	10	L
64S	Chalazion – removal -- under general anesthetic or IV sedation (includes post-op recovery)	$183.45	$183.45	10	L
65S	Cauterization – lid	$20.90	$20.90	0	L
	Trichiasis				
66S	Epilation – unilateral	$28.00	$28.00	0	L
431S	Electrolysis or laser ablation – unilateral	$33.60	$33.60	10	L
432S	Cryotherapy – unilateral	$66.50	$59.80	10	L

S E C T I O N 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	$69.60	$62.55	10	L
69S	Tarsorrhaphy -- permanent -- double adhesion	$171.25	$154.15	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	$53.55	$53.55	10	L
	Excision – repair with sutures (use 380N)				
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

S E C T I O N S – Ophthalmology

		Specialist	General Practitioner	Class	Anes
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
	Lacrimal Tract				
50S	Duct Probing -- local anesthesia	$30.60	$30.60	0	
51S	Duct Probing -- general anesthesia	$183.45	$183.45	0	
52S	Duct probing and insertion of plastic tube or similar method, total care	$250.80	$225.75	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	$568.35	$511.45	42	M
131S	-- second muscle -- either eye --add bill units	$424.35	$381.85	42	M
132S	-- any additional muscle (s) -- either eye --add bill units	$146.50	$131.90	42	M
133S	-- adjustable suture technique per muscle --add bill units	$318.60	$286.75	42	M
134S	-- two muscle transposition procedure	$816.60	$735.00	42	M
	For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician"				
690S	Corneal collagen cross-linking -- professional fee	$543.40	$489.10	42	L
691S	Corneal collagen cross-linking -- 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	$53.50	$53.50	D	L

S E C T I O N S – Ophthalmology

		Specialist	General Practitioner	Class	Anes
	Conjunctiva – Cornea – Sclera				
90S	Conjunctiva, cornea, sclera - foreign body or bodies -- removal -- unembedded	$23.60	$23.60	0	L
91S	Conjunctiva, cornea, sclera - foreign body or bodies -- removal -- embedded - local anesthesia	$51.30	$46.20	0	L
106S	Conjunctiva, cornea, sclera - foreign body or bodies -- removal -- general anesthesia	$169.80	$152.70	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	Keratectomy – 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	$321.20	$289.05	42	L
96S	Subconjunctival injection	$22.90	$22.90	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
	For billing of technical component see "Definitions" (19) and "Services Supervised by a Physician"				
300S	Phototherapeutic keratectomy for anterior scarring, hereditary congenital dystrophy or recurrent erosion syndrome -- professional component	$367.00	$330.30	42	L
301S	Phototherapeutic keratectomy for anterior scarring, hereditary congenital dystrophy or recurrent erosion syndrome -- 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	$128.40	$128.40	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	$76.50	$76.50	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	$127.50	$114.75	42	M

S E C T I O N S – Ophthalmology

		Specialist	General Practitioner	Class	Anes
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	$267.65	$240.85	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
	Glaucoma				
180S	Laser trabeculoplasty -- per eye -- bill units	$165.00	$148.50	10	
159S	Cyclodiathermy, cycloelectrolysis or cyclocryothermy	$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 goniopuncture – unilateral	$184.50	$166.10	42	L
162S	Goniotomy and/or goniopuncture – 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 units	$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	$356.80	$321.10	42	L
	Complicated with vitrectomy, use vitrectomy codes				
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

S E C T I O N S – Ophthalmology

		Specialist	General Practitioner	Class	Anes
	Complex Cataracts				
673S	Pupil expansion device, insertion and removal, unilateral, bill units -- add to 135S, 139S, 142S, 226S, 236S, 220S, 230S	$83.15	$74.80	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	Orbit exenteration	$713.70	$642.30	42	M
110S	Orbit abscess -- incision and drainage (general practitioners – billable "by report" only)	$281.40	$253.20	42	L
111S	Orbit enucleation	$481.75	$433.55	42	M
112S	Orbit enucleation -- with insertion of an integrated orbital ocular implant in scleral shell – add	$128.40	$115.60	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 -- Immediately 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	Orbit - excise anterior tumor	$499.60	$449.60	42	M
489S	Orbit - excise posterior tumor	$776.90	$698.40	42	M
490S	Orbit - biopsy anterior tumor	$333.40	$300.00	10	L
491S	Orbit - 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	

S E C T I O N S – Ophthalmology

		Specialist	General Practitioner	Class	Anes
	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
	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	LB
	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

S E C T I O N S – Ophthalmology

		Specialist	General Practitioner	Class	Anes
	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
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 2 units for bilateral -- add to 170S, 174S, 175S, 176S, 177S, 178S, 180S, 182S, 186S,187S, 189S, 285S, 286S, 493S, 494S, 495S, 496S, 497S For billing of technical component see “Definitions” (19) and “Services Supervised by a Physician”. Please note that 181S is considered an “add” code and must be submitted on the same claim number as one of the above-listed “base” codes. <u>Example:</u> Claim no 10001: 170S (base code) Claim no 10001: 181S (add code)	$30.00	$30.00	D	

S E C T I O N T – Otolaryngology

		Specialist in Otolaryngology	
		Referred	Not Referred
	Visits		
5T	**Initial assessment** -- of a specific condition includes: a) pertinent family history; b) patient history; c) history of presenting complaint; d) functional enquiry; e) diagnosis-tentative or final; f) clinical examination of affected part(s) or system(s); g) necessary treatment; h) advice to the patient; and, i) record of service provided.	$60.35*	$48.30*
7T	**Follow-up assessment** -- includes: a) history review; b) functional enquiry; c) clinical examination; d) diagnosis tentative or final; e) necessary treatment; f) advice to the patient; and, g) record of the service provided.	$57.20*	$55.55*
9T	**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	$94.60*	
11T	**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 service code 7T "follow-up assessment" is appropriate.	$59.00*	

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

S E C T I O N T – Otolaryngology

			Specialist in Otolaryngology Referred	Specialist in Otolaryngology 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 codes 627A-629A – Special Care Home Management.			
25T	-- 1-10 days	-- per day -- bill units (max 10)	$59.00	$59.00
26T	-- 11-20 days	-- per day -- bill units (max 10)	$59.00	$59.00
27T	-- 21-30 days	-- per day -- bill units (max 10)	$59.00	$59.00
28T	-- 31 days and thereafter	-- per day -- bill units (max 99)	$59.00	$59.00
	Virtual Care Services			
	Please see Virtual Care preamble in the introductory section of the Payment Schedule for more information.			
807T	**Virtual follow-up assessment provided via telephone or secure videoconference**-- includes: a) history review; b) functional enquiry; c) diagnosis, tentative or final; d) necessary treatment; e) advice to the patient; and f) record of service provided.		$51.50	$48.35
809T	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; d) written submission of the consultant's opinion; and e) recommendations to the referring doctor.		$85.15	
811T	**Repeat virtual consultation provided via telephone or secure videoconference:** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual 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 virtual follow-up of the patient for which service code '807T" "Virtual follow-up assessment" is appropriate.		$53.10	

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S E C T I O N 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	
431T	Diagnostic pure tone audiogram in sound-proof room including thresholds and four frequencies -- air	$25.00	$25.00	D	
432T	Diagnostic pure tone audiogram in sound-proof room including thresholds and four frequencies -- air and bone	$25.00	$25.00	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	$60.00	$60.00	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	$37.00	$37.00	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	$16.80	$16.80	0	
54T	Ear - foreign body – removal, simple	$21.40	$21.40	0	L
55T	Ear - foreign body – removal, complicated, under injected local or general anesthesia	$77.50	$77.50	10	L
56T	Ear - foreign body – removal, involving post-aural incision	$254.90	$229.40	42	L
57T	Paracentesis of eardrum	$51.00	$51.00	0	L
58T	Ear - polyp – removal, simple	$25.50	$25.50	10	L
59T	Ear - polyp -- removal under local or general anesthesia	$60.00	$60.00	10	L

S E C T I O N T – Otolaryngology

		Specialist	General Practitioner	Class	Anes
61T	Labyrinthotomy	$611.70	$550.50	42	L
62T	Endolymphatic sac surgery -- initial or revision	$839.30	$839.30	42	L
70T	Mastoidectomy -- infant -- antrotomy	$780.00	$702.00	42	L
71T	Mastoidectomy -- simple -- complete any age	$780.00	$702.00	42	L
72T	Mastoidectomy -- radical -- classical – revision	$960.00	$863.95	42	L
74T	Mastoidectomy -- revision -- same surgeon	$960.00	$863.95	42	L
75T	Mastoidectomy -- revision -- different surgeon	$900.00	$809.95	42	L
76T	Mastoidectomy -- revision - with musculoplasty, add to 72T, 74T, 75T, 87T	$86.40	$77.65	42	L
77T	Review of radical mastoid cavity -- removal of cerumen and debris – unilateral	$40.00	$40.00	0	L
78T	Post-aural fistula -- closing	$120.00	$108.00	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	$422.40	$380.15	42	L
82T	Sinus thrombosis -- operative management with mastoidectomy	$371.50	$334.35	42	L
83T	Tympanotomy, exploratory (internal) (not paid in addition to inner ear surgery)	$183.50	$165.15	42	L
283T	Tympanotomy with ossicular chain reconstruction	$407.80	$367.00	42	L
84T	Myringoplasty -- per canal approach only	$175.00	$158.05	42	L
85T	Tympanoplasty -- with widening of external auditory canal and exploration of attic with or without antrotomy	$540.00	$486.00	42	L
86T	Tympanoplasty -- with ossicular reconstruction	$735.00	$661.45	42	L
87T	Tympanoplasty -- with radical mastoidectomy	$1,101.10	$990.95	42	L
88T	Myringotomy with insertion of tube (total care)	$96.50	$86.85	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	$35.00	$35.00	0	L
93T	Post-nasal packing -- unilateral or bilateral	$100.00	$100.00	0	L
292T	Post-nasal packing -- removal -- bilateral	$25.50	$25.50	0	L
393T	Epistaxis, for anterior packing and postnasal packing -- unilateral or bilateral	$203.90	$203.90	0	L

S E C T I O N T – Otolaryngology

		Specialist	General Practitioner	Class	Anes
94T	Nose - foreign body removal -- simple	$32.00	$32.00	0	L
95T	Nose - foreign body removal -- complicated -- general anesthetic	$102.00	$102.00	10	L
96T	Nose - polyp removal -- single -- in office	$60.00	$60.00	10	L
296T	Nose - polyp removal -- single -- in operating room	$103.00	$103.00	10	L
97T	Nose - polyp removal -- multiple -- unilateral -- in operating room	$85.00	$76.45	10	L
98T	Nose - polyp removal -- choanal	$83.60	$75.20	10	L
99T	Nose - 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	$352.00	$316.80	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	$28.70	$28.70	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	$615.65	$554.05	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	$750.00	$674.95	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	$380.00	$342.00	42	M
126T	Sinus -- frontal -- intranasal	$190.00	$171.05	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	$510.00	$510.00	42	M
129T	Transantral orbital decompression -- bilateral	$680.00	$680.00	42	M
130T	Turbinate -- cauterization -- cautery or diathermy -- unilateral or bilateral	$61.20	$61.20	0	L
131T	Turbinate -- resection – partial – unilateral or bilateral	$75.00	$67.50	10	M
132T	Turbinate -- submucous resection of – unilateral or bilateral	$75.00	$67.45	10	M
450T	Turbinate -- sinuscopy -- unilateral or bilateral	$33.35	$30.00	D	L

S E C T I O N T – Otolaryngology

		Specialist	General Practitioner	Class	Anes
	Throat and Mouth				
138T	Frenectomy -- without anesthesia	$45.05	$45.05	10	L
139T	Frenectomy -- under general anesthesia	$102.00	$102.00	10	M
140T	Abscess - incision and drainage with scalpel -- peritonsillar or retropharyngeal	$315.00	$315.00	10	M
142T	Adenoidectomy	$300.00	$270.00	42	M
145T	Tonsillectomy with or without adenoidectomy	$438.00	$438.00	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	$40.00	$40.00	D	L
174T	Laryngoscopy -- direct - with biopsy	$258.00	$232.20	D	M
175T	Laryngoscopy -- direct - with benign tumor removal or cord stripping	$244.70	$220.20	42	M
275T	Laryngoscopy -- with microscope -- with biopsy or cord stripping	$315.00	$283.50	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	$500.00	$450.00	42	M
178T	Complete change of tracheostomy tube or Blom Singer prosthesis	$125.10	$125.10	0	L
	Miscellaneous				
192T	Arytenoidopexy or arytenoidectomy	$450.00	$405.00	42	M
193T	Total laryngectomy	$1,365.00	$1,228.55	42	H
293T	Primary creation/insertion of voice prosthesis	$200.00	$180.00	42	H
194T	Partial laryngectomy -- not laryngofissure	$749.40	$674.45	42	H
195T	Laryngofissure	$856.40	$770.70	42	M
196T	Anterior or lateral pharyngotomy	$550.00	$495.00	42	M
197T	Total maxillectomy with or without orbital exenteration	$1,000.00	$900.00	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. 2. Paid in addition to the following office procedures only: 173T, 174T, 175T, 450T	$19.70	$19.70		

S E C T I O N 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:

Physician	Payment Approved For
Pathologist	List 1, 2, 3
Physician with a registered Laboratory Technician	List 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)	$6.00
15V	Hematocrit or packed cell volume (PCV)	$4.85
31V	Blood sugar -- diagnostic stick -- whole blood	$5.40
32V	Blood sugar -- serum -- machine read (when done on an Ames seralyzer or a similar machine)	$6.40
59V	Urinalysis -- dipstick	$5.35
60V	Urinalysis -- complete -- dipstick and microscopic	$6.30
62V	Test for pregnancy -- any method	$12.10
70V	Examination of slide for trichomas, yeast, scales - lab licence not required to perform this service	$6.40
80V	Occult blood	$4.70
90V	Microalbumin testing -- max one per year per patient (for diabetic patients with negative albumin only) urine dipstick	$8.60

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.

S E C T I O N 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)	$11.55
14V	Hemoglobin (Hgb)	$6.30
15V	Hematocrit (HCT) or packed cell volume (PCV)	$5.10
17V	Erythrocyte sedimentation rate (ESR)	$4.00
18V	Smear with differential count	$5.55
19V	White blood cell count (WBC)	$3.45
904V	Automated or semi-automated hematology profile, counts and indices (includes Hgb, RBC, WBC, HCT, MCH, MCHC, and MCV, when performed)	$12.10
27V	Blood urea nitrogen -- serum -- machine read (when done on an Ames seralyzer or a similar machine)	$3.55
29V	Blood urea nitrogen -- diagnostic stick -- whole blood	$2.35
31V	Blood sugar -- diagnostic stick -- whole blood	$5.65
32V	Blood sugar serum -- machine read (when done on an Ames seralyzer or a similar machine)	$6.70
33V	Blood glucose test or glucose tolerance test (including urine test), per unit	$7.35
59V	Urinalysis -- dipstick	$5.65
60V	Urinalysis -- complete -- dipstick and microscopic	$6.70
62V	Test for pregnancy -- any method	$12.70
70V	Examination of slide for trichomonas, yeast, scales -- lab licence not required to perform this service	$6.70
80V	Occult blood	$5.20
512V	Prothrombin -- Quick's one stage prothrombin time with control	$6.35
627V	Spot test for mononucleosis	$9.45
90V	Microalbumin testing --max one per year per patient (for diabetic patients with negative albumin only) urine dipstick	$9.05

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

S E C T I O N 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 they 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 their 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: 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) advice to the patient as required.	$28.10

Only payable to physician providing a surgical biopsy (standard assessment rules apply).

Specimen Collection and Referral

751V	Phlebotomy, venipuncture	$27.35
752V	Phlebotomy, pediatric (0 to 6 years)	$41.15
771V	Referral -- blood	$13.90
770V	Referral -- urine	$13.90
772V	Referral -- other	$17.75
756V	Referral -- transfer of dangerous goods (TDG) - blood	$43.20
757V	Referral -- transfer of dangerous goods (TDG) - urine	$43.20
758V	Referral -- transfer of dangerous goods (TDG) - other	$43.20

S E C T I O N V – Laboratory Medicine

Specialist in Pathology

Chemistry

Blood Gases

111V	Blood gases (pH, p02, pC02, 02 saturation)		$9.60
112V	Blood gas (pH only)		$6.80
113V	Blood gas and metabolites -	pH, p02, pC02, 02 saturation, sodium, potassium, chloride, glucose, lactate	$14.00
114V	Blood gas and metabolites -	pH, p02, pC02, 02 saturation, sodium, potassium, chloride, glucose, lactate and ionized calcium	$15.15
118V	CoOximetry (any single test)		$6.80
119V	CoOximetry (methemoglobin, carboxyhemoglobin, oxyhemoglobin)		$8.60
120V	Blood gas, metabolites and CoOximetry (pH, p02, pC02, 02 saturation, sodium, potassium, chloride, glucose, lactate, ionized calcium, methemoglobin, carboxyhemoglobin, oxyhemoglobin, hemoglobin-arterial)		$18.65
121V	Ionized calcium - whole blood		$6.80
122V	Ionized calcium - serum		$6.80

Routine

130V	Specimen may be serum/plasma/urine/fluids -- single analyte		$6.80
131V	For each additional analyte performed on the same specimen from the following menu add:		$0.90

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	$8.05
133V	Urine microscopy		$6.80
134V	Myoglobin urine		$25.45
135V	Occult blood (stool/gastric)		$6.80
136V	Osmolality urine/serum		$23.20
137V	Ketones, reducing substances (urine/feces)		$2.25
138V	24-hour urine, creatinine clearance		$19.20
139V	24-hour urine, total protein		$18.30

Urinalysis/Urine Testing

141V	Albumin/creatinine ratio		$45.35
433V	Microalbumin - by automated method		$18.75
140V	Pregnancy test – human chorionic gonadotropin (HCG) - urine or serum		$26.45

S E C T I O N V – Laboratory Medicine

Specialist in Pathology

	Chemistry - Immunology/Rheumatology	
151V	Alpha 1 antitrypsin	$18.75
152V	C3	$18.75
153V	C4	$18.75
162V	Ceruloplasmin	$18.75
155V	C-reactive protein (CRP)	$18.75
240V	Electrophoresis (serum)	$45.35
156V	Electrophoresis creatine kinase (CK)	$45.35
157V	Electrophoresis cerebrospinal fluid (CSF)/urine	$56.85
158V	Immunoglobulin A (IgA)	$18.75
159V	Immunoglobulin G (IgG)	$18.75
161V	Immunoglobulin M (IgM)	$18.75
163V	Immunofixation (serum/CSF/urine)	$110.10
630V	Rheumatoid factor (RF)	$18.75
166V	Transferrin	$18.75
167V	Cryoglobulins	$28.25
	Chemistry - Endocrinology and Therapeutic Drug Monitoring	
171V	For any single analyte ordered on the same specimen from the following group	$12.55
172V	For each additional analyte ordered from the following group add: - Alpha fetoprotein (AFP) - Carbamazepine - Carcinoembryonic Antigen (CEA) - Digoxin - Ferritin - Follicle stimulating hormone (FSH) - Gentamicin - Luteinizing hormone (LH) - Phenobarbital - Phenytoin - Prolactin - Serum beta HCG, quantitative - Theophylline - Tobramycin - Troponin 1 - Valproic acid - Vancomycin	$4.05
173V	Estradiol	$34.50
174V	Free T3	$9.40
175V	FreeT4	$9.40
270V	Thyroid-stimulating hormone (TSH)	$9.40
271V	Thyroid-stimulating hormone (TSH) - (free T4 reflexed)	$12.65
181V	Thyroid-stimulating hormone (TSH) - (free T4 & free T3 reflexed)	$16.15
182V	Amikacin	$15.70
183V	Cortisol	$15.70
185V	Cyclosporine	$21.95
186V	Methotrexate	$15.70
187V	Prostate specific antigen (PSA)	$12.55
188V	Secobarbital, phenytoin, amobarbital, butalbarbital, pentobarbital, phenobarbital (urine/serum) (when done as a panel of six)	$62.75
189V	Tacrolimus	$25.00
190V	Thiopental	$46.90
203V	Toxicology screen (serum or urine)	$108.65

S E C T I O N V – Laboratory Medicine

Specialist in Pathology

	Chemistry - Miscellaneous	
204V	B2 microglobulin	$15.70
205V	Bilirubin amniotic - B12/RBC folate - see hematology section	$43.20
302V	Calculus analysis	$34.50
142V	Carotene	$78.45
206V	Chylomicrons (refridge & visual)	$25.00
207V	Chymex	$46.90
208V	Cryofibrinogen	$46.90
168V	Cryoglobulin	$28.25
209V	Ethanol, isopropanol, methanol (when done as a panel of 3)	$50.10
210V	Ethylene glycol	$50.10
211V	Fat globule (prep, stain, interp)	$62.75
412V	Fecal fat assay	$172.30
212V	Free erythrocyte protoporphyrin (FEP) assay	$59.45
213V	Gastric analysis	$18.65
214V	Glucose by glucose meter	$8.05
215V	Haptoglobin	$18.75
216V	Hemoglobin A1C - iron/iron binding/% saturation - see Hematology Section	$13.55
249V	Lithium	$12.65
217V	Lecithin-sphingomyelin (LS)/phophatidylglycerol (PG) on amniotic fluid	$156.35
338V	Melanin	$31.20
202V	Methemalbumin	$65.55
425V	Mucin	$15.70
218V	pH - pH meter (fluid)	$6.80
219V	Phenylalanine	$46.90
221V	Plasma hemoglobin	$46.90
349V	Porphobilinogen screen	$28.25
222V	Porphyrin screen (feces/urine/serum)	$31.20
224V	Prealbumin	$18.75
225V	Pregnancy test - human chorionic gonadotropin (HCG) - serum	$26.45
227V	Sweat chloride analysis (does not include specimen collection)	$18.65
418V	Trypsin	$34.50
229V	Xylose	$25.00
	Chemistry – Allergy	
235V	Immunoglobulin E (IgE)	$78.80
236V	Food mix screen	$78.80
237V	Inhalant screen IgE	$78.80
238V	For each additional specific allergen ordered with total Immunoglobulin E (IgE) or a screen, add	$10.95
239V	For each allergen, if ordered individually - some common allergens are: dog dander, dust, milk, yellow hornet, honey bee, peanut	$78.80
	Hematology - Routine	
422V	CBC 8 parameters + histograms, 3 or 5 part differential	$14.35
423V	CBC 8 parameters or less (hemoglobin, HCT, RBC, WCB, MCV, MCH, MCHC + platelets)	$8.60

S E C T I O N V – Laboratory Medicine

Specialist in Pathology

	Miscellaneous	
251V	B12	$12.55
253V	Cell count and differential cerebrospinal fluid (CSF)	$60.70
434V	Erythrocyte sedimentation rate	$11.55
464V	Estimate - platelet/white blood cell (WBC) count	$8.60
254V	Red blood cell (RBC) folate	$31.20
180V	Iron, total iron binding capacity (TIBC) and % saturation	$14.60
255V	Manual differential	$31.75
257V	Manual hemoglobin (Hgb)	$31.75
476V	Manual white blood cell (WBC) count	$18.00
259V	Monotest	$18.00
260V	Morphology	$8.60
470V	Reticulocyte count	$26.10
494V	Blood parasites (malarial & others)	$63.65
261V	Bone marrow - assist, stain, differential, iron	$266.50
262V	Bone marrow - for each additional 500 cells counted, add	$57.45
263V	Bone marrow - for each additional slide stained	$57.45
265V	Buffy coat preparation	$46.25
481V	Cell count and differential	$52.10
266V	Cytospin	$20.25
267V	Eosinophil smear (sputum)	$23.20
268V	Eosinophil smear (urines)	$43.30
550V	Esterase, iron, peroxidase, sudan black, TRAP	$58.00
274V	Fluid crystals	$18.00
497V	Heinz bodies (direct)	$43.30
346V	Hemoglobin (HGB) pigments (qualitative)	$34.70
275V	Hemolysate preparation	$49.30
276V	Iron stain hematology	$14.35
277V	Leukocyte alkaline phosphatase score	$104.80
278V	Hemosiderin – urine	$18.00
	Hematology - Coagulation	
279V	Prothrombin time (PT)/INR & Activated Partial Thromboplastin Time (APTT)	$13.00
280V	Prothrombin time (PT)/INR	$11.55
281V	Activated Partial Thromboplastin Time (APTT)	$11.55
282V	D-dimer – automated	$106.05
283V	Factor assays (each)	$76.00
506V	Fibrinogen	$11.55
	Hematology - Flow Cytometry	
284V	CD4/CD8	$422.95
285V	CD34-peripheral blood	$311.60
287V	CD34-apheresis	$414.95

S E C T I O N V – Laboratory Medicine

Specialist in Pathology

	Transfusion Medicine	
560V	ABO & RH typing (group & type)	$49.40
563V	Antibody screen	$44.55
289V	Antibody panel	$74.15
290V	Antibody panel -- each additional panel	$74.15
291V	Antigen typing	$44.55
600V	Direct antiglobulin test (Coombs & fractionation)	$54.40
559V	Crossmatch (group & type, antibody screen & 2 units of packed cells)	$108.65
293V	Crossmatch (group & type, antibody screen & 2 units of packed cells) - each additional unit of packed cells	$19.65
295V	Human leukocyte antigen (HLA) typing (ABC/DR typing)	$1,378.55
	Microbiology – Routine	
297V	Blood culture and sensitivity (C&S) for bacteria &/or yeast - automated	$50.40
690V	Blood culture and sensitivity (C&S) for bacteria &/or yeast - manual	$90.20
299V	Cervix culture and sensitivity (C&S)	$50.10
300V	Cerebrospinal fluid (CSF) culture and sensitivity (C&S)	$77.00
301V	Dermatophyte culture	$176.35
305V	Direct gram stain only	$38.20
306V	Effluent culture	$67.60
307V	Environmental culture	$37.75
309V	Fluids culture and sensitivity (C&S)	$98.00
311V	Fungal culture and sensitivity (C&S)	$176.35
312V	Lower Respiratory CBS with gram stain	$69.55
724V	Microscopic exam for Fungus	$26.45
313V	Miscellaneous culture and sensitivity (C&S)	$106.05
314V	Methicillin-resistant staphylococcus aureus (MRSA) culture	$61.05
731V	Parasite examination - pinworm paddle	$26.45
725V	Parasite examination - skin scrapings	$53.15
317V	Parasite examination -- stool - full ova and parasites (O&P) workup	$115.45
318V	Parasite examination -- stool - giardia/cryptosporidium screen	$26.45
319V	Parasite examination -- trichomonas	$26.45
729V	Parasite examination -- urine	$55.95
321V	Pneurnocystis examination	$139.30
322V	Stool for culture and sensitivity (C&S)	$59.90
323V	Stool for Clostridium difficile toxin	$32.35
324V	Streptozyme screen	$20.45
325V	Throat culture and sensitivity (C&S)	$32.35
326V	Ureaplasma urealyticum testing	$36.85
327V	Urethra culture and sensitivity (C&S)	$50.10
329V	Urine culture and sensitivity (C&S)	$29.50
331V	Vaginal or vaginal/rectal swab for group B strep	$38.65
333V	Vaginal swab for bacterial vaginosis examination	$38.20
334V	Vancomycin resistant enterococcus (VRE) screen	$38.90

S E C T I O N V – Laboratory Medicine

Specialist in Pathology

335V	Wound culture - deep site	$98.00
337V	Wound culture - surface site	$79.95
	Microbiology – Tuberculosis (TB)	
344V	Bronchial washing tuberculosis (TB) culture	$245.25
345V	Cerebrospinal fluid (CSF) tuberculosis (TB) culture	$233.25
347V	Fluid tuberculosis (TB) culture	$267.75
351V	Gastric washing tuberculosis (TB) culture	$188.25
352V	Polymerase chain reactin (PCR) for mycobacterium tuberculosis (TB)	$273.05
242V	Polymerase chain reactin (PCR) for mycobacteria species	$273.05
722V	Smear only	$108.65
354V	Sputum tuberculosis (TB) culture	$267.75
355V	Stool tuberculosis (TB) smear	$108.65
356V	Miscellaneous tuberculosis (TB) culture	$233.25
357V	Tissue tuberculosis (TB) culture	$267.75
358V	Urine tuberculosis (TB) culture	$212.10
	Microbiology - Virology	
359V	Cytomegalovirus (CMV) antigenemia	$478.60
360V	Cytomegalovirus (CMV) IgG	$75.40
	Epstein-Barr virus (EBV) serology -- Epstein-Barr virus nuclear antigen (EBNA); Epstein-Barr viral-capsid antigen (VCA) IgM or IgG	
361V	-- if ordered individually.	$67.05
363V	-- If added to an existing order ---add	$25.20
368V	Epstein-Barr Virus (EBV) early antigen (EA) -- if ordered individually	$167.00
369V	Epstein-Barr Virus (EBV) early antigen (EA) -- If added to an existing order ---add	$125.95
	Hepatitis testing	
370V	-- single marker	$83.80
371V	-- for each additional marker added to order -- add	$41.85

Includes the following list of markers:

- Hepatitis A Antibody
- Hepatitis A immunoglobulin G (IgG)
- Hepatitis A immunoglobulin M (IgM)
- Hepatitis B Core Antibody
- Hepatitis B Core immunoglobulin M (IgM)
- Hepatitis B Surface Antibody
- Hepatitis B Surface Antigen
- Hepatitis C Antibody

373V	Herpes antibody	$75.40
374V	Mycoplasma pneumonia antibodies	$75.40
375V	Parvovirus serology (B19 - immunoglobulin G (IgG) and immunoglobulin M (lgM))	$184.30
376V	Rubella immunoglobulin G (IgG) antibody	$67.05
377V	Rubella immunoglobulin M (IgM) antibody	$58.70
379V	Toxoplasma immunoglobulin G (IgG)	$58.70
383V	Toxoplasma immunoglobulin M (IgM)	$58.70
384V	Varicella immunoglobulin G (IgG) antibody	$75.40
385V	Chlamydia culture	$160.45

S E C T I O N V – Laboratory Medicine

Specialist in Pathology

386V	Respiratory specimen for viruses by direct fluorescent antibody tests	$234.70
387V	Rotavirus antigen test	$67.05
388V	Viral culture -- cerebrospinal fluid (CSF)	$243.85
389V	Viral culture -- eye	$253.25
390V	Viral culture -- genital	$164.40
391V	Viral culture -- miscellaneous	$379.10
392V	Viral culture -- respiratory	$277.10
393V	Viral culture -- skin	$296.90
394V	Viral culture -- stool	$300.95
395V	Viral culture -- tissue	$395.05
396V	Viral culture -- urine	$233.25
	Microbiology dimethyl pimelimidate (DMP)	
398V	Chlamydia trachomatis polymerase chain reaction (PCR)	$178.95
399V	Hepatitis C polymerase chain reaction (PCR)	$393.80
400V	Herpes simplex virus polymerase chain reaction (PCR)	$221.35
401V	Pertussis polymerase chain reaction (PCR)	$214.70
402V	Varicella polymerase chain reaction (PCR)	$140.55
	Cytology – Gynecologic	
403V	Cytology – gynecologic specimen -- 1 slide (Papanicolau) (PAP)	$28.15
405V	Cytology – gynecologic specimen -- each additional slide (Papanicolau) (PAP)	$9.50
	Cytology – Medical	
407V	Fine needle biopsy - CytoSpin handling -- 1 slide	$327.40
409V	Fluid for cells -- 1 slide	$131.25
411V	Sputum for cells -- 1 slide	$124.60
413V	Urine for cells -- 1 slide	$131.25
415V	Urine for cells -- each additional slide	$29.75

S E C T I O N 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.

Additional units/scans done for comparison purposes are not billable.

		Technical Component*	Interpretation Component	Technical* & Interpretation Component
	Head and Neck			
11W	Echoencephalography (midline and ventricular size)	$33.25	$28.05	$61.30
12W	Thyroid	$37.05	$26.80	$63.85
13W	Thyroid -- with 7.5 or 10 mhz transducer	$72.45	$33.05	$105.50
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	$46.30	$34.95	$81.25
	Chest			
20W	Echocardiography, M-mode	$51.05	$40.25	$91.30
21W	Ultrasonically-guided pericardiocentesis or thoracocentesis, bill units	$48.30	$39.50	$87.80
22W	Chest -- for pleural effusion	$43.95	$16.40	$60.35
23W	Breast -- for breast mass (per breast) -- bill units	$51.30	$49.65	$100.95
	Abdomen			
30W	Complete - Kidneys, liver, pancreas, gall bladder, spleen, aorta and related structures	$101.10	$64.40	$165.50
33W	Limited – Confined to a single organ, system or quadrant (e.g. RUQ), or follow-up study. For renal- use 31W. Maximum one per patient per day.	$71.85	$40.35	$112.20
31W	Renal -- independent study only	$60.10	$46.50	$106.60
32W	Ultrasonically guided biopsy or cyst aspiration	$44.15	$34.20	$78.35
73W	Hypertrophic pyloric stenosis	$61.55	$39.25	$100.80

S E C T I O N 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 p rofiles, 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	$101.00	$55.20	$156.20

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	$101.00	$55.20	$156.20
412W	Second trimester - Complete – twins - not to be billed before 16 weeks	$124.35	$69.75	$194.10
422W	Second trimester - Complete – triplets or greater - not to be billed before 16 weeks.	$147.15	$90.95	$238.10

S E C T I O N 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	$51.65	$28.10	$79.75
	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	$101.00	$55.20	$156.20
413W	Third trimester - Complete – twins	$124.35	$69.75	$194.10
423W	Third trimester - Complete – triplets or greater	$147.15	$90.95	$238.10
433W	Third trimester - Limited – singleton, twins or triplets or greater	$51.65	$28.10	$79.75
44W	Ultrasonically guided amniocentesis	$47.05	$36.05	$83.10
46W	Biophysical profile of fetus (not to be billed before 28 weeks) – max of 1 per day	$75.10	$48.55	$123.65
446W	Biophysical profile per additional multiple fetus (not to be billed before 28 weeks)	$51.60	$36.65	$88.25
149W	Nuchal translucency screening	$45.05@	$31.60@	$76.65@
150W	Nuchal translucency screening -- each additional fetus (add to 149W)	$32.95@	$23.10@	$56.05@

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".

S E C T I O N W – Diagnostic Ultrasound

		Technical Component*	Interpretation Component	Technical* & Interpretation Component
	Gynecology			
42W	Intrauterine contraceptive device (IUCD) localization	$35.65	$28.10	$63.75
43W	Pelvis	$81.95	$50.25	$132.20
45W	Transvaginal ultrasound study in addition to 43W, 401W-433W	$38.40	$23.55	$61.95
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.	$72.65	$39.15	$111.80
449W	Transvaginal ultrasound follicle tracking follow-up study -- subsequent exam within 22 days	$43.85	$29.15	$73.00
	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.	$69.15	$35.80	$104.95
51W	Flow studies including arterial or venous or fetal monitoring or shunt assessment, etc. -- each additional fetus -- bill units	$50.10	$25.80	$75.90
34W	Flow studies of the portal venous system --- add to 33W. Only billable for patients with confirmed or suspected hepatic disease, or if the study is specifically requested by a physician as part of hepatic screening.	$30.35	$13.65	$44.00
54W	Peripheral venous -- per limb -- bill units	$120.45	$53.70	$174.15
	Prostate/Testicles			
60W	Transrectal ultrasound of prostate	$64.75	$43.95	$108.70
62W	Testicles	$57.20	$33.15	$90.35

S E C T I O N 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		$61.55	$39.25	$100.80
122W	Torso -- excluding axilla or groin		$61.55	$39.25	$100.80
124W	Back		$61.55	$39.25	$100.80
126W	Shoulder to elbow	- two units may be billed for bilateral	$61.55	$39.25	$100.80
128W	Elbow to fingers	- two units may be billed for bilateral	$61.55	$39.25	$100.80
130W	Axilla	- two units may be billed for bilateral	$61.55	$39.25	$100.80
132W	Hip to knee	- two units may be billed for bilateral	$61.55	$39.25	$100.80
134W	Knee to toes	- two units may be billed for bilateral	$61.55	$39.25	$100.80
136W	Groin	- two units may be billed for bilateral	$61.55	$39.25	$100.80
	Joint Ultrasound				
200W	Spine		$83.70	$47.10	$130.80
202W	Neck		$83.70	$47.10	$130.80
204W	Complete shoulder or acromioclavicular joint	- two units may be billed for bilateral	$83.70	$47.10	$130.80
206W	Elbow	- two units may be billed for bilateral	$83.70	$47.10	$130.80
208W	Wrist	- two units may be billed for bilateral	$83.70	$47.10	$130.80
210W	Hand -- fingers -- thumb	- two units may be billed for bilateral	$83.70	$47.10	$130.80
212W	Hip	- two units may be billed for bilateral	$83.70	$47.10	$130.80
214W	Knee	- two units may be billed for bilateral	$83.70	$47.10	$130.80
216W	Ankle	- two units may be billed for bilateral	$83.70	$47.10	$130.80
218W	Foot -- toes	- two units may be billed for bilateral	$83.70	$47.10	$130.80

Additional units/scans done for comparison purposes are not billable.

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S E C T I O N X – Diagnostic Radiology

Specialist in Diagnostic Radiology

9X Special review of x-rays by Radiologist with written report to referring physician(s) - by report $82.45#

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 they have performed the procedure personally or the technical component was performed by qualified staff for which they assume 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	$33.20	$16.25	$49.45
101X	Nasal sinuses	$32.30	$17.45	$49.75
102X	Mastoids	$35.95	$19.45	$55.40
103X	Facial Bones and/or Zygoma	$32.35	$18.30	$50.65
104X	Nasal bones	$23.90	$9.75	$33.65
105X	Salivary duct	$24.75	$16.55	$41.30
106X	Internal auditory meati	$32.60	$14.25	$46.85
107X	Mandible	$29.20	$13.20	$42.40
108X	Temporomandibular joints	$32.30	$15.65	$47.95
109X	Eye -- without localization -- bill units	$27.60	$14.80	$42.40
110X	Sella turcica	$23.80	$13.55	$37.35
	Teeth			
120X	Pantomography - not insured for routine dental care	$20.85	$15.70	$36.55
121X	Teeth -- isolated area -- bill units	$7.25	$4.95	$12.20
122X	Teeth -- quarter set	$10.95	$7.10	$18.05
123X	Teeth -- half set	$14.35	$8.30	$22.65
124X	Teeth -- full set	$20.65	$13.00	$33.65
125X	Eye -- Sweet (or equivalent) localization for foreign body in eye or orbit	$38.70	$26.95	$65.65

	S E C T I O N X – Diagnostic Radiology		Technical Component*	Interpretation Component	Technical* & Interpretation Component
	Spine and Pelvis				
130X	Cervical		$47.00	$20.50	$67.50
131X	Thoracic		$37.70	$16.45	$54.15
132X	Lumbar		$47.00	$20.50	$67.50
133X	Sacro-iliac joints		$23.60	$15.55	$39.15
134X	Sacrum and coccyx		$23.60	$15.55	$39.15
135X	Scoliosis survey (limited)		$21.60	$12.25	$33.85
136X	Oblique views of spine -- add - bill units		$18.00	$10.00	$28.00
137X	Lumbar spine with flexion and extension		$43.55	$23.40	$66.95
138X	Cervical spine with flexion and extension		$43.55	$23.40	$66.95
140X	Scoliosis survey -- full		$37.05	$23.10	$60.15
141X	Myelogram		$96.85	$62.15	$159.00
142X	Discogram		$96.75	$57.40	$154.15
143X	Pelvis		$25.05	$12.95	$38.00
144X	Pelvis and one or both hips		$43.55	$19.10	$62.65
145X	Smith-Peterson pinning		$76.05	$49.30	$125.35
	Thorax				
150X	Chest		$36.50	$18.25	$54.75
151X	Thoracic inlet		$20.85	$11.30	$32.15
152X	Ribs		$27.20	$12.50	$39.70
153X	Clavicle		$23.90	$10.85	$34.75
154X	Sternum or sternoclavicular joints		$23.90	$10.30	$34.20
157X	Bronchogram (unilateral)		$47.70	$25.30	$73.00
158X	Chest films with fluoroscopy		$28.90	$20.85	$49.75
159X	Heart survey and/or cardiac pacemaker evaluation		$29.65	$13.45	$43.10
	Extremities				
160X	Acromioclavicular joint	Two units billable for bilateral	$23.90	$11.45	$35.35
161X	Shoulder	Two units billable for bilateral	$25.80	$12.75	$38.55
361X	Shoulder -- 4 views – unilateral	Two units billable for bilateral	$33.45	$13.95	$47.40
162X	Humerus	Two units billable for bilateral	$23.90	$10.85	$34.75
163X	Elbow	Two units billable for bilateral	$23.90	$10.85	$34.75
164X	Forearm -- radius and ulna	Two units billable for bilateral	$23.90	$10.85	$34.75
165X	Wrist	Two units billable for bilateral	$23.90	$10.85	$34.75
166X	Carpals	Two units billable for bilateral	$23.90	$10.65	$34.55
167X	Hand	Two units billable for bilateral	$29.70	$14.65	$44.35
168X	Scapula	Two units billable for bilateral	$23.80	$11.75	$35.55
170X	Femur	Two units billable for bilateral	$23.80	$11.75	$35.55
171X	Knee	Two units billable for bilateral	$29.70	$14.65	$44.35
172X	Tibia and fibula	Two units billable for bilateral	$23.80	$11.75	$35.55
173X	Ankle	Two units billable for bilateral	$28.45	$14.20	$42.65
373X	Ankle -- specialty view -- (4 views) unilateral	Two units billable for bilateral	$39.45	$15.75	$55.20

S E C T I O N X – Diagnostic Radiology

			Technical Component*	Interpretation Component	Technical* & Interpretation Component
	Extremities				
174X	Tarsus	Two units billable for bilateral	$28.45	$14.20	$42.65
175X	Forefoot	Two units billable for bilateral	$23.80	$11.75	$35.55
176X	Os calcis	Two units billable for bilateral	$23.80	$11.75	$35.55
190X	Single digit, same hand or foot		$22.50	$11.35	$33.85
191X	Digits, same hand or foot		$23.90	$11.45	$35.35
192X	Orthoroentgenograms		$23.00	$13.75	$36.75
	Bone Survey				
193X	Bone survey		$64.80	$31.45	$96.25
194X	Joint survey		$63.35	$30.65	$94.00
195X	Wrist -- four views	Two units billable for bilateral	$24.95	$15.10	$40.05
196X	Knee -- four views	Two units billable for bilateral	$33.40	$17.25	$50.65
197X	Skeletal survey -- infant		$43.90	$22.65	$66.55
	Abdomen				
200X	Single film of abdomen (KUB.)		$20.30	$11.30	$31.60
201X	Acute abdomen survey with erect and/or lateral views		$29.30	$19.30	$48.60
210X	Esophagus		$39.55	$20.05	$59.60
211X	GI Series		$73.35	$40.80	$114.15
212X	Small bowel study		$57.10	$25.75	$82.85
213X	Colon -- enema		$89.50	$45.35	$134.85
214X	Colon -- double contrast enema		$127.65	$58.15	$185.80
215X	Fluoroscopy for position of tube in abdomen		$15.85	$15.95	$31.80
216X	Hypotonic duodenography		$40.05	$26.50	$66.55
217X	Double contrast GI with glucagon		$65.90	$26.15	$92.05
	Biliary System				
220X	Cholecystogram		$34.85	$18.20	$53.05
221X	Cholangiogram -- intravenous		$88.60	$39.45	$128.05
222X	Cholangiogram -- operative		$61.70	$31.50	$93.20
223X	Cholangiogram -- post-operative (T-tube)		$64.55	$20.00	$84.55
224X	Cholangiogram -- transhepatic, percutaneous		$92.70	$45.30	$138.00
	Urinary System				
228X	Percutaneous renal cystography		$25.55	$31.55	$57.10
229X	Intravenous pyelogram (hypertensive survey)		$77.75	$25.85	$103.60
230X	Cystogram		$40.25	$17.40	$57.65
231X	Pyelogram -- intravenous		$101.05	$32.00	$133.05
232X	Pyelogram -- retrograde		$31.25	$9.95	$41.20
233X	IVP -- with voiding cystourethrogram		$84.80	$32.55	$117.35
234X	Voiding cystourethrogram		$78.40	$41.20	$119.60
235X	Drip infusion pyelogram		$92.75	$44.15	$136.90
239X	Urethrogram (retrograde)		$32.00	$15.40	$47.40

S E C T I O N X – Diagnostic Radiology

		Technical Component*	Interpretation Component	Technical* & Interpretation Component
	Obstetrics and Gynecology			
240X	Fetus -- scout film	$16.80	$11.50	$28.30
241X	Fetus -- maturity and/or position	$16.80	$11.50	$28.30
243X	Pelvimetry	$29.40	$17.45	$46.85
244X	Utero-salpingogram	$31.55	$19.25	$50.80
245X	Intrauterine blood transfusion	$28.30	$17.40	$45.70
	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 Saskatchewan Medical Care Insurance Act*. 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.	$67.70	$67.90	$135.60
312X	Repeat mammography for radiological localization of non-palpable breast lesion -- bill units	$104.80	$33.80	$138.60
301X	Soft tissues of the neck	$22.80	$9.90	$32.70
302X	Laryngogram	$40.55	$24.55	$65.10
303X	Planigraphy -- first cut	$26.05	$12.20	$38.25
304X	Planigraphy -- each additional cut -- bill units	$9.50	$6.20	$15.70
306X	Cinefluorograph or videotape		$17.85	17.85
307X	Cardiac catheterization	$35.55	$24.25	$59.80
	Miscellaneous -- with contrast media			
320X	Fistula or sinus tract	$26.90	$11.35	$38.25
321X	Sialogram	$58.40	$36.50	$94.90
322X	Arthrogram	$69.80	$35.50	$105.30
323X	Lymphangiography - upper and lower extremities, including pelvis, chest and abdomen	$57.10	$28.75	$85.85
324X	Dacryocystography	$28.30	$16.85	$45.15
325X	Venogram	$53.40	$28.30	$81.70
327X	Selective cavogram	$53.85	$30.80	$84.65
328X	Azygography	$57.00	$27.65	$84.65
329X	Ventriculogram or encephalogram	$57.00	$27.65	$84.65
330X	Arteriography -- peripheral	$57.00	$27.65	$84.65
331X	Arteriography -- cerebral	$67.55	$36.05	$103.60

S E C T I O N X – Diagnostic Radiology

		Technical Component*	Interpretation Component	Technical* & Interpretation Component
332X	Aortography -- aortic	$57.00	$27.65	$84.65
333X	Aortography -- selective - coronary, renal, mesenteric, bronchial etc	$57.00	$27.65	$84.65
334X	Cardiac angiography	$67.55	$36.05	$103.60
335X	Portogram through umbilical vein	$67.55	$36.05	$103.60
336X	Posterior fossa myelogram	$75.80	$34.70	$110.50

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S E C T I O N X – Diagnostic Radiology

		Specialist in Diagnostic Radiology		
		Specialist	Class	Anes
10X	Consultation -- requires formal referral – includes: 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. This code does not apply when the radiologist is only providing information to the patient and/or getting consent for a procedure. # Payment for patients 0-5 years of age and patients 65 years of age and older are automatically applied.	$70.75#		
	Classification: Radiologist Clinical Procedures 1. The following procedures are insured services where provided by a radiologist. 2. Payment to a radiologist will be made only where the radiologist has performed the procedure personally. 3. Multiple diagnostic procedures are paid at 100% 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%.			
	Angiography a) These codes are for use by Radiologists only. b) Cardiologists will find applicable angiography in the A Section.			
501X	Vascular access -- for angiography purposes only – max of 2 units per case	$70.75		H
502X	Aortography -- for a dedicated Aortogram(s) only – max of 1 unit per case	$72.40		H
503X	Large vessel angiography -- for angiograms of the main cerebral and visceral trunks of the aorta, maximum of 3 units per case	$82.45		H
504X	Extremity angiogram -- for visualization of vascular structures in either arm or leg, maximum of 2 units per case -- one per extremity # 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.	$77.75		H
	Transluminal angioplasty			
600X	Transluminal angioplasty -- peripheral	$271.00	0	H
601X	Transluminal angioplasty -- renal	$318.20	0	H
602X	Transluminal angioplasty -- subclavian artery	$270.35	0	H
603X	Transluminal angioplasty -- aorta or aortic valve	$494.90*	0	H
604X	Stent placement following angioplasty of peripheral, renal or subclavian vessels – add to appropriate angioplasty code – each vessel – bill units	$78.20	0	H

***Note: Post-angioplasty care for elective procedures is included in the payment for this procedure**

S E C T I O N 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	$84.85	D	
607X	Selective catheterization of renal vein by Seldinger technique or cut down, bilateral	$122.55	D	L
608X	Selective catheter embolization	$270.35	0	M
609X	Intravascular thrombolysis -- composite professional fee	$539.90	0	L
610X	Intravascular thrombolysis -- composite professional fee -- repeats within 48 hours	$276.90	0	L
612X	Selective transarterial catheterization with infusion	$251.05	0	L
613X	Azygography	$47.30	D	L
614X	Peripheral venography -- unilateral	$78.30	D	L
615X	Cavography -- percutaneous or catheter	$100.80	D	L
616X	Lymphangiography -- unilateral including pelvis, abdomen and chest	$93.20	D	L
617X	Arthrography --each -- bill units	$71.85	D	L
618X	Bronchogram – unilateral	$59.25	D	
619X	Laryngogram	$38.70	D	
620X	Myelography	$112.25	D	L
621X	Discography -- one or more discs	$61.30	D	L
622X	Sialography -- each -- bill units	$76.80	D	L
623X	Injection of a sinus tract	$61.85	D	L
624X	Reduction or attempted reduction of intussusception by barium enema	$76.65	0	L
625X	Percutaneous cholangiography	$153.10	D	L
626X	Percutaneous renal cystography	$57.10	D	
627X	Percutaneous renal cystography -- with alcohol obliteration of renal cyst	$91.85	0	
628X	Dacryocystography -- each -- bill units	$61.30	D	
629X	Portogram through umbilical vein	$103.60	D	
631X	Pelvic venography	$38.70	D	L
632X	Tube positioning for small bowel study	$33.30	D	L
639X	Epidurography	$68.45	D	
640X	Lumbar epidural venography	$93.20	D	
641X	Ureteral stent placement via nephrostomy tract	$156.20	0	L

S E C T I O N X – Diagnostic Radiology

		Specialist in Diagnostic Radiology		
		Specialist	Class	Anes
	Procedures under fluoroscopic, CT or ultrasonic guidance			
642X	Percutaneous intrathoracic biopsy	$138.45	D	L
643X	Percutaneous intra-abdominal biopsy	$138.45	D	L
644X	Percutaneous intra-abdominal drainage	$192.10	0	L
645X	Percutaneous biliary drainage	$324.05	0	L
646X	Change of drainage tube in relation to 644X, 645X, 647X, 650X, 651X	$71.00	0	
647X	Percutaneous nephrostomy with nephrogram	$330.00	0	L
648X	Manipulation of peritoneal dialysis catheter	$64.40	0	
649X	Transjugular liver biopsy	$271.00	0	
650X	Percutaneous gastrotomy	$197.35	0	L
651X	Percutaneous jejunostomy	$220.95	0	L
652X	Percutaneous insertion of vena cava filter	$182.60	0	
653X	Fallopian tube cannulation and dilatation -- with selective salpingography, unilateral or bilateral	$143.75	10	L
654X	Removal of intravascular foreign body – composite fee	$265.15	0	
655X	Transjugular portosystemic shunts (TIPS) – composite fee	$636.20	0	
656X	Non-palpable breast lesion -- needle localization – each, bill units	$76.65	D	L
657X	Stereotactic mammographic guided breast biopsy – each, bill units	$34.50	D	L
658X	Mammographic or ultrasound guided breast biopsy	$170.85	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	$10.60	0	
660X	-- professional component -- bill units	$24.70	0	
661X	Percutaneous insertion of pleural catheter for closed chest drainage (includes 659X and 660X) – each, bill units	$112.00	0	L
662X	Percutaneous intravenous central catheter (PICC) -- includes placement, removal venography and ultrasound – composite fee	$244.00	0	L
	Portacath, Infusaport, Hemo-Cath, Hickman-Broviac for chemotherapy or long-term TPN (PORT)			
663X	-- insertion, composite fee	$265.30	10	L
664X	-- remove and replace, composite fee	$382.45	10	L
665X	-- remove or revise, same site, composite fee	$144.10	0	L
670X	Tunnelled paracentesis drainage catheter -- insertion	$261.60	0	L
671X	Tunnelled paracentesis drainage catheter -- removal	$172.00	0	L
672X	Tunnelled pleural drainage catheter -- insertion	$214.40	0	L
673X	Tunnelled pleural drainage catheter -- removal	$79.45	0	L

S E C T I O N X – Diagnostic Radiology

		Specialist in Diagnostic Radiology		
		Specialist	Class	Anes
680X	Rhizotomy - sacroiliac (SI) joint (hospital location) - medial branch nerves of multiple facets and SI joints - includes all ablations of multiple target zones Note: Specialists in Anesthesia must use code 680H.	$560.00	0	L
681X	Rhizotomy (hospital location) – spinal, radiofrequency	$202.20	0	L
682X	Percutaneous radiofrequency ablation of solid tumors using CT/ultrasound guidance -- first lesion	$614.40	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	$334.00		L
	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.			

S E C T I O N 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