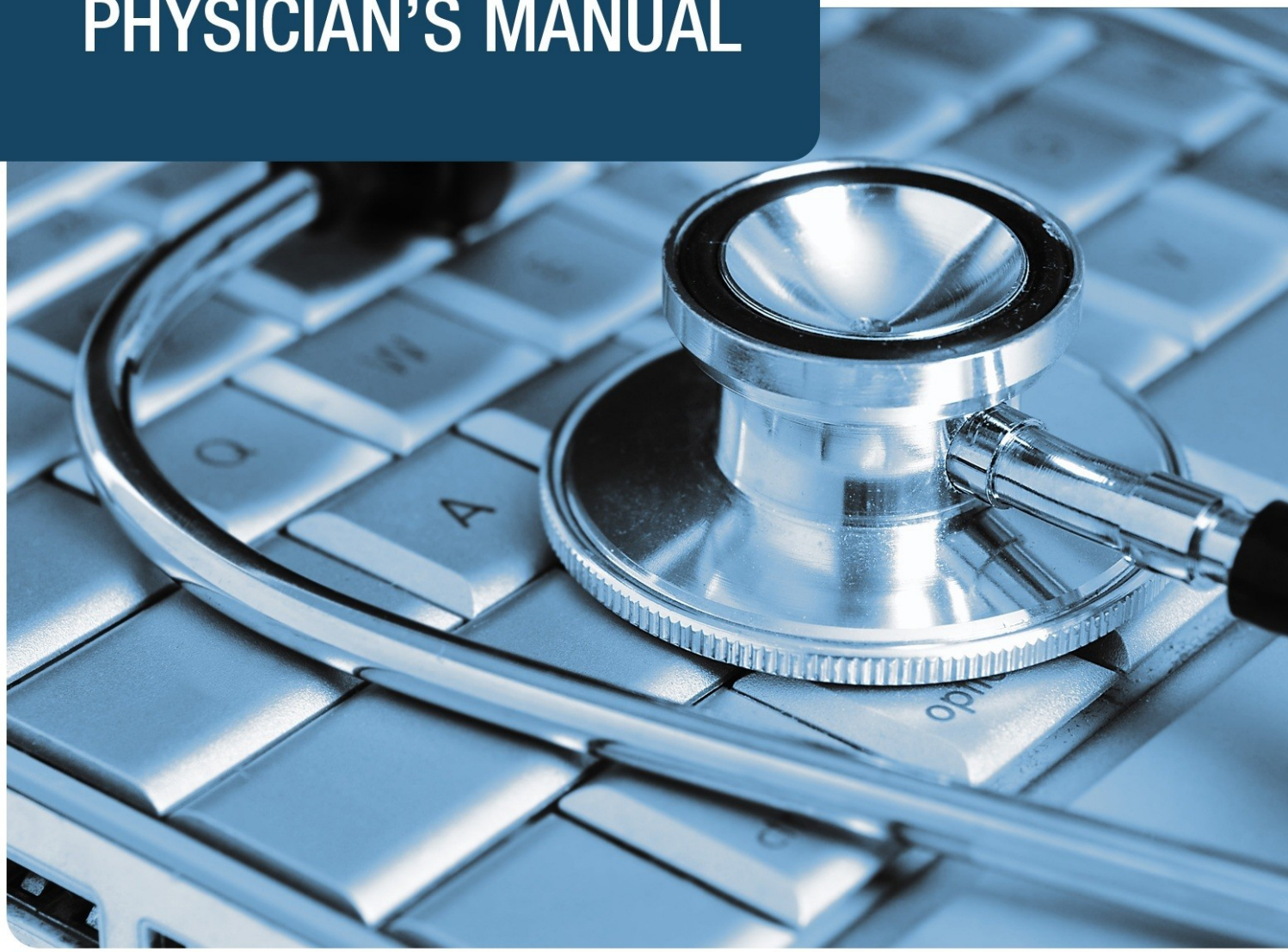
NOVA SCOTIA MEDICAL SERVICES INSURANCE

# PHYSICIAN'S MANUAL



## 2026

Last updated: July 2026

# PHYSICIAN'S MANUAL 2026 - INTRODUCTION

A key purpose of the Nova Scotia Physician's Manual is to prepare and sustain accurate and supporting documentation. This newly updated Physician's Manual integrates policy changes as previously published in Physician's Bulletins from 2014 onward including those approved by the Medical Advisory Management Group.

## NS MSI PHYSICIAN'S MANUAL 2026 - ORIENTATION

The NS MSI Physician's Manual 2026 has eight sections:

- Section 1: General Considerations
- Section 2: Services Insured, Not Insured, Out of Province and Third Party
- Section 3: Service Reporting and Claims Submission
- Section 4: Tariff
- Section 5: Claim Submission Assessment Rules
- Section 6: Terms and Definitions
- Section 7: Appendices
- Section 8: Nova Scotia Medical Services Insurance Schedule of Benefits

- The introductory page to each section provides an overview of the content of the section and includes the definitions of key terms.
- Italicized numeric paragraph identifiers (e.g., 1.0.2) are included at the end of all headings and paragraphs in Section 1 to 7. These identifiers can be used when needing to refer to a specific item, for example when a billing clerk is contacting MSI with a question.
- There are more cross-references across Sections.

The contents of this Manual are updated regularly to include updates published in the Physician's Bulletins; however, it may be necessary to refer to Physician's Bulletins for additional detailed information and any billing clarifications or reminders.

*The Physician's Manual is comprised of:*

- *Preamble*
- *List of insured health service codes and descriptions*
- *Explanatory codes and descriptions*

## QUESTIONS

If you have any questions as you use this Manual, please contact MSI for assistance. Refer to Section I: General Considerations of this Manual for contact information. MSI will make every attempt to reply to inquiries in a prompt and accurate manner.

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# SECTION 1: GENERAL CONSIDERATIONS *(1.0.0)*

*This section provides an overview of each component's contents.* *(1.0.1)*

*The schedule of medical benefits lists all insured procedures, their descriptions and codes, any special conditions, and the value in units. When the term schedule is used in this Preamble, it means the schedule of benefits (this refers to the electronic document).* *(1.0.2)*

*This section also explains that participating physicians are those who are registered with MSI to receive compensation for insured medical services and that non-participating physicians have elected not to receive compensation for insured medical services from MSI. Reporting obligations for each physician group are identified.* *(1.0.3)*

*Lastly, contact information for various resources available to provide assistance with reporting questions is listed.* *(1.0.4)*

**Key Terms Relevant *to This Section*** *(1.0.5)*

*Bulletin: An MSI administrative update that indicates and/or clarifies changes and subjects of concern with respect to service encounter submissions, assessment and other pertinent information.* *(1.0.6)*

# PREAMBLE *(1.1.0)*

The Preamble is the authority for the proper interpretation of the fee schedule. Fees will not be correctly interpreted without reference to the Preamble. This fee schedule is maintained through mutual agreement by the Department of Health and Wellness and Doctors Nova Scotia. *(1.1.1)*

Physicians may be paid by the Nova Scotia Department of Health and Wellness using various remuneration methods. The Medical Services Insurance (MSI) physician's manual details fee-for-service remuneration. Remuneration methods, other than fee-for-service, follow the conditions of the contracts or agreements as agreed to by the physicians, the Nova Scotia Department of Health and Wellness and Doctors Nova Scotia with respect to the specific arrangement. *(1.1.2)*

Each physician who participates in the care of a patient is entitled to fair and appropriate compensation for the services rendered to the patient. *(1.1.3)*

The fee schedule identifies the amounts prescribed as claimable for insured services rendered by physicians. Insured services mean all services that are medically necessary and are not specifically excluded by legislation or regulation. The listing of any service or procedure in the fee schedule does not ensure payment by MSI if the service is provided when it is not medically necessary. *(1.1.4)*

Unless otherwise indicated, fees listed are for professional services only. *(1.1.5)*

Professional services provided to a patient may be claimed by a physician only when they personally render the visit or procedure or when they supervise the procedure. *(1.1.6)*

If, however a family physician directly employs a nurse or nurse practitioner, the physician may claim for pap smears and simple injections such as immunizations done by the nurse, provided the physician is on the premises. This does not apply to other procedures, visits or counselling nor for services done by nurses who are employed by third parties such as the Nova Scotia Health Authority. *(1.1.61)*

When a patient lacks the capacity to make decisions, physicians may interact with the patient's substitute decision maker (SDM), as described through the Nova Scotia Personal Directives Act, to provide services to their patients. The patient must be present during the service encounter. This provision is not intended for family meetings. The SDM and the circumstances requiring the physician to provide care through the SDM must be documented in the patient's health record. *(1.1.62)*

All insured services include, where appropriate, any necessary discussion or advice to the patient or their substitute decision maker (SDM), completion of a medical record, prescribing of medication or therapy, requisitioning of diagnostic services, arranging referrals, including a letter of referral where required, and similar activities normally associated with providing insured services to patients. *(1.1.7)*

Where provision of a service generates charges for long distance telephone calls, unusual postal or other expenses, the physician may deem them to exceed the normal allowance made in the tariff and bill the patient directly, subject to the conditions for billing non-insured services. *(1.1.8)*

Physicians are required to submit service encounters for insured services provided to eligible patients in the format prescribed by MSI. Non-participating physicians are required by Regulation under the Health Services and Insurance Act to give reasonable notice of this fact to a patient or someone acting on their behalf, before providing a service. *(1.1.9)*

Service encounters submitted beyond 90 days from date of service shall not be payable and will be adjudicated to pay zero unless MSI is of the opinion the delay is justified. Resubmission of refused service encounters must be within 185 days of the date of service. The only exception to this policy will be through special consideration in exceptional extenuating circumstances. Note: WCB and facility-based service encounters follow the same ruling. (See Section 3 (3.2.7)) *(1.1.10)*

Claims for registered hospital inpatients must also be submitted within the 90-day time limitation whether or not the patient has been discharged or continues as an inpatient. *(1.1.11)*

In situations where the physician knows that the claims will not be submitted within the prescribed time period, loss of revenue can potentially be avoided by contacting MSI to request an extension. *(1.1.12)*

For unregistered babies, the service encounters should be held for a minimum period of one week to allow sufficient time for the parent/guardian to register the baby. It is the responsibility of the parent/guardian to contact MSI. For deceased or adopted babies, a generic health card number will be provided to enable the submission of a claim. Please contact the MSI Assessment Department to obtain the generic health card number. *(1.1.13)*

Service encounters for services to patients from other provinces that are covered under the reciprocal billing agreement must be submitted within one year of date of service. (See Section 2 Interprovincial Reciprocal Billing Agreement (2.4.2) for further details on reciprocal billing). *(1.1.14)*

## PRINCIPLES OF ETHICAL BILLING *(1.1.15)*

A physician who provides professional services to a patient is entitled to compensation commensurate with the services provided to the patient. These services are designated as either insured or non-insured. Insured services are those listed in the MSI Physician's Manual. *(1.1.16)*

Ethical principles of billing for non-insured services can be obtained by contacting Doctors Nova Scotia. *(1.1.17)*

The following principles apply to service encounters for insured services: *(1.1.18)*

- All insured services claimed must reflect services rendered personally by the physician in an appropriate clinical setting. Certain delegated medical acts done under supervision of the physician present on the premises may also be claimed. *(1.1.19)*
- A physician will not claim for services rendered to members of their family. *(1.1.20)*
- It is not appropriate for two physicians to claim the same service for the same patient on the same day.
- As part of the provision of an insured service, patients may be charged directly for the provision of consumable items not covered by MSI, completing forms, photocopying, long distance telephone, and similar charges. These charges must be explained and agreed to by the patient before the insured service is provided. (See Section 2 (2.2.36)) *(1.1.21)*

Billing for insured and non-insured services at the same visit: *(1.1.22)*

- A physician must exercise caution whenever billing MSI and the patient or a third party during the same visit. In principle, under no circumstances should any service, or any component of a service, be claimed for twice. *(1.1.23)*
- Whenever possible, the attending physician must acquaint the patient, or person responsible for the patient, with the financial obligation involved in the patient's care. *(1.1.24)*
- If the insured service is the primary reason for the visit, any additional charges for non-insured services must be explained to, and accepted by, the patient before provision of these services. Charges for non-insured services will reflect only those services over and above those provided on an insured basis. It is not appropriate to bill both MSI and Workers' Compensation Board (WCB) for the same service. *(1.1.25)*
- At no time should provision of insured services be contingent upon the patient agreeing to accept additional non-insured services. *(1.1.26)*
- When physicians are providing non-insured services, they are required to advise the patient of insured alternatives, if any exist. *(1.1.27)*
- Incidental findings:

1. If an inconsequential health matter or finding is discovered or discussed during the provision of a non-insured service, it is not appropriate to claim for an insured service.
2. If a significant health matter or finding becomes evident, necessitating additional insured examinations or treatments, then these subsequent medically necessary services may be claimed to MSI. *(1.1.28)*

- When a non-insured service is the primary reason for the visit, any service encounter for insured services provided as a medical necessity will reflect only services over and above those provided on a non-insured basis. *(1.1.29)*

## PHYSICIAN RECORD REQUIREMENTS TO SUPPORT CLAIMS *(1.1.30)*

This section is to further assist the service provider and billing staff in submitting service encounters to MSI. *(1.1.31)*

Use the W5 approach – what, when, where, why and who. Translate this information into codes that the system can process. Some fields are mandatory which means the service encounter will not be processed if they are not completed. Please take care to ensure that all required fields are completed and that the information is accurate. This will reduce the number of adjustments or refusals that occur and the follow up that you will have to do.

**WHAT** The service that was done, coded by health service code from the Physician's Manual Schedule of Benefits, and what role the service provider performed.

**WHEN** The time of day that the service occurred, translated into services unscheduled, subdivisions of the day, or time modifiers.

**WHERE** The facility number, functional centre and location code for service provided.

**WHY** The diagnostic codes and injury diagnostic code if applicable.

**WHO** The health care number (HCN) and date of birth (DOB) of the service recipient and the service provider number. *(1.1.32)*

An appropriate medical record must be maintained for all insured services claimed. The minimum record must contain, for MSI purposes, the following:

a) Patient's name
b) Patient's Nova Scotia health card number
c) Date of the service for which the claim is being made
d) Reason for the visit/presenting complaints
e) Any clinical findings appropriate to the presenting complaints and reflective of the service codes claimed
f) Working diagnosis
g) Treatment prescribed
h) Time and duration of visit in the case of time-based fees
i) Name of referring provider, where appropriate
j) Name of consultant and rationale of referral, where appropriate, and whether referred for diagnosis or treatment and
k) A consultant will send a report to the referring provider where appropriate and retain same on file. *(1.1.33)*

Procedural codes are listed by anatomical region in each appropriate section of the Physician's Manual. The numeric index contains the health service code and the page on which it can be found. All health service codes for visits are found in each specialty section in the Physician's Manual. *(1.1.34)*

Where a procedural code is claimed, the patient record of that procedure must contain information that is sufficient to verify the type and extent of the procedure according to the fees claimed. *(1.1.35)*

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed and be billed in accordance with the Preamble. If the record does not substantiate the claim for the service, then the service is not paid for or a lesser benefit is given. *(1.1.36)*

Where a differential fee is claimed based upon time, location, etc., the information on the patient record must substantiate the claim. *(1.1.37)*

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service. *(1.1.38)*

Documentation of services that are being claimed to MSI must be completed before claims for those services are submitted to MSI. *(1.1.39)*

For MSI purposes, it is required that physicians maintain records supporting services claimed to MSI for a period of five years in order to substantiate claims submitted. For medicolegal purposes adult patients' records should be retained for a minimum of 10 years from the date of the last entry in the record. For patients who are children, physicians should keep the record until 10 years after the day on which the patient reached or would have reached the age of 19 years, the age of majority in Nova Scotia. When implementing business practices at the time of entering into a group practice or locum tenens, or when winding down a practice, physicians should confirm that their records will be easily retrievable if they are required to substantiate claims to MSI. *(1.1.40)*

All service items claimed to MSI are the sole responsibility of the physician rendering the service with respect to appropriate documentation and claim submission. *(1.1.41)*

## USING NOVA SCOTIA MEDICAL SERVICES INSURANCE SERVICES *(1.1.42)*

### INFORMATION *(1.1.43)*

MSI publishes the Physician's Manual of insured services for registered service providers. The Manual consists of three components: *(1.1.44)*

- Preamble: Contains policies, rules and assessment directives that apply to the submission of service encounters. *(1.1.45)*
- Health Service Codes List: Indicates health service codes, qualifiers, unit values, and any applicable modifiers and cross references. *(1.1.46)*
- Explanatory Codes: These codes explain why a service encounter has been refused, reduced in payment or otherwise changed. *(1.1.47)*

The Physician's Manual Preamble is essential to the service provider and billing staff to ensure the codes, modifiers and rules are accurate and appropriate for the services provided. *(1.1.48)*

### BULLETINS *(1.1.49)*

MSI Physician Bulletins are published periodically throughout the year and are available on the MSI website https://msi.medavie.bluecross.ca/physicians-bulletins/ to highlight subjects of concern and to provide clarification on special topics. The detailed billing guidelines associated with health service codes are detailed and updated in these bulletins. Tables are published yearly indicating the cut off and payment dates for submissions as well as recognized holidays for the year. Please ensure the Bulletins are provided to billing staff. As well, storing Bulletins along with the Physician's Manual allows for easy cross-reference. Physicians can subscribe to receive email notifications of new Physicians Bulletins being published on the MSI website at https://msi.medavie.bluecross.ca/subscription/. *(1.1.50)*

## DEPARTMENTS AND THEIR RESPONSIBILITIES *(1.1.51)*

There are a number of departments within MSI which provide information and materials required by service providers submitting service encounters. *(1.1.52)*

## SERVICES *(1.1.53)*

Please contact MSI for assistance with inquiries concerning any aspect of the billing process. MSI will make every attempt to reply to inquiries in a prompt and accurate manner. *(1.1.54)*

## CONTACTS *(1.1.55)*

Various kinds of assistance and information may be obtained by contacting the following numbers: *(1.1.56)*

Registration and Enquiry can help with information pertaining to:

- Patient eligibility
- Health card number identification
- Birthdates

Telephone: 902-496-7008
Toll Free: 1-800-563-8880
Fax: 902-481-3160
Email: msi@medavie.ca *(1.1.57)*

MSI Assessment Department can help with:

- Electronic billing, adjudication, or payment questions
- Service encounter submission policies and procedures
- Forms and reference material
- Bank deposit enquiries

Telephone: 902-496-7011
Toll Free: 1-866-553-0585
Fax: 902-490-2275
Email: MSI_Assessment@medavie.bluecross.ca *(1.1.58)*

Provider Coordinator Department can assist with enquiries regarding:

- Registration of new service providers
- Changes to provider address
- Change of bank or account information

Telephone: 902-496-7011
Toll Free: 1-866-553-0585
Fax: 902-496-4674 or 1-877-910-4674
Email: MSIProviders@medavie.ca *(1.1.59)*

The phone lines are staffed from 8:00 to 5:00 – Mondays through Fridays, except for the Government's Statutory Holidays.

Mailing Address:
Nova Scotia Medical Services Insurance
PO Box 500
Halifax NS B3J 2S1

Physical Address:
Nova Scotia Medical Services Insurance
230 Brownlow Avenue
Park Place V
Dartmouth NS B3B 0G5 *(1.1.60)*

# SECTION 2: SERVICES INSURED, NOT INSURED, OUT OF PROVINCE AND THIRD PARTY *(2.0.0)*

*Nova Scotia Medical Services Insurance Plan is administered and operated in accordance with the Nova Scotia Health Services and Insurance Act on a not-for-profit basis to provide benefits for health services to all eligible residents of Nova Scotia. MSI is responsible for maintaining health care insurance information such as registration of residents, processing service encounters and maintaining payments to service providers. Medavie Blue Cross administers the MSI programs on behalf of the Department of Health and Wellness. (2.0.1)*

*The Medical Reciprocal Program is an agreement by which a Nova Scotia service provider obtains payment for medically necessary services provided to eligible residents of other Canadian provinces and territories, excluding Quebec. (2.0.2)*

*Medically necessary services may be defined as those services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction, as well as those services generally accepted as promoting health through prevention of disease or dysfunction. (2.0.3)*

*The provision of a service listed in the schedule of benefits does not ensure payment by MSI. Services provided in circumstances where they were not medically necessary are not insured. For the purpose of this Preamble, medical services that are explicitly deemed to be non-insured under the Health Services and Insurance Act or its Regulations remain uninsured regardless of individual judgments regarding their medical necessity. (2.0.4)*

***Key Terms Relevant to This Section (2.0.5)***

- *Health Card Number (HCN): A lifetime identification number used to identify all Nova Scotia residents who are registered with MSI. (2.0.6)*
- *Resident of Nova Scotia: A person lawfully entitled to be or remain in Canada, and who makes their home and is ordinarily present in Nova Scotia. A resident does not include a tourist, a transient or a visitor to Nova Scotia. (2.0.7)*
- *Service Provider: An individual who provides a health service for which a service encounter is submitted to MSI. (2.0.8)*
- *Third Party: A person or organization other than the patient, their substitute decision maker (SDM), or MSI that is requesting and/or assuming financial responsibility for a medical or medically related service. (2.0.9)*
- *Travel: Movement from one geographic location to another. Interpretations specific for travel to certain locations: (2.0.10)*
    - *Within an apartment building, movement from one unit to another is considered travel. (2.0.11)*
    - *Movement within a hospital, even between separate buildings on one contiguous site, is not considered travel. If a hospital has several geographically separate sites, movement between sites is considered travel. (2.0.12)*
    - *Movement between rooms or units of a licensed nursing home or special care institution is not considered travel. (2.0.13)*
    - *If a physician maintains a medical office within or adjoining their place of residence, entering the office for the purpose of rendering emergency treatment is considered travel during certain time periods. (2.0.14)*
    - *If a physician has arranged to have an office in a hospital or in an attached building, going from the office to the hospital to attend a patient is not considered travel. (2.0.15)*

# SERVICES INSURED BY MSI *(2.1.0)*

Services insured by MSI include: *(2.1.1)*

- Physician's services rendered to persons registered with MSI in a recognized clinical setting, e.g. the patient's home, the doctor's office, at a hospital, clinic or institution, or scene of an emergency. This includes all diagnostic, medical, psychiatric, surgical, or therapeutic procedures, including the services of anaesthetists and assistants as per the definition of medical necessity (See Section 6 (6.0.52)). Some services may require prior approval (See Appendix C Service Encounters Requiring Prior Approval/Preauthorization (7.3.0)). *(2.1.2)*

Services that are insured, but with restrictions: *(2.1.5)*

- Coverage for routine refractive vision analysis is limited to once every 24 months for persons under 10 years of age and for those 65 years of age and over. For all others, routine refractive vision analysis is an uninsured service. *(2.1.6)*
- Age specific preventive services where indicated as determined by current guidelines for well baby care, vaccinations, inoculations, etc. This would include examinations offered to individuals who have a family history, symptoms or signs or other diseases that put them at risk for preventable target conditions. *(2.1.7)*
- Group sessional clinics, e.g., immunization or "well person", when preapproved by MSI. (See Section 6 (6.0.86)) *(2.1.8)*
- Complete history and physical examinations, but only when medically necessary to establish a diagnosis. (See Services Not Insured by MSI) *(2.1.9)*
- The services of an anaesthetist when required in conjunction with specified dental surgical procedures listed in the Insured Dental Service Tariff Regulations of the Health Services and Insurance Act and only when medical necessity requires these services to be performed in a hospital. *(2.1.10)*
- Dental services as described in the Children's Oral Health Program and Dental Surgical Program. *(2.1.12)*
- Services provided virtually via telephone, telehealth network, or PHIA compliant network when in compliance with the Provision of Publicly Funded Virtual Health Services Policy. *(2.1.13)*

When complications occur following a non-insured procedure, treatment that is medically necessary is an insured service. *(2.1.11)*

# SERVICES NOT INSURED BY MSI *(2.2.0)*

The following services are not insured by MSI. The physician must determine who has responsibility for payment, if any. *(2.2.1)*

- Services available to residents of Nova Scotia under the Workers' Compensation Act, through the Department of Veterans Affairs, Canadian Forces, the Hospital Insurance Act, any Act of the Parliament of Canada or under any statute or law of any other jurisdiction either within or without Canada. *(2.2.2)*
- Outside of the telephone prescription renewal TPR1, when a prescription or a requisition for a diagnostic or therapeutic service is provided to a patient without a clinical evaluation of the patient, the requirements of an insured visit service have not been met and no service encounter should be submitted. *(2.2.3)*
- Diagnostic, preventive or other physician's services available through the Nova Scotia Hospital Insurance Program, the Department of Health and Wellness, or other government agencies. *(2.2.4)*
- Physician's services provided to their own families *(2.2.6)*
- Services which, in the opinion of the Department of Health and Wellness, have been performed for cosmetic purposes only: *(2.2.7)*
    - Cosmetic surgery is defined as a service done solely for the purpose of altering the appearance of the patient and not medically necessary. *(2.2.8)*
    - When there is doubt as to whether the proposed surgery is medically required or cosmetic, the operating surgeon should obtain prior approval from MSI. Anaesthetic and other fees associated with non-insured services are non-insured as well. MSI will pay for a visit or consultation to determine if a treatment method is insured, even though the proposed procedure is non-insured. If the proposed procedure or treatment is always uninsured, a visit or consultation may not be claimed. *(2.2.9)*
- Group immunizations performed without receiving preapproval by MSI. *(2.2.10)*
- Acupuncture *(2.2.11)*
- Electrolysis *(2.2.12)*
- Reversal of sterilization *(2.2.13)*
- In vitro fertilization *(2.2.14)*
- Provision of travel vaccines *(2.2.15)*
- Newborn circumcision *(2.2.16)*
- Release of tongue tie in newborn *(2.2.17)*
- Removal of cerumen, except in the case of a febrile child *(2.2.18)*
- Treatment of warts or other benign conditions of the skin by excision, cryotherapy, electrocautery, curettage or any other means with the exception of the following:
    - Plantar warts or molluscum contagiosum.
    - Treatment of a malignant or recognized premalignant condition (includes clinical suspicion of malignancy)
    - Excision of a sebaceous cyst when infected or otherwise medically necessary
    - Excision of a lipoma when large and/or causing interference with function
    - Excision of a subcutaneous neuroma when large and/or causing interference with function
    - Other specific conditions as outlined in the Schedule of Benefits *(2.2.19)*

Comprehensive visits when there are no signs, symptoms or family history of disease or disability that would make such an examination medically necessary. This excludes those examinations performed in accordance with guidelines (See Section 2 (2.1.7)) relating to preventive health exams. *(2.2.20)*

Services provided by other health care workers, with certain exceptions, are not insured under MSI. This would include services of pharmacists, chiropractors, podiatrists, physiotherapists, naturopaths, osteopaths, psychologists, nurses, nurse practitioners or other paramedical personnel: *(2.2.21)*

- Dental services, except those which are described as benefits under the MSI Dental Program. Information can be obtained by contacting Green Shield Canada 1-833-739-4035. *(2.2.22)*
- Ancillary services, such as charges for an ambulance, etc. *(2.2.23)*
- Optometric services, except those that are described as benefits under the MSI Optometric Program. Information can be obtained by contacting the MSI office. *(2.2.24)*

The following are excluded from the definition of insured psychotherapy and therefore not insured: movement therapy, energy therapy, and other types of alternative or integrative treatments.

Costs of medical services that are primarily related to research or experimentation are not the responsibility of the patient or MSI. *(2.2.25)*

### Meet and Greet *(2.2.54)*

Outside of the new patient intake visit NPIV1, all services billed to MSI must be medically necessary. There must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" visit with a new patient unless a health-related concern/complaint has been addressed at the visit. Similarly, it is not appropriate to bill a comprehensive visit or counselling for such encounters unless the visit is medically necessary and Preamble requirements for the codes have been satisfied. *(2.2.55)*

### Services at the Request of Third Parties *(2.2.26)*

Health examinations or provision of health information required in connection with employment, insurance, admission, legal proceedings, etc., or any similar request by a third party are not insured. Responsibility for payment may lie either with the patient or the third party requesting the examination or information. This excludes third party as defined in Section 18 of the Health Services and Insurance Act. *(2.2.27)*

The following are examples only and do not represent a complete list: *(2.2.28)*

- Insurance company examinations and requests for medical information. *(2.2.29)*
- Examinations requested by educational institutions, youth groups, summer camps. *(2.2.30)*
- Employer requested examinations and sick certificates. *(2.2.31)*
- Examinations required to support legal claim. *(2.2.32)*
- Services required by a legal proceeding including preparation of records, reports, letters or certificates, or appearance and/or testimony in a court or other tribunal. *(2.2.33)*
- Department of Immigration passport or visa. *(2.2.34)*
- Any diagnostic services associated with the above. *(2.2.35)*

### Services, Supplies and Other Materials Not Part of Office Overhead *(2.2.36)*

Services, supplies and other materials provided through the physician's office when such supplies are not normally considered part of office overhead: *(2.2.37)*

- Photocopying or other costs associated with transfer of records. See clause 14 and 15 under the Personal Health Information Act regarding accessing Personal Health Information Records. *(2.2.38)*
- Long distance telephone charges incurred specifically on the patient's behalf. *(2.2.39)*
- Items such as drugs, injectable materials, biological sera, dressings, strapping, tray fees, etc. used in rendering medical care, except for Pap smear tray fees and provincial immunization tray fees. *(2.2.40)*
- Medical or health devices e.g., eyeglasses, contact lenses, hearing aids, surgical appliances, trusses, wheelchairs, crutches and prosthetic appliances. *(2.2.41)*

- Physician's advice by letter, fax or e-mail is an uninsured service. However, telephone, fax or e-mail advice for home dialysis, home care, anticoagulant supervision and palliative care are insured services under certain circumstances. Telephone services are insured when in compliance with the Provision of Publicly Funded Virtual Health Services Policy. *(2.2.42)*
- Mileage or travelling time except as defined in (See Section 5 (5.1.48)) relating to detention time or blended mileage/travel detention for home visits *(2.2.43)*
- For patients registered in home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia. *(2.2.56)*
- Mileage for home visits will be reimbursed only when a visit has been requested by the patient or patient's representative and the patient is considered homebound. The mileage/travel detention fee is a blended rate based on kilometres travelled for the round trip. Text for the claim must include: The start and finish time of the visit, point of origin, destination address, and the distance in kilometers. The distance in kilometres should be entered in the multiple field of the service encounter. A record should be kept in your office of the starting and destination points. *(2.2.44)*

### Blood Alcohol Sampling Impaired Drivers *(2.2.45)*

Claims for blood alcohol sampling on impaired drivers will be processed by Medavie Blue Cross, Accounting Department and then reimbursed by the Department of Justice. The total fee should include:

a) Venipuncture, if performed by the physician at the rate listed in the schedule of benefits.
b) Kilometres to be paid at the current government rate (can be obtained from the Department of Health and Wellness or any other provincial department).
c) If travel is involved, the rate will be based on the fee for detention as listed in the Schedule of Benefits.
d) If appropriate documents are completed a fee of 45 units may be claimed.
e) If insured services are provided to the impaired driver, the physician should claim under the appropriate MSI health service code in the usual manner. If insured medical services are not provided to the impaired driver, the appropriate visit fee may be added to the above and billed the Department of Justice. It is not appropriate to bill both MSI and the Department of Justice for the same service. *(2.2.46)*

Please forward service encounters for the above on the physician's letterhead to:

MSI Accounting Department
PO Box 500
Halifax, NS B3J 2S1 *(2.2.47)*

### Sexual Assault Examination *(2.2.48)*

This is an assessment of a patient in which the physician follows the protocol prescribed by the Department of Justice for the investigation of alleged sexual assault. *(2.2.49)*

The forensic examination portion of the treatment of a sexual assault victim is not insured under MSI, but payment is included in the Health Services Code 03.03G Examination of a victim of an alleged sexual assault and evidence collection. MSI will recover this portion of the fee from the Department of Justice. *(2.2.50)*

HSC 03.03G: This fee includes all aspects of the medical history, the medical, psychological and forensic examination, including collection of evidence according to the protocol prescribed by the Department of Justice for the investigation of an alleged sexual assault and the initial medical treatment of the victim by the physician. Not to be billed with any other fees during the same time period. To be eligible for this fee, the evidence must be collected and the documentation submitted according to the Department of Justice protocol. *(2.2.51)*

**Physician Testimony – Sexual Assault Prosecution** ***(2.2.52)***

In the event that a charge of sexual assault is laid and a prosecution results, a physician may be subpoenaed by the Crown to testify in court. All costs associated with preparation for that court appearance and testifying in court should be submitted in an invoice to the Nova Scotia Public Prosecution Service by the physician. *(2.2.53)*

# REGISTRATION AND CONDITIONS OF PARTICIPATION FOR NOVA SCOTIA RESIDENTS *(2.3.0)*

## INTRODUCTION *(2.3.1)*

Service providers can claim payment from MSI for insured services provided to eligible Nova Scotia residents. The registration covers insured services and hospitalization benefits. Permanent residents of Nova Scotia are required to register with MSI. *(2.3.2)*

## DEFINITION OF A RESIDENT *(2.3.3)*

A resident of Nova Scotia is a person who is:

- lawfully entitled to be in Canada
- makes their home in Nova Scotia
- ordinarily physically present at least 183 days in a calendar year in Nova Scotia
- not a visitor, tourist or transient.

The following section is provided to help determine if and when a patient may be eligible. *(2.3.4)*

## ELIGIBILITY GENERAL RULES *(2.3.5)*

### CANADIAN CITIZENS AND PERMANENT RESIDENTS *(2.3.6)*

a) A Canadian citizen or permanent resident moving to Nova Scotia from elsewhere in Canada with the intent of establishing permanent residence in the province is entitled to receive benefits under MSI commencing on the first day of the third month immediately following the month in which they become residents of Nova Scotia, e.g., arrived January 17th, eligibility date will be April 1st.

b) A Canadian or permanent resident moving to Nova Scotia from outside Canada, who is lawfully entitled to remain in Canada, with the intent of establishing permanent residence in the province, is entitled to receive benefits under MSI commencing on the day they become a resident of Nova Scotia.

c) Proof of Canadian citizenship or permanent residency is required. *(2.3.7)*

### STUDENTS FROM OTHER PROVINCES *(2.3.8)*

Students from other Canadian provinces are normally not eligible for MSI. They are insured by their home province. *(2.3.9)*

### STUDENTS FROM OTHER COUNTRIES *(2.3.10)*

a) Coverage is effective the first day of the thirteenth month after the student's arrival in Nova Scotia; providing the student is in possession of a valid study permit and has not been absent from Nova Scotia for more than 31 consecutive days during that period or any subsequent year, except in the course of their studies.

b) Such coverage valid only for health services received in Nova Scotia.

c) Dependents of students to be granted coverage on the same basis once the student has gained entitlement.

d) Coverage is effective until the expiry date on the study permit or health card. To maintain coverage, the student must not be absent from Nova Scotia for more than 31 consecutive days, except in the course of study, and a declaration must be presented to MSI each year.

e) Once coverage has terminated, the student is treated as never having qualified for health services and must comply with paragraph (a) above before coverage will be extended. *(2.3.11)*

## WORKERS FROM OTHER COUNTRIES *(2.3.12)*

a) Workers may register for MSI on the date of arrival in Nova Scotia; provided they are in possession of a valid work permit for at least a 12-month period.
b) Dependents of workers to be granted coverage on the same basis once the worker has gained entitlement.
c) Coverage effective until the expiry date on the work permit or health card. To maintain coverage, the worker must not be absent from Nova Scotia for more than 31 consecutive days, except in the course of employment, and a renewal and declaration must be presented to MSI each year.
d) Once coverage has terminated, the worker is treated as never having qualified for health services and must comply with paragraph (a) above before coverage will be extended. *(2.3.13)*

## PERSONS WITH OTHER IMMIGRATION DOCUMENTS *(2.3.14)*

Persons in possession of other immigration documents may or may not be eligible for MSI benefits. They should be encouraged to contact the MSI office for clarification of their status. *(2.3.15)*

## TRANSIENTS, TOURISTS, OR VISITORS TO NOVA SCOTIA *(2.3.16)*

Transients, tourists, or visitors to Nova Scotia are not eligible to receive benefits under MSI. *(2.3.17)*

## TEMPORARY ABSENCE FROM NOVA SCOTIA *(2.3.18)*

Residents of Nova Scotia who leave the province on a temporary basis with the intention of returning may be eligible to receive benefits under MSI for insured services. The period and extent of MSI coverage will vary according to the circumstances surrounding the resident's temporary absence. *(2.3.19)*

## PERMANENT DEPARTURE FROM NOVA SCOTIA *(2.3.20)*

a) Residents leaving the province to establish residence elsewhere in Canada will be covered under MSI up to and including the last day of the second month following the month in which they establish residence in their new province, e.g., persons establishing residency on June 21st, their eligibility will cease August 31st.
b) If the resident is moving outside Canada, coverage will cease from the date of departure from Canada. *(2.3.21)*

## OTHER *(2.3.22)*

Eligibility situations not outlined in the previous sections should be clarified by contacting MSI at 902-496-7008 or toll free 1-800-563-8880. *(2.3.23)*

## REGISTRATION *(2.3.24)*

In order to register for MSI, the new resident(s) must complete an Application for Health Services which can be obtained by calling or visiting the MSI office. It should be noted that although an individual or family may have registered with MSI, they will not become eligible for benefits until they have satisfied the residency requirements. Upon the successful completion of an Application for Health Services, every eligible Nova Scotia resident will receive a health card reflecting their unique 10-digit lifetime health number. The health number is required for claims to be prepared. The health card shows the resident's name, date of birth, gender if applicable, date of eligibility for MSI, card expiry date and organ donor status. *(2.3.25)*

## REPORTING CHANGES *(2.3.26)*

It is important that residents keep MSI informed of any changes in their registration information. Any changes e.g., birth, adoption, death, marriage, legal separation, change of address, or departure from the province should be reported to the MSI office without delay. *(2.3.27)*

## ORGAN DONATION *(2.3.28)*

The Human Organ and Tissue Donation Act became effective January 2021. Eligible Nova Scotia residents who do not have a donation decision recorded in the province's health card registry are considered donors after death. Eligible Nova Scotia residents can register their decision to be a donor or opt out by contacting MSI, or residents can also opt out at www.novascotia.ca/organtissuedonation. Their decision will be kept on their registration file and the word donor will be embossed on their health card with a one-digit code. The codes are: (1) indicates they wish to donate all organs and tissues and (2) indicates only specific organs or tissues are to be donated, alternatively 'opt out' will be embossed on the health card should the resident choose to opt out. The signed health card with donor designation is a legal document. *(2.3.29)*

## EXPIRY DATES *(2.3.30)*

Nova Scotia health cards have an expiry date which provides for regular contact with our residents to maintain accurate files. The expiry date is a four-year term determined by birthdate, e.g., birthdate June 15, 2020, health card expiry date would be May 31, 2024. The expiry date is in relation to the duration of the card and not necessarily to the eligibility status of the individual. Renewal notices will be mailed to the address on the registration file three months prior to the expiry date. *(2.3.31)*

## LOST OR STOLEN HEALTH CARDS *(2.3.32)*

If a resident indicates that their health card has been lost or stolen, please advise them to contact the MSI office immediately. There is a fee to replace a lost or stolen card. *(2.3.33)*

## NEW PATIENTS *(2.3.34)*

Please take special care to review the patient's personal health card the first-time treatment is provided. Additional identification must be requested to ensure the patient's identity. *(2.3.35)*

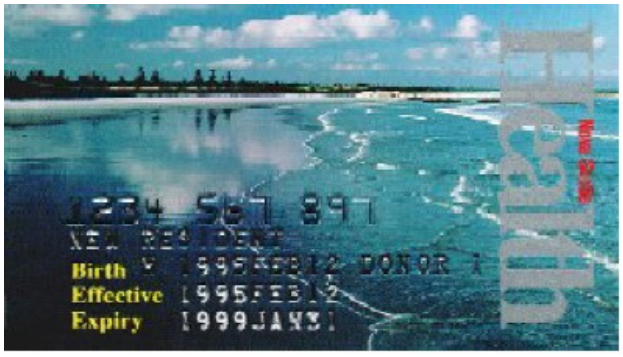
## CLAIM REFUSAL *(2.3.36)*

In some situations, a service provider's claims may be refused; the existence of a health card is not a guarantee of coverage. It is the service provider's responsibility to try and contact the patient. However, if unsuccessful, please contact the MSI Registration Department for assistance.

Telephone: 902-496-7008

Toll Free: 1-800-563-8880

**Sample of Nova Scotia Health Card** *(2.3.37)*




*(2.3.38)*

# SERVICE ENCOUNTERS FOR PATIENTS FROM OUT OF PROVINCE *(2.4.0)*

## INTERPROVINCIAL RECIPROCAL BILLING AGREEMENT *(2.4.1)*

Service providers may be required to render medical services to patients from other provinces within Canada who are visiting or travelling within Nova Scotia. Effective April 1, 1988, all provinces and territories, except Quebec, agreed to participate in a reciprocal billing agreement under which a service provider would submit service encounters directly to their own provincial medical plan for eligible Canadian patients. *(2.4.2)*

### CRITERIA *(2.4.3)*

For a service encounter to be processed through the reciprocal billing agreement, it must meet all of the following conditions:

- The service must be medically necessary and must be provided by a registered service provider.
- The service must be provided to eligible residents from a Canadian province or territory, except for Quebec. Please contact the MSI Assessment Department at 902-496-7011 or toll free 1-866-533-0585, if out of province claim forms are required.
- The benefit must be claimed according to the Nova Scotia Medical Services Physician's Manual schedule of benefits. *(2.4.4)*

All provinces have their own established fee schedule, regulations and assessment rules for insured services provided to eligible residents. The medical plans, in turn, arrange periodic reimbursement between one another for the medical service encounters paid on behalf of eligible patients from other provinces/territories. *(2.4.5)*

Overall, the reciprocal program enhances the universality of Canada's Medicare program. The system allows for smoother, faster, and less costly processing and payment of service encounters for eligible out of province patients. This benefits physicians, patients, and medical plans. *(2.4.6)*

### ELIGIBILITY REQUIREMENTS *(2.4.7)*

To be eligible to submit service encounters through the reciprocal billing agreement the following conditions must be met:

- The patient must be insured through the medical plan in their own province of residence.
- The patient must show a valid health insurance card from their home province as evidence of eligibility.
- To verify that a card is valid, please check that it indeed applies to the patient in question; also check for an effective date of coverage and/or an expiry date. Make sure that either the effective date of coverage or the expiry date or both are current for the dates of services you are providing.
- If the patient cannot present a valid card, the service provider cannot submit a service encounter to MSI under the medical reciprocal program. *(2.4.8)*

Note: Health insurance cards differ from one provincial medical plan to another and in some cases quite substantially. To help identify valid out of province cards, full descriptions of each card, including an illustration, plus pointers on what to look for are included in Appendix A Interprovincial Health Cards (7.1.0). *(2.4.9)*

### CHECKING FOR EXCLUDED SERVICES *(2.4.10)*

The intent of the reciprocal billing agreement is to provide universal medical service coverage for out of province patients. However, because each province has slightly different coverage, or has special rules for certain services, not all services are covered by the reciprocal billing agreement. *(2.4.11)*

### Identified Excluded Services *(2.4.12)*

The following services are excluded from Canada's reciprocal billing agreement for processing out of province medical service encounters:

1. Surgery for alteration of appearance (cosmetic surgery)
2. Gender affirming surgery
3. Breast augmentation surgery for transgender women
4. Surgery for reversal of sterilization
5. Routine periodic health examinations, including routine eye examinations
6. In vitro fertilization, artificial insemination
7. Lithotripsy for gallbladder stones
8. Treatment of port wine stains on other than the face or neck, regardless of the modality of treatment
9. Acupuncture, acupressure, transcutaneous electronerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
10. Services to persons covered by other agencies; Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, and Correctional Services of Canada federal penitentiaries
11. Services requested by a third party
12. Team conferences
13. Genetic screening and other genetic investigation, including DNA probes
14. Procedures still in the experimental or developmental phase
15. Anaesthetic services and surgical assistant services associated with all of the foregoing *(2.4.13)*

It should be noted that some services, even though excluded from the reciprocal billing agreement, might still be covered by individual provincial medical plans. In this situation, it is suggested that an out of province claim is completed. *(2.4.14)*

## SPECIAL RECIPROCAL BILLING SITUATIONS *(2.4.15)*

There are several situations relating to payment for medical services provided which require special attention. They include service encounters for newborns, Workers' Compensation Board patients and some referred patients. *(2.4.16)*

### NEWBORNS *(2.4.17)*

When claiming for services rendered to children from other provinces that are not yet registered in their home province, use the mother's health insurance number and the child's name and the child's birth date. *(2.4.18)*

### WCB EXCLUSION *(2.4.19)*

Workers' Compensation Board service encounters are excluded from medical reciprocal processing. Please submit Workers' Compensation Board service encounter for an out of province patient to the Workers' Compensation Board of whichever province is responsible. Check with the patient to determine which province is responsible for the WCB claim. *(2.4.20)*

## SUBMITTING RECIPROCAL SERVICE ENCOUNTERS FOR PAYMENT *(2.4.21)*

There are two methods available to obtain payment for services: *(2.4.22)*

1) To obtain payment through the reciprocal billing agreement:

   Submit service encounters for eligible patients the same as claims for eligible Nova Scotia patients. For the payment responsibility, indicate the applicable province code and include a person data record (See

Section 3 (3.2.141)). Payments for these service encounters are based on the Nova Scotia Medical Services (MSI) Physician's Manual, the master service unit (MSU) and governing rules. *(2.4.23)*

2) The alternate method for submitting service encounters for patients not eligible for reciprocal billing is the out of province claim form developed specifically for this purpose. The procedure is as follows:

   When completed, the service encounter is sent to the provincial health care plan with which the patient has coverage. The service provider may mail the service encounter, or the patient may be asked to forward it, particularly if payment is to be made to the patient.

Note: Submit out of province service encounters promptly. The time limit for submission in most provinces is one year from the date of service. *(2.4.24)*

# INFORMATION CONCERNING VARIOUS SERVICE ENCOUNTER SITUATIONS *(2.5.0)*

## WCB SERVICE ENCOUNTERS FOR NOVA SCOTIA RESIDENTS *(2.5.1)*

WCB service encounters are processed through the electronic system at Medavie using the same technology as for the submission of MSI related service encounters. Physicians must submit their service encounters through this system for Nova Scotia residents 16 years of age and over who meet the eligibility requirements of WCB. Medical and surgical appliances as well as other services will continue to be the responsibility of the Workers' Compensation Board. Section 3 (3.2.115) details the payment responsibility field to enter for a WCB service encounter. When submitting a claim with a payment responsibility of WCB, the patient's WCB claim number, and/or the patient's injury date (month and year) is required in the appropriate fields. *(2.5.2)*

### Health Service Codes to be Used When Claiming for WCB Services *(2.5.3)*

| | | | |
|---|---|---|---|
| DEFT | WCB2 | WCB Office Visit Examination for Pneumoconiosis | 20.5 units |
| DEFT | WCB12 | EPS physician assessment Service.<br>Combined office visit and completion of Form 8/10 | |
| | | RO=EPS1 RP=INTL | $230.35+MU |
| | | RO=EPS1 RP=SUBS | $230.35 |
| DEFT | WCB13 | Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals | |
| | | - plus multiples, if applicable (SP=GENP) | $56.42 per 15 min |
| | | RO=EPS1 | $67.43 per 15 min |
| | | Specialists | $75.86 per 15 min |
| DEFT | WCB15 | Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed | |
| | | by the Treating Physician - plus multiples, if applicable (SP=GENP) | $56.42 per 15 min |
| | | RO=EPS1 | $67.43 per 15 min |
| | | Specialists | $75.86 per 15 min |
| DEFT | WCB17 | Photocopying of charts. Photocopying of chart notes | |
| | | 10 pages or less ME=UP10 | $33.80 |
| | | 11-25 pages ME=UP25 | $67.43 |
| | | 26-50 pages ME=UP50 | $134.65 |
| | | Over 50 pages ME=OV50 | $201.78 |
| DEFT | WCB20 | Carpal Tunnel Syndrome (CTS) Form Payment | |
| | | This form is only to be used upon request from the WCB case worker | $86.43 |
| DEFT | WCB21 | Follow-up visit report | $50.62 |
| DEFT | WCB22 | Completed Mandatory Generic Exemption Request Form | $16.99 per form |
| DEFT | WCB23 | Completed Non-Opioid Special Authorization Request Form | $16.99 per form |
| DEFT | WCB24 | Completed Opioid Special Authorization Request Form | $56.71 per form |
| DEFT | WCB25 | Completed WCB Substance Abuse Assessment Form | $37.86 |
| DEFT | WCB26 | Return to Work Report – Physician's Report Form 8/10 | $86.43 |

| | | | |
|---|---|---|---|
| DEFT | WCB27 | Eye Report | $75.86 |
| DEFT | WCB28 | Comprehensive Visit for Work Related Injury or Illness | $86.96 |
| DEFT | WCB29 | Initial Request Form for Medical Cannabis | $93.83 |
| DEFT | WCB30 | Extension Request Form for Medical Cannabis | $56.42 |
| DEFT | WCB31 | WCB Interim Fee- Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed | $86.99 |
| DEFT | WCB32 | WCB Safe Work Connectedness Report Specialists | $75.86 |

Note: All forms are forwarded directly to the Workers' Compensation Board whereas the service encounter is billed electronically to MSI. *(2.5.5)*

## WCB Service Encounters for Non-Residents *(2.5.6)*

A Workers' Compensation Board service encounter for a non-resident cannot be submitted electronically to MSI for payment. Service encounters for services provided to a non-resident temporarily working for a Nova Scotia company, as a result of an on-the-job injury, should be submitted directly to the Nova Scotia Workers' Compensation Board at the following address:

Workers' Compensation Board of Nova Scotia
5668 South Street
PO Box 1150
Halifax NS B3J 2Y2 *(2.5.7)*

Service encounters and appropriate WCB forms provided to a non-resident working for a non-Nova Scotia company must be sent directly to the Workers' Compensation Board of their home province. *(2.5.8)*

Below is the list of WCB locations for the Provinces and Territories: *(2.5.9)*

**WORKERS' COMPENSATION BOARD OF ALBERTA**
PO Box 2415
9912-107 Street
Edmonton AB T5J 2S5
Tel: 780-498-3999
Toll Fee Fax: 1-800-661-1993
Toll Free: 1-866-922-9221
http: www.wcb.ab.ca

**WORKSAFEBC**
WorkSafeBC
PO Box 5350
Vancouver, BC V6B 5L5
Tel: 604-273-2266
Fax: 604-276-3151
Toll Free: 1-888-967-5377
http: www.worksafebc.com

**WORKERS' COMPENSATION BOARD OF THE NORTHWEST TERRITORIES AND NUNAVUT**
PO Box 8888
Yellowknife NT X1A 2R3
Tel: 867-920-3888
Fax: 867-873-4596
Toll Free: 1-800-661-0792
http: www.wscc.nt.ca

**WORKERS' COMPENSATION BOARD OF NOVA SCOTIA**
5668 South Street
PO Box 1150
Halifax NS B3J 2Y2
Tel: 902-491-8999
Fax: 902-491-8002
Toll Free Mainland Nova Scotia 1-800-870-3331
Toll Free Sydney 1-800-880-0003
http: www.wcb.ns.ca

**WORKERS' COMPENSATION BOARD OF MANITOBA**
333 Broadway
Winnipeg MB R3C 4W3
Tel: 204-954-4321
Fax: 204-954-4968
Toll Free: 1-855-954-4321
http: www.wcb.mb.ca

**WorkSafeNB**
1 Portland Street
PO Box 160
Saint John NB E2L 3X9
Tel: 506-632-2200
Fax: 506-632-4999
Toll Free: 1-800-999-9775
http: www.worksafenb.ca

**WorkplaceNL**
146-148 Forest Road
PO Box 9000, Station B
St. John's NL A1A 3B8
Tel: 709-778-1000
Fax: 709-738-1714
Toll Free: 1-800-563-9000
http: https://workplacenl.ca/

**SASKATCHEWAN WORKERS' COMPENSATION BOARD**
200-1881 Scarth Street
Regina SK S4P 4L1
Tel: 306-787-4370
Fax: 306-787-0213
Toll Free: 1-800-667-7590
http: http://www.wcbsask.com/

**WORKPLACE SAFETY AND INSURANCE BOARD**
200 Front Street West
Toronto ON M5V 3J1
Tel: 416-344-1000
Fax: 416-344-3999
Toll Free: 1-800-387-0750
http: www.wsib.on.ca

**WORKERS COMPENSATION BOARD OF PRINCE EDWARD ISLAND**
14 Weymouth Street
Charlottetown PE C1A 4Y1
Tel: 902-368-5680
Fax: 902-368-5705
Toll Free: 1-800-237-5049
http: www.wcb.pe.ca

**COMMISSION DE LA SANTÉ ET DE LA SÉCURITÉ DU TRAVAIL DU QUEBEC** (Occupational Health and Safety Commission)
524, rue Bourdages Quebec (Quebec) G1M 1A1Tel Can and US: 1-844-838-0808
Outside Can and US: 514-906-3266
http: www.cnesst.gouv.qc.ca

**YUKON WORKERS' COMPENSATION HEALTH & SAFETY BOARD**
401 Strickland Street
Whitehorse YK Y1A 5N8
Tel: 867-667-5645
Fax: 867-393-6279
Toll Free: 1-800-661-0443
http: www.wcb.yk.ca *(2.5.10)*

## COMMUNITY SERVICES MEDICAL ASSESSMENT *(2.5.11)*

A medical assessment form completed for a patient on behalf of Community Services (COM) is to be forwarded to Community Services. The service encounter is submitted electronically to MSI. The appropriate health service code is C9999, Payment responsibility COM with a diagnostic code Z99, i.e., community services. The health service code (HSC) is claimed at 40 units, however; in this case the payment rate is remunerated at one dollar ($1.00) per unit for a total of $40.00. Any patient over 65 years of age does not qualify for this service. *(2.5.12)*

If the form is completed for a patient who is registered but not yet eligible under MSI, the physician can still submit to MSI in the above manner. However, if the individual has not registered and maintains an out of province health card number, the physician must submit directly to Community Services for payment. *(2.5.13)*

## COMMUNITY SERVICES – REQUEST FOR ESSENTIAL MEDICAL TREATMENT *(2.5.14)*

Effective October 1, 2013, the Employment Support and Income Assistance (ESIA) program will allow some medical treatments to be funded that currently are not covered. Examples of the health-related special needs services that may be considered, as a result of this change include massage therapy; chiropractic treatments; and acupuncture. As part of the eligibility criteria, the essential medical treatment must be prescribed by a physician, dentist or nurse practitioner and provided by a medical professional licensed or registered to practice in Nova Scotia. *(2.5.15)*

A form called "Request for Essential Medical Treatments" has been devised to cover applications for these special needs services only. This form must be completed and approved prior to treatment. *(2.5.16)*

Once completed for a patient on behalf of Community Services, the "Request for Essential Medical Treatment" form will be delivered to the assigned caseworker by the patient. The service encounter is submitted electronically to MSI. The appropriate health service code is C9999, Payment responsibility COM with a diagnostic code Z99 (i.e., community services). The HSC is claimed at 40 units, however; in this case the payment rate is remunerated at one dollar ($1.00) per unit for a total of $40.00. Any patient over 65 years of age does not qualify for this service. *(2.5.17)*

If this form is completed for a patient who is registered, but not yet eligible, under MSI the physician can still submit to MSI in the above manner. However, if the individual has not registered and maintains an out of province health card number, the physician must submit directly to Community Services for payment. *(2.5.18)*

# SECTION 3: SERVICE REPORTING AND CLAIMS SUBMISSION *(3.0.0)*

*A business arrangement is an agreement between a service provider and MSI covering the payment arrangements for health services provided. The business arrangement defines the service providers and the payee. All service providers registered with MSI must have or be part of a business arrangement in order to claim for services. Some service providers may have and/or be part of more than one business arrangement. It is the service provider's decision not to have basic health insured services submitted to MSI for direct payment. (3.0.1)*

*An accredited submitter is an organization or individual accredited by MSI to send service encounter transactions in an electronic format on behalf of service providers with the ability to retrieve results electronically from MSI. A list of approved service bureaus can be found on the MSI website. (3.0.2)*

*An accredited vendor is an organization or individual that has developed a software program that has been accredited by MSI to electronically submit service encounters. A list of approved vendors can be found on the MSI website. (3.0.3)*

*An electronic adjudication response results is sent to a submitter detailing the assessment results of each service encounter submission. It will be produced whenever service encounter submissions are processed. Service encounters that are reduced, refused or paid at zero will have an explanatory code attached.* (3.0.4)

***Key Terms Relevant to This Section** (3.0.5)*

*Claims Assessment: (3.0.6)*

- *Bottom Line Adjustments: Adjustments in payment made by MSI that reflect credits or debits resulting from extenuating circumstances e.g., audit recovery. (3.0.7)*
- *Explanatory Code: An explanation that indicates why a service encounter has been refused, reduced, paid at zero or changed in some other manner. (3.0.8)*
- *Paid at Zero: Term used to indicate that additional information may be required from the provider to aid in the assessment of the claim. (3.0.9)*
- *Statement of Account: A statement is based on the number of service encounters processed on a biweekly basis indicating the amount MSI has released for payment. The statement can be retrieved electronically from the MSI system. (3.0.10)*

*Clinical Vocabularies: (3.0.11)*

- *Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP): A catalogue of procedures that was produced by Statistics Canada to provide a national procedure classification standard. (3.0.12)*
- *Diagnostic Code: A three-to-five-digit international coding system which identifies the medical condition for which a service provider is billing services ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification). (3.0.13)*
- *Health Service Code (HSC): A code identifying services or procedures performed by a service provider to a service recipient. In most cases, these codes are CCP codes or CCP codes with a qualifier to further define the service. NOTE: Non-CCP health services codes are used to identify non-procedural services. Example: C9999. (3.0.14)*

*Physician Types: (3.0.15)*

- *General Practitioner: A physician who engages in the general practice of medicine or a physician who is not a specialist as defined by the Medical Act. (3.0.16)*
- *Locum Tenens: A service provider who replaces and provides services for another established service provider who is temporarily away from work. (3.0.17)*

- *Most Responsible Physician: The most responsible physician (MRP) is the attending physician who is primarily responsible for the day-to-day care of the patient in hospital. (3.0.18)*
- *Physician: A legally qualified medical practitioner whose name is entered in the register kept by the College of Physicians and Surgeons of Nova Scotia as being qualified and licensed to practice medicine. They must be in good standing and not under suspension pursuant to any of the provisions of the Medical Act. (3.0.19)*
- *Specialist/Specialty: A specialist is defined as one whose name appears in the specialist register of the College of Physicians and Surgeons of Nova Scotia. However, when the term specialty is used, it means any or all specialties, including general or family practice. For the purpose of this Preamble, the terms general and family practice are used interchangeably. (3.0.20)*

*Other Terms: (3.0.21)*

- *Accredited Service Bureau: An approval given by MSI to a service bureau to provide service encounter submissions for service providers. (3.0.22)*
- *Age: Where age is a factor in determining eligibility for payment, or modifies the service, the following age ranges are defined:*
  - *Premature – 2,500 grams or less at birth*
  - *Neonate/Newborn - the 10 days following delivery*
  - *Infant - up to and including 23 months*
  - *Child - up to and including 15 years of age*
  - *Adult - 16 years of age and over (3.0.23)*
- *Direct Deposit: A method by which a service provider's payments from MSI are transferred directly into their bank account. This is also referred to as electronic funds transfer. (3.0.24)*
- *Discipline: A specific branch or field of study in which a service provider has been licensed to participate, e.g., medicine, dentistry, optometry or pharmacy. (3.0.25)*
- *Facility: A physical location, e.g., hospital, institution or office, where health services are routinely performed. All facilities are formally recognized on the MSI Register. (3.0.26)*
- *Facility Number: A number which uniquely identifies a physical location where health services are routinely performed. (3.0.27)*
- *Locum Period: A period of time during which a locum tenens provides services in the absence of the established service provider. (3.0.28)*
- *Payment Responsibility: A mandatory field on a service encounter that identifies which organization is responsible for the payment of the service, i.e., MSI, WCB, Community Services (COM). There are also out of province codes that identify the provincial health care plan where the patient has medical coverage. (3.0.29)*
- *Service Encounter: A transaction which describes the health service performed by the provider to the service recipient. (3.0.30)*
- *Service Encounter Number: A number assigned to each service encounter, which distinguishes that service encounter from others. It is comprised of the submitter ID, year, sequence number and check digit. (3.0.31)*
- *Service Recipient: An individual who receives insured services by a registered Nova Scotia service provider. (3.0.32)*

# RECORDING SERVICE PROVIDER INFORMATION *(3.1.0)*

## BACKGROUND *(3.1.1)*

All service providers who wish to receive compensation from Medical Service Insurance (MSI) for insured medical services must be registered with MSI. *(3.1.2)*

## PROVIDER REGISTRY *(3.1.3)*

The provider coordinators maintain all records for registered service providers. Below are some of the services that are processed into the MSI system by the provider coordinator.

- Locum tenens
- Business arrangements
- New facility registration
- Specialties
- Address changes
- Updates from College of Physicians and Surgeons Nova Scotia *(3.1.4)*

Keeping registration details current is a very important matter for every service provider. Changes may have an effect on the payment of service encounters. Please notify MSI immediately of changes. *(3.1.5)*
To Contact MSI:

Nova Scotia Medical Services Insurance
Telephone: 902-496-7011
Toll Free: 1-866-553-0585
Fax: 902-469-4674 or 1-877-910-4674
E-mail: MSIproviders@medavie.ca *(3.1.6)*

## LOCUM TENENS *(3.1.7)*

Locum tenens refers to a physician who temporarily replaces another physician who is absent from an existing practice. Locum service providers must use their own provider number. A business arrangement number must also be effective in order to submit service encounters under the MSI program. *(3.1.8)*

The provider coordinators should be notified prior to any locum arrangements. All documents should be completed and returned to the provider coordinators to ensure payment of service encounters. *(3.1.9)*

Should locum physicians desire to participate in supplemental activities (e.g., Community Hospital Inpatient Program, Primary Maternity Care), they will be eligible to do so in addition to the locum hours and will be compensated per the supplemental program's funding model. However, a locum physician must fulfill the hours specified for the locum income received on the day before claiming any additional remuneration. Locum hours cannot be 'made up' on a subsequent day. *(3.1.25)*

- Where possible, the supplemental activity should be fulfilled before or after the 'locum' hours.
- Where frequent interruptions are expected throughout any given day (e.g., urgent inpatient response, antenatal services) and there is a considerable likelihood a full day of locum services cannot be achieved, the host/locum physicians should consider the half-day guarantee or FFS remuneration for the care services.
- If a locum physician does not fulfill the service requirement as stated on the host application and/or claim form, the locum physician must advise Medavie for an adjustment to the locum compensation where applicable. *(3.1.26)*

## BUSINESS ARRANGEMENTS/DIRECT BANK DEPOSITS *(3.1.10)*

A business arrangement is an agreement between a service provider and MSI that defines payment of health services provided. *(3.1.11)*

All service providers registered with MSI must have their own or be part of a group business arrangement in order to claim for services. Some service providers may have and/or be part of more than one business arrangement. Please contact the Provider Coordinator whenever business arrangements need to be added, changed or ended. *(3.1.12)*

## NEW FACILITY *(3.1.13)*

A facility is a physical location (e.g., service provider's office, institution, or hospital) where health services are routinely performed. All recognized facilities are assigned a unique identifier number. *(3.1.14)*

All service providers applying for payment through the MSI billing system are required to identify their practice location and notify MSI of any changes. For further information, please call 902-496-7011 or Toll Free 1-866-553-0585. *(3.1.15)*

## SPECIALTIES/SPECIALIST *(3.1.16)*

A specialist is defined as one whose name appears on the specialist register provided by the College of Physicians and Surgeons. The College of Physicians and Surgeons provides MSI with a specialties listing which designates specialty accreditation under which services can be performed; such as dermatology, general surgery, etc. *(3.1.17)*

Specialty codes are used to determine the applicable payment amount, e.g., a specialist may be paid a different amount for a visit than a general practitioner. *(3.1.18)*

Please advise MSI if planning to practise and submit service encounters requiring specific specialties. MSI cannot recognize a specialty without confirmation from the appropriate licensing body. *(3.1.19)*

## OPTING OUT OF THE NOVA SCOTIA MEDICAL SERVICES INSURANCE PLAN *(3.1.20)*

### OPTED OUT SERVICE PROVIDERS *(3.1.21)*

A service provider may at any time notify MSI, in writing, of the decision to opt out of the MSI program. Such a request will become effective from the first day of the month after the expiration of sixty days from the date the MSI Program receives notice. To charge the patient for insured services, the provider must give reasonable notice to the patient prior to rendering the service. The service provider must also provide the necessary information to the patient to enable them to claim the insured services directly from MSI. *(3.1.22)*

## BILLING ABOVE TARIFF *(3.1.23)*

Under an agreement effective July 1, 1984, Nova Scotia service providers who submit claims to MSI may not bill their patients in excess of the current rates for basic health services. If a service is medically required, a service encounter is submitted to MSI and no additional amount may be billed to the patient. It is important that service providers keep in mind that the amendments to the Act relate only to insured services. There is no change in the service provider's right to charge for uninsured services such as periodic health assessments, the cost of medical supplies such as drugs, dressings and other items not insured by MSI. *(3.1.24)*

# PREPARING SERVICE ENCOUNTERS *(3.2.0)*

## SERVICE ENCOUNTER FORMAT *(3.2.1)*

This section contains information about these requirements. It is to assist service providers and their staff by describing the structural format of a service encounter transaction by detailing how the data fields of each service encounter are to be completed. *(3.2.2)*

Accredited vendors have been approved by MSI based on their ability to meet established criteria. If you wish to receive a list of accredited vendors, please visit our website under the New Registration section. *(3.2.3)*

The accredited vendor selected will assist with system requirements and technical training to facilitate the submission of service encounters to MSI. *(3.2.4)*

This manual defines the conditions under which service encounters for services provided may be submitted. *(3.2.5)*

### SERVICE ENCOUNTER SUBMISSION DEADLINE *(3.2.6)*

The deadline for service encounter submission is 90 days from the date of service unless evidence of extenuating circumstances is provided in writing to the MSI office to request approval. Resubmission of services must be received within 185 days from the date of service. Note: WCB and facility based non patient specific service encounters follow the same ruling. *(3.2.7)*

## SERVICE ENCOUNTER TRANSACTION COMPONENTS *(3.2.8)*

All service encounter transactions are assigned a unique service encounter number by the billing system. This number is important for reconciliation and follow up purposes. All service encounter numbers consist of the submitter ID, year, sequence number and check digit. *(3.2.9)*

### SERVICE ENCOUNTER SEGMENTS *(3.2.10)*

There are four record types and every service encounter transaction is made up of at least one record. However, there can be more than one record type in a service encounter depending on the nature of the service encounter. *(3.2.11)*

1. **Service Encounter Detail Record** *(3.2.12)*
   This record contains the base data for service encounters submitted by in province service providers. Most in province service encounters will only require this record. *(3.2.13)*
2. **Person Data Record** *(3.2.14)*
   The person data record is used to provide information on individuals who do not have a Nova Scotia health card number. The person data record is mandatory if the service recipient is from out of province. *(3.2.15)*
3. **Supporting Text Record** *(3.2.16)*
   This record is used when supporting text is required to adjudicate a service encounter. In addition, a text record must be submitted when the '**R**' (re-adjudicate) action code is used. Up to 999 records, each containing three lines of text can be included for one service encounter. *(3.2.17)*
4. **Supporting Text Cross Reference Record** *(3.2.18)*
   This record is used when the supporting text for the service encounter is used for another service encounter. Only one record can be included to indicate the other service encounter number that shares the same text. *(3.2.19)*

### ACTION CODES *(3.2.20)*

Every service encounter transaction requires an action code. The action code indicates whether the service encounter is new or is a request for re-adjudication of a previously processed service. The valid action codes that can be attached to a service encounter are **A**, **R** and **D**. *(3.2.21)*

**A** Enter this action code when submitting a service encounter for the first time or resubmitting a service encounter that had previously been refused. A refused service encounter is one that passes through the system and is refused due to an edit rule, assessment rule, a type of restriction, etc. Having been processed through the system, this service encounter will show as R refused on the adjudication response along with an explanatory code. If resubmitting this type of refused service encounter use action code A and a new service encounter number. *(3.2.22)*

**R** Enter this action code to allow a previously approved service encounter to be re-adjudicated with supporting text explaining in the text record why the original assessment is to be reviewed. In normal circumstances, supporting text is not taken into account when a service encounter is initially adjudicated, except for specific situations e.g., service encounter for exceptional circumstances. A base service encounter record cannot be included. All re-adjudication requests must be initiated electronically. *(3.2.23)*

**D** Enter this action code to reverse or delete a service encounter that has been approved, reduced or paid at zero. The original service encounter number must be provided. However, the detail record is not required. *(3.2.24)*

## MODIFIERS *(3.2.25)*

MSI adjudication system employs modifiers to determine the payment amount of a service encounter (See Appendix H Modifier Types and Values (7.8.0)). Modifiers can affect payment such as:

- Adding an amount to the basic fee
- Subtracting an amount from the basic fee
- Replacing the basic fee with a different amount
- Indicating role, time, method, age *(3.2.26)*

### IMPLICIT MODIFIERS *(3.2.27)*

Some modifiers are known as implicit or derived modifiers. This kind of modifier is derived by the service encounter processing system based on the information submitted on a service encounter and is not entered as a modifier such as, specialty of physician, functional centre, referral, etc. The implicit modifier for location is derived from the location code field on the service encounter transaction. *(3.2.28)*

### EXPLICIT MODIFIERS *(3.2.29)*

Some modifiers are called explicit modifiers. These modifiers are required to further identify the nature of the service for payment purposes. Explicit modifiers exist as data entry fields and must be indicated on the incoming service encounter transaction. Up to six explicit modifiers can be entered on a service encounter to further identify the nature of the service being claimed. *(3.2.30)*

An example of an explicit modifier is the role modifier. This modifier indicates the role that the service provider was performing for the service, e.g., RO=SRAS surgical assistant, RO=ANAE anaesthetist. *(3.2.31)*

An example of two modifiers being required thus two explicit modifier fields are completed, is a service encounter involving a role and an unscheduled service time block. Payment would be affected by the role of the service provider, e.g., "RO=ANAE anaesthetist and by the time block, e.g., US=PREM premium time in which the service was performed. *(3.2.32)*

The applicable explicit modifiers for each type of service encounter are described at the end of this chapter. *(3.2.41)*

## SERVICE ENCOUNTER SUBMISSION LAYOUT *(3.2.42)*

### FIELD NAME FIELD VALUE AND CHARACTER LENGTH *(3.2.43)*

A – Alphanumeric, N – Numeric, ( ) Number of Characters *(3.2.44)*

| Field Name | Field Value/ Character Length | Other |
|---|---|---|
| Service Encounter Type | A (4) | |
| Provider Type | A (2) | |
| Service Provider Number | N (6) | |
| Specialty Code | A (4) | |
| Service Recipient HCN | A (12) | |
| Service Recipient Birth Date | N (8) | (YYYY/MM/DD) |
| Health Service Code | A (6) | |
| Service Start Date | N (8) | (YYYY/MM/DD) |
| Service Occurrence Number | N (1) | |
| Diagnostic Code | A (5) | 1._____2._____3._____ |
| Multiples | N (3) | |
| Explicit HSC Modifier | A (6) | 1._____2._____3._____<br>4._____5._____6._____ |
| Facility Number | N (6) | |
| Functional Centre | A (4) | |
| Location Code | A (4) | |
| Business Arrangement | N (7) | |
| Pay To Code | A (4) | |
| Pay To HCN | N (10) | |
| Referral Provider Type | A (2) | |
| Referral Provider Number | N (6) | |
| OOP Referral Indicator | A (1) | Can only be "Y" or blank |
| Payment Responsibility | A (3) | |
| Program | A (3) | |
| Chart Number | A (5) | |
| Claimed Unit Value | N (9) | |
| Claimed Amount | N (9) | |
| Unit Value Indicator | A (1) | Can only be "Y" or blank |
| Paper Supporting Document Indicator | A (1) | Can only be "Y" or blank |
| Hospital Admit Date | N (8) | (YYYY/MM/DD) |
| Intensive Care Unit Admit Date | N (8) | (YYYY/MM/DD) |
| First Anaesthetist Start Time | N (4) | |
| Consecutive Anaesthetist Start Time | N (4) | |
| Preauthorization Number | A (8) | |
| Injury Diagnostic Code | A (5) | |

*(3.2.45)*

## SERVICE ENCOUNTER FIELDS REQUIRING COMPLETION *(3.2.46)*

This section describes the individual fields and records that make up a service encounter for a provider's services. Careful attention to the instructions provided should facilitate prompt payment of service encounters. *(3.2.47)*

The individual fields requiring completion are described below: *(3.2.48)*

1. Service encounter type *(3.2.49)*
   For all in province service providers, the service encounter type is RGLR. Every service encounter must have this code entered in this field. *(3.2.50)*
2. Provider type *(3.2.51)*
   The discipline of the service provider, e.g., PH for physician. *(3.2.52)*
3. Service provider number *(3.2.53)*
   All service providers are assigned a unique six-digit ID number by MSI. *(3.2.54)*
4. Specialty code *(3.2.55)*
   The specialty under which the service provider provided the service. The valid specialty or specialties for each provider are maintained by MSI provider coordinators. *(3.2.56)*
5. Service recipient health card number (HCN) *(3.2.57)*
   Eligible residents of Nova Scotia have a unique 10-digit health card number. If the service recipient is from out of province, the registration number from the home province is entered here. *(3.2.58)*
6. Service recipient birth date *(3.2.59)*
   Mandatory for Nova Scotia HCN YYYYMMDD format. *(3.2.60)*
7. Health service codes (HSC) *(3.2.61)*
   The health service performed (may or may not be a defined CCP).
   The HSC applies to:
   - A valid service based on the provider's specialty and any service restriction applicable to the specialty.
   - A service relevant to a recipient's gender and age.
   - A service based on the restriction defined by the business arrangement number.
   - A facility functional centre based on restrictions defined by the capabilities of the facility.
   - The HSC and modifiers implicit and explicit must be a valid service and will determine the amount that MSI reimburses for the service.
   - Implicit modifiers derived from other data fields on the service encounter.
   - Explicit modifiers entered on the service encounter in one or more of the explicit modifier fields. *(3.2.62)*

   Qualifiers, alpha characters appended to a health service code, are used to distinguish multiple MSI service codes where the unit value differs and/or they cannot be distinguished by modifiers. The primary HSC and wording appears as part of the text above the qualified code that represents the definition of the composite fee. *(3.2.63)*

   Examples of Qualifiers:
   e.g. 01.03A Endoscopy with removal of benign growth – larynx
   01.03B Endoscopy with removal of foreign body – larynx
   01.03G Direct laryngoscopy without biopsy *(3.2.64)*

8. Service start date *(3.2.65)*
   The day the health service was performed YYYYMMDD format. A separate service encounter is submitted for each hospital visit. The hospital admit date is required for each hospital inpatient visit service encounter. *(3.2.66)*

9. Service occurrence number *(3.2.67)*
   The occurrence refers to the medical necessity of the number of separate times the same provider sees the same recipient on the same day. Enter the number which indicates if the service was performed during the first, second, third, etc. time that the service provider saw the service recipient on the same day. All services performed during the same encounter with the service recipient must be given the same service occurrence number. Second and subsequent service occurrences may only be submitted for separate and distinct episodes of care. *(3.2.68)*

10. Diagnostic code *(3.2.69)*
    The diagnostic code format is the ICD-9-CM version. The code for the primary diagnosis is entered in the first field. Two additional diagnostic code fields are available to enter any secondary diagnosis, if applicable. *(3.2.70)*

11. Multiples *(3.2.71)*
    The multiples (MU) field is used to indicate either the number of services performed, (e.g., number of lesions), the length of time, (e.g., 15-minute time blocks detention, counselling) or the percentage of the body, (e.g. burns or surface area treated, e.g. sq. inches). If the number of multiples exceeds the number indicated for the health service code, the maximum for the code will be paid. To claim additional multiples, a service encounter must be resubmitted with action code R indicating total number of multiples with supporting text and a copy of the patient record. *(3.2.72)*

Following are examples of multiples used when billing certain services: *(3.2.81)*

**Psychotherapy time values:** Psychotherapy cannot be paid for less than 30 minutes with a maximum of 1 1/2 hours per day *(3.2.82)*

| Minutes | Multiple | Units |
|---|---|---|
| 30 | 3 | 30 |
| 45 | 4 | 45 |
| 60 | 5 | 60 |
| 75 | 6 | 75 |
| 90 | 7 | 90 |

*(3.2.83)*

**Excision of Lesions with a Base Unit of 20** i.e., enter the multiple that corresponds to the number of lesions, e.g., five lesions = five multiples *(3.2.84)*

**Multiples of**: *(3.2.85)*

| # of Lesions | # of Units |
|---|---|
| 1 to 5 | 20 |
| 6 to 10 | 30 |
| 11 to 15 | 40 |
| 16 to 20 | 50 |
| 21 to 25 | 60 |

*(3.2.86)*

For simple excision, cryotherapy, curettage, electrocautery, when the value exceeds 60 units, the rate is paid on the basis of 60 units per hour and supporting text and duration of service must be submitted. *(3.2.87)*

Excision of burned tissue prior to immediate skin grafting: Multiples are shown as percent of the body surface (e.g., one percent = multiple of one). *(3.2.88)*

**Multiples up to**: *(3.2.89)*

| Percent of Body Surface | # of Units |
|---|---|
| 5 | 50 |
| 6 – 10 | + 25 |
| 11 – 15 | + 25 |
| 16 – 20 | + 25 |
| 21 – 25 | + 25 |

*(3.2.90)*

### Debridement of Burns *(3.2.91)*

**Multiples of**: *(3.2.92)*

| Percent of Body Surface | # of Units |
|---|---|
| 1 to 5 | 20 |
| 6 to 10 | 40 |
| 11 to 15 | 60 |
| 16 to 20 | 80 |
| 21 to 25 | 100 |
| 26 to 30 | 120 |
| 31 to 35 | 140 |
| 36 to 40 | 160 |
| 41 to 45 | 180 |
| 46 to 50 | 200 |
| 51 to 55 | 220 |
| 56 to 60 | 240 |
| 61 to 65 | 260 |

*(3.2.93)*

### Multiples of Fingers and Toes/Joints *(3.2.94)*

When the same procedure is claimed on the right and left region for multiples on either side and/or multiple joints on the same digit, submit a re-adjudicate on the previously approved service encounter with supporting text indicating which joints/digits are involved, e.g., HSC 93.16 Metatarsophalangeal Fusion. *(3.2.95)*

### Other Multiples *(3.2.96)*

When billing multiples of the same procedure, submit as one service encounter indicating in the multiples field the number of times the procedure was performed.

Examples:

a) HSC 98.81C Category MISG
Three biopsies from the area leg/arm/neck MU 3
First procedure paid at 100 percent each additional paid at 65 percent

b) HSC 97.91 Category VADT
Three breast aspirations MU 3
First procedure paid at 100 percent each additional paid at 50 percent *(3.2.97)*

12. Explicit health service code modifier *(3.2.98)*
The explicit HSC modifier fields are used to further identify the nature of the service for payment purposes. Six fields are provided if needed. Explicit HSC modifiers are those that cannot be derived from other data on the service encounter. An example of an explicit HSC modifier is the role modifier which indicates the role, e.g., surgical assist RO=SRAS, or anaesthetist RO=ANAE. *(3.2.99)*

13. Facility number *(3.2.100)*
All institutions, hospitals and service provider offices are assigned unique numbers by MSI. A facility number is required for locations other than HOME, OTHR or HMHC. If services are performed at a different location other than your assigned sites, you must use the facility number of the location where the service was rendered. The facility number for hospitals can be obtained from your software program or by contacting MSI. *(3.2.101)*

14. Functional centre *(3.2.102)*
The functional centre code must be entered if the service is performed at a registered hospital facility. MSI catalogues the valid functional centres as determined by the Department of Health and Wellness (DHW) for each registered facility. It identifies the specific area within the facility where the service was performed, e.g., outpatient department FN=OTPT, or neonatal intensive care centre FN=NICU. The functional centre should be indicated as FN=INPT on all registered inpatients except when the patient is in intensive care where the functional centre should be indicated as FN=NICU or FN=INCU. When a registered inpatient is taken to the outpatient department for a service, the functional centre FN=OTPT should be indicated and text is required explaining the details. *(3.2.103)*

15. Location code *(3.2.104)*
"A location code is required on all service encounters. Examples of location codes are:

| | |
|---|---|
| HOME | The service recipient's home |
| OTHR | Other (side of the road, etc.) |
| HMHC | Home Hospital Care |
| HOSP | Hospital |
| NRHM | Nursing Home |
| OFFC | Office |
| CCNT | Correctional Centre *(3.2.105)* |

16. Business arrangements are agreements between providers or provider groups and the Nova Scotia Department of Health and Wellness for payment of services. All providers in Nova Scotia must have a business arrangement registered with MSI in order to claim for services. Providers may have multiple business arrangements to reflect, among other things, different locations in which they practice or different arrangements to make payment to provider groups, as opposed to the specific provider claiming the service. *(3.2.106)*

17. Pay to code *(3.2.107)*
The pay to code indicates the person or organization to which payment is to be made. The pay to code refers to the business arrangement under which the service was performed. Value for pay to code is: BAPY Business Arrangement Payee, e.g., service provider, group. *(3.2.108)*

18. Referral provider type *(3.2.109)*
The discipline of the referring provider, e.g., PH for physician, DE for dentist, OP for optometrist, NP for nurse practitioner, MW for midwife and AD for audiologist. *(3.2.110)*

19. Referral provider number *(3.2.111)*
    When claiming a referred service from another provider in Nova Scotia, the referring service provider's number must be entered here. The referral number for all dental practitioners is 103481. *(3.2.112)*

20. Out of province (OOP) referral indicator *(3.2.113)*
    If applicable, enter Y to indicate that the service was referred from an OOP service provider. *(3.2.114)*

21. Payment responsibility *(3.2.115)*
    Normally the payment responsibility for most services is entered as MSI. However, there are instances where the payment responsibility will change, for example, service encounters under Workers' Compensation Board (WCB), Out of Province (OOP) and Community Services (COM). If the service encounter is for services provided to a service recipient registered with another provincial health plan except Quebec the home province code is entered in this field, e.g., NB, ON, PE. The service also requires a person data record for the service recipient.
    Acceptable province codes:

    | | |
    |---|---|
    | NB New Brunswick | PE Prince Edward Island |
    | NF Newfoundland | ON Ontario |
    | MB Manitoba | SK Saskatchewan |
    | AB Alberta | BC British Columbia |
    | YT Yukon Territories | NT Northwest Territories |
    | NU Nunavut | |

    WCB (WCB service encounters) Note: WCB claims can only be claimed for Nova Scotia residents 16 years of age and over who are eligible for MSI coverage.
    COM (Community Services) *(3.2.116)*

22. Program *(3.2.117)*
    The MSI program applicable to the service claimed. Currently, the only value is MC for Medicare. *(3.2.118)*

23. Chart number *(3.2.119)*
    This is a service providers use field. A source reference number can be entered here, if desired. *(3.2.120)*

24. Claimed unit value *(3.2.121)*
    The unit value claimed by the service provider. If this field is blank, the unit value indicator should also be blank. *(3.2.122)*

25. Claimed amount *(3.2.123)*
    This field is for submitter/provider reconciliation purposes. It may be left blank or could be used to carry the software calculations indicating the amount anticipated to be paid by MSI. *(3.2.124)*

26. Unit value indicator *(3.2.125)*
    Enter a Y in this field if claiming a unit value less than the normal unit value listed in the Physician's Manual. The claimed unit value must also be entered. *(3.2.126)*

27. Paper supporting documentation indicator *(3.2.127)*
    Enter Y in this field if a paper document is being sent. Paper documentation should be sent when it is not possible to include the information in the electronic text field. The paper supporting documentation must reference the service encounter number and the patient's health card number. *(3.2.128)*

28. Hospital admit date *(3.2.129)*
    Service encounters for visits or procedures claimed for a registered inpatient must be submitted listing the date of admission on each service encounter. Format YYYYMMDD *(3.2.130)*

29. Intensive care unit admit date *(3.2.131)*

The date the service recipient was admitted to the intensive care unit. Format YYYYMMDD. It is required on all intensive care unit visits. *(3.2.132)*

30. First anaesthetist start time *(3.2.133)*
    The start time of the first anaesthetist involved in the procedure. This field is required on service encounters submitted by the replacement anaesthetist. Format HHMM 24-hour clock. *(3.2.134)*
31. Consecutive anaesthetist start time *(3.2.135)*
    When consecutive anaesthetists are submitting, the role modifier must indicate RO=ANAE and the service will be identified by entering the first anaesthetist start time and consecutive anaesthetist start time. Format HHMM 24-hour clock. *(3.2.136)*
32. Preauthorization number *(3.2.137)*
    A preauthorization number is required when approval has been granted for certain procedures. Your request for preauthorization information should be forwarded to the medical consultant at MSI. Upon approval of this request, a preauthorization number will be issued. The number must be indicated on the claim in the appropriate field. Please note: If indicated in the electronic text, the service encounter will be refused. *(3.2.138)*
33. Injury diagnostic code *(3.2.139)*
    A diagnostic code field used to indicate the external cause of injury that initiated the service encounter. They are located in the E-Section of the International Classification of Diseases (External Causes of Injury). *(3.2.140)*

## PREPARING SERVICE ENCOUNTERS PERSON DATA RECORD *(3.2.141)*

The person data record is used to provide information on individuals who do not have a Nova Scotia health card number. The person data record is mandatory if the service recipient is from out of province. *(3.2.142)*

The following describes the breakdown of this record:

Surname - Mandatory - Enter the last name of the service recipient
Given name - Mandatory - Enter the first name of the service recipient
Date of birth - Mandatory for reciprocal billing YYYYMMDD format
Gender code - Mandatory for reciprocal billing - valid codes are (M) and (F)
Address line 1 - Mandatory
Address line 2
City Name - Mandatory
Postal code
Province code - Mandatory
Country
Guardian/parent HCN *(3.2.143)*

## SUPPORTING TEXT RECORD *(3.2.144)*

This record is used when supporting electronic text is required to adjudicate a service encounter. In addition, a text record must be submitted when the **R** action code re-adjudicate is used. Up to 999 records, each containing three lines of text can be included for one service encounter. *(3.2.145)*

## SUPPORTING TEXT CROSS REFERENCE *(3.2.146)*

This record is used when the supporting electronic text for the service encounter is used for another service encounter. Only one record can be included to indicate the other service encounter number, which shares the same text. *(3.2.147)*

# RECEIVING SERVICE ENCOUNTER RESULTS *(3.3.0)*

## SERVICE ENCOUNTER PROCESS *(3.3.1)*

### BACKGROUND *(3.3.2)*

All service encounters to MSI are transmitted electronically in a batch format that utilizes a high-speed computer process to handle the numerous claim submissions. *(3.3.3)*

Incomplete or incorrect information will cause a service encounter to be rejected, refused or be held for further processing thereby causing a possible delay in processing and payment. *(3.3.4)*

The adjudication response is the report that MSI issues to help you track your service encounters and identify what problems or delays if any that may have occurred following each submission. Details of the report will be outlined in this section. *(3.3.5)*

## VERIFICATION OF YOUR SERVICE ENCOUNTER *(3.3.6)*

### SUBMISSION OF SERVICE ENCOUNTER DATA *(3.3.7)*

After the necessary data for the service encounter has been successfully submitted, each service undergoes a thorough validation with regards to an edit check, i.e., patient's health card number eligibility under MSI and any assessment rule that may govern that particular service. *(3.3.8)*

If a problem is identified, the service encounter will be returned with the appropriate explanatory code. A corrected service encounter must be submitted whether it is a re-adjudicate or an add claim. If a deletion is required on a previously approved service, the adjudication must be returned showing the delete as accepted prior to submitting a new service encounter. If not, it will cause the new service encounter to refuse as a duplicate. *(3.3.9)*

## SERVICE ENCOUNTER PROCESSING RESULT *(3.3.10)*

### CHECKING YOUR ADJUDICATION RESPONSE *(3.3.11)*

After each service encounter transmission has been received and processed an adjudication response is prepared for the site to retrieve. Service encounters can be submitted on a daily basis; however: each submission creates an individual adjudication response. *(3.3.12)*

This verifies the outcome of the service encounters and allows the person submitting service encounters to maintain a record and to identify any that may require further action. *(3.3.13)*

The adjudication response also indicates a service encounter number that is comprised of a submitter ID, year, seven-digit sequence number and a check digit. The adjudication response also includes a sequence number that increases in increments of one each time a response is produced. It assists in reconciling the service encounters. *(3.3.14)*

An explanatory code is intended to explain the reason for any modification on the service encounter. The codes cannot be correctly interpreted without reference to the Preamble. *(3.3.15)*

A format of the adjudication response follows along with descriptions of the fields. *(3.3.16)*

## SERVICE ENCOUNTER ADJUDICATION RESPONSE FIELD DESCRIPTION *(3.3.17)*

This adjudication response file contains the results of processing for all service encounter transactions submitted. Only the service encounters applicable to a submitter are provided to that submitter. *(3.3.18)*

These details can be used by the submitter for any processing requirements, e.g., reconciliation of input files. Each result record will also include the service recipient's HCN. *(3.3.19)*

If a service encounter transaction has been held by MSI for review, the adjudication response for the transaction will indicate held and a subsequent adjudication response detail record will be sent when the final outcome of the transaction has been determined. *(3.3.20)*

If a previously processed service encounter is internally reassessed with a resulting change in the approved unit value, an adjudication response detail record will be sent to the submitter who initiated the transaction. *(3.3.21)*

1. Service encounter number *(3.3.22)*
   It is comprised of the submitter ID (3), Year (4), sequence number (7) and check digit (1). The service encounter number has a total number of 15 digits. *(3.3.23)*
2. Transaction tag number *(3.3.24)*
   Set to 0001 for the initial transaction that created a service encounter and then incremented by one for every transaction/reassessment against the service encounter. *(3.3.25)*
3. Transaction action code *(3.3.26)*
   **A** Indicates the adjudication response is for the originating service encounter add transaction
   **D** Indicates the adjudication response is for a delete transaction
   **R** Indicates the adjudication response is for a re-adjudication transaction *(3.3.27)*
4. Reassess explanation code *(3.3.28)*
   If the adjudication response detail is for a re-adjudication of a service encounter, this indicates the reason for the adjudication, e.g., affected by another service. *(3.3.29)*
5. Assessment outcome *(3.3.30)*
   Indicates the outcome of the submitted transaction. The outcome can be one of: **A** Indicates transaction was approved/accepted and an approved unit value has been determined. The unit value could be a reduced unit value or could be zero. In these cases, the explanatory codes indicate the reason for the reduction. An approved service encounter can later be reassessed. **H** Indicates transaction is currently being held for review by MSI. **R** Indicates transaction was refused. The explanatory codes indicate the reason for the refusal. Refused add transactions must be resubmitted as a new service encounter once the correct information is determined. If a re-adjudicate or delete transaction is refused, the original service encounter is left unchanged. *(3.3.31)*
6. Assessment result action *(3.3.32)*
   **R** indicates the record is a reversal of an adjudication response result for the service encounter. If the assessment outcome is **A** Approved and the transaction action code is an **R** Re-adjudication, two adjudication response detail records will be created; the first is a reversal of the old approved unit value and the second is the new approved unit value. Both records will have different transaction tag numbers. If the assessment outcome is **A** Approved and the transaction action code is **A** Add or the assessment outcome is **R** Refused or **H** Held, only a current assessment result record will be created. If the assessment outcome is **A** Approved and the transaction action code is **D** Delete, only a reversal record will be created. *(3.3.33)*
7. Chart number *(3.3.34)*
   As originally coded on the submitted service encounter from an individual site. *(3.3.35)*
8. Service recipient health card number *(3.3.36)*
   A lifetime identification number used to uniquely identify all residents who are registered with MSI. Also used for reciprocal registration. *(3.3.37)*

9. Expected payment date YYYYMMDD *(3.3.38)*
   The expected date on which your payment will occur. *(3.3.39)*
10. Adjudication date YYYYMMDD *(3.3.40)*
    The date the service encounter was adjudicated/re-adjudicated. *(3.3.41)*
11. Approved unit value 9999999V99 *(3.3.42)*
    Approved unit value is the value that has been assessed for the service encounter. These fields will not have commas or decimal points in them. The format will be 9999999V99, where the V designates an implied decimal point. If you were to look at the physical file, you would see 999999999. *(3.3.43)*
12. Claimed amount 9999999V99 *(3.3.44)*
    The claimed amount as coded on the submitted transaction. These fields will not have commas or decimal points in them. The format will be 9999999V99, where the V designates an implied decimal point. If you were to look at the physical file, you would see 999999999. *(3.3.45)*
13. Unit value indicator *(3.3.46)*
    **Y** indicates that the service provider claimed a unit value less than the normal unit value for the service. *(3.3.47)*
14. Explanatory codes (Up to six) *(3.3.48)*
    If the approved unit value is not the normal value to be paid for the service or the service encounter has been refused, the explanatory codes provide the reason for the reduction or refusal. *(3.3.49)*
15. Health service code (HSC) *(3.3.50)*
    A code identifying services/procedures performed by a service provider to a service recipient. *(3.3.51)*
16. HSC modifiers used *(3.3.52)*
    The list of implicit and explicit fee modifiers that were used to determine the approved unit value. *(3.3.53)*
17. Business arrangement number *(3.3.54)*
    The business arrangement that the service provider is claiming under. *(3.3.55)*
18. Provider type *(3.3.56)*
    Indicates the discipline of the service provider. *(3.3.57)*
19. Service provider number *(3.3.58)*
    All service providers will have a unique ID number assigned by MSI. *(3.3.59)*
20. Service start date *(3.3.60)*
    Indicates the date the health service was performed. *(3.3.61)*
21. Pay to code *(3.3.62)*
    Indicates to what person or organization the payment is to be made. *(3.3.63)*
22. Preauthorization number *(3.3.64)*
    Is used when submitting a service encounter that has previously been authorized. *(3.3.65)*

## RECONCILE REGULARLY *(3.3.66)*

MSI recommends that all service providers regularly reconcile each of their adjudication responses with their service encounter submissions to ensure that all submitted service encounters have been processed. Most of this reconciliation effort can be done via computer output details obtained from your accredited submitter. Your reconciliation routine should acknowledge service encounters that have been received but not yet been fully assessed. Each of these service encounters will appear on a future statement once the assessment is complete. *(3.3.67)*

## CHECKING YOUR STATEMENT OF ACCOUNT *(3.3.68)*

MSI also issues a report called the Statement of Account. This report outlines the amounts being released for payment based on service encounters assessed. It is produced in conjunction with the payment process, which is currently on a biweekly basis. *(3.3.69)*

A current Statement of Account contains summary information regarding the adjudication response that was issued since the previous statement of account was produced. It will also identify any other payments and recoveries that may be made in the interim, e.g., bottom line adjustments. *(3.3.70)*

## STATEMENT OF ACCOUNT *(3.3.71)*

### GENERAL DESCRIPTION *(3.3.72)*

This document describes in point form the electronic statement format for providers. *(3.3.73)*

There will normally be one statement for each business arrangement, whether the business arrangement belongs to a group or to a provider. If multiple business arrangements for a group or provider point to one bank account, those business arrangements will be combined on one statement for the direct deposit. Separate totals will be given for every business arrangement on a statement: *(3.3.74)*

- It is possible that a statement could be for negative amounts if the provider's reversals for the pay period added up to more than the service encounters. Bottom line adjustments will never cause negative statements. *(3.3.75)*
- Each statement is in a separate file. *(3.3.76)*
- The file is in comma delimited format.
  - Fields are not fixed length,
  - All fields are separated by commas,
  - Character fields are surrounded in double quotes, and
  - All records end in carriage return line feed. *(3.3.77)*
- Numeric fields that specify the decimal will include the decimal point, but no dollars or commas. They are not zero filled. Negative numbers will be preceded by the negative sign. The negative sign counts as one of the digits defined in the maximum length. For instance, a number defined as having eight digits before the decimal and two after, e.g., numeric 8.2, can fall in the range: -9999999.99 to 99999999.99. *(3.3.78)*
- There are four types of records that may be in each statement. Their formats are given in the next section:*(3.3.79)*

  1. Detail records: These contain the service encounter details and amounts paid and occur first in the statement. There is one detail record for every service encounter and reversal in the pay period. These records are sorted in order of business arrangement number, provider type, provider number, service date, service encounter number, sequence number, and tag number. *(3.3.80)*

  2. Bottom line adjustment records: These contain adjustment amounts applied to a provider or provider group in the pay period. There is one bottom line adjustment record for every business arrangement, which was adjusted during the current pay period. If a business arrangement was not adjusted during the pay period, there will be no records of this type. If a business arrangement was adjusted by more than one type of adjustment, there will be one record for each adjustment applied. These records occur after the detail records for the business arrangement to which they apply. If it is a group business arrangement, the adjustment records occur after the detail records for the specific provider being adjusted. *(3.3.81)*

3. Service provider total records: These contain totals per service provider and business arrangement, including a bottom-line adjustment total. There is one service provider total record after each service provider's detail records. These occur after the bottom-line adjustment records in a statement. There could be multiple of these records if the statement is for a group or if the statement includes multiple business arrangements. *(3.3.82)*

4. Group total records: These contain the totals per group and business arrangement before and after bottom line adjustments. There is one group total record for each business arrangement for a provider group. The records occur after the last provider total and last bottom line adjustment for the business arrangement. There are no group total records if the statement is not for a group. *(3.3.83)*

## RECORD FORMATS *(3.3.84)*

### Data Statement Record/Statement Details *(3.3.85)*

| Field | Format (Max Length) | Value |
|---|---|---|
| Record Type | Character (1) | D (Detail) |
| Group Number | Numeric (6) | Unique identifier for a provider group |
| Provider Type | Character (2) | Physicians (PH), dentists (DE), midwives (MW), nurse practitioners (NP), optometrists (OP), audiologists (AD) |
| Provider Number | Numeric (6) | Unique identifier for the provider |
| Business Arrangement Number | Numeric (7) | Unique identifier for a business arrangement |
| Payment Run Number | Numeric (7) | Internal MSI identifier for the payment runs. The same number appears for all service encounters in one payment period. It's not consecutive from one pay period to the next. |
| Payment Responsibility | Character (3) | One of MSI, WCB, COM (Community Services), or a valid 2 letter province code for reciprocal service encounters (AB, BC, MB, NB, NF, NT, NU, ON, PE, SK, YT) |
| Health Card Number | Character (12) | Service recipient's health card number |
| Service Start Date | Numeric (8) | Format is: YYYYMMDD |
| Health Service Code | Character (6) | CCP code and qualifier |
| Service Encounter Number | Character (15) | Service encounter number – corresponds to what was supplied on adjudication response |
| Service Encounter Sequence Number | Character (4) | Service encounter sequence – corresponds to what was supplied on adjudication response |
| Transaction/Response Tag Number | Character (4) | Transaction Response Tab Number – corresponds to what was supplied on adjudication response (not necessarily consecutive) |

*(3.3.86)*

### Bottom Line Adjustment Records *(3.3.87)*

| Field | Format (Max Length) | Value |
|---|---|---|
| Record Type | Character (1) | A (bottom line adjustment) |
| Group Number | Numeric (6) | Unique identifier for a provider group |
| Provider Type | Character (2) | Physicians (PH), dentists (DE), midwives (MW), nurse practitioners (NP), optometrists (OP), audiologists (AD) |
| Provider Number | Numeric (6) | Unique identifier for provider |
| Business Arrangement Number | Numeric (7) | Unique identifier for a business arrangement |

| Field | Format (Max Length) | Value |
|---|---|---|
| Bottom Line Adjustment Number | Numeric (7) | Unique identifier for a bottom line adjustment |
| Payment Run Number | Numeric (7) | Internal MSI identifier for the payment run |
| Adjustment Amount | Numeric (8.2)<br>99999999.99 | Adjustment amount on a business arrangement (negative or positive) |
| Adjustment Type | Numeric (5) | Type of adjustment. Possible values:<br>1 = Garnishee<br>2 = Audit recovery<br>3 = Capping reconciliation adjustment |

*(3.3.88)*

## Provider Total Records *(3.3.89)*

| Field | Format (Max Length) | Value |
|---|---|---|
| Record Type | Character (1) | T (Total) |
| Group Number | Numeric (6) | Unique identifier for a provider group |
| Provider Type | Character (2) | PH for physicians, OP for optometrists, NP for nurse practitioners |
| Provider Number | Numeric (6) | Unique identifier for provider |
| Business Arrangement Number | Numeric (7) | Unique identifier for a business arrangement |
| Payment Run Number | Numeric (7) | Internal MSI identifier for the payment run |
| Statement Start Date | Numeric (8)<br>YYYYMMDD | Start date of payment period |
| Statement End Date | Numeric (8)<br>YYYYMMDD | End date of payment period |
| Total Units | Numeric (8.2)<br>99999999.99 | Total units amassed this pay period |
| Total Fees | Numeric (8.2)<br>99999999.99 | Fees paid, before adjustments ( + or - ) |
| Total Adjustments | Numeric (8.2)<br>99999999.99 | Total bottom line adjustments ( + or - ) |
| Total Paid | Numeric (8.2)<br>99999999.99 | Fees paid + adjustments ( + or - ) |
| Number of Service Encounters | Numeric (5) | Number of service encounters for provider |
| Number of Reversals | Numeric (5) | Number of reversals for provider |

*(3.3.90)*

## Provider Group Total Records *(3.3.91)*

| Field | Format (Max Length) | Value |
|---|---|---|
| Record Type | Character (1) | G (Group Total) |
| Group Number | Numeric (6) | Unique identifier for a provider group |
| Business Arrangement Number | Numeric (7) | Unique identifier for a business arrangement |
| Payment Run Number | Numeric (7) | Internal MSI identifier for the payment run |

| Field | Format (Max Length) | Value |
|---|---|---|
| Statement Start Date | Numeric (8)<br>YYYYMMDD | Start date of payment period |
| Statement End Date | Numeric (8)<br>YYYYMMDD | End date of payment period |
| Total Units | Numeric (8.2)<br>99999999.99 | Total approved units ( + or - ) |
| Total Fees | Numeric (8.2)<br>99999999.99 | Feed paid, before adjustments ( + or - ) |
| Total Adjustments | Numeric (8.2)<br>99999999.99 | Total bottom line adjustments ( + or - ) |
| Total Paid | Numeric (8.2)<br>99999999.99 | Fees paid + bottom line adjustments ( + or - ) |
| Number of Service Encounters | Numeric (5) | Number of service encounters per group |
| Number of Reversals | Numeric (5) | Number of reversals per group |

*(3.3.92)*

## FOLLOWING UP ON PROCESSED SERVICE ENCOUNTERS *(3.3.93)*

The adjudication response, whether received directly from MSI or an accredited submitter, reports the results after the service encounters have been processed. *(3.3.94)*

When reconciling the statement, there may be some service encounters that have been reduced in payment or altered in some other way. It may be determined that a paid service encounter contains some incorrect information, or a processed service encounter should not have been submitted. It is important that service encounters be reviewed to determine any need for follow-up action. *(3.3.95)*

### REFUSED SERVICE ENCOUNTERS *(3.3.96)*

If a service encounter transaction has been refused due to incorrect service encounter data, a correction can be submitted by creating a new service encounter transaction using a new service encounter number and action code A. *(3.3.97)*

### REASSESS SERVICE ENCOUNTERS *(3.3.98)*

If the service encounter information is correct but MSI review of the assessment of a service encounter which has been reduced or paid at zero is desired, then resubmit the service encounter using the same service encounter number and action code R. A supporting text segment explaining the request for a reassessment must be included. *(3.3.99)*

### CHANGING SERVICE ENCOUNTER DATA *(3.3.100)*

If the service encounter information has been submitted in error or is not correct for a service encounter which has been paid in full, reduced or paid at zero and a correction is to be created, first submit a delete with action code D on the original service encounter. No data portion is required; just the header portion which indicates the service encounter number of the previous submission. The adjudication response will indicate that the service accepted as deleted and then a new service encounter with action code A can be submitted. Failure to wait for the delete before submitting will result in a duplicate service encounter submission for the service. *(3.3.101)*

The results of the add, re-adjudicate or delete service encounters transactions will be reported on the adjudication response with appropriate explanatory codes. If any of these resubmissions are refused, the service encounter that was to be deleted, added or re-adjudicated is left as is. *(3.3.102)*

Review of Section 3 (3.2.0) will provide details about submitting service encounters, whether for the first time or as a follow-up to previously submitted service encounters. The accredited software vendor will assist with the technical details surrounding service encounters submission processes. *(3.3.103)*

## PUBLIC PSYCHIATRY ACTIVITY REPORTING *(3.3.104)*

The public psychiatry activity record is a form that may be used by individual psychiatric contract or salaried service providers for reporting to the facility's finance department. A callback to the facility may be recorded on the callback record. These, or similar forms collecting the same information, must be used to record regular and callback activities. *(3.3.105)*

### PSYCHIATRY BILLING INFORMATION *(3.3.106)*

All billing information on the service provider's forms is recorded and paid at an hourly rate. Facilities will submit the psychiatry forms and be reimbursed according to the hourly rate in effect on the dates of services. All facilities will be provided with updates prior to changes affecting payment. Facilities will then be responsible for reimbursement of their salaried and contracting service providers. Please use the table below for contracted psychiatric services. Billing must be done within three months of date of service. *(3.1.107)*

### District Psychiatry Contract – Hourly Rates *(3.3.108)*

| District Psychiatry Contract – Hourly Rates | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2018-19** | **2019-20** | **2020-21** | **2021-22** | **2022-23** | **2023-24** | **2024-25** |
| Certified | $153.67 | $156.74/186.91 | $204.20 | $209.59 | $213.83 | $220.24 | $226.85 |
| Non-Certified | $113.33 | $115.60/137.85 | $150.60 | $154.57 | $157.70 | $165.62 | $170.59 |

*(3.3.109)*

Callbacks are paid through the facility and are billed on the callback records provided for that purpose. Recording of the patient's name and MSI number are required. Callbacks may be claimed by contract or salaried physicians, noting that a callback must be an urgent request for attendance by facility staff necessitating a return to the facility outside normal facility working hours. Separate entries must be made for each individual patient seen. *(3.3.110)*

### DIRECT PATIENT CARE *(3.3.111)*

Involves face to face clinical interaction with patients. Care of patients registered with the mental health facility through inpatient, outpatient or day programs of the facility. The charting of progress notes is included as direct patient care time. *(3.3.112)*

- Inpatient Medical Earned Hours: Those medical earned hours of direct patient care provided on inpatient units. *(3.3.113)*
- Clinics Medical Earned Hours: Those medical earned hours of direct patient care provided to all outpatients. *(3.3.114)*
- Day Hospital Medical Earned Hours: Those medical earned hours of direct patient care provided to mental health day hospital partial hospital programs. *(3.3.115)*

### INDIRECT CARE MEDICAL EARNED HOURS *(3.3.116)*

Non-patient contact activities directly related to the care of an individual patient or group of patients including: *(3.3.117)*

- **Third Party**: Interviewing family members or other persons relevant to patient care. *(3.3.118)*
- **Staff Liaison**: Coordination of care with other health care workers. *(3.3.119)*
- **Case Conferences**: Discussion of cases with other health care workers. *(3.3.120)*

- **Reports**: Reading or preparing clinical reports. *(3.3.121)*
- **Academic Hours**: This includes academic administration education and research. *(3.3.122)*
- **Travel/Medical Earned Hours:** Time spent in authorized travel, e.g., clinic to satellite, hospital to home visit. It does not include commuting to or from home or private office to the facility. *(3.3.123)*
- **Community Care Medical Earned Hours**: Includes community liaison time spent in consultation with other organizations or agencies relating to community health or support services. This time is not patient specific. When time involves providing consultation to a community agency regarding a specific registered patient of the facility, then that time is considered indirect care/medical earned hours. *(3.3.124)*
- **Administration Medical Earned Hours**: Nonclinical time related to supervision of staff and programs of a facility. *(3.3.125)*
- **Telephone Calls**: Providing it relates to patient care would also be included as indirect care medical earned hours. *(3.3.126)*

# SECTION 4: TARIFF *(4.0.0)*

*A tariff is compensation associated with the provision of insured health services as governed by the Nova Scotia Health Services and Insurance Act.* *(4.0.1)*

*The MSI tariff is the actual monetary value of a service. It is derived from the number of units applicable to a service which may vary according to relevant modifiers, the Medical Service Unit Value, and any individual billing factors based on practice location or billing thresholds, or other factors that may exist from time to time. The MSI schedule of benefits uses units to represent the value of a service. The value of a unit varies according to the applicable tariff. Two unit values exist: an anaesthetic unit value used specifically for claiming anaesthetic services, and a medical service unit value specifying the dollar value of all other services.* *(4.0.2)*

*Tariffs are paid on a fee-for-service, contractual or sessional basis according to an approved plan for payment or insured list of professional services or products. Payments are made directly to service providers when rendering services to registered residents of Nova Scotia. Payments are also made to registered residents of Nova Scotia who provide proof of payment for receipt of an insured service.* *(4.0.3)*

*Allowance is sometimes made for alteration of the tariff associated with individual service encounters when a physician can demonstrate significantly increased difficulty, time, or other factors involved in providing care. When the tariff for a service is modified by specialty, time, or some other factor, the applicable tariff may vary according to the specific circumstances.* *(4.0.4)*

***Key Terms Relevant to This Section** **(4.0.5)***

- *Independent Consideration: A process for assessing services where a unit value is not listed.* *(4.0.6)*
- *Interim Fee: May be established in certain circumstances with approval by Department of Health and Wellness. A CCP code will be activated to describe the new service and an interim fee assigned. Interim fees will be published in the MSI Physician's Bulletin.* *(4.0.7)*
- *Modifiers: Special codes added to the record of a service that identify the generic context within which the service was provided, e.g., specialty, time, place, etc. Some modifiers are for the purpose of clarification; others affect the tariff applied to the service.* *(4.0.8)*
- *Qualifier: A qualifier is an alpha character appended to some service codes to subdivide the code and thereby distinguish differences specific to that procedure, e.g., 03.26A, 98.12B.* *(4.0.9)*
- *Service: When the term service is used in this manual, it is in the context of an insured visit or procedure that is identified by a specific service code in the MSI schedule of benefits.* *(4.0.10)*

# TARIFF *(4.1.0)*

The MSI tariff is negotiated between the Department of Health and Wellness and Doctors Nova Scotia. *(4.1.1)*

The Canadian Classification of Diagnostic Therapeutic and Surgical Procedures (CCP) forms the basis for descriptions of services in the schedule of benefits insured by MSI. *(4.1.2)*

The MSI adaptation of CCP does not include all possible CCP codes and MSI uses two additional levels of detail as follows: *(4.1.3)*

- Qualifiers are appended to a CCP code to distinguish between related procedures applied to the same anatomic area or condition, or to accommodate procedures that are a composite of two or more services *(4.1.4)*
- Modifiers describe the context of a service according to who performed the service, who received the service and when, where, and sometimes how the service was provided. *(4.1.5)*

Units per service are determined through the Fee Committee, a standing committee of the Physician Agreement Management Group with representation from Doctors Nova Scotia, Department of Health and Wellness and the District Health Authorities. An attempt is made to set the number of units for a service relative to other services in the schedule, reflecting factors such as duration, complexity, overhead, specialty status, and time of day or week. Practitioners are expected to use the published units for insured services except in the following instances: *(4.1.6)*

| | | | |
|---|---|---|---|
| MAAS | IC | Independent Consideration | IC |
| MAAS | IF | Interim Fee | IF |
| MAAS | EC | Exceptional Circumstances | EC *(4.1.7)* |

- **Independent Consideration:** Is applied to certain services recognized to have wide variation in case-to-case complexity and time. Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested (See Section 6 (6.0.43)). *(4.1.8)*

- **Interim Fees:** May be established in certain circumstances with approval by Department of Health and Wellness. A CCP code will be activated to describe the new service and an interim fee assigned. Interim fees will be published in the MSI Physician's Bulletin. A complete list of all current active interim fees can be found on the MSI Website: Interim Fee Reference Guide (PDF). *(4.1.10)*

- **Exceptional Clinical Circumstances**: May warrant a fee other than that listed in the schedule of benefits. In the event a practitioner performs a service they believe should be insured but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The service encounter is submitted under health service code EC and it must contain electronic text concerning the procedure, start/finish time and a claimed unit value. The request must be accompanied by complete details adequate to explain and justify the number of units requested.
  - Note: The exceptional fee process is not intended for use on a routine basis when a physician disagrees with the listed tariff for a service. *(4.1.11)*

If a physician feels a particular fee is under or overvalued in relation to similar services, they should request Doctors Nova Scotia consider renegotiating the fee with the Department of Health and Wellness. *(4.1.12)*

## PROCEDURES FOR AMENDMENTS TO THE PREAMBLE AND FEE SCHEDULE *(4.1.13)*

In the course of normal program administration, interim fees are occasionally set and will be published in a Physician's Bulletin as necessary. Before becoming permanent, interim fees are reviewed to ensure the codes description, billing rules and value are aligned with other, similar fees. *(4.1.14)*

## UNIT VALUES *(4.1.18)*

Two unit values exist, an Anaesthetic Unit (AU) value used specifically for claiming anaesthetic services and a Medical Service Unit (MSU) specifying the unit value of all other services. The chart below reflects the historical MSU and AU rate increases for both MSI and WCB. Changes to payment rates are communicated via Physicians Bulletins. *(4.1.19)*

| | April 1, 2020 to March 31, 2021 | April 1, 2021 to March 31, 2022 | April 1, 2022 to March 31, 2023 | April 1, 2023 to March 31, 2024 | April 1, 2024 to March 31, 2025 | April 1, 2025 to March 31, 2026 | August 27, 2025 to March 31, 2026 | April 1, 2026 to March 31, 2027 |
|---|---|---|---|---|---|---|---|---|
| MSU (MSI) | $2.58 | $2.63 | $2.68 | $2.76 | $2.84 | $2.90 | $2.90 | $2.96 |
| AU (MSI) | $22.71 | $23.88 | $25.30 | $26.06 | $26.84 | $27.38 | $27.38 | $27.93 |
| MSU (WCB) | $2.87 | $2.92 | $2.98 | $3.07 | $3.16 | $3.23 | $2.90 | $2.96 |
| AU (WCB) | $25.23 | $26.53 | $28.11 | $28.96 | $29.83 | $30.43 | $27.38 | $27.93 |

*(4.1.20)*

## SESSIONAL PAYMENT RATES *(4.1.21)*

| | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 | 2025-26 | 2026-27 |
|---|---|---|---|---|---|---|---|
| Specialists | $180.60 | $184.10 | $187.60 | $193.23 | $199.03 | $203.01 | $207.07 |
| GP | $154.80 | $157.80 | $160.80 | $165.62 | $170.59 | $174.00 | $177.48 |

*(4.1.22)*

# SECTION 5: CLAIM SUBMISSION ASSESSMENT RULES *(5.0.0)*

*This section provides important information about approved policy on which assessment rules are built and applied to submitted claims. Individuals responsible for submitting claims should have a deep understanding of the content included in this section and refer to the information when uncertain about making a claim for provided health services.* *(5.0.1)*

*Examples of topics covered in this section include an explanation of different types of visits and related reporting requirements, content specific to physician specialties and assessment rules for procedures.* *(5.0.2)*

***Key Terms Relevant to This Section** **(5.0.3)***

*Care Locations* (5.0.4)

- *Emergency Care Centre: A special designation provided by the Department of Health and Wellness to emergency departments meeting certain standards including 24 hour onsite on call.* *(5.0.5)*
- *Functional Centre: A standard area or site within a hospital or institution; e.g., outpatient department, intensive care unit, etc. Assigned functional centre modifier will be required as part of a service encounter for services provided in such areas.* *(5.0.6)*
- *Home/Residence: Includes patient's home, group homes, seniors' lodges, personal care homes and provincial correctional centres. It does not include institutions.* *(5.0.7)*
- *Hospital: For the purposes of this Preamble, hospital means a facility for the observation, care and treatment of persons suffering from a psychiatric disorder or a hospital for treatment of persons with sickness, disease or injury, including maternity care, as approved under the Health Services and Insurance Act.* *(5.0.8)*
- *Institution: Licensed and approved chronic care hospitals, residential centres, nursing homes and homes for special care.* *(5.0.9)*
- *Intensive Care Unit: Special areas recognized and funded by the Department of Health and Wellness to provide high intensity care. These units would include neonatal, paediatric, coronary, and such other units as are recognized by the Department. Generally, special fees apply to patients in such areas unless the patients no longer need the care of such a unit, but remain in the intensive care area, e.g., due to lack of beds on general ward or recovery room.* *(5.0.10)*
- *Office: The location where a physician is practicing their profession. An office may be located in the physician's home, in a hospital, in an institution, or in other facilities or buildings.* *(5.0.11)*
- *Other Locations: This modifier applies to locations of service not defined elsewhere, such as recreational facilities, watercraft, or roadside.* *(5.0.12)*

*Home Care* *(5.0.13)*

- *Home Care: Home support services, personal care services, nursing services and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. Services provided have the objectives of maintaining or improving the individual's level of functioning; addressing the individuals' needs during rehabilitation or convalescence; delaying or preventing admission into institutions; and/or providing family relief services to the individual's informal caregivers.* *(5.0.15)*

*Visits Related to Pregnancy* *(5.0.16)*

- *Antenatal or Prenatal: Applies to pregnancy related visits from the time of confirmation of pregnancy to delivery.* *(5.0.17)*
- *Postnatal: Describes a single limited visit performed approximately six weeks following delivery for the purpose of assessment and advice to the mother.* *(5.0.18)*
- *Postpartum: Describes in hospital limited visits to the mother following delivery.* *(5.0.19)*

*Other Important Terms (5.0.20)*

- *Add-On: A procedure that is always performed in association with another procedure and never by itself. An add-on procedure is paid at full fee. (5.0.21)*
- *Detention and Office Visits: Medical detention occurs when a practitioner's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time may only be claimed for emergency care and/or treatment provided outside of the office. (5.0.22)*
- *Group Practice Clinic: A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients. (5.0.23)*
- *Interpretive Component: This is the interpretation of the results of a diagnostic procedure for which a fee may be claimed separately from performing the procedure itself. Any claim with the modifier RO=INTP (role = interpretation) must be submitted with the date the services were performed and not the date of interpretation. (5.0.24)*
- *Premium Fees: Additional amounts paid above normal or customary rates on eligible services provided on an emergency basis during designated times. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient. (5.0.25)*
- *Sessional Fees: Apply to preapproved services of a physician engaged on a time basis; e.g., approved group immunization and Well Women's Clinics, public health medicine or other professional services to a government department, agency or public body. (5.0.26)*
- *Statutory Holiday: Holidays are defined for the purpose of claiming special rates as New Year's Day, Heritage Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Truth and Reconciliation Day, Thanksgiving, Remembrance Day, Christmas Day and Boxing Day. The list of dates designated as statutory holidays will be issued annually by MSI. Note: If a physician chooses to provide routine, scheduled services during a statutory holiday, they are not entitled to payment at the holiday rate. (5.0.27)*
- *Technical Component: Some diagnostic procedures have separately listed technical and interpretive components. When a physician must perform the technical component of a procedure that is normally carried out by a technician, the physician may claim a fee for the technical component. If a technician carries out the technical component, the physician may claim for the interpretive component only. (5.0.28)*
- *Transfer of Care: Occurs when the responsibility for the care of a patient is completely transferred, either temporarily or permanently, from one physician to another. (5.0.29)*

# ASSESSMENT RULES FOR VISITS AND RELATED SERVICES *(5.1.0)*

Visit is a generic term used for service encounters where there is an evaluation of a patient either as the sole service or in association with one or more procedural services. A visit may not be claimed where the procedural service includes a visit component or where claiming a visit is otherwise prohibited. Visits are governed by a common set of rules, and more specific rules apply to different categories of visits. Visits may occur in all locations and include consultations, counselling, psychotherapy and care, as in ICU, directive, continuing, or supportive care. *(5.1.1)*

There are several different Canadian Classification of Procedures (CCP) codes that apply to visits and multiple factors that modify these codes. Care must be taken to identify the appropriate code for the visit service provided, and any modifying factors. Not all combinations of codes and modifiers are valid. *(5.1.2)*

There are 5 health service codes that describe diagnostic interview and evaluation and consultations including:

**03.03** - Diagnostic Interview and Evaluation, described as Limited - Limited assessment with history of the presenting problem.

**03.04** - Diagnostic Interview and Evaluation, described as Comprehensive - In depth evaluation with complete history and physical examination.

**03.05** - Other Diagnostic Interview and Evaluation (includes critical care, ventilatory care, comprehensive care, intensive care, neonatal intensive care).

**03.07** - Consultation, described as Limited – Examination limited to the relevant body systems and a history relating to the presenting problem with a written report to the referring provider.

**03.08** - Consultation, described as Comprehensive – In depth evaluation with complete history and physical examination appropriate to the physician's specialty with a written report to the referring provider. *(5.1.3)*

## VISIT TYPES *(5.1.4)*

### LIMITED VISIT *(5.1.5)*

A limited visit or an initial limited visit may be claimed when the physician provides a limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems. *(5.1.6)*

### COMPREHENSIVE VISIT *(5.1.7)*

A comprehensive visit or a subsequent comprehensive visit is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaints or medical condition. This service includes ensuring a complete history is recorded in the medical record and performing a physical examination appropriate to the physician's specialty and the working diagnosis. *(5.1.8)*

Documentation of the following provides a clear indication that a comprehensive visit has taken place:

1. A detailed patient history including:

- Relevant history of presenting complaint
- Relevant past medical and surgical history
- Medication list
- Allergies
- Family history, as appropriate
- Social history, as appropriate

2. A complete physical exam including:

- A complete physical examination, appropriate to the physician's specialty and relevant to the presenting complaint.
- Documentation describing the pertinent positive and negative findings of the physical examination. It is not adequate to indicate 'physical exam is normal' without indicating what was examined.

In situations in which these criteria are not met, it would be appropriate to claim the visit as a limited visit, i.e., 03.03.

Comprehensive visits may not be claimed within 30 days of a previous limited or comprehensive visit. However, a subsequent comprehensive visit may be claimed by the specialties of internal medicine, neurology and paediatrics.

For internal medicine, neurology and paediatrics, an initial comprehensive visit may be claimed provided all of the above requirements are met and the patient is being seen for a new condition or complication of an existing condition. If the patient is not being seen for a new condition or complication of an existing condition, an initial visit may not be claimed and either a subsequent 03.04 or 03.03 should be claimed, depending on whether the above requirements have been satisfied.

It is not appropriate to claim either an initial or subsequent 03.04 for all follow-up visits after 30 days have passed; the requirements noted above must be satisfied.

## GENERAL VISIT RULES *(5.1.9)*

a) When the sole reason for the visit is to provide a procedure to a patient, only the listed procedure fee will apply. *(5.1.10)*
b) Only one visit may be claimed from a single service encounter. *(5.1.11)*
c) A comprehensive or initial limited visit may not be claimed within 30 days of a comprehensive consultation on the same patient for the same condition. *(5.1.12)*
d) A comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. However, a subsequent comprehensive visit service may be claimed by the specialties of internal medicine, neurology, and paediatrics. These restrictions do not apply to general practice. *(5.1.13)*
e) An initial limited visit service used by certain specialties may not be claimed within 30 days of any visit or procedure. A limited visit only will apply. *(5.1.14)*
f) Visits requested in one time period and performed in another time period must always be claimed using the lesser of the two rates. *(5.1.15)*
g) When follow-up visits are made at the convenience of the physician, the 0800 to 1700, Monday to Friday visit rate will apply. *(5.1.16)*
h) If more than one visit is provided by the same physician to the same patient on the same day in separate service encounters, documentation of the necessity for the extra visits must be recorded on the chart. Time of service occurrence must be provided on second and subsequent visits. *(5.1.17)*
i) A Pap smear may not be claimed in addition to a visit, consultation or procedure for a gynaecological or obstetrical diagnosis, nor is it payable in addition to a complete physical exam. *(5.1.18)*
j) When a visit is made solely for an injection, then only an injection may be claimed. The injection must be provided under the direct supervision of a physician physically present on the premises. *(5.1.19)*
k) A visit is not claimable with psychotherapy or counselling codes at the same service encounter. *(5.1.20)*

## CARE BY MORE THAN ONE PHYSICIAN – LIMITED VISITS *(5.1.21)*

Care by more than one physician refers to ongoing visit services provided to a patient where some form of coordination of the responsibility for the patient's care between a referring physician and the consultants is implied. All care visits are coded as limited visits, and the nature of the responsibility of the physicians involved determines the role claimed (See Definition for Transfer of Care in Section 6 (6.0.100)). *(5.1.22)*

**Supportive Care**: Is defined as a limited visit provided by the family physician or referring physician in a situation where the responsibility for the medical and surgical care of a registered hospital inpatient has temporarily been transferred to a consultant.

a) Service encounters are limited to only once every three days from the date of hospital admission up to and including the ninth day, and twice weekly thereafter for the remainder of the patient's hospital stay.
b) If medical complications develop or are present that require active management by the referring physician, regular hospital visits, not supportive care, should be claimed. *(5.1.23)*

**Directive Care**: Is defined as a limited visit following a consultation that can be claimed for services provided in the office, home or to registered inpatients by specialist consultants. It is intended that the referring physician is responsible for the general condition of the patient and that the consultant is directing only the care relevant to their specialty. In such cases the consultant may claim directive care and the referring physician may claim the appropriate home, office or inpatient visit. More than one specialist at a time may claim directive care on a patient. *(5.1.24)*

**Continuing Care**: Is defined as a limited visit following a consultation that can be claimed for services provided in the office, home or to registered inpatients by specialist consultants. It is intended that the consultants assume responsibility for the care of the patient's medical condition. When the patient remains in the hospital and the consultant is providing continuing care, the general practitioner or paediatrician may claim supportive care. Only one consultant may claim continuing care for a hospital inpatient at a time. When a specialist is providing continuing care in the home or office, the general practitioner may claim the appropriate visit code. *(5.1.25)*

## LIMITED VISITS BY LOCATION *(5.1.26)*

a) **Office**: A limited visit may be claimed when the physician sees the patient and performs a limited assessment for a new condition or when monitoring or providing treatment of an established condition. *(5.1.27)*
b) **Outpatient Department (OPD) Emergency Department**: A limited visit may be claimed when the physician provides medical treatment to a patient presenting to an OPD emergency department. It is payable at the appropriate fee for the time at which the service is provided. *(5.1.28)*
c) **Hospital**: A limited visit may be claimed when the physician provides daily care to the patient. Daily limited visits may be claimed by more than one physician when different conditions are being treated. A weekly maximum applies to routine hospital visits to patients after 56 days hospitalization except for paediatricians. Multiple unscheduled visits on the same day are excluded from the weekly maximum. This composite fee includes reviewing lab work, discussions with the patients and/or their families and instances in which the physician electively returns to reassess a patient. Additional visits may not be claimed for such activities as they are included in the daily rate. *(5.1.29)*
d) **Home Care**: A limited visit may be claimed when the physician provides daily care to the patient and may occur at the patient's home or OPD. Home care services are to be discontinued when no longer required. The patient's requirement for home care is reviewed regularly. *(5.1.33)*

In exceptional circumstances, extended admissions for up to a total of 30 days may be authorized by the care coordinator in consultation with the attending physician. *(5.1.34)*

e) **Home or Other Locations**: A limited visit may be claimed when the physician provides a limited examination for diagnosis and treatment of a patient's condition or provides ongoing treatment of an established condition. Requirements specific to location (5.1.44) must be met. *(5.1.35)*

f) **Institutions**: See Section 6 (6.0.45). *(5.1.36)*

## COMPREHENSIVE VISITS BY LOCATION *(5.1.37)*

a) **Office**: Comprehensive visits in the office may not be claimed more than once every 30 days when diagnosing and treating a new condition or further complications of an existing condition. Visits provided within a 30-day period for the same condition or complication should be claimed as a limited visit. *(5.1.38)*

b) **OPD or Emergency Department**: A comprehensive visit may be claimed, when appropriate, in the OPD or emergency when a patient is seen for the first time that day by that physician. Follow-up visits for the same condition on the same or subsequent day should be claimed as a limited visit. *(5.1.39)*

c) **Hospital**: A comprehensive visit may be claimed for the first examination in hospital for diagnosis and treatment once per patient per admission for each specialty involved in the care of the patient. If a patient has a comprehensive visit in the emergency department (ED) by the family doctor covering the ED and is then admitted and has a second comprehensive visit by a different admitting family doctor, the ED physician may claim the complete examination code and the admitting physician may claim the first examination code. *(5.1.40)*

   i. If a specialist readmits a referred patient within 30 days for the same or related condition, only a limited visit may be claimed.
   ii. There are no restrictions on paediatricians readmitting referred patients.
   iii. If a specialist readmits a non-referred patient within 10 days for the same or related condition, only a limited visit may be claimed.
   iv. If a general practitioner readmits any patient within 10 days for the same or related condition, only a limited visit may be claimed. *(5.1.41)*

d) **Home or Other Locations**: A comprehensive visit may be claimed when diagnosing and treating a new condition or further complication of an existing condition but may not be claimed more than once every 30 days. Comprehensive visits provided within a 30-day period will be approved at the appropriate limited visit fee. Requirements specific to location (5.1.44) must be met. *(5.1.42)*

e) **Institutions**: See Section 6 (6.0.45). *(5.1.43)*

## RULES SPECIFIC TO LOCATION *(5.1.44)*

a) **OPD and Emergency Department**: If the patient is kept in OPD or emergency under observation for more than four hours, an additional limited visit may be claimed when the need can be supported by the patient's condition and documentation on the chart. *(5.1.45)*

   i. First Patient Seen: The rate for the first patient seen is only applicable for those cases requiring the physician to make a separate trip to the OPD or emergency department.
   ii. Additional Patients: An extra patient limited visit is applicable for additional patients seen following the first patient. The rate for extra patients is applicable for additional patients seen following each separate trip to the hospital. An extra patient limited visit applies in those situations where a physician is in the hospital for any purpose and is asked to see a patient in the OPD or Emergency Room. *(5.1.46)*

b) **The Emergency Care Centre**: Visit rates may only be claimed in designated emergency care centres approved by the Department of Health and Wellness. *(5.1.47)*

c) **A Home Visit**: Is a service rendered by a physician to a homebound patient or patients following travel to the patient's home. The patient or patient's representative has requested a visit with the physician. A home visit may only be claimed when the patient's condition or situation justifies the service, and the patient is homebound.
A patient is considered to be homebound when one or more of the following conditions are met and documented in the health record:
i. Leaving the home isn't recommended because of the patient's condition;
ii. The patient's condition keeps them from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person);
iii. Leaving home takes a considerable and taxing effort.
If the patient is not considered homebound, the visit is considered to be rendered at home for convenience. In this situation, the visit may be claimed at the normal office rate and travel may not be claimed. *(5.1.48)*
   i. Additional patients seen in the same apartment or private dwelling: The first person seen is claimed at the appropriate home visit. Other patients seen are claimed as additional patients. However, a visit to another apartment in the same building is regarded as a separate home visit and the appropriate fee should be claimed for the first person seen therein. *(5.1.49)*

d) **An Institutional First Visit**: Arises when, at the specific request of an appropriate institutional authority, patient or patient's family or guardian, the physician visits and renders services to the patient in an institution. *(5.1.50)*
   i. Additional patients seen at the same visit should be claimed at the appropriate limited visit fee.
   ii. When prearranged routine trips are made to an institution, limited visit fees shall be claimed only for those patients where medical necessity exists.
   iii. If the physician believes their services are inadequately compensated under the institutional visit rules, they may enter into a contractual agreement with the institution for a form of retainer or other remuneration method to supplement their income from visit fees.
   iv. Physicians may also report additional visits when required by medical necessity (or necessity for follow up of an ongoing medical problem) and there has been a request from the patient, their family or nursing home staff for the visit. *(5.1.51)*

## URGENT VISITS (ALL LOCATIONS) *(5.1.52)*

An urgent visit is such that the physician responds immediately with regard to the patient's condition. Attendance due to personal choice or availability does not constitute an urgent visit. If a physician is called to attend a patient that interrupts their regular office hours and travels from one location to another, the appropriate explicit modifier must be entered on the service encounter to ensure payment of the appropriate rate. For example, modifier type and value US=UIOH describes unscheduled = urgent visit interrupting normal office hours. Travel is defined in 2.0.10. *(5.1.53)*

The underlying principle is that the demands of the patient's condition and/or the physician interpretation of that condition, is such that the physician must respond immediately. Immediate attendance because of personal choice or availability does not constitute an urgent visit. (See Section 6 (6.0.101)). While an urgent visit is appropriate for the first patient seen at a facility, it does not apply to the second or subsequent patients seen at the same location as the physician is already physically in the facility and thus no travel occurred. *(5.1.54)*

a) **Urgent Visit Hospital Inpatient**: Request by hospital staff. An urgent visit applies when a physician travels to see a registered inpatient at the request of hospital staff. *(5.1.55)*

b) **Urgent Care in Office Request by Patient**: An urgent care visit applies when the physician is called to see the patient and must travel to their office outside the hours of 0800 to 1700 Monday to

Friday or during other scheduled office hours. An urgent care visit does not apply to a patient attending the office during scheduled office hours regardless of the patient's condition. If additional patients are seen at the same time, a limited visit applies. *(5.1.56)*

c) **Urgent Visit Sacrifice of Office Hours**: All other locations. An urgent visit may be applied when the physician is called to see a patient and interrupts their regular office hours and travels from one location to another to attend the patient. *(5.1.57)*

## GENERAL PRACTICE COMPLEX CARE VISIT *(5.1.58)*

A complex care visit code may be billed a maximum of four times per patient per year by the family physician and/or the practice (not by walk in clinics) providing ongoing comprehensive care to the patient who is under active management for three or more of the following chronic diseases: asthma, chronic obstructive pulmonary disease, diabetes, chronic liver disease, hypertension, chronic renal failure, congestive heart failure, ischemic heart disease, dementia, chronic neurological disorders, or cancer. The physician must spend at least 15 minutes in direct patient intervention and the visit must address at least one of the chronic diseases either directly or indirectly. Start and finish times are to be recorded on the patient's chart. *(5.1.59)*

Documentation must indicate the three eligible chronic diseases under active management or there must be a readily accessible patient profile listing the chronic diseases in the patient record. The documentation or profile may include the date of onset (when/if this is known by the physician). *(5.1.60)*

### Definitions *(5.1.61)*

- The term active management is intended to mean that the patient requires ongoing monitoring, maintenance or intervention to control, limit progression, or palliate a chronic disease. *(5.1.62)*
- The term chronic neurological disorders is intended to include progressive degenerative disorders such as multiple sclerosis, amyotrophic lateral sclerosis, Parkinson's disease, Alzheimer's disease, stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia and epilepsy. *(5.1.63)*
- Chronic Renal Failure is defined as: (eGFR) <60 mL/min/1.73 $m^2$ for three months or equivalent calculated creatinine clearance. *(5.1.64)*

## CASE MANAGEMENT CONFERENCE FEE *(5.1.65)*

A case management conference is a formal, scheduled, multidisciplinary health team meeting. It is initiated by an employee of the Nova Scotia Health Authority/Izaak Walton Killam Hospital or a non-physician regulated health care professional within the patients circle of care at a provincially registered nursing home, residential care facility or hospital to discuss the provision of health care to a specific patient. Neither the patient nor the family need to be present. *(5.1.66)*

It may be claimed by more than one physician simultaneously as necessary for case management. *(5.1.67)*

The case conference must be documented in the health record with a list of all physician participants. *(5.1.68)*

To claim the case management conference fee, the physician must participate in the conference for a minimum of 15 minutes and remuneration will be calculated in 15-minute time increments based on the sessional rate. Start and finish times are to be recorded on the patient's chart. 80% of a 15-minute time interval must be spent at the conference in order to bill that time interval. *(5.1.69)*

Multi-disciplinary refers to the attendance of two or more licensed health care professionals in addition to a physician. *(5.1.70)*

The case management conference fee is not to be used for attendance at regularly scheduled meetings concerning ongoing care planning or patient management for one or more patients; i.e., grand rounds, tumor board case rounds, teaching rounds, transplant rounds or other similar methods of specialist physicians

conferring about the medical management of complex cases. It is not to be used in circumstances which are a usual part of patient care such as transfer of care between physicians on evenings and weekends. *(5.1.71)*

Physician attendance at case management conferences held by video conferencing or teleconferencing is eligible for payment providing all other eligibility requirements are met. *(5.1.72)*

Each case conference must be specific to an individual patient and the time spent by the physician at the conference must be documented in the health record of that patient. However, consecutive formal scheduled conferences, each pertaining to one named patient, with start and finish times recorded in each health record, would be permitted. *(5.1.73)*

NOTE: If the patient is located in an institution, documentation pursuant to the billing guidelines must be located within the patient record in the institution. If the patient is not located in an institution, documentation regarding the case management conference must be readily available; e.g., in the patient record maintained by the physician claiming the fee. The onus will be on the physician billing the fee to ensure appropriate documentation is readily available. *(5.1.74)*

## DETENTION TIME *(5.1.75)*

Medical detention occurs when a service provider's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time is not payable when provided in the office. (See Section 6 (6.0.23)) *(5.1.76)*

Visits: When detention is claimed with limited or comprehensive visit services, detention commences 30 minutes after the practitioner is first in attendance and may be claimed in 15-minute increments thereafter. The first 30 minutes is the appropriate visit fee.

Consultations: When detention is claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour.

Obstetrical Delivery: When detention is claimed with an obstetric delivery provided by a general practitioner, detention time commences after 3 hours.

This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor facility to the recipient facility for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor facility. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the start and finish times involved, should be documented with the service encounter and in the patient record. *(5.1.77)*

The fee for detention is 15 units per 15 minutes for general practitioners and 17.5 units per 15 minutes for specialists. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)*

Detention time does not apply to:

a) Waiting time for an operating room, x-rays, laboratory results or administrative duties
b) Counselling or psychotherapy
c) Advice given to the patient or patient's family or representatives
d) Waiting time for a patient's arrival for assessment or treatment
e) Waiting time for attendance by another medical practitioner or consultant
f) Return trip if the physician is not in attendance with a patient
g) Time spent in completing or reviewing patient charts
h) More than one patient at a time
i) Office visits *(5.1.79)*

Detention time is not payable in conjunction with fees paid for the following on the same day:

a) Intensive care or critical care (See Section 5 (5.1.123 and 5.1.133))
b) Diagnostic and therapeutic procedures
c) Obstetrical delivery by specialties other than general practitioner *(5.1.80)*

## PREMIUM FEES *(5.1.81)*

Premium fees (See Section 6 (6.0.72)) may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient. *(5.1.82)*

Premium fees may be claimed for:

a) Consultations except where a consult is part of the composite fee
b) Surgical procedures except those performed under local or no anaesthetic
c) Fractures regardless of whether an anaesthetic is administered
d) Obstetrical deliveries
e) Newborn Resuscitation
f) Selected diagnostic imaging services
g) Pathology services
h) Selected endoscopic procedures (See Appendix F 7.6.0) *(5.1.83)*

The designated times where premium fees may be claimed and the payment rates are: *(5.1.84)*

| Time Period | Time | Payment Rate Increase |
|---|---|---|
| Monday to Friday | 17:00 – 23:59 | US = PREM (35 percent) |
| Tuesday to Saturday | 00:00 – 07:59 | US = PR50 (50 percent) |
| Saturday | 08:00 – 16:59 | US = PREM (35 percent) |
| Saturday to Monday | 17:00 – 07:59 | US = PR50 (50 percent) |
| Recognized Holidays | 08:00 – 23:59 | US = PR50 (50 percent) |

*(5.1.85)*

Premium fees also apply to emergency anaesthesia for a surgical procedure (not a diagnostic or therapeutic procedure) provided by a non-certified anaesthetist at the interruption of their regularly scheduled office hours. *(5.1.86)*

Premium fees are paid at 35 percent or 50 percent of the appropriate service code but at not less than 18 units for patient specific services and at not less than 9 units for non-patient specific diagnostic imaging and pathology. *(5.1.87)*

The premium fee modifier type and value US=PREM Unscheduled Premium 35 percent or US=PR50 Unscheduled Premium 50 percent must be indicated. *(5.1.88)*

If a service requires use of an anaesthetic, the anaesthetic start time determines if a premium fee may be claimed. *(5.1.89)*

Premium fees may not be claimed with:

a) Detention
b) Critical care/intensive care
c) Diagnostic and therapeutic procedures other than selected diagnostic imaging services and selected endoscopic procedures (See Appendix F 7.6.0)
d) Surgeons and assistants fees for liver transplants *(5.1.90)*

## RADIOLOGY PREMIUM FEES *(5.1.201)*

Premium fees can be claimed in situations in which there has been a direct request made to a radiologist for an emergency interpretation of a specific study because of the condition of the patient and the radiologist responds without delay to the request. Services of a non-emergency nature or services of an emergency nature but not performed without delay during these times do not qualify for premium rates. This includes booked procedures performed during premium hours, during times the radiologist or the resident they are supervising is scheduled to be onsite in the radiology department, and interpretations done after hours for which there has not been a specific request made to the radiologist about a specific imaging study. If a study has been ordered but the radiologist has not been specifically contacted by the attending physician and requested to provide an emergency interpretation, a premium cannot be claimed. *(5.1.202)*

All physicians claiming premium fees are required to be able to provide documentation that verifies requirements for these services have been met. *(5.1.203)*

## AFTER HOURS SERVICE PREMIUM (AHSP1) *(5.1.204)*

This premium applies in circumstances where elective procedures are moved to an eligible premium time period due to factors beyond control of the physician. The 35% after hours service premium is intended to compensate the physician for the disruption of their personal time while providing extended hours of service in addition to the scheduled workday. *(5.1.205)*

The AHSP1 may only be reported for scheduled electively booked interventional procedures that have been moved to a premium eligible time period due to factors beyond control of the physician. The premium does not apply to elective procedures that have been intentionally booked to start before 0800 hours, scheduled weekend joint replacement OR lists etc. *(5.1.206)*

Only one claim for AHSP1 is required for all applicable services billed during the same occurrence. While not a billing requirement, physicians may reference in the text the service encounter number(s) or health service code(s) the premium should apply to, as this may expedite processing and reduce wait times. *(5.1.207)*

The AHSP1 is restricted to hospital location and surgical specialities, endoscopies and interventional radiology.

| Time Period | Time |
|---|---|
| Monday to Friday | 17:00 – 23:59 |
| Tuesday to Saturday | 00:00 – 07:59 |
| Saturday | 08:00 – 16:59 |
| Saturday to Monday | 17:00 – 07:59 |
| Recognized Holidays | 08:00 – 23:59 |

*(5.1.208)*

## REFERRED SERVICES *(5.1.91)*

Referred services include all types of consultations and any visits subsequent to the original referral. In the absence of a proper referral, specialty rates may not apply. *(5.1.92)*

A consultation may not be claimed in the circumstances listed below:

a) Where ongoing care is provided without an original referral the appropriate non-referred visit is payable.
b) The patient's regular attending physician cannot claim a consultation and must claim the appropriate visit.
c) A consult may not be claimed for referrals from other health care professionals; e.g., nurses, podiatrists. However, consults may be claimed for referrals from nurse practitioners, midwives, optometrists and dentists, as well as audiologists to specific specialties.

d) A consultation may only be claimed by the following specialties when a patient is referred by an audiologist: Otolaryngology, Neurology and Internal Medicine specialists. Their referrals are limited to 03.07 and 03.08 only. All applicable preamble rules apply. *(5.1.93)*

Some services may not be claimed in addition to a consultation (See Section 5 (5.3.25)). *(5.1.94)*

**Consultation**: A consultation is a service resulting from a formal request by the patient's physician, nurse practitioner, midwife, optometrist or dentist after appropriate evaluation of the patient, for an opinion from a physician qualified to furnish advice. This may arise when the complexity, obscurity or seriousness of the patient's condition demands a further opinion, when the patient requires access to specialized diagnostic or therapeutic services, or when the patient, or an authorized person acting on the patient's behalf, requests another opinion. *(5.1.95)*

A consultation requires a written report to the referring physician, nurse practitioner, midwife, optometrist, dentist or audiologist; an evaluation of relevant body systems; an appropriate record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient, other persons relevant to the case, and the referring physician, nurse practitioner, midwife, optometrist or dentist. The composition of a consultation will vary with a particular specialty. *(5.1.96)*

Consultations are listed as health service codes 03.08 comprehensive consultation and 03.07 limited or repeat consultation. The amount payable for the service varies according to the specialty and additional modifiers or modifier combinations. For example, a repeat consultation with a premium fee would be shown as modifier type and value, RP=REPT, US=PREM a repeat service, unscheduled premium fee 35 percent. A valid referring service provider number must be provided when submitting a service encounter for a consultation. *(5.1.97)*

The Health Services and Insurance Act, Item 33, provides that Nova Scotia Medical Services Insurance has the authority to require a copy of the consultation report for administrative purposes. *(5.1.98)*

**Comprehensive Consultation**: A comprehensive consultation is a comprehensive visit (See Section 5 (5.1.7)) with a written report to the referring physician, nurse practitioner, midwife, optometrist, dentist or audiologist. This service includes performing and recording of a complete history and a complete physical examination appropriate to the physician's specialty. *(5.1.99)*

**Limited Consultation**: A limited consultation is performed when the nature of the patient's problem does not warrant a comprehensive consultation. A limited consultation includes a history limited to and related to the presenting problem, and an examination that is limited to relevant body systems. *(5.1.100)*

**Repeat Consultation**: A repeat consultation applies only where there has been a re-referral of the patient by the same physician, nurse practitioner, midwife, optometrist, dentist or audiologist to the same consultant for the same condition or complication thereof within 30 days of the initial consultation. A repeat consultation requires all the elements of a limited consultation and implies interval care by another physician. *(5.1.101)*

The situation where the consultant requests the patient to return for a later examination is not a repeat consultation. *(5.1.102)*

**Prolonged Consultation:** A prolonged consultation may be applied to cases where the consultation extends beyond one hour for comprehensive consultations. A prolonged consultation cannot be claimed with a limited consultation. Prolonged consultations are paid in 15-minute time blocks or portion thereof. Prolonged consultations are not to be confused with active treatment associated with detention. These are entered on the service encounter as multiples. As with all services paid based on time, start and finish times must be recorded on the patient record. *(5.1.103)*

An obstetrics and gynaecology prolonged consultation may be applied to cases where the consultation extends beyond thirty minutes for a Comprehensive Consultation specifically for preconceptual consultation (Maternal fetal medicine), consultation for issues of sexual dysfunction, reproductive endocrinology, gynaecologic oncology, and urogynaecology and may be claimed by physicians with recognized expertise in these fields. No other fee codes may be billed for the same patient for that time period. Obstetrics and gynaecology prolonged consultations are paid in 15-minute time intervals or portions thereof, 80% of the time must be direct physician to patient contact *(5.1.104)*

A prolonged consultation may be claimed only by the following specialties:

| | | |
|---|---|---|
| a) | Anaesthesia | 15 units per 15 minutes |
| b) | Internal medicine | 15.5 units per 15 minutes |
| c) | Neurology | 15.5 units per 15 minutes |
| d) | Physical medicine | 15.5 units per 15 minutes |
| e) | Paediatrics | 16.3 units per 15 minutes |
| f) | Obstetrics and gynaecology | 13.5 units per 15 minutes |
| g) | Palliative care | 15.5 units per 15 minutes *(5.1.105)* |

Example: <u>Internal medicine comprehensive consultation</u>

| | | |
|---|---|---|
| MU=2 | 1 1/4 hour | Total Time |
| MU=3 | 1 1/2 hour | Total Time |
| MU=4 | 1 3/4 hour | Total Time |
| MU=5 | 2 hour | Total Time |

<u>Repeat consultation or obstetrics and gynaecology consultation</u>

| | | |
|---|---|---|
| MU=2 | 3/4 hour | Total Time |
| MU=3 | 1 hour | Total Time |
| MU=4 | 1 1/4 hour | Total Time |
| MU=5 | 1 1/2 hour | Total Time |

Example: Obstetrics and gynaecology

<u>Comprehensive consultation</u>

| | | |
|---|---|---|
| MU=2 | 3/4 hour | Total Time |
| MU=3 | 1hour | Total Time |

<u>Repeat consultation</u>

| | | |
|---|---|---|
| MU=2 | 3/4 hour | Total Time |
| MU=3 | 1 hour | Total Time *(5.1.106)* |

**Non-specialist physicians:** Consultations for non-specialist physicians will usually be paid at the general practitioner consultation rate except where alternative arrangements have been made with the Department of Health and Wellness. *(5.1.107)*

**Extended Comprehensive Psychiatry Consultation 03.08A *(5.1.209)***

When direct physician to patient time exceeds 60 minutes. The extended comprehensive psychiatry consultation follows all preamble rules pertaining to comprehensive visits and consultations. After the initial 60 minutes of direct physician to patient time, the psychiatrist must spend at least 80% of the time in direct physician to patient contact. Multiples may be claimed after 75 minutes and are calculated in 15-minute intervals, or portion thereof to a maximum of 180 minutes. 80% of the time must be in direct physician to patient contact. *(5.1.210)*

| Example: | Multiples | Time Claimed | Time spent with patient |
|---|---|---|---|
| | MU=1 | 61 minutes | 61-71 minutes |
| | MU=2 | 75 minutes | 72-86 minutes |
| | MU=3 | 90 minutes | 87-101 minutes |
| …max | MU=9 | 180 minutes | 177-180 minutes |

**Family Physician (GENP) Comprehensive Consultation** ***(5.1.225)***

When a patient is referred to a family physician (GENP), a comprehensive consultation may only be claimed by Family Physicians (GENP) who hold and maintain a Certificate of Added Competence (CAC) awarded by the College of Family Physicians of Canada (CFPC) and only in the area of the CAC in which they hold; (Addiction Medicine, Care of the Elderly, Emergency Medicine, Enhanced Surgical Skills, Family Practice Anesthesia, Obstetric Surgical Skills, Palliative Care, Sports and Exercise Medicine). All Preamble rules pertaining to consultations and comprehensive visits must be followed *(5.1.225)*

**Colon Cancer Prevention Program Referral**

When a patient is referred with a formal referral from the Colon Cancer Prevention Program for a colonoscopy, a limited consultation (HSC 03.07) may be billed at the time of the colonoscopy procedure, in accordance with the Preamble rules, if the patient has not previously been seen in consultation. *(5.1.211)*

When a patient is referred from the CCPP with a formal referral from the Colon Cancer Prevention Program for a medical assessment prior to booking a colonoscopy a comprehensive (03.08) or limited (03.07) consultation may be billed depending on the situation, in accordance with the Preamble rules. *(5.1.212)*

## OTHER CARE OR VISITS *(5.1.108)*

### TRANSFER OF CARE *(5.1.109)*

a) **A transferral**: As distinguished from a referral, takes place when there is formal transfer of responsibility for the patient's care from one physician to another (See Section 6 (6.0.100)). *(5.1.110)*
**Temporary transfer**: Would include situations where the first physician must be absent, e.g., holiday or illness and arranges patient coverage by the second physician with the intention of resuming care of the patient upon return. *(5.1.111)*
**Permanent transfer**: Would involve any situation where the physician has no intention of resuming care of the patient. *(5.1.112)*

b) Regardless of specialty, the physician to whom the patient is transferred is not entitled to a consultation or comprehensive visit fee. When transfers occur from one specialty to another or from one hospital to another, the receiving physician may be entitled to a consultation or comprehensive visit fee. *(5.1.113)*

c) However, if the patient has a medical problem necessitating referral to another physician, and responsibility for the patient's care is transferred with or subsequent to the referral, it is appropriate for the receiving physician to claim a consultation. *(5.1.114)*

### SUPERVISION *(5.1.115)*

Supervision of treatment by a physician, without actually having a face-to-face interaction with the patient, is a service that may be claimed in the following special cases: *(5.1.116)*

Supervision of home dialysis refers to supervision by a nephrologist of patients registered in a home dialysis program.

a) Home dialysis program registration is initiated when a patient begins training or is accepted into a program, and terminates with successful transplantation, change to in centre dialysis, loss of resident status, or death.
b) No inpatient chronic dialysis supervision fees may be charged on the registered patients. However, if a registered patient is admitted to a centre without an attending nephrologist and the patient is incapable of performing their own dialysis, the attending physician may claim the treatment of chronic renal failure by any dialytic method. Other inpatient visits and procedures may be claimed during hospital admission.
c) The supervisory fee is for comprehensive management of all aspects of home dialysis care for registered patients, including all scheduled or emergent outpatient visits, direction of care by phone or other means, and liaison with other treating physicians.
d) Supervisory fee is claimed monthly by the supervising nephrologist for each home dialysis program patient registered as of the first day of that month. For newly registered patients, service encounters commence the following month. *(5.1.117)*

Payment for supervision of a home care patient can include medical chart review, telephone calls, fax or e-mail advice and blended mileage travel detention (See Section 2 (2.2.43)). *(5.1.119)*

Supervision of a patient on long term warfarin therapy (13.99C) may be claimed once monthly if the patient's treatment is managed by telephone, fax or e-mail advice and the patient is not participating in the Community Pharmacy-led Anticoagulant Management Services. If the date of service falls within a complete month of hospitalization, this service may not be claimed. *(5.1.118)*

Community Pharmacy-led Anticoagulant Management Services (CPAMS) enables patients on warfarin to see a pharmacist for point-of-care INR testing and dosage adjustments. If a physician's patient is participating in CPAMS, the physician may only bill the management fee (13.99H) when they are specifically asked to consult with the pharmacy on the patient's case. More information can be found on the Pharmacy Association of Nova Scotia (PANS) website: https://pans.ns.ca/cpams *(5.1.213)*

## TUNNELED CATHETER FOR USE IN DIALYSIS (66.98E, 66.98F, 66.98G) *(5.3.261)*

These are comprehensive codes for the percutaneous insertion, removal and repositioning of a tunneled intraperitoneal catheter. 66.98E and 66.98G include all imaging guidance and injection of contrast as required to complete the procedure, and 66.98F includes all services required to remove the device and close the wound. These three health service codes are restricted to SP=NEPH and LO=HOSP, QEII only. *(5.3.261)*

## DISCHARGE SERVICES *(5.1.214)*

### Hospital Discharge Fee (03.02A) *(5.1.215)*

This fee may be claimed by the physician, either a general practitioner or a specialist when a patient is admitted for non-surgical hospitalization, who performs the activities involved in discharging a hospital inpatient. These activities include, as necessary, the completion of the patient's chart, discharge summary, writing prescriptions for the patient, providing discharge instructions to the patient and arranging for follow-up care for the patient.

The fee is not payable where major surgery, minor surgery, major fracture and/or minor fracture care is provided in a hospital setting unless a patient is transferred to a general practitioner or internal medicine specialist for follow-up care after surgery/fracture care. In this case, the general practitioner or internal medicine specialist may claim the discharge fee if the general practitioner or internal medicine specialist performs the discharge duties. This fee cannot be claimed by the operation surgeon in association with any surgical code being billed. A hospital visit fee may be claimed in addition to the discharge fee where a hospital visit is provided on the same day. (SP=GENP, SP=INMD, SP=NEUR, SP=PHMD) *(5.1.216)*

**Complex Comprehensive Acute Care Hospital Discharge Fee** (03.04F) *(5.1.217)*

This fee may be claimed by the most responsible physician only (the general practitioner or internal medicine specialist) in charge of the patients care for any given day and only once per hospital inpatient hospital admission. It is intended to be used when the services provided on the day of discharge require greater than 30 minutes of the physicians time. This HSC includes all services provided to the patient on the day of discharge from the acute care hospital. These services include the discharge day examination of the patient, the completion of the patients chart, discharge summary, writing any prescriptions required for the patient, providing discharge instructions to the patient (or caregivers) and arranging for follow-up care for the patient. Every effort is made by the discharge physician to communicate with the community physician who will be most responsible for the patient's care after discharge.

If the situation arises where the complex comprehensive discharge process occurs over 2 days, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be claimed once by the MRP and may not be unbundled to accommodate splitting the workload.

A hospital visit is considered an integral part of this service and is not reportable in addition. The physician claiming this health service code may not report any other visit service for the same patient, same day. In addition, 03.02A may not be claimed as this service is included in 03.04F. Do not count time for services provided after the patient physically leaves the hospital.

The fee is not payable where major surgery, minor surgery, major fracture and/or minor fracture care is provided in a hospital setting unless a patient is transferred to a general practitioner or internal medicine specialist for follow-up care after surgery/fracture care. In this case, the general practitioner or internal medicine specialist may claim the complex discharge fee if the general practitioner or internal medicine specialist performs the complex comprehensive discharge duties. This fee cannot be claimed by the operation surgeon in association with any surgical code being billed. (SP=GENP, SP=INMD, SP=NEUR, SP=PHMD) *(5.1.218)*

**First Visit After Acute Care Inpatient Hospital Discharge – Complex Care** (HSC 03.03S) *(5.1.219)*

A complex care patient is defined as: a patient with multiple (two or more) chronic conditions; a condition expected to last one year or more, a condition that requires ongoing medical management.

This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care inpatient hospital discharge to the primary care provider responsible for the patient's ongoing care. The physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days. It is not reportable in the walk-in clinic setting. This add on is restricted to 03.03, 03.03A and 03.03E. *(5.1.220)*

This fee is reportable only if the visit occurs in the primary physician's office or the patient home within 14 calendar days after hospital discharge. It is not reportable for services rendered in other locations such as nursing homes, residential care facilities, or hospice. Hospital length of stay must be greater than or equal to 48 hours. It is not reportable if the admission to hospital was for the purpose of performing elective surgery or fracture care (major or minor), obstetrical care or newborn care. The physician must be the provider most responsible for the patient's ongoing complex care. Once per patient per inpatient admission and not reportable for any subsequent discharges within 30 days. Not reportable with in the same month as other monthly care fees such as 13.99C. Maximum of 4 claims per physician per patient per year. *(5.1.221)*

**First Visit After Inpatient Hospital Discharge – Maternal and Newborn Care** (HSC 03.03P) *(5.1.222)*

This is an additional fee for the first maternal/newborn office visit within 14 days of inpatient hospital discharge to the primary care provider responsible for the patient's ongoing care. The primary care physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of

discharge to better facilitate the patient being seen within 14 days. It is not reportable in the walk-in clinic setting. This add on is restricted to 03.03 office visit and well baby care. *(5.1.223)*

This fee is reportable only if the visit occurs in the primary physician's office or the patient home within 14 calendar days after hospital discharge. Physician must be the provider most responsible for the mother and child's ongoing care. Claimable once per patient per inpatient admission for obstetrical delivery and only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery. It is not reportable for any subsequent discharges within 30 days. Maximum of one claim per pregnancy (mother) and one claim per infant. *(5.1.224)*

## MANAGEMENT OF CLOSED HEAD INJURY *(5.1.120)*

Initial examination and recommendation re: further treatment. This service may be claimed only by a paediatrician or neurosurgeon. *(5.1.121)*

## INTENSIVE CARE UNIT *(5.1.122)*

Intensive care unit (ICU) services refers to services rendered in intensive care units (ICUs) approved by the Department of Health and Wellness by physicians who have been assigned by a hospital to the ICU staff by reason of special training or experience. *(5.1.123)*

### General Rules *(5.1.124)*

i) The 24-hour time period for claiming ICU services is from 8 a.m. to 8 a.m. of the following day. *(5.1.125)*

ii) There should only be one Day 1 (first day) claimed during the same ICU admission even if the patient's status changes. Day 1 is normally the date of admission to the ICU. However, if the physician does not actually see the patient until the next day, e.g., because a resident is covering, then day 1 can be the date when the patient is first seen by the physician. Day 1 can only be claimed again if the patient is readmitted to the ICU at least 24 hours after discharge. This does not preclude ventilatory care day 1 and critical care day 1 being claimed on the same day. *(5.1.126)*

iii) Two physicians may claim ICU fees for the same patient on the same day but not the same fee code; e.g., one can claim critical care and the other can claim ventilatory care. However, no other ICU fee code may be claimed in addition to comprehensive care. Also, the intensive care daily rate may not be claimed in addition to critical care. *(5.1.127)*

iv) If a patient is transferred from one ICU to another in the same institution, both sites can claim ICU fees on the same day. However, this precludes billing another day 1. *(5.1.128)*

v) When a transfer to a different hospital occurs, more than one physician (in different hospitals) can claim in a 24-hour period. *(5.1.129)*

vi) ICU fees can be claimed up to and including the day that the patient is medically suitable for transfer from the ICU or off ICU care. Then the intensive care daily rate or continuing care, depending on the condition of the patient, should be claimed if the patient remains in the ICU after the transfer order is written. *(5.1.130)*

vii) To claim ICU fees under ordinary circumstances, intensivists should be immediately available to the ICU. *(5.1.131)*

viii) A surgeon can claim ICU fees, except for ICU day 1 codes immediately following surgery, for their own postoperative patient if they are the sole providing physician to the patient in the ICU. Surgeons do not ordinarily claim ICU fees during the postoperative period because other physicians provide care in the ICU. However, some facilities do not have enough staff available for separate coverage of the ICU and, under these circumstances a surgeon can claim ICU fees. This does not prevent a surgeon from claiming ICU fees for nonoperative patients. If more than one physician is covering the ICU, only one physician may claim a visit. *(5.1.132)*

## Critical Care Codes (Critical Care, Ventilatory Care and Comprehensive Care) *(5.1.133)*

These codes may only be claimed for daily care of critically ill patients admitted to intensive care units approved by the Department of Health and Wellness. The critical care, ventilatory care and comprehensive care services listed below include initial consultation and assessment and daily management of the patient. Use of these codes precludes claiming for detention on any patient on the same day. *(5.1.134)*

a) **Critical Care**: Critical care comprises all aspects of care of a critically ill patient in a designated intensive care area. Critical care excludes ventilatory support except as designated below. These fees do not apply when patients who are not critically ill are admitted to an intensive care area or when patients who were critically ill recover but remain in the intensive care area, e.g., lack of beds on general ward or recovery room. *(5.1.135)*

b) **Ventilatory Care**: This includes provision of all types of ventilatory care including face mask ventilation; e.g., BiPAP ventilation; management of the intubated airway, including tracheal toilet by suction catheter with or without instillation; and use of mechanical ventilation of the critically ill patient as well as the supervision and obtaining of blood for blood gas assessment. *(5.1.136)*

c) **Comprehensive Care**: When a physician provides both critical care and ventilatory support services to a patient, a service encounter claim should be submitted for comprehensive care. *(5.1.137)*

d) **Extracorporeal membrane Oxygenation (ECMO)**: When one physician provides critical care, ventilator support services, and manages extracorporeal membrane oxygenation for the patient in a designated intensive care area, a service encounter claim should be submitted for Comprehensive care for patient requiring Extracorporeal Membrane Oxygenation. *(5.1.138)*

e) The following specific procedures are included within the critical care tariff:
- Arterial puncture
- Blood gases
- Cardiac arrest
- Cardioversion and noninvasive transthoracic pacing
- Defibrillation
- Emergency resuscitation
- Haematology and biochemistry
- Insertion of arterial lines percutaneously or by cut down
- Insertion of chest tube
- Insertion of CVP catheters percutaneously or by cut down
- Insertion of intravenous lines
- Insertion of urinary catheters and nasogastric tubes
- Interpretation of laboratory tests
- Interpretation of rhythm strips
- Intracranial pressure monitoring interpretation
- Lumbar puncture
- Management of cardiac arrhythmias
- Paracentesis
- Stress test
- Thoracentesis
- Venipuncture of peripheral and central veins *(5.1.139)*

f) The following procedures are excluded from critical care and may be claimed separately:
- Bedside percutaneous tracheostomy
- Bronchoscopy
- Insertion of temporary pacemakers

- Intra-aortic balloon catheters
- Left heart catheterization with angiograms and coronary arteriograms
- Esophagogastroscopy
- Peritoneal dialysis for acute renal failure
- Radionuclide scans
- Selective coronary graft angiography
- Selective pulmonary angiogram
- Swan Ganz catheterization
- Ultrasonography *(5.1.140)*

## INTENSIVE CARE *(5.1.141)*

The intensive care daily rate may be claimed by one physician per patient per 24 hours. Should a procedure be performed on the patient during this time, then the physician has the option of claiming for the procedure or for the intensive care but not for both. *(5.1.142)*

Intensive care detention may be claimed on an hourly basis, if needed, when a patient destabilizes. If codes for detention are claimed for a patient, then the intensive care daily rate cannot be claimed for that patient. The daily rate may be charged for other patients. The duration of service must be provided on these service encounters and, as with all services paid based on time, start and finish times of the encounter must be recorded on the patient record. An hourly sessional fee may be claimed in certain circumstances. *(5.1.143)*

## BEATING HEART DONOR *(5.1.144)*

If the support of a beating donor (03.05A) does not require continuous attendance by an ICU physician and the physician can attend to other patients, then the regular intensive care unit codes are to be claimed for the support of the beating donor. *(5.1.145)*

## PALLIATIVE CARE *(5.1.146)*

### Consultation *(5.1.147)*

The palliative care consultation can only be claimed by designated physicians, general practitioners or specialists, with recognized expertise in palliative care. The service provided must fulfill the normal requirements for a consultation as specified in the Preamble. The consultation includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling, and consideration of appropriate community resources where indicated. Specialists can claim the palliative care consultation fee or the consultation fee appropriate to their specialty. It is payable once per patient per physician. Physicians billing the palliative care consult must forward a letter to MSI indicating their credentials. *(5.1.148)*

Physicians providing palliative care consultations must have completed a minimum of six days of intensive didactic or small group training in palliative care, and a one week clinical practicum in palliative care with a qualified physician supervisor. *(5.1.149)*

### Support Visit *(5.1.150)*

The palliative care support visit is a time-based all-inclusive visit for the purpose of providing pain and symptom management, emotional support and counselling to patients with terminal disease. The physician must spend at least 80 percent of the time claimed with the patient and cannot claim for any other visits with the patient on the same day. Can be claimed if the patient is registered with the district integrated palliative care service. *(5.1.151)*

### Chart Review and/or Telephone Call *(5.1.152)*

The palliative care medical chart review and/or telephone call, fax or e-mail advice services eligible for payment are those initiated by health care professionals involved with the care of the palliative care patient. Telephone calls, fax or e-mails initiated by the palliative patient or their family members are not eligible. Physicians and health care professionals involved should keep a detailed record of telephone calls, fax or e-mails. Palliative care medical chart review and/or telephone calls, fax or e-mails can be claimed if the patient is registered with the district integrated palliative care service. *(5.1.153)*

## HOME CARE *(5.1.154)*

Physicians can claim for medical chart review and telephone call, fax or e-mail advice for patients registered in the home care program. Medical chart review and/or telephone call, fax, or e-mail advice for up to three per day per patient can be claimed at a total of 11.5 medical service units (MSUs) for each patient per day. Each additional group of up to three per patient per day can be claimed at 11.5 MSUs in total. Only services initiated by the care coordinator or health care professionals of Home Care Nova Scotia are eligible for this reimbursement. Physicians and Home Care Nova Scotia representatives are advised to keep a record of telephone calls, faxes, or e-mails. *(5.1.155)*

## CANCER CARE *(5.1.156)*

Telephone advice and medical chart review of a cancer patient by the medical oncologist at the request of the physician(s) monitoring the patient's care outside the Cancer Care Centre. This is only payable when the call is initiated by the physician(s) in the patient's home community who are responsible for monitoring the administration of chemotherapy between visits to the oncologist. Both physicians must keep a detailed record of the phone call. *(5.1.157)*

Comprehensive reassessment of a cancer patient: This is a comprehensive visit by a medical or radiation oncologist with a cancer patient who is currently undergoing cytotoxic antineoplastic chemotherapy or radiation treatments. It may be claimed once every 21 days during the active treatment cycles. It may not be claimed for hormonal therapy, immunotherapy or when using other biological modifiers. *(5.1.158)*

## GERIATRIC CARE *(5.1.159)*

### Geriatrician's Initial Comprehensive Geriatric Consultation to Include Comprehensive Geriatric Assessment (CGA) (HSC 03.04D) *(5.1.160)*

This fee is for the comprehensive assessment of the frail patient 65 years or older (frailty as characterized by low functional reserve, decreased muscle strength, and high susceptibility to disease). To be billed only when the entire assessment is performed by a physician with a Geriatric Medicine Subspecialty or Internal Medicine plus completion of a minimum 8 weeks training (PGY4 or greater) in geriatric assessment. The Comprehensive Geriatric Assessment will include all of the following elements and be documented in the heath record in addition to Start and Stop times. Assessment requires a minimum of 90 minutes of patient to physician contact. Time spent with family/care givers to obtain pertinent information that cannot be obtained from the patient will constitute time spent in direct contact with the patient for the purposes of billing this code. *(5.1.161)*

A. Assessment of cognition–usually using the Mini-Mental State Examination. If cognitive impairment is present, whether it meets the criteria for dementia, delirium or depression.
B. Other aspects of the mental state. Such as the presence of depression or other mood disorder. The presence of perceptual disturbances. Motivation. Health attitude.
C. Evaluation of special senses–functional ability in speech, hearing and vision is recorded.
D. Neuromuscular examination to assess strength and specifically to evaluate deconditioning.

E. A functional assessment of mobility and balance to include detailed recording of the hierarchal assessment of balance and mobility (MacKnight C., Rockwood K., A hierarchical assessment of balance and mobility, Age and Ageing, 1995;24:126-130) is carried out.
F. Bowel and bladder function is recorded.
G. A brief nutritional screen focusing on weight and appetite is completed.
H. Functional capacity in personal instrumental and basic activities of daily living is recorded.
I. Sleep disruptions are recorded as is the presence of daytime somnolence.
J. Social Assessment. To include information about the extent of social engagement, the presence of a caregiver, the marital state and living arrangements of the individual, condition of the house and whether or not they need to be able to navigate stairs in order to be safe at home. The presence of supports is recorded as well as some information about the caregiver, including their coping ability, their own health and their outlook.
K. Documentation of advanced care directives. CGA procedure: Note 1: For people being assessed during an acute illness, items D through H are recorded both for the baseline state (2 weeks previously) and currently. CGA procedure Note 2: All this information is in addition to the general medical information recorded in the general medicine consult. *(5.1.162)*

This is a time-based fee requiring a minimum of 90 minutes. Greater than 80% of time must be spent in direct patient contact. No other fee codes may be billed for that patient in the same time period. This Initial Assessment may be billed only once per patient per lifetime. Time spent with family/care givers to obtain pertinent information that cannot be obtained from the patient will constitute time spent in direct contact with the patient for the purpose of billing this code. *(5.1.163)*

**Family Physician's Initial Geriatric Inpatient Medical Assessment** (HSC 03.04E) *(5.1.164)*

This fee is for the complete initial assessment of the geriatric hospital inpatient, age greater than or equal to 65 years, by the family physician most responsible for the patient's ongoing inpatient hospital care. May be billed only once per patient per admission. May not be billed again for 6 months for the same patient. *(5.1.165)*

This complete assessment is to include all of the following elements and be documented in the health record – include all positive and pertinent negative finds (based on Professional Standard Regarding Medical Records - 2016, CPSNS):

1. Complete history: Extended history of the Chief Complaint, review of systems related to the problem, complete past medical and social history, pertinent family history.
2. Comprehensive Physical Examination: Extensive examination of the affected body area(s) and related system(s) plus extensive multisystem examination (3 or more systems in total).
3. Review of patient's hospital documents relating to current and prior visits.
4. Obtaining collateral history and information from caregivers.
5. Performance of a complete medication review to include collateral information from pharmacy and long-term care facility as appropriate.
6. Obtaining advanced care directives (code status).
7. Reviewing and documenting relevant laboratory, imaging, and other test results pertaining to the present visit.
8. Formulating diagnoses and identifying important issues affecting the present admission.
9. Initiating an appropriate and timely management plan including a treatment plan, further investigations, advanced care planning and specialist or interdisciplinary consultation.

Not to be billed for transfers within the same hospital. *(5.1.166)*

Recognized Systems for the purpose of billing this code:

- Eyes
- Ears, nose, throat

- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic *(5.1.167)*

**Long Term Care Geriatric Assessment** (CGA) *(5.1.168)*

The Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviors, and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However, the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team. The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice. *(5.1.69)*

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc.) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of care given. *(5.1.170)*

Billing Guidelines:

- Family physicians will be remunerated for the completion of a Long-Term Care Clinical Geriatric Assessment (CGA) for residents of licensed Nursing Homes and Residential Care Facilities (RCF's) funded by the Department of Health only.
- The CGA may be billed twice per fiscal year (April 1 – March 31), per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission once the physician and clinical team have had time to become familiar with the resident/patient.
- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviors), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers. *(5.1.171)*

The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA form. This service encounter is included in the CGA fee. The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the Preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be tracked on the CGA form. *(5.1.172)*

- Prior to claiming the CGA fee, the physician must review, complete, and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.
- The date of service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.
- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings. *(5.1.173)*

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible. *(5.1.174)*

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid quarterly from MSI. *(5.1.175)*

### Community-based Comprehensive Geriatric Assessment *(5.3.257)*

A community-based Comprehensive Geriatric Assessment (CGA) equips primary health care providers with a well-established, evidence-informed process to detect the early onset of health problems in their geriatric patients and potentially enable timely intervention to improve health. The CGA is a process of care available to all physicians, in which older adults health and function are assessed and a corresponding treatment plan is developed. The CGA and documentation thereof in a patient's health record may form part of the prolonged geriatric visit. Age-related health problems once identified through the CGA could be modified through targeted interventions. Evidence supports the role of early intervention in slowing the progression of health conditions and improving long-term health outcomes. *(5.3.258)*

It is recommended that the CGA process be initiated and documented as a baseline in all patients over the age of 65 who exhibit signs of frailty. If frailty is identified, development and implementation of a wellness plan is recommended with the CGA process repeated and documented yearly. In the non-frail elderly population, it is recommended that the CGA process be repeated every five years. The CGA should be made available to frail patients for inclusion in their Green Sleeve, for presentation when seeking acute care, and be attached to all consultation requests. *(5.3.259)*

The CGA tool is available to all primary care providers in paper-based or electronic format in their EMRs.

### Long Term Care Medication Review *(5.1.176)*

This incentive is available for Family Physicians who complete medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only. Information about eligible facilities can be found on the Department of Health Continuing Care website at:

https://novascotia.ca/dhw/ccs/documents/Nursing-Homes-and-Residential-Care-Directories.pdf *(5.1.177)*

Billing Guidelines:

- To claim the fee, the physician must review, complete, date and sign the pharmacy- generated Medical Administration Recording System (MARS) drug review sheet for the resident.
- A maximum of two (2) medication reviews will be payable per resident per fiscal year, regardless of Nursing home or RCF facility of residence. A facility transfer does not necessarily require a new medication review if the existing medication review is up to date.
- The medication review fee is payable in addition to any associated visit fee, if applicable.
- The date of service is the date the MARS form is signed by the physician.
- A copy of the completed and signed MARS form needs to be readily available within the patient record (located in the Nursing Home)

NOTE: This fee can only be claimed for reviewing, completing and signing the pharmacy-generated MARS form. The fee is not to be claimed for re-ordering of medications requested by the nursing home or the completion of any other type of form. *(5.1.178)*

**ADULTS WITH DEVELOPMENT DISABILITIES** (HSC 03.03E and 03.04C) *(5.1.179)*

These fees apply to the care of adults with developmental disabilities by family physicians in the office, hospital, at home, or in residential care facilities. The following diagnostic codes are eligible:

- 29900 Autism
- 29980 Retts Disorder, Pervasive Developmental Disorder, Asperger's Disorder
- 3155 Mixed Developmental Disorder
- 3430 Cerebral Palsy (paraplegic, congenital)
- 3431 Cerebral Palsy (hemiplegic, congenital)
- 7580 Chromosomal Abnormalities
- 7580 Down's Syndrome
- 7583 Cri du Chat syndrome
- 7583 Velo-cardiofacial syndrome
- 7595 Tuberous sclerosis
- 75989 Noonan Syndrome
- 75981 Prader Willi
- 75983 Fragile X
- 75989 Angelman's Syndrome
- 76071 Fetal Alcohol Syndrome

To include those not specifically coded:

- Under 758:
  - Williams Syndrome
  - Deletion 22q11.2
  - Smith-Magenis Syndrome (17p deletion)
  - Charge (Hall Hittner) Syndrome
- Under 3155:

  May include conditions that are frequently but not always associated with developmental or cognitive disability, such as:

  - Cerebral Palsy, Neurofibromatosis
  - Deletion22q11.2
  - Chronic Brain injury (traumatic or hypoxic).

In these cases, the physician may be expected to record the ICD code, if one is available, and add "with Developmental Disability" or "with DD" in text. *(5.1.180)*

**ADVANCE CARE PLANNING DISCUSSION (ADCP1)** ***(5.3.260)***

Advance Care Planning Discussion may be claimed when the patient's family physician, or if the patient is admitted to an acute care facility, their most responsible physician, has a face to face (in person) conversation with the patient (or the patients substitute decision maker either face to face or virtually) to discuss their wishes for future health care based on their beliefs and values, determines the substitute decision maker (SDM), documents the conversation in the patient's health record, and captures the outcome of that conversation by completing the initial Patient-Centred Priorities and Goals of Care (GOC) form. In extenuating circumstances, for established homebound patients only, as defined by the Preamble, this service may be rendered virtually by

telephone or PHIA compliant video platform. The circumstances necessitating the virtual visit must be documented in the health record. Where possible, the GOC form should be submitted to the patient's hospital chart through the appropriate health records department. A copy of the document must be shared with the patient so that it may be added to their Green Sleeve folder, if applicable.

## GP Enhanced Office Visit Fees (ME=CARE) *(2.2.225)*

Family physicians who deliver comprehensive and continuous care to patients with whom they have an ongoing relationship will have an increase to several health service codes (See Section 8: Schedule of Benefits – Family Practice). The enhanced fees are only available to family physicians who attest, via declaration letter, that they are providing comprehensive and continuous care to patients. To claim the enhanced fee, physicians should use the ME=CARE modifier on applicable claims. *(5.1.226)*

Comprehensive and continuous care is defined as having an ongoing relationship as a primary care provider to the patient and you ensure the continuity of their medical care. It does not include episodic care provided to walk-in patients. If your practice offers evening hours or walk-in service, you should bill the enhanced fee whenever you are seeing one of your own patients, or a patient of your practice (that is, you may bill the enhanced fee for any patient for whom you, or a colleague in your practice provide comprehensive and continuous care and maintain their medical record). *(5.1.227)*

When providing prenatal care to patients, physicians may bill the enhanced fees in the following scenarios:

i) When providing prenatal care to your own long-term patients;
ii) When providing prenatal care to patients of colleagues within your practice;
iii) When providing prenatal care to patients referred from the community from another family physician (i.e., temporary transfer) Document that you are prepared to assume comprehensive and continuous care of the patient for the duration of the patients pregnancy;
iv) When providing prenatal care to patients referred to you from a walk-in clinic without a family physician. Document that you are prepared to assume comprehensive and continuous care of the patient for the duration of the patients pregnancy. *(5.1.228)*

## GP Enhanced Hours Modifier *(5.1.188)*

This modifier is intended to promote enhanced patient access to primary care outside of traditional office hours. This modifier is available for select services to physicians who have an ongoing relationship with their patients and select services for physicians providing care at walk-in clinics. *(5.1.189)*

Billing Guidelines:

- The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m to 10p.m on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 6a.m to 10p.m
- Physicians should offer and book appointments during these time periods.
- Select services provided in walk-in clinics are eligible for the Enhanced Hours Modifier during these eligible time periods. *(5.1.190)*

The following visit services are eligible for the 25% Enhanced Hours Modifier:

- 03.03 Office visits – includes WBCR, ANTL, PTNT etc.
- 03.03A Geriatric office visits
- 03.03C Palliative care support
- 03.03E Adults with developmental disabilities
- 03.03J OAT initial visit

- 03.03K OAT transfer of care from program
- 03.03L OAT transfer of care
- 03.03V Medical abortion
- 03.04 Comprehensive visit
- 03.04I PSP Mental health visit
- 03.09C Palliative care consultation
- 08.41 Hypnotherapy
- 08.44 Group therapy
- 08.45 Family therapy
- 08.49A Counselling
- 08.49B Psychotherapy

The following visit services are eligible for the 25% Enhanced Hours Modifier when billed by the patient's family physician only. Walk-in clinics may not bill the following services:

- 03.03B Complex care
- 08.49C Lifestyle counselling *(5.1.229)*

Claims for eligible services should be submitted with the modifier TI=GPEW. *(5.1.191)*

NOTE: For services where the Enhanced Hours Modifier has been claimed, a record must be maintained and readily available to verify that the patient was seen for an appointment during an eligible time period. The appointment time should be recorded in the patient's record. *(5.1.192)*

Contract physicians may shadow bill the GP Enhanced Hours Modifier as appropriate. *(5.1.193)*

| Time Period | Time | Payment Rate Increase |
|---|---|---|
| Monday to Friday | 6:00a.m – 8:00a.m | TI=GPEW (25%) |
| Monday to Friday | 5:00p.m – 10:00p.m | TI=GPEW (25%) |
| Saturday and Sunday | 6:00a.m – 10:00p.m | TI=GPEW (25%) |
| Recognized Holidays | 6:00a.m – 10:00p.m | TI=GPEW (25%) |

*(5.1.230)*

## FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM *(5.1.195)*

The Chronic Disease Management Incentive is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases. *(5.1.196)*

The CDM incentive is claimed through a fee code, HSC CDM1. APP contract physicians are also eligible for the incentive and are paid quarterly based on their aggregate shadow billings. *(5.1.197)*

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic diseases (s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this

care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.

4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year and must be submitted on or before March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - Type 1 and Type 2 Diabetes defined as: FPG $^{3}$7.0 mmol/L or Casual PG $^{3}$11.1 mmol/L + symptoms or 2hPG in a 75-g OGTT $^{3}$11.1 mmol/L; and/or,
   - Ischemic Heart Disease (IHD) characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal Smibi; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr);
   - Chronic Obstructive Pulmonary Disease (COPD), a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1$< 80% and predicted $FEV_1$/FVC < 0.70.
8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient ad a copy available in the patients record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;
   - the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
   - the CDM indicators required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional CDM flow sheet at or before the time of billing. *(5.1.198)*

In order to claim a CDM incentive payment the following indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or IHD. The required indicators include all relevant common indicators plus the specific indicators for each disease. *(5.1.199)*

Common Indicators for Diabetes and IHD

- Blood pressure – 2 times per year
- Lipids – once per year
- Weight/nutrition counseling – once per year

Common Indicators for Diabetes, IHD, and COPD

- Smoking cessation – discussed once per year if smoker (document smoker or non-smoker)
- Immunizations discussed and or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

Plus either of the following:

Indicators for Diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ACR or Egfr ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

Indicators for IHD only

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year
- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

Indicator for COPD only

- COPD Action Plan required – Develop and then review and complete once per year *(5.1.200)*

## MEDICAL ASSISTANCE IN DYING (MAiD) *(5.1.231)*

Please refer to the College of Physicians and Surgeons of Nova Scotia Professional Standard regarding Medical Assistance in Dying.

Fees are paid for an increment of 15 minutes, with multiples for each additional 15 minutes up to 4 hours. Start and stop times must be recorded in the patient's medical record and on the MSI claim. Total duration of all components may be claimed. *(5.1.232)*

### First Physician Assessor (03.03M) *(5.1.233)*

This fee is to compensate the first physician assessor for time spent providing MAiD services. It includes but is not limited to; the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAiD criteria and arrangement for a second physician to assess the patient. *(5.1.234)*

Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. *(5.1.235)*

If the physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same documentation requirements as noted above. MAiD must be noted in the text on the MSI claim. *(5.1.236)*

### Second Physician Assessor (03.03O) *(5.1.237)*

This fee is to compensate the second physician assessor for time spent providing MAiD services. It includes but is not limited to; the time spent conducting the subsequent assessment of the patient for MAiD criteria. *(5.1.238)*

Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. *(5.1.239)*

### Prescribing Physician (03.03N) *(5.1.240)*

This fee is to compensate the prescribing physician for time spent providing MAiD services. It includes, but is not limited to; procuring the medication and administration at the patient's request. This physician must also be either the first physician or second physician assessor. *(5.1.241)*

Non face to face components include all documentation required by the pharmacist and the administration process. *(5.1.242)*

RO=FPHN must have previously claimed for a MAiD service with the same patient. When a second physician assists at the time of administering the medication, RO=SPHN may be claimed. This fee is not intended to compensate for a second physician for administrative duties or procurement/return of medications as these activities are considered to be the responsibility of the FPHN. *(5.1.243)*

## GENDER AFFIRMING CARE *(5.1.275)*

**03.04K Gender transition readiness assessment, follow up of patients undergoing medical transition, and follow up of patients undergoing surgical transition where the primary care provider is required to provide postoperative care.**

Gender transition readiness assessment, gender transition follow-up of patients who are undergoing medical transition, and postoperative care of patients who have had gender affirming surgery provided to them in or out of province.
Any necessary counselling or physical examinations are included in the 03.04K and should not be claimed separately. This code is to be used only for services provided that are directly related to Gender Affirming Care; it does not replace all visit codes for that patient.

The 03.04K has a base of 30 minutes of time spent by the physician in direct patient care with multiples of 15 minutes when the service encounter exceeds 30 minutes, to a maximum of 75 minutes. 80% of the time claimed must be in direct patient care. When claiming multiples on a time-based service, the start and stop times must be documented in the health record and submitted in the text on the msi claim.

Physicians providing Gender Affirming Care (GAC) and billing for GAC codes must be informed, knowledgeable and experienced in providing culturally competent and safe trans care and are required to complete and return the GAC Competency Declaration. *(5.1.276)*

## OPIOID AGONIST TREATMENT (OAT) *(5.1.244)*

### The required elements of HSC 03.03J, 03.03K and 03.03L include: *(5.1.245)*

- A complete substance use history including illicit, prescription, and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug
- A complete addiction treatment history
- Past medical and surgical history
- Family history
- Psychosocial history, including living situation, source of income and education
- Review of systems
- A focused physical examination
- Review of treatment options
- Formulation of treatment plan
- Communication with the patient and/or family to obtain information for the assessment as well as with support staff working in the treatment environment
- Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary
- Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS)
- Obtain a urine drug screen
- The health care provider should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider

- Consider obtaining an ECG if indicated

Start and stop times are to be documented in the health record. It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. *(5.1.246)*

**Initial Opioid Use Disorder Assessment for Initiation of Opioid Agonist Treatment – Community Primary Care Setting Only (03.03J)** ***(5.1.247)***

This is a time-based fee for the complete assessment of the patient entering into opioid agonist treatment (OAT) for the first time as prescribed by their primary care provider. The required elements of the service must be documented in the patient's health record. *(5.1.248)*

Billable only by the health care provider who is most responsible for the patients ongoing OAT in the community primary care setting. Once per health care provider per patient. Not reportable if care provided in an Opioid Use Disorder Treatment Program. Multiples may be billed in addition to the base fee to a maximum of 60 minutes in total. 80% of the time must be in face-to-face contact with the patient and/or family. If time is less than 25 minutes, bill as a regular visit. *(5.1.249)*

**Initial Opioid Use Disorder Assessment for Opioid Agonist Treatment – Transfer from Opioid Use Disorder Treatment Program to Community Primary Care Provider (03.03K)** ***(5.1.250)***

This is a fixed fee for the complete assessment of the patient being transferred from an established Opioid Use Disorder Treatment Program to the primary health care provider who will be most responsible for that patient's ongoing OAT. *(5.1.251)*

Reportable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting. Once per patient per health care provider. Applies only to patients transferred from a recognized Opioid Use Disorder Treatment Program. Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program. *(5.1.252)*

**Permanent Transfer of a Patient on Active Opioid Agonist Treatment for Opioid Use Disorder – Full Acceptance of Responsibility for Ongoing Care – Initial Visit with Accepting Health Care Provider (03.03L)** ***(5.1.253)***

This is a fixed fee available to the primary care provider accepting full and ongoing responsibility for OAT for the patients substance use disorder from the community health care provider currently providing care, due to a patient's relocation or desire for permanent change in health care provider.

Regular visit fees may be billed as subsequent visits. *(5.1.254)*

Reportable only by the heath care provider who is most responsible for the patient's ongoing OAT. Once per patient per health care provider. Reportable only by the accepting health care provider. Not reportable for health care providers within the same group practice. Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program. *(5.1.255)*

**The required elements of OAT Monthly Management Fees OAT1 and OAT2 include:** ***(5.1.256)***

- All medication reviews and OAT dosage adjustments as required
- Communicating on a regular and timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions

- Counselling the patient on issues related to their opioid use disorder
- Connecting the patient to appropriate community resources
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers
- Arranging random point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of random UDS encounters, collection of urine, interpretation of results, documentation of the process of randomization and results of the screen in the health care record, and provision of feedback to the patient based on the results

A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.

An annual discussion of treatment options with rationale for continued OAT must be documented in the health record. *(5.1.257)*

### Monthly Management Fee for the Comprehensive Primary Care Provider Only (OAT1) *(5.1.258)*

This fee may be billed once per month by the comprehensive primary care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment as defined by the current DSM-criteria. The patient will be seen by the health care provider for a face-to-face visit or counselling session at least once per month (not including visits for urine drug screening alone). *(5.1.259)*

Only one claim per patient per month. Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/responsible for the patient's use of OAT (ME=CARE). If there is no evidence to support randomization of the POC UDS then the fee will not be paid. Not reportable for care provided in an Opioid Use Disorder Treatment Program. Payment stops when the patient stops OAT. Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30-day period. *(5.1.260)*

### Monthly Management Fee for Provision of OAT Only (OAT2) *(5.1.261)*

Patient Referred by Another Health Care Provider with Written Progress Updates Supplied to the Primary Care Provider at least quarterly. *(5.1.262)*

This fee may be billed once per month by the health care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment as defined by the current DSM-criteria. The patient will be seen by the health care provider for a face-to-face visit or counselling session at least once per month (not including visits for urine drug screening alone). *(5.1.263)*

Written progress updates will be supplied to the patient's comprehensive primary care provider at least quarterly and documented in the health record. *(5.1.264)*

Only one claim per patient per month. Billable only by the health care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/responsible for the patient's use of OAT. If there is no evidence to support randomization of the POC UDS then the fee will not be paid. Not reportable for care provided in an Opioid Use Disorder Treatment Program. Payment stops when the patient stops OAT. Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30-day period. *(5.1.265)*

### Urine Drug Screen Tray Fee (UDS1) *(5.1.266)*

When the physician has incurred the cost of supplies when performing a UDS, a tray fee can be claimed. The tray fee may not be claimed if the UDS kits have been provided free of charge. *(5.1.267)*

The HSC UDS1 is an add on for 03.03J, 03.03K, 03.03L, OAT1, OAT2 and 03.08 (SP=GENP). *(5.1.268)*

Maximum of 1 UDS tray fee per patient for health service codes 03.03J, 03.03K and 03.03L. *(5.1.269)*

Maximum of 4 UDS tray fees per patient per 30 days for health service codes OAT1 and OAT2. Special permission is required if greater than 4 tests have been provided to a patient in 30 days. *(5.1.270)*

### Insertion of Buprenorphine Implant for Treatment of Opioid Use Disorder (13.59P) *(5.1.271)*

This health service code is for the insertion of the non-biodegradable buprenorphine delivery implant for the treatment of opioid use disorder (e.g., Probuphine).

### Removal of Buprenorphine Implant (13.59Q) *(5.1.272)*

This health service code us for the removal of the non-biodegradable buprenorphine delivery implant.

For removal and reinsertion of the non-biodegradable buprenorphine delivery implant, report the removal code at 100% and the insertion code at LV50. *(5.1.273)*

Codes may not be claimed in addition to OAT1 or OAT2 by any physician for the same patient for 6 months following implantation. If the implant is removed early or there are special circumstances to consider, the physician should add text to the OAT management claim explaining the circumstances. *(5.1.274)*

### Use of Official Interpreter Services when caring for patient of Limited English Proficiency (OFI1)
***(5.3.262.)***

This incentive is available to health care professionals who utilize the services of an official interpreter, as designated by the NSHA or IWK, when providing care to a patient of Limited English Proficieny (LEP). LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write or understand English. This definition includes individuals who are deaf or hearing impaired and communicate using American Sign Language. Contact with the interpreter may be in person or via real time PHIA compliant technology. The interpreter's official identification must be documented in the patient's health record.

# ASSESSMENT RULES FOR SPECIALIZED SERVICES *(5.2.0)*

## GENERAL RULES REGARDING SPECIALIZED SERVICES *(5.2.1)*

### PAYMENT OF SPECIALIST FEES (SEE SECTION 3 (3.1.16)) *(5.2.2)*

Under MSI, insured services provided by specialists would only be payable at the rate listed for visits under that particular specialty when the service provided is within the field of the specialty concerned. If such services are not considered to be within the specialty field, payment will be made at appropriate family practice rates. Physicians who are not specialists but do specialist work will not be paid specialist rates. Specialist visit rates are payable only to those physicians whose names appear on the specialist register of the College of Physicians and Surgeons of Nova Scotia and where there has been a referral of the patient to the specialist by the attending physician, nurse practitioner, midwife, optometrist, dentist or audiologist. Patients seen at the initiative of the specialist without a referral will not entail payment of specialist rates. *(5.2.3)*

The MSI physician number of the referring doctor, the MSI midwife number of the referring midwife, optometrist provider number, dentist provider number or the MSI nurse practitioner number of the referring nurse practitioner, who is subject to a collaborative practice agreement with a physician as approved by the Diagnostics and Therapeutics Committee of the College of Registered Nurses of Nova Scotia ("the Nurse Practitioner" ) and who has the agreement of the physician to refer patients to specialists, must appear on the service encounter. If the number of the referring doctor, the nurse practitioner, midwife, optometrist, dentist or audiologist is not indicated, then the service encounter will be returned for resubmission. Where no prior service by the referring doctor, nurse practitioner, optometrist, dentist, midwife or audiologist can be identified, a confirmation of referral may be requested. *(5.2.4)*

### CLINICAL SUPERVISION *(5.2.5)*

1. **ELIGIBLE CLAIMS**:
    a. A physician who supervises a Medical Trainee who renders an insured service is eligible to submit a claim for the insured service as if the physician had performed the insured service personally, subject to any terms, conditions and limitations fund in this Clinical Supervision section.

    b. The terms, conditions and limitations described in this Clinical Supervision section are for the sole purpose of defining when an insured service is payable by Nova Scotia Medical Services Insurance (MSI). These terms and conditions do not alter the College of Physicians and Surgeons of Nova Scotia professional standards and guidelines, or any requirements of Dalhousie Medical School providing undergraduate or postgraduate education. *(5.2.6)*

2. **DEFINITIONS**:
    a. **Supervision**: is performed by the supervising physician and includes the responsibility to guide, observe and assess the clinical activities of the Medical Trainee.
        i. Supervision of the Medical Trainee may occur in person, by telephone, or PHIA compliant virtual care video platform, provided that the Supervising Physician and the Medical Trainee are physically present in the same clinical facility at the time the insured service is rendered.
        ii. Supervision provided in a setting approved by Dalhousie Medical School.
        iii. The Supervising Physician and Medical Trainee must be physically present in Nova Scotia.

    b. **Supervising Physician**: is a physician who performs Supervision of a Medical Trainee who renders an insured service to an insured person. The Supervising Physician must hold an academic

appointment with Dalhousie Medical School and be an approved preceptor with Dalhousie Medical School. The Supervising Physician shall be present at the performance of such insured services or shall be immediately available to render assistance when necessary. The Supervising Physician may or may not be the Most Responsible Physician (MRP) for the patient to whom the insured service is being provided.

c. **Medical Trainee**:
   i. A Medical Trainee is defined as the following:
      1. Undergraduate medical students registered with Dalhousie Medical School;
      2. Residents in an accredited postgraduate specialty or subspecialty training program through Dalhousie Medical School;
      3. Practice ready assesses participating in the remaining cohorts or the Practie Ready Assessment Program (PRAP).
      4. Other practice ready assesses not part of the Physician Assessment Centre of Excellence (PACE).

   ii. A Medical Trainee does not include:
      1. Clinical Observers
      2. Clinical fellows
      3. PACE assessees
      4. Physician extenders such as physician assistants or associate physicians, and their learners
      5. other healthcare providers, and their learners *(5.2.7)*

**3. BILLING GUIDELINES:**

a. An insured service rendered by a Medical Trainee is only eligible for payment to the Supervising Physician where Supervision is provided as defined in the other areas of this Clinical Supervision section.

b. Where a Medical Trainee with an MSI provider number is providing insured services independently and outside their training program, the insured service is not eligible for payment to a Supervising Physician as there is no supervision provided.

c. Provider to provider insured services are not eligible for payment to the Supervising Physician when rendered by a Medical Trainee (e.g., 03.09K, 03.09L etc.). *(5.2.8)*

**4. INSURED SERVICES**

a. An insured service rendered by a Medical Trainee is only eligible for payment to the Supervising Physician when the Supervising Physician:
   i. Is aware the Medical Trainee will render the insured service; and
   ii. Is physically present in the same clinical facility as the Medical Trainee at the time the insured service is rendered; and
   iii. Is immediately available to personally respond to the patient when requested by the patient, the Medical Trainee or other healthcare professionals.

b. An insured service that includes the completion of a form is not eligible for payment to a Supervising Physician if rendered by a Medical Trainee unless the form has been reviewed and signed by the Supervising Physician.

c. When there is more than one Medical Trainee participating in the rendering of an insured service, only the insured service (and the time units or multiples, if applicable) rendered by one Medical Trainee are eligible for payment to the Supervising Physician.

d. Any time taken in general medical education with the Medical Trainee about the case, but not specific to the insured service, *is not eligible* for payment in this Clinical Supervision section.

e. As a reminder, as per the Canadian Medical Protective Association (CMPA), patients must be informed about the involvement of Medical Trainees in their care. *(5.2.9)*

**5. DOCUMENTATION:**

a. Supervision of the Medical Trainee by the Supervising Physician must be evident in the patient's medical record. This may include a physical visit to the patient and/or a chart review with detailed discussion between the Supervising Physician and the Medical Trainee and other member(s) of the healthcare team (where appropriate). *(5.2.10)*

b. An insured service is only eligible for payment to the Supervising Physician when the medical record of the patient(s) identifies all the following information at the time of the provision of the insured service:
   i. The Supervising Physician
   ii. The Medical Trainee and the level of training
   iii. The description of the insured service performed by the Medical Trainee *(5.2.11)*

c. The Supervising Physician must have signed off on the insured service rendered by the Medical Trainee in the patient's medical record. *(5.2.12)*

d. The service date used for claims is the date the Medical Trainee rendered the insured service to the patient. *(5.2.13)*

## ANAESTHETIC SERVICES *(5.2.14)*

An anaesthetic consultation applies if a registered anaesthetist is requested by another physician to see a patient in consultation because of the complexity, obscurity, or significance of pre-existing medical problems prior to the administration of an anaesthetic. In these circumstances, the anaesthetist may claim a consultation fee as well as the anaesthetic fee. *(5.2.15)*

An anaesthetic consultation may also apply in situations where the anaesthetist has been referred a patient for the purpose of pain control or other anaesthesia specialty related services. *(5.2.16)*

The routine preanaesthetic evaluation does not qualify as a consultation, regardless of where and when this evaluation is performed, as this evaluation is included in the fee for the anaesthesia. Preanaesthetic clinic assessments for same day surgery shall not be deemed to form part of the fee for anaesthesia services. *(5.2.17)*

### GENERAL RULES FOR ANAESTHETIC SERVICES *(5.2.18)*

The fees listed are for all types of anaesthetic services required for the performance of an insured procedure by another physician. *(5.2.19)*

a) A physician cannot claim for both the anaesthesia and the procedures performed under that anaesthesia, except where the procedure is an anaesthesia related procedure; e.g., fibreoptic bronchoscopy for airway management, pulmonary toilet, etc. *(5.2.20)*
b) All anaesthetic services are time based composite fees that normally include a preoperative evaluation, administration of anaesthetic substances, injections, transfusions, IVs, procedures such as intubation, laryngoscopy, use of anaesthesia monitoring equipment, other procedures related to the anaesthetic technique used and postoperative attendance. *(5.2.21)*
c) Postoperative attendance is interpreted as terminating at that time when the anaesthetist is no longer in personal attendance, having determined that the patient can safely be placed under the customary postoperative supervision. Additional time for repeat visits to the patient in the recovery room, as the need occurs, may be added to the anaesthesia time. *(5.2.22)*
d) Approved preanaesthetic clinics for same day surgery are paid as sessional fees. *(5.2.23)*
e) Anaesthetic services must be provided in a hospital or facility approved by the Department of Health and Wellness. *(5.2.24)*

If general anaesthetic is deemed medically necessary when providing a dental service, the anaesthetic fee is payable whether the dental surgery is an insured or uninsured service. The anaesthetist must indicate the medical necessity in the text segment of the service encounter. *(5.2.25)*

## CALCULATION OF ANAESTHETIC FEES *(5.2.26)*

Anaesthetic fees are determined by adding the basic units and anaesthesia time units. *(5.2.27)*

**Basic Unit**: Is listed for most procedures. It is the value assigned to each procedure to cover all anaesthetic services except the time actually spent either in administering the anaesthesia or in unusual detention with the patient. Additional procedures, not routine components of an anaesthetic procedure, will be billed either as additional anaesthesia procedures or as replacements for, or additions to, the basic units. These procedures include the following items, for which the basic rate will be increased or replaced by a unit value specific to the factors listed below: *(5.2.28)*

i. **Controlled Hypotension**: When using a specific technique to produce hypotension in association with an anaesthetic, the units will be increased. The use of CO=CHYO is intended for longer cases with excessive bleeding to minimize blood loss and reduce the need for transfusions provided there are no contradictions for this technique. It is also intended for specific cases in order to optimize surgical view. Text is required on the MSI claim. *(5.2.29)*
ii. **Resuscitation of Newborn**: When providing anaesthesia for a delivery, it becomes necessary to provide active resuscitation of the newborn, an additional fee may be added to the mother's service encounter for anaesthetic. If the anaesthetist was not involved in the mother's care, service encounters for resuscitation should be claimed under resuscitation in the normal manner. *(5.2.30)*
iii. **Anaesthesia for infants under 5,000 grams**: The units are increased. *(5.2.31)*
iv. **Anaesthetic for pacemakers**: When monitoring of pacemaker function with pacemaker monitoring programming equipment is performed in addition to the anaesthesia for pacemaker insertion, an additional fee may be claimed. *(5.2.32)*
v. **Cardiac Bypass**: When a pump with or without an oxygenator and with or without hypothermia is employed in conjunction with an anaesthetic, the anaesthetic basic units will be replaced. Note: Arterial catheterization, right cardiac catheterization (Swan Ganz) and central venous pressure monitoring may not be claimed in addition to the basic units for cardiac bypass. *(5.2.33)*
vi. **Hypothermia**: When employed in conjunction with anaesthesia, the basic unit will be replaced. *(5.2.34)*

vii. **Epidural Anaesthesia**: The basic units for obstetrical or non-obstetrical pain management for the introduction of catheter and maintenance care are different and will be distinguished by an appropriate modifier. *(5.2.35)*
HSC 16.91R: This service is paid as a flat rate of 166 MSU. To include the entire epidural insertion, all top ups, maintenance, normal vaginal delivery and removal of epidural catheter. To be billed only by the physician who initiates the epidural. Once per patient per labour. *(5.2.36)*
HSC 16.91J: The maintenance for this service is calculated as one anaesthetic unit for each subsequent injection or 1/2 hour of maintenance to a maximum of six units. *(5.2.37)*

viii. **Morbid Obesity:** When providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than or equal to 40, the units will be increased. The health service code to claim for this add on is 99.09A. The Morbid Obesity add on fee is billable once per patient per physician in addition to the amount payable for the major procedure(s) where a morbidly obese patient undergoes surgery to the neck, hip, or trunk and:
    a. has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record.
    b. the procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia.
    c. the principal technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization.
    d. not billable for bariatric surgery. *(5.2.38)*

**Anaesthetic Time Units**: For the purposes of calculating anaesthesia time units, time should be calculated from the time documented in the perioperative record when both the patient and anaesthetist are present in the OR and the time ends when both the patient and anaesthetist leave the OR (See Section 1 (1.1.38)). In addition to this documented time an additional single time unit may be claimed for the preoperative assessment and anaesthesia setup, another single time unit may be claimed for the postoperative attendance of the patient. (See Section 5 (5.2.22)). These 2 additional units may be claimed without the need for any additional documentation requirements over and above that recorded in the perioperative record. *(5.2.39)*

In unusual circumstances where the preoperative care is prolonged or repeat trips back to PACU are required, additional time may be added to the anaesthesia time. This additional time must be clearly documented by the anaesthetist in the patient medical record with start and stop times. (See Section 1 (1.1.38)). *(5.2.40)*

It is understood that there may be overlapping time units in anaesthesia. *(5.2.41)*

If resuscitation is necessary during the anaesthetic time, add the time for resuscitation to the anaesthetic time. Resuscitation and anaesthesia time cannot be claimed simultaneously. *(5.2.42)*

When billing anaesthetic double set up for obstetrical complications and no further procedure is required, the appropriate HSC is 87.99A with a basic of four + time. If double set up has started and anaesthesia is required for delivery, time units only for the double set up should be added to the basic + time for the delivery. *(5.2.43)*

## ANAESTHETIC SERVICES *(3.2.73)*

When claiming an anaesthetic service with a base unit of four or five, the rate is one unit per 15 minutes, or portion thereof, for the first hour. The rate for time over one hour is two units per 15 minutes, or portion thereof. *(3.2.74)*

When claiming an anaesthetic service with a base unit of six or greater, the rate is one unit per 15 minutes, or portion thereof, up to two hours. The rate for time over two hours is two units per 15 minutes, or portion thereof. *(3.2.75)*

Examples of Anaesthetic Base Units *(3.2.76)*

The number indicated in the multiple fields will determine the number of units paid: *(3.2.77)*

| Base + | Time/Minutes | Anaesthetic Units | Multiple |
|---|---|---|---|
| 4 | 0 | 4 | 1 |
| 4 | 15 | 5 | 2 |
| 4 | 30 | 6 | 3 |
| 4 | 45 | 7 | 4 |
| 4 | 60 | 8 | 5 |
| 4 | 75 | 10 | 6 |
| 4 | 90 | 12 | 7 |
| 4 | 105 | 14 | 8 |
| 4 | 120 | 16 | 9 |

*(3.2.78)*

| Base + | Time/Minutes | Anaesthetic Units | Multiple |
|---|---|---|---|
| 5 | 0 | 5 | 1 |
| 5 | 15 | 6 | 2 |
| 5 | 30 | 7 | 3 |
| 5 | 45 | 8 | 4 |
| 5 | 60 | 10 | 5 |
| 5 | 75 | 11 | 6 |
| 5 | 90 | 13 | 7 |
| 5 | 105 | 15 | 8 |
| 5 | 120 | 17 | 9 |

*(3.2.79)*

| Base + | Time/Minutes | Anaesthetic Units | Multiple |
|---|---|---|---|
| 6 | 0 | 6 | 1 |
| 6 | 15 | 7 | 2 |
| 6 | 30 | 8 | 3 |
| 6 | 45 | 9 | 4 |
| 6 | 60 | 10 | 5 |
| 6 | 75 | 11 | 6 |
| 6 | 90 | 12 | 7 |
| 6 | 105 | 13 | 8 |
| 6 | 120 | 14 | 9 |
| 6 | 135 | 16 | 10 |
| 6 | 150 | 18 | 11 |
| 6 | 165 | 20 | 12 |
| 6 | 180 | 22 | 13 |
| 6 | 195 | 24 | 14 |
| 6 | 210 | 26 | 15 |
| 6 | 225 | 28 | 16 |

| Base + | Time/Minutes | Anaesthetic Units | Multiple |
|---|---|---|---|
| 6 | 240 | 30 | 17 |

*(3.2.80)*

## EXPLICIT MODIFIERS THAT CHANGE OR REPLACE THE BASIC UNIT OF AN ANAESTHETIC PROCEDURE *(3.2.33)*

1. Controlled Hypotension: When using a specific technique to produce hypotension in association with an anaesthetic, the basic unit is increased by 10. The explicit modifier for this is CO=CHYO. It is intended for longer cases with excessive bleeding to minimize blood loss and reduce the need for transfusions provided there are no contradictions for this technique. It is also intended for specific cases in order to optimize surgical view. *(3.2.34)*
2. Resuscitation of Newborn: The anaesthetist services include the usual and immediate care of the newborn. When active resuscitation is necessary, add three units. The explicit modifier for this is CO=INFE. *(3.2.35)*
3. Anaesthesia for infants under five kilograms or 5,000 grams. The anaesthesia fee is increased by five basic units. The explicit modifier for this is CO=UN5K. If the cardiac bypass pump is used use CO=BPU5. *(3.2.36)*
4. Monitoring for Insertion of Pacemaker: An extra five units is added to the anaesthetic fee when monitoring of pacemaker function is performed. The explicit modifier for this is CO=PACM. *(3.2.37)*
5. Cardiac Bypass: When a pump with or without an oxygenator and with or without hypothermia is employed in conjunction with an anaesthetic, the anaesthetic basic will be 35. The explicit modifier for this is CO=CRBY. *(3.2.38)*
6. Hypothermia: When hypothermia is employed in conjunction with anaesthesia, the basic unit will be 25. The explicit modifier for this is CO=HPTH. *(3.2.39)*

**Note**: If billing for a health service code that requires the explicit modifier indicated above, but not listed in the electronic health service code file, the original service encounter must be re-adjudicated with action code R indicating in electronic text the requested explicit modifier and the increase of units required. *(3.2.40)*

## CLAIMING FOR PROCEDURES IN ADDITION TO ANAESTHETIC FEES *(5.2.44)*

When an approved add-on procedure is performed for the purpose of monitoring a patient intraoperatively or postoperatively, e.g., insertion of an arterial line, pulmonary artery catheter (Swan Ganz) or central venous pressure catheter, nerve block or insertion of epidural catheter for postoperative pain management, the appropriate HSC codes may be claimed in addition to the usual anaesthetic fee according to rules for payment of multiple diagnostic and therapeutic procedures. *(5.2.45)*

## ANAESTHETIST'S PRESENCE REQUIRED *(5.2.46)*

Where a physician requests an anaesthetist to be available to provide monitored anaesthesia care at any period during which the physician is carrying out a procedure without general or regional anaesthesia, they shall be paid the usual anaesthetic fee for basic and time value for the complete period, whether or not anaesthesia is administered for any or all of that period. *(5.2.47)*

The anaesthetist should be in the operating room area. During this time no other procedures may be claimed. *(5.2.48)*

## MORE THAN ONE ANAESTHETIST PRESENT AT THE SAME TIME *(5.2.49)*

When special circumstances require the services of more than one anaesthetist in the interest of the patient, the second anaesthetist will be entitled to claim 50 percent of the applicable anaesthetic fee, except in the case where specific second anaesthetist fee schedules exist, e.g., liver transplantation. *(5.2.50)*

## CONSECUTIVE ANAESTHETIST *(5.2.51)*

Where one anaesthetist starts a procedure and is replaced by another during an anaesthetic procedure, the first anaesthetist should claim the appropriate basic fee plus time units for the time they are present, and the second anaesthetist should claim the time units for which they are present. The start time of the first anaesthetist shall dictate when double time units begin, for either and both anaesthetists. The second anaesthetist will start to claim double time units when the double time unit point is reached, based on the case start time, if not already beyond this point, in which case double time units would be claimed at the time of takeover. Accordingly, the consecutive anaesthetist must indicate the case start time as well as the consecutive start time. The end time for the first anaesthetist and the start time for the consecutive anaesthetist should coincide. *(5.2.52)*

## ANAESTHETIC STAND BY FEE *(5.2.53)*

This fee applies only when a scheduled anaesthesia is not given or is delayed for more than one hour. The standby fee is claimed using the medical service unit value rather than the anaesthetic unit value and is calculated in half hour intervals or portion thereof. The specific anaesthetic stand by fee code is to be used. *(5.2.54)*

## CANCELLED SURGERY *(5.2.55)*

a) If an anaesthetist examines a patient prior to surgery and
   i. Determines the patient is not a candidate for surgery and the operation is cancelled prior to the induction of anaesthesia, the anaesthetist may claim a limited consult; or
   ii. If the surgery is cancelled for some other non-anaesthetic reason prior to the induction of anaesthesia, they may claim a limited visit for this service. *(5.2.56)*

b) If the operation is cancelled after induction, regardless of whether the surgeon has started, the procedural basic units plus time units shall apply, except in the case where a higher basic fee would apply as might occur, for example, in the case of cardiac arrest resuscitation. *(5.2.57)*

## BILATERAL/MULTIPLE PROCEDURES *(5.2.58)*

When bilateral or multiple surgical, diagnostic, or therapeutic procedures are performed during the same anaesthetic, the anaesthetist shall claim the basic units corresponding to the procedure having the highest basic, plus time units. When procedures are performed at separate times with separate anaesthetics, the anaesthetist is entitled to claim full anaesthetic units for each procedure. *(5.2.59)*

## ANAESTHETIC DETENTION *(5.2.60)*

When the safety and welfare of the patient necessitates the presence of an anaesthetist immediately before or after anaesthesia for services not considered usual pre or postoperative care, it is appropriate to claim this time as anaesthetic time and add it to the total time claimed. *(5.2.61)*

If an epidural has not been inserted for labour or for the surgical delivery (caesarean section) but is inserted post-delivery for pain control, an anaesthetist may claim for maintenance of postoperative epidural pain control using time units only. *(5.2.62)*

An anaesthetist may claim a new basic for postoperative pain control following an initial anaesthetic service if there has been a time lapse from the time that they released the patient to the recovery room staff. *(5.2.63)*

## ANAESTHETIC INDEPENDENT CONSIDERATION *(5.2.64)*

Anaesthetic independent consideration is for a health service code that has no listed anaesthetic unit value. For procedures indicated that have no listed value, the basic portion of the calculated value will be the same as that listed for a comparable procedure. The service encounter is submitted using the appropriate HSC with electronic text indicating the basic unit value as listed for a comparable procedure with consideration for region and

modifying conditions or techniques. Documentation of the modifying factors is required by MSI (See Section 3 (3.2.25)). *(5.2.65)*

## OBSTETRICAL SERVICES *(5.2.66)*

### ROUTINE PRENATAL CARE *(5.2.67)*

a) Routine prenatal care includes care for less serious obstetrical complications incidental to the pregnancy, e.g., cystitis and simple anaemia, false labour, mild hypertension, leucorrhea, vaginal discharge and obesity. *(5.2.68)*
b) Only one prenatal comprehensive visit may be claimed per pregnancy. *(5.2.69)*
c) No more than 12 limited (routine) prenatal visits may be claimed for one patient's pregnancy regardless of the number of physicians involved. *(5.2.70)*
d) All prenatal visits include pregnancy related counselling or advice to the patient or patient's representatives. *(5.2.71)*
e) Any prenatal visit, limited or comprehensive, includes a Pap smear. The prenatal comprehensive assessment includes venipuncture as well. *(5.2.72)*
f) Complicated pregnancies may require more than the limit of 12 prenatal visits. Prenatal care does not include services rendered for major complications related to pregnancy requiring hospital care, visits or services for conditions unrelated to pregnancy, or care of the newborn. If billing for additional visits for major complications of pregnancy such as preeclampsia, extremely high blood pressure, diabetes, etc. include the diagnostic code for the complication on the service encounter. *(5.2.73)*

   Visits for less serious obstetrical complications incidental to the pregnancy, e.g., cystitis, simple anaemia, false labour, mild hypertension, leucorrhoea, vaginal discharge and obesity are included in the 12 prenatal visits and additional visits may not be claimed for them. *(5.2.74)*

### ATTENDANCE AT LABOUR AND DELIVERY *(5.2.75)*

This is a service involving constant or periodic attendance on a patient during the period of labour to provide all aspects of care. This includes the initial assessment, and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition. *(5.2.76)*

Obstetrical delivery covers services rendered during delivery, including medical or surgical inductions by the attending physician, suturing of minor lacerations, hypnosis, detention time during labour except as identified in 5.1.75, local or regional anaesthesia and manual removal of placenta by the attending physician, and all obstetrical manoeuvers that may be required, e.g., use of forceps. *(5.2.77)*

### OBSTETRICAL DELIVERY SPECIFIC RULES *(5.2.78)*

a) All deliveries performed between 1700 to 0800 hours; all day Saturdays, Sundays and holidays (See Section 6 (6.0.93)) qualify for the appropriate premium fee (See Section 5 (5.1.81)). *(5.2.79)*
b) Multiple deliveries
   i. Multiple vaginal births are paid additional fees.
   ii. In the case of multiple births, when both a vaginal delivery and a caesarean section must be performed, the C-section is claimed at full fee and the vaginal delivery at 65 percent.
   iii. When multiple babies are delivered by caesarean section, only one service encounter may be made with the addition of the fee for multiple births by caesarean section where appropriate. *(5.2.80)*

c) Obstetrical surgeries do not follow the usual surgical rules (See Section 5 (5.3.54 and 5.3.55)). Pre and postoperative visits with a pregnancy related diagnosis are paid in addition to the surgical procedure. *(5.2.81)*

d) Obstetrical non-surgical deliveries.

i. Pre-delivery consultation for obstetrical non-surgical deliveries may be billed only in exceptional clinical circumstances.

ii. The delivery fee may be billed only when the estimated gestational age is greater than twenty weeks. When the estimated gestational age is less than twenty weeks, only the appropriate procedural fee or visit code is payable. *(5.2.82)*

## POSTPARTUM CARE *(5.2.83)*

In hospital postpartum care is the routine care of a well mother in the postpartum period. Visits may be billed starting on the first calendar day following birth. Although not normally claimed by more than one physician, general practitioners and delivering specialists may charge postpartum visits concurrently. *(5.2.84)*

## POSTNATAL CARE VISIT *(5.2.85)*

A postnatal care visit usually occurs about six weeks following delivery. The service may include a pelvic examination with Pap smear. It may be billed only once following delivery by one physician. A diaphragm fitting or insertion of an intrauterine device can be claimed with a post-natal visit. *(5.2.86)*

## SPECIALIST OBSTETRICAL CARE *(5.2.87)*

Specialist rates may be claimed only when there is both a referral and medical necessity for the referral. The fact that the patient has been referred does not in itself indicate the presence of obstetrical difficulties necessitating referral. The indications for the medical necessity must be stated on the service encounter. Where there is no medical necessity, transfer of a patient to a doctor who does not practice obstetrics is not a referral. *(5.2.88)*

## OBSTETRICIAN OR GP PRESENT TO ASSIST AT DELIVERY *(5.2.89)*

The following services may be claimed in addition to the service encounter for delivery by the physician receiving assistance. *(5.2.90)*

a) When an obstetrician's presence is requested at a delivery, performed by another physician, they should claim an obstetrical delivery using the assistant modifier type and value RO=OBDA (role = obstetrical delivery assistant). *(5.2.91)*

b) When an obstetrician is present at a delivery to assist a general practitioner, they may claim a specialist obstetrical delivery. *(5.2.92)*

c) MSI recognizes and preauthorizes certain non-obstetricians in areas without specialist obstetrical services as being allowed to claim obstetrical assistance to another physician during labour and delivery. The rate claimed is equivalent to the specialist obstetrical delivery. *(5.2.93)*

## OBSTETRICAL PATIENTS TRANSFERRED DURING LABOUR *(5.2.94)*

A transfer fee may be claimed for situations where a general practitioner admits and provides care for an obstetrical patient and then transfers that patient to another facility for delivery because of complications of the mother and/or fetus requiring specialist intervention. This fee is billable by general practitioners only. *(5.2.95)*

Detention may be claimed with this fee if the general practitioner accompanies the patient by ambulance to the second facility but is only payable for the time the physician spends on route to the second facility. *(5.2.96)*

The transfer fee, with or without detention, is not payable if the referring general practitioner attends the delivery at the second facility and is paid the delivery fee. *(5.2.97)*

### PRENATAL ULTRASOUND *(5.2.98)*

**Nuchal translucency:** The 11-14 week prenatal screening ultrasound for the determination of nuchal translucency requires that images of the nuchal area, nasal bones, intracranial contents, abdomen, heart and upper and lower extremities must be obtained in addition to the standard images for ultrasound <13 weeks. This fee may be billed by fetal maternal medicine specialists and radiologists only. Operators must be certified by the Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre in which the service is provided, must supply evidence of current certification to MSI to be kept on file. Only physicians with qualifications as stipulated will be eligible for remuneration for this service. *(5.2.99)*

**Genetic sonogram:** The genetic sonogram for known or suspected fetal anatomic or genetic abnormality in high-risk pregnancies in multifetal pregnancies includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers). Soft markers to include: Increased nuchal translucency, absent nasal bone, echogenic bowel, pyelectasis, ventriculomegaly, shortened long bones (humerus, femur), echogenic intracardiac focus, choroid plexus cysts. This fee may be billed only once per patient per pregnancy. Patients must be at an increased risk for genetic aneuploidy either by maternal age>40, or by past obstetrical or family history. To be billed only by fetal maternal medicine specialists and radiologists with the credentials to perform fetal ultrasound/echocardiography. The sonogram must be performed personally by the physician specialist for payment. The fee includes all necessary imaging. Routine ultrasound codes are not to be billed in addition to these patient specific codes. *(5.2.100)*

## PAEDIATRIC SERVICES *(5.2.101)*

### NEWBORN CARE *(5.2.102)*

Newborn care is the routine in hospital care of a healthy infant on a daily basis up to the first five days after birth. It includes a comprehensive assessment, limited visits as appropriate and necessary parental advice. Care of unhealthy infants who are born with an existing medical condition, or whose condition deteriorates after birth, should be claimed as any other hospitalized patient. Newborn care includes treatment of minor conditions *(5.2.103)*

Newborn care may not normally be claimed for the same patient by more than one physician per day. When a well baby is transferred to another hospital, service encounters for newborn care by a physician at each hospital may be appropriate. *(5.2.104)*

### WELL BABY CARE *(5.2.105)*

Well baby care refers to periodic office visits of a well baby for routine measurement of growth and development, necessary parental instructions, and necessary immunizations. Well infant/childcare visits are payable as one per month during the first six months; one visit during each three-month period up to one year of age; and one visit at 18 months of age. It is recommended that the Rourke Baby Record be used to guide each visit and be documented in the health record. In order to provide optimal protection, age recommendations from the Nova Scotia Provincial Immunization Schedule must be followed.

A comprehensive well infant/child visit may be claimed for 2 visits between 0 and <6 months, 1 between 6 months and <12 months, 1 visit between 12 months and <18 months, and 1 visit between 18 months and <24 months. In order to claim the comprehensive well infant/child visit, a complete physical and developmental assessment must be performed, the Rourke Baby Record (RBR) must be used to guide the visit, completed in full, reviewed and signed by the physician and documented in the health record. Age-appropriate preventative care

and education to the parent(s)/caregiver according to the RBR must be delivered and documented in the RBR and recorded in the health record

All other well infant/child visits to be claimed at the regular, applicable well baby care rate. *(5.2.106)*

## PAEDIATRIC CARE BY A PAEDIATRICIAN *(5.2.107)*

a) If newborn and premature care is provided by a paediatrician (care of a healthy newborn in hospital) the paediatrician must claim at the same rate as newborn care for a general practitioner. No consultation is payable to the paediatrician if the infant is referred for the care of a healthy newborn. *(5.2.108)*
b) If newborn and premature care is provided by a paediatrician to an infant who appears initially well but becomes ill after a number of days with a condition that would normally require a consultation, a consultation may be claimed. *(5.2.109)*
c) Routine care is considered to include minor conditions; e.g., mild jaundice, cradle cap and mild skin conditions. *(5.2.110)*

## ATTENDANCE AT HIGH-RISK DELIVERY *(5.2.111)*

a) Paediatrician
Attendance by a paediatrician at a high-risk delivery is payable as a comprehensive consultation and, if it is extended beyond one hour, it is payable as a prolonged consultation. *(5.2.112)*
b) Non-Paediatrician
Attendance by a non-paediatrician at a high-risk delivery is payable as a limited visit in hospital modified with the role of resuscitation. *(5.2.113)*

## A. PAEDIATRIC CARE OF PATIENTS AGE 0-18 YEARS OF AGE INCLUSIVE (UP TO 19TH BIRTHDAY) *(5.2.114)*

Paediatric fee codes apply to patients 0-18 years of age inclusive. This includes services provided in the hospital or office for consultations and visits, provided all other health service code requirements are met. *(5.2.115)*

## B. PAEDIATRIC CARE OF OVERAGE PATIENTS 19 YEARS AGE AND OLDER *(5.2.116)*

- Overage is defined as the day of the 19th birthday and over.
- All services associated with the care of overage patients in hospital by a paediatrician are to be paid at paediatric rates.
- Paediatric consultations, whether comprehensive or limited, outside hospital for overage patients are to be paid at paediatric rates.
- Visits, excluding paediatric consultations, outside hospital for overage patients are not to be paid at paediatric rates except with prior approval for:
    - Behavioral management.
    - Follow-up visits in a paediatrician's office for approved overage patients with complex multi-system medical problems.

Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient. Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems. Approvals will be granted for a maximum of 24 months. *(5.2.117)*

## ANTENATAL PALLIATIVE CARE *(5.2.118)*

Antenatal Palliative Care Limited Consultation and follow up visit codes (HSC 03.09H and 03.03H). *(5.2.119)*

This may be billed for the limited consultation and follow up visits provided by the paediatric palliative care specialist to the mother of the fetus diagnosed with a potentially lethal anomaly or condition. The consultation covers the physical, emotional, social, spiritual issues related to the birth of a newborn diagnosed with a potentially lethal condition. To be billed by the paediatric palliative care physician using the MSI number of the mother for services rendered during the antenatal period. Consultation may only be billed once per mother per pregnancy. A list of qualified specialists is to be kept on file at MSI. The fetal diagnosis must be recorded in text and on the mother's health record. *(5.2.120)*

## COMPREHENSIVE EVALUATION OF SUSPECTED AUTISM SPECTRUM DISORDER (HSC 03.04J) *(5.2.160)*

This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported only when the physician's time has been dedicated to this service encounter and no other concurrent clinical work. If two visits are planned to complete the required elements, only the final visit may be reported as the health service code 03.04J. The first visit is included with the final 03.04J billing. If the service occurs over two visits, at least one of the visits must be in-person and the visits must occur within 2 weeks of the first. The medical record must clearly indicate when the visit is virtual. If exceptional circumstances that are beyond the physician's control occur, documentation must clearly indicate the reason for the second visit being delayed. Time to generate a report and recommendations is considered to be included in the service. Physicians must ensure all elements and dates of the 03.04J are documented in a single form, which should be within the patient's chart on the final service date of the 03.04J billing. Start and stop times must be recorded in the health record. Reportable no more than once per patient per 12-month period. Restricted to IWK and Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview. *(5.2.161)*

## GENETICS SERVICES *(5.2.162)*

### Complex Genetic Counselling Consultation (03.09A) *(5.2.163)*

This code may only be used by a physician who is: certified in Medical Genetics by the RCPSC or certified in Clinical Genetics by the Canadian College of Medical Genetics and/or registered by the College of Physicians and Surgeons of Nova Scotia as a specialist in Medical Genetics (SP=MEGE) or Human Genetics (SP=HUGE). *(5.2.164)*

This is a specific and detailed activity, which includes interviewing of appropriate family members, and collection and assessment of adequate clinical and genetic data to characterize the problem, establish a likely diagnosis (or differential diagnosis), construct a family pedigree and assess (both qualitatively and quantitatively) the risks to the persons seeking advice. It includes imparting this information and the various options for dealing with the problem to the individuals and appropriate family members in such a way that they can make informed decisions about the genetic problem. It may, in addition or alternatively, include establishment or verification of a plan for further, investigative and/or therapeutic management. *(5.2.165)*

This type of consultation is to be distinguished from a routine genetics consult. It requires one of both of the following: Detailed, intensive review of patient data (including medical records and diagnostic studies) or detailed and lengthy review of appropriate medical literature because of the complexity and/or rarity of the problem. *(5.2.166)*

Because of the complexity involved in such a service is it expected that more than one hour is required for the completion of this consultation. A prolonged Complex Genetic Counselling Consultation may be reported if the encounter exceeds 90 minutes. Two additional 15-minute multiples may be reported for a total of 120 minutes. If reporting prolonged consultation service, start and stop times must be documented in the health record and the text field of the MSI claim. *(5.2.167)*

As is the case for all consultations, a request for consultation must be initiated by a referring physician, and a written report with the opinion and recommendations of the consultant must be sent to the referring physician. A written summary report may be also sent to the patient or family. This fee code may be claimed only once per patient. No other fee codes may be reported for the same patient for that time period. *(5.2.168)*

This service may be performed via PHIA compliant, synchronous, virtual care platform (ME=VTCR). *(5.2.169)*

**Medical Geneticist Virtual Care Follow-up Visit** (03.03W ME=VTCR) *(5.2.170)*

This is a time-based health service code for follow up visits by the geneticist post genetics consultation using a PHIA compliant, synchronous, virtual care platform. Report virtual face to face care with geneticist only, 80% of the documented clinical encounter time must be virtual face to face with the geneticist. Start and stop times must be documented in the health record and text field of the MSI claim. A total of four 15-minute time increments may be reported for any one encounter. Should the patient-physician encounter take longer than 60 minutes, report EC with text explaining the clinical circumstances. (SP=HUGE, SP=MEGE) *(5.2.171)*

**Clinical Interpretation of Complex Genetics Tests** (HSC 03.39T) *(5.2.172)*

E.g., microarray analysis, next generation sequencing, and exome sequencing) by geneticist, findings must be recorded in the health record and recommendations made in writing to the referring physician. *(5.2.173)*

This is a time-based code, per 15 minutes, to enable clinical reporting of the time spent by the geneticist who interprets complex abnormal genetic test results and relays that information in writing to the referring physician. Start and stop times must be recorded in the health record. No other health service codes are reportable during that time period for that physician. (SP=HUGE, SP=MEGE). *(5.2.174)*

**Review by Geneticist of Patient Encounter with Genetics Counsellor** (HSC RGN1) *(5.2.175)*

This health service code is for the review by the geneticist of the patient encounter performed solely by the genetics counsellor. This service includes the review of any pertinent investigations and results. The letter back to the referring physician must be reviewed and co-signed by the geneticist and must indicate that the patient was seen by the genetics counsellor. It is not payable if the patient has been seen by the geneticist within 30 days. The encounter must be documented in the health record and indicate that the patient was seen by the genetics counsellor alone but the clinical information and letter to the referring physician were reviewed by the geneticist. (SP=HUGE, SP=MEGE). *(5.2.176)*

## STIPENDS *(5.2.177)*

### Teaching Stipend *(5.2.178)*

| HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | PAYMENT |
|---|---|---|
| PREC1 | Preceptor Stipend for Pre-Clerkship (Med 1 and Med 2), Clerkship (Med 3 and Med 4), First Year Residents (PGY1), Physician Assistant students, and any approved allied providers. | |

RP=INTL ..... $210
RP=INTL, PO=HALF..... $105
RP=SUBS ..... $105 +MU
RP=SUBS, PO=HALF..... $52.50 +MU

PREC2 Preceptor Stipend for Second Year Residents (PGY2) and Integrated Family Medicine Residents (iFMEM).
RP=INTL ..... $130
RP=INTL, PO=HALF..... $65
RP=SUBS ..... $65 +MU
RP=SUBS, PO=HALF..... $32.50 +MU

PREC3 Daily preceptor stipend for senior residents (PGY3+)
RP=INTL ..... $100
RP=INTL, PO=HALF..... $50
RP=SUBS ..... $50 +MU
RP=SUBS, PO=HALF..... $25 +MU

Electronic claims for PREC1, PREC2 and PREC3 should be claimed using health card number 0000002352 with date of birth April 1, 1969. Diagnostic code V623 is required. Text is required on the claim indicating the name and student ID # for the learner(s) present on the day this code is being claimed. *(5.2.179)*

Precepting Stipend health service codes are for Dalhousie-appointed and approved preceptors. The stipends for Medical Students and Residents are available for all learners who are located in Nova Scotia at the time of their instruction, not just Dalhousie learners. *(5.2.180)*

The stipends are available at the FFS rate for physicians paid via FFS, LFM, APP, ED, Sessional, hospitalist/hourly and FFS academic Dept or division. Physicians who are part of C/AFP will not be paid the stipends in addition to block funding, but are eligible to be shadow billed.*(5.2.181)*

When teaching multiple learners at the same time on the same day, the claim for the highest rate learner should be submitted with RP=INTL and subsequent learners should be submitted with RP=SUBS (with multiples). When teaching a learner (or learners) for a half day, the claim should be submitted with PO=HALF. Half day for the preceptor stipends is equal to 3.5 hours. The stipends are available for billing 7 days a week. The Preceptor Stipends follow eligibility guidelines per Preamble 5.2.5 Clinical Supervision. *(5.2.182)*

### Primary Maternity Care (PMC) Program *(5.2.183)*

The Primary Maternity Care (PMC) program is a funding model that provides an increased daily and on-call stipend for doctors who provide primary maternity care services in eligible Nova Scotian regional hospital communities. This is intended to ensure all PMC patients, with or without a family doctor, can receive comprehensive regional primary maternity care (including newborns) as required to meet community needs 24/7/365 across the province. The PMC program has been designed to stabilize primary maternity care services at participating sites. The PMC funding model is available to family physicians providing primary maternity care at the following regional hospitals:

- South Shore Regional Hospital, Bridgewater
- St. Martha's Regional Hospital, Antigonish
- Cumberland Regional Hospital, Amherst
- Yarmouth Regional Hospital, Yarmouth
- Cape Breton Regional Hospital, Sydney *(5.2.184)*

Physicians participating in the PMC program will be paid a daily stipend. Each month, the site's Representative Physician (or designate) will submit a payment form to Medavie. *(5.2.185)*

The PMC model is designed to support the primary maternity care services in eligible Nova Scotian regional hospital communities. Physicians will sign a declaration demonstrating their agreement toward contributing to the site delivery plan and overall requirements of the program. *(5.2.186)*

Additional details can be found in Schedule H of the 2023-2027 Physician Agreement.

### Community Hospital Inpatient Program (CHIP) *(5.2.187)*

The Community Hospital Inpatient Program (CHIP) us a funding model that supports 24/7/365 care in eligible community hospitals across the province. The program provides an increased daily and on-call stipend for family physicians who provide inpatient care at these facilities. The overall goal of CHIP is quality and safe patient care for all patients, attached and unattached. *(5.2.188)*

Physicians participating in the program will be paid a daily stipend. Each site has been approved for a fixed daily rate. Rates vary by site dependant on the number/acuity of patients. Each month, the site's Representative Physician will submit a payment form to Medavie. *(5.2.189)*

The CHIP model is designed to support the delivery of inpatient care in eligible Nova Scotian community hospitals. Each site develops a site delivery plan outlining the services they will provide and expectations for participation in the program. Physicians will sign a declaration demonstrating their agreement toward contributing to the site delivery plan and overall requirements of the program. *(5.2.190)*

Additional details can be found in Schedule G of the 2023-2027 Physician Agreement.

### Facility On-Call *(5.2.191)*

Facility On-Call payments are made directly to MSI as Fee-for-Service electronic claims. Health service codes are established for each rota and physicians are paid per the categories as specified in the Nova Scotia Facility On-Call Program Guidelines. *(5.2.192)*

Although the Facility On-Call Program is for 24-hours, the funding being provided is intended to recognize "after-hours" emergency calls/services, not routine consultation, or the routine care of inpatients. "After-hours" is defined as weekday (Mon-Thurs) evenings/nights (1700 – 0800), weekends (Fri, Sat, Sun) (24 hours) and holidays (24 hours) beginning at 0800. It is meant to provide remuneration for the physician where personal time is disrupted by having to provide on-call services. *(5.2.193)*

Claims for Facility On-Call should be submitted with the generic health card number 0000002352, date of birth April 1, 1969 and diagnostic code V689. Use the service date that aligns with the beginning time of the shift covered (i.e., weekday coverage claims should be made with the service date that aligns with the 1700 start time) *(5.2.194)*

This process does not apply for on-call services remunerated within program funding (e.g., AFP, ICU-APP Option Levels 1-3). *(5.2.195)*

The following options exist where rotas have organized themselves to share in the call payments for any given shift(s):

- Use the 50% modifier when billing; both physicians would claim the Facility On-Call fee and use the modifier PO=HALF.
- Multiple physicians regularly share in the call stipend: using a group BA; the most responsible physician would claim the stipend for the shift. MSI will make the payment to the group bank account. It is left to the group administrator to disburse funding to the participating physicians. *(5.2.196)*

The Health Service Code can be billed once per eligible physician per rota per 24-hour period. *(5.2.197)*

For quarterly and annual review purposes, DHW will require documentation. This will include written on-call schedules and, for callback claims, documentation of the reason for each callback. Physicians should keep records of their call participation and what portion of call shifts are fulfilled. Additionally, all service claims made while on-call should use the appropriate modifiers where applicable (e.g., nighttime claims should use nighttime and/or urgent modifiers). *(5.2.198)*

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | PAYMENT |
|---|---|---|---|
| **FACILITY ON-CALL CATEGORY 1** | | | |
| 1 | F1001 | Anaesthesia Weekday | $350 |
| | | Anaesthesia Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1002 | General Surgery Weekday | $350 |
| | | General Surgery Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1003 | Internal Medicine Weekday | $350 |
| | | Internal Medicine Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1004 | Obstetrics/Gynecology Weekday | $350 |
| | | Obstetrics/Gynecology Weekend/Holiday (DA=RGE1) | $500 |
| | | RO=OBS1 (Yarmouth and IWK only) Weekday | $350 |
| | | RO=OBS1 (Yarmouth and IWK only) Weekend/Holiday (DA=RGE1) | $500 |
| | | RO=OBS2 (IWK only) Weekday | $350 |
| | | RO=OBS2 (IWK only) Weekend/Holiday (DA=RGE1) | $500 |
| | | RO=GYN1 (Dartmouth and IWK only) Weekday | $350 |
| | | RO=GYN1 (Dartmouth and IWK only) Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1005 | Family Medicine-Primary Maternity Care Weekday | $350 |
| | | Family Medicine-Primary Maternity Care Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1006 | Hospitalist Weekday | $350 |
| | | Hospitalist Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1007 | Diagnostic Imaging Weekday | $350 |
| | | Diagnostic Imaging Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1008 | Family Medicine O.R. Call Assists Weekday | $350 |
| | | Family Medicine O.R. Call Assists Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1009 | Family Medicine (Mental Health) Weekday | $350 |
| | | Family Medicine (Mental Health) Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1010 | Orthopedics Weekday | $350 |
| | | Orthopedics Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1011 | Pediatrics Weekday | $350 |
| | | Pediatrics Weekend/Holiday (DA=RGE1) | $500 |

| | | | |
|---|---|---|---|
| 1 | F1012 | Psychiatry Weekday | $350 |
| | | Psychiatry Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1013 | Urology Weekday | $350 |
| | | Urology Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1014 | Ophthalmology Weekday | $350 |
| | | Ophthalmology Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1015 | Palliative Care Weekday | $350 |
| | | Palliative Care Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1016 | Nephrology Weekday | $350 |
| | | Nephrology Weekend/Holiday (DA=RGE1) | $500 |
| 1 | F1017 | Otolaryngology Weekday | $350 |
| | | Otolaryngology Weekend/Holiday (DA=RGE1) | $500 |

**FACILITY ON-CALL CATEGORY 2**

| | | | |
|---|---|---|---|
| 2 | F2011 | Pediatrics Weekday | $300 |
| | | Pediatrics Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2013 | Urology Weekday | $300 |
| | | Urology Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2014 | Ophthalmology Weekday | $300 |
| | | Ophthalmology Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2017 | Otolaryngology Weekday | $300 |
| | | Otolaryngology Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2018 | Vascular Surgery Weekday | $300 |
| | | Vascular Surgery Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2004 | Obstetrics/Gynecology Weekday | $300 |
| | | Obstetrics/Gynecology Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2019 | Plastic Surgery Weekday | $300 |
| | | Plastic Surgery Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2020 | Neonatology Weekday | $300 |
| | | Neonatology Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2021 | Neurosurgery Weekday | $300 |
| | | Neurosurgery Weekend/Holiday (DA=RGE1) | $350 |
| 2 | F2022 | Neurology Weekday | $300 |

| | | | |
|---|---|---|---|
| | | Neurology Weekend/Holiday (DA=RGE1) | $350 |

**FACILITY ON-CALL CATEGORY 3**

| | | | |
|---|---|---|---|
| 3 | F3012 | Psychiatry Weekday | $200 |
| | | Psychiatry Weekend/Holiday (DA=RGE1) | $250 |
| | | Psychiatry Callback (US=CALL) | $150 |
| 3 | F3023 | Pathology Weekday | $200 |
| | | Pathology Weekend/Holiday (DA=RGE1) | $250 |
| | | Pathology Callback (US=CALL) | $150 |
| 3 | F3024 | Child Psychiatry Weekday | $200 |
| | | Child Psychiatry Weekend/Holiday (DA=RGE1) | $250 |
| | | Child Psychiatry Callback (US=CALL) | $150 |
| 3 | F3016 | Nephrology Weekday | $200 |
| | | Nephrology Weekend/Holiday (DA=RGE1) | $250 |
| | | Nephrology Callback (US=CALL) | $150 |
| 3 | F3017 | Otolaryngology Weekday | $200 |
| | | Otolaryngology Weekend/Holiday (DA=RGE1) | $250 |
| | | Otolaryngology Callback (US=CALL) | $150 |
| 3 | F3025 | Radiation Oncology Weekday | $200 |
| | | Radiation Oncology Weekend/Holiday (DA=RGE1) | $250 |
| | | Radiation Oncology Callback (US=CALL) | $150 |
| 3 | F3026 | Medical Oncology Weekday | $200 |
| | | Medical Oncology Weekend/Holiday (DA=RGE1) | $250 |
| | | Medical Oncology Callback (US=CALL) | $150 |
| 3 | F3027 | Tissue Bank Weekday | $200 |
| | | Tissue Bank Weekend/Holiday (DA=RGE1) | $250 |
| | | Tissue Bank Callback (US=CALL) | $150 |
| 3 | F3028 | Hyperbaric Unit Weekday | $200 |
| | | Hyperbaric Unit Weekend/Holiday (DA=RGE1) | $250 |
| | | Hyperbaric Unit Callback (US=CALL) | $150 |
| 3 | F3029 | Urology Transplant Weekday | $200 |
| | | Urology Transplant Weekend/Holiday (DA=RGE1) | $250 |
| | | Urology Transplant Callback (US=CALL) | $150 |
| 3 | F3030 | Ophthalmology – Orbital Reconstruction Weekday | $200 |
| | | Ophthalmology – Orbital Reconstruction Weekend/Holiday (DA=RGE1) | $250 |
| | | Ophthalmology – Orbital Reconstruction Callback (US=CALL) | $150 |
| 3 | F3040 | Inpatient Withdrawal Management Weekday | $200 |
| | | Inpatient Withdrawal Management Weekend/Holiday (DA=RGE1) | $250 |

| | | | |
|---|---|---|---|
| 3 | F3041 | Recovery Support Center Weekday | $200 |
| | | Recovery Support Center Weekend/Holiday (DA=RGE1) | $250 |

A physician may also claim a callback rate in addition to the Category 3 daily rate if they are required to return to the hospital while providing call services. To claim, first submit for the appropriate daily rate, followed by a second claim for the same health service code using the US=CALL modifier. Physicians not scheduled to provide Facility On-Call services may not claim a callback. *(5.2.199)*

**FACILITY ON-CALL CATEGORY 4**

| | | | |
|---|---|---|---|
| 4 | F4CB1 | Callback (US=CALL) | $350 |

Facility On-Call category 4 callback fee may only be claimed once per 24 hours. It is available to physicians whose specialty or subspecialty does not have a designated on-call rota. *(5.2.200)*

**COMMUNITY HOSPITAL INPATIENT PROGRAM (CHIP)**

| | | |
|---|---|---|
| FCHP1 | Community Hospital Inpatient Program Weekday | $350 |
| FCHP1 | Community Hospital Inpatient Program Weekend/Holiday (DA=RGE1) | $500 |

**COMMUNITY ON CALL CEC**

| | | |
|---|---|---|
| C1001 | Community On-Call for CEC Physicians Weeknight/Weekend/Holiday | $150 |

Community On-Call for CEC physicians should use the generic HCN 0015713084, DOB April 1, 1969 and Dx code V689 for billing purposes. For coverage running from 1700 to 0800 hours the following day, the claim should include the service date that aligns with the 1700 start time. Only one physician can bill the stipend her site, per night. Call coverage is remuneration $150 per night regardless of weeknight/weekend/holiday.

## PSYCHIATRIC SERVICES *(5.2.121)*

### DOCUMENTATION FOR PSYCHIATRIC AND COUNSELLING SERVICES *(5.2.201)*

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptation's, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying, or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional wellbeing of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy" etc., is not considered appropriate documentation for the billing of psychotherapy of counselling services. *(5.2.202)*

### PSYCHIATRIC CARE *(5.2.122)*

Psychiatric care is any form of assessment or treatment by a psychiatrist on the register of specialists of the Province of Nova Scotia, in which there is consideration and attempted alteration of the patient's biopsychosocial functioning. When psychiatric care extends beyond six months, the psychiatrist must document the rationale for

continued specialist care in the patients health record, and in a brief written report to the patient's primary care provider at least every six months. *(5.2.123)*

### PSYCHIATRIC ASSESSMENT *(5.2.124)*

Psychiatric assessment of an accused person when requested by the court requires the name of the judge involved in the case. *(5.2.125)*

### THERAPEUTIC/DIAGNOSTIC INTERVIEW *(5.2.126)*

This service relates to a specific child and may take place with parents and/or caregivers allied health professionals, education, correction, or other community resources. This applies to interviews by psychiatrists but does not preclude medical resident involvement. *(5.2.127)*

### SALARIED OR CONTRACT FACILITY BASED PSYCHIATRY *(5.2.128)*

This refers to non-fee-for-service psychiatric care provided in the context of public mental health services.

a) Physicians providing these services are remunerated on a salaried or contract basis.
b) No physician providing salaried or contract psychiatric services may claim on a fee-for-service basis for any services to a patient registered as a public mental health services client except by special arrangement between the director of the facility at which the patient is registered, MSI, and the psychiatrist involved. *(5.2.129)*

## PSYCHOTHERAPY *(5.2.130)*

The following services apply to general practitioners and psychiatrists. Restrictions apply to general practitioners only (See Section 6 (6.0.36)). *(5.2.131)*

The provision of psychotherapeutic services by general practitioners is limited to 20 hours per patient or family or group per physician per year. To exceed this limit for individual patients or families or groups, the general practitioner must either: document on the chart and notify MSI, through the text field on the service encounter, that a psychiatrist concurs that extended psychotherapeutic services are needed; or, if the general practitioner is unable to access a psychiatric consultant directly, then the option will be available to obtain an exemption in a timely manner through MSI from a psychiatric consultant skilled in psychotherapy and its applications. *(5.2.132)*

### INDIVIDUAL PSYCHOTHERAPY *(5.2.133)*

Individual psychotherapy is any form of treatment for mental illness, behavioural maladaptation's and/or other problems that are assumed to be of an emotional nature in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying or retarding existing symptoms, of attenuating or reversing disturbed patterns of behaviour and of promoting positive personality growth and development. *(5.2.134)*

a) Individual psychotherapy is claimed in 15-minute intervals. The therapist must spend at least 80 percent of the time claimed in therapeutic intervention with the patient. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.135)*
b) Restrictions apply to general practitioners only:
    i. A minimum of two intervals must be claimed per visit.
    ii. Treatment for medical complaints, acute adjustment reactions or bereavement reactions do not qualify as psychotherapy. They should more appropriately be claimed as counselling.
    iii. Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, individual psychotherapy may not be claimed for the following:

- More than 90 continuous minutes or six continuous 15-minute intervals per patient per day.
- A patient younger than four years old.
- More than one general practitioner treating the same illness for a particular patient. *(5.2.136)*

## GROUP PSYCHOTHERAPY *(5.2.137)*

Group psychotherapy differs from individual psychotherapy in that it is provided to a group of four to eight individuals per session. *(5.2.138)*

a) Group Psychotherapy is claimed in 15-minute intervals. The therapist must spend at least 80 percent of the time claimed in therapeutic intervention with the group of patients. Start and finish times must be recorded in each patient record and in the text field of the MSI claims. *(5.2.132)*
b) Restrictions apply to general practitioners only:
    i. A minimum of two intervals must be claimed per group session.
        - Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, group psychotherapy may not be claimed for the following:
            - More than two continuous hours or eight continuous 15-minute intervals per group per day.
            - A group member younger than four years old.
            - More than one general practitioner treating the same illness for a particular group of patients. *(5.2.139)*

## FAMILY THERAPY *(5.2.140)*

Family therapy is defined as psychotherapy in which the therapist regards the patients as a subsystem of a family and in which the therapeutic responsibility is not only to the patients but to other family members as well. *(5.2.141)*

a) The assessment rules are the same as for group psychotherapy, but two or more members of the family must be present for the session to qualify as family therapy. *(5.2.142)*
b) Family therapy is claimed in 15-minute intervals. The therapist must spend at least 80 percent of the time claimed in therapeutic intervention with the family. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.143)*
c) Restrictions apply to general practitioners only:
    i. A minimum of two intervals must be claimed per family session.
    ii. Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, family therapy may not be claimed for the following:
        - More than two continuous hours or eight continuous 15-minute intervals per family per day.
        - A patient younger than four years old.
        - More than one general practitioner treating the same family group. *(5.2.144)*

## HYPNOTHERAPY *(5.2.145)*

The following services apply to general practitioners and psychiatrists. Restrictions apply to general practitioners only. *(5.2.146)*

Physicians practicing hypnotherapy must provide proof of current full membership in the Canadian Federation of Clinical Hypnosis (CFCH) to bill hypnotherapy. These credentials can be forwarded to msi_assessment@medavie.bluecross.ca for review.

Hypnotherapy is therapy undertaken with a patient who has been placed in an altered state of consciousness. *(5.2.147)*

a) Hypnotherapy is claimed in 15-minute intervals. The hypnotherapist must spend at least 80 percent of the time claimed in direct therapeutic intervention with the patient. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.148)*
b) Physicians practising hypnotherapy must have at least 20 hours of training in clinical hypnotherapy and be an active member in good standing of a recognized Canadian Clinical Hypnosis society. *(5.2.149)*
c) Restrictions apply to general practitioners only:
    i. A minimum of two intervals must be claimed per session.
    ii. Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, hypnotherapy may not be claimed for the following:
        - More than 10 hours per patient per physician per year.
        - More than 90 continuous minutes or six continuous intervals per patient per day.
        - A patient younger than four years old.
        - More than one general practitioner treating the same illness for a particular patient. *(5.2.150)*

## MINDFULNESS BASED COGNITIVE THERAPY (MBCT) (08.44A) *(5.2.203)*

Mindfulness Based Cognitive Therapy is defined as a specific psychological intervention incorporating elements of cognitive behavioral therapy and mindfulness. The HSC 08.44A is for each two hour session of the eight week MBCT course provided for a group of 8-12 patients with recurrent episodes of depression. Fee is per patient, per two hour session. One series of 8 sessions per patient per 365 days. The session dates and start/stop times must be documented in the health record of each participant. Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist, if applicable. Session outline and activities are standardized to be completed in 2 hours. *(5.2.204)*

Physicians eligible to claim this code must submit credentials to MSI directly. *(5.2.205)*

## PRACTICE SUPPORT PROGRAM (PSP) MENTAL HEALTH COMPREHENSIVE VISIT (03.04I) *(5.2.206)*

This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnosis criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. It is not intended for patients with self-limited or short-lived mental health symptoms. *(5.2.207)*

The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. *(5.2.208)*

The complete assessment is to include all of the following elements and be documented in the health record prior to reporting the PSP Mental Health Plan visit service:

- The patient's DSM diagnosis, psychiatric history, and current mental state, including suicide risk assessment as appropriate
- Obtaining collateral history and information from caregivers as required

- Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate
- Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results
- Documentation of a clinical plan for the patients care over the next year. Includes advanced care planning where appropriate
- Outline of expected outcomes as a result of treatment plan
- Outline of linkages with other health care providers and community resources who will be involved in the patient's care
- Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate
- A documented care plan must be in place before access to additional counselling hours is provided. *(5.2.209)*

If more than one visit is required to complete the required elements, only the final visit may be reported as the PSP health service code 03.04I, all other visits may be reported at the usual rate. The 03.04I is payable at 50 MSU for the first 30 minutes, 25 MSU for each additional 15 minutes up to a maximum of 1 hour. *(5.2.210)*

The PSP MHP visit is only reportable by the patient's PSP trained physician. It is not reportable with any other visit fee for the same physician, same patient, same day. Reportable once per patient per year. It is not reportable for services provided at walk-in clinics* or for patients living in nursing homes, residential care facilities or hospices. Start and stop times must be reported in the text field of the claim to MSI as well as in the health record. *(5.2.211)*

***Note**: The HSC may be claimed by physicians in episodic walk-in clinics if the patient is unattached (this must be documented in the health record and text on the claim). *(5.2.212)*

## COUNSELLING *(5.2.151)*

a) The following services and restrictions apply to general practitioners only. *(5.2.152)*

b) Counselling is a prolonged discussion directed at addressing issues pertaining to the patients underlying mental illness, acute adjustment disorder or bereavement. Counselling may be claimed by family physicians for patients who meet the current DSM (Diagnosis and Statistical Manual of Mental Disorders) diagnostic criteria for the diagnosis of a mental health disorder. *(5.2.153)*
Counselling may be claimed in 15-minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. Start and finish times must be recorded in the patient record and in the text field of the MSI claim. *(5.2.154)*
Restrictions:
Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following:

- More than five hours per patient per physician per year.
- More than one hour per patient per day.
- A patient younger than four years old.
- More than one general practitioner providing counselling to a particular patient.

Physicians who have completed training in the Practice Support Program Adult Mental Health Module may have access to an additional 4 hours of counselling per patient per year. The physicians name must be in the Nova Scotia Health Authority database confirming completion of training. *(5.2.155)*

## LIFESTYLE COUNSELLING *(5.2.156)*

The following services and restrictions apply to general practitioners only.

Lifestyle Counselling is a prolonged discussion where the physician attempts to direct the patient in the proper management of health related concern; e.g., lipid or dietary counselling, AIDS advice, smoking cessation, healthy heart advice, etc. This is only billable by the general practitioner providing on-going primary care to the patient. *(5.2.157)*

a) Lifestyle counselling may be claimed in 15-minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.158)*

b) Restrictions:
Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, lifestyle counselling may not be claimed for the following:

- More than two hours per patient per physician per year.
- More than 30 minutes per patient per day.
- A patient younger than four years old.
- More than one general practitioner providing lifestyle counselling to a particular patient at the same service encounter. *(5.2.159)*

# ASSESSMENT RULES FOR PROCEDURES *(5.3.0)*

Procedures are a type of patient service distinguished from visits by several features. They generally have a specifically defined technique involving either a physical therapeutic intervention with the patient; the obtaining of some diagnostic sample, image or biophysiological measurement; or the interpretation of a sample, measurement, or image. A procedure may include elements of a visit, evaluation, or care depending on the specific procedure and the clinical setting. *(5.3.1)*

- Procedures fall into three categories for assessment purposes: diagnostic and therapeutic procedures, surgical procedures, and fractures. Subject to the rules in this section, procedures may be claimed in association with visit services, or with other procedures. *(5.3.2)*
- Procedures may be claimed only when they are carried out by, or under the supervision of, a physician. *(5.3.3)*

## DIAGNOSTIC AND THERAPEUTIC PROCEDURES *(5.3.4)*

Diagnostic and therapeutic procedures are divided into two groups, procedures that cannot be claimed with a visit code and those where a visit service may be claimed if one is provided. *(5.3.23)*

a) Procedures designated as visit excluded cannot have a service encounter for any visit service from the same service encounter.
   i. When a visit excluded procedure is the sole reason for the service encounter, the procedure alone should be claimed.
   ii. If a visit service and a visit excluded procedure are provided at the same service encounter, only the service of greater value should be claimed. *(5.3.24)*

b) Procedures designated as visit allowed may have a service encounter for any visit related service from the same service encounter with the exception that the following procedures may not be claimed in association with a consult:
   i. Tonometry
   ii. Gonioscopy
   iii. Visual fields tangent, screen and/or perimetry
   iv. Flexible fibreoptic endoscopy of the nose, nasopharynx, and larynx
   v. Pap smear
   vi. Venipuncture of a person seven years or older
   vii. Medical certificate for observation for psychiatric evaluation 1st doctor
   viii. Medical certificate for observation for psychiatric evaluation 2nd doctor *(5.3.25)*

No premium fees may be claimed for diagnostic and therapeutic procedures other than selected diagnostic imaging services and selected endoscopic procedures (See Section 5 (5.1.81)). *(5.3.5)*

Diagnostic and therapeutic procedures can be performed in any location, with the exception of the following procedures which have location specific restrictions and may be claimed only when performed by a physician in the appropriate subspecialty: *(5.3.6)*

a) When performed outside of a hospital
   i. Electrocardiogram – internist and paediatrician.
   ii. Electromyogram – neurologist (including paediatric neurologist), physiatrist and neurosurgeon.
   iii. Electroencephalogram – neurologist (including paediatric neurologist) and neurosurgeon. *(5.3.7)*

b) When performed in hospital
   i. Stress Test – internist and physiatrist in approved centres as they have a cardiologist, access to a cardiologist, or an internist with a special interest in cardiology, who supervises the program. *(5.3.8)*
   ii. Procedures performed in a catheterization lab – cardiologist including paediatric cardiologist and radiologist. *(5.3.9)*

**SUBMAXIMAL EXERCISE TESTING** *(5.3.10)*

This service may only be claimed in approved centres. *(5.3.11)*

a) If the patient has been seen in consultation by the specialist performing the test within the previous 14 days, no visit service or consultation may be claimed. *(5.3.12)*
b) If the patient has not been seen by the specialist within the previous 14 days, a comprehensive initial visit or consultation service may be claimed. However, it should be noted that there must be a medical necessity for the comprehensive visit and components of this visit (See Section 5 (5.1.7)) must be performed and documented in the patient's chart. Similarly, if a consultation is claimed with an exercise test, the rules governing referred services (See Section 5 (5.1.91)) must be followed. *(5.3.13)*
c) If the patient has been examined by another specialist within the previous 14 days for a problem related to the condition for which the exercise test is being performed, a comprehensive initial visit service, but not a consultation, may be claimed. *(5.1.14)*

**INTERPRETATION OF HOLTER MONITORING STUDIES *(5.3.15)***

Interpretation of Holter Monitoring may be claimed only when abnormalities are present. *(5.3.15)*

**CARDIAC ABLATION PROCEDURES *(5.3.16)***

Cardiac ablation for complex cardiac arrhythmias (HSC 49.98I): This is a composite fee for the intracardiac catheter ablation of an arrythmogenic focus or foci. The fee may be claimed for the treatment of complex cardiac arrhythmias (not atrioventricular nodal reentry or atrioventricular reentry), atrial fibrillation, ventricular tachycardia, and cases of arrhythmia in patients with complex congenital heart malformations. This fee includes percutaneous right heart catheterization, transeptal left heart catheterization, all diagnostic imaging (including angiography), electrocardiograms, electrophysiologic mapping, ablation, and electric counter shock of heart as required. This fee does not apply to the treatment of reentrant supraventricular tachycardia (atrioventricular nodal reentry or atrioventricular reentry). This fee is not billable with:

- 49.95, A, B
- 49.96, A through H
- 49.97, A through G
- 49.98, A through H
- ADON 50.83, 50.91, 50.98A, 13.72 *(5.3.16)*

Where multiple diagnostic and therapeutic procedures are performed at the same service encounter, the procedure with the greater value is claimed at 100 percent and subsequent procedures at 50 percent. Procedures defined as add-ons in the schedule text may be claimed at 100 percent. *(5.3.17)*

Service encounters by assistants are not normally applicable to diagnostic and therapeutic procedures with the following exceptions. Assistant fees should be claimed at the current surgical assistant rate (See Section 5 (5.3.119)). *(5.3.18)*

a) Excisional breast biopsy after localization of a mammographic abnormality

b) Mediastinoscopy: when assisting with a mediastinoscopy, regardless of whether a flexible or rigid bronchoscopy is also performed, claim the assistant fee for mediastinoscopy alone
c) Fetal procedures under ultrasound guidance
d) Catheter ablation of cardiac arrhythmias
e) Percutaneous endoscopic gastrostomy
f) Percutaneous endoscopic gastrojejunostomy *(5.3.19)*

**VENIPUNCTURE *(5.3.20)***

Venipuncture for the purpose of blood collection is not an insured service when performed by a physician with the following exceptions:

a) The physician's office is greater than 24 km (15 miles) from the closest laboratory blood collection service.
b) When the physical condition of the patient makes it medically necessary for the physician to personally take the sample. *(5.3.20)*

**INSERTION OF NASOGASTRIC TUBE *(5.3.21)***

Nasogastric (Levine) tube insertion is considered part of the appropriate visit service encounter. *(5.3.21)*

**INSERTION OF INTRAVENOUS *(5.3.22)***

Intravenous insertion may only be claimed when the physician has personally performed the service. These health service codes may not be claimed when they are carried out by another health care provider such as a nurse, nurse practitioner or X-Ray technologist as part of their usual duties. *(5.3.22)*

**CATHETER INSERTION *(5.3.227)***

Health Service Code 69.94; insertion of indwelling urinary catheter, should only be claimed as a stand-alone procedure. Physicians may only claim for insertion of a catheter when they have personally performed the service. It may not be claimed when carried out by another health care provider such as a nurse, nurse practitioner, or X-Ray technologist as part of their usual duties. Text is required on all claims explaining why the physician had to personally perform the catheter insertion. If performed by a urologist, no other procedures may be claimed during the same encounter. *(5.3.228)*

**LASER TREATMENT *(5.3.229)***

Laser treatment of malignant neoplasms of esophagus bronchi, etc. in addition to scope, HSC 44.0A is an add-on fee and should only be claimed after an appropriate base fee for bronchoscopy or esophagoscopy is paid. *(5.3.230)*

**PROVINCIAL IMMUNIZATIONS *(5.3.26)***

Physicians may claim for the administration of immunizations covered by the Provincial Immunization Program. These services may be claimed by any registered physician. *(5.2.27)*

If one vaccine is administered but there is no associated office visit billable, i.e., the sole purpose of the visit is the immunization, one injection can be claimed at a full fee. *(5.3.28)*

If one or more vaccines are administered in conjunction with an office visit, the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50 percent of the specified MSU. *(5.3.29)*

If two vaccines are administered at the same visit but there is no associated office visit, a claim for each specific immunization can be submitted at full fee. All subsequent injections will be paid at 50 percent of the specified MSU. *(5.3.30)*

For children 18 months of age and under, if a vaccine is administered in conjunction with a well baby care visit, the well baby care visit and the immunization may be claimed. *(5.3.31)*

### Provincial Immunization Tray Fee *(5.3.32)*

When a physician has incurred the cost of supplies when administering an immunization covered by the provincial program, a tray fee can be claimed for each injection. There is to be no charge to the patient or family for the supplies and/or disposables associated with any of these immunizations. Enter multiples for additional tray fees. Maximum of four tray fees can be claimed per service encounter. *(5.3.33)*

## PAP SMEARS *(5.3.34)*

An office visit may be claimed in conjunction with a Pap smear only if the visit is for a non-gynaecologic complaint. A Pap smear may not be claimed in addition to a visit, consultation or procedure for a gynaecologic or obstetrical diagnosis nor is it payable in addition to a complete physical examination. *(5.3.35)*

A visit for a Pap smear and an unrelated medical condition can include a claim for the office visit, Pap smear and Pap smear tray fee. *(5.3.36)*

### Pap Smear Tray Fee *(5.3.37)*

When a physician has incurred the cost of supplies when performing a pap smear, a tray fee can be claimed. There will be no charge to the patient for any supplies, equipment or disposables associated with the performance of a pap smear. *(5.3.38)*

A Pap smear tray fee can be claimed when a pap smear is performed alone or as part of a comprehensive examination, an office visit, or a gynaecological procedure. *(5.3.39)*

## COMPREHENSIVE PELVIC EXAMINATION WITH SPECULUM *(5.3.256)*

For the performance of a comprehensive pelvic examination in either a symptomatic patient, or screening for sexually transmitted infections, when a PAP smear is not indicated nor required.

Visual inspection of the vulva and perineum, insertion of the speculum into the vagina to inspect the vault and cervix, bimanual examination of the pelvis when required, and conduction of a pelvi-rectal examination where indicated are elements to be documented in the heath record.

The comprehensive pelvic examination 03.26C is not billable with PAP smear 03.26A or tray fee 03.26B. *(5.3.256)*

## ELECTROMYOGRAPHY *(5.3.40)*

When referring to electromyography with muscles of more than one region, or examination of a specific region, region is intended to mean one or more of the four following anatomical areas: head and neck, both upper limbs, both lower limbs or trunk anterior and posterior. *(5.3.41)*

When referring to nerve condition studies, per nerve studied is intended to mean both the motor and sensory nerve conduction examination of a single nerve, mixed, motor or sensory. Multiples may be claimed when another nerve, mixed, motor or sensory is examined and when separate nerve conduction studies of a major nerve branch are required.

Health service codes 07.08A, 07.08B and 07.08C are to be used when the appropriate studies are performed as part of a diagnostic work-up. It is not appropriate to use these codes as proxies for intraoperative nerve integrity testing. Such testing is considered an integral part of surgical procedures performed near vital nerve structures. *(5.3.42)*

## PACEMAKER VISIT AND PROGRAMMING *(5.3.231)*

Health Service Codes 49.83B and 49.83C visit and programming to a pacemaker include a visit in their description. It is not appropriate to make a separate claim for a visit or consult service at the same encounter. *(5.3.232)*

Health service codes for pacemaker battery change and leads replacement/adjustment include any necessary programming. It is not appropriate to make a separate claim for pacemaker programming. *(5.3.233)*

## SLEEP STUDIES *(5.3.43)*

Health service codes exist in Nova Scotia for Level 1, Level 2, and Level 3 sleep studies. When claiming these studies, the following requirements apply:

Health service code 03.19C is for a Level 1 study (overnight polysomnography) a full sleep study in a hospital sleep laboratory with a sleep technician in continuous attendance. At a minimum, all of the following must be recorded: 2-3 leads of electroencephalogram, 2 leads of electrooculogram, submental EMG, ECG, airflow nose and mouth by thermistor or nasal pressure cannulae, respiratory effort, oxygen saturation, snoring, anterior tibialis electromyogram and body position. Physicians must have formal fellowship level training and be credentialed to interpret Level 1 sleep studies by the Nova Scotia Health Authority in order to claim this health service code.

Health service code 03.19F is Level 2 sleep apnea testing. At a minimum all of the following must be measured: electrooculogram, heart rate, air flow, respiratory effort, oxygen saturation, anterior tibialis EMG, and body position. Physicians must have completed fellowship level training including interpretation of sleep studies.

Health service code 03.19G is Level 3 sleep apnea testing. All of the following parameters must be measured: heart rate, air flow, respiratory effort, oxygen saturation, body position. Physicians must have completed fellowship level training including interpretation of sleep studies. *(5.3.44)*

## AUDIOMETRY *(5.3.234)*

HSC 09.41E is described as Impedance audiometry including tympanometry, static compliance, multiple frequency acoustic reflex and/or reflex decay testing including interpretation. HSC 09.41F is described as Impedance audiometry interpretation only of tympanogram, impedance/compliance and stapedial reflex tests. HSC 09.41G is described as Impedance audiometry including tympanometry, static compliance, single frequency acoustic reflex and/or reflex decay testing including interpretation. *(5.3.235)*

HSC 09.41E and 09.41G should only be claimed when the physician personally performs and interprets the test. HSC 09.41F should only be claimed when the physician personally interprets the tests (09.41E or G). Only one of these codes may be claimed per patient per day. *(5.3.236)*

All components of a complete hearing test: pure tone audiometry (air and bone), tympanometry, and a speech test must be performed in order to claim health service code 09.41D. *(5.3.237)*

It is not appropriate to claim Health Service Code 09.41H Tympanometry only if another code was claimed during the same encounter that includes tympanometry. *(5.3.238)*

## PERIPHERAL NERVE BLOCKS *(5.3.45)*

If at the time of performing temporary nerve blocks (HSC 17.72C) additional injections are needed to secure adequate analgesia, either at the trunk level or more peripherally, this is included in the original nerve block code and not payable as a multiple. Additionally, only one occipital nerve block per side may be claimed. *(5.3.46)*

## TRIGGER POINT INJECTIONS *(5.3.47)*

The correct health service code when claiming for injection of trigger points is 17.72J (myofascial injections). Health service codes 93.92A (injection into joint or ligament) and 95.94A (injection into soft tissue) are not to be used when carrying out trigger point injections. *(5.3.48)*

### INJECTION OF BOTOX *(5.3.239)*

MSI insures the injection of Botox by physicians for the following clinical indications only:

- focal spasticity related to stroke, multiple sclerosis, spinal cord or traumatic brain injury,
- laryngeal dystonia,
- equinus foot deformity in cerebral palsy patients 2 years of age and older,
- cervical dystonia,
- blepharospasm, hemifacial spasm (VII nerve disorder) or strabismus in patients 12 years of age and older,
- achalasia,
- urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis (MS) or subcervical spinal cord injury (SCI) in patients who have failed to respond to behavioral modification and anticholinergics and/or are intolerant to anticholinergics,
- idiopathic overactive bladder unresponsive to behaviour modification, medications and peripheral nerve stimulation. *(5.3.240)*

### INTRAVENOUS INFUSION FOR CHRONIC PAIN MANAGEMENT *(5.3.241)*

In the performance of Health Service Code 13.59N intravenous infusion of local anaesthetic/adrenergic drugs for chronic pain management procedure, patients are to be monitored with both an electrocardiogram and a pulse oximeter. An intravenous line is established and an infusion pump is used to deliver the drug. The physician must be in attendance or readily available to intervene to ensure that side effects do not occur and to make the necessary adjustments in the dosage of the medication. The patient must be monitored 10-15 minutes after the infusion is completed and then transferred to a 'post-recovery area' where they are continued to be monitored for a further 30 minutes before being discharged. *(5.3.242)*

### ACUTE STROKE PROTOCOL *(5.3.243)*

Health service code 13.99F assessment and management of patient with acute stroke, from activation of Acute Stroke Protocol through completion of thrombolytic therapy (e.g., t-PA) is specific for the assessment and management of a patient experiencing symptoms of acute stroke, and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging and completion of thrombolytic therapy (e.g., t-PA) and is reportable by one physician per patient per day. Must complete thrombolytic therapy in order to report this HSC, if patient does not receive thrombolytic therapy, only the pertinent visit code is reportable. Is it reportable from provincial stroke centres only. *(5.3.244)*

Health service code 13.99G assessment and management of patient with acute stroke, from activation of Acute Stroke Protocol through receiving endovascular thrombectomy (EVT) with or without administration of thrombolytic therapy is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging, with or without thrombolytic therapy, and supervision of patient receiving EVT and is reportable by one physician per patient per day. Patient must undergo EVT to report this HSC. It is specialty restricted to Neurologists and the Halifax Infirmary. *(5.3.245)*

## SURGICAL SERVICES *(5.3.49)*

### SURGICAL SERVICES MAJOR *(5.3.50)*

Surgical procedures are described as major if they have a value in excess of 50 units: *(5.3.51)*

The procedure fee is intended to cover the operation and customary preoperative, operative and postoperative care by the surgeon or a designated covering physician. *(5.3.52)*

a) A consultation at any time prior to surgery may be claimed, even if the surgery is on the same day. A visit other than a consultation is not payable the same day as a major surgical procedure. *(5.3.53)*
b) Preoperative care includes:
    i. Comprehensive visit (the admission history and physical exam)
    ii. Hospital visits for up to two calendar days immediately prior to and including the day of surgery
    iii. Hospital visits in a preoperative period that extends beyond two days should be claimed using the appropriate visit codes *(5.3.54)*
c) Postoperative care includes care during the postoperative hospital stay up to 14 days. *(5.3.55)*
d) Urgent visits or emergency hospital visits (See Section 5 (5.1.52)) to attend the patient for an unrelated condition are not included in the surgical benefit and may be claimed accordingly. *(5.3.56)*
e) Hospital visits may be claimed starting on the 15th postoperative day for visits if the post-operative in hospital stay exceeds 14 consecutive calendar days. For the purpose of calculation, the day of the last operative procedure is considered day zero. Weekly routine visit maximums beyond 56 days apply starting from the date of admission. *(5.3.57)*
f) When a patient is readmitted to hospital during the first 14 days of the post surgical period because of postoperative complications which do not require a surgical procedure, the surgeon or other physician attending this readmitted patient should claim hospital visits as for a new admission. *(5.3.58)*

## SURGICAL SERVICES MINOR *(5.3.60)*

Surgical procedures are described as minor if they are less than or equal to 50 units: *(5.3.61)*

a) When a visit service is provided during the same service encounter as a minor surgical procedure for a reason other than the condition for the minor surgery, the greater of either the visit or the minor surgery may be claimed, otherwise only the minor surgery service encounter applies. However, in the case of a service encounter for suture of a laceration with a value less than or equal to 50 units, the appropriate visit may also be claimed. *(5.3.62)*
b) A consultation prior to surgery may be claimed, even if the surgery is on the same day, except where the consultation is explicitly included as part of the procedure. *(5.3.63)*
c) Postoperative care following minor surgery may be claimed, except for those minor surgical procedures which specify complete care (See Appendix D Complete Care Codes (7.4.0)) and include all postoperative visits by the same physician in the 14 days following the procedure. *(5.3.64)*
d) The services of an assistant at minor surgery are not usually required. *(5.3.65)*

## SURGICAL SERVICES MAJOR OR MINOR *(5.3.66)*

Special restrictions or interpretations applicable to major or minor surgery: *(5.3.67)*

a) Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes. *(5.3.68)*
b) Local anaesthesia is not payable in addition to the surgical fee. *(5.3.69)*
c) Endoscopic procedures performed on a patient on the same day as major urological surgery by the same physician may be claimed at 50 percent in addition to the major surgical fee except where the surgery is done in a separate operating room. Other diagnostic and therapeutic procedures may be claimed at 100 percent with other major urology surgery. *(5.3.70)*
d) When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed;

e.g. a laparotomy is not to be claimed to provide access to the abdominal cavity except when no definitive procedure is performed within the abdomen. When one physician provides surgical exposure for a procedure performed by a physician in another specialty, the exposure and definitive procedures may be claimed separately by the respective physicians. *(5.3.71)*

e) Fees for the application of casts, splints and dressings at the time of surgery may not be claimed. *(5.3.72)*

f) Fees for the application or removal, by the operating surgeon, of casts, splints and dressings during the 30 days following surgery may not be claimed. *(5.3.73)*

g) Vascular Procedure Service encounters
   i. Repair/bypass/graft includes thromboendarterectomy and/or anastomosis and/or thrombectomy of the peripheral artery being repaired and harvesting of vein unless otherwise specified in the procedure description.
   ii. Common femoral artery repair includes repair to the profunda artery before the second major branch of the profunda artery.
   iii. If the profunda artery repair extends beyond the second major branch of the profunda artery, an extended profundoplasty fee may be claimed in addition as the second procedure.
   iv. When resection of an abdominal aneurysm is combined with an aortic graft plus femoral artery repair (unilateral or bilateral) only one procedure, whichever has the higher unit value, should be claimed. *(5.3.74)*

h) Arthroscopy
   i. Composite arthroscopy fees include the procedure and arthroscopy.
   ii. When other or multiple surgical procedures are performed through the arthroscope, only the major fee applies. *(5.3.75)*

i) Injections of medication into a bursa, ganglion, joint, or tendon may not be claimed with surgery performed in the same location. This applies whether the medication is delivered via arthroscope or directly into the location. *(5.3.76)*

j) Compression Sclerotherapy (Feganization)

k) Codes for compression sclerotherapy for varicose veins are designed to cover all services for that diagnosis, for the same leg, for a period of one year. *(5.3.77)*

l) Bilateral Procedures
   i. Unless otherwise specified, bilateral procedures are claimed at an additional 70 percent of the unilateral procedure.
   ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 70 percent and 35 percent.
   iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 70 percent and 35 percent.
   iv. When performed under separate anaesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)*

m) Multiple Surgical Procedures Same Physician
   i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principal procedure will be claimed plus 70 percent for the secondary procedures (secondary incidental procedures, such as appendectomy, which are not indicated by pathology, shall not be claimed).
   ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 70 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions.
   iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be available that supports the rationale for the appendectomy. *(5.3.79)*

n) The full procedural fee will apply when subsequent, related operative procedures are performed during the postoperative period. *(5.3.80)*

o) Combinations of multiple and bilateral procedures should be claimed based on the rules applicable to the highest valued procedure. *(5.3.81)*

p) Unrelated surgical procedures different physicians
When two or more unrelated procedures are performed through separate incisions or in unrelated areas, but utilizing the same anaesthetic, by two different physicians in different fields of practice and with different skills, the fee provided in the schedule under each procedure will be paid at 100 percent to each physician. *(5.3.82)*

q) An arthrodesis procedure includes bone grafting. *(5.3.83)*

r) Percutaneous urteroscopy with ultrasonic lithotripsy and/or uteroscopy with electohydraulic lithotripsy (HSC 68.85B) should not be claimed with HSC 68.98C, 68.99A, 68.99C as all are inherent parts of this procedure.

s) HSC 98.22, 98.22A, 98.22B, and 98.22D may only be claimed when suturing of lacerations is provided as a stand-alone procedure. They may not be claimed where skin suturing is an integral aspect of another procedure such as removal of a cutaneous lesion. Physicians may claim multiples when multiple lacerations are sutured. It is not appropriate to claim multiples for each suture.

t) Health service codes 69.0A cystoscopy with removal of foreign body/calculus, 01.34A cystoscopy with or without catheterization of ureters, and 01.34B cystoscopy with urethral dilation, cannot be claimed in the same encounter as 72.1B endoscopy transurethral electro-resection, and vice versa.

u) Debridement
All claims for debridement, HSC 98.11, must indicate in electronic text the area debrided, the start and finish time, and whether performed under a local or general anaesthetic. Only the time from the start to the finish of the debridement may be claimed. *(5.3.84)*

v) The Morbid Obesity add on fee is billable once per patient per physician in addition to the amount payable for the major procedure(s) where a morbidly obese patient undergoes surgery to the neck, hip, or trunk and:
a. has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record.
b. the procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia.
c. the principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization.
d. not billable for bariatric surgery. *(5.3.85)*

### CANCELLED SURGERY *(5.3.86)*

a) In the event of cancellation of surgical procedure before it has started, regular visit rules apply for surgeons.

b) In the event of cancellation of surgical procedure after it has commenced, the procedural units for the intended principal procedure will apply. *(5.3.87)*

## FRACTURES *(5.3.88)*

### SURGICAL RULES *(5.3.89)*

Surgical rules (See Section 5 (5.3.49)) apply to treatment of fractures except:

a) A fracture procedure, not dislocation, includes necessary after care up to 14 days. The application and removal of casts or traction devices is included in the fee, even if removal takes place after the 14 day period.

b) Regardless of the type of anaesthesia employed, all fracture service encounters are eligible for premium fees during the designated times. *(5.3.90)*

**MAJOR FRACTURES *(5.3.91)***

Major fractures are defined as those requiring procedures in excess of 50 units. Rules for major surgery apply and an appropriate consult may be claimed preoperatively. A comprehensive consultation is appropriate only for those patients who are referred with significant systemic illness or requiring general anaesthesia. A limited consultation is appropriate only for those patients who are referred and where the diagnosis is unclear, or management alternatives require prolonged discussion or assessment. *(5.3.92)*

**MINOR FRACTURES *(5.3.93)***

Minor fractures are defined as those procedures less than or equal to 50 units. Minor surgical rules apply to minor fractures including preoperative consultation (See Section 5 (5.3.60)). Rules regarding non-bilateral multiple fractures may be claimed at fee + 65 percent. A fracture procedure (not dislocation) includes necessary after care up to 14 days. *(5.3.94)*

**FRACTURE AND NON-FRACTURE PROCEDURES PERFORMED AT THE SAME SERVICE ENCOUNTER *(5.3.95)***

a) When fracture procedures and non-fracture procedures are performed at different sites, claim 100 percent for the greater and 65 percent for the lesser procedure.
b) When performed at the same site, claim 100 percent for the greater procedure and 50 percent for the lesser procedure. *(5.3.96)*

**TREATMENT OF FRACTURE WITH NO REDUCTION *(5.3.97)***

When a fracture is treated by any method other than an open or closed reduction, visit fees apply. This shall include the application, changing and removal of casts and/or splints. *(5.3.98)*

**CLOSED REDUCTION *(5.3.99)***

Closed reduction is the reduction of a fracture by manipulation or traction. *(5.3.100)*

**MULTIPLE CLOSED REDUCTIONS *(5.3.101)***

Where multiple closed reductions are carried out for the same fracture, at different service encounters, the following rules apply:

a) When performed by the same physician, claim 50 percent for each reduction.
b) When performed by different physicians, the first physician's payment will be reduced to 50 percent of the listed fee and the second physician's payment will be valued at 100 percent. *(5.3.102)*

**OPEN REDUCTION *(5.3.103)***

Open reduction is the reduction of a fracture by an operative procedure and includes exposure of the fracture site with fixation as indicated. If an open reduction with extensive debridement is necessary, the appropriate open reduction should be claimed plus a service encounter for independent consideration or exceptional clinical circumstances covering the debridement portion of the service. The supporting text should indicate the total duration of service. *(5.3.104)*

**MULTIPLE OPEN REDUCTIONS *(5.3.105)***

Multiple open reductions performed at different service encounters may each be claimed at 100 percent. *(5.3.106)*

### CLOSED FOLLOWED BY OPEN REDUCTION *(5.3.107)*

Where a closed reduction is followed by an open reduction, whether performed by the same or different physician, the service encounter will be reduced to 50 percent for the closed reduction and the service encounter for the open reduction will be valued at 100 percent. *(5.3.108)*

### COMPOUND FRACTURES OR DISLOCATIONS *(5.3.109)*

The following should be applied when claiming for treatment of a compound fracture or dislocation:

a) The service encounter for closed treatment of a compound fracture or dislocation is 150 percent of the service encounter for the appropriate non-compound fracture or dislocation.
b) If an open reduction is performed, only a service encounter for the open reduction will apply. *(5.3.110)*

### MULTIPLE FRACTURES *(5.3.111)*

a) Where multiple major fractures are treated by the same surgeon, the greater procedure is claimed at 100 percent and 50 percent is claimed for each additional fracture.
b) When multiple major fractures involve different long bones where long bones are specified as clavicle, humerus, radius, contralateral ulna, femur, tibia and contralateral fibula, occur at the same time and are managed under the same anaesthetic, the greater procedure is claimed 100 percent and 85 percent is claimed for each additional long bone fracture, unless specified otherwise. This does not apply to fractures of the ulna when the radius on the same side is fractured or fractures of the fibula when the tibia on the same side is fractured.

   See Appendix G (7.7.0) for a list of applicable codes. *(5.3.112)*

### REFRACTURE *(5.3.113)*

Where a refracture procedure has been performed, a service encounter for exceptional clinical circumstances may be made. *(5.3.114)*

### BONE GRAFTING FOR FRACTURES *(5.3.115)*

a) For a primary bone graft in a fresh fracture, claim 50 percent of the appropriate bone graft code in addition to the primary fracture procedure.
b) Treatment of a nonunion fracture with bone grafting is claimed under the appropriate bone graft procedure code except when there is a new displacement where both the open reduction and the bone graft are claimed.
c) Reaming is not considered a bone graft for assessment purposes and should not be claimed. *(5.3.116)*

## SURGICAL ASSISTANTS *(5.3.117)*

A surgical assistant is defined as a physician who assists the operating surgeon throughout a substantial portion of the operation. *(5.3.118)*

### SURGICAL ASSISTANT'S SERVICE ENCOUNTER *(5.3.119)*

An assistant should render a separate service encounter for services provided. A surgical assistant's service encounter is 33.8 percent of the surgical fee regardless of whether the assistant is certified as a specialist. The health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and all surgical assistant claims should adhere to the Preamble guidelines. The service encounter should be calculated to the nearest unit with a minimum of 21 units. However, when a general practitioner who has participated in the prenatal care assists at a vaginal delivery or a caesarean section, they will be paid a full

general practitioner delivery fee. The delivery fee would apply to another general practitioner covering the practice. *(5.3.120)*

a) Surgical assists are not payable for minor procedures or diagnostic and therapeutic services (See Section 5 (5.3.18)). When add-on ADON procedures are done during a major surgical procedure for which a surgical assistant is payable, the assistant's service encounter is 33.8 percent of the total surgical fee. In unusual circumstances where an assistant fee is not normally paid, the assistant should submit a service encounter with an accompanying letter from the surgeon explaining the necessity. In cases of fracture procedures, no visits may be claimed pertaining to the post fracture care up to 14 days following the fracture procedure (See Section 5 (5.3.88)). *(5.3.121)*
b) A surgical assist is not payable for some major surgical procedures. (See Appendix E Major Surgical Procedures with no Assistant Allowed (7.5.0)). *(5.3.122)*
c) Service encounters for routine hospital visits, in the 14 days postoperative, are not allowed in addition to an assist fee. However, service encounters for the following services are allowed:
    i. A home, office or OPD visit on the same day if medical necessity is established
    ii. Comprehensive visit same day as trauma or emergency surgery
    iii. Procedures with visits allowed
    iv. Supportive care
    v. Visits in postoperative period for diagnosis unrelated to the surgery
    vi. If transfer of care from the surgeon to the assistant occurs because the surgeon is unavailable, e.g., out of town, the assistant may claim daily visits for in hospital postoperative care. *(5.3.123)*

The assistant fee for insured dental surgery performed by a dentist is claimed at 33.8 percent of the dental surgical fee. The service encounter is submitted under HSC 36.99A with modifier type and value RO=DTAS role = dental assistant with electronic text indicating the procedure performed. *(5.3.124)*

### SECOND ASSISTANT *(5.3.125)*

When a second surgical assistant is necessary, the service is paid at 50 percent of the stated fee paid to the first assistant to a minimum of 10.5 units. The need for a second assistant is to be supported by a letter from the surgeon explaining the necessity. A supporting letter from the surgeon explaining the necessity for a second assistant should be forwarded to the MSI Medical Consultant for approval. *(5.3.126)*

HSC 54.45, 54.47 Esophageal anastomosis with interposition of colon and/or other interposition and 67.51 Renal transplantation are set up with modifier type and value RO=SNAS role = second assistant. *(5.3.127)*

All other service encounters for a second surgical assistant are to be entered using HSC EC with text indicating the HSC of the procedure performed and the duration of the service, as well as indicating approval has been granted for the second surgical assist claim. *(5.3.128)*

### CANCELLED SURGERY *(5.3.129)*

a) When an anaesthetic has begun and the operation is cancelled prior to commencement of surgery, if the assistant has scrubbed but is not required to do more, only a hospital visit may be claimed.
b) If the operation is cancelled after surgery has commenced, the procedural units for the intended principal procedure will apply. *(5.3.130)*

## RADIATION ONCOLOGY *(5.3.131)*

Treatment planning may not be claimed with a consultation on the same day by the same physician. However, it may be claimed as an additional fee following gold seed and caesium needle implants. Gold seed and caesium needle implants should be classified as major surgical procedures. *(5.3.132)*

# PATHOLOGY AND DIAGNOSTIC IMAGING SERVICES *(5.3.133)*

Most service encounters for services in the schedule of benefits for these specialties are processed by a special arrangement with MSI. These service encounters are limited to hospital-based physicians in the appropriate specialties. Procedures not covered by these special arrangements should be claimed on a fee-for-service basis as listed in the schedule of benefits. *(5.3.134)*

Diagnostic Imaging service encounters should conform to the requirements set out in the Preamble. *(5.3.135)*

## RADIOLOGY *(5.3.139)*

### Interpretation Fee *(5.3.140)*

This represents the benefit for consultation between the radiologist and the referring service provider, fluoroscopy, interpretation of diagnostic images, fluoroscopic findings and supervision of diagnostic imaging services by a radiologist. If a formal written report is not generated on a separate document, the interpretation fee is incomplete and may not be billed. In addition, an immediate oral report may be given if indicated and/or requested. Additionally, radiologists may only claim for the services provided by a resident if they, as the attending, are onsite. A physician may claim either for the resident's procedure or for their own services, but not both, when they are performed at the same time. *(5.3.141)*

### Fee Schedule Interpretation *(5.3.142)*

Self referral is not ethical and a consultation with the referring service provider should be held before performing any further examination. However, where the referring service provider is not immediately available, in exceptional cases further examination may be provided if considered necessary by the radiologist. *(5.3.143)*

Although there is no provision for additional views, the fee schedule recognizes that added views are sometimes necessary; therefore, this has been taken into consideration for fees where additional views may be performed. *(5.3.144)*

### A. Radiographs *(5.3.145)*

- When a requisition for one extremity is received, no additional charge shall be made for comparison x-rays of the opposite site. *(5.3.146)*
- IVP includes an abdominal survey film. No separate claim shall be made for the abdomen. If tomography is routinely performed there shall be no extra fee. *(5.3.147)*
- The fluoroscopy claim shall not be submitted for an examination performed by the radiologist where fluoroscopy is an integral part of the examination; e.g., examination of gastrointestinal tract, urinary tract, special procedures. *(5.3.148)*
- The fluoroscopy only charge is for use when no other procedure is claimed. *(5.3.149)*
- Abdomen and chest studies shall not be claimed in gastrointestinal. *(5.3.150)*
- Sacrum, coccyx, abdomen, sacroiliac joints and pelvis shall not be claimed in lumbar spine examinations. Thoracic spine shall not be claimed in chest examinations. *(5.3.151)*
- Chest studies shall not be claimed in mammography cases. *(5.3.152)*
- Nasal bones or sinuses shall not be claimed in skull examinations. *(5.3.153)*
- An upper GI series includes a study of the swallowing mechanism and esophagus. An esophagus can only be billed if additional special views including video, food bolus, etc., are made. *(5.3.154)*
- Submitted films are films deemed to be those from another institution whose reinterpretation has been requested by a service provider. *(5.3.155)*
- The necessity of having plain film studies available prior to special procedures, is obvious. It is not essential that they be done at the same institution. If they have been done at an outside institution, then it is the responsibility of the referring service provider and the radiologist to have these

images available. If, however, they cannot be made available to the radiologist, it is acceptable practice to repeat the appropriate examination and claim for it. *(5.3.156)*

- Reasonable effort should be made to review original examinations from another centre. No current outside examination of acceptable quality should be repeated. *(5.3.157)*
- When using the paediatric codes, upper GI, colon and cystography, it is recognized the added time these examinations take; however, the age limit for these fee codes is 12 years not 16 years as in the workload measurement system. *(5.3.158)*
- When a CT examination is performed with and without contrast, the combined code shall be used. *(5.3.159)*
- HSC 1180 may only be claimed when 3D reconstruction has been carried out. It may not be claimed for 2D reconstruction or multiplanar reconstruction.
- The 3D add-on for CT scans is for volume rendering only

**B. Ultrasound** ***(5.3.160)***

- An abdominal general ultrasound includes a study of all appropriate areas and organs. No restricted or special fees may be added to this examination. Specific fees shall be used as appropriate; e.g., pylorus, appendix, aorta, kidneys and bladder; these fees are not cumulative. *(5.3.161)*
- An ultrasound examination of the pelvis in the first trimester of pregnancy is to be billed as a pelvic ultrasound. *(5.3.162)*
- Biophysical profile shall only be charged when films are made and a written report generated by a radiologist. *(5.3.163)*
- The fee for a radiologist performing a portable examination is an add-on fee to be charged for studies performed outside the department which require the radiologist to be in attendance for the entire examination. *(5.3.164)*
- When both pelvic and endovaginal examinations are performed, they shall be as endovaginal with pelvic. *(5.3.165)*
- The intraoperative code is to be used when the radiologist is present in the operating room and no other code may be claimed for that examination. *(5.3.166)*

**C. Vascular Studies** ***(5.3.167)***

- Unilateral and bilateral venogram studies of the extremities should include a central film. No additional claim may be made for that film. *(5.3.168)*
- Only one claim should be made for angiography, irrespective of the number of modalities used; e.g., cut film, DSA, cine. *(5.3.169)*
- No claim may be made for an arch or abdominal aortic angiogram unless a proper flush study has been performed. An angiographic interpretation fee may only be charged when the vessel has been specifically selected and films taken. *(5.3.170)*
- The DSA interpretation fees apply to venous injections only. *(5.3.171)*

**D. Drainage or Biopsy Procedures** ***(5.3.172)***

- Drainage or biopsy procedures charged through MSI billing include imaging and no separate claim may be made for the imaging or interpretation. Abscess cavity films are part of the drainage fee. *(5.3.173)*

**E. Nuclear Medicine** ***(5.3.174)***

- A thyroid uptake special includes stimulation and/or suppression studies. *(5.3.175)*

- Bill both plasma volume and red cell volume only if they are measured separately. *(5.3.176)*
- ACE inhibitor renogram should be billed when the ACE Inhibitor is administered by and directly supervised by the service provider. If not, a renal scan and renogram should be billed. *(5.3.177)*
- Renal static imaging is to be billed instead of a renal scan and renogram when only static (e.g., DMSA) images are obtained. *(5.3.178)*
- Residual urine volume is an add-on fee. *(5.3.179)*
- Tomography will be an add-on fee, every time it is used. *(5.3.180)*
- Hepatobiliary with a pharmacological stimulation includes either morphine stimulation or CCK stimulation. *(5.3.181)*
- One area for bone, bone marrow and gallium scans indicates one body area; e.g. skull, foot, pelvis. *(5.3.182)*
- Flow studies, when appropriate, will be an add-on fee. *(5.3.183)*
- Computer manipulation is included in the interpretation fee and is no longer recognized as a separate item. *(5.3.184)*
- Myocardial rest quantitative, myocardial stress and rest quantitative are add-on fees. *(5.3.185)*
- Tumour imaging includes one whole body imaging for thyroid cancer or specialized tumour imaging studies; e.g., labeled antibody studies for the specific detection of tumours. It does not include other studies with specific codes. It is not an add-on fee. *(5.3.186)*
- PET/CT is insured for the following indications:

| Cancer | Indications |
|---|---|
| Breast | Evaluation of recurrence/residual disease, distant metastases (staging/restaging) and disease/therapeutic monitoring |
| Colorectal | Evaluation of recurrence/restaging, distant metastases and disease/therapeutic monitoring |
| Lung | Diagnosis of single pulmonary nodule, staging distant metastases, recurrence/restaging and disease/therapeutic monitoring |
| Head and Neck | Diagnosis of occult and synchronous tumours and recurrence/restaging and radiation planning |
| Lymphoma | Staging, restaging and monitoring |
| Oesophageal | Staging, restaging and monitoring |
| Melanoma | Recurrence/restaging, distant metastases |
| Thyroid | Limited to recurrent disease not confirmed by $I^{131}$ scintigraphy |
| Pancreatic | Diagnosis when conventional imaging results are inclusive |

*(5.3.187)*

### F. Magnetic Resonance Imaging *(5.3.246)*

The claim for MRI interpretation repeat sequence fee should only be made after the matching base spin echo or inversion recovery MRI interpretation has been claimed and accepted at the same occurrence. All interpretation requests generated from the same encounter should be claimed using the same service occurrence number. A repeat sequence code cannot be submitted until after the matching base MRI code has been submitted. *(5.3.247)*

## INTERNAL MEDICINE *(5.3.188)*

- Electrocardiogram, electroencephalogram and Holter monitoring are for interpretation only when performed in hospital. *(5.3.189)*
- Pulmonary functions: simple spirometry, flow/volume loops, helium dilution, carbon monoxide single breath, pulmonary stress test, bedside spirometry, body plethysmography are insured when performed in hospital. *(5.3.190)*

- Echocardiography: M mode, two dimensional, Doppler quantitative, Doppler qualitative are insured when performed in hospital. *(5.3.191)*
- When submitting claims for echocardiograms, physicians may claim either I1312 (Doppler – quantitative) or I1313 (Doppler – qualitative), but not both. A quantitative study includes elements of a qualitative study. *(5.3.248)*

## PATHOLOGY *(5.3.192)*

Effective April 1, 2015, Pathologists may claim pathology units from MSI by submitting their services as patient specific electronic claims. Pathology interpretation billing and service date must be the date the patient was seen in hospital and had specimens removed. The date the report was completed is not the correct service date. The only exception would be for consults or second opinion, which should be claimed for the date of service of the consult. *(5.3.194)*

Third party requests for services should continue to be billed directly to the third party, e.g., medical examiners autopsies or requests from WCB, etc. *(5.3.195)*

### Surgicals: Gross and Microscopic *(5.1.196)*

When more than one surgical specimen is received from a patient, the following rules apply:

- P2325 may be claimed for each specimen taken from anatomically distinct surgical sites.
- P2345 may be claimed when three or more separate surgical specimens are taken from the same anatomic site.
- P2346 may be claimed when a single large complex cancer specimen, which includes lymph nodes, is examined for the purposes of providing a pathologic cancer staging. *(5.3.197)*

**Definitions: Anatomically distinct site *(5.3.198)***

For the purposes of correctly interpreting anatomic pathology fee code P2325, the body is considered to be divided into the following distinct anatomical areas: head and neck; upper limbs; trunk anterior and posterior. The following organ systems are also considered to be distinct surgical sites: upper GI tract; reproductive system; separate organs within the abdominal or thoracic cavities may be claimed as distinct sites. For example, two separate skin specimens from the right and left arms are considered as one site; specimens from uterus and ovary are one site; specimens from colon and liver are two sites. *(5.3.199)*

### Clarifications *(5.3.200)*

**Frozen sections intra operative consult with tissue:** For the purposes of correctly interpreting anatomic pathology fee code P2326, all frozen sections taken from one surgical specimen are considered to be one frozen section. When separate organs or anatomic areas are sent for frozen section, then it is appropriate to bill for two frozen sections; separate sentinel nodes may also be considered as separate specimens. For example, examination of several margins from one skin cancer is one frozen section; examination of multiple margins from two separate skin cancers, even though they may be within the same anatomically distinct surgical site as defined above, can be considered as two frozen sections. *(5.3.201)*

**Second opinion consults:** Health Service codes 03.09I and 03.09J are for use when a pathologist has been asked to review material sent by an outside institution or when a second opinion is medically necessary from a pathologist who has additional training/expertise in the area of concern. They may not be claimed for quality assurance activities. The date of service on the claim should reflect the date the pathologist has rendered their opinion. *(5.3.202)*

Pathologists are reminded that they may claim either HSC P2330 (cytology with a screener) or P2331 (interpretation and report – GYN cytology slides) but not both for the same specimen. If a pathologist claims a P2330, then later signs out the case and wishes to change the claim to P2331, they must delete the claim for the P2330 first. *(5.3.249)*

The multiples permitted for HSC P2345 or P2325 may not be the same as the number of specimens received and examined. Please ensure the multiples claimed are submitted correctly. *(5.3.250)*

## OPHTHALMOLOGICAL SERVICES *(5.3.203)*

### COMPLETE EYE EXAM *(5.3.204)*

a) An eye examination is payable under MSI when it is medically required. The service encounter should show an indication of presenting symptoms or diagnoses. *(5.3.205)*
b) Coverage for routine refractive vision analysis is limited to once every 24 months for persons under 10 years of age and for those 65 years of age and over. For all others, routine refractive vision analysis is an uninsured service. *(5.3.206)*
c) Visual fields, tonometry and gonioscopy are included in the fee for a complete eye exam and ophthalmological consultation. *(5.3.207)*

A complete ophthalmological exam including refraction may be claimed before and after cataract surgery. *(5.3.208)*

### CONTACT LENS FITTING *(5.3.209)*

Fitting of medically indicated contact lenses by a physician is an insured service under Nova Scotia Medical Services Insurance. In view of continuing developments and improvements in contact lens materials and therapy, it is recognized that they may prove to be of benefit in conditions not as yet listed. *(5.3.210)*

a) There are two types of lenses recognized:
    i. Bandage contact lens/lenses should be claimed for zero prescription lens/lenses applied to immobilize the eye to enable recovery for certain conditions. Follow-up visits may be claimed in addition.
    ii. Corrective lenses may be fitted to restore monocular or binocular vision where this cannot be achieved by other methods and to improve visual fields where this is compromised by high refractive error. *(5.3.211)*
b) Conditions for which contact lens fitting is an insured service on the basis of medical necessity: Albinism, aniridia, anterior membrane corneal dystrophies, aphakia, astigmatism requiring over five dioptres of cylindrical correction, bullous keratopathy, chronic corneal edema, corneal abrasion, corneal burn, corneal lacerations, corneal ulcer, descemetocele, dry eye syndromes, entropion, high refractive errors (six dioptres spherical equivalent or over in children under age 16, 10 dioptres spherical equivalent or over in adults), keratoconus, neuroparalytic keratopathy, nystagmus, old trachoma, paralysis of superior rectus muscle, pemphigus, post penetrating keratoplasty, post-operative discomfort or lacerations or perforations, prevention of symblepharon, recurrent cornea erosion, Stevens Johnson disease, stromal herpes simplex, thermal burns, trichiasis, vernal conjunctivitis, anisometropia, corneal degeneration, epithelial defect, pathological myopia, Marfan's Syndrome and pseudophakia. *(5.3.212)*
c) Conditions for which contact lens fitting may not be claimed:
Macular degeneration, open angle glaucoma, diabetic retinopathy, strabismus, borderline glaucoma and amblyopia *(5.3.213)*
d) Contact lens fitting includes follow up for 90 days by the same physician. *(5.3.214)*

When, as the result of an error or omission by the patient, an insured service is provided within the two year limit, the provider will be notified by MSI that an uninsured service has been rendered. The provider may then bill the patient the usual and customary fee. If the provider is unable to collect, a reduced fee will be paid by MSI. This service applies only to patients in the insured age group. *(5.3.215)*

### INTRAVITREAL INJECTION OF PHARMACOLOGIC AGENT (HSC 28.73F) *(5.3.218)*

This fee includes the counselling of the patient, preparation of the eye, administration of subconjunctival anaesthesia and topical antibiotic as required and injection of the pharmacologic agent. It may only be claimed

with the following specific diagnoses: 362.52 Exudative senile macular degeneration, 362.01 Diabetic macular edema, 362.35 Central retinal vein occlusion 362.36 Venous tributary (branch) occlusion, and 379.27 Vitreomacular adhesion (VMA). *(5.3.219)*

**OPTIC NERVE IMAGING** (HSC 02.02B) *(5.3.251)*

Optic Nerve Imaging by any means (e.g., OCT, HRT) for patients with a diagnosis of glaucoma, wet AMD, retinal vein occlusion, diabetic macular edema, and patients starting hydroxychloroquine or chloroquine treatment. This fee is for the interpretation of scanning computerized ophthalmic diagnostic imaging, with interpretation and written report, unilateral or bilateral, of the optic nerve and/or retina regardless of the technology used to perform the imaging. Not to be used for glaucoma screening. It may only be claimed with the specific diagnoses: 362.52 Exudative Senile Macular Degeneration, 362.01 Background Diabetic Retinopathy, 362.35 Central retinal vein occlusion, 362.36 Venous tributary occlusion, 379.27 Vitreomacular adhesion, 365.9 unspecified glaucoma, and for patients on hydroxychloroquine as there is no specific ICD9 code, use 362.10 background retinopathy unspecified. When using this DX the claim will require text stating the type of medication and any additional risk factors. *(5.3.252)*

**RETINAL DETACHMENT *(5.3.220)***

When claiming for repair of a retinal detachment, physicians may only bill for one therapeutic modality i.e. either diathermy (Health Service Codes 28.41 and 28.41A), or cryotherapy (Health Service Codes 28.42 and 28.42A), or photocoagulation (Health Service Codes 28.44A, 28.44B and 28.44C). It is not permitted to bill more than one of these codes for the same repair. *(5.3.221)*

**CATARACT SURGERY *(5.3.253)***

Monitoring of intraocular pressure is a part of the customary operative or post-operative care when providing cataract surgery. Health service code 03.12 Tonometry should not be reported in addition. This applies only to the day of surgery, and not over the remainder of the post-operative period. *(5.3.253)*

**TRABECULECTOMY *(5.3.254)***

Health service codes for trabeculectomy (HSC 26.25, 26.25B, 26.25C and 26.25D) are for invasive major surgical procedures and as such may only be claimed for services provided in an operating room. *(5.3.254)*

**IRIDOTOMY** (HSC 26.52) *(5.3.255)*

The fee for iridotomy should only be used when treating glaucoma. It is not appropriate to bill iridotomy when the procedure is solely used as means of access for another procedure. *(5.3.255)*

## PRONOUNCEMENT OF DEATH *(5.3.222)*

For attendance on the patient for the purpose of pronouncement of death, a limited visit may be claimed. This service may not be claimed using an urgent modifier. If another health care provider, such as a nurse, pronounces the patient, the physician may not claim a visit. It is not appropriate to claim a visit for filling out the death certificate or for telephone calls related to the death. *(5.3.223)*

## DENTAL SERVICES *(5.3.224)*

Referrals from dentists to physician specialists are acceptable provided that the dentist discusses the patient with the family physician before seeking such consultation and that the physician specialist sends a copy of their report to the family physician as well as to the referring dentist. *(5.3.225)*

Other physician's services provided at the request of a dentist are regarded as non-referred services; consultation or referred visit service codes shall not be used when submitting service encounters. *(5.3.226)*

# SECTION 6: TERMS AND DEFINITIONS *(6.0.0)*

| Term | Definition |
|---|---|
| **Accredited Service Bureau** | An approval given by MSI to an organization or individual to send service encounter transactions in an electronic format on behalf of service providers, with the ability to retrieve results electronically from MSI. A list of approved bureaus can be found on the MSI website. *(6.0.1)* |
| **Accredited Submitter** | An organization or individual accredited and approved by MSI to send service encounter transactions in an electronic format on behalf of service providers with the ability to retrieve results electronically from MSI, e.g., individual physician, group or service bureau. *(6.0.2)* |
| **Accredited Vendor** | An organization or individual that has developed a software program that has been accredited by MSI to electronically submit service encounters.<br>A list of approved vendors can be found on the MSI website. *(6.0.3)* |
| **Add-On** | An add-on is a procedure that is always performed in association with another procedure and never by itself. An add-on procedure is paid at full fee. *(6.0.7)* |
| **Adjudication Response/Results** | An electronic response that is sent to a submitter detailing the assessment results of each service encounter submission. It will be produced whenever service encounter submissions are processed. Service encounters that are reduced, refused or paid at zero will have an explanatory code attached. These explanatory codes are listed in the MSI Physician's Manual. *(6.0.8)* |
| **Age** | Where age is a factor in determining eligibility for payment, or modifies the service, the following age ranges are defined:<br>• Premature – 2,500 grams or less at birth<br>• Neonate/Newborn – the 10 days following delivery<br>• Infant – up to and including 23 months<br>• Child – up to and including 15 years of age<br>• Adult – 16 years of age and over *(6.0.9)*<br>Health service codes age distinction or modification *(6.0.10)*<br>The following are examples of age related services. The appropriate modifiers must be indicated on the service encounter.<br>HSC 50.99H Modifiers<br>Venipuncture:<br>a) Person seven years and older AG=PR07<br>b) Child up to seven years AG=CH07<br>HSC 76.0 Circumcision:<br>a) Infant or child under 16 years AG=CH16<br>b) Adult AG=ADUT *(6.0.11)*<br>Please note: Circumcision of a newborn is uninsured from birth to age one unless medical necessity warrants payment. *(6.0.12)* |
| **Amount Above Tariff** | Any amount above tariff or balance billing has been prohibited in Nova Scotia since July 1, 1984 for physicians, and July 1, 1988 for optometrists. *(6.0.13)* |
| **Antenatal (Prenatal)** | The term antenatal or prenatal applies to pregnancy related visits from the time of confirmation of pregnancy to delivery. *(6.0.14)* |
| **Basic Health Benefits** | The *Health Services and Insurance Act* makes provision for the payment of benefits with respect to the costs of health services provided to eligible residents. The basic health services provided include:<br>• Medically required physician's services<br>• Optometric services *(6.0.15)* |

| Term | Definition |
|---|---|
| **Bottom Line Adjustments** | Bottom line adjustments refer to adjustments in payment made by MSI that reflect credits or debits resulting from extenuating circumstances, e.g., audit recovery. *(6.0.16)* |
| **Bulletin** | An MSI administrative update that indicates and/or clarifies changes and subjects of concern with respect to service encounter submissions, assessment and other pertinent information. *(6.0.17)* |
| **Business Arrangement (BA)** | An agreement between a service provider and MSI covering the payment arrangements for health services provided. The business arrangement defines the service providers and the payee.<br>All service providers registered with MSI must have or be part of a business arrangement in order to claim for services. Some service providers may have and/or be part of more than one business arrangement. *(6.0.18)* |
| **Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP)** | A catalogue of procedures that was produced by Statistics Canada to provide a national procedure classification standard. *(6.0.19)* |
| **Certification** | The certification by a licensing body that recognizes specific capabilities of a service provider to provide health services. *(6.0.20)* |
| **Home Care** | home care provides home support services, personal care services, nursing services and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. Services provided have the objectives of maintaining or improving the individual's level of functioning; addressing the individuals' needs during rehabilitation or convalescence; delaying or preventing admission into institutions; and/or providing family relief services to the individual's informal caregivers.<br>The location modifier type and value for home care is LO=HMHC. Home Care Nova Scotia can be contacted by telephone at 1-800-225-7225. *(6.0.21)* |
| **Default** | Default means the action which automatically happens in the system, unless you give instruction otherwise. *(6.0.22)* |
| **Detention and Office Visits** | Medical detention occurs when a practitioner's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time may only be claimed for emergency care and/or treatment provided outside of the office (See Section 5 (5.1.75)). *(6.0.23)* |
| **Diagnostic Code** | A three to five digit international coding system which identifies the medical condition for which a service provider is billing services ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification). *(6.0.24)* |
| **Direct Deposit** | A method by which a service provider's payments from MSI are transferred directly into their bank account. This is also referred to as electronic funds transfer. *(6.0.25)* |
| **Discipline** | A specific branch or field of study in which a service provider has been licensed to participate, (e.g., medicine, dentistry, optometry or pharmacy). *(6.0.26)* |
| **Electronic Funds Transfer (EFT)** | A method by which a service provider's payments from MSI are transferred directly into their bank account. *(6.0.27)* |
| **Emergency Care Centres** | An emergency care centre is a special designation provided by the Department of Health and Wellness to emergency departments meeting certain standards including 24 hour on site on call. *(6.0.28)* |
| **Exceptional Clinical Circumstances** | Allowance is sometimes made for alteration of the tariff associated with individual service encounters when a physician can demonstrate significantly increased difficulty, time, or other factors involved in providing care (See Section 4 (4.1.11)). *(6.0.29)* |
| **Excluded Reciprocal Services** | Excluded reciprocal services are medical services, which have been identified as not payable under the Medical Reciprocal Program. *(6.0.30)* |

| Term | Definition |
|---|---|
| **Explanatory Code** | An explanation that indicates why a service encounter has been refused, reduced, paid at zero or changed in some other manner. *(6.0.31)* |
| **Facility** | Facility is a physical location, e.g., hospital, institution or office where health services are routinely performed. All facilities are formally recognized on the MSI Register. *(6.0.32)* |
| **Facility Number** | A number which uniquely identifies a physical location where health services are routinely performed (See Section 3 (3.2.100). *(6.0.33)* |
| **Functional Centre** | Facilities may have a further definition of their structure. This is done by identifying the functional centres within that facility (See Section 3 (3.2.102). *(6.0.34)*<br>Examples of functional centres include a standard area or site within a hospital or institution; e.g. outpatient department, intensive care unit, etc. Assigned functional centre modifiers will be required as part of a service encounter for services provided in such areas. *(6.0.35)* |
| **General Practitioner** | General practitioner means a physician who engages in the general practice of medicine. *(6.0.36)* |
| **Governing Organization** | An organization that has the mandate to certify or license service providers or facility capabilities, e.g., College of Physicians & Surgeons of Nova Scotia and the Department of Health and Wellness, etc. *(6.0.37)* |
| **Group Practice/Clinic** | A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients. *(6.0.38)* |
| **Health Card Number (HCN)** | A lifetime identification number used to identify all Nova Scotia residents who are registered with MSI. *(6.0.39)* |
| **Health Service Code (HSC)** | A code identifying services/procedures performed by a service provider to a service recipient. In most cases, these codes are CCP codes or CCP codes with a qualifier to further define the service. A list of health service codes and their descriptions are found in the Physician's Manual. Note: Non-CCP health services codes are used to identify non-procedural services. Example: C9999. *(6.0.40)* |
| **Home/Residence** | Home includes patient's home, group homes, seniors' lodges, personal care homes and provincial correctional centres. It does not include institutions. *(6.0.41)* |
| **Hospital** | For the purposes of this Preamble, hospital means a facility for the observation, care and treatment of persons suffering from a psychiatric disorder or a hospital for treatment of persons with sickness, disease or injury, including maternity care, as approved under the *Health Services and Insurance Act*. *(6.0.42)* |
| **Independent Consideration** | Independent consideration is a process for assessing services where a unit value is not listed (See Section 4 (4.1.8)). *(6.0.43)* |
| **In Province Registries** | The Nova Scotia College of Physicians & Surgeons is responsible for the registration and licensing of a new physician and for making changes to the physician registry information. *(6.0.44)* |
| **Institution** | Licensed and approved chronic care hospitals, residential care facilities, nursing homes and homes for special care. *(6.0.45)* |
| **Intensive Care Unit** | Intensive care units are special areas recognized and funded by the Department of Health and Wellness to provide high intensity care. These units would include neonatal, paediatric, coronary, and such other units as are recognized by the Department. Generally, special fees apply to patients in such areas unless the patients no longer need the care of such a unit, but remain in the intensive care area (e.g., due to lack of beds on general ward or recovery room). *(6.0.46)* |
| **Interim Fee** | May be established in certain circumstances with approval by Department of Health and Wellness. A CCP code will be activated to describe the new service and an interim fee assigned. Interim fees will be published in the MSI Physician's Bulletin. (See Section 4 (4.1.10)). *(6.0.47)* |

| Term | Definition |
|---|---|
| **Interpretive Component** | This is the interpretation of the results of a diagnostic procedure for which a fee may be claimed separately from performing the procedure itself. *(6.0.48)* |
| **Locum Tenens** | A physician who temporarily replaces another physician who is absent from the practice (See Section 3 (3.1.7)).<br>Note: The locum physician may not claim under the provider number of the physician being replaced. *(6.0.49)* |
| **Locum Period** | A period of time during which a locum tenens provides services in the absence of the established service provider. *(6.0.50)* |
| **Medavie Blue Cross** | Medavie Blue Cross administers the MSI programs on behalf of the Department of Health and Wellness. *(6.0.51)* |
| **Medical Necessity** | Medically necessary services may be defined as those services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction, as well as those services generally accepted as promoting health through prevention of disease or dysfunction. *(6.0.52)*<br>The provision of a service listed in the schedule of benefits does not ensure payment by Medical Services Insurance. Services provided in circumstances where they were not medically necessary are not insured. For the purpose of this Preamble, medical services that are explicitly deemed to be non-insured under the *Health Services and Insurance Act* or its Regulations remain uninsured regardless of individual judgments regarding their medical necessity. *(6.0.53)* |
| **Medical Reciprocal Program** | An agreement by which a Nova Scotia service provider obtains payment for medically required services provided to eligible residents of other Canadian provinces and territories, excluding Quebec. *(6.0.54)* |
| **Medical Reciprocal Service Encounter** | Service encounters submitted to MSI for service recipients from other provinces and territories that are eligible under the Medical Reciprocal Program. *(6.0.55)* |
| **Modifier** | Modifiers are codes added to the service encounter to identify the generic context within which the service was provided, e.g., specialty, time, place, etc. Some modifiers are for the purpose of clarification; others affect the tariff applied to the service.<br>Modifiers can be explicit or implicit. Explicit modifiers need to be entered as modifiers on a service encounter. Example: A service encounter for role of surgical assist is made by indicating the appropriate modifier, (RO=SRAS). Implicit modifiers are derived by the system based on the information submitted on the service encounter or from information that exists in the system. The purpose of implicit modifiers is to eliminate duplicate entry and data that is already available. Example: service provider's specialty. A detailed list of modifiers may be found in Appendix H Modifier Types and Values (See Section 7 (7.8.0)) *(6.0.56)* |
| **Most Responsible Physician** | The most responsible physician is the attending physician who is primarily responsible for the day to day care of the patient in hospital. *(6.0.57)* |
| **Non-Participating Physician** | A physician who has elected not to receive compensation for insured medical services from MSI (See Section 3 (3.1.20)). *(6.0.58)* |
| **Nova Scotia Medical Services Insurance (MSI)** | MSI is responsible for maintaining health care insurance information such as registration of residents, processing service encounters and maintaining payments to service providers. *(6.0.59)* |
| **Nova Scotia Medical Services Insurance Plan** | A plan administered and operated in accordance with the *Nova Scotia Health Services and Insurance Act* on a not for profit basis to provide benefits for health services to all eligible residents of Nova Scotia. *(6.0.60)* |
| **Office** | An office is defined as the location where a physician is practicing their profession. An office may be located in the physician's home, in a hospital, in an institution, or in other facilities or buildings. *(6.0.61)* |
| **Opting In** | It is the service provider's decision to have all basic health insured services submitted to MSI for direct payment. *(6.0.62)* |

| Term | Definition |
|---|---|
| **Opting Out** | It is the service provider's decision not to have basic health insured services submitted to MSI for direct payment. *(6.0.63)* |
| **Other Locations** | This modifier applies to locations of service not defined elsewhere, such as recreational facilities, watercraft, or roadside. *(6.0.64)* |
| **Paid at Zero** | Term used to indicate that additional information may be required from the provider to aid in the assessment of the claim. *(6.0.65)* |
| **Participating Physician** | A physician who is registered with MSI to receive compensation for insured medical services. *(6.0.66)* |
| **Payment Responsibility** | The payment responsibility is a mandatory field on a service encounter that identifies which organization is responsible for the payment of the service, i.e., MSI, WCB, Community Services (COM). There are also out of province codes that identify the provincial health care plan where the patient has medical coverage (See Section 3 (3.2.115)). *(6.0.67)* |
| **Physician** | Physician means a legally qualified medical practitioner whose name is entered in the register kept by the College of Physicians & Surgeons of Nova Scotia as being qualified and licensed to practice medicine. They must be in good standing and not under suspension pursuant to any of the provisions of the *Medical Act*. *(6.0.68)* |
| **Physician's Manual** | The physician's manual is comprised of:<br>• Preamble<br>• List of Insured Health Service Codes and Descriptions<br>• Explanatory Codes and Descriptions *(6.0.69)* |
| **Post Natal** | The term postnatal describes a single limited visit performed approximately six weeks following delivery for the purpose of assessment and advice to the mother. *(6.0.70)* |
| **Postpartum** | The term postpartum describes in hospital limited visits to the mother following delivery. *(6.0.71)* |
| **Premium Fees** | Premium fees are additional amounts paid above normal or customary rates on eligible services provided on an emergency basis during designated times. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient (See Section 5 (5.1.81)). *(6.0.72)* |
| **Qualifiers** | A qualifier is an alpha character appended to some health service codes (HSC) to subdivide the code and thereby distinguish differences specific to that procedure, e.g., 98.12W excision of lesions, 98.12U cryotherapy of lesions, and 98.12X electrocautery of lesions (See Section 3 (3.2.63)). *(6.0.73)* |
| **Rate** | When the tariff for a service is modified by specialty, time, or some other factor, the applicable tariff may vary according to the specific circumstances. *(6.0.74)* |
| **Registrant** | Nova Scotia resident in whose name the Nova Scotia Health Care coverage is specifically registered. *(6.0.75)* |
| **Registry** | A registry is a single repository containing pertinent data about service recipients, service providers, facilities, etc. which are part of the Nova Scotia health service delivery system. *(6.0.76)* |
| **Resident of Nova Scotia** | A person lawfully entitled to be or remain in Canada, and who makes their home and is ordinarily present in Nova Scotia. A resident does not include a tourist, a transient or a visitor to Nova Scotia. *(6.0.77)* |
| **Schedule of Benefits** | The schedule lists all insured procedures, their descriptions and codes, any special conditions, and the value in units. When the term schedule is used in this Preamble, it means the schedule of benefits (This refers to the electronic document). *(6.0.78)* |
| **Service** | When the term service is used in this manual, it is in the context of an insured visit or procedure that is identified by a specific service code in the MSI schedule of benefits. *(6.0.79)* |
| **Service Encounter** | A transaction which describes the health service performed by the provider to the service recipient. *(6.0.81)* |

| Term | Definition |
|---|---|
| **Service Encounter Number** | A service encounter number is assigned to each service encounter which distinguishes that service encounter from others. It is comprised of the submitter ID, year, sequence number and check digit. *(6.0.82)* |
| **Service Provider** | A service provider is an individual who provides a health service for which a service encounter is submitted to MSI. *(6.0.83)* |
| **Service Recipient** | An individual who receives insured services by a registered Nova Scotia service provider. *(6.0.84)* |
| **Service Representatives** | Personnel within MSI who offer assistance with inquiries to service providers and their staff. *(6.0.85)* |
| **Sessional Fees** | Sessional fees apply to preapproved services of a physician engaged on a time basis. *(6.0.86)*<br>These include for example:<br>Well Woman's Clinic (requires prior approval)<br>Well Man's Clinic (requires prior approval)<br>Immunization Clinic (requires prior approval)<br>Anaesthetic Clinic<br>Paediatric Amputee Clinic<br>Palliative Care<br>Correctional Centre<br>Public Health Medicine<br>Other professional services to a government department, agency or public body *(6.0.87)* |
| **Submitter ID** | This is a unique identifier originally given to the Submitter, from MSI, attached to business arrangement numbers to download electronic payment statements directly to the office that is billing for a provider. *(6.0.88)* |
| **Specialist/Specialty** | A specialist is defined as one whose name appears in the specialist register of the College of Physicians & Surgeons of Nova Scotia. *(6.0.89)* |
| **Specialty** | A specialty is a certification recognized by a governing body which is used in the provision of a health service, e.g., family practice, general surgery. *(6.0.90)* However, when the term specialty is used, it means any or all specialties, including general or family practice. For the purpose of this Preamble, the terms general and family practice are used interchangeably. *(6.0.91)* |
| **Statement of Account** | A statement is based on the number of service encounters processed on a biweekly basis indicating the amount MSI has released for payment. The statement can be retrieved electronically from the MSI system. *(6.0.92)* |
| **Statutory Holiday** | Holidays are defined for the purpose of claiming special rates as New Year's Day, Heritage Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving, Remembrance Day, Christmas Day and Boxing Day. The list of dates designated as statutory holidays will be issued annually by MSI.<br>Note: If a physician chooses to provide routine, scheduled services during a statutory holiday, they are not entitled to payment at the holiday rate. *(6.0.93)* |
| **Tariff** | A tariff is compensation associated with the provision of insured health services as governed by the *Nova Scotia Health Services and Insurance Act*. *(6.0.95)*<br>Tariffs are paid on a fee-for-service, contractual or sessional basis according to an approved plan for payment or insured list of professional services or products. Payments are made directly to service providers when rendering services to registered residents of Nova Scotia. Payments are also made to registered residents of Nova Scotia who provide proof of payment for receipt of an insured service. *(6.0.96)*<br>The MSI tariff is the actual monetary value of a service. It is derived from the number of units applicable to a service which may vary according to relevant modifiers, the medical service unit value, and any individual billing factors based on practice location or billing thresholds, or other factors that may exist from time to time. *(6.0.97)* |

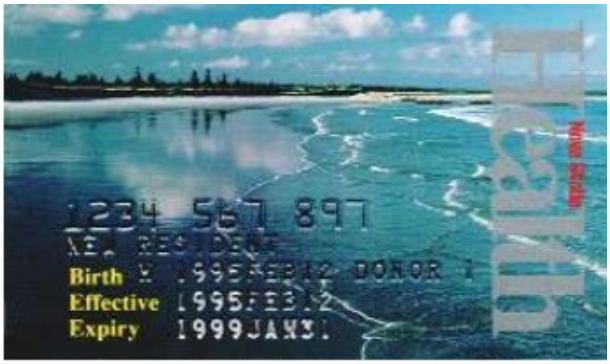
| Term | Definition |
|---|---|
| **Technical Component** | Some diagnostic procedures have separately listed technical and interpretive components. When a physician must perform the technical component of a procedure that is normally carried out by a technician, the physician may claim a fee for the technical component. If a technician carries out the technical component, the physician may claim for the interpretive component only. *(6.0.98)* |
| **Third Party** | A person or organization other than the patient, their agent, or MSI that is requesting and/or assuming financial responsibility for a medical or medically related service. *(6.0.99)* |
| **Transfer of Care** | Transfer of care occurs when the responsibility for the care of a patient is completely transferred, either temporarily or permanently, from one physician to another (See Section 5 (5.1.109)). *(6.0.100)* |
| **Travel** | Travel means movement from one geographic location to another. Interpretations specific for travel to certain locations: *(6.0.101)*<br>Within an apartment building, movement from one unit to another is considered travel. *(6.0.102)*<br>Movement within a hospital, even between separate buildings on one contiguous site, is not considered travel. If a hospital has several geographically separate sites, movement between sites is considered travel. *(6.0.103)*<br>Movement between rooms or units of a licensed nursing home or special care institution is not considered travel. *(6.0.104)*<br>If a physician maintains a medical office within or adjoining their place of residence, entering the office for the purpose of rendering emergency treatment is considered travel during certain time periods. *(6.0.105)*<br>Travel from physician personal home location to patient home is not eligible for travel, only travel from office to patient home. (Unless the physician has at at-home office registered with MSI).<br>If a physician has arranged to have an office in a hospital or in an attached building, going from the office to the hospital to attend a patient is not considered travel. *(6.0.106)* |
| **Units/Unit Value** | The MSI schedule of benefits uses units to represent the value of a service. The value of a unit varies according to the applicable tariff. Two unit values exist, an anaesthetic unit value used specifically for claiming anaesthetic services, and a medical service unit value specifying the dollar value of all other services. *(6.0.107)* |

# SECTION 7: APPENDICES *(7.0.0)*

# APPENDIX A – INTERPROVINCIAL HEALTH CARDS *(7.1.0)*

## SAMPLE OF NOVA SCOTIA HEALTH CARD *(7.1.1)*

The plastic card with a magnetic-stripe depicts a Nova Scotia scene of the Kejimkujik Seaside Adjunct National Park. The card contains the 10-digit lifetime identification number, the resident's name, gender (if applicable), date of birth, organ donor status, effective date and expiry date of the card. This information is in silver, embossed lettering.

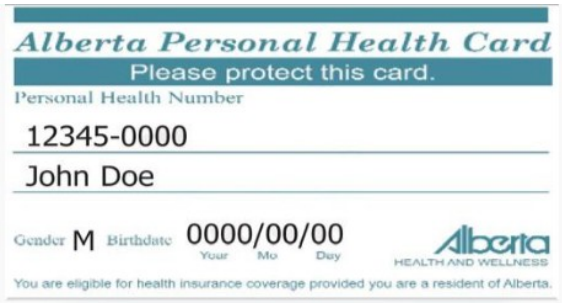


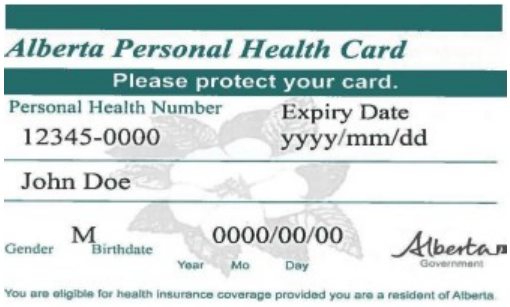

*(7.1.2)*

## SAMPLE OF ALBERTA HEALTH CARD *(7.1.3)*

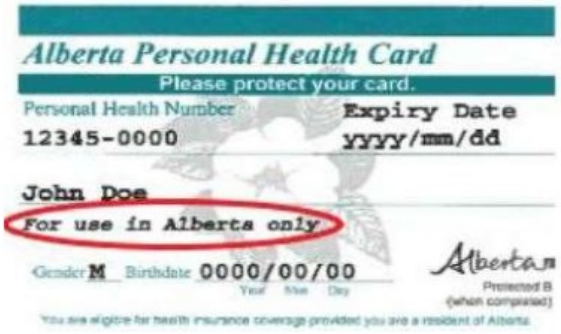
Annual personal health cards are no longer issued. New residents and newborns are issued cards when they are registered. Replacement cards are issued upon request. *(7.1.4)*

Information on the card includes the individual's nine-digit personal health number (PHN), name, gender (if applicable), date of birth and expiry date of the card if applicable. *(7.1.5)*




Cards indicated 'For use in Alberta only' cannot be used for Reciprocal Billing.




*(7.1.6)*

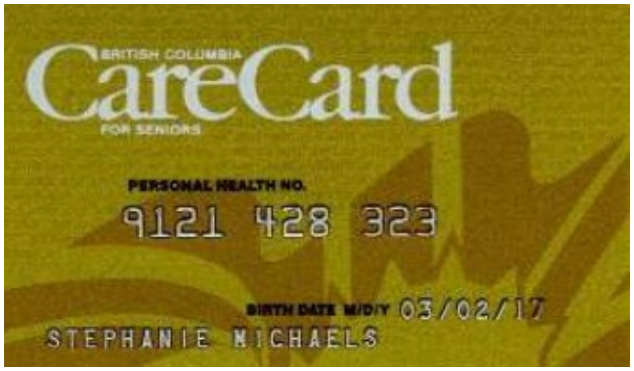
## SAMPLE OF BRITISH COLUMBIA HEALTH CARD *(7.1.7)*

The regular card is on a white background with the word "Care Card" filling the background in grey. The words "British Columbia Care" are blue and "Card" is red. The flag is red, blue, white and yellow. Plan member information is in black. *(7.1.8)*




*(7.1.9)*

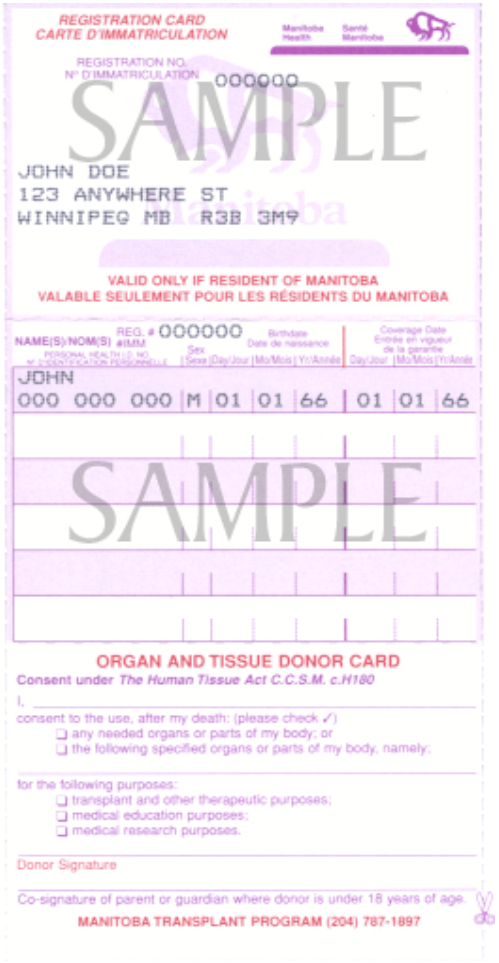
A gold Care Card is issued to seniors a few weeks before they reach age 65. It is gold with the words "British Columbia Care Card FOR SENIORS" in white. Plan information is also in white. *(7.1.10)*

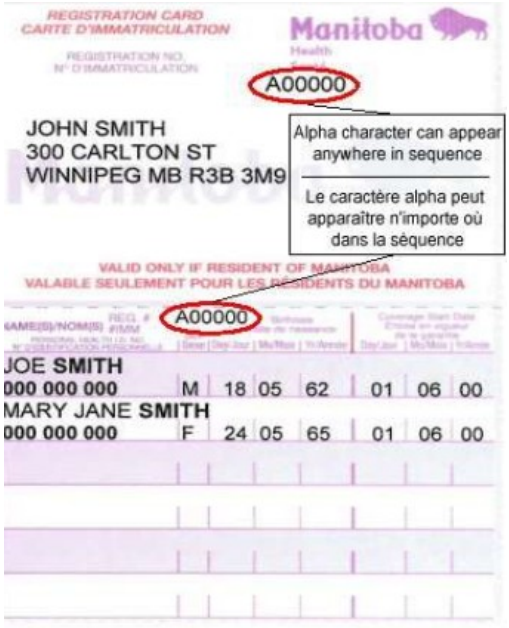



*(7.1.11)*

## SAMPLE OF MANITOBA HEALTH CARD *(7.1.12)*

Manitoba Health issues a card (or registration certificate) to all Manitoba residents, which includes a 9-digit lifetime identification number for each family member. The white paper card has purple and red print and includes the previous 6-digit family or single person's registration number, name and address of Manitoba resident, family member's given name and alternate (if applicable), sex, birth date, effective date of coverage, and 9-digit Personal Health Identification Number (PHIN). *(7.1.13)*

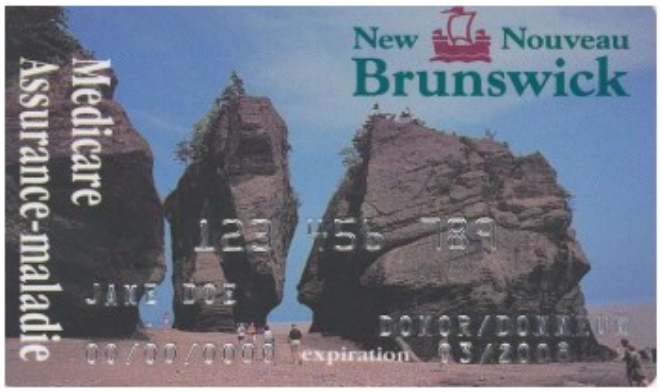



*(7.1.14)*

## SAMPLE OF NEW BRUNSWICK HEALTH CARD *(7.1.15)*

The plastic card with a magnetic-stripe depicts a New Brunswick scene of the Flowerpot Rocks-Hopewell Cape. The New Brunswick logo is displayed in the upper right corner. The card contains the 9-digit Medicare registration number, the subscriber's name, date of birth and expiry date of the card. This information is in silver, embossed lettering. *(7.1.16)*



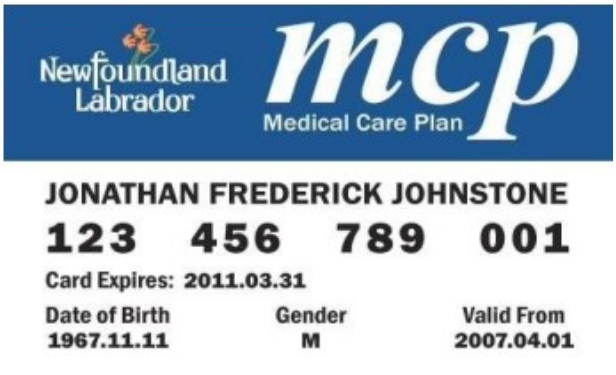


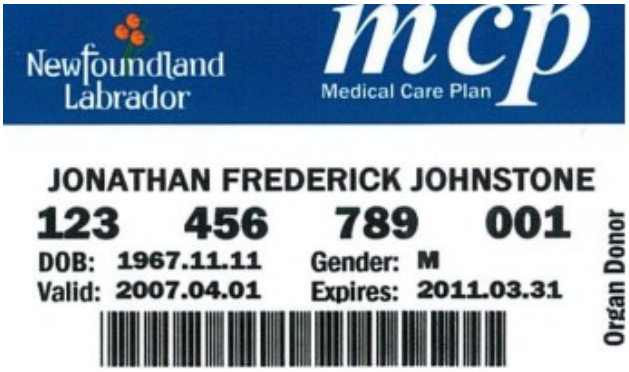


*(7.1.17)*

## SAMPLE OF NEWFOUNDLAND HEALTH CARD *(7.1.18)*

The MCP cards contains the 12-digit identification number, an individual's name, gender, MCP number and birth date to provide additional security to ensure that only the person to whom the card is issued will be able to use it. In addition, the cards have an expiry date to allow the Department of Health and Community Services to periodically update the MCP database and provide an improved mechanism for accountability. *(7.1.19)*



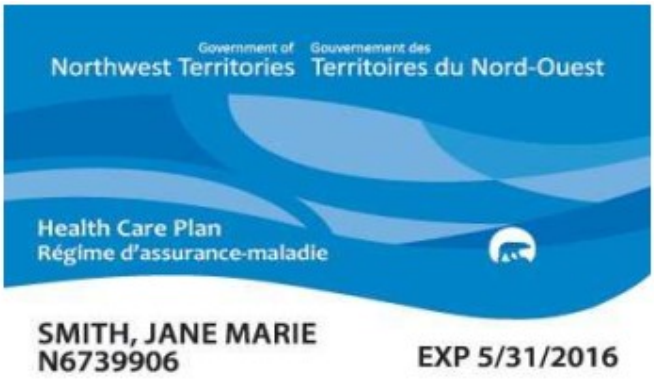



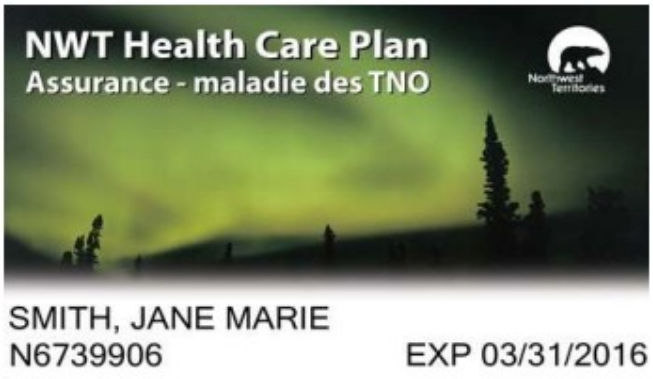

*(7.1.20)*

## SAMPLE OF NORTHWEST TERRITORIES HEALTH CARD *(7.1.21)*

The Northwest Territories have a paper health card which features a northern landscape as a faint background screen. The letters and numbers are in black. The card bears the name, 7-digit identification number and expiry date. *(7.1.22)*

Close attention should be paid to the expiry date. *(7.1.23)*



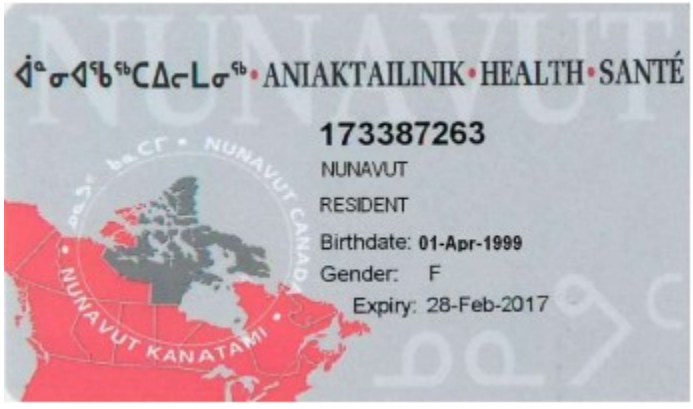

*(7.1.24)*

## SAMPLE OF NUNAVUT HEALTH CARD *(7.1.25)*

The Nunavut health card is made of pale grey plastic. It features a territorial map of Canada, in red, on which Nunavut is shown in dark grey. A circle is superimposed around the Territory, with the words NUNAVUT CANADA in three languages. In the upper portion of the card the word NUNAVUT appears in pale grey, with the word HEALTH superimposed in four languages. The card bears the following information: the nine-digit health insurance number, name and date of birth of the insured person, as well as the card's expiry date. *(7.1.26)*

The reverse side features the address and telephone number of the Nunavut administrative services, as well as the signature of the cardholder. *(7.1.27)*

Close attention should be paid to the expiry date. *(7.1.28)*




*(7.1.29)*

## SAMPLE OF ONTARIO HEALTH CARD *(7.1.30)*

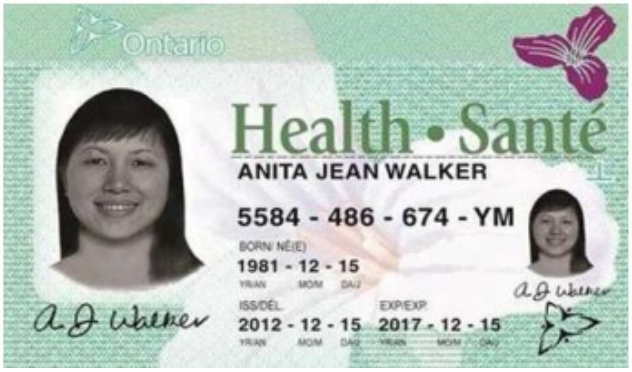
The Ministry of Health and Long-Term Care recognizes the importance of having a secure Health Card and is introducing changes to enhance the security of its current card. These additional security enhancements will make the Health Card more tamperproof and counterfeit resistant. In order to further protect personal health information, address information has been removed from the back of the Health Card. *(7.1.31)*

Ontarians will not receive an enhanced Health Card until their current card expires, or a replacement card is required. Both the red and white and the current photo health card remain acceptable as proof of entitlement to medically necessary insured health services providing they are valid and belong to the person presenting the card. *(7.1.32)*

The additional security features include:
- A new security background
- Secondary photo and signature
- Tactile features (Health Number, Version Code, and Ontario trillium logo)
- A 2D bar code

Children under the age of 15 ½ years have health cards that are exempt from both photo and signature. *(7.1.33)*



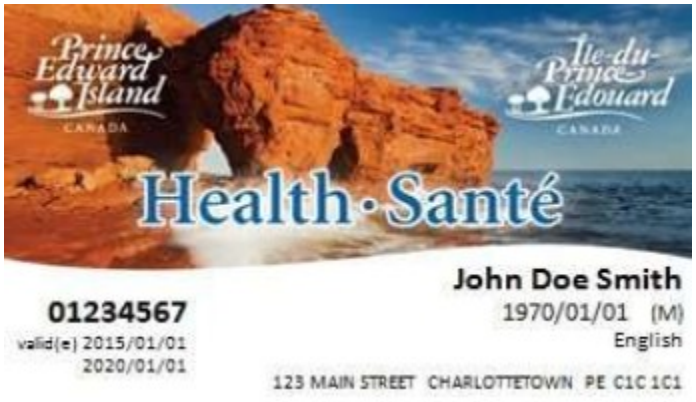




*(7.1.34)*

## SAMPLE OF PRINCE EDWARD ISLAND HEALTH CARD *(7.1.35)*

This card assigns a unique 8-digit lifetime identification number to all eligible P.E.I. residents. Also displayed on the card are the given name(s), birth date, gender of the resident and expiry date of the health card. *(7.1.36)*




*(7.1.37)*

## SAMPLE OF SASKATCHEWAN HEALTH CARD *(7.1.38)*

The plastic cards are blue above and grey below a green, yellow and white stripe. Cards contain a Personal Health Number, name, effective date for coverage, termination date for coverage, sex, beneficiary's month and year of birth and 8-digit Family/Beneficiary number. *(7.1.39)*




*(7.1.40)*

## SAMPLE OF QUEBEC HEALTH CARD *(7.1.41)*

The Régie issues a Health Insurance Card to persons eligible for the Québec Health Insurance Plan. Because the Health Insurance Card gives access to insured healthcare services, it is important for insured persons to carry their card with them at all times. This card contains the 12-digit health insurance number, the person's first and last names at birth, spouses name or sequential number, date of birth, sex, the year and month of expiry, photo and signature (if applicable), consent to organ donation and number of cards issued to the person since 1984. The two dimensional bar-code issued as of January 24, 2018 contains information such as first and last names and date of birth. *(7.1.42)*













*(7.1.43)*

The person's photograph and signature, are digitized and incorporated into the card. Cards issued to persons not required to provide a photo and a signature, such as children under age 14, have no photo or signature spaces, while cards issued to persons exempt from providing their photo, their signature or both, are marked "exempté" in the appropriate space(s). *(7.1.44)*

## SAMPLE OF YUKON HEALTH CARD *(7.1.46)*

The plastic cards are blue in color with black print. It contains the 9-digit identification number, the resident's name, gender, date of birth, organ donor status, address, effective date and expiry date of the card. *(7.1.47)*




*(7.1.48)*

A green health care card is issued to Yukon senior citizens registered with the Pharmacare and Extended Benefits programs, replacing the blue health care insurance plan card. This one card entitles holders to all seniors' benefits, hospital and physician services. Persons are eligible for the card if they are a Yukon resident aged 65 years or older, or if they are 60 years of age or older and married to a living Yukon resident who is 65 years of age or older. *(7.1.49)*




*(7.1.50)*

# APPENDIX B – ABBREVIATIONS *(7.2.0)*

## SPECIALTY ABBREVIATIONS *(7.2.1)*

| | | |
|---|---|---|
| ANAE | - | Anaesthesia |
| ANPA | - | Anatomical Pathology |
| CARD | - | Cardiology |
| CASG | - | Cardiovascular/Thoracic Surgery |
| CLIA | - | Clinical Immunology & Allergy |
| COMD | - | Community Medicine |
| DENT | - | Dental Practitioner |
| DERM | - | Dermatology |
| DIRD | - | Diagnostic Radiology |
| EMMD | - | Emergency Medicine |
| ENDO | - | Endodontics |
| ENME | - | Endocrinology & Metabolism |
| GAST | - | Gastroenterology |
| GEMD | - | Geriatric Medicine |
| GENP | - | General Practitioner |
| GNSG | - | General Surgery |
| HAGY | - | Haematology |
| HAPA | - | Haematological Pathology |
| HUGE | - | Human Genetics |
| INDI | - | Infectious Diseases |
| INMD | - | Internal Medicine |
| MDON | - | Medical Oncology |
| MEBI | - | Medical Biochemistry |
| MEGE | - | Medical Genetics |
| MEMI | - | Medical Microbiology |
| NCMD | - | Nuclear Medicine |
| NEPA | - | Neuropathology |
| NEPE | - | Neurology Paediatric |
| NEPH | - | Nephrology |
| NEUR | - | Neurology |
| NUSG | - | Neurosurgery |
| OBGY | - | Obstetrics & Gynaecology |
| ODON | - | Orthodontics |
| OPHT | - | Ophthalmology |
| OPTO | - | Optometry |
| ORAL | - | Oral Surgery |
| ORTH | - | Orthopaedic Surgery |
| OTOL | - | Otolaryngology |
| PATH | - | General Pathology |
| PEDI | - | Paediatrics |
| PEDO | - | Pedodontics |
| PERI | - | Periodontics |
| PHMD | - | Physical Medicine & Rehabilitation |
| PLAS | - | Plastic Surgery |
| PROS | - | Prosthodontics |
| PSYC | - | Psychiatry |
| RADI | - | Diagnostic & Therapeutic Radiology |
| RDON | - | Radiation Oncology |
| RHEU | - | Rheumatology |
| RSMD | - | Respiratory Medicine |
| THSG | - | Thoracic Surgery |
| UROL | - | Urology |
| VASG | - | Vascular Surgery *(7.2.2)* |

## CATEGORY ABBREVIATIONS *(7.2.3)*

| | | |
|---|---|---|
| ADON | - | Add On |
| ALPM | - | Alternate Payments |
| ANAE | - | Anaesthesia |
| BOGR | - | Bone Graft |
| CASP | - | Casts and Splints |
| COCR | - | Complete Care |
| CONS | - | Consultation |
| CRCR | - | Intensive Care / Critical Care |
| DEFT | - | Default |
| DISL | - | Dislocation |
| MAAS | - | Manual Assess |
| MAFR | - | Major Fracture |
| MASG | - | Major Surgery |
| MIFR | - | Minor Fracture |
| MISG | - | Minor Surgery |
| OBST | - | Obstetrical |
| OPTO | - | Optometry |
| PMNO | - | Pain Management (non obstetrical) |
| PSYC | - | Psychiatric Care |
| VADT | - | Visit Allowed Diagnostic & Therapeutic Procedure |
| VEDT | - | Visit Excluded Diagnostic & Therapeutic Procedure |
| VIST | - | Visit *(7.2.4)* |

# APPENDIX C – SERVICE ENCOUNTERS REQUIRING PRIOR APPROVAL/PREAUTHORIZATION (NOVA SCOTIA RESIDENTS) *(7.3.0)*

A request by a specialist must be submitted in writing to the Medical Consultant MSI outlining the medical necessity for the procedure. Upon review of the information a response will be issued. If the procedure is approved you will be advised of the Preauthorization Number. To ensure payment of the service the Preauthorization Number has to be entered in the appropriate field on the service encounter. *(7.3.1)*

## PRIOR APPROVAL/PREAUTHORIZATION (RECIPROCAL RESIDENTS) *(7.3.2)*

The same listing of health service codes also applies for service encounters submitted using the reciprocal billing process. Approval has to be obtained from the recipient's home province Medicare Plan. If approval is received, forward a copy of the documentation to MSI requesting a Preauthorization Number. To ensure payment of the service the Preauthorization Number has to be entered in the appropriate field on the service encounter. *(7.3.3)*

Service encounters submitted for the following procedures must have prior approval and a valid referral in order to be paid. *(7.3.5)*

***Please note the health service codes not requiring prior approval if performed for malignant or premalignant conditions.** *(7.3.4)*

***** Prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition *(7.3.6)*

| Health Service Code | Description |
|---|---|
| **13.59O** | Injection of OnabotulinumtoxinA for treatment of Chronic Migraine |
| **22.5C** | Plastic repair (without skin graft) eyelid - no prior approval required if condition is trauma related |
| **30.4** | Surgical correction of prominent ear – congenital (18 years and older) |
| **30.61A** | External ear otoplasty, exclusive of simple lacerations (minor) |
| **30.61A** | External ear otoplasty, exclusive of simple lacerations (major) |
| **30.61B** | Total reconstruction of ear (Pinna) (18 years and older) |
| **33.74** | Rhinoplasty with bone or cartilage graft (entire) |
| **33.74** | Rhinoplasty with bone or cartilage graft (partial) |
| **33.76B** | Complete rhinoplasty with submucous resection without skin grafting |
| **33.76D** | Rhinoplasty – removal of hump |
| **33.76E** | Scalping rhinoplasty – two stages |
| **33.79B** | Reconstruction of nasal tip, ala and columella |
| **56.93** | Gastroplasty or gastric bypass for morbid obesity |
| **97.31A*** | Unilateral mammoplasty with nipple transplantation |
| **97.31C** | Unilateral functional pedicled breast reduction (unilateral) |
| **97.32*** | Bilateral reduction mammoplasty |
| **97.32B** | Bilateral functional pedicled breast reduction |
| **97.43*** | Unilateral augmentation mammoplasty by implant or graft |
| **97.44*** | Bilateral augmentation mammoplasty by implant or graft |
| **97.44A** | Feminization of Chest Wall |
| **97.6B*** | Breast reconstruction by myocutaneous flap and breast prosthesis |
| **97.6C*** | Breast reconstruction using rectus abdominis flap, including reconstruction of the rectus sheath as required. |

| Health Service Code | Description |
|---|---|
| **97.6D*** | Deep inferior epigastric perforator (DIEP) free flap breast reconstruction |
| **97.75A*** | Breast reconstruction by myocutaneous flap and prosthesis |
| **97.77*** | Other repair or reconstruction of nipple |
| **97.79B** | Masculinization of Chest Wall |
| **97.94A*** | Removal of breast prosthesis |
| **97.94B*** | Removal of breast prosthesis with capsulectomy |
| **97.99B** | Revision of gender affirming chest surgery |
| **98.12R** | Destruction (dermabrasion) of single area (e.g. trauma scar) |
| **98.93A** | Dermabrasion – full face |
| **98.93B** | Dermabrasion – less than 1/4 of face |
| **98.93C** | Dermabrasion of single area face (e.g., trauma scar) |
| **98.93D** | Dermabrasion between 1/4 and 1/2 of face |

*(7.3.7)*

NOTE: The diagnostic code and description to use when billing for malignant or premalignant conditions are as follows: *(7.3.8)*

| Code | Description |
|---|---|
| **1740** | Mal Neo Breast Nipple/Areola |
| **1741** | Mal Neo Central Portion Breast |
| **1742** | Mal Neo Upper Inner Quad Breast |
| **1743** | Mal Neo Lower Inner Quad Breast |
| **1744** | Mal Neo Upper Outer Quad Breast |
| **1745** | Mal Neo Lower Outer Quad Breast |
| **1746** | Mal Neo Auxiliary Tail Breast |
| **1748** | Oth Spec Mal Neo Female Breast |
| **1749** | Mal Neo Breast Unspec |
| **19881** | Secondary Mal Neo Breast |
| **2330** | Carcinoma in situ of Breast |

*(7.3.9)*

# APPENDIX D – COMPLETE CARE CODES *(7.4.0)*

Complete care codes are minor surgical procedures, which include the visit the same day and related visits by the same physician for 14 days following the procedure. Counselling related to the procedure cannot be claimed during this period. The following is a list of complete care codes: *(7.4.1)*

## COMPLETE CARE CODES *(7.4.2)*

| HSC | Description |
|---|---|
| **10.15** | Fitting for contraceptive diaphragm (complete care) |
| **22.13A** | Chalazion or tarsal cyst single or multiple complete care (one lid), local or general anaesthetic |
| **32.09A** | Myringotomy general anaesthetic complete care |
| **33.1A** | Drainage of abscess or hematoma of septum, complete care |
| **39.0** | Drainage of Ludwig's angina, complete care |
| **40.0A** | Drainage of retropharyngeal abscess intra oral, complete care |
| **66.0A** | Drainage of abdominal wall abscess general anaesthetic complete care |
| **81.8** | IUCD (complete care) |
| **83.2C** | Abscess of vulva, Bartholin's or Skene's gland complete care local anaesthetic |
| **98.02** | Perianal or pilonidal general anaesthetic, complete care |

*(7.4.3)*

# APPENDIX E – MAJOR SURGICAL PROCEDURES WITH NO ASSISTANT ALLOWED

*(7.5.0)*

There are some major surgical procedures where no assistant fee is allowed. A list of these procedures is as follows: *(7.5.1)*

| HSC | Descriptions |
|---|---|
| **01.03A** | Endoscopy with Removal of Benign Growth |
| **01.03B** | Endoscopy with Removal of Foreign Body |
| **01.34D** | Cystoscopy with Brush Biopsy of Renal Pelvis |
| **01.34F** | With Urethral Meatotomy and Plastic Repair |
| **06.34A** | Gold seed implants |
| **06.34B** | Caesium needle implants |
| **12.24A** | Removal of Foreign Body or Calculus |
| **14.13C** | Burr Holes Diagnostic |
| **14.85** | Percutaneous Ventriculogram |
| **15.42B** | Exteriorization of distal end cerebralspinal fluid shunt |
| **17.08C** | Avulsion of Mandibular, Supraorbital |
| **17.08E** | Morton's Neuroma |
| **17.61B** | Repair of Palmar Nerve |
| **17.61D** | Peripheral Nerve Minor digital, primary suture |
| **19.09** | Incision Abscess (Thyroid Gland) |
| **22.41** | Ptosis Lid Suspension |
| **22.5B** | Tarsorrhaphy |
| **22.5C** | Plastic Repair (Without Graft) |
| **22.5D** | Plastic Repair with Graft |
| **22.69C** | Flap to Eyebrow – 2nd Stage |
| **26.37** | Cyclocryotherapy |
| **26.62** | Freeing of other anterior synechiae |
| **26.62B** | Intraocular synechiolysis with or without surgery to the pupil and iris |
| **27.3** | Capsulotomy |
| **27.49A** | Excision Crystalline Lens Senile or Other |
| **27.59A** | Excision Crystalline Lens Senile or Other |
| **27.71A** | Repositioning Dislocated Intraocular Lens |
| **27.72** | Insertion of Intraocular Lens Prosthesis with Cataract Extraction One stage |
| **27.73** | Secondary Insertion of Intraocular Lens Prosthesis |
| **27.8** | Removal of implanted Lens |
| **28.44A** | Photocoagulation Repeat |
| **31.11** | Stapedectomy with Prosthesis |
| **31.59A** | Tympanoplasty and Ossiculoplasty with/without Canal Plasty |
| **33.04** | Ligation of Anterior Ethmoid Artery |
| **33.05** | Ligation Internal Maxillary Artery |
| **33.06** | Suture Ligation Carotid in Neck – Simple |
| **33.21A** | Excision of Choanal Atresia – Bony |
| **33.4A** | Submucous Resection Including Resection of Inferior Turbinates |
| **33.4** | Submucous Resection |
| **33.74** | Grafting for Nasal Deformity |
| **34.1A** | Maxillary, Intranasal – Unilateral |

| HSC | Descriptions |
|---|---|
| **34.31** | Frontal Trephine and Sinusectomy |
| **34.42A** | Ethmoidotomy |
| **34.43A** | Sphenoidostomy with Sinusoscopy Control |
| **37.09B** | Local Excision of Simple Tumor Tongue |
| **39.39B** | Excision of Ranula or Dermoid Cyst |
| **40.0B** | Lateral Pharyngeal |
| **40.2A** | Tonsillectomy (Child Under 16) |
| **40.2A** | Tonsillectomy (Adult GA) |
| **40.2A** | Tonsillectomy (Adult LA) |
| **40.7A** | Post op Haemorrhage T&A Referred (Consult and Procedure) |
| **42.09** | Excision Benign Growth(s) |
| **46.04A** | Incision thoracotomy – closed drainage, includes Hemlick valve device |
| **46.81A** | Thoracoscopy with installation of Fibrin Glue |
| **50.48E** | Short Saphenous Ligation and Stripping |
| **50.48P** | Cauterization of Varicose Veins |
| **50.72A** | Suture Ligation – Jugular |
| **50.78A** | Suture Ligation – Femoral |
| **51.92** | Injection of sclerosing agent or solution into vein – compression sclerotherapy (feganization) |
| **54.71** | Introduction of Souter Tube |
| **54.91A** | Injection, Oesophageal Varices with Esophagoscopy Initial |
| **54.92E** | Dilation of Oesophagus with Esophagoscopy Initial |
| **58.41A** | Revision of Colostomy or Ileostomy |
| **58.41C** | Revision of Ileostomy |
| **58.44A** | Revision of Colostomy or Ileostomy |
| **60.0A** | Proctotomy With Exploration |
| **60.0B** | - With Decompression (Imperforate Anus) |
| **60.0C** | - With Drainage (Perirectal Abscess) |
| **60.0D** | Pelvic Abscess Drainage |
| **60.21A** | Cauterization of Small Rectal Carcinoma |
| **60.24C** | Transanal endoscopic microsurgery |
| **60.39E** | Membranous Obstruction of Anus |
| **61.01B** | Unroofing Complete Care |
| **61.2** | Local excision of lesion (fissure) |
| **61.4A** | Internal Sphincterotomy plus Excision of Fissure |
| **61.69C** | Excision Scar for Stenosis |
| **62.49B** | Donor hepatectomy |
| **66.2A** | Umbilectomy Plastic |
| **66.83** | Laparoscopy |
| **66.83** | Laser Laparoscopy |
| **67.11D** | Percutaneous Endopyelotomy |
| **68.0B** | Manipulation Only Stone Not Removed |
| **68.89A** | Ureterocoele |
| **68.95A** | Ureteroscopy with or without Biopsy |
| **68.95B** | Ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrodynamic lithotripsy |
| **68.95C** | Ureteroscopy plus basket |

| HSC | Descriptions |
|---|---|
| **69.0A** | - With Removal of Foreign Body or Calculus |
| **69.0B** | - With Litholapaxy, Visual or Tactile and Removal of Fragments |
| **69.0C** | Cystoscopy with Ultrasonic or Electrohydraulic Lithotripsy |
| **69.13** | Cystotomy |
| **69.14** | Cystostomy |
| **69.29A** | With electrocoagulation or Tumor-Single |
| **69.29B** | With electroexcision of Tumor or Tumors including Base and adjacent muscle-Single |
| **69.29C** | - With electrocoagulation of Hunner's Ulcers |
| **69.29D** | - With Resection of Bladder Neck |
| **69.29E** | - With Electrosurgical Ureteral Meatotomy |
| **69.29G** | Cystoscopy with electrocoagulation of tumor – multiple |
| **69.29H** | Cystoscopy – with electroexcision of Tumor or Tumors including base and adjacent muscle – multiple |
| **70.0A** | Perineal Urethrostomy |
| **70.2C** | Caruncle – Including Cystoscopy |
| **70.2D** | Urethral Papilloma |
| **70.2L** | Prolapse with Cystoscopy |
| **70.4B** | Internal Urethrotomy |
| **71.7B** | Cystoscopy and Endoscopic Mucosal Injection Teflon (Sting) |
| **71.7C** | Cystoscopy and Injection of Collagen into Periurethral Tissue at Bladder Neck for Stress Urinary Incontinence |
| **71.7F** | Cystoscopy with intravesicular injection(s) of chemodenervating agent |
| **72.1B** | Transurethral Electro-Resection |
| **72.1C** | Endoscopy Resection of Bladder Neck – Transurethral Prostatectomy |
| **72.1D** | Transurethral Electro-Resection |
| **73.0B** | Exploration Scrotum |
| **73.2B** | Resection Scrotum |
| **74.1B** | Biopsy of Testis with Vasography |
| **74.2** | Orchidectomy – Unilateral |
| **74.31** | Orchidectomy – both testes |
| **74.51A** | Ruptured Testicle |
| **75.0A** | Hydrocoele – Single |
| **75.0B** | Varicocoele – Single |
| **75.1A** | Spermatocoele |
| **75.3** | Epididymectomy – Unilateral |
| **75.42** | Reduction of torsion of testes or spermatic cord |
| **75.73** | Anastomosis |
| **78.49A** | Sterilisation by transcervical tubal occlusion (both tubes) |
| **79.1** | Conization of Cervix by any Means |
| **81.01** | Incomplete Abortion |
| **81.61** | Incomplete Abortion |
| **81.91** | Insertion of Radium |
| **82.23C** | Local Excision of Cyst |
| **83.14** | Bartholin's Gland Cyst |
| **83.3B** | Clitoris – Amputation |
| **83.61** | Perineorrhaphy |

| HSC | Descriptions |
|---|---|
| **87.94** | Manual Replacement of Inverted Uterus |
| **89.19B** | Foraging of os calcis (regions required) |
| **89.59D** | Bone biopsy – superficial |
| **89.98A** | Punch biopsy of vertebra |
| **89.99B** | Punch biopsy – with x-ray control |
| **91.08L** | Spinal trauma without cord injury cranio-skeletal traction tongs |
| **91.08M** | Spinal trauma with cord injury cranio-skeletal traction tongs |
| **94.01A** | Acute Tenosynovitis of Finger – Drainage |
| **94.01B** | Tendon Sheath – Simple Ganglion |
| **94.01C** | Tendon or Tendon Sheath – Explore |
| **94.04** | Incision and Drainage of palmer and thenar space |
| **94.11A** | Tendon Sheath – Release – Finger |
| **94.11B** | Tenotomy |
| **94.13** | Fasciotomy |
| **94.21A** | Tendon Sheath – Simple Ganglion |
| **94.21D** | Biopsy Through Incision |
| **94.82A** | Tenotomy |
| **94.86B** | Tenodesis – hand |
| **95.01A** | Tendon Sheath – Simple Ganglion |
| **95.01B** | Tendon or Tendon Sheath – Explore |
| **95.01** | Incision of Tendon Sheath |
| **95.03C** | Ulnar or Radial Bursa – Drainage |
| **95.09A** | Palmar or Plantar Space |
| **95.13B** | Tendon Sheath – Release – Wrist |
| **95.13C** | Tenotomy |
| **95.15A** | Plantar Fasciotomy |
| **95.15** | Fasciotomy |
| **95.21A** | Tendon Sheath – Simple Ganglion |
| **95.21B** | Biopsy Through Incision |
| **95.35A** | Fasciotomy |
| **95.76C** | Tenotomy |
| **95.77A** | Tenodesis – hand |
| **97.11A** | Excisional Biopsy with Intra operative needle localization |
| **97.11B** | Lumpectomy for breast tumor (regions required) |
| **97.11** | Excisional Biopsy Breast |
| **98.12F** | Lipoma |
| **98.12H** | Dermoid Cyst |
| **98.12P** | Lip Shave |
| **98.13A** | Carcinoma Local Excision Skin Graft |
| **98.13B** | Carcinoma Local Excision Graft Larger Than 5 sq. in. |
| **98.13C** | Carcinoma Local Excision with Rotation Flaps |
| **98.13F** | V-Excision for Carcinoma |
| **98.14A** | Pilonidal Cyst |
| **98.99H** | MOHS micrographic surgery (MMS) for the removal of histologically confirmed cutaneous malignancy – initial level and debulking |

*(7.5.2)*

# APPENDIX F – SELECT ENDOSCOPIC PROCEDURES ELIGIBLE FOR PREMIUM FEES

*(7.6.0)*

| HSC | Description |
|---|---|
| 01.08A | Transbronchial lung biopsy with fiberscope |
| 01.09 | Other nonoperative bronchoscopy |
| 01.09A | Bronchoscopy with biopsy |
| 01.09B | Bronchoscopy - with foreign body removal |
| 01.12 | Other nonoperative esophagoscopy |
| 01.12A | Esophagobronchoscopy |
| 01.12B | Esophagoscopy with biopsy |
| 01.12C | Esophagoscopy - with removal of foreign body |
| 01.14A | Injection of ulcer through the scope for G.I. bleed or application of crazy glue into fundal region of stomach (scope included) |
| 01.14C | Esophagogastroscopy |
| 01.14D | Esophagogastroscopy with biopsy |
| 01.14E | Esophagogastroscopy - with removal of foreign body |
| 01.14F | Insertion of intragastric balloon in addition to gastroscopic fee |
| 01.14G | Removal of polyps in addition to the appropriate esophagogastroscopy – plus multiples, if applicable |
| 01.22C | Colonoscopy of descending colon |
| 01.22F | Balloon dilation of colonic stricture (In addition to colonoscopy) |
| 54.21A | Electrocautery of GI bleeding lesions - add on to endoscopic fees |
| 63.82A | Esophagogastroduodenoscopy - with papillotomy |
| 63.95A | Esophagogastroduodenoscopy - with basket extraction of stones |
| 63.95B | Esophagogastroduodenoscopy - with indwelling nasobiliary catheter |
| 63.95C | Esophagogastroduodenoscopy - with biliary stents |
| 64.91A | Esophagogastroduodenoscopy - with cannulation of pancreatic duct |
| 64.91B | Choledochoscopy with associated procedure |

*(7.6.1)*

# APPENDIX G – SELECT MULTIPLE FRACTURE PROCEDURES ELIGIBLE FOR LV=85 FEES *(7.7.0)*

| HSC | Descriptions |
|---|---|
| 91.30A | Fractured humerus neck without dislocation of head – open reduction |
| 91.30B | Fractured humerus shaft – open reduction |
| 91.30C | Fractured humerus – epicondyle – medial – open reduction |
| 91.30D | Fractured humerus – epicondyle – lateral – open reduction |
| 91.30E | Fractured humerus tuberosity – open reduction |
| 91.30F | Fractured humerus neck with dislocation of head – open reduction |
| 91.30G | Fractured humerus – supra or transcondylar – open reduction |
| 91.31 | Open reduction of fracture with internal fixation, radius and ulna |
| 91.31A | Open reduction – fractured olecranon |
| 91.31B | Open reduction – radius – head or neck |
| 91.31C | Open reduction fractured radius or ulna – shaft |
| 91.31D | Colles' or Smith's fracture – open reduction |
| 91.31E | Monteggia's or Galleazzi's fracture – open reduction |
| 91.31G | Distal comminuted intra-articular fracture of radius (to include distal ulna) due to high energy trauma. To include open reduction, internal/external fixation as required when performed in conjunction with remote donor site bone graft. |
| 91.34A | Fracture femur neck – open reduction with internal fixation |
| 91.34B | Fractured femur – pertrochanteric – open reduction |
| 91.34C | Fractured femur – shaft or transcondylar – open reduction |
| 91.34D | Fracture femur neck – prosthetic replacement |
| 91.35A | Fracture – tibia with or without fibula – shaft – open reduction |
| 91.35B | Fractured tibial plafond, with or without fibula, open reduction and internal fixation – including removal of pre-existing internal or external fixation devices. |
| 91.35C | Fractured tibia with or without fibula – plateau – open reduction |
| 91.35D | Fractured ankle – single malleolus – open reduction |
| 91.35E | Fracture fibula – open reduction |
| 91.35F | Fractured ankle – bi or trimalleolar – open reduction |
| 91.35G | Orif bicondylar tibial plateau fracture |
| 91.38A | Fractured – clavicle – open reduction |
| 91.95C | External fixation of tibial plafond fracture |
| 91.95D | External fixation of tibial plafond fracture, with open reduction and internal fixation of fibular fracture. |

*(7.7.1)*

# APPENDIX H – MODIFIER TYPES AND VALUES *(7.8.0)*

MSI adjudication system employs modifiers to determine the payment amount of a service encounter. Modifiers can affect payment such as:

- Adding an amount to the basic fee
- Subtracting an amount from the basic fee
- Replacing the basic fee with a different amount
- Indicating role, time, method, age *(7.8.1)*

| Modifier Type | Name | Description |
|---|---|---|
| **AG** | Age | Indicates the age of the patient |
| **AN** | Anaesthetic | Type of anaesthetic |
| **AP** | Approach | Defines the approach taken to perform the procedure |
| **CO** | Condition | The condition of the patient under anaesthetic |
| **CT** | Component | Defines the component of the procedure |
| **DA** | Date Of Service | Daily rate or date range |
| **FN** | Functional Centre | Indicates a specific type of centre within a facility |
| **IN** | Intensive Care | Describes the level and type of intensive care |
| **LO** | Location | Indicates where the service was provided |
| **LV** | Lesser Value | Second or subsequent procedure |
| **ME** | Method/Technique | Defines the technique of the procedure |
| **OL** | Originating Location | Indicates the location from where the home hospital care patient was admitted |
| **PO** | Portion | Defines the degree which a procedure is performed |
| **PT** | Patient | Defines first or additional patient seen at the same location |
| **RF** | Referred | Physician's referring number |
| **RG** | Region | Defines the region of the body |
| **RO** | Roles | The function the service provider performs at the service encounter |
| **RP** | Repeat Or Subsequent | When the same or similar service is provided more than once |
| **SE** | Sex | Gender of patient |
| **SP** | Specialty Code | Indicates physician's specialty |
| **TI** | Time | Defines the time block the service was provided |
| **US** | Unscheduled | Defines the type of unscheduled service |

*(7.8.2)*

## MODIFIER VALUES *(7.8.3)*

The following is a list of all available modifiers. In order to be paid the correct value for the service rendered, the appropriate modifiers and/or modifier combinations must be submitted. This Physician's Manual provides a list of the base unit values for the Health Service Codes. The complete list of all unit values and modifiers or modifier combinations is also available on your computer system. *(7.8.4)*

| Type | Value | Description |
|---|---|---|
| **AG** | ADUT | Person 16 years and older |
| **AG** | CH03 | Child up to three years |
| **AG** | CH04 | Child up to four years |
| **AG** | CH07 | Child up to seven years |
| **AG** | CH12 | Child up to twelve years |
| **AG** | CH16 | Child up to sixteen years |
| **AG** | NWBN | Newborn (infant up to and including ten days) |
| **AG** | OV65 | Person 65 years and older |
| **AG** | PR07 | Person seven years and older |
| **AN** | DFED | Delivery following epidural introduction |
| **AN** | EPID | Epidural anaesthetic |
| **AN** | GENL | General anaesthetic |
| **AN** | LABR | Labour |
| **AN** | LOCL | Local anaesthetic |
| **AN** | PNCT | Pain control |
| **AN** | REGL | Regional |
| **AP** | ABDO | Abdominal |
| **AP** | ANTE | Anterior |
| **AP** | CERV | Cervical |
| **AP** | CLSD | Closed procedure |
| **AP** | DRSL | Dorsal |
| **AP** | EXTR | External |
| **AP** | INPR | Intra peritoneal |
| **AP** | LMBR | Lumbar |
| **AP** | OPEN | Open procedure |
| **AP** | PERC | Percutaneous approach |
| **AP** | PERI | Perineal |
| **AP** | PHON | Occurred via telephone |
| **AP** | POST | Posterior |
| **AP** | SUBC | Subcutaneous |
| **AP** | THOR | Thoracic |
| **AP** | TRUR | Transurethral |
| **AP** | VAGN | Vaginal |
| **AP** | VIRC | Occurred via virtual care video platform |
| **AP** | WPLC | With pleura closed |
| **AP** | WPLO | With pleura open |
| **CO** | BPU5 | Bypass pump – patient under 5000 grams |
| **CO** | CHYO | Controlled hypotension |
| **CO** | CRBY | Cardiac bypass with pump |

| Type | Value | Description |
|---|---|---|
| **CO** | HPTH | Hypothermia |
| **CO** | INFE | Infant resuscitation after delivery |
| **CO** | PACM | Pacemaker monitoring |
| **CO** | UN5K | Patient under 5000 grams |
| **CT** | PROF | Professional component |
| **CT** | TECH | Technical component |
| **DA** | DA23 | Second or third date of admission or day out of ICU |
| **DA** | DA45 | Fourth or fifth day of care |
| **DA** | DA47 | Fourth to seventh date of admission or day out of ICU |
| **DA** | DALY | Daily rate applies |
| **DA** | RGE1 | Date range defining Saturday, Sunday and Holidays |
| **DA** | RGE2 | Sundays and Statutory Holidays |
| **DA** | WKLY | Weekly rate applies |
| **FN** | DTOX | Detox Centre |
| **FN** | EMCC | Emergency Care Centre |
| **FN** | INCU | Intensive care |
| **FN** | INPT | Inpatient |
| **FN** | NICU | Neonatal Intensive Care |
| **FN** | OTPT | Outpatient |
| **IN** | CC01 | Critical care first day |
| **IN** | CC10 | Critical care day 2 to 10 inclusive |
| **IN** | CC11 | Critical care 11$^{th}$ day onward |
| **IN** | CP01 | Comprehensive care first day |
| **IN** | CP10 | Comprehensive care day 2 to 10 inclusive |
| **IN** | CP11 | Comprehensive care 11$^{th}$ day onward |
| **IN** | INCR | Intensive care per day |
| **IN** | INHD | Intensive care per half day |
| **IN** | INPH | Intensive care per hour |
| **IN** | NIC1 | Neonatal intensive care day 1 |
| **IN** | NIC4 | Neonatal intensive care day 2 to 4 inclusive |
| **IN** | NIC5 | Neonatal intensive care day 5 onward |
| **IN** | RCV5 | Respiratory care per visit |
| **IN** | RPC1 | Respiratory care day 1 hourly rate |
| **IN** | RPC4 | Respiratory care day 2 to 4 inclusive hourly rate |
| **IN** | RPC5 | Respiratory care day 5 onward hourly rate |
| **IN** | VC01 | Ventilatory care first day |
| **IN** | VC10 | Ventilatory care day 2 to 10 inclusive |
| **IN** | VC11 | Ventilatory care 11$^{th}$ day onward |
| **LO** | CCNT | Correctional Centre |
| **LO** | HMHC | Home Care |
| **LO** | HOME | Home |
| **LO** | HOSP | Hospital |
| **LO** | NRHM | Nursing Home |
| **LO** | OFFC | Office |
| **LO** | OTHR | Other |

| Type | Value | Description |
|---|---|---|
| **LV** | DIFF | Indicates the surgical procedure done through a separate approach |
| **LV** | LV50 | The second or subsequent procedure done through the same approach |
| **LV** | LV65 | Indicates a procedure done through separate approach |
| **LV** | LV85 | The second or subsequent procedure involving the fracture of a different long bone |
| **LV** | SAME | The second or subsequent surgical procedure done through the same approach |
| **ME** | ABDM | Abdominal |
| **ME** | CARE | Comprehensive and Continuous care for Family Physicians |
| **ME** | CMST | Composite procedure |
| **ME** | COMP | Complicated procedure |
| **ME** | CONV | Occurred at home for convenience |
| **ME** | CRYO | Cryotherapy treatment by freezing |
| **ME** | CURT | Curettage scraping |
| **ME** | ECMO | Extracorporeal membrane oxygenation |
| **ME** | ELEC | Electrocautery removal by burning |
| **ME** | EXRM | Removal by excision |
| **ME** | EXTN | External |
| **ME** | FTSG | First stage |
| **ME** | HEMO | Hemodialysis |
| **ME** | INTN | Internal |
| **ME** | INTR | Intrauterine |
| **ME** | LAPA | Procedure performed by laparotomy |
| **ME** | LASR | Procedure performed using laser technique |
| **ME** | MAJO | Extensive complication |
| **ME** | MINO | Complexity minor or limited |
| **ME** | OV50 | Photocopying – over 50 pages |
| **ME** | PERI | Peritoneal Dialysis |
| **ME** | RADI | Radical extensive procedure |
| **ME** | SCOP | Procedure performed through scope |
| **ME** | SDSG | Second stage |
| **ME** | SIMP | Simple procedure |
| **ME** | TELE | Telemedicine Conference |
| **ME** | UP10 | Photocopying – 10 pages or less |
| **ME** | UP25 | Photocopying – 11 to 25 pages |
| **ME** | UP50 | Photocopying – 26 to 50 pages |
| **ME** | VAGN | Vaginal |
| **ME** | VTCR | Virtual care platform |
| **PO** | COML | Entire procedure performed |
| **PO** | ONTW | One to twenty percent of body |
| **PO** | PART | Partial procedure performed |
| **PO** | RADI | Procedure to the fullest extent |
| **PO** | SBTL | Subtotal (less than complete) |
| **PO** | SEGM | Segmental part of the body |
| **PO** | TOTF | Twenty-one to thirty-five percent of body |
| **PO** | TSOV | Thirty-six percent of body and over |
| **PO** | WEGE | Wedge part of the segment |

| Type | Value | Description |
|---|---|---|
| **PT** | CDDR | Cadaver donor |
| **PT** | DONR | Donor |
| **PT** | EXPT | Additional patient seen at same location |
| **PT** | FTPT | First patient seen |
| **PT** | LIDR | Live donor |
| **PT** | PRBK | Patient referred back |
| **PT** | PRTO | Patient referred to Ophthalmologist |
| **PT** | RECP | Recipient |
| **PT** | RISK | High risk patient |
| **RF** | REFD | Referring doctor |
| **RG** | ASCE | Ascending |
| **RG** | BOT2 | Both sides, 2 levels |
| **RG** | BOT3 | Both sides, 3 levels |
| **RG** | BOTH | Bilateral procedure |
| **RG** | CAUD | Caudal |
| **RG** | CERV | Cervical |
| **RG** | DESC | Descending |
| **RG** | FEMR | Femur head and neck |
| **RG** | GVCC | Great Vessel – left common carotid |
| **RG** | GVIB | Great Vessel – innominate / brachiocephalic |
| **RG** | GVSA | Great Vessel – left subclavian |
| **RG** | INRE | Infra renal |
| **RG** | IVCA | Inferior Vena Cava (IVC) |
| **RG** | LANT | Anterior Tibial – left side |
| **RG** | LAXI | Axillary – left side |
| **RG** | LBAC | Basilic or cephalic – left side |
| **RG** | LBRA | Brachial – left side |
| **RG** | LBRC | Brachiocephalic – left side |
| **RG** | LCOI | Common iliac – left side |
| **RG** | LCSF | Common femoral / Superficial femoral – left side |
| **RG** | LEFT | Procedure performed on the left side of the body |
| **RG** | LEXI | External iliac – left side |
| **RG** | LINI | Internal iliac – left side |
| **RG** | LPER | Peroneal – left side |
| **RG** | LPOP | Popliteal – left side |
| **RG** | LPOT | Posterior Tibial – left side |
| **RG** | LPRF | Profunda femoris – left side |
| **RG** | LRMV | Renal (main vessel) – left side |
| **RG** | LRSV | Renal (segmental vessel) – left side |
| **RG** | LRUA | Radial or ulnar – left side |
| **RG** | LSIG | Sigmoid sinus – left side |
| **RG** | LSUB | Subclavian – left side |
| **RG** | LTRA | Transverse sinus – left side |
| **RG** | LUMB | Lumbar |
| **RG** | ONE2 | One side, 2 levels |

| Type | Value | Description |
|---|---|---|
| **RG** | ONE3 | One side, 3 levels |
| **RG** | OTSE | Other segments |
| **RG** | RANT | Anterior Tibial – right side |
| **RG** | RAXI | Axillary – right side |
| **RG** | RBAC | Basilic or cephalic – right side |
| **RG** | RBRA | Brachial – right side |
| **RG** | RBRC | Brachiocephalic – right side |
| **RG** | RCOI | Common iliac – right side |
| **RG** | RCSF | Common femoral / Superficial femoral – right side |
| **RG** | REXI | External iliac – right side |
| **RG** | RIGT | Procedure performed on the right side of the body |
| **RG** | RINI | Internal iliac – right side |
| **RG** | RPER | Peroneal – right side |
| **RG** | RPOP | Popliteal – right side |
| **RG** | RPOT | Posterior Tibial – right side |
| **RG** | RPRF | Profunda femoris – right side |
| **RG** | RRMV | Renal (main vessel) – right side |
| **RG** | RRSV | Renal (segmental vessel) – right side |
| **RG** | RRUA | Radial or ulnar – right side |
| **RG** | RSIG | Sigmoid sinus – right side |
| **RG** | RSUB | Subclavian – right side |
| **RG** | RTRA | Transverse sinus – right side |
| **RG** | SAGG | Saggital sinus |
| **RG** | SURE | Supra renal |
| **RG** | SVCA | Superior Vena Cava |
| **RG** | VCEL | Visceral – celiac |
| **RG** | VHEP | Visceral – hepatic |
| **RG** | VIMA | Visceral – IMA |
| **RG** | VPOR | Visceral – portal |
| **RG** | VREN | Visceral – renal |
| **RG** | VSMA | Visceral – SMA |
| **RG** | VSPL | Visceral – splenic |
| **RG** | VSUM | Visceral – superior mesenteric |
| **RO** | ABAS | Abdominal assistant |
| **RO** | ABDM | Abdominal surgeon two team approach |
| **RO** | ABDO | Abdominal surgeon |
| **RO** | ANAE | Anaesthetist |
| **RO** | ANCO | Anticoagulant supervision per month |
| **RO** | ANTL | Antenatal |
| **RO** | CAPT | Comprehensive reassessment of a cancer patient |
| **RO** | CCDT | Continuing care and detention |
| **RO** | CCDX | Continuing care in conjunction with attending and describing a differential diagnosis |
| **RO** | CHDT | Closed head injury with detention |
| **RO** | CLHD | Closed head injury |
| **RO** | CNTC | Continuing care |

| Type | Value | Description |
|---|---|---|
| **RO** | CO19 | Covid-19 immunization |
| **RO** | COMB | Combination of injections not otherwise defined in conjunction with visit |
| **RO** | CRTC | Palliative care medicine chart review (and/or telephone call, fax or e-mail initiated by a health care professional) |
| **RO** | DBSU | Double set up |
| **RO** | DETE | Detention |
| **RO** | DIRC | Directive care |
| **RO** | DRDT | Directive care and detention |
| **RO** | DTAS | Dental assistant |
| **RO** | DUTY | Duty doctor |
| **RO** | DYDT | Duty doctor and detention |
| **RO** | EPS1 | WCB EPS Physician |
| **RO** | EXEM | Injection when potential for allergic reaction to ingredient exists |
| **RO** | FPHN | First physician |
| **RO** | GAIG | Measles immunoglobulin |
| **RO** | HAHB | Hepatitis A and B vaccine |
| **RO** | HAIG | Hepatitis A immunoglobulin |
| **RO** | HAVV | Hepatitis A vaccine |
| **RO** | HBIG | Hepatitis B immunoglobulin |
| **RO** | HBVV | Hepatitis B vaccine |
| **RO** | HDIN | High-dose influenza – inactivated |
| **RO** | HIBV | Haemophilus influenza type B vaccine |
| **RO** | HMDY | Home dialysis |
| **RO** | HMTE | home care, medical chart review, telephone calls, fax or e-mail |
| **RO** | HPV4 | HPV-4 Human Papillomavirus vaccine |
| **RO** | HPV9 | HPV-9 Human Papillomavirus vaccine |
| **RO** | INCH | Physician in hyperbaric chamber |
| **RO** | INFL | Injection for various strains of influenza |
| **RO** | INPR | Interpretation and procedure |
| **RO** | INTP | Interpretation |
| **RO** | IPVV | IPV inactivated polio vaccine |
| **RO** | MENB | Meningococcal B vaccine |
| **RO** | MENC | Meningococcal type C conjugate vaccine |
| **RO** | MENQ | Men-C-ACYW-135 Meningococcal conjugate quadrivalent vaccine |
| **RO** | MMAR | Injection for measles, mumps and rubella |
| **RO** | MMRT | Injection for MMR for travel to at risk areas (See July 2014 Bulletin) |
| **RO** | MMRV | Measles, Mumps, Rubella, and Varicella vaccine |
| **RO** | NBCR | Newborn care |
| **RO** | OBDA | Obstetrical delivery assist |
| **RO** | OTCH | Physician out of hyperbaric chamber |
| **RO** | PAMO | Pathology materials only |
| **RO** | PCSV | Palliative care support visit |
| **RO** | PEAS | Perineal assistant |
| **RO** | PENT | Injection for diphtheria, pertussis, tetanus, poliomyelitis and haemophilus influenza type B |
| **RO** | PNEC | Pneumococcal conjugate vaccine (Prevnar) |

| Type | Value | Description |
|---|---|---|
| **RO** | PNEU | Injection for pneumococcal pneumonia, bacteraemia and meningitis |
| **RO** | PRIN | Perineal surgeon two team approach |
| **RO** | PROC | Procedure |
| **RO** | PTNT | Post natal |
| **RO** | PTPP | Post partum |
| **RO** | RABI | Rabies immunoglobulin |
| **RO** | RABV | Rabies vaccine |
| **RO** | RESC | Resuscitation |
| **RO** | RNDT | Resuscitation of newborn with detention |
| **RO** | SNAS | Second assistant |
| **RO** | SPCR | Supportive care |
| **RO** | SPHN | Second physician |
| **RO** | SPIN | Supervision and interpretation |
| **RO** | SRAS | Surgical assistant |
| **RO** | SSAN | Second simultaneous anaesthetist |
| **RO** | STBY | Standby |
| **RO** | SUPV | Supervision |
| **RO** | TCCP | Telephone advice and medical chart review of a cancer patient by the Oncologist |
| **RO** | TDAP | Tetanus toxoid, diphtheria, acellular pertussis vaccine |
| **RO** | TDPP | Tetanus toxoid, diphtheria, acellular pertussis, polio vaccine |
| **RO** | TEDV | Tetanus toxoid, diphtheria vaccine |
| **RO** | TEIG | Tetanus immunoglobulin |
| **RO** | TIPV | TD-IPV vaccine |
| **RO** | TRPL | Treatment planning |
| **RO** | TRTL | Trauma team leader |
| **RO** | UPCK | Visit pacemaker check |
| **RO** | VAIG | Varicella zoster immunoglobulin |
| **RO** | VARV | Varicella vaccine |
| **RO** | VGSG | Vaginal surgeon |
| **RO** | WBCR | Well baby care |
| **RP** | CON2 | Second chronic disease managed |
| **RP** | CON3 | Third chronic disease managed |
| **RP** | INTL | Initial |
| **RP** | REPT | A repeat of a service |
| **RP** | REVS | Revision |
| **RP** | SUBS | Subsequent similar service |
| **SE** | FEML | Female |
| **SE** | MALE | Male |
| **SP** | ANAE | Anaesthetist |
| **SP** | ANPA | Anatomical Pathology |
| **SP** | CARD | Cardiology |
| **SP** | CASG | Cardiovascular/Thoracic surgery |
| **SP** | CLIA | Clinical Immunology and Allergy |
| **SP** | COMD | Community Medicine |
| **SP** | DENT | Dental General Practitioner |

| Type | Value | Description |
|---|---|---|
| **SP** | DERM | Dermatology |
| **SP** | DIRD | Diagnostic Radiology |
| **SP** | EMMD | Emergency Medicine |
| **SP** | ENDO | Endodontics |
| **SP** | ENME | Endocrinology and Metabolism |
| **SP** | GAST | Gastroenterology |
| **SP** | GEMD | Geriatric Medicine |
| **SP** | GENP | General Practitioner |
| **SP** | GNSG | General Surgery |
| **SP** | HAGY | Haematology |
| **SP** | HAPA | Haematological Pathology |
| **SP** | HUGE | Human Genetics |
| **SP** | INDI | Infectious Diseases |
| **SP** | INMD | Internal Medicine |
| **SP** | MDON | Medical Oncology |
| **SP** | MEBI | Medical Biochemistry |
| **SP** | MEGE | Medical Genetics |
| **SP** | MEMI | Medical Microbiology |
| **SP** | NCMD | Nuclear Medicine |
| **SP** | NEPA | Neuropathology |
| **SP** | NEPE | Neurology Paediatric |
| **SP** | NEPH | Nephrology |
| **SP** | NEUR | Neurology |
| **SP** | NUSG | Neurosurgery |
| **SP** | OBGY | Obstetrics and Gynaecology |
| **SP** | ODON | Orthodontics |
| **SP** | OPHT | Ophthalmology |
| **SP** | OPTO | Optometry |
| **SP** | ORAL | Oral Surgery |
| **SP** | ORTH | Orthopaedic Surgery |
| **SP** | OTOL | Otolaryngology |
| **SP** | PATH | General Pathology |
| **SP** | PEDI | Paediatrics |
| **SP** | PEDO | Pedodontics |
| **SP** | PERI | Periodontics |
| **SP** | PHMD | Physical Medicine and Rehabilitation |
| **SP** | PLAS | Plastic Surgery |
| **SP** | PROS | Prosthodontics |
| **SP** | PRPR | Prosthetic Provider |
| **SP** | PSYC | Psychiatry |
| **SP** | RADI | Diagnostic and Therapeutic Radiology |
| **SP** | RDON | Radiation Oncology |
| **SP** | RHEU | Rheumatology |
| **SP** | RSMD | Respiratory Medicine |
| **SP** | THSG | Thoracic Surgery |

| Type | Value | Description |
|---|---|---|
| **SP** | UROL | Urology |
| **SP** | VASG | Vascular Surgery |
| **TI** | AMNN | 0801-1200 |
| **TI** | ETMD | 2001-2359 |
| **TI** | EVNT | 1701-2000 |
| **TI** | EVWH | Weekday evenings after 1800, weekends and holidays |
| **TI** | GPEW | General Practice enhanced hours premium (M-F 0600-0800 1700-2200 or S/S/H 0900-2200) |
| **TI** | MDNT | 0000-0800 |
| **TI** | NNEV | 1201-1700 |
| **US** | PREM | Premium fee of 35 percent |
| **US** | PR50 | Premium fee of 50 percent |
| **US** | SCHD | Planned / Scheduled outpatient visit (0800-2000) |
| **US** | UIOH | Urgent visit interrupting normal office hours |
| **US** | UNOF | Urgent visit not interrupting office hours |

*(7.8.5)*

# APPENDIX I – EXPLANATORY CODES *(7.9.0)*

| Explanatory Code | Description |
|---|---|
| **AD001** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **AD002** | Service encounter has been refused as a duplicate billing exists. |
| **AD003** | Service encounter has been refused as electronic text is required. |
| **AD004** | Service encounter has been refused as this service has previously been approved. |
| **AD005** | Service encounter has been refused. A previous service encounter for 13.59L, RO=INPN has been approved at this same encounter. |
| **AD006** | Service encounter has been refused as a previous service encounter has been approved and includes this service. |
| **AD007** | Service encounter has been refused as previous payment has been approved under 13.59L, RO=INTD. |
| **AD008** | Service encounter has been refused. Delete original immunization approved this day and submit a new service encounter using the appropriate combination modifier value. |
| **AD009** | Service encounter has been refused. Delete one of the original submissions and submit a service encounter for the combination of this immunization and the one from the deleted service encounter. |
| **AD010** | Service encounter has been refused as previous payment has been made this day for a portion of this combination. |
| **AD011** | Service encounter has been refused. Previous payment has been made this day for a portion of this combination injection. |
| **AD012** | Service encounter has been refused. Previous payment has been made this date for a portion of this combination injection. |
| **AD013** | Service encounter has been refused as electronic text is required for this service to be approved at location indicated. |
| **AD014** | Service encounter has been disallowed as surgery has been performed during this hospitalization. |
| **AD015** | Service encounter has been disallowed as a previous service encounter has been approved for the discharge fee at this hospitalization. |
| **AD016** | Service encounter has been disallowed as surgery has been performed by you during this hospitalization. |
| **AD017** | Service encounter has been disallowed as patient history indicates conflicting hospital admit dates. Check your records to confirm admit date and submit a reassess (action code R) once you have verified the date. |
| **AD018** | Service encounter has been refused as you have been approved this service under a combination code. |
| **AD019** | Service encounter has been refused. A portion of this combination service has previously been approved to you. |
| **AD020** | Service encounter has been refused. Previous payment has been made to you for a portion of this service. |
| **AD021** | Service encounter has been refused. Previous approval has occurred to you under MMRV. |
| **AD022** | Service encounter has been refused. Previous approval has occurred to you under PENV. |
| **AD023** | Service encounter has been refused. Previous approval has occurred to you under MMQU. |
| **AD024** | Service encounter has been refused. Previous approval has occurred under MMR2 and/or QUAD. |
| **AD025** | Service encounter has been refused as previous approval has occurred to you under MMQU. |
| **AD026** | Service encounter has been refused as you have previously been approved an injection covered in this service. |
| **AD027** | Service encounter has been refused as a portion of this service has been previously approved. |

| Explanatory Code | Description |
|---|---|
| **AD028** | Service encounter has been reduced to 50%. Only one immunization at full fee is payable when a visit is claimed. |
| **AD029** | Service encounter has been reduced to 50% as two previous immunizations were paid at full fee on this date. |
| **AD030** | Service encounter has been refused. Two immunizations have been paid at full fee this date. Delete one immunization and resubmit at LV50 along with your visit/consult claim. |
| **AD031** | Service encounter has been refused as the patient's birth date is inappropriate for this service. |
| **AD032** | Service encounter has been refused as the maximum number of PENT injections has been reached. |
| **AD033** | Service encounter has been refused as patient must be one year of age. |
| **AD034** | Service encounter has been reduced to 50% as a visit and previous injection have been billed. |
| **AD035** | Service encounter has been refused as the maximum number of PNEC injections have been approved. |
| **AD036** | Service encounter has been refused as the patient has not reached the appropriate age for this type of injection. |
| **AD037** | Service encounter has been refused as the diagnostic code indicated and age of patient does not warrant payment of the influenza vaccine. |
| **AD038** | Service encounter has been refused as a maximum of three 13.59L RO=PNEU immunizations have been previously paid. |
| **AD039** | Service encounter has been refused as a claim for Thrombolysis has already been made for this day |
| **AD040** | Service encounter has been refused as you have previously billed HSC 98.51C, 98.51D, 95.01, 92.63A, 92.63B, 93.79B, 93.79C, or 93.79E for this patient on the same day. |
| **AD042** | Service encounter has been refused as a claim was already made for this service on the same date. |
| **AD043** | Service encounter has been refused as a claim was previously made for HSC 46.04L: Intraoperative placement of interpleural catheter for paravertebral block, for this patient on the same day. |
| **AD044** | Service encounter has been refused as you have previously billed the maximum of two claims for HSC 13.59L RO=MMRV for this patient. |
| **AD045** | Service encounter has been refused as this patient has previously received a dosage of Quadracel vaccine. |
| **AD046** | Service encounter has been refused as an immunization injection must be claimed prior to the tray fee. |
| **AD047** | Service encounter has been refused as HSC 98.49C must be submitted prior to the add on 98.49D. |
| **AD048** | Service encounter has been refused as you have previously billed HSC 66.3E or 66.3F. |
| **AD049** | Service encounter has been refused as the patient age is not within 6 months and one week prior to 12 months. |
| **AD050** | Service encounter has been refused as electronic text is required stating the reasoning for administering the MMRT immunization. |
| **AD051** | Service encounter has been disallowed. When claiming for high-risk patients (PT=RISK), text is required. Please resubmit with the appropriate text. |
| **AD052** | Service encounter has been refused as the patient is less than 6 weeks old. |
| **AD053** | Service encounter has been refused as a PENT injection has been previously approved in the previous 4 weeks. |
| **AD054** | Service encounter has been refused as you have been previously billed HSC 90.09G for this patient on this day. |
| **AD055** | Service encounter has been refused as there is no claim for an eligible premium service billed at the same encounter |
| **AD056** | Service encounter has been disallowed as you have previously billed HSC 95.94A at the same encounter |

| Explanatory Code | Description |
|---|---|
| **AD057** | Service encounter has been refused as an influenza injection has already been approved in the previous 6 months. |
| **AD058** | Service encounter has been refused as a third injection for RO=HPV4 requires modifier PT=RISK |
| **AD059** | Service encounter has been refused as the maximum number of HPV4 injections has been reached. |
| **AD060** | Service encounter has been refused as the second dose of the measles, mumps and rubella vaccine cannot be administered within 28 days of the first dose. |
| **AD061** | Service encounter has been refused as the tetanus toxoid, diphtheria, and acellular pertussis immunization has previously been claimed for this patient while over 18 years of age. |
| **AD062** | Service encounter has been refused as the maximum number of IPVV injections has been reached. |
| **AD063** | Service encounter has been refused as a tetanus toxoid, diphtheria injection has already been approved in the previous 10 years. |
| **AD064** | Service encounter has been disallowed as claim does not include electronic text. To claim the HOVM1 fee, text must include the start and finish time of day, point of origin, destination address, and distance in KM. Please resubmit with text. |
| **AD065** | Service encounter has been refused as in order to claim HOVM1, a home visit with the patient must be submitted first for the same service occurrence. |
| **AD066** | Service encounter has been refused as a colonoscopy add on fee may only be claimed after a colonoscopy is billed for the same occurrence. |
| **AD067** | Service encounter has been refused. Resubmit using the appropriate health service code and modifier combination with the PT=RISK modifier and text explaining high risk. |
| **AD068** | Service encounter has been refused as the HSC 03.03P has previously been paid. |
| **AD069** | Service encounter has been refused. You must claim an appropriate office visit service before claiming this add on fee for the same encounter. |
| **AD070** | Service encounter has been refused as you have previously claimed the first visit after discharge add on fee for this period. |
| **AD071** | Service encounter has been refused as you have previously claimed the first visit after discharge add on fee the maximum of four times in the past year. |
| **AD072** | Service encounter has been refused as you have previously claimed a monthly care fee in the same calendar month. |
| **AD073** | Service encounter has been refused as you have previously claimed HSC 03.03S in the same calendar month. |
| **AD074** | Service encounter has been refused as patient is 5 years of age or over. |
| **AD075** | Service encounter has been disallowed as text is required indicating the need for additional doses of the MMAR vaccine. |
| **AD076** | Service encounter has been refused as the HSC 03.03P cannot be claimed for patient ages 1-10. |
| **AD077** | Service encounter has been refused as a third injection for RO=HPV9 requires PT=RISK. Please resubmit with the appropriate modifiers. |
| **AD078** | Service encounter has been refused as patient is not 65 years of age or older. |
| | |
| **AD080** | Service encounter has been refused as the maximum number or HPV9 injections has been reached. |
| **AD081** | Service encounter has been refused as HSC HOVM1 cannot be claimed on home visits that occur for patient or physician convenience. |
| **AD082** | Service encounter has been refused as the interpreter incentive may only be claimed after a visit or consult during the same occurrence. |
| **AD083** | Service encounter has been refused based on the age of the recipient. |
| **AD084** | Service encounter has been refused as HSC 02.84A which is a stand-alone procedure has already been claimed during the same encounter. |

| Explanatory Code | Description |
|---|---|
| **AD085** | Service encounter has been refused as the maximum number of rotavirus immunizations has been reached. |
| **AD086** | Service encounter has been refused as you must claim the base delivery dee (HSC 87.98) prior to claiming detention during obstetrical delivery. |
| | |
| **AD088** | Service encounter has been refused as a claim for 13.59L RO=CO19 has been approved in the previous 18 days. |
| **AD089** | Service encounter has been refused as this is an add on fee to HSC associated with OAT provision only. |
| **AD090** | Service encounter has been refused as only 1 urine drug screen tray fee can be billed in association with 03.03J, 03.03K or 03.03L. |
| **AD091** | Service encounter has been disallowed as the maximum of 4 urine drug screen tray fees per patient in the previous 30 days has been reached. Please include text indicating if special permission has been granted to exceed this maximum. |
| **AD092** | Service encounter has been refused as the maximum number of mpox injections has been reached |
| **AD093** | Service encounter has been refused as a claim for 13.59L RO=MPOX has been approved in the previous 28 days |
| **AD094** | Service encounter has been reduced to 50%. Only one 13.59L at full fee is payable when NPIV1 is claimed. |
| **AD095** | Service encounter has been refused as you must claim the diagnostic mammography fee prior to claiming digital breast tomosynthesis. This service may not be claimed independently. |
| **AD096** | Service encounter has been refused as the date of birth of the patient is prior to January 1, 1970. Please resubmit with text indicating if the patient is a healthcare worker or post secondary student. |
| **AD097** | Service encounter has been refused as the maximum number of doses of 13.59L RO=PNEU immunizations have previously been paid. |
| **AD098** | Service encounter has been disallowed as RO=RSVV may not be claimed from this location |
| **AD099** | Service has been refused as the maximum number of SHVV injections has been reached. |
| **AD102** | Service encounter has been refused as claims for the RSVM immunization for patients greater than 8 months of age require PT=RISK. Please resubmit with the appropriate modifiers. |
| **AD104** | Service encounter has been refused as a second or subsequent injection for RO=RSVM requires PT=RISK. Please resubmit with the appropriate modifiers. |
| **AS105** | Service encounter has been refused. No more than 2 doses during a single season may be claimed. |
| **AD106** | Service encounter has been refused as the maximum number of RSVM injections has been reached. |
| **AD107** | Service encounter has been refused as this is an add on fee that may only be claimed with 03.08 SP=GENP, 03.08B, or HSC associated with OAT provision. |
| **AJ001** | Service encounter has been adjusted according to information provided by you. |
| **AJ002** | Service encounter has been adjusted according to information provided on another service encounter. |
| **AN001** | Service encounter has been refused. When multiple procedures are performed during the same time, only one anaesthetic fee applies. |
| **AN002** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **AN003** | Service encounter has been refused as this service can only be claimed by Anaesthesiologists. |
| **AN004** | Service encounter has been refused as the first anae start time specified on this claim does not match the time provided on the previously submitted claim for the first anaesthesiologist service, |
| **AN005** | Consecutive anaesthetist claims cannot be processed until after the first anaesthetist claim has been submitted. A per preamble 5.2.52. |

| Explanatory Code | Description |
|---|---|
| **AN006** | Service encounter has been refused as the consecutive anaesthetic health service code claimed does not match first anaesthetic health service coded. Please resubmit using the correct health service code. |
| **BG001** | Service encounter has been approved at 50% of the appropriate bone graft code in addition to the primary fracture procedure. |
| **BG002** | Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%. |
| **BG003** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **BG004** | Service encounter has been approved at 50% as another procedure has been approved at 100% for this same service encounter. |
| **BG005** | Service encounter has been approved at 50%. When multiple procedures are performed at the same time only one is approved at 100%. |
| **BK001** | Service encounter has been disallowed as you have not included text referring to the anatomical site specimen was taken from. Please resubmit with appropriate text. |
| **BK002** | Service encounter has been refused as you have previously claimed for an abdominal survey film at the same encounter. |
| **BK003** | Service encounter has been refused as you have previously claimed for an intravenous urogram (IVP) at the same encounter. |
| **BK004** | Service encounter has been disallowed as at the same encounter you have claimed for an intravenous urogram (IVP) which cannot be claimed with routine tomography. If tomography was not routine, please resubmit with text indicating the situation. |
| **BK005** | Service encounter has been refused as you have previously billed for a service in which fluoroscopy is included for the same encounter. |
| **BK006** | Service encounter has been refused as you have previously billed for a fluoroscopy during the same encounter. |
| **BK007** | Service encounter has been refused as this service is not yet eligible for electronic billing. |
| **BK008** | Service encounter for fluoroscopy has been refused as you have previously billed for another service at the same encounter. |
| **BK009** | Service encounter has been refused as you have previously billed for a stand-alone fluoroscopy fee at the same encounter. |
| **BK010** | Service encounter has been refused as the patient is over 12 years old. Please submit a claim for the applicable non paediatric code for payment. |
| **BK011** | Service encounter has been refused as you have previously claimed for an upper G.I. series for this patient at the same encounter. |
| **BK012** | Service encounter has been refused as you have previously claimed for a colon G.I. series for this patient at the same encounter. |
| **BK013** | Service encounter has been refused as you have previously claimed for a cystography or cystourethrogram for this patient at the same encounter. |
| **BK014** | Service encounter has been refused as you have previously claimed a CT fee for the same region during this encounter. When a CT examination is performed with and without contrast, the combined code should be used. |
| **BK015** | Service encounter has been refused as you have previously submitted a separate claim for this CT with or without contrast at the same encounter. Please submit a delete for the individual fee before claiming this combined code. |
| **BK016** | Service encounter has been refused as you have previously submitted a claim for this CT with and without contrast combination code at the same encounter. |

| Explanatory Code | Description |
|---|---|
| **BK017** | Service encounter has been refused as you have previously billed for an ultrasound of the aorta, appendix, kidneys, or pylorus at the same encounter. These are meant to be included in the abdomen general ultrasound fee. |
| **BK018** | Service encounter has been refused as you have previously billed for an abdomen general ultrasound at the same encounter. An ultrasound of the aorta, appendix, kidneys, or pylorus is meant to be included in the abdomen general ultrasound fee. |
| **BK019** | Service encounter has been refused as you have previously billed for an U/S of the aorta, appendix, kidneys, or pylorus at the same encounter. These fees are not cumulative. An abdominal general U/S (HSC R1205) is the composite fee for these services. |
| **BK020** | Service encounter has been refused as this fee is considered to be an add on code and may only be claimed after a base service has been billed. |
| **BK021** | Service encounter has been refused as you have previously billed for an endovaginal U/S (R1225) at the same encounter. To claim for both, please submit a delete for the endovaginal U/S and create a new claim for endovaginal with pelvic (R1226). |
| **BK022** | Service encounter has been refused as you have previously billed for a pelvic ultrasound (R1220) at the same encounter. To claim for both, please submit a delete for the pelvic ultrasound and create a new claim for endovaginal with pelvic (R1226) |
| **BK023** | Service encounter has been refused as you have previously billed for the endovaginal and pelvic ultrasound combination fee at the same encounter. |
| **BK024** | Service encounter has been refused as you have previously submitted a claim for either the stand alone pelvis ultrasound or endovaginal ultrasound fee. |
| **BK025** | Service encounter has been refused as you have previously submitted for another code at the same encounter. When the intraoperative code is used, no other code may be claimed for that examination. |
| **BK026** | Service encounter has been refused as you have previously submitted for an intraoperative ultrasound fee at the same encounter. When the intraoperative code is used, no other code may be claimed for that examination. |
| **BK027** | Service encounter has been refused as HSC 03.38A has already been claimed for this patient on this day. |
| **BK028** | Service encounter has been refused as you have previously submitted the bilateral fee code for his patient at the same encounter. |
| **BK029** | Service encounter has been refused as you have previously submitted the unilateral fee code for this service at the same encounter. Please submit a delete for the unilateral service before claiming the bilateral fee. |
| **BK030** | Service encounter has been refused as you have previously submitted a venogram extremity claim at the same encounter. The venogram extremity fee includes the central film. |
| **BK031** | Service encounter has been refused as you have previously submitted a central film claim at the same encounter. A venogram extremity fee includes he central film. Please submit a delete for HSC R605 before resubmitting the venogram extremity fee. |
| **BK032** | Service encounter has been refused as you have previously submitted a renal scan and renogram claim at the same encounter. |
| **BK033** | Service encounter has been refused as you have previously submitted an A.C.E. renal scan claim at the same encounter. |
| **BK034** | Service encounter has been disallowed. Please resubmit indicating in the text field who performed the injection. |
| **BK035** | Service encounter has been refused as this fee is considered to be an add on code and may only be claimed after a renal scan (R1875, R1880, or R1881) has been billed. |

| Explanatory Code | Description |
|---|---|
| **BK036** | Service encounter has been refused as you have previously billed for the multiple areas fee at the same encounter. |
| **BK037** | Service encounter has been refused as you have previously billed for the single area fee at the same encounter. |
| **BK038** | Service encounter has been refused as an autopsy has already been claimed for this individual. |
| **BK039** | Service encounter has been disallowed as you have previously claimed a visit for this individual at the same encounter. |
| **BK040** | Service encounter has been disallowed as you have previously claimed a consult for this individual at the same encounter. |
| **BK041** | Service encounter has been refused as this facility is not permitted to claim for these mammogram fees. |
| **BK042** | Service encounter has been refused as you have previously claimed for renal static imaging at the same encounter. |
| **BK043** | Service encounter has been accepted at a reduced value as a claim for cytology screener code P2330 has previously been made for this specimen. |
| **BK044** | Service encounter has been refused as a claim has previously been made for the interpretation and report of these GYN cytology slides (HSC P2331) |
| **BK045** | Service encounter has been refused as you have previously billed for a Doppler quantitative interpretation at the same encounter. |
| **BK046** | Service encounter has been refused as you have previously billed for a Doppler qualitative interpretation at the same encounter. |
| **BK047** | Service encounter has been refused as you have previously billed for a genetic sonogram at the same encounter. A genetic sonogram includes all necessary imaging. |
| **BK048** | Service encounter has been refused as you have previously billed a critical or comprehensive care fee for the patient on this day which includes all EKG interpretation performed. |
| **BK049** | Service encounter has been refused as you have previously billed an EKG interpretation fee for the patient on this day. Please submit a delete for the EKG interpretation before making a submission for a critical or comprehensive care fee. |
| **BK050** | Service encounter has been refused as HSC 03.38B or 03.38C has already been claimed for this patient on this day, |
| **BK051** | Service encounter has been refused as a mammography screening has already been claimed for this patient on this day. |
| **BK052** | Service encounter has been refused as you have previously billed this MRI interpretation service for the same patient on this day. |
| **BK053** | Service encounter has been refused as a repeat sequence can only be claimed after the matching base multisection MRI fee is claimed for the same occurrence. Please claim the base fee for this MRI before submitting the repeat sequence claim. |
| **BK054** | Service encounter has been refused as you have already claimed this service for the same patient on the same day. |
| **BK055** | Service encounter has been refused as a fee for gating may only be claimed after a MRI thorax with multiple sequences has been claimed during the same encounter. |
| **BK056** | Service encounter has been disallowed as this echocardiograph service has already been claimed for this patient on this day. Please resubmit with electronic text explaining the reason for the subsequent service. |
| **BK057** | Service encounter has been refused as this service cannot be billed from this facility. |
| **BK058** | Service encounter has been disallowed as you have previously billed for a quantitative or qualitative Doppler interpretation on the same day. Please resubmit this claim with electronic text explaining the necessity of the 2nd interpretation. |

| Explanatory Code | Description |
|---|---|
| **BK060** | Service encounter has been refused as the following HSCs I1310, I1312 and I1313 may only be billed once per patient per day. |
| **BK061** | Service Encounter has been disallowed. Please submit a copy of the first and subsequent echo reports along with clinical documentation before requesting a reassessment for this claim. |
| **BK062** | Service encounter has been refused as HSC 02.75C has already been claimed for this patient at the same encounter. |
| **BK063** | Service encounter has been disallowed as this service has already been claimed on the same day as 50.0B. Please resubmit with text indicating the medical necessity for an additional claim. |
| **BK064** | Service encounter has been disallowed as you have not included text referring to the inspired program. Please resubmit with appropriate text |
| **CC001** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **CC002** | Service encounter has been approved at 50% as another procedure has previously been approved at 100% at this same encounter. |
| **CC004** | Service encounter has been disallowed as HSC 03.05 has previously been claimed. Documentation must be provided if re-assessment is required. |
| **CN001** | Service encounter has been refused. When billing a stress test and a consultation and the patient has been examined by a different cardiologist in the previous 14 days, a visit fee only applies. |
| **CN002** | Service encounter has been refused as a repeat consultation is not payable unless a consultation for a related diagnosis with the same referring physician has been approved in the previous 30 days. |
| **CN003** | Service encounter has been refused as a complete care code includes related visits for the following 14 days. |
| **CN004** | Service encounter has been refused as you have previously been paid a visit or consultation this day under the same service occurrence number. |
| **CN005** | Service encounter for a consultation with detention has been refused as you have previously been approved a visit allowed procedure at the same service encounter. |
| **CN006** | Service encounter has been refused as a consultation and psychotherapy or counselling are not payable at the same service encounter. |
| **CN007** | Service encounter has been disallowed as this service is included in the post-operative care. |
| **CN008** | Service encounter has been disallowed as this service is included in the post-operative care of fractures. |
| **CN009** | Service encounter has been disallowed as contact lens fitting includes follow up for three months. |
| **CN010** | Service encounter has been disallowed. The first post-operative clinic or office recheck should be claimed but will be approved at 0 units during the 90 days following major surgery. |
| **CN011** | Service encounter has been disallowed as a consultation is not approved the same day as critical care. |
| **CN012** | Service encounter has been disallowed as compression sclerotherapy includes after care for one year. |
| **CN013** | Service encounter has been refused as detention is not payable in the office. |
| **CN014** | Service encounter has been disallowed as it is included as post-operative care of a fracture. |
| **CN015** | Service encounter has been disallowed. Contact lens fitting includes follow up for three months. |
| **CN016** | Service encounter has been disallowed as a consultation is considered included in the procedural code for induction of labour by artificial rupture of membranes as well as the procedural code for removal of retained placenta. |
| **CN017** | Service encounter has been disallowed as this service is payable once per patient per physician. |
| **CN018** | When a comprehensive or limited consultation is billed within 30 days of a PACS consultation the PACS consultation is disallowed. |

| Explanatory Code | Description |
|---|---|
| **CN019** | Service encounter has been disallowed as a consultation is considered included in the fee for an obstetrical trauma repair. |
| **CN020** | Service encounter has been disallowed as an 03.09B has previously been approved for this day. |
| **CN021** | Service encounter has been refused as you have already billed remote specialist telephone advice for this patient on this date. |
| **CN022** | Invalid referral provider type for specialty code present on service encounter. |
| **CR001** | Service encounter has been disallowed as a comprehensive critical care visit has been approved to you or another physician on this day. |
| **CR002** | Service encounter has been refused as another intensive care visit has been approved to you or another physician this day. |
| **CR003** | Service encounter has been refused as modifier type {in} value, date of service and admit to intensive care date do not agree. |
| **CR004** | Service encounter has been disallowed. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **CR005** | Service encounter has been refused as date of service indicated is prior to intensive care admit date given. |
| **CR006** | Service encounter has been refused as you have previously been approved a consultation or visit this day. |
| **CR007** | Service encounter has been disallowed. Critical care and ventilatory support are included in comprehensive care. |
| **CR008** | Service encounter has been refused as your specialty is not valid for providing intensive care associated with respiratory insufficiency. |
| **CR009** | Service encounter has been refused as modifier type {in} value, admit to intensive care date and date of service do not agree. |
| **CR010** | Service encounter has been refused as modifier type {in} value, date of service and admit to intensive care date do not agree. |
| **CR011** | Service encounter has been refused as this service has already been billed for this date. |
| **CR012** | Service encounter has been refused as a fee for intensive care has already been claimed for this patient on this date. Critical or comprehensive care cannot be claimed on the same day as intensive care. |
| **CR013** | Service encounter has been refused. When a physician provides both critical and ventilatory care to a patient they should claim comprehensive care. Please delete the previously paid ventilatory care and submit a claim for comprehensive care. |
| **CR014** | Service encounter has been refused. When a physician provides both critical and ventilatory care to a patient they should claim comprehensive care. Please delete the previously paid critical care and submit a claim for comprehensive care. |
| **CR015** | Service encounter has been refused as a fee for comprehensive care has previously been claimed for this patient on this day (5.1.124). |
| **CR016** | Service encounter has been refused as a fee for critical or ventilatory care has previously been claimed for this patient on this day (5.1.124). |
| **CR017** | Service encounter has been refused as a fee for intensive care has previously been claimed for this patient on this date. |
| **CR018** | Service encounter has been refused as a fee for comprehensive or critical care has previously been claimed for this patient on this date. |
| **CR019** | Service encounter has been disallowed as the day one fee has already been claimed for this patient during the same ICU admission. Please submit a new claim with the appropriate daily modifier. |
| **CR020** | Service encounter has been disallowed as a claim for directive care or continuing care has already been approved for this patient on the same day. |

| Explanatory Code | Description |
|---|---|
| **CS001** | Service encounter has been disallowed as application of casts and/or splints is not approved following a fracture procedure. |
| **CS002** | Service encounter has been disallowed as application of casts and/or splints is included in the fracture procedure. |
| **CS003** | Service encounter has been disallowed as it is included in the surgery performed. |
| **CS004** | Service encounter has been reduced. When multiple procedures are performed at the same time only one is approved at 100%. |
| **CS006** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **CS007** | Service encounter has been disallowed. When a visit and cast and/or splint are performed at the same service encounter, only one is approved. |
| **CS008** | Service encounter has been disallowed as application of casts and/or splints is included in the fracture procedure. |
| **DE001** | Service encounter has been refused as payment responsibility is invalid for service provided. |
| **DE002** | Service encounter has been refused as payment responsibility is not valid for service indicated. |
| **DE003** | Service encounter has been refused. Payment responsibility indicated is not valid for this service. |
| **DE004** | Service encounter has been refused as payment responsibility and service indicated do not agree. |
| **DE005** | Service encounter has been disallowed as electronic text is required for this service. |
| **DE006** | Service encounter has been disallowed as C9999 has been approved to you or another provider in the previous 30 days. |
| **DE007** | Service encountered has been disallowed as this service is restricted to individuals aged 18-64 years. |
| **DE008** | Service encounter has been disallowed as the recipient is 65 years of age or older. |
| **DE009** | Service encounter has been refused as this service has already been approved for this year. |
| **DE010** | Service encounter has been refused as two medication reviews have previously been approved for this year. |
| **DE011** | Service encounter has been refused as the second condition amount has already been approved for this year. |
| **DE012** | Service encounter has been refused as there is already one Unattached Patient Bonus payment claim on history. |
| **DE013** | Service encounter has been refused as two Long-Term Care Clinical Geriatric Assessments have previously been paid this year. |
| **DE014** | Service encounter has been refused as invalid or omitted location. |
| **DE015** | Service encounter has been refused as the previously claimed 03.04D also includes the fee for a comprehensive geriatric assessment. |
| **DE016** | Service encounter has been refused as the second condition amount has already been approved for this year. |
| **DE017** | Service encounter has been refused as the care plan oversight fee has previously been claimed for this patient for the same month. |
| **DE018** | Service encounter has been refused as the care plan oversight fee has already been claimed the maximum of six times for this patient during this calendar year. |
| **DE019** | Service encounter has been refused as in order to claim the care plan oversight fee you must have seen the patient for a face-to-face visit at least once in the past six months prior to reporting CPO. |
| **DE020** | Service encounter has been refused as a claim for long term care medication review has previously been made for this patient during the same calendar year. CPO1 cannot be claimed with either of these fees. |

| Explanatory Code | Description |
|---|---|
| **DE021** | Service encounter has been refused as a claim for supervision of long-term care anticoagulant therapy has previously been made for this patient during the same calendar month. CPO1 cannot be claimed with this fee. |
| **DE022** | Service encounter has been refused as a claim for care plan oversight has previously been made for this patient during the same calendar year. ENH1 cannot be claimed with this fee. |
| **DE023** | Service encounter has been refused as a claim for care plan oversight has previously been made for this patient during the same calendar month. 13.99C cannot be claimed with this fee. |
| **DE024** | Service encounter has been refused as this service has already been approved for this month. |
| **DE029** | Service encounter has been refused as a claim for care plan oversight or long-term care clinical geriatric assessment has previously been made for this patient during the same calendar month. |
| **DE030** | Service encounter has been refused as a claim for care plan oversight has previously been made for this patient during the same calendar month. |
| **DE031** | Service encounter has been disallowed. When both a clinical geriatric assessment and care plan oversight fee been claimed for a patient in the same calendar year, the second CGA fee requires text explaining the necessity. Please resubmit this claim with text referring to the necessity of this service. |
| **DE033** | Service encounter has been refused as there have been no visit services claimed by you for this patient in the previous 365 days. |
| **DE034** | Service encounter has been refused as there have been no services claimed by you for this patient in the previous 30 days. |
| **DE035** | Service encounter has been disallowed as OAT1 and OAT2 may not be claimed in the 6 months following an insertion of buprenorphine implant for the treatment of opioid use disorder. |
| **DE036** | Service encounter has been refused as a claim 13.99H (CPAMS) has previously been billed for this patient in the same month. CPO1 cannot be claimed with this fee. |
| **DE037** | Service encounter has been refused as the maximum number of 4 telephone prescription renewals per patient per year has been reached. |
| **DE038** | Service encounter has been refused as you have already billed a visit or procedure service for this patient on the same day. |
| **DE039** | Service encounter has been refused as this service may only be claimed once per patient per day. |
| **DE040** | Service encounter has been disallowed as text indicating necessity/intervention is required when there has already been a visit claimed for this patient on the same day. Please resubmit with appropriate text. |
| **DE041** | Service encounter has been refused as you must submit your signed confirmation letter in order to claim NPIV1. |
| **DE042** | Service encounter has been refused as comprehensive care services have previously been claimed for this patient. |
| **DE043** | Service encounter has been refused as this service may only be claimed once per patient. |
| **DE045** | Service encounter has been refused as a visit or procedure has previously been billed for this patient on the same day. |
| **DE046** | Service encounter has been refused. Two immunizations have been paid at full fee this date. Delete one immunization and resubmit at LV50 along with your NPIV1 claim. |
| **DE048** | Service has been disallowed as you have claimed a visit on the same day. Please resubmit with explanatory text. |
| **DE049** | Service encounter is refused as it is included in a service already claimed on this date. |
| **DE050** | Service encounter has been refused. Please resubmit with text indicating the circumstances of the virtual service. |
| **DL001** | Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%. |

| Explanatory Code | Description |
|---|---|
| **DL002** | Service encounter has been disallowed. When a visit and dislocation are performed at the same service encounter, only one is approved. |
| **DL003** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **DL004** | Service encounter has been approved at 50% as another procedure has previously been approved at 100%. |
| **DL005** | Service encounter has been reduced to 50% as another procedure has previously been approved at 100% at this same encounter. |
| **DL006** | When multiple procedures are performed at the same time, only one is approved at 100%. |
| **DL007** | Service encounter has been disallowed as a visit and major surgery are not both payable the same day. |
| **ED001** | Invalid or omitted record type. |
| **ED002** | Omitted action code or invalid action code and record sub-type combination. |
| **ED003** | Invalid service encounter number. (Invalid or omitted submitter ID, year, sequence number, and/or check digit.) |
| **ED004** | Invalid or omitted txn. Type. |
| **ED005** | Omitted record sub-type or invalid txn. Type and record sub-type combination. |
| **ED006** | Invalid payment responsibility. |
| **ED007** | Invalid or omitted service encounter type. |
| **ED008** | Invalid or omitted service start date. |
| **ED009** | Invalid or omitted service occurrence number. |
| **ED010** | Invalid or omitted diagnostic code 1. |
| **ED011** | Invalid or omitted diagnostic code 2 or 3. |
| **ED012** | Invalid multiples indicated. |
| **ED013** | Invalid modifier type, modifier value or invalid combination of type and value. |
| **ED014** | Invalid claimed unit value. |
| **ED015** | Claimed unit value must be numeric if unit value indicator contains a value of Y or health service code contains a value of EC, IC, or IF. |
| **ED016** | Invalid claimed amount. |
| **ED017** | Invalid unit value indicator. |
| **ED018** | Unit value indicator must be blank if claimed unit value is blank. |
| **ED019** | Invalid paper support document indicator. |
| **ED020** | Invalid or omitted hospital admit date or hospital admit date inappropriate for the location. |
| **ED021** | Hospital admit date cannot be subsequent to service date. |
| **ED022** | Hospital admit date must be present if service is for a registered inpatient. |
| **ED023** | Invalid intensive care admit date. |
| **ED024** | Intensive care admit date cannot be prior to hospital admit date. |
| **ED025** | Intensive care admit date is required when functional centre contains a value of NICU or INCU. |
| **ED026** | Invalid start time. |
| **ED027** | Invalid pre-authorization number. |
| **ED028** | Invalid injury diagnostic code. |
| **ED029** | Omitted or invalid service provider number or number not valid for date of service. |
| **ED030** | Invalid or omitted provider type. |
| **ED031** | Provider type is not valid for service provider number and/or date of service indicated. |
| **ED032** | Invalid referral provider number |

| Explanatory Code | Description |
|---|---|
| **ED033** | Referral provider number must be present and must be valid. |
| **ED034** | Referral provider number and referral provider type must be blank if OOP referral indicator contains a value of Y. |
| **ED035** | Referral provider number must be blank if referral provider type is blank. |
| **ED036** | Referral provider number must be present if referral provider type is present. |
| **ED037** | Invalid referral provider type. |
| **ED038** | Referral provider type must be blank if referral provider number is blank. |
| **ED039** | Invalid business arrangement for provider number or provider type or ineffective for the service start date on the service encounter. |
| **ED040** | Business arrangement is not valid for service provider number and/or date of service. |
| **ED041** | Invalid or omitted specialty code. |
| **ED042** | Specialty code not valid for service provider number and/or date of service. |
| **ED043** | Specialty code present on service encounter is invalid for business arrangement indicated. |
| **ED044** | Invalid or omitted facility number or functional centre. |
| **ED048** | Invalid or omitted service recipient health card number. |
| **ED049** | Invalid service recipient health card number for date of service or recipient is ineligible for the program. |
| **ED050** | Duplicate service encounter number previously submitted. |
| **ED051** | Service encounter number match not found. |
| **ED052** | Referral provider type must be present and valid for service date if referral provider number is indicated. |
| **ED053** | Invalid or omitted referral provider type. |
| **ED054** | Referral provider type not valid for date of service for referral provider number indicated. |
| **ED055** | Facility number invalid for location code indicated. |
| **ED056** | Facility number present on service encounter is invalid for business arrangement indicated. |
| **ED057** | Invalid or omitted location code. |
| **ED058** | Invalid or omitted program. |
| **ED060** | Service recipient birth date is omitted, or service start date is prior to birth date. |
| **ED062** | Health service code is invalid, omitted, or invalid for the business arrangement indicated. |
| **ED063** | Invalid or omitted pay to code. |
| **ED064** | Invalid pay to health card number. |
| **ED065** | Service encounter has been refused as the service encounter that shares the same text cannot be found. |
| **ED066** | Invalid record sequence. |
| **ED067** | Invalid or omitted surname on person data record. |
| **ED068** | Invalid or omitted given name on person data record. |
| **ED069** | Invalid date of birth on person data record. |
| **ED070** | Birth date in person data record must be blank if pay to code is OTHR and birth date must be present on person data record if pay to code is RECP. |
| **ED071** | Invalid gender code on person data record. |
| **ED072** | Omitted address on person data record. |
| **ED073** | Invalid or omitted city name on person data record. |
| **ED074** | Invalid or omitted province/state code on person data record. |
| **ED075** | Invalid country on person data record. |
| **ED076** | Service encounter has been refused as the person data record is absent. |

| Explanatory Code | Description |
|---|---|
| **ED077** | Only one CPD1, CBE1, or CTX1 permitted for each service encounter transaction. |
| **ED078** | Recipient health card number and pay to health card number are the same. |
| **ED079** | Remuneration method not fee for service or shadow billing. |
| **ED080** | Health service code must contain supporting text and claimed unit value. |
| **ED081** | Invalid health card number check digit. |
| **ED082** | Invalid record length. |
| **ED083** | CPD1 record sub-type present when it is not required. |
| **ED084** | Out of province referral indicator is not blank or it contains a value other than Y. |
| **ED085** | Non-printable characters in chart number field. |
| **ED086** | Non-printable characters in unused field. |
| **ED087** | Invalid postal code format. |
| **ED088** | Guardian/parent HCN is not alphanumeric. |
| **ED089** | Supporting text contains unprintable characters. |
| **ED090** | Invalid submitter ID. |
| **ED091** | Invalid year in the service encounter number on the CTX1 record sub type. |
| **ED092** | Invalid sequence number in the service encounter number on the CTX1 record sub type. |
| **ED093** | Invalid check digit on the service encounter number on the CTX1 record sub type. |
| **ED094** | Unsupported transaction type. |
| **ED095** | Transaction badly formed. |
| **ED096** | Parent or guardian must contact MSI to validate health card number for preregistered newborn. |
| **ED097** | Date of service is subsequent to expiry date for health card number. |
| **ED098** | Hospital admit date and intensive care admit date must be blank for action code of P. |
| **ED099** | Birth date is blank on base service encounter record and person data record. |
| **ED100** | Duplicate service encounter number previously submitted, currently in held status, waiting for manual review. |
| **ED101** | Provider type not allowed to bill. |
| **ED102** | Provider type not allowed to refer. |
| **ED103** | Service recipient birth date does not match birth date on health card. |
| **ED104** | Service encounter accepted at zero as it is outdated. |
| **ED105** | Service encounter has been refused as outside date of death grace period. |
| **ED106** | Payment responsibility is incorrect for the health card number provided. |
| **ED118** | Invalid WCB claim number. |
| **ED119** | Invalid date of injury. |
| **ED120** | WCB claim number and date of injury are missing. |
| **ED121** | Invalid WCB claim number and DOI. |
| **ED122** | WCB claim number not found. |
| **ED123** | HSC is invalid for LTB claim. |
| **ED124** | HSC is invalid for WCB RTW claim. |
| **ED125** | WCB claim number and/or DOI not valid for claim payment responsibility. |
| **ED126** | Service encounter has been refused as the compensation variable must be a two digit numerical value. |
| **ED127** | Service encounter has been refused as the compensation variable used is invalid. |
| **ED128** | Service encounter has been refused as compensation variable may not be claimed for payment responsibility used. |

| Explanatory Code | Description |
|---|---|
| **ED129** | Service encounter has been refused as a compensation variable may not be used for provider type used. |
| **ED130** | Patient health card number is missing and cannot be 0000 000 000. |
| **ED131** | Patient health card number submitted was not recognized by MSI. Please check number for errors. |
| **ED132** | Ineligible patient health card number. Patient did not have MSI coverage on the date of service, please contact the patient. |
| **GN001** | Service encounter has been refused as a similar service has been approved on the same day. |
| **GN002** | Service encounter has been refused as hospital admit date is required for services performed on registered inpatients. |
| **GN003** | Service encounter has been refused as this is an excluded service under the reciprocal billing agreement. |
| **GN004** | Service encounter has been refused as self referral is not acceptable. |
| **GN005** | Service encounter has been refused as payment responsibility WCB is not valid for patient under sixteen. |
| **GN006** | Service encounter has been refused as hospital admit date is necessary for processing this service. |
| **GN007** | Service encounter has been refused as modifier AG value does not agree with age of patient. |
| **GN008** | Service encounter has been disallowed as this procedure is included in critical care. |
| **GN009** | Service encounter has been refused as patient's sex is invalid for service provided. |
| **GN010** | Service encounter has been refused. Please resubmit with text indicating specific areas involved. |
| **GN011** | Service encounter has been disallowed as a consultation has been approved to you in the previous 14 days. |
| **GN012** | Service encounter has been refused as no preauthorization number was indicated or number indicated is invalid. |
| **GN013** | Service encounter has been refused as it is a duplicate submission. |
| **GN014** | Service encounter has been refused as a previously reduced matching service encounter is not present. |
| **GN015** | Service encounter has been reassessed. |
| **GN016** | Invalid or omitted health service code. |
| **GN017** | Service encounter has been refused as your specialty is not approved for performing this service. |
| **GN018** | Service encounter has been refused as first and consecutive anaesthetic start times cannot be the same. |
| **GN019** | Service encounter has been refused as it is an exact duplicate to a previously submitted service encounter. |
| **GN020** | Service encounter has been adjudicated according to information provided. |
| **GN021** | Service encounter has been adjudicated according to a decision by the medical claims evaluation committee. |
| **GN022** | Service encounter has been refused as it is an uninsured service under MSI. |
| **GN023** | Service encounter has been refused as it is outdated. |
| **GN024** | Service encounter has been disallowed as it is an uninsured service under MSI. |
| **GN025** | Service encounter has been refused as this service is included in the composite fee. |
| **GN026** | Service encounter has been adjudicated based on duration of service. |
| **GN027** | Service encounter has been refused as it requires multiples. Resubmit using the correct number of multiples. |
| **GN028** | Service encounter has been disallowed. Resubmit indicating duration of service. |
| **GN029** | Service encounter has been refused as an assistant is not approved for this service. |

| Explanatory Code | Description |
|---|---|
| **GN030** | Service encounter has been refused. If resubmitting, provide all details that will assist in determining payment. |
| **GN031** | Service recipient birth date does not match birth date on health card. Birth date from health card should be used. This does not affect payment. |
| **GN032** | Service encounter has been refused. Resubmit using the appropriate health service code(s) as listed in your Physician's Manual. |
| **GN033** | Service encounter has been refused. Resubmit, indicating in the claimed unit value field the number of units required for the procedure performed. |
| **GN034** | Service encounter has been refused as the pay to code indicated is not appropriate. |
| **GN035** | Service encounter has been refused as pay to code indicated is not valid for payment responsibility indicated. |
| **GN036** | Service encounter has been refused as a previous service under this same service code has been approved. |
| **GN037** | Service encounter has been refused as a previous service has been approved under this same service code at this service encounter. |
| **GN038** | Service encounter has been refused as a previous service encounter has been accepted for this same service code. |
| **GN039** | Service encounter has been refused as a previous service encounter for this same health service code has been approved. |
| **GN040** | Service encounter has been disallowed as a visit and surgery are not both payable. |
| **GN041** | Service encounter has been refused as a previous service encounter was approved for this same health service code. |
| **GN042** | Service encounter has been refused as payment responsibility is not valid for date of service indicated. |
| **GN043** | Service encounter has been disallowed. Resubmit indicating start and finish time for procedure performed. |
| **GN044** | Service encounter has been disallowed as a service occurrence other than one has been used without explanatory text. |
| **GN045** | Service encounter has been disallowed as text provided does not include the original service encounter number. |
| **GN046** | Service encounter had been disallowed as text provided does not include the time of the encounter. |
| **GN047** | Service encounter has been refused. Submit a reassess (action code R) for the original submission to aid in the assessment of your claim. |
| **GN048** | Service encounter has been disallowed. Submit a reassess (action code R) for the original submission to aid in the assessment of your claim. |
| **GN049** | Service encounter has been disallowed as text provided does not provide sufficient details. If resubmitting, please provide more details to aid in the assessment of your claim. |
| **GN050** | Service encounter has been refused. Resubmit under the same health service code using the appropriate lesser value modifier for the service provided. |
| **GN051** | Service encounter has been refused as a service occurrence one (1) has not been claimed for this day by this physician. |
| **GN052** | Service encounter has been disallowed. Please submit a reassess (action code R) along with a copy of the time sheet for the surgery performed to aid in the adjudication of your claim. |
| **GN053** | Service encounter has been refused as it is not appropriate to claim diagnostic code V650, V651, V681, V709, or V729 for this service. |
| **GN054** | Service encounter has been refused as the diagnostic code submitted is not valid for patients over 18 months of age. |

| Explanatory Code | Description |
|---|---|
| **GN055** | Service encounter has been refused as you have already claimed the surgeon/surgical assist fee for this service. |
| **GN056** | Service encounter has been refused as you have already claimed the surgical assist fee for this service. |
| **GN057** | Service encounter has been disallowed as the diagnostic code submitted does not warrant a premium fee. |
| **GN058** | When claiming multiples for a time-based service the start and end times must be included in the text field. |
| **GN059** | A consult has previously been approved for your specialty during this hospitalization. |
| **GN060** | Service encounter has been reduced to reflect maximum daily time allowed. |
| **GN061** | Service encounter has been refused based on the preamble ruling for payment of detention time. See Preamble 5.1.75. |
| **GN062** | Service encounter has been refused as you have not supplied the start and end times in the electronic text field. |
| **GN063** | Multiple SRAS have claimed for this patient on the same day. If second surgical assist for same surgery claim EC. If claiming as surgical assist on a different surgery (same patient/same day) resubmit with text indicating subsequent surgery. |
| **GN064** | Surgical assist claims (RO=SRAS) cannot be claimed until after the surgeon's claim has been received and processed. Once this is complete, you may resubmit using the same HSC as the surgeon. |
| **GN065** | Service encounter has been refused as this service has already been claimed by another provider on this day. |
| **GN066** | Service encounter has been refused as the clinical documentation provided appears to be a duplicate of previously provided documentation with no new clinical information to support this claim. |
| **GN067** | Service encounter has been refused as you have previously billed HSC 82.64D at the same encounter |
| **GN068** | Service encounter has been refused as you have already billed HSC 82.64E at the same encounter. |
| **GN069** | Service encounter has been disallowed (refused) as the service date is not within the approved date range. |
| **GN070** | Service encounter has been refused as this service can not be billed from this facility. |
| **GN071** | Service encounter has been disallowed as you have previously billed for sole operative procedure fee 90.69D at the same encounter. |
| **GN072** | Service encounter has been disallowed as you have previously billed another service at the same encounter. HSC 90.69D can only be billed if the removal of fixation device is the sole operative procedure. |
| **GN073** | Please submit documentation to further assist in assessing this claim. |
| **GN074** | The information provided on your claim does not match the surgeon's submission. |
| **GN075** | Please provide text indicating approval was given by public health. |
| **GN076** | Service encounter has been disallowed as you have already billed a visit at the same encounter. Please submit a delete for the visit before resubmitting for the CGA1. |
| **GN077** | Service encounter has been disallowed as you have already claimed a service that includes suturing at the same encounter. |
| **GN078** | Service encounter has been refused as the provider number is not valid for this service. |
| **GN079** | Service encounter has been disallowed. IV insertion is considered a part of this procedure and it has already been claimed at the same service encounter. |
| **GN080** | MSI Result. |
| **GN081** | Service encounter has been refused as the hospital admit date is before the date of birth. |
| **GN082** | Service encounter has been disallowed as you are not currently permitted to bill this service. Please contact CPSNS to register. Refer to November 2016 Physicians Bulletin. |

| Explanatory Code | Description |
|---|---|
| **GN083** | Service encounter has been disallowed as the documentation does not include a description of the claimed procedure. |
| **GN084** | Service encounter has been disallowed because the procedure is a necessary part of another paid service encounter. |
| **GN085** | Service encounter has been disallowed as assistant fees cannot be claimed in these circumstances. |
| **GN086** | For attendance on the patient for the purpose of pronouncement of death, a limited visit only may be claimed, per Preamble 5.3.223. |
| **GN087** | Service encounter has been refused as you have previously bulled HSC 68.95B at the same encounter. |
| **GN088** | Service encounter has been refused as a claim for HSC 57.6D has been approved on this day. |
| **GN089** | Service encounter has been disallowed. Please resubmit with text indicating specific areas involved. |
| **GN090** | Service encounter has been disallowed because the procedure is necessary to allow access/visualization to perform the surgery. |
| **GN091** | Service encounter has been refused. Please resubmit using the appropriate modifier(s). |
| **GN092** | Service encounter has been refused as text is required for non face to face services. |
| **GN093** | Service encounter has been refused as you have already billed a non face to face service for this patient on the same day. |
| **GN094** | You have billed for a non face to face service and we are requesting the supporting documentation to aid in the evaluation of this claim. |
| **GN095** | Service encounter has been reduced to the appropriate fee for the service provided. |
| **GN096** | Pre Payment Review. Please submit documentation to further assist in assessing this claim. |
| **GN097** | Service encounter has been disallowed. Ensuring the functional integrity of vital structures during a surgical procedure is included in the surgical HSC. |
| **GN098** | Service encounter has been disallowed. There was no separate and distinct surgical service. The HSC claimed was part of another paid service encounter. |
| **GN099** | Service encounter has been disallowed; insertion of the indwelling urinary catheter can not be claimed with any other procedure fees during the same encounter. |
| **GN100** | Service encounter has been refused as you must submit your signed Physician Confirmation letter in order to bill the enhanced fees for office and geriatric visits. |
| **GN101** | Service encounter has been refused as this service is not billable from a hospice facility. |
| **GN102** | Service encounter has been refused as HSC 02.84A which is a stand-alone procedure has already been claimed during the same encounter. If an ultrasound has occurred, the appropriate ultrasound fee should be claimed along with add on HSC 02.84B – obstetrical doppler in conjunction with ultrasound. |
| **GN103** | Service encounter has been disallowed as this service may not be billed if a pathologist has reviewed the slides and claimed for the service. |
| **GN104** | Service Encounter has been refused. Health card number is not valid for service provided. |
| **GN105** | Service encounter has been disallowed as you have already claimed a surgical procedure on this day. Tonometry is considered to be an included part of any surgical procedure. |
| **GN106** | Service encounter has been disallowed as you have already claimed tonometry on this day for this patient. Tonometry is considered to be an included part of any surgical procedure. |
| **GN107** | Service encounter has been refused as you have already claimed a teaching stipend on this date. |
| **GN108** | Service encounter has been refused as you are not authorized to claim the teaching stipend. |
| **GN109** | Service encounter has been refused as this ROTA has already been claimed at either half or full value from this facility for this same service date. |
| **GN110** | Service encounter has been refused as this ROTA has already been claimed at full value from this facility for the same service date. |

| Explanatory Code | Description |
|---|---|
| **GN111** | Service encounter has been refused as you have already claimed a facility on-call callback rate for this service date. |
| **GN112** | Service encounter has been refused as the community hospital inpatient program has already been claimed from the same hospital on this date. |
| **GN113** | Service encounter has been refused as you must claim a category 3 facility on-call daily rate prior to claiming the associated callback fee. |
| **GN114** | Service encounter has been refused as the maximum of 2 ophthalmology ROTAs have already been claimed from this facility on this date. |
| **GN115** | Service encounter has been refused as the maximum of 4 diagnostic imaging ROTAs have already been claimed from this facility on this date. |
| **GN116** | Service encounter has been refused as a claim for the facility on call obstetrics/gynecology ROTA using the same role modifier has already been claimed from the IWK for this date. |
| **GN117** | Service encounter has been refused as claims for F1004 from this facility should not include a role modifier. |
| **GN118** | Service encounter has been refused as claims for HSC F1004 from Yarmouth should be made using the RO=OBS1 modifier. |
| **GN119** | Service encounter has been refused as claims for HSC F1004 from Dartmouth General should be made using the RO=GYN1 modifier. |
| **GN120** | Service encounter has been refused as claims for HSC F1004 from the IWK should be made using the appropriate RO modifier for 1st or 2nd obstetrics, or 1st gynecology. |
| **GN121** | Service encounter has been disallowed as a claim for HSC 50.0B has already been claimed at the same encounter. HSC 50.0B is a comprehensive fee that includes all access and visualization to perform the procedure. |
| **GN122** | Service encounter has been disallowed as this service is not reportable if the consultation results in a face to face service within the next 14 days or the next available appointment. |
| **GN123** | Service encounter has been refused as the maximum of 2 hospitalist rotas have already been claimed from this facility on this date. |
| **GN131** | Service encounter has been refused as you must submit your completed GAC physician declaration in order to claim 03.04K. |
| **GN132** | Service encounter has been refused as you have already billed a telephone prescription renewal for this patient on the same day. |
| **GN133** | Service encounter has been refused as NPIV1 has previously been billed for this patient on the same day. |
| **GN134** | Service encounter has been refused. Health card number is not valid for the HSC being claimed. |
| **GN135** | Service encounter has been refused as you have already claimed a facility on-call inpatient withdrawal management rota for this service date. |
| **GN136** | Service encounter has been refused as you have already claimed a facility on-call recovery support center rota for this service date. |
| **GN137** | Invalid referral provider type for this service. |
| **GN138** | Service encounter has been refused as this service may not be claimed with ADCP1. |
| **GN141** | AHCP1 and TPR1 may not be claimed with NHTA1. |
| **GN142** | NHTA1 may not be claimed with AHCP1 or TPR1. |
| **GN143** | NHTA1 may not be claimed with nursing home medical chart review. |
| **GN144** | NHTA1 may not be claimed during the same service occurrence as a visit or consult. |
| **GN145** | This health service code may not be claimed during the same service occurrence as NHTA1. |
| **GN146** | Service encounter has been refused as you have already claimed a preceptor stipend on this date. |

| Explanatory Code | Description |
|---|---|
| **GN147** | Service encounter has been refused. Please resubmit with text indicating the name and student number of the learner. |
| **GN148** | Service encounter has been refused as preceptorship stipend may not be claimed on the same day as a teaching stipend. |
| **GN149** | Service encounter has been refused as a preceptorship stipend has already been claimed at either half or full value for the same service date. |
| **GN150** | Service encounter has been refused as a preceptorship stipend has already been claimed at full value for the same service date. |
| **GN151** | Service encounter has been refused. This HSC may only be claimed by family physicians GENP who hold and maintain a certificate of added competence (CAC) awarded by the College of Family Physicians of Canada CFPC |
| **GN152** | Service encounter has been refused. This HSC has already been claimed 4 times in the previous 12 months for this diagnosis. Please delete and submit a limited office visit instead. |
| **GN153** | Service encounter has been disallowed. Please resubmit with text indicating the consultant provider number. |
| **GN154** | Service encounter has been refused. 03.09K may not be claimed with any other service on the same day. |
| **GN155** | Service encounter has been refused. 03.09K has already been claimed on this date for this patient. No other service may be claimed on this date for this patient. |
| **GN156** | Service encounter has been refused. Your specialty is not eligible to claim this HSC with multiples. |
| **GN157** | Service encounter has been refused because 03.09K has been claimed for this patient in the previous 7 days. |
| **GN158** | Service encounter has been refused. Service provider must have submitted a signed me=care declaration letter or be providing women's sexual and reproductive health services to claim this HSC. |
| **LF001** | Service encounter has been refused as no more than 24 hours may be billed per day for HSC HDAY1. |
| **LF002** | Service encounter has been refused as no more than 24 hours may be billed per day for HSC HEVW1. |
| **LF003** | Service encounter has been refused as you cannot claim 0 hours for this HSC. |
| **LF004** | Service encounter has been refused as no more than 24 hours may be billed per day for all longitudinal family medicine (LFM) model hourly fee codes combined. |
| **LF005** | Service encounter has been refused as this HSC has already been claimed for this date. |
| **LF006** | Service encounter has been refused as no more than 24 hours may be billed per day for HSC HUTC1 |
| **LF007** | Service encounter has been refused as no more than 24 hours may be billed per day for HSC HEDD1 |
| **LF008** | Service encounter has been refused as no more than 24 hours may be billed per day for HSC HEDE1 |
| **LF009** | Service encounter has been refused as no more than 24 hours may be billed per day for HSC HIPD1 |
| **LF010** | Service encounter has been refused as no more than 24 hours may be billed per day for HSC HIPE1 |
| **MA001** | Service encounter has been approved at 50%. When multiple closed or no reductions are performed on the same fracture at different service encounters by the same provider, 50% for each reduction should be claimed. |
| **MA002** | Service encounter has been reduced. 50% of the listed fee for the initial closed or no reduction is approved when a different physician performs a subsequent closed or no reduction on the same fracture. |
| **MA003** | Service encounter for closed reduction has been approved at 50% of the listed fee as it has been followed by an open reduction. |
| **MA004** | Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%. |
| **MA005** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |

| Explanatory Code | Description |
|---|---|
| **MA006** | Service encounter has been reduced. When multiple procedures are performed at the same encounter only one is approved at 100%. |
| **MA007** | Service encounter has been reduced. Only one procedure is approved at 100% when multiple procedures are performed at the same time. |
| **MA008** | Service encounter has been refused. Interim service code has expired. Application must be submitted to the Fee Committee for establishing a permanent health service code. |
| **MA009** | Service encounter has been refused as you have already made a claim for health service code 90.4A, 98.79A, 90.69B, 89.3A, or a BOGR category code at the same encounter. |
| **MA010** | Service encounter has been refused as you have already made a claim for health service code 90.40B at the same encounter. |
| **MA011** | Service encounter has been refused as you have already made a claim for health service code 16.09A, 16.09B, 16.09C, 16.09D, 16.1A, 16.1B, 16.2A, 16.2B, 16.3A, 16.3B, 16.3C, 16.49A, 16.5A, 16.5B, 16.93D at the same encounter. |
| **MA012** | Service encounter has been refused as you have already made a claim for health service code 16.09J at the same encounter. |
| **MA013** | Service encounter has been refused as you have already made a claim for health service code 17.05D or 17.5A at the same encounter. |
| **MA014** | Service encounter has been refused as you have already made a claim for health service code 17.5B at the same encounter. |
| **MA015** | Service encounter has been refused as you have already billed a blepharoptosis code for the same eye on that date. |
| **MA016** | Service encounter has been refused as you have already billed a blepharoplasty code for the same eye on that date. |
| **MA017** | Service encounter has been refused as you have already billed a blepharoplasty or blepharoptosis code for the same eye on that date. |
| **MA018** | Service encounter has been refused as you have already billed a removal of periorbital fat code for the same eye on that date. |
| **MA019** | Service encounter has been refused. When a blepharoplasty is performed for a diagnosis of blepharochalasis or dermatochalasis, code 22.5C should be used, not a lid ptosis code. Prior to submitting 22.5C, please contact the assessment dept for a PA number. |
| **MA020** | Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/28.42A/28.44A or 28.72 on that date. |
| **MA021** | Service encounter has been refused as you have already billed HSC 28.73E or 28.49A on that date. |
| **MA022** | Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/28.42A or 28.44A on that date. |
| **MA023** | Service encounter has been disallowed as you have previously billed another major surgery for this patient on the same day. |
| **MA024** | Service encounter has been refused as HSC 77.19C, 57.59A, or 80.4C has been billed at this encounter. |
| **MA025** | Service encounter has been refused as HSC 66.83 has been billed at this same encounter. |
| **MA026** | Service encounter has been refused as you have previously billed a portion of this composite service at the same encounter (bronchoscopy, decortication, or mediastinal lymph node dissection). |
| **MA027** | Service encounter has been refused as you have previously billed a VATS lung lobectomy at the same encounter. |
| **MA028** | Service encounter has been refused as you have previously billed health service code 77.3 at the same encounter. |
| **MA029** | Service encounter has been refused as you have previously billed health service code 77.19A at the same encounter. |

| Explanatory Code | Description |
|---|---|
| **MA030** | Service encounter has been refused as you have previously billed health service code 77.52 at the same encounter. |
| **MA032** | Service encounter has been refused as a surgical assist cannot be performed in the office. |
| **MA033** | Service encounter has been refused as you have previously claimed health service code 26.62 or 26.62B at the same encounter. |
| **MA034** | Service encounter has been refused as you have previously claimed a composite cataract fee at the same encounter. |
| **MA035** | Service encounter has been refused as you have previously billed HSC 83.61 at the same encounter. |
| **MA036** | Service encounter has been refused as you have previously billed HSC 61.69G at the same encounter. |
| **MA037** | Service encounter has been refused as you have already billed a portion of this comprehensive fee (HSC 54.33A, 54.42, 54.43, 54.44A, 54.45, 54.47, 46.2, 55.1, 55.3, 55.5, or 58.39A). |
| **MA038** | Service encounter has been refused as you have previously billed the comprehensive fee for Esophagectomy with immediate reconstruction by interposition of hollow viscous (HSC 54.47A). |
| **MA039** | Service encounter has been refused as you have previously billed for a laparoscopy at the same encounter. |
| **MA040** | Service encounter has been refused as you have previously billed HSC 78.39A at the same encounter. |
| **MA041** | Service encounter has been refused as you have previously claimed an oophorectomy for this patient (same side) at the same encounter. |
| **MA042** | Service encounter has been refused as you have previously claimed HSC 78.1A for this patient (same side) at the same encounter. |
| **MA043** | Service encounter has been refused as you have previously claimed a salpingectomy, salpingostomy, or oophorectomy for this patient at the same encounter. |
| **MA044** | Service encounter has been refused as you have previously claimed for a removal of extrauterine pregnancy (HSC 86.3A) at the same encounter. |
| **MA045** | Service encounter has been refused as you have previously billed HSC 80.81, 81.09, 81.09A, 81.69A, 80.19B, or 03.26 at the same encounter. |
| **MA046** | Service encounter has been refused as you have previously billed HSC 80.19A endometrial ablation at the same encounter. |
| **MA047** | Service encounter has been refused as you have previously billed HSC 29.94A, 29.94B, or 29.94C at the same encounter. |
| **MA048** | Service encounter has been refused as you have previously billed HSC 22.5C at the same encounter. |
| **MA049** | Service encounter has been refused as cataract surgery cannot be claimed with tonometry. |
| **MA050** | Service encounter has been refused as you have previously billed 58.11 or 57.59. |
| **MA051** | Service encounter has been refused as you have previously billed HSC 60.55. |
| **MA052** | Service encounter has been refused as you have previously billed HSC 66.4A or 66.3. |
| **MA053** | Service encounter has been refused as you have previously billed HSC 65.51D or 65.51E |
| **MA054** | Service encounter has been refused as you have previously billed HSC 97.95, 97.43, 97.44 |
| **MA055** | Service encounter has been refused as you have previously billed HSC 97.6E |
| **MA056** | Service encounter has been refused as you have previously billed for a resection of bowel or formation of colostomy or ileostomy. |
| **MA057** | Service encounter has been refused as you have previously billed for a laparoscopic total colectomy or laparoscopic assisted abdominoperineal resection. |
| **MA058** | Service encounter has been refused as you have previously billed HSC 83.61. |
| **MA059** | Service encounter has been refused as you have previously billed HSC 83.61. |
| **MA060** | Service encounter has been refused as you have previously billed HSC 66.82A |

| Explanatory Code | Description |
|---|---|
| **MA061** | Service encounter has been disallowed. Please submit a reassess (action code R) along with a copy of the operative report and indicate skin to skin time in text to aid in the assessment. |
| **MA062** | Service encounter has been refused as a cystoscopy has previously been billed for this patient on the same day. |
| **MA063** | Service encounter has been refused as cystoscopy is included in the fee for HSC 71.4C which has been previously billed for this patient on this day. |
| **MA064** | Service encounter has been refused as you have previously billed for a sigmoidoscopy, colostomy, or ileostomy at the same encounter. |
| **MA065** | Service encounter has been refused as you have previously billed for 57.5B, 60.4C or 60.52B at this encounter. If you are attempting to claim an ileostomy with this procedure, please use the add on HSC 58.01A |
| **MA066** | Service encounter has been refused as a second physician claim exists for this encounter. A surgical assist cannot also be claimed. |
| **MA067** | Service encounter has been refused as HSC 60.52B cannot be claimed with HSC 66.19, 66.83, 60.52A at the same encounter. |
| **MA068** | Service encounter has been refused as HSC 66.19 or 66.83 cannot be claimed with HSC 60.52B at the same encounter. |
| **MA069** | Service encounter has been refused as the patient is over 6 months old. |
| **MA070** | Service encounter has been disallowed has you have previously claimed another surgery on this eye during the same encounter. The fee for iridotomy should only be used when it is a stand-alone procedure. |
| **MA071** | Service encounter has been refused as HSC 01.34A, 68.83A, 68.99A, or 68.99C has already been billed at the same encounter. |
| **MA072** | Service encounter has been refused as HSC 03.12 was billed at the same encounter and is a component of this procedure. |
| **MA073** | Claim for radical neck dissection has been refused as it is not payable at the same encounter as a glossectomy, parotidectomy or floor of mouth tumor codes. Composite fees exist that should be used instead. |
| **MA074** | Claim for glossectomy, parotidectomy or floor of mouth tumor has been refused as it is not payable at the same encounter as a radical neck dissection. Composite fees exist that should be used instead. |
| **MA075** | Service encounter has been refused as your specialty is not approved to bill this service. If the exploration of a peripheral nerve has been done as a separate and distinct procedure, the service can be submitted as EC with text and include the operative report which will be reviewed prior to payment. |
| **MA076** | Service encounter has been refused as you are not permitted to claim this fee. |
| **MA077** | Service encounter has been refused as HSC 67.3 may not be claimed at the same encounter as HSC 67.6, 66.3 or 67.29A |
| **MF001** | Service encounter has been refused as a removal of fixation device claim was previously made for the same region on that service date. |
| **MF002** | Service encounter has been refused as a removal of fixation device fee is included in previously billed 91.35B |
| **MF003** | Service encounter has been refused as you have already made a claim for health service code 91.35B or 91.35E. |
| **MF004** | Service encounter has been refused as you have already made a claim for health service code 91.35C or 91.35D. |
| **MF005** | Service encounter has been reduced. When multiple procedures for fractures involving different long bones are performed at the same time, only one is approved at 100%. |

| Explanatory Code | Description |
|---|---|
| **MF006** | Service encounter has been refused as you have previously claimed HSC 90.06A, 90.09A, 92.15 or 92.89N for the same patient on the same day. |
| **MF007** | Service encounter has been refused as you have previously bulled for an ORIF bicondylar tibial plateau fracture for this patient on this day. |
| **MF008** | Service encounter has been refused as you have previously claimed a fracture code for the same site/region on this day. |
| **MF009** | Service encounter has been refused as this health service code cannot be claimed with HSC 92.89N at the same encounter. |
| **MI001** | Service encounter has been approved at 50%. When multiple closed or no reductions are performed on the same fracture at different service encounters by the same provider, 50% for each reduction should be claimed. |
| **MI002** | Service encounter has been refused. 50% of the listed fee for the initial closed or no reduction is approved when a different provider performs a subsequent closed or no reduction on the same fracture. |
| **MI003** | Service encounter for no or closed reduction has been approved at 50% of the listed fee as it has been followed by an open reduction. |
| **MI004** | Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%. |
| **MI005** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **MI006** | Service encounter has been reduced. When multiple procedures are performed at the same encounter, only one is approved at 100%. |
| **MI008** | Service encounter has been refused as the maximum of 3 procedures per patient per lifetime has been reached. |
| **MJ001** | Service encounter has been reduced to 50%. When multiple surgical procedures are performed at the same time, only one is approved at 100%. |
| **MJ002** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **MJ003** | Service encounter has been refused as this once per lifetime procedure has previously been approved. |
| **MJ004** | Service encounter has been refused as this adjustment of leads occurred within 30 days of pacemaker insertion. |
| **MJ005** | Service encounter has been refused as initial cauterization of the rectum has been approved in the previous 30 days. |
| **MJ006** | Service encounter has been refused as initial photo coagulation has been approved for eye(s) indicated in the previous 30 days. |
| **MJ007** | Service encounter has been refused as this is not the appropriate health service code for post-op haemorrhage when claimed by the surgeon who performed the tonsillectomy. |
| **MJ008** | Service encounter has been refused as a preauthorization number was not indicated. |
| **MJ009** | Service encounter has been adjudicated based on the surgeon's submission. |
| **MJ010** | Service encounter has been refused. Resubmit with a copy of the operative report to aid in the adjudication of your service encounter. |
| **MJ011** | Service encounter has been refused based on the age of the recipient. |
| **MJ012** | Service encounter has been refused as this health service is not appropriate for persons 16 years or older. |
| **MJ013** | Service encounter has been refused as this health service is not appropriate for persons under 16 years of age. |

| Explanatory Code | Description |
|---|---|
| **MJ014** | Service encounter has been reduced to 50%. Only one procedure is approved at 100% when multiple surgical procedures are performed at the same time. |
| **MJ015** | Service encounter has been disallowed as this procedure is included in a previously approved service. |
| **MJ016** | Service encounter has been disallowed as this service is included in a previously approved procedure. |
| **MJ017** | Service encounter has been refused as no preauthorization number was indicated. |
| **MJ018** | Service encounter has been disallowed as this service requires electronic text or a prior approval number. |
| **MJ019** | Service encounter has been refused as a previous service encounter for a second physician has been approved. |
| **MJ020** | Service encounter has been refused as a previous service encounter for an assist fee has been approved. |
| **MJ021** | Service encounter has been disallowed. Resubmit with a copy of the outpatient report to aid in the adjudication of your service encounter. |
| **MJ022** | Service encounter has been refused as a total abdominal hysterectomy or repair of inverted uterus has already been claimed by you for this date. |
| **MJ023** | Service encounter has been refused as you have already claimed a repair of obstetrical trauma or anal sphincter on this date. |
| **MJ024** | Service encounter has been refused as you have already claimed a repair of obstetrical trauma on this date. |
| **MJ025** | Service encounter has been refused as a claim for donor has already been received for this patient. A patient cannot be both a donor and recipient of a liver. |
| **MJ026** | Service encounter has been refused as a claim for recipient has already been received for this patient. A patient cannot be both a donor and recipient of a liver. |
| **MJ027** | Service encounter has been disallowed as the injected substance has not been indicated. |
| **MJ028** | Service encounter has been refused as a claim for the ICD insertion team fee has already been made for this patient. |
| **MJ029** | Service encounter has been refused as a claim for the ICD insertion composite fee has already been made for this patient. |
| **MJ030** | Service encounter has been refused as you have previously billed HSC 82.41, 82.42, or 82.43 for this patient on the same day. |
| **MJ031** | Service encounter has been refused as you have previously billed HSC 80.2B, 80.3A, or 80.4A for this patient on the same day. |
| **MJ032** | Service encounter has been refused as you have previously billed HSC 71.5A for this patient on the same day. |
| **MJ033** | Service encounter has been refused as you have previously billed HSC 80.3B for this patient on the same day. |
| **MJ034** | Service encounter has been refused as you have previously billed a local tissue shift (HSC 98.51C or 98.51D) for this patient on the same day. |
| **MJ035** | Service encounter has been refused as you have previously billed a complex palmar fasciectomy (HSC 94.13C) for this patient on the same day. |
| **MJ036** | Service encounter has been refused as you have previously billed HSC 66.19 or 66.83 for this patient on the same day. |
| **MJ037** | Service encounter has been refused as you have previously billed HSC 57.59A or 60.52B for this patient on the same day. |
| **MJ038** | Service encounter has been refused as you cannot bill a 60.52A and a 60.52B for this patient on the same day. |

| Explanatory Code | Description |
|---|---|
| **MJ039** | Service encounter has been refused as you have previously billed health service code 94.13D for this patient on the same day. |
| **MJ040** | Service encounter has been refused as a 01.34A has previously been billed for this patient on this day. |
| **MJ041** | Service encounter has been refused as you have already billed a service that is included in this fee. |
| **MJ042** | Service encounter has been refused as you have already billed HSC 94.13E at the same encounter. |
| **MJ043** | Service encounter has been disallowed as the provider number is not valid for this service. |
| **MJ044** | Service encounter has been refused as HSC 01.24C has previously been billed fir this patient on this day. |
| **MJ045** | Service encounter has been refused as HSC 01.34A has already been billed for this patient on this day. |
| **MJ046** | Service encounter has been disallowed as surgical assist claims for HSC 98.49C or 98.49D cannot be claimed until the surgeon has claimed for the surgical services |
| **MJ047** | Service encounter has been refused as HSC 57.59 or 60.52 has previously been billed for this patient on the same day. |
| **MJ048** | Service encounter has been refused as HSC 60.55C has previously been billed for this patient on the same day. |
| **MJ049** | Service encounter has been refused as you have previously billed HSC 90.06B for this patient on this day. |
| **MJ050** | Service encounter has been refused as you have previously billed on of the following HSCs 01.34A,B,C,D,E,F,G,H 71.02, 82.7 or 68.98 at the same encounter. |
| **MJ051** | Service encounter has been refused as you have already billed an enterocele repair (HSC 82.7 or 82.64B) at the same encounter. |
| **MJ052** | Service encounter has been refused as you have already billed HSC 82.64F at the same encounter. |
| **MJ053** | Service encounter has been refused as you have previously billed 01.24C at the same encounter. |
| **MJ054** | HSC 46.41 decortication of lung may not be billed with any other major surgery. |
| **MJ055** | Service encounter has been disallowed as MSI requires the start and end times of this procedure to assess. Please resubmit this claim with the start and end times in the text field. |
| **MJ056** | Service encounter has been disallowed as you have previously billed health service code 68.95B for this patient at the same encounter. Please submit a reassess (action code R) along with the OR report to aid in the assessment of your claim. |
| **MJ057** | Service encounter has been disallowed as you have previously billed health service code 68.0A for this patient at the same encounter. Please submit a reassess (action code R) along with a copy of the operative report to aid in the assessment of your claim. |
| **MJ058** | Service encounter has been refused as HSC 29.94A, 24.94B and 29.94C may not be claimed together at the same encounter. |
| **MJ059** | Date of service on claim does not match date of service on operative report. |
| **MJ060** | Service encounter has been disallowed as a claim for cystoscopy has already been submitted for this patient at the same encounter. If additional cystoscopic procedure is required, please resubmit with supporting text. |
| **MJ061** | Service encounter has been disallowed as you have previously billed HSC 72.1B at the same encounter. If additional cystoscopic procedure is required, please resubmit with supporting text. |
| **MJ062** | Service encounter has been disallowed as you have previously billed HSC 07.08A, B or C at the same encounter. |
| **MJ063** | Service encounter has been refused as you have previously billed a cystoscopy related service at the same encounter. |

| Explanatory Code | Description |
|---|---|
| **MJ064** | Service encounter has been refused as you have previously claimed for urethral dilation at the same encounter. This service includes any urethral dilation required to insert the device. |
| **MJ065** | Service encounter has been refused as claim for programming to a pacemaker which is part of this service has already been claimed on this day. |
| **MJ066** | Service encounter has been refused as you have previously claimed for health service code 47.25, 48.13 or 50.34B at the same encounter. |
| **MJ067** | Service encounter has been refused as you have previously claimed for health service code 47.25A or B at the same encounter. |
| **MJ068** | Service encounter has been reduced to 70%. When multiple surgical procedures are performed at the same time, only one is approved at 100%. |
| **MJ069** | Service encounter has been refused as you have previously billed HSC 33.59A at the same encounter. |
| **MJ070** | Service encounter has been refused as you have previously billed HSC 34.32 at the same encounter. |
| **MJ071** | Service encounter has been refused as you have previously billed HSC 34.31 at the same encounter. |
| **MJ072** | Service encounter has been refused as you have previously billed HSC 34.42 at the same encounter. |
| **MJ073** | Service encounter has been refused as you have previously billed HSC 34.42A, 34.54A or 34.54B at the same encounter. |
| **MJ074** | Service encounter has been refused as you have previously billed HSC 34.42A at the sae encounter |
| **MJ075** | Service encounter has been refused as you have previously billed HSC 34.54A or 34.54B at the same encounter. |
| **MJ076** | Service encounter has been refused as you have previously billed HSC 34.4A at the same encounter. |
| **MJ077** | Service encounter has been refused as you have previously billed HSC 34.55 or 34.54A at the same encounter. |
| **MJ078** | Service encounter has been refused as HSC 34.54A and 34.54B may not be claimed together at the same encounter. |
| **MJ079** | Service encounter has been refused as HSC 34.55 and 34.54A may not be claimed together at the same encounter. |
| **MJ080** | Service encounter has been disallowed as you have already claimed HSC 33.22A or 34.0A at the same encounter which is considered to be an included part of the procedure. |
| **MJ081** | Service encounter has been refused as there is already a paid claim on history for HSC 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B, 97.77, 98.51B, 98.51C, 98.51D or 98.51E at the same encounter. |
| **MJ082** | Service encounter has been refused as there is already a paid claim on history for HSC 97.79B at the same encounter. |
| **MJ083** | Service encounter has been refused as there is already a paid claim on history for HSC 97.43, 97.44, 98.98, 97.6B, 97.6C, 97.6D, 97.75A, 97.77, 98.51B, 98.51C, 98.51D or 98.51E at the same encounter. |
| **MJ084** | Service encounter has been refused as there is already a paid claim on history for HSC 97.44A at the same encounter. |
| **MJ085** | Service encounter has been refused as there is already a paid claim on history for HSC 97.99B at the same encounter. |
| **MJ086** | Service encounter has been refused as HSC 26.29F may only be claimed once per eye per surgical encounter. |
| **MJ087** | Service encounter has been refused as HSC 26.25, 26.25D, 26.29D, 26.29E or 26.34 has already been claimed at the same encounter. |
| **MJ088** | Service encounter has been refused as HSC 26.29F has already been claimed at the same encounter. |
| **MJ089** | Service encounter has been refused as HSC 26.29G may only be claimed once per eye per surgical encounter. |

| Explanatory Code | Description |
|---|---|
| **MJ090** | Service encounter has been refused as HSC 26.25, 26.25C, 26.25D, 26.29E or 26.34 has already been claimed at the same encounter. |
| **MJ091** | Service encounter has been refused as HSC 26.29G has already been claimed at the same encounter. |
| **MJ092** | Service encounter has been refused as HSC 92.89N cannot be claimed with HSC 91.35A or 91.35C at the same encounter. |
| **MJ093** | Service encounter has been refused as you have previously claimed HSC 72.1A, 72.1B, 72.1C or 72.1D at the same encounter. |
| **MJ094** | Service encounter has been effused as you have previously claimed 71.2E at the same encounter. |
| **MJ095** | Service encounter has been refused as HSC 92.84B has already been claimed for this patient on this day. |
| **MJ096** | Service encounter has been refused as HSC 92.is a composite fee and may not be claimed at the same service occurrence as any other procedures involving the hip. |
| **MJ097** | Service encounter has been refused as HSC 92.is a composite fee. No other procedures involving the hip may be claimed at the same service occurrence. |
| **MN001** | Service encounter has been disallowed as it is included in the delivery. |
| **MN002** | Service encounter has been disallowed as compression sclerotherapy includes after care for one year. |
| **MN003** | Service encounter has been disallowed. When a visit and a surgical procedure are claimed together, only one is approved. |
| **MN004** | Service encounter has been disallowed. When a visit and minor surgery are performed at the same service encounter, only one is approved. |
| **MN005** | Service encounter has been refused as this procedure has been performed within the previous 7 days. |
| **MN006** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **MN007** | Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%. |
| **MN008** | Service encounter has been refused as it is an uninsured service for patients under one year of age. |
| **MN009** | Service encounter has been reduced. When multiple procedures are performed at the same encounter, only one is approved at 100%. |
| **MN010** | Service encounter has been disallowed as it is included in the fee for the adenoidectomy. |
| **MN011** | Service encounter has been disallowed as procedure claimed and a consultation are not both payable. |
| **MN012** | Service encounter has been disallowed as you have already claimed this service for this patient on the same day. |
| **MN014** | Service encounter has been refused as HSC 60.52A cannot be claimed with 60.52B at the same encounter. |
| **MN015** | Service encounter has been disallowed as you previously billed at the same encounter a service where suturing of the skin is included in the procedure. |
| **MN016** | Service encounter has been refused as you have previously claimed for an insertion or removal with or without reinsertion of a penile prosthesis at the same encounter which includes any urethral dilation required to insert the device. |
| **MN017** | Service encounter has been refused as you have previously billed HSC 34.31, 34.32, 34.54A, 34.54B or 34.55 at the same encounter. |
| **MN018** | Service encounter has been refused as this procedure is considered part of the surgery performed at the same encounter. |
| **MN019** | Service encounter has been refused as there is already a paid claim on history for HSC 97.77, 98.51B, 98.51D or 98.51E at the same encounter. |

| Explanatory Code | Description |
|---|---|
| **MS001** | Service encounter has been refused. Complete details are necessary when billing this service. |
| **NR001** | Service encounter has been adjudicated based on a decision by the medical consultant. |
| **NR002** | Service encounter has been approved under the appropriate code. |
| **NR003** | Service encounter has been refused as a second assistant is not approved for this service. |
| **NR004** | Service encounter has been adjudicated based on the fee payable for the assistant. |
| **NR005** | Service encounter has been adjudicated based on the fee payable to the second assistant. |
| **NR006** | Service encounter has been disallowed. Indicate actual procedure performed when resubmitting. |
| **NR007** | Service encounter has been approved at the general practice rate re age of patient. |
| **NR008** | Service encounter has been refused. Submit a new service encounter once approval has been received from the psychotherapy waiver review committee. |
| **NR009** | Please delete original submission and submit a new service encounter for a partial eye exam. |
| **NR010** | Service encounter has been refused as this visit is not payable during intensive care. |
| **NR011** | Service encounter has been refused as date of service appears incorrect according to our records. |
| **NR012** | Service encounter has been adjusted based on information provided by MSI audit. |
| **NR013** | Service encounter has been refused. Delete original submission and resubmit using the appropriate modifier of region both. |
| **NR014** | Service encounter has been disallowed. Resubmit with a copy of the pathology report to aid in the adjudication of your service encounter. |
| **NR015** | Service encounter has been approved at the internal medicine rate re age of patient. |
| **NR016** | Service encounter has been disallowed as all the requirements for billing this service have not been met. |
| **NR017** | Service encounter has been refused as a previous payment covers all or a portion of this combination. |
| **NR018** | Service encounter has been refused as previous payment covers this submission. |
| **NR019** | Service encounter has been refused as this same service has been approved for another provider. |
| **NR020** | Service encounter has been refused. Resubmit using the appropriate service occurrence number. |
| **NR021** | Service encounter has been adjudicated based on the time indicated for the consecutive anaesthetist. |
| **NR022** | Service encounter has been adjudicated according to the weekly maximum payable after 56 days of hospitalization. |
| **NR023** | Service encounter has been disallowed as a pap smear is not payable with a visit for a gynaecological or obstetrical diagnosis. |
| **NR024** | Service encounter has been adjusted in accordance with the surgical rules described in the Preamble. |
| **NR025** | Service encounter has been adjudicated based on the Preamble ruling for outdated submissions. |
| **NR026** | Service encounter has been refused as the hospital admit date indicated is incorrect. |
| **NR027** | Service encounter has been adjudicated based on Preamble rules. |
| **NR028** | Service encounter has been adjudicated based on payment for a bilateral procedure. |
| **NR029** | Resubmit under the appropriate health service code for this bilateral procedure. |
| **NR030** | Service encounter has been disallowed as medical necessity was not indicated. |
| **NR031** | Service encounter has been disallowed as the appropriate documentation has not been received. |
| **NR032** | Service encounter has been disallowed as copies of the referral letter and consult report are required. |
| **NR033** | Service encounter has been disallowed as the required WCB form was not received within the appropriate time. |
| **NR034** | Service encounter has been adjudicated according to the rate set by workers' compensation board. |
| **NR035** | Service encounter has been refused as region (right, left, both) was not indicated. |

| Explanatory Code | Description |
|---|---|
| **NR036** | Service encounter may be readjudicated according to the submission by the surgeon. |
| **NR037** | Service encounter has been disallowed as the injection indicated is not on the provincial immunization list. |
| **NR038** | Service encounter has been disallowed as the tray fee is not applicable for service provided. |
| **NR039** | Service encounter has been accepted at zero as it is outdated. |
| **NR040** | Service encounter has been refused as prior approval number indicated is not valid. |
| **NR041** | Service encounter has been disallowed as the maximum number of this type of visit allowed without a prior approval number has been approved for this episode. |
| **NR042** | Service encounter has been disallowed as the maximum number of preauthorized visits for this episode has been approved. |
| **NR043** | Service encounter has been disallowed as the maximum number of encounters for this service per year has been reached. |
| **NR044** | Service encounter has been disallowed as the maximum number of well baby visits allowed has been approved for payment. |
| **NR045** | Service encounter has been refused. Resubmit using the appropriate health service code(s) as listed in the Physician's Manual and/or Physician's Bulletin. |
| **NR046** | Service encounter payment has been calculated based on the percentage payable on the total major surgical procedural fee(s) excluding the premium fee portion. |
| **NR047** | Service encounter has been refused. Resubmit using the appropriate health service code based on information provided. |
| **NR048** | Service encounter has been refused. Resubmit indicating the base units used for the procedure performed. |
| **NR049** | Service encounter has been refused. Resubmit indicating the correct region. |
| **NR050** | Service encounter has been disallowed as text provided does not warrant approval. |
| **NR051** | Patient history transfer has occurred due to duplicate registration of individual. Patient history will now appear under the active registration number. |
| **NR052** | Service encounter has been refused as previous payment has occurred under an incorrect HCN. Internal adjustment will be made to correct our records. |
| **NR053** | Service encounter has been refused as the business arrangement indicated is incorrect according to our records. |
| **NR054** | Service encounter has been disallowed. Delete the original submission and submit a new service encounter under the appropriate business arrangement. |
| **NR055** | Service encounter has been disallowed as patient history indicates conflicting intensive care admit dates. Confirm intensive care admit date and submit a reassess (action code R) once you have verified the date you have indicated is correct. |
| **NR056** | Service encounter has been adjudicated based on information published in a Physician's Bulletin. |
| **NR058** | Service encounter has been adjudicated based on information contained in the Physician's Manual. |
| **NR059** | Service encounter has been refused as electronic text was not present explaining date of service and modifier used in relation to intensive care admit date indicated. |
| **NR060** | Service encounter has been refused. Delete the original submission and submit a new encounter based on the information you have provided. |
| **NR061** | Service encounter has been refused re diagnosis indicated. |
| **NR062** | Service encounter has been refused as this service is only insured in conjunction with prescribed medication. An over-the-counter drug or product is not insured. |
| **NR063** | Service encounter has been refused as diagnosis indicated does not warrant approval of a comprehensive visit. |
| **NR064** | Service encounter has been refused. Referring provider indicated is invalid for referral. |

| Explanatory Code | Description |
|---|---|
| **NR065** | Service encounter has been adjudicated based on telephone conversation. |
| **NR066** | Service encounter has been refused as hospital admit date is incorrect. |
| **NR067** | Service encounter has been refused as intensive care admit date is incorrect. |
| **NR068** | Service encounter has been adjudicated based on the operative and/or pathology report. |
| **NR069** | Service encounter has been refused. Resubmit a new service encounter based on information published in the Physician's Bulletin. |
| **NR070** | Service encounter has been adjudicated based on the time indicated for the simultaneous anaesthetist. |
| **NR071** | Indicate type of anaesthesia (general or local) for procedure performed. |
| **NR072** | Service encounter has been disallowed. Submit a reassess (action code R) along with a copy of the operative report to aid in the assessment of your service encounter. |
| **NR073** | Service encounter has been disallowed as a pap smear is not payable in addition to a visit, consultation or procedure for a gynaecological or obstetrical diagnosis. |
| **NR074** | Service encounter has been refused. A maximum of one hour only for a Palliative Care Support Visit is payable per patient per day. |
| **NR075** | Service encounter for tray fee has been adjusted to agree with number of injections approved. |
| **NR076** | Service encounter has been adjudicated based on diagnosis indicated. |
| **NR077** | Service encounter has been adjudicated based on correspondence from MSI. |
| **NR078** | Service encounter has been disallowed. Submit a reassess (action code R) along with a copy of the outpatient report to aid in the assessment of your service encounter. |
| **NR079** | Service encounter payment has been calculated based on the percentage payable on the total major surgical procedure(s). |
| **NR080** | Service encounter has been refused as the pay to code is not BAPY. |
| **NR081** | Service encounter has been adjudicated according to the weekly maximum of 80 units per week after 56 days from admission. |
| **NR082** | Please contact MSI regarding this claim. |
| **NR083** | Service encounter has been refused as a substance other than air was injected. |
| **NR084** | Service encounter has been refused. Resubmit using the appropriate health service code. If there is no code for the service you are trying to claim, please contact Doctors NS to apply for a new fee. |
| **NR085** | Service encounter has been paid as a result of a pre-payment assessment review. |
| **NR086** | Request for readjudication has been refused. Delete this submission and submit a new encounter based on the information you have provided. |
| **NR087** | Service encounter has been refused as you have previously billed HSC 71.7F at the same encounter. |
| **NR088** | Service encounter has been refused as you have previously claimed for urethral dilation at the same encounter. This service includes any urethral dilation required to insert the device. |
| **NR089** | Service encounter has been refused as this procedure should only be billed from a hospital location. If valid reason exits for billing this procedure from a location other than hospital, please resubmit with supporting documentation. |
| **OB001** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **OB002** | Service encounter has been disallowed as you have previously been approved for transfer during labour. |
| **PC002** | Service encounter has been refused as psychotherapy or counselling and a visit are not payable at the same service encounter. |
| **PC003** | Service encounter has been refused. A maximum of 90 continuous minutes of individual psychotherapy only is allowed per patient per day. |

| Explanatory Code | Description |
|---|---|
| **PC004** | Service encounter has been refused as a minimum of one-half hour must be spent per visit for psychotherapy to be payable. |
| **PC005** | Service encounter has been refused as patient is under four years of age. |
| **PC006** | Service encounter has been adjudicated according to total hours approved in the previous 365 days. |
| **PC007** | Service encounter has been refused as another physician is providing psychotherapy to this patient. |
| **PC008** | Service encounter has been refused. A maximum of 2 hours of group psychotherapy only is allowed per patient per day. |
| **PC009** | Service encounter has been refused. A maximum of 2 hours of family therapy only is allowed per patient per day. |
| **PC010** | Service encounter has been refused as you have previously been approved the intensive care daily rate this day. |
| **PC011** | Service encounter has been refused. A maximum of 90 minutes of hypnotherapy only is allowed per patient per day. |
| **PC012** | Service encounter has been refused. A minimum of one-half hour must be spent per visit for hypnotherapy to be payable. |
| **PC013** | Service encounter has been refused. A maximum of one hour of counselling only is allowable per patient per day. |
| **PC014** | Service encounter has been refused. A maximum of 30 minutes of lifestyle counselling only is allowable per patient per day. |
| **PC015** | Service encounter has been refused as you have not indicated that a waiver or prior approval has been issued. Maximum limit of 15 hours per year for individual psychotherapy has previously been approved. |
| **PC016** | Service encounter has been refused as you have not indicated that a waiver or prior approval has been issued. Maximum limit of 15 hours per year of group psychotherapy has previously been approved. |
| **PC017** | Service encounter has been refused. Maximum limit of 15 hours of family therapy per year has previously been approved. |
| **PC018** | Service encounter has been refused. Maximum limit of 10 hours of hypnotherapy per year has previously been approved. |
| **PC019** | Service encounter has been refused. Maximum limit of 5 hours of counselling per year has previously been approved. |
| **PC020** | Service encounter has been refused. Maximum limit of 2 hours of lifestyle counselling per year has previously been approved. |
| **PC021** | Service encounter has been approved at the maximum allowed per day for this service. |
| **PC022** | Service encounter has been disallowed as patient is 19 years of age or greater. |
| **PC023** | Service encounter has been disallowed as location and/or provider specialty is not appropriate for service claimed. |
| **PC024** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for individual psychotherapy has previously been approved. |
| **PC025** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for group psychotherapy has previously been approved. |
| **PC026** | Service encounter has been refused. Maximum limit of 20 hours of family therapy per year has previously been approved. |
| **PC027** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for family therapy has previously been approved. |
| **PC028** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for group therapy has previously been approved. |

| Explanatory Code | Description |
|---|---|
| **PC029** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for individual therapy has previously been approved. |
| **PC030** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 10 hours per year for hypnotherapy has previously been approved. |
| **PC031** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 2 hours per year for lifestyle counselling has previously been approved. |
| **PC032** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 5 hours per year for counselling has previously been approved. |
| **PC033** | Service encounter has been refused as psychotherapy or counselling and a consult are not payable at the same service encounter. |
| **PC034** | Service encounter has been disallowed as you do not have approval to bill for this service. Please submit your qualifications to provide hypnotherapy to MSI. |
| **PC035** | Service encounter has been refused as the maximum of 8 sessions for mindfulness based cognitive therapy in a 365-day period has been reached. |
| **PC036** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 9 hours for a PSP physician per year for counselling has previously been approved. |
| **PV001** | Service encounter has been refused as your collaborative practice declaration form must be submitted before claiming CFP1. |
| **PV002** | Service encounter has been refused as only ME=CARE eligible physicians may claim CFP1. |
| **PV003** | Service encounter has been refused as you have already claimed this HSC in the current month. |
| **PV004** | Service encounter has been refused as you have already claimed this HSC 12 times during the current fiscal year. |
| **PV005** | Service encounter has been refused as you have already claimed a CFP1A during the current fiscal year. |
| **RF001** | Service encounter has been refused. No adjustment is warranted. |
| **RF002** | Service encounter has been refused. Delete original submission(s) and submit new action code A transaction based on correct information or information provided by you. |
| **RF003** | Request for readjudication has been refused. Approval for this request has been previously processed. |
| **RF004** | Request for readjudication has been refused. Denial of this request has been previously processed. |
| **RF005** | Payment under this visit service cannot be approved. Delete the original service encounter and submit under the appropriate subsequent visit service. |
| **VA001** | Service encounter has been disallowed as a pap smear is not payable with a comprehensive evaluation. |
| **VA002** | Service encounter has been refused as this service is included in the consultation. |
| **VA003** | Service encounter has been reduced. When multiple diagnostic and therapeutic procedures are performed, only the fee for one is approved at 100%. |
| **VA004** | Service encounter has been disallowed as this procedure cannot be claimed in addition to the basic units for cardiac bypass. |
| **VA005** | Service encounter has been disallowed as it is included in limited prenatal and postnatal visits. |
| **VA006** | Service encounter has been disallowed as it is included in the delivery. |
| **VA007** | Service encounter has been disallowed as venipuncture is not payable in hospital unless medical necessity exists. |
| **VA008** | Service encounter has been refused as service is not approved in location indicated. |
| **VA009** | Service encounter has been disallowed as the maximum limit per week has previously been approved. |

| Explanatory Code | Description |
|---|---|
| **VA010** | Service encounter has been disallowed as local anaesthetic is not approved when performed in conjunction with minor surgery. |
| **VA011** | Service encounter has been refused as you have previously been approved a consultation with detention at the same service encounter. |
| **VA012** | Service encounter has been refused as venipuncture is included in the comprehensive prenatal exam. |
| **VA013** | Service encounter has been refused as modifier value indicated and patient's age do not agree. |
| **VA014** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **VA015** | Service encounter has been disallowed as this service is included in a visit or consultation. |
| **VA016** | Service encounter has been refused as this service is included in the fee for a complete eye exam. |
| **VA017** | Service encounter has been refused as your specialty is not approved for performing this procedure. |
| **VA018** | Service encounter has been reduced. When multiple diagnostic and therapeutic procedures are performed, only one is approved at 100%. |
| **VA019** | Service encounter has been refused as it is a stand-alone procedure and another service has been approved. |
| **VA020** | Service encounter has been refused as a previous stand-alone procedure has been approved. |
| **VA021** | Service encounter has been refused as you have previously been approved a visit with detention at the same service encounter. |
| **VA022** | Service encounter has been refused as this service is included in the comprehensive visit. |
| **VA023** | Service encounter has been refused. This service is included in the comprehensive visit. |
| **VA024** | Service encounter has been refused as this procedure is included in the comprehensive visit. |
| **VA025** | Service encounter has been disallowed as this service is included in the surgery. |
| **VA026** | Service encounter has been refused as the provider must be a qualified allergist. |
| **VA027** | Service encounter has been refused as this service is only approved at hospital locations. |
| **VA028** | Service encounter has been disallowed as this service is included in the visit previously approved at this same service encounter. |
| **VA029** | Service encounter has been disallowed as this procedure is included in the previously approved visit. |
| **VA030** | Service encounter has been disallowed as local anaesthesia is not payable in addition to the surgical fee. |
| **VA031** | Service encounter has been refused as a comprehensive examination for the same or similar diagnosis has been approved to you within the past year. Please provide further details regarding the medical necessity of this complete examination. |
| **VA032** | Service encounter has been refused as a comprehensive examination has been paid to you within the last year. |
| **VA033** | Service encounter has been refused as you have already claimed the maximum of four subsequent days for invasive EEG video telemetry. |
| **VA034** | Service encounter has been refused as you have already claimed the maximum of nine subsequent days for non-invasive EEG video telemetry. |
| **VA035** | Service encounter has been refused as you cannot claim electrophysiology studies on the same day as the insertion of CRT pacemaker/defibrillator device. |
| **VA036** | Service encounter has been refused as you have already billed the maximum of four angioplasties for the same encounter. |
| **VA037** | Service encounter has been disallowed as the injection used to treat wet AMD has not been specified. Please resubmit, indicating the injected substance. |
| **VA038** | Service encounter has been refused as the maximum of six OCT fees have already been claimed for this patient within the past year. |

| Explanatory Code | Description |
|---|---|
| **VA039** | Service encounter has been refused as you have already claimed an angioplasty for the same extremity or region during this encounter. |
| **VA040** | Service encounter has been refused as an angioplasty can only be billed from a hospital location. |
| **VA041** | Service encounter has been refused as you have already billed 2 vessels for this side. |
| **VA042** | Service encounter has been refused as you have previously claimed a pay smear or tray fee for this patient on the same day. |
| **VA043** | Service encounter has been refused as you have previously claimed a pelvic examination for this patient on the same day. |
| **VA044** | Service encounter has been refused as you cannot claim a tray fee with a pelvic examination (HSC 03.26C). |
| **VA045** | Service encounter has been disallowed as HSC 69.94 requires text indicating why the catheter insertion was performed by the physician. |
| **VA046** | Service encounter has been refused as only one 09.13B can be paid in a 365-day period. |
| **VA047** | Service encounter has been refused. HSC 03.26A and 03.26C is included in the complete care code 81.8 which was previously billed for this patient on this day. |
| **VA048** | Service encounter has been refused as cystoscopy cannot be billed in addition to HSC 71.4B. |
| **VA049** | Service encounter has been refused as a 01.14C, 54.71, or 54.92E has been billed at this same encounter. |
| **VA050** | Service encounter has been refused as a 01.14H has been billed at the same encounter. |
| **VA051** | Service encounter has been refused as a 49.95A, 49.95B, 49.96A,B,C,D,E,F,G,H, 49.97A,B,C,D,E,F,G, 49.98A,B,C,D,E,F,G,H, 50.83, 50.91, 50.98A, or 13.72 has been billed at this same encounter. |
| **VA052** | Service encounter has been refused as a 49.98I has been billed at this same encounter. |
| **VA053** | Service encounter has been refused as you have previously billed HSC 50.37D at the same encounter. |
| **VA054** | Service encounter has been refused as you have previously billed HSC 50.37A at the same encounter. |
| **VA055** | Service encounter for surgical assist has been refused as the role of second physician was previously billed for this service. |
| **VA056** | Service encounter has been refused as the diagnostic code provided is not valid for this service. |
| **VA057** | Service encounter has been refused as tonometry cannot be claimed with cataract surgery. |
| **VA058** | Service encounter has been refused as HSC 60.24C has previously been billed for this patient on this day. |
| **VA059** | Service encounter has been refused as HSC 71.4D has already been billed on this day which includes cystoscopy. |
| **VA060** | Service encounter has been refused as you have previously billed HS 09.02 or 09.04 for this patient at the same encounter. |
| **VA061** | Service encounter has been refused as only six 03.19H can be billed per patient per year for this diagnosis. |
| **VA062** | Service encounter has been refused as only two 03.19H can be billed per patient per year for this diagnosis. |
| **VA063** | Service encounter has been refused as the diagnostic code used us not valid for this service. |
| **VA064** | Provider is not permitted to claim for this service and must contact the medical consultant for approval. |
| **VA065** | Service encounter has been refused as you have previously billed for a colectomy with coloproctostomy at this encounter. |
| **VA066** | Service encounter has been refused as you have previously billed 60.59B at the same encounter. |
| **VA067** | Service encounter has been refused as you have previously billed HSC 09.02H at the same encounter. |
| **VA068** | Service encounter has been disallowed as you have previously billed HSC 13.59L at the same encounter. |

| Explanatory Code | Description |
|---|---|
| **VA069** | Service encounter has been refused as you have previously billed for an ultrasound fee at the same encounter. Genetic sonogram includes all necessary imaging. Please submit a delete for original interpretation before resubmitting genetic sonogram. |
| **VA070** | Service encounter has been refused as only one optic nerve imaging fee can be billed per year for this diagnosis. |
| **VA071** | Service encounter has been refused as the maximum of 6 claims allowed per year for this service have been approved. |
| **VA072** | Service encounter has been disallowed as there is already a claim at the same encounter for a procedure that includes intravenous insertion. |
| **VA073** | Service encounter has been refused as a claim for dialysis has already been billed for this patient on this day. |
| **VA074** | Service encounter has been refused as only one fee for either HSC 09.41E, 09.41F or 09.41G should be claimed per patient per day. |
| **VA075** | Service encounter has been refused as you have previously billed HSC 09.41D at the same encounter which includes this procedure. |
| **VA076** | Service encounter has been refused as HSC 09.41A, 09.41B or 09.41H has already been billed at the same encounter and is a component of this procedure. |
| **VA077** | Service encounter has been disallowed, please resubmit with documentation indicating that the service was provided by the physician, not another professional. |
| **VA078** | Service encounter has been refused as you have already billed an esophagogastroduodenoscopy code at the same encounter. |
| **VA079** | Service encounter has been refused as you must bill the appropriate base fee for bronchoscopy or esophagoscopy. |
| **VA080** | Service encounter has been refused as HSC 27.72, 27.72B, 27.73, 27.73A or 27.73B was billed at the same encounter and includes this procedure. |
| **VA081** | Service encounter has been disallowed as a claim for 51.95 RP=INTL has already been claimed for this patient. |
| **VA082** | Service encounter has been disallowed; insertion of the indwelling urinary catheter can not be claimed with any other procedure fees during the same encounter. |
| **VA083** | Service encounter has been disallowed as you have previously billed 72.1B at the same encounter. If an additional cystoscopic procedure is required, please resubmit with supporting text. |
| **VA084** | Service encounter has been disallowed as you have previously billed a major surgery procedure at the same encounter. |
| **VA085** | Service encounter has been refused as you have previously billed HSC 97.99A at the same encounter. |
| **VA086** | Service encounter has been refused as a visit or consult has already been claimed at the same encounter. HSC 49.83B and 49.83C include the accompanying visit in the health service description. |
| **VA087** | Service encounter has been refused as you have previously claimed for an insertion or removal with or without reinsertion of a penile prosthesis at the same encounter which includes any urethral dilation required to insert the device. |
| **VA088** | Service encounter has been disallowed. Please resubmit, indicating in the text field this claim is for the removal of an intradermal device. |
| **VA089** | Service encounter has been disallowed as HSC 50.99A requires text indicating the intravenous was performed by the physician. |
| **VA090** | Service encounter has been refused as the previously billed HSC 09.41E, F or G includes tympanometry. |
| **VA091** | Service encounter has been refused. HSC 09.41E, F or G cannot be billed at the same encounter has HSC 09.41H as they include tympanometry. |

| Explanatory Code | Description |
|---|---|
| **VA092** | Service encounter has been refused as a claim for either battery or leads replacement/adjustment has already been claimed on this day which includes any necessary programming. |
| **VA093** | Service encounter has been disallowed as it is included in the remuneration of another service recently billed for this patient. |
| **VA094** | Service encounter has been refused as electronic text is required on the claim stating type of medication and any additional risk factors. |
| **VA095** | Service encounter has been refused as the maximum number of OCT fees per year for this diagnosis have previously been claimed in the past year. |
| **VA096** | Service encounter has been refused as HSC 02.84A is a stand-alone procedure and may not be claimed with any other ultrasounds during the same encounter. |
| **VA097** | Service encounter has been refused as you have previously billed HSC 01.09D or 01.09E for this patient at the same encounter |
| **VA098** | Service encounter has been refused as you have previously billed 01.08A, 01.09, 01.09A or B, 46.82, 46.82A or B for this patient at the same encounter. |
| **VA099** | Service encounter has been disallowed as you have not included text stating the number of stations or structures. |
| **VA100** | Service encounter has been refused as you have previously claimed one of the following health service codes: 50.99C, 50.06C, or 50.08B. These services are considered to be inclusive of the current claim. |
| **VA101** | Service encounter has been disallowed as you have previously claimed one of the following health service codes: 50.82, 50.82C or 50.88A. These services are considered to be inclusive of the current claim. |
| **VA102** | Service encounter has been refused as you have previously claimed on of the following comprehensive health service codes: 48.0A, 48.0C, 48.0F. |
| **VA103** | Service encounter has been disallowed as you have previously claimed one of the following comprehensive health service codes: 48.0A, 48.0C, 48.0F. |
| **VA104** | Service encounter has been refused as you have previously claimed HSC 48.0A percutaneous coronary angioplasty during this encounter. The claim for coronary angioplasty includes selective coronary angiography. |
| **VA105** | Service encounter has been disallowed as you have previously claimed a portion of this fee (HSC 48.98B selective coronary angiography) during this encounter. Please submit a reversal for the prior 48.98B before submitting a reassessment request for this comprehensive claim. |
| **VA106** | Service encounter has been refused as a claim for Community Pharmacy-led Anticoagulant Management Service (CPAMS) has previously been billed for this patient in the same month. |
| **VA107** | Service encounter has been refused as a claim 13.99H (CPAMS) has previously been billed for this patient in the same month. 13.99C cannot be claimed with this fee. |
| **VA108** | Service encounter has been refused as a claim for 13.99C has previously been billed for this patient in the same month. 13.99H (CPAMS) cannot be claimed with this fee. |
| **VA109** | Service encounter has been refused as you have previously billed HSC 09.13A at the same encounter. |
| **VA110** | Service encounter has been refused as you have previously billed HSC 09.13A at the same encounter. |
| **VA111** | Service encounter has been refused as you have previously billed HSC 03.12, 09.13A or 19.13B at the same encounter. |
| **VA112** | Service encounter has been refused as you have previously billed HSC 02.02C at the same encounter. |
| **VA113** | Service encounter has been refused as you must submit your signed declaration of subspecialty training and competency in order to claim ERCP health service codes. |
| **VE001** | Service encounter has been disallowed as visit excluded procedures are included in the consultation. |
| **VE002** | Service encounter has been reduced. When multiple diagnostic and therapeutic procedures are performed, only the fee for one is approved at 100%. |

| Explanatory Code | Description |
|---|---|
| **VE003** | Service encounter has been disallowed. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **VE004** | Service encounter has been disallowed as visit excluded procedures and a visit are not payable at the same service encounter. |
| **VE005** | Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved. |
| **VE006** | Service encounter has been disallowed as this service applies only to patients in the insured age group. |
| **VE007** | Service encounter has been refused as the conduction of anaesthesia for relief of pain in labour has already been claimed for this patient. |
| **VE008** | Service encounter has been refused as you have previously billed HSC 09.03A for this patient at the same encounter. |
| **VE009** | Service encounter has been refused as this service has already been claimed for this patient on the same day. |
| **VE010** | Service encounter has been refused as HSC I1110 or I1140 has already been claimed for this patient on this day. |
| **VE011** | Service encounter has been refused as you have previously billed one of the following services at the same encounter 03.12, 09.01A, 09.05 or 09.13B. |
| **VE012** | Service encounter has been disallowed as the maximum limit per year has already been approved for this service. |
| **VE013** | Service encounter has been refused as a physician has previously billed another pulmonary function test for this patient on the same day. |
| **VE014** | Service encounter has been refused as a physician has previously billed for a stand-alone fee 03.38D for this patient on the same day. |
| **VE015** | Service encounter has been refused as you cannot bill 03.38B and 03.38C on the same day. |
| **VE016** | Service encounter has been refused as the patient requires one previously billed cataract surgery in the past year to claim for the third examination in a year, or two cataract surgeries for the fourth examination. |
| **VE017** | Service encounter has been refused as HSC 04.49B has already been claimed for this patient on this day. |
| **VE018** | Service encounter has been refused as HSC 04.49A has already been claimed for this patient on this day. |
| **VE019** | Service encounter has been refused as you have previously billed HSC 66.89A at the same encounter. |
| **VE020** | Service encounter has been refused as an injection of ONA for chronic migraine has already been approved in the previous 10 weeks. |
| **VE021** | Service encounter has been refused as no more than 11 injections of ONA for chronic migraine may be claimed over a 24-month period. If treatment continues to be recommended after this time period, prior approval must be requested again. |
| **VE022** | Service encounter has been refused as a claim for assessment and management of a patient with acute stroke was previously made for this patient on this day. |
| **VE023** | Service encounter has been refused as this facility is not authorized to claim the acute stroke protocol fee. |
| **VE024** | Service encounter has been refused as this service may only be claimed from the QEII. |
| **VE025** | Service encounter has been refused as you previously claimed a visit with this patient in the last 30 days. |
| **VE026** | Service encounter has been refused as no other fees are payable during the same time period as HSC 03.39T. |

| Explanatory Code | Description |
|---|---|
| **VE027** | Service encounter has been refused as no other fees are payable during the same time period as HSC 03.09A. |
| **VE028** | Service encounter has been refused as a chronic dialysis management daily treatment and supervision fee has already been claimed for this patient on that date. |
| **VE029** | Service encounter has been disallowed as an outpatient visit or consult from a related specialty has been claimed for this patient on that date. |
| **VE030** | Service encounter has been refused as the specialty submitted may only claim this service from the Yarmouth Regional Hospital. |
| **VE031** | Service encounter has been refused as another chronic dialysis fee has already been claimed for this patient on that date. |
| **VE032** | Service encounter has been refused as HSC R1135, R1141, R1145 or R1180 has already been claimed for this patient at the same encounter. |
| **VE033** | Service encounter has been refused as you have previously claimed a separate fee for a portion of this service on the same date. |
| **VE034** | Service encounter has been refused as you have previously claimed the comprehensive transcutaneous aortic valve implantation (TAVI) fee for this patient on this day. |
| **VE035** | Service encounter has been disallowed as this interpretation is included in the comprehensive fee for transcutaneous aortic valve implantation performed on that date. |
| **VE036** | Service encounter has been disallowed as a claim for access or visualization has already been claimed at the same encounter. HSC 50.0B is a comprehensive fee that includes all access and visualization. |
| **VE037** | Service encounter has been refused as this service may only be billed once per patient. |
| **VE038** | Service encounter has been refused as this service may not be claimed with any other autopsy HSC. |
| **VE039** | Service encounter has been refused as HSC 03.8C has already been claimed at the same encounter. |
| **VE040** | Service encounter has been disallowed as this service may not be billed if performed as part of a complete autopsy. |
| **VE041** | Service encounter has been refused. You may not claim a visit and 99.82A or 99.82B with the same diagnosis within the same week |
| **VE042** | Service encounter has been refused as you have previously billed health service code 99.82A or 99.82B for this patient in the previous week |
| **VE043** | Service encounter has been disallowed as you have not included text referring to the inspired program. Please resubmit with appropriate text |
| **VE044** | Service encounter has been disallowed as prior approval is required for this service. |
| **VT001** | Service encounter has been disallowed as this service is included in the postoperative care of fractures. |
| **VT002** | Service encounter for comprehensive evaluation has been refused as a comprehensive evaluation has been approved in the previous 30 days. |
| **VT003** | Service encounter for in-patient comprehensive evaluation has been refused as another incpa-patient comprehensive evaluation has been approved to you or another physician in your specialty for this admission. |
| **VT004** | Service encounter has been disallowed as an in-patient comprehensive evaluation has previously been approved and the patient has been readmitted within 30 days for the same or related condition. |
| **VT005** | Service encounter has been refused as the patient has been readmitted within 10 days for the same or similar diagnosis. |
| **VT006** | Service encounter has been refused as a comprehensive pregnancy exam has been approved during the previous nine months to you or another physician. |

| Explanatory Code | Description |
|---|---|
| **VT007** | Service encounter has been refused as a previous postnatal care visit has been approved to you or another physician. |
| **VT008** | Service encounter has been disallowed as a complete care code includes a visit the same day and related visits for the following 14 days. |
| **VT009** | Service encounter has been disallowed as a fracture procedure has been approved to you on the same day or in the previous 14 days. |
| **VT010** | Service encounter has been disallowed as a well baby visit is not payable after one year of age. |
| **VT011** | Service encounter has been disallowed as a well baby visit has been approved to you or another physician during this age interval. |
| **VT012** | Service encounter has been disallowed as after six months of age well baby visits are approved on the basis of once every three months up to one year of age. |
| **VT013** | Service encounter for comprehensive visit has been refused as you have been approved a consultation in the previous 30 days. |
| **VT014** | Service encounter has been disallowed as the maximum number of prenatal visits have been approved. |
| **VT015** | Service encounter has been disallowed as a post partum visit cannot be approved on the same day as a delivery. |
| **VT016** | Service encounter has been refused as you or another physician have previously been approved for first exam of healthy newborn. |
| **VT017** | Service encounter has been refused as newborn care of a healthy infant is only approved for the first five days after birth. |
| **VT018** | Service encounter has been disallowed as visit excluded procedures and a visit are not payable at the same service encounter. |
| **VT019** | Service encounter has been disallowed as another physician has been approved an inpatient hospital visit on this date. |
| **VT020** | Service encounter has been disallowed as this is included in the assist fee. |
| **VT021** | Service encounter has been refused as continuing or directive care must be preceded by a consultation. |
| **VT022** | Service encounter has been refused as a visit and psychotherapy or counselling are not payable at the same service encounter. |
| **VT023** | Service encounter has been refused as you have previously been approved a visit or consultation this day under the same service occurrence number. |
| **VT024** | Service encounter has been disallowed as this service is included in the preoperative care. |
| **VT025** | Service encounter has been disallowed as this service is included in the postoperative care. |
| **VT026** | Service encounter has been refused as you or another physician have previously been approved anticoagulant supervision for this same month. |
| **VT027** | Service encounter has been disallowed as contact lens fitting includes follow up for three months. |
| **VT028** | Service encounter for a visit on the same day as a stress test has been disallowed as the patient was seen in consultation in the previous 14 days. |
| **VT029** | Service encounter has been disallowed as a visit is not approved the same day as critical care. |
| **VT030** | Service encounter has been disallowed as compression sclerotherapy includes after care for one year. |
| **VT031** | Service encounter has been refused as detention is not payable in the office. |
| **VT032** | Service encounter for a visit with detention has been refused as you have previously been approved a visit allowed procedure at the same service encounter. |
| **VT033** | Service encounter has been adjudicated according to the weekly maximum of 44 units allowed per week after 56 days from admission. |

| Explanatory Code | Description |
|---|---|
| **VT034** | Service encounter has been disallowed as an inpatient comprehensive evaluation has previously been approved and the patient has been readmitted within 10 days for the same or related condition. |
| **VT035** | Service encounter has been disallowed as a comprehensive visit has been previously approved to you this day or subsequent day for the same or related condition. |
| **VT036** | Service encounter has been refused as a comprehensive visit has been approved to you in the previous 30 days. |
| **VT037** | Service encounter has been refused as a previous visit has been claimed by you in the previous 30 days. |
| **VT038** | Service encounter has been refused as you have been approved a consultation in the previous 30 days for the same or related diagnosis. |
| **VT039** | Service encounter for initial limited visit has been refused as you have attended this patient in the previous 30 days. |
| **VT040** | Service encounter has been disallowed as supportive care is approved once every three days up to and including the ninth day from admission and twice weekly thereafter. |
| **VT041** | Service encounter has been accepted at zero. The first postoperative clinic or office recheck should be claimed but will be approved at 0 units during the 90 days following major surgery. |
| **VT042** | Service encounter has been disallowed. When a visit and surgery are performed at the same service encounter, only one is approved. |
| **VT043** | Service encounter has been refused as a newborn care visit has previously been approved for this day. |
| **VT044** | Service encounter has been refused as modifier DA value is inappropriate after 56 days from admission. |
| **VT045** | Service encounter has been refused as this is an invalid service for age of patient. |
| **VT046** | Service encounter has been refused as health service code and modifier combination indicated is invalid for your specialty. |
| **VT047** | Service encounter has been refused as the maximum of three services per patient per day has been approved. |
| **VT048** | Service encounter has been disallowed as it is not payable in addition to the assistant fee. |
| **VT049** | Service encounter has been disallowed as it is included in the postoperative care of fractures. |
| **VT050** | Service encounter has been refused. Resubmit under the visit code using modifier for role of detention in conjunction with all other required modifiers. |
| **VT051** | Service encounter has been refused. You have previously been approved a comprehensive evaluation during this hospitalization. |
| **VT052** | Service encounter has been disallowed as a previous well baby visit has been approved for this three-month period. |
| **VT053** | Service encounter has been disallowed as it is included in the surgery performed at this same encounter. |
| **VT054** | Service encounter has been disallowed as it is included in the fracture procedure performed this same day. |
| **VT055** | Service encounter has been disallowed. Contact lens fitting includes follow up care for three months. |
| **VT056** | Service encounter has been disallowed as this service has been approved to you or another physician. |
| **VT057** | Service encounter has been disallowed as attendance with patient during labour is included in the delivery. |
| **VT058** | Service encounter has been refused as the patient has not yet reached the age of 65. |
| **VT059** | Service encounter has been refused. Two previous service encounters have been approved for immunizations at this same encounter. |

| Explanatory Code | Description |
|---|---|
| **VT060** | Service encounter has been disallowed as a visit the same day as major surgery is included in the surgery. |
| **VT061** | Service encounter has been disallowed as it is included in a diagnostic and therapeutic procedure previously approved at this same service encounter. |
| **VT062** | Service encounter has been disallowed as you have previously been approved a delivery fee. |
| **VT063** | Service encounter has been disallowed as delivery did occur at the same facility. |
| **VT064** | Service encounter has been disallowed as a visit is included in the previously approved procedure. |
| **VT065** | Service encounter has been disallowed as 30 days has not elapsed since recipient was last seen by this provider. |
| **VT066** | Service encounter has been disallowed. Comprehensive visits cannot be approved within 30 days of a previous visit by the same provider. |
| **VT067** | Service encounter has been disallowed. This service is only approved for general practitioners. |
| **VT068** | Service encounter has been refused. Resubmit as a limited visit or resubmit providing electronic text explaining the medical necessity of a comprehensive visit within 30 days of a previous visit. |
| **VT069** | Service encounter has been disallowed based on the limitations applied to supportive care visits. |
| **VT070** | Service encounter has been disallowed as you have been approved a visit during the previous two days. |
| **VT071** | Service encounter for supportive care has been disallowed as you have been approved two visits within the previous two days. |
| **VT072** | Service encounter for supportive care has been disallowed as you have been approved two visits within the previous three days. |
| **VT073** | Service encounter for supportive care has been disallowed as you have been approved two visits within the previous four days. |
| **VT074** | Service encounter for supportive care has been disallowed as you have been approved two visits within the previous five days. |
| **VT075** | Service encounter for supportive care has been disallowed as you have been approved two visits within the previous six days. |
| **VT076** | Service encounter has been refused as modifier value OV65 does not agree with age of patient. |
| **VT077** | Service encounter has been refused. Resubmit under the same health service code using the appropriate modifiers for the service provided. |
| **VT078** | Service encounter has been refused as patient's age is inappropriate for this service. |
| **VT079** | Service encounter has been refused as the maximum number of complex care visits for the year has previously been approved. |
| **VT080** | Service encounter has been refused as modifier DA value is inappropriate after 56 days from hospital admission. |
| **VT081** | Service encounter has been refused as the maximum of eight well baby care visits in the first 13 months of life has been approved. |
| **VT082** | Service encounter has been refused as the maximum of eight well baby care visits in the first 13 months of life has been approved. |
| **VT083** | Service encounter has been refused as the patient is not insured for this service at this time. |
| **VT084** | Service encounter has been refused as the patient is not insured for this service at this time. |
| **VT085** | Service encounter has been refused as the maximum of nine well baby care visits has previously been approved. |
| **VT086** | Service encounter has been refused as only one well baby care visit is insured when patient age is 18 months. |
| **VT087** | Service encounter has been refused as you have previously been approved this service for this diagnosis. |

| Explanatory Code | Description |
|---|---|
| **VT088** | Service encounter has been refused as you or another provider have previously been approved this service for this diagnosis. |
| **VT089** | Service encounter has been refused as functional center is not indicated. |
| **VT090** | Service encounter has been disallowed as electronic text is required to indicate the start date and duration of the current treatment cycle. |
| **VT091** | Service encounter has been disallowed as this service is included in the CGA1 service that has previously been approved. |
| **VT092** | Service encounter has been refused as 03.03 supportive care has been claimed this day. |
| **VT093** | Service encounter has been refused as 03.03E or 03.04C has been claimed this day. |
| **VT094** | Service encounter has been refused as you have not used a qualifying diagnostic code. |
| **VT095** | Service encounter has been refused as an initial hospital visit has already been claimed for this patient on the same admission date. |
| **VT096** | Service encounter has been refused as the maximum number of subsequent limited visits has already been claimed for this patient this week. |
| **VT097** | Service encounter has been refused as you have already been approved for a supportive care claim within the past three days (Preamble 5.1.23). |
| **VT098** | Service encounter has been refused as you have already been approved for two supportive care claims within the past seven days (Preamble 5.1.23). |
| **VT099** | Service encounter has been refused as you can only claim subsequent weekly visits after 56 days from hospital admission. Prior to that you may claim subsequent daily visits. |
| **VT100** | Service encounter has been refused as a 03.26A or 03.26C has previously been billed for this patient on the same day. |
| **VT101** | Service encounter has been refused as a diagnostic code used is not valid for urgent services. |
| **VT102** | Service encounter has been disallowed. Please submit a copy of the clinical record before requesting a reassessment for this claim. |
| **VT103** | A comprehensive or initial limited visit may not be claimed within 30 days of a comprehensive consultation on the same patient for the same condition. See Preamble 5.1.12. |
| **VT104** | A comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. See Preamble 5.1.13. |
| **VT105** | Service encounter has been disallowed as a previously approved surgery includes post-operative care for up to 14 days after the date of service. (Preamble 5.3.50). |
| **VT106** | Service encounter has been disallowed as a consultation has been billed in the previous 7 days for this patient by this provider. |
| **VT107** | Service encounter has been refused as four of these services have previously been approved in the past 365 days. |
| **VT108** | Service encounter has been refused as this code is not payable in addition to any other service for the same patient by the same physician on the same day. |
| **VT109** | Service encounter has been refused as no other fees are payable during the same time period as 03.03G. |
| **VT110** | Service encounter has been refused as HSC 03.03G is not payable when other fees are billed during the same time period. |
| **VT111** | Service encounter has been refused as the patient is less than 65 years old. |
| **VT112** | Service encounter has been refused as the initial geriatric inpatient medical assessment has already been claimed for this hospital admission. |
| **VT113** | Service encounter has been refused as the initial geriatric inpatient medical assessment has already been claimed for this patient within the past 6 months. |

| Explanatory Code | Description |
|---|---|
| **VT114** | Service encounter has been refused as the geriatrician's initial comprehensive geriatric consultation has previously been claimed for this patient. |
| **VT115** | Service encounter has been refused as you have previously billed another service for this patient during the same time period. |
| **VT116** | Service encounter has been refused as you have previously billed a visit or consultation on this day for this patient. |
| **VT117** | Service encounter has been refused as you have previously claimed HSC 03.09G on this day for this patient. |
| **VT118** | Service encounter has been disallowed as HSC 03.09G has previously been approved for this patient. |
| **VT119** | Service encounter has been refused as a consult and psychotherapy or counselling are not payable at the same service encounter. |
| **VT120** | Service encounter has been disallowed as HSC 03.09H has previously been approved for this patient. |
| **VT121** | Service encounter has been disallowed as the provider number is not valid for this service. |
| **VT122** | When claiming this service the fetal diagnosis must be recorded in the text field. |
| **VT123** | Service encounter has been disallowed as you do not have approval to bill for this service. |
| **VT124** | Service encounter has been disallowed as an urgent visit (all locations) applies only when a physician travels from one location to another. Preamble 5.1.52. Resubmit with text stating details of physician's travel. |
| **VT125** | Service encounter has been refused as this claim does not meet the criteria for an urgent visit, as per Preamble 5.1.55, 5.1.56, 5.1.57. |
| **VT126** | Service encounter has been disallowed as an additional visit for an OPD or EMERG patient is only payable if the patient is under observation for more than 4 hours. Preamble 5.1.45. Resubmit with text explaining the necessity of an additional visit. |
| **VT127** | Service encounter has been refused. The documentation provided supports a continuing care visit, not a consult. (See Preamble 5.1.25). Please resubmit with the appropriate HSC. |
| **VT128** | Service encounter has been refused. The documentation provided supports a limited visit, not a comprehensive visit. (See Preamble 5.1.4). Please resubmit with the appropriate HSC. |
| **VT129** | Service encounter has been refused as HSC 82.64E is a comprehensive service and you have already claimed another service at the same encounter. |
| **VT130** | Service encounter has been refused. The documentation provided supports an initial visit with complete examination, not a consult (see Preamble 5.1.7). Please resubmit with the appropriate HSC. |
| **VT131** | Claim has been disallowed as this service should be billed in groups of 3. If 4 or more are necessary, submit an additional service occurrence for each additional group of 3 with supporting text. |
| **VT132** | Service encounter has been disallowed as a claim for critical care has already been approved for this patient on the same day. |
| **VT133** | Service encounter has been refused as you have previously billed HSC WCB28 for this patient on the same day. |
| **VT134** | Service encounter has been refused as the initial opioid use disorder assessment has previously been paid. |
| **VT135** | Service encounter has been refused as the initial opioid use disorder assessment for methadone treatment – transfer from clinic to physician has been paid. |
| **VT136** | Service encounter has been refused as the permanent transfer of patient on active methadone treatment for substance use disorder – initial visit with accepting physician has been previously paid. |
| **VT137** | It is not appropriate to bill MSI for a meet and greet visit with a new patient unless a health-related concern/complaint has been addressed at the visit. |
| **VT138** | Service encounter has been refused and cannot be processed until after the first physician claim has been received and processed. |

| Explanatory Code | Description |
|---|---|
| **VT139** | Service encounter has been refused as MSI requires first and second physician claims to process the prescribing physician claim. |
| **VT140** | Service encounter has been refused as a minimum of one-half hour must be spent for MAiD fees to be payable. |
| **VT141** | Service encounter has been reduced as a maximum of 2 hours is payable per patient for this health service code. |
| **VT142** | Service encounter has been refused as a daily hospital visit rate for the most responsible physician has already been claimed for the patient on this day. |
| **VT143** | Service encounter has been refused as the DA=DA23 modifier may only be used on the 2nd and 3rd admission dates (or days out of ICU). |
| **VT144** | Service encounter has been refused as the DA=DA47 modifier may only be used on the 4th to 7th admission dates (or days out of ICU). |
| **VT145** | Service encounter has been refused as you have already claimed a visit service for this patient on the same day. |
| **VT146** | Service encounter has been refused as you have already claimed the complex comprehensive acute care hospital discharge fee for this patient on the same day. |
| **VT147** | Service encounter has been refused as the patient must have previously been seen for a face-to-face encounter by this provider within the last 9 months. |
| **VT148** | Service encounter has been refused as HSC 03.09K may not be billed in addition to any other service for this patient on the same day. |
| **VT149** | Service encounter has been refused as calls between a referring provider and specialist in the same institution or practice location are not permitted for this service. |
| **VT150** | Service encounter has been disallowed as you have previously billed for specialist telephone advice for this patient within the previous 14 days which includes any subsequent calls necessary to complete the consultation. |
| **VT151** | Service encounter has been disallowed as you have already billed a face-to-face visit for this patient in the previous 14 days. |
| **VT152** | Service encounter has been disallowed as the text does not warrant payment of a comprehensive visit, please resubmit as a limited visit. |
| **VT153** | Service encounter has been disallowed as an urgent visit applies when a physician travels to see a registered inpatient at the request of hospital staff. Preamble 5.1.54. Resubmit with text stating the necessity of the service and travel details. |
| **VT155** | Service encounter has been refused as a claim for HSC 49.83B or 49.83C has already been claimed at the same encounter and includes the accompanying visit in the health service description. |
| **VT156** | Service encounter has been disallowed as start and stop times for this service must be included in text. |
| **VT162** | Service Encounter has been refused as HSC 03.03V may not be billed in addition to other services for this patient on the same day. |
| **VT163** | Service encounter has been refused as a consult may not be claimed in addition to 03.03V for this patient on the same day. |
| **VT164** | Service encounter has been disallowed as Medical Assistance in Dying claims require start and stop times. |
| **VT165** | Service encounter has been refused as HSC 03.03N cannot be claimed unless the provider has previously claimed for a MaiD service with the same patient. |
| **VT166** | Service encounter has been disallowed as text indicating the stop and start times for this service is required |
| **VT167** | Service encounter has been refused as HSC 03.04I is not reportable with any other visit fees on the same day |

| Explanatory Code | Description |
|---|---|
| **VT168** | Service encounter has been refused as HSC 03.04I may only be reported once per patient per year |
| **VT169** | Service encounter has been refused as you are not authorized to provide this service over a virtual care platform |
| **VT170** | Service encounter has been refused as 03.04J has already been approved for this patient in the previous 12 months. |
| **VT171** | Service encounter has been refused as you have already made the maximum of two claims for HSC 03.03X for this patient on this service date. |
| **VT172** | Service encounter has been disallowed as a chronic dialysis management daily treatment and supervision fee has been claimed for this patient on that date. |
| **VT173** | Service encounter has been disallowed as you have previously claimed a daily dialysis management fee for this patient on this date. If this visit is unrelated to dialysis management, please submit a reassess request with supporting information. |
| **VT174** | Service encounter has been refused as the maximum of 9 well infant/child visits has been reached. |
| **VT175** | Service encounter has been refused as the maximum of 5 comprehensive well infant/child visits using the Rourke Baby Record has been reached. |
| **VT176** | Service encounter has been disallowed as a well infant/child visit claimed by a provider other than the family physician requires text indicating that the patient is unattached. |
| **VT177** | Service encounter has been refused as it can only be claimed by the physician who claimed the original GAS surgery. |
| **VT178** | Service encounter has been refused as this service is only payable once per patient within 18 months post surgery. |
| **VT179** | Service encounter has been refused. You may not claim a visit and 99.82A or 99.82B with the same diagnosis within the same week |
| **VT180** | Service encounter has been disallowed as you have claimed NSHP1 or NSHP2 on the same day. Please resubmit with explanatory text. |
| **VT181** | Service encounter has been refused as HSC may only be billed from a location of HOSP or NRHM. |
| **VT182** | Nursing home medical chart review may not be claimed with NHTA1. |
| **VT183** | Service encounter has been refused. This code may only be claimed by paediatricians trained in the administration of the autism diagnostic interview and approved by PPAS |
| **VT184** | Service encounter has been refused. A comprehensive consult (03.08) must have previously been billed for the same patient within the previous 12 months to claim this code. |
| **VT185** | Service encounter has been refused. 03.04L has already been claimed for this patient. |
| **WB001** | Service encounter has been disallowed according to information provided by workers' compensation board. |
| **WB004** | Service encounter has been adjusted based on an audit of the form 8/10 for legibility, completeness or quality as per contract conditions. The visit fee only (WCB28) will be paid on this claim. |
| **WB007** | Service encounter has been refused as this form code has not been approved for implementation. |
| **WB008** | Service encounter has been refused re payment responsibility indicated. |
| **WB010** | Service encounter has been refused as a consultation service has not been claimed for this date. |
| **WB011** | Service encounter has been refused as this type of visit is no longer payable under WCB. Please resubmit using the appropriate physician assessment health service code. |
| **WB012** | Service encounter has been refused as you have previously claimed a physician assessment service this day. |
| **WB013** | Service encounter has been refused as you have previously claimed a physician assessment service this day. |
| **WB014** | Service encounter has been refused as you have previously been paid a special assessment service for this date. |

| Explanatory Code | Description |
|---|---|
| **WB015** | Service encounter has been refused as you have previously been paid an assessment service with completion of form 8/10 this date. |
| **WB016** | Service encounter has been refused as a previous assessment has been claimed by you for this date. |
| **WB017** | Service encounter has been refused as a previous assessment has been claimed by you for this date. |
| **WB018** | Service encounter has been refused as a previous chart summary has been claimed by you for this date. |
| **WB019** | Service encounter has been refused as a previous chart summary has been claimed by you for this date. |
| **WB020** | Service encounter has been refused as a previous case conference has been claimed by you for this date. |
| **WB021** | Service encounter has been refused as a previous case conference has been claimed by you for this date. |
| **WB022** | Service encounter has been disallowed as a previous service for WCB has been claimed this day. |
| **WB023** | Service encounter has been disallowed as a previous visit fee has been claimed this day. |
| **WB024** | WCB has adjusted this claim to the appropriate visit fee as the client is on long term benefits and form 8/10 is only necessary when there is a change in condition or treatment as per contract conditions. |
| **WB027** | Service encounter has been refused as this WCB code cannot be claimed if you have already claimed another fee for the same patient on the same date. |
| **WB030** | Service encounter has been disallowed as you can only bill for WCB21 after a follow-up office visit code has been claimed. |
| **WB031** | Service encounter has been refused as the provider indicated is not valid for this service. |
| **WB033** | Service encounter has been refused as the required WCB form was not received within the appropriate time. |
| **WB034** | Service encounter has been refused as you are not listed as an approved EPS physician. |
| **WB035** | Service encounter has been refused as a claim for WCB17 has already been approved for this date. |
| **WB036** | Service encounter has been refused as the initial or extension medical cannabis form has already been claimed for this patient on this day. |
| **WB037** | Service encounter has been refused as an initial or extension request for medical cannabis was previously claimed in the past seven weeks. |
| **WBHLT** | HSC invalid for WCB LTB claim. |
| **WBHNC** | Individual has no WCB coverage. |
| **WBHRT** | HSC Invalid for WCB RTW claim. |
| **WBHSD** | Service date not within WCB coverage period. |
| **WBHUJ** | File is being adjudicated for workers compensation with a province other than NS. |
| **WBHOK** | Eligibility approved by WCB. |
| **WBHNM** | WCB did not receive medical documentation for service date billed. |
| **WBPPC** | Physician compliance. Fees adjusted or reversed due to non-compliance of the DOCS NS contract. |
| **WBPUF** | Firm / Employer not registered with WCB. |
| **WBPUH** | No WCB claim with that health card number. |
| **WBPUI** | WCB claim inactive / closed. |
| **WBPUJ** | Not in WCB NS Jurisdiction. |
| **WBPUM** | WCB claim disallowed. |
| **WBPUP** | Provider compliance – fees reduced or reversed due to form 8/10 quality issues (incomplete fields, timelines, illegibility, etc.). |
| **WBPUW** | Not work related / no action. |

***(7.9.1)***

# APPENDIX J – HEALTH SERVICE CODES WITH PHYSICIAN RESTRICTIONS *(7.10.0)*

MSI adjudication system has rules in place to ensure physicians have the appropriate qualifications to claim specific services. *(7.10.1)*

| Health Service Code | Restriction | Specialties |
|---|---|---|
| **02.75B** | Diagnostic & Therapeutic Radiology level 2 (150 cases plus 8 weeks training in CT angiography) or greater certification for CT angiography as described by the Canadian Association of Radiologists and Canadian Cardiovascular Society. Qualifications must be submitted to be kept on file at MSI. | SP=RADI, SP=DIRD |
| **02.89A** | Fetal maternal medicine specialists only. Operators must be certified by the Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre must provide evidence of current certification and quality assurance to MSI. | SP=OBGY |
| **02.89B**<br>**R1225, R1226, R1245, R1246, R1250, R1255, R1256, R1306, R1309** | Fetal maternal medicine specialists and radiologists with the credentials to perform fetal ultrasound/echocardiography. | SP=OBGY, SP=DIRD, SP=RADI |
| **03.03 ME=VTCR**<br>**03.03A ME=VTCR** | Providers must be designated as Virtual Care Health Care Providers. | SP=ANAE, SP=DERM, SP=GENP, SP=ENME, SP=GEMD, SP=HAGY, SP=INMD, SP=MDON, SP=NEPH, SP=RHEU, SP=NUSG, SP=OBGY, SP=ORTH, SP=PEDI, SP=HUGE, SP= MEGE, SP=PHMD, SP=PLAS, SP=PSYC, SP=RDON, SP=CASG, SP=GNSG, SP=THSG |
| **03.03 ME=CARE**<br>**03.03A ME=CARE** | Physicians must sign a confirmation letter confirming that they will bill the enhanced fees only for visits with patients for whom they are providing comprehensive and continuous care. | SP=GENP |
| **03.03H**<br>**03.09H** | Paediatrician with additional training in Paediatric Palliative Care. | SP=PEDI |
| **03.09C** | Physicians with recognized expertise in Palliative Care or Certificate of added competence | |
| **03.04D** | Physician with Geriatric Medicine speciality or Internal Medicine with a minimum of 8 weeks recognized Geriatric subspecialty training (PGY4 or greater). | SP=GEMD<br>SP=INMD + |
| **03.04I** | Practice Support Program trained General Practitioner | SP=GENP |
| **03.04K** | Gender Affirming Care, Transition Readiness Assessment, Follow-up.<br>Must be informed, knowledgeable and experienced in providing culturally competent and safe trans care and are required to complete and return the GAC Competency Declaration. | SP=GENP |

| Health Service Code | Restriction | Specialties |
|---|---|---|
| **08.41** | Physicians providing hypnotherapy must have at least 20 hours of training in clinical hypnotherapy and be an active member in good standing of a recognized Canadian Clinical Hypnosis society. | SP=PSYC, SP=GENP |
| **08.44A** | PSYC trained in MBCT or GENP trained in group psychotherapy and MBCT. Credentials must be submitted to MSI directly. | SP=PSYC, SP=GENP |
| **03.08 SP=GENP** | Family Physician must hold and maintain a Certificate of Added Competence (CAC) awarded by the College of Family Physicians of Canada (CFPC) and only in the area of the CAC in which they hold. | SP=GENP |
| **38.39C** | Members of the head and neck subsection within the Dalhousie Division of ORL-HNS | SP=OTOL |
| **51.95A**<br>**51.95C** | Internal Medicine specialist must be in acting role of the Nephrologist at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director. | SP=NEPH<br>SP=INMD |
| **52.31A** | Members of the head and neck subsection within the Dalhousie Division of ORL-HNS | SP=OTOL |
| **60.4B** | Fellowship in colorectal surgery and/or fellowship in minimally invasive surgery (MIS) is required to be submitted and kept on file at MSI | SP=GNSG |
| **60.24C** | Fellowship in colorectal surgery and/or fellowship in minimally invasive surgery (MIS) is required to be submitted and kept on file at MSI | SP=GNSG |
| **60.52B** | Primary surgeon – Fellowship in minimally invasive surgery MIS required to be submitted and kept on file at MSI | SP=GNSG |
| **63.82A, 63.89A, 63.95A, 63.95B, 63.95C, 64.91A, 64.96A** | Endoscopic Retrograde Cholangiopancreatography (ERCP) requires appropriate training, demonstrated competency, specialized equipment, and suitable facility resources. Physicians are now required to request preapproval for providing ERCP related health service codes by completing and returning the ERCP Declaration form. | |
| **98.99H**<br>**98.99I** | Proof of Mohs Micrographic Surgery Fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS) is required to be kept on file at MSI | SP=DERM, SP=PLAS |

*(7.10.2)*

# SECTION 8: NOVA SCOTIA MEDICAL SERVICES INSURANCE SCHEDULE OF BENEFITS

# SERVICES FOR MULTIPLE SPECIALTIES

(Specialties with unit values that differ from the below will be specified in their respective sections)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **PALLIATIVE CARE** | | | | |
| CONS | 03.09C | Palliative Care Consultation (Once per patient per physician) | 62+MU | |
| VIST | 03.03C | Palliative Care Support Visit<br>RO=PCSV | 30 per 30 min | |
| | | (15 units per 15 min. thereafter, maximum of 60 min. per patient per day) | | |
| VIST | 03.03 | Palliative Care Medical Chart Review and/or Telephone Call, Fax or E-mail initiated by a health care professional - up to three telephone calls/faxes or e-mails per day per patient<br>RO=CRTC | 11.5 | |
| | | **Note**: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 units | | |
| **HOME** | | | | |
| VIST | 03.04 | Initial Visit<br>LO=HOME (RF=REFD) | 23 | |
| | | LO=HOME, RO=DETE (RF=REFD) | 23+MU | |
| VIST | 03.03 | Home Visit (0800 - 1700)<br>LO=HOME, PT=FTPT (RF=REFD) | 21.3 | |
| | | LO=HOME, PT=FTPT, RO=DETE (RF=REFD) | 21.3+MU | |
| VIST | 03.03 | Home Visit (1701 - 2000)<br>LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 | |
| | | LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU | |
| VIST | 03.03 | Home Visit (2001 - 2359)<br>LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 | |
| | | LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU | |
| VIST | 03.03 | Home Visit (0000 - 0800)<br>LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 38.3 | |
| | | LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 38.3+MU | |
| VIST | 03.03 | Home Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 28.3 | |
| | | LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU | |

VIST 03.03 Home Visit (1201 - 1700) Sat., Sun., Holidays
LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 28.3
LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Home Visit - Extra Patient
LO=HOME, PT=EXPT (RF=REFD) ..... 10.5

VIST 03.03 Home Emergency Visit
LO=HOME, US=UIOH (RF=REFD) ..... 35.2
LO=HOME, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU

VIST 03.03 Continuing Care
LO=HOME, RO=CNTC, RF=REFD ..... 13.5
LO=HOME, RO=CCDT, RF=REFD ..... 13.5+MU

VIST 03.03 Directive Care
LO=HOME, RO=DIRC, RF=REFD ..... 13.5
LO=HOME, RO=DRDT, RF=REFD ..... 13.5+MU

**HOME CARE**

VIST 03.04 Transfer to Home Care from Inpatient
LO=HMHC, OL=INPT (RF=REFD) ..... 28.6
LO=HMHC, OL=INPT, RO=DETE (RF=REFD) ..... 28.6+MU

**HOSPITAL DETOX CENTRE**

VIST 03.03 Detox Centre (0800 - 1700)
LO=HOSP, FN=DTOX, PT=FTPT (RF=REFD) ..... 21.3
LO=HOSP, FN=DTOX, PT=FTPT RO=DETE (RF=REFD) ..... 21.3+MU

VIST 03.03 Detox Centre (1701 - 2000)
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (2001 - 2359)
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (0000 - 0800)
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU

VIST 03.03 Detox Centre (0801 - 1200) Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF
(RF=REFD) ..... 28.3
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF,
RO=DETE (RF=REFD) ..... 28.3+MU

| | | |
|---|---|---|
| VIST | 03.03 | Detox Centre (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF<br>(RF=REFD) ..... 28.3<br>LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF,<br>RO=DETE (RF=REFD) ..... 28.3+MU |
| VIST | 03.03 | Detox Centre (0801 - 1201) Extra Patient<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN (RF=REFD) ..... 8.4<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 8.4+MU |
| VIST | 03.03 | Detox Centre (1201 - 1700) Extra Patient<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV (RF=REFD)..... 8.4<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 8.4+MU |
| VIST | 03.03 | Detox Centre (1701 - 2000) Extra Patient<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT (RF=REFD) ..... 10.5<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Detox Centre (2001 - 2359) Extra Patient<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Detox Centre (0000 - 0800) Extra Patient<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT (RF=REFD)..... 10.5<br>LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Detox Centre (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) ..... 10.5<br>LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 10.5+MU |
| VIST | 03.03 | Detox Centre (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD)..... 10.5<br>LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 10.5+MU |

**CORRECTIONAL CENTRE**

| | | |
|---|---|---|
| VIST | 03.03 | Office Visit<br>LO=CCNT, RP=SUBS (RF=REFD)..... 12.5 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000)<br>LO=CCNT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359)<br>LO=CCNT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800)<br>LO=CCNT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays<br>LO=CCNT, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=CCNT, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=CCNT, PT=EXPT (RF=REFD)..... 10.5

VIST 03.03 Correctional Centre - Emergency Visit
LO=CCNT, US=UIOH (RF=REFD)..... 35.2
LO=CCNT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU

**OTHER**

VIST 03.03 Unspecified Emergency Visit
LO=OTHR, US=UIOH (RF=REFD) ..... 35.2
LO=OTHR, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU

VIST 03.03 Unspecified Location (0800-1700)
LO=OTHR, PT=FTPT (RF=REFD) ..... 21.3
LO=OTHR, PT=FTPT, RO=DETE (RF=REFD) ..... 21.3+MU

VIST 03.03 Unspecified Location (1701-2000)
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location (2001-2359)
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location (0000-0800)
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU

VIST 03.03 Unspecified Location (0801-1200) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 28.3
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 28.3+MU

VIST 03.03 Unspecified Location (1201-1700) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 28.3
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location - Extra Patient
LO=OTHR, PT=EXPT (RF=REFD) ..... 10.5

**OTHER TERMINATION OF EARLY PREGNANCY**

VIST 03.03V Medical abortion/termination of early pregnancy..... 67.03

**CASE MANAGEMENT CONFERENCE**

VIST 03.03D Case Management Conference Fee..... 17.5 per 15 min
(SP=GENP)..... 15 per 15 min

**MEDICAL ASSISTANCE IN DYING**

| | | | |
|---|---|---|---|
| VIST | 03.03M | MAiD – First Physician assessor<br>(15 units for each 15 min. thereafter) | 30 per 15 min + MU |
| VIST | 03.03O | MAiD – Second Physician assessor<br>(15 units for each 15 min. thereafter) | 30 per 15 min + MU |
| VIST | 03.03N | MAiD – Prescribing Physician<br>RO=FPHN<br>(15 units for each 15 min. thereafter)<br>RO=SPHN | 30 per 15 min + MU<br><br>56 |

**INCENTIVE**

| | | | |
|---|---|---|---|
| ADON | OFI1 | Incentive for use of Official Interpreter services when caring for a patient of limited English proficiency (LEP) | 5 |

# ANAESTHESIA

(SP=ANAE)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation (Prolonged) | | |
| | | RF=REFD (ME=TELE) | 59.5+MU | |
| | | RF=REFD, US=PREM (ME=TELE) | 80.33+MU | |
| | | RF=REFD, US=PR50 (ME=TELE) | 89.25+MU | |
| | | RF=REFD, RO=DETE (ME=TELE) | 59.5+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 80.33+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 89.25+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 41 | |
| | | RF=REFD, US=PREM (ME=TELE) | 59 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 61.5 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 41+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 59+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 61.5+MU | |
| CONS | 03.07 | Repeat Consultation (Prolonged) | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 36+MU | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 54+MU | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 54+MU | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 36+M | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 54+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 54+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visits | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 16.5 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Continuing Care | |
| | | LO=OFFC, RO=CNTC, RF=REFD | 13.5 |
| | | LO=OFFC, AG=OV65, RO=CNTC, RF=REFD | 16.5 |
| VIST | 03.03 | Directive Care | |
| | | LO=OFFC, RO=DIRC, RF=REFD | 13.5 |
| | | LO=OFFC, AG=OV65, RO=DIRC, RF=REFD | 16.5 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000) | |
| | | LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359) | |
| | | LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800) | |
| | | LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient | |
| | | LO=OFFC, PT=EXPT (RF=REFD) | 10.5 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | | |
|---|---|---|---|
| VIST | 03.04 | Anaesthetic Standby (refer to the Preamble) | |
| | | LO=HOSP, FN=INPT, RO=STBY, SP=GENP, SP=ANAE (RF=REFD) | 10+MU per ½ hour |
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) | 24 |
| | | LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) | 24+MU |
| VIST | 03.04 | Initial Visit | |
| | | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | 25 |
| | | LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) | 25+MU |
| VIST | 03.03 | Continuing Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD | 15+MU |
| VIST | 03.03 | Directive Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD | 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15 |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU |
| VIST | 03.03 | Resuscitation of Newborn |
| | | LO=HOSP, FN=INPT, RO=RESC (RF=REFD)..... 50 |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD)..... 68 |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD) ..... 75 |
| | | LO=HOSP, FN=INPT, RO=RNDT (RF=REFD)..... 50+MU |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD)..... 68+MU |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD) ..... 75+MU |
| ADON | 03.02A | Hospital Discharge Fee |
| | | LO=HOSP, FN=INPT ..... 10 |
| VIST | 03.03 | Urgent Hospital Care |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Emergency Visit |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, (RF=REFD)..... 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF(RF=REFD) ..... 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7 | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU | |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) ..... 10.5 | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5 | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4 | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4 | |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF (RF=REFD)..... 10.5 | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF,RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU | |

## PROCEDURES

**OTHER COMPUTERIZED AXIAL TOMOGRAPHY**

| | | | |
|---|---|---|---|
| ANAE | 02.75A | CAT scan performed under general anaesthesia..... | 4+T |

**MAGNETIC RESONANCE IMAGING**

| | | | |
|---|---|---|---|
| ANAE | 02.76 | Magnetic resonance imaging..... | 4+T |

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS**

| | | | |
|---|---|---|---|
| ANAE | 03.39Q | Examination under anaesthesia with intubation..... | 4+T |
| ANAE | 03.39R | Examination under anaesthesia without intubation. ..... | 4+T |

**OTHER RADIOTHERAPEUTIC PROCEDURE**

| | | | |
|---|---|---|---|
| ANAE | 06.39A | Radiotherapy procedures without intubation..... | 4+T |
| ANAE | 06.39B | Radiotherapy procedures with intubation ..... | 4+T |

**INSERTION OF ENDOTRACHEAL TUBE**

| | | | |
|---|---|---|---|
| ANAE | 10.04 | Insertion of endotracheal tube for airway obstruction..... | 6+T |

**OTHER LAVAGE OF BRONCHUS AND TRACHEA**

| | | | |
|---|---|---|---|
| MISG | 10.66A | Tracheo-bronchial toilet to include laryngoscopy if necessary two hour post-operative (other than immediate post-op care) ..... 25 | |
| ANAE | 10.66B | Bronchio-alveolar lavage ..... | 8+T |

**INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC**

| | | | |
|---|---|---|---|
| PMNO | 13.59K | Acute pain management (non-obstetrical) consultation, institution of PCA and care on day 1 when unrelated to delivery of anaesthesia<br>SP=ANAE, SP=GENP ..... 41 | |
| PMNO | 13.59H | Acute pain management (non-obstetrical) institution of PCA and care on day 1 when in addition to delivery of anaesthesia on that day<br>SP=ANAE, SP=GENP ..... 13.5 | |
| PMNO | 13.59F | Acute pain management (non-obstetrical) maintenance care, per day, day 2 onwards<br>SP=ANAE, SP=GENP ..... 13.5 | |

**OTHER CONVERSION OF CARDIAC RHYTHM**

| | | | |
|---|---|---|---|
| ANAE | 13.79A | Cardio-pulmonary resuscitation - outside anaesthesia including cardiac arrest - maximum of 15 anaesthetic units..... | 6+T |

**INJECTION OF ANAESTHETIC INTO SPINAL CANAL FOR ANALGESIA**

| | | | |
|---|---|---|---|
| ANAE | 16.91J | Continuous epidural block<br>AN=PNCT, RP=INTL ..... | 5+T |
| | | AN=PNCT, RP=SUBS ..... | Time Only |
| VADT | 16.91L | Post-op pain control performed in conjunction with anaesthesia (caudal/intercostal/intrapleural/psoas compartment) - plus multiples, if applicable<br>SP=ANAE, SP=GENP ..... 10 | |
| PMNO | 16.91M | Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of epidural/spinal catheter and care on day 1<br>SP=ANAE, SP=GENP ..... 100 | |
| PMNO | 16.91N | Acute pain management (non-obstetrical) assessment and care following epidural/spinal catheter placement, when the catheter is inserted by another physician, day 1<br>SP=ANAE, SP=GENP ..... 59 | |
| PMNO | 16.91O | Acute pain management (non-obstetrical) insertion of epidural/spinal catheter in conjunction with anaesthesia<br>SP=ANAE, SP=GENP ..... 33 | |

| | | |
|---|---|---|
| PMNO | 16.91P | Acute pain management (non-obstetrical) maintenance of epidural/spinal catheter by primary anaesthetist, day 1<br>SP=ANAE, SP=GENP ..... 26 |
| PMNO | 16.91Q | Acute pain management (non-obstetrical) maintenance, per day, day 2 onwards<br>SP=ANAE, SP=GENP ..... 30 |
| VEDT | 16.91R | Continuous conduction anaesthesia for relief of pain in labour<br>SP=ANAE, AN=LABR ..... 166<br>SP= GENP, AN=LABR ..... 166 |

**INJECTION OF ANAESTHETIC INTO SYMPATHETIC NERVE FOR ANALGESIA**

| | | | |
|---|---|---|---|
| ANAE | 18.21F | Monitored anaesthesia care with retrobulbar block by ophthalmologist ..... | 4+T |

**OTHER DENTAL OPERATIONS NEC**

| | | | |
|---|---|---|---|
| ANAE | 36.99 | Other dental operations NEC..... | 5+T |

**INSERTION OF INTERPLEURAL CATHETER**

| | | |
|---|---|---|
| PMNO | 46.04D | Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when unrelated to delivery of anaesthesia.<br>SP=ANAE; SP=GENP ..... 54 |
| PMNO | 46.04E | Acute pain management (non-obstetrical) insertion of interpleural catheter and care on day 1 when in addition to delivery of anaesthesia on that day.<br>SP=ANAE; SP=GENP ..... 30 |
| PMNO | 46.04F | Acute pain management (non-obstetrical) interpleural catheter maintenance care, per day, day 2 onwards.<br>SP=ANAE; SP=GENP ..... 20 |
| PMNO | 46.04G | Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of CPNB catheter and care on day 1.<br>SP=ANAE ..... 75 |
| PMNO | 46.04H | Acute Pain management (non-obstetrical) assessment and care following CPNB catheter placement, when the catheter is inserted by another physician, day 1.<br>SP=ANAE ..... 44 |
| PMNO | 46.04I | Acute pain management (non-obstetrical) insertion of CPNB catheter in conjunction with anaesthesia.<br>SP=ANAE ..... 25 |
| PMNO | 46.04J | Acute pain management (non-obstetrical) maintenance of CPNB catheter by primary anaesthetist, day 1.<br>SP=ANAE ..... 25 |
| PMNO | 46.04K | Acute pain management (non-obstetrical) CPNB maintenance, per day, day 2 onwards.<br>SP=ANAE ..... 25 |

**CONTROL OF HEMORRHAGE, NOT OTHERWISE SPECIFIED**

| | | | |
|---|---|---|---|
| ANAE | 51.98A | Post partum haemorrhage | 6+T |

**DELIVERY NEC**

| | | | |
|---|---|---|---|
| ANAE | 87.98 | Delivery NEC | 4+T |
| | | AN=DFED | Time Only |
| | | CO=INFE | 7+T |

**OTHER OBSTETRIC OPERATIONS NEC**

| | | | |
|---|---|---|---|
| ANAE | 87.99A | Anaesthetic double set-up | 4+T |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

**PREMIUM**

| | | | |
|---|---|---|---|
| ADON | AHSP1 | After Hours Service Premium (extended service hours) | 35% |

## INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

These codes must be claimed from LO=HOSP

**ECHOCARDIOGRAPHY**

| | | | |
|---|---|---|---|
| BULK | I1310 | Two dimensional | 47.56 |
| BULK | I1312 | Doppler – quantitative | 30.45 |
| BULK | I1313 | Doppler – qualitative | 15.23 |

# DERMATOLOGY

(SP=DERM)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 52 | |
| | | RF=REFD, US=PREM (ME=TELE) | 70.2 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 78 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 52+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 70.2+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 78+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 28 | |
| | | RF=REFD, US=PREM (ME=TELE) | 46 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 46 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 28+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 46+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 46+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 27.1 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 45.1 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 45.1 | |
| | | RF=REFD, RP=REPT, RO=DETE (ME=TELE) | 27.1+MU | |
| | | RF=REFD, RP=REPT, RO=DETE, US=PREM (ME=TELE) | 45.1+MU | |
| | | RF=REFD, RP=REPT, RO=DETE, US=PR50 (ME=TELE) | 45.1+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Dermatological Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 16. | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF(RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5

**HOSPITAL** (Includes LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Dermatological Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

| | | | |
|---|---|---|---|
| ADON | 03.02A | Hospital Discharge Fee | |
| | | LO=HOSP, FN=INPT | 10 |
| VIST | 03.03 | Urgent Hospital Visit | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD) | 22 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD) | 22+MU |
| VIST | 03.03 | Hospital Emergency Visit | |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD) | 35.2 |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD) | 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) | 13.5 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) | 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF(RF=REFD) | 26 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) - Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF,RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) - Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF,RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV(RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, US=UNOF (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 10.5+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, US=UNOF (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, US=UNOF (RF=REFD)..... 11.4<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 11.4+MU | |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF,RO=DETE<br>(RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, US=UNOF(RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, US=UNOF,RO=DETE<br>(RF=REFD) ..... 10.5+MU | |

## PROCEDURES

**APPLICATION OF PRESSURE DRESSING**

| | | | |
|---|---|---|---|
| MISG | 07.56A | Plantar warts, application of occlusive boot ..... 30 | |

**LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | |
|---|---|---|---|
| MISG | 98.12R | Destruction (dermabrasion) of single area (e.g., trauma scar)..... 35<br>(Prior-Approval Required) | 4+T |
| MAAS | 98.12S | Extensive and complicated lesions ..... IC | 4+T |
| MISG | 98.12T | Carcinoma of skin, curettage and electrocautery<br>- plus multiples, if applicable ..... 38 | 4+T |

**BIOPSY OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | |
|---|---|---|---|
| MISG | 98.81C | Biopsy of skin or mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management<br>- plus multiples, if applicable ..... 20 | 4+T |
| MISG | 98.81D | Punch biopsy of skin or mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management - plus multiples, if applicable..... 15 | |

**DERMABRASION**

| | | | |
|---|---|---|---|
| MASG | 98.93A | Dermabrasion full face (prior approval) ..... 100 | 5+T |
| MISG | 98.93B | Dermabrasion less than 1/4 of face (prior approval) ..... 25 | 5+T |

| | | | | |
|---|---|---|---|---|
| MISG | 98.93C | Dermabrasion single area face; e.g., trauma scar (prior approval) ..... 35 | | 4+T |
| MASG | 98.93D | Dermabrasion between 1/4 and 1/2 face (prior approval) ..... 75 | | 5+T |

**OTHER OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 98.99C | Treatment of lesions by dye tunable or krypton lasers for port wine stain (face/neck only) glomus tumours, lymphangiomas, pyogenic granulomas, Fabry's Disease ..... 0.76+MU | | 4+T |
| MASG | 98.99H | MOHS micrographic surgery (MMS) for the removal of a histologically confirmed cutaneous malignancy – initial level and debulking..... 155<br>*Physician Restrictions in Place (See Appendix J) | | |
| ADON | 98.99I | Additional levels (comprehensive of all additional levels for complete excision) ..... 135<br>*Physician Restrictions in Place (See Appendix J) | | |

**PHOTOTHERAPY**

| | | | | |
|---|---|---|---|---|
| VEDT | 99.82A | Supervision of Photodynamic Therapy by Dermatologist – per patient per week in the office setting wherein the dermatologist is responsible for payment of the technician's salary in addition to the purchase and maintenance of the phototherapy equipment<br>LO=OFFC ..... 25 | | |
| VEDT | 99.82B | Supervision of Photodynamic Therapy by Dermatologist – per patient per week in hospital outpatient setting wherein the dermatologist is not responsible for payment of the technician's salary or the purchase and maintenance of the phototherapy equipment<br>LO=HOSP ..... 10 | | |

# DIAGNOSTIC & THERAPEUTIC

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **RHINOSCOPY** | | | | |
| VADT | 01.01 | Rhinoscopy (included in a consultation) | 10 | 4+T |
| **INDIRECT LARYNGOSCOPY** | | | | |
| VADT | 01.02A | Indirect endoscopy of larynx with biopsy | 20 | 6+T |
| **DIRECT LARYNGOSCOPY** (for other laryngoscopy procedures, refer to the Otolaryngology Section) | | | | |
| VADT | 01.03C | Direct laryngoscopy with dilation | 50 | 6+T |
| VADT | 01.03D | Direct endoscopy of larynx with biopsy | 36 | 6+T |
| VADT | 01.03G | Direct laryngoscopy without biopsy | 22.5 | 6+T |
| VADT | 01.03H | Guided laryngoscopic botox injection of vocal cord (includes visit, laryngoscopy of any kind and injection) | 50 | 6+T |
| **OTHER NONOPERATIVE LARYNGOSCOPY** | | | | |
| VADT | 01.04A | Flexible fibre-optic endoscopy of nasopharynx or larynx (Included in a consultation) | 10 | 4+T |
| VADT | 01.04B | Videostroboscopy (to include the procedure and interpretation) | 50 | 6+T |
| **FIBEROPTIC BRONCHOSCOPY** | | | | |
| VADT | 01.08A | Transbronchial lung biopsy with fiberscope | 110 | 6+T |
| **OTHER NONOPERATIVE BRONCHOSCOPY** | | | | |
| VADT | 01.09 | Other nonoperative bronchoscopy | 60 | 6+T |
| VADT | 01.09A | Bronchoscopy with biopsy | 65 | 6+T |
| VADT | 01.09B | Bronchoscopy - with foreign body removal | 85 | 6+T |
| **OTHER NONOPERATIVE ESOPHAGOSCOPY** | | | | |
| VADT | 01.12 | Other nonoperative esophagoscopy | 60 | 4+T |
| VADT | 01.12A | Esophagobronchoscopy | 85 | 6+T |

| | | | | |
|---|---|---|---|---|
| VADT | 01.12B | Esophagoscopy with biopsy | 65 | 4+T |
| VADT | 01.12C | Esophagoscopy - with removal of foreign body | 85 | 4+T |
| VADT | 01.12E | Functional endoscopic examinations of swallowing mechanism | 45 | |

**OTHER NONOPERATIVE GASTROSCOPY**

| | | | | |
|---|---|---|---|---|
| VADT | 01.14A | Injection of ulcer through the scope for G.I. bleed or application of crazy glue into fundal region of stomach (scope included) | 120 | 4+T |
| VADT | 01.14C | Esophagogastroscopy | 70 | 4+T |
| VADT | 01.14D | Esophagogastroscopy with biopsy | 75 | 4+T |
| VADT | 01.14E | Esophagogastroscopy-with removal of foreign body | 85 | 4+T |
| ADON | 01.14F | Insertion of intragastric balloon in addition to gastroscopic fee | 50 | |
| ADON | 01.14G | Removal of polyps in addition to the appropriate esophagogastroscopy - plus multiples, if applicable | 10 | |
| VADT | 01.14H | Esophagogastroscopy plus endoscopic placement of esophageal stent with or without the use imaging | 90 | 4+T |

**OTHER NONOPERATIVE COLONOSCOPY**

| | | | | |
|---|---|---|---|---|
| ADON | 01.22A | Colonoscopy with one/more biopsies | 10 | |
| ADON | 01.22B | Polypectomy via colonoscopy (OPD and Pathology report required with submission) - plus multiples, if applicable | 20 | |
| VADT | 01.22C | Colonoscopy of descending colon | 40 | 4+T |
| VADT | 01.22D | Colonoscopy of descending and transverse colon | 70 | 4+T |
| VADT | 01.22E | Colonoscopy of descending, transverse and ascending colon | 100 | 4+T |
| ADON | 01.22F | Balloon dilation of colonic stricture (in addition to colonoscopy) | 30 | |

**OTHER NONOPERATIVE PROCTOSIGMOIDOSCOPY**

| | | | | |
|---|---|---|---|---|
| VADT | 01.24 | Other nonoperative proctosigmoidoscopy AG=CH16 | 25 | 4+T |
| VADT | 01.24B | Proctoscopic examination | 5 | |
| VADT | 01.24C | Sigmoidoscopic examination (with or without biopsy of rectum or sigmoid) AG=ADUT | 15 | 4+T |
| VADT | 01.24D | Biopsy of rectosigmoid for Hirschsprung's Disease through sigmoidoscope | 40 | 4+T |

**OTHER NONOPERATIVE CYSTOSCOPY** (for other cystoscopy procedures, refer to the Urology Section)

| | | | | |
|---|---|---|---|---|
| VADT | 01.34A | Cystoscopy with or without catheterization of ureters (the performance of a cystoscopy is included in the fee for urethral vesicle sling procedure) | 43.6 | 4+T |
| VADT | 01.34B | Cystoscopy - with urethral dilation | 45.5 | 4+T |
| VADT | 01.34C | Cystoscopy - with bladder dilation | 52 | 4+T |
| VADT | 01.34G | Cystoscopy - with multiple biopsies of bladder | 52.5 | 4+T |

**OTHER NONOPERATIVE ENDOSCOPY NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 01.39B | Sinusoscopy | 25 | |

**CYSTOGRAM NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 02.42 | Cystogram NEC | 15 | 4+T |

**ILEAL CONDUITOGRAM**

| | | | | |
|---|---|---|---|---|
| VADT | 02.43 | Ileal conduitogram | 16 | |
| VADT | 02.43A | Ileal conduitogram with dilation of stoma | 25 | |

**X-RAY OF FALLOPIAN TUBES AND UTERUS**

| | | | | |
|---|---|---|---|---|
| VADT | 02.46A | Sonohysterography only (patient specific) | 58.45 | |
| VADT | 02.46B | Sonohysterography, including transvaginal ultrasound (TVUS) with interpretation and written report (patient specific) | 85 | |

**COMPUTERIZED AXIAL TOMOGRAPHY OF ABDOMEN**

| | | | | |
|---|---|---|---|---|
| VADT | 02.51A | Percutaneous biopsy of solid masses for cytology or histology using CAT | 100 | |

**OTHER COMPUTERIZED AXIAL TOMOGRAPHY**

| | | | | |
|---|---|---|---|---|
| VEDT | 02.75B | Coronary CT angiography | 120 | |

**MAGNETIC RESONANCE IMAGING**

| | | | | |
|---|---|---|---|---|
| VEDT | 02.76A | Bilateral breast MRI - first sequence units | 46.6 | |
| | | Subsequent sequence units (maximum 3 multiples) | 23.3 | |

**OTHER X-RAY NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 02.79A | Fluoroscopy and/or orthodiagram | 5 | |
| VEDT | 02.79B | PET / CT scan and interpretation, one body region | 87 | 4+T |
| VEDT | 02.79C | PET / CT scan and interpretation, multiple body regions (Including whole body scan) | 125 | 4+T |

**DIAGNOSTIC ULTRASOUND OF HEART**

| | | | |
|---|---|---|---|
| ADON | 02.82C | Intracoronary ultrasound in addition to coronary angioplasty/stenting..... 40 | |

**DIAGNOSTIC ULTRASOUND OF DIGESTIVE SYSTEM**

| | | | |
|---|---|---|---|
| VADT | 02.84A | Obstetrical doppler of umbilical artery in the presence of IUGR and other pregnancies at high risk for IUGR - stand alone procedure..... 20 | 4+T |
| ADON | 02.84B | Obstetrical doppler of umbilical artery in the presence of IUGR and other pregnancies at high risk for IUGR in conjunction with obstetrical ultrasound..... 10 | 4+T |

**DIAGNOSTIC ULTRASOUND NEC**

| | | | |
|---|---|---|---|
| VADT | 02.89A | 11-14 week prenatal screening ultrasound for the determination of nuchal translucency..... 35<br>Each additional fetus (maximum 3)<br>SP=OBGY..... 24.5<br>*Physician Restrictions in Place (See Appendix J) | |
| VADT | 02.89B | Genetic Sonogram<br>Includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers) ..... 60<br>Each additional fetus (maximum 3)<br>SP=OBGY..... 42<br>*Physician Restrictions in Place (See Appendix J) | |

**OTHER THERMOGRAPHY**

| | | | |
|---|---|---|---|
| VADT | 02.99A | Thermography - total body interpretation only - in chronic pain patients ..... 10 | |
| VADT | 02.99B | Thermography - regional interpretation only - in chronic pain patients..... 5 | |

**TONOMETRY**

| | | | |
|---|---|---|---|
| VADT | 03.12 | Tonometry (included in a consultation and surgical procedures)..... 4.5 | |

**ELECTROENCEPHALOGRAM**

| | | | |
|---|---|---|---|
| VADT | 03.16 | Electroencephalogram<br>RO=INTP..... 10.5 | |
| ADON | 03.16A | Electroencephalogram - with insertion of subtemporal needles - plus multiples, if applicable ..... 10.5 | |
| ADON | 03.16B | Electroencephalogram - with activating drugs, metrazol - additional - plus multiples, if applicable ..... 10.5 | |
| VADT | 03.16C | EEG video monitor - maximum 28 units per event, maximum 6 per week per patient ..... 28 | |
| VADT | 03.16D | Video-EEG telemetry - maximum once per patient per day..... 60 | |

VADT 03.16E EEG monitoring during intracarotid sodium amytal study ..... 30

VADT 03.16F EEG Video Telemetry - Invasive Day 1
SP=NEUR or SP=NUSG, LO=HOSP, FN=INPT ..... 150

VADT 03.16G EEG Video Telemetry - Invasive Subsequent day (maximum 4 days)
SP=NEUR, SP=NUSG, LO=HOSP, FN=INPT ..... 100

VADT 03.16H EEG Video Telemetry - Non-invasive Day 1
SP=NEUR, SP=NUSG, LO=HOSP, FN=INPT ..... 90

VADT 03.16I EEG Video Telemetry - Non-invasive
Subsequent days (maximum 5 days per week, maximum 2 weeks)
SP=NEUR, SP=NUSG, LO=HOSP, FN=INPT ..... 60

**OTHER NONOPERATIVE NEUROLOGICAL FUNCTION TESTS**

VADT 03.17A Major testing of innervation of more than 3 muscles ..... 18

VADT 03.17B Faradic & galvanic testing (strength duration and chronaxie) ..... 10

VADT 03.17C Minor testing of innervation ..... 7.5

VADT 03.17D Repetitive nerve stimulation study - plus multiples, if applicable
RO=INPR ..... 20

ADON 03.17E Reflex latency studies - plus multiples, if applicable
RO=INPR, RG=BOTH ..... 15

VADT 03.17F Anterior compartment pressure studies ..... 30

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC**

VADT 03.19A Somatosensory evoked potential - plus multiples, if applicable
RO=INPR ..... 35

VADT 03.19B Sensory evoked potential ..... 35

VADT 03.19E Interpretation by Ophthalmologists of Orthoptic Evaluation including measurements of all of the following: visual acuity (distance and near), ocular alignment (distance and near), binocularity including stereopis and vergences and ductions.
RO=INPR ..... 10

**URINARY MANOMETRY**

VADT 03.21A Whittaker test ..... 50

**CYSTOMETROGRAM**

| | | | |
|---|---|---|---|
| VADT | 03.22 | Cystometrogram - plus multiples, if applicable | 17.8 |

**URETHRAL SPHINCTER ELECTROMYOGRAM**

| | | | |
|---|---|---|---|
| VADT | 03.23 | Urethral sphincter electromyogram | 32.7 |

**UROFLOMETRY (UFR)**

| | | | |
|---|---|---|---|
| VADT | 03.24 | Uroflometry (UFR) | 32.7 |

**URETHRAL PRESSURE PROFILE (UPP)**

| | | | |
|---|---|---|---|
| VADT | 03.25 | Urethral pressure profile (UPP) - plus multiples, if applicable | 32.7 |

**GYNECOLOGICAL EXAMINATION**

| | | | |
|---|---|---|---|
| VADT | 03.26A | Pap smear (included in a consultation) | 10.5 |
| ADON | 03.26B | Pap smear tray fee | 2 |
| VADT | 03.26C | Comprehensive pelvic examination with speculum | 10.5 |

**ESOPHAGEAL MANOMETRY**

| | | | |
|---|---|---|---|
| VADT | 03.32 | Esophageal manometry | |
| | | CT=PROF | 9.5 |

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS**

| | | | |
|---|---|---|---|
| VADT | 03.39A | Esophageal motility study | |
| | | CT=TECH | 24 |
| VADT | 03.39B | Anorectal motility studies | |
| | | RO=INTP | 5 |
| | | CT=TECH | 15 |
| VADT | 03.39C | Secretin test | |
| | | CT=PROF | 5 |
| VADT | 03.39D | Gastric secretory studies | |
| | | CT=PROF | 5 |
| VADT | 03.39E | HCL drip test | |
| | | CT=PROF | 5 |
| | | CT=TECH | 10 |
| VADT | 03.39F | ACTH Stimulation test | |
| | | RO=INPR | 10 |

| | | |
|---|---|---|
| VADT | 03.39G | Dexamethasone suppression test for diagnosis of Cushing's Syndrome<br>RO=INTP ..... 7.5 |
| VADT | 03.39H | Pentagastrin stimulation test of calcitonin<br>RO=INPR ..... 25 |
| VADT | 03.39I | Water deprivation test ..... 15 |
| VADT | 03.39J | Propranolol exercise growth hormone stimulation test<br>RO=INTP ..... 10 |
| VADT | 03.39K | Prolonged fast test<br>RO=INPR ..... 10 |
| VADT | 03.39L | Tolbutamide tolerance test<br>RO=PROC ..... 15 |
| VADT | 03.39M | Insulin hypoglycemia test<br>RO=INPR ..... 25 |
| VADT | 03.39N | TRH stimulation test<br>RO=INPR ..... 10 |
| VADT | 03.39O | Arginine insulin stimulation test<br>RO=INPR ..... 25 |
| VADT | 03.39P | Glucagon stimulation test<br>RO=INPR ..... 10 |

**CARDIOVASCULAR STRESS TEST USING TREADMILL**

| | | |
|---|---|---|
| VADT | 03.41A | Pulmonary stress test (non-invasive) ..... 38 |
| VADT | 03.41B | Pulmonary stress test (invasive) to include insertion of an arterial line for blood gas monitoring. Includes EKG's and ECG monitoring ..... 48 |

**CARDIOVASCULAR STRESS TEST USING BICYCLE ERGOMETER**

| | | |
|---|---|---|
| VADT | 03.43 | Cardiovascular stress test using bicycle ergometer ..... 38 |

**OTHER CARDIOVASCULAR STRESS TEST**

| | | |
|---|---|---|
| VADT | 03.44A | Myocardial perfusion study includes IV setup and medication ..... 48 |
| VADT | 03.44B | Graded testing utilizing treadmill with continuous ECG monitoring ..... 38 |

**ARTIFICIAL PACEMAKER RATE CHECK**

| | | |
|---|---|---|
| VADT | 03.45A | Remote follow up ICD device ..... 15 |

**OTHER ELECTROCARDIOGRAM**

VADT 03.52 Other electrocardiogram
RO=INPR ..... 9.2
RO=INTP ..... 4.6

VADT 03.52A Electrocardiogram before and after exercise ..... 15.6

VEDT 03.52B Review of Pacemaker patient's chart, following technologist clinic visit or remote interrogation ..... 8
(Includes review and interpretation of interrogation record and ECG, and written report to family physician or referring physician and applies to all permanently implanted single chamber, dual chamber and defibrillating pacemakers.)

**VECTORCARDIOGRAM (WITH EKG)**

VADT 03.53 Vectorcardiogram (with EKG)
CT=TECH ..... 10
RO=INTP ..... 10

**PHONOCARDIOGRAM WITH EKG LEAD**

VADT 03.55 Phonocardiogram with EKG lead
RO=SPIN ..... 10

**OTHER CARDIOVASCULAR MEASUREMENTS NEC**

VADT 03.69A Tilt table study includes IV injection ..... 50

**MICROSCOPIC EXAMINATION OF SPECIMEN FROM EAR, NOSE, THROAT AND LARYNX – OTHER MICROSCOPIC EXAMINATION**

VEDT 04.29A Nasal smear for eosinophils ..... 2

**MICROSCOPIC EXAMINATION OF BLOOD, OTHER MICROSCOPIC EXAMINATION**

VEDT 04.49A HLA typing ..... 52.90

VEDT 04.49B HLA identification and crossmatch ..... 52.90

VEDT 04.49C Peripheral blood film review ..... 10

VEDT 04.49D Flow cytometry ..... 52.90

**MICROSCOPIC EXAMINATION OF SPECIMEN FROM BLADDER, URETHRA, PROSTATE, SEMINAL VESICLE, PERIVESICAL TISSUE, AND OF URINE AND SEMEN - CULTURE AND SENSITIVITY**

VADT 05.23A Antidiuretic hormone response test ..... 15

VADT 05.23B Vasopressor or depressor test ..... 15

**MICROSCOPIC EXAMINATION OF SPECIMEN FROM BLADDER, URETHRA, PROSTATE, SEMINAL VESICLE, PERIVESICAL TISSUE, AND OF URINE AND SEMEN - OTHER MICROSCOPIC EXAMINATION**

VADT 05.29A Fertility investigation, sperm count and morphology ..... 5

**SUPERFICIAL RADIATION**

VADT 06.31 Superficial radiation ..... 6

**INJECTION OR INSTILLATION OF RADIOISOTOPES**

VADT 06.35B Thyroid malignancy ..... 20

VADT 06.35C Hyperthyroidism ..... 20

VADT 06.35D Polycythemia ..... 10

VADT 06.35E Metastatic disease of bone ..... 20

VADT 06.35F Arthritis single or multiple site ..... 8

**OTHER RADIOTHERAPEUTIC PROCEDURE**

VADT 06.39D Percutaneous image guided radiofrequency ablation of solid tumour
- plus multiples, to a maximum of 3, if applicable ..... 250 4+T

**ELECTROMYOGRAPHY (EMG)**

VADT 07.08A Electromyography, major with muscles of more than one region examined ..... 38

VADT 07.08B Electromyography, minor, examination of a specific muscle/region ..... 20

VADT 07.08C Nerve conduction studies, per nerve studied
- plus multiples, to a maximum of 6, if applicable, ..... 27

VADT 07.08D MS system - single fibre (EMG (SFEMG))
- minimum of 20 coupled potentials ..... 84

**PSYCHIATRIC COMMITMENT EVALUATION**

VADT 08.12 Psychiatric commitment evaluation (included in a consultation)
RO=FPHN ..... 15
RO=SPHN ..... 15

**LIMITED EYE EXAMINATION**

VADT 09.01A Gonioscopy (included in a consultation) ..... 6

**COMPREHENSIVE EYE EXAMINATION**

VEDT 09.02 Comprehensive eye examination - Including refraction ..... 20.3

VEDT 09.02A Low vision clinic fees (for prolonged visits beyond one hour, a rate of 13.7 units per 15 minutes applies) - plus multiples, if applicable
RP=INTL ..... 50

| | | | | |
|---|---|---|---|---|
| VEDT | 09.02B | Reduced payment for uninsured service | 10.4 | |
| VEDT | 09.02D | Low vision clinic fees - follow-up after 30 days | 25 | |

**EYE EXAMINATION UNDER ANAESTHESIA**

| | | | | |
|---|---|---|---|---|
| VEDT | 09.04 | Eye examination under anaesthesia | 27 | 4+T |
| | | Prolonged eye examinations under general anaesthesia for children (50 units per half hour) - plus multiples, if applicable | | |
| | | AG=CH16 | 50 | 4+T |

**VISUAL FIELD STUDY**

| | | | | |
|---|---|---|---|---|
| VADT | 09.05 | Visual field study (included in a consultation) | 12 | |

**FLUORESCEIN ANGIOGRAPHY OR ANGIOSCOPY OF EYE**

| | | | | |
|---|---|---|---|---|
| VADT | 09.12 | Fluorescein angiography or angioscopy of eye | 22 | |
| VADT | 09.12B | Indocyanine green angiography - including interpretation | 22 | |

**ULTRASOUND STUDY OF EYE**

| | | | | |
|---|---|---|---|---|
| VADT | 09.13A | Real time (eye) ultrasound | 38.70 | |
| VADT | 09.13B | Axial length measurement by ultrasound | 25.44 | |

**ELECTRORETINOGRAM (ERG)**

| | | | | |
|---|---|---|---|---|
| VADT | 09.21 | Electroretinogram (ERG) | | |
| | | RO=INTP | 8 | |
| | | RO=SUPV | 17 | |

**ELECTRO-OCULOGRAM (EOG)**

| | | | | |
|---|---|---|---|---|
| VADT | 09.22 | Electro-oculogram (EOG) | | |
| | | RO=INTP | 10 | |
| | | RO=SUPV | 15 | |

**VISUAL EVOKED POTENTIAL (VEP)**

| | | | | |
|---|---|---|---|---|
| VADT | 09.23 | Visual evoked potential (VEP) | | |
| | | RO=INTP | 12 | |

**ELECTRONYSTAGMOGRAM (ENG)**

| | | | | |
|---|---|---|---|---|
| VADT | 09.24 | Electronystagmogram | 35 | |
| | | RO=INTP | 13.5 | |

**TONOGRAPHY, PROVOCATIVE TESTS, AND OTHER GLAUCOMA TESTING**

| | | | | |
|---|---|---|---|---|
| VADT | 09.26 | Tonography, provocative tests, and other glaucoma testing | | |
| | | CT=PROF | 10 | |
| | | CT=TECH | 10 | |

| | | | |
|---|---|---|---|
| VADT | 09.26A | Kinetic minimum, two isopters | 17 |
| VADT | 09.26B | Kinetic, with static cuts or Humphrey field analysis | 22 |
| VADT | 09.26C | Ophthalmodynamometry | 10 |

**PRESCRIPTION, FITTING, AND DISPENSING OF CONTACT LENS**

| | | | |
|---|---|---|---|
| VADT | 09.32A | Contact lens fitting - with follow-up for 3 months | |
| | | AG=ADUT | 196 |
| | | AG=CH16 | 245 |
| VADT | 09.32B | Bandage contact lens (regions required) | 40 |

**AUDIOMETRY**

| | | | |
|---|---|---|---|
| VADT | 09.41 | Audiometry | |
| | | RO=INTP | 4.5 |
| VADT | 09.41A | Pure tone audiogram, right, left or both | |
| | | SP=OTOL | 9 |
| VADT | 09.41B | Pure tone audiogram, bone conduction | |
| | | SP=OTOL | 11 |
| VADT | 09.41C | Bekesy audiometry | 10 |
| VADT | 09.41D | Complete hearing test (including audiometry, tuning fork and speech test) | 23 |
| VADT | 09.41E | Impedance, audiometry, including tympanometry, static compliance, multiple, etc., | |
| | | RO=INTP | 15 |
| VADT | 09.41F | Impedance audiometry interpretation only of tympanogram, impedance/compliance and stapedial reflex studies | 5 |
| VADT | 09.41G | Impedance audiometry tympanometry, static compliance, single frequency acoustic reflex and/or reflex decay testing | |
| | | RO=INTP | 7.5 |
| VADT | 09.41H | Tympanometry only | |
| | | SP=OTOL | 5 |

**OTHER AUDITORY AND VESTIBULAR FUNCTION TESTS**

| | | | |
|---|---|---|---|
| VADT | 09.46 | Other auditory and vestibular function tests | 21.6 |
| VADT | 09.46A | SISI tests | 5 |
| VADT | 09.46B | Speech reception and discrimination test | |
| | | SP=OTOL | 10 |

| | | | | |
|---|---|---|---|---|
| VADT | 09.46C | Tone decay tests | 10 | |
| VADT | 09.46D | Alternate loudness balance | 15 | |
| VADT | 09.46E | Auditory evoked potential<br>RO=INPR | 35 | |
| | | RO=INTP | 5 | |

**INSERTION OF SENGSTAKEN TUBE**

| | | | | |
|---|---|---|---|---|
| VADT | 10.06A | Gastroesophageal tamponade | 20 | 4+T |

**INSERTION OF OTHER (NASO-) GASTRIC TUBE**

| | | | |
|---|---|---|---|
| VADT | 10.07A | 24-hour pH measurement of the upper GI Tract | 19 |

**INSERTION OF OTHER VAGINAL PESSARY**

| | | | |
|---|---|---|---|
| VADT | 10.16 | Insertion of other vaginal pessary examination and insertion of pessary and 1 follow-up visit | 33.16 |

**GASTRIC LAVAGE**

| | | | |
|---|---|---|---|
| VADT | 10.33 | Gastric lavage | 10 |
| VADT | 10.33A | Aspiration of esophagus/stomach and preparation of material for cytological examination | 10 |

**OTHER GENITOURINARY INSTILLATION**

| | | | |
|---|---|---|---|
| VADT | 10.56A | Instillation of chemotherapy with bladder catheterization | 17.5 |

**IRRIGATION OF EAR**

| | | | |
|---|---|---|---|
| VADT | 10.62B | Removal of cerumen from a febrile child, with or without irrigation, unilateral or bilateral<br>AG=CH12 (included in a consultation) | 5 |

**OTHER LAVAGE OF BRONCHUS AND TRACHEA**

| | | | | |
|---|---|---|---|---|
| VADT | 10.66C | Total lung lavage requiring a double lumen endotracheal tube, generally used for alveolar proteinosis - per hour - plus multiples, if applicable | 58 | 8+T |

**EXCHANGE TRANSFUSION (ADULT) (NEWBORN)**

| | | | |
|---|---|---|---|
| VADT | 13.01 | Exchange transfusion (adult) (newborn) | 165 |

**OTHER TRANSFUSION OF WHOLE BLOOD**

| | | | |
|---|---|---|---|
| VADT | 13.03 | Other transfusion of whole blood | 6 |

**TRANSFUSION OF PACKED (RED) CELLS**

| | | | |
|---|---|---|---|
| VADT | 13.04A | Therapeutic plasmapheresis | 25 |

**VACCINATION AGAINST TUBERCULOSIS**

| | | | |
|---|---|---|---|
| VADT | 13.13 | Vaccination against tuberculosis | 5 |

**IMMUNIZATION FOR ALLERGY**

| | | | |
|---|---|---|---|
| VEDT | 13.42 | Immunization for allergy - plus multiples, if applicable | |
| | | RP=INTL | 10.5 |
| | | RP=SUBS | 6 |

**INJECTION OF ANTIBIOTIC**

| | | | |
|---|---|---|---|
| VADT | 13.51A | Transtympanic injection of Gentamycin - maximum of three injections per day (regions required) | 15 |

**INJECTION OF STEROID**

| | | | |
|---|---|---|---|
| VADT | 13.53A | Intradermal progestin contraceptive device | 20 |
| VADT | 13.53C | Removal of Intradermal progestin contraceptive device (text required) | 20 |

**INJECTION OF OTHER HORMONE**

| | | | | |
|---|---|---|---|---|
| VADT | 13.54A | Intradermal scalp injection for alopecia areata | 5 | |
| VADT | 13.54B | Implantation of hormone pellets | 10 | 4+T |

**INJECTION OR INFUSION OF CANCER CHEMOTHERAPEUTIC SUBSTANCE NEC**

| | | | |
|---|---|---|---|
| VADT | 13.55 | Injection or infusion of cancer chemotherapeutic substance NEC - plus multiples, if applicable | |
| | | AG=ADUT | 7.7 |
| | | AG=CH16 | 11.6 |
| VADT | 13.55B | Administration by a physician of a test dose of a chemotherapeutic agent when there is a risk of a severe allergic reaction e.g. L-asparaginase Maximum once per patient per drug | 15 |

**INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC**

| | | | |
|---|---|---|---|
| VEDT | 13.59 | Injection or infusion of therapeutic or prophylactic substance NEC one/more injections at one visit | 6 |
| VADT | 13.59A | Multiple inoculation for immunotherapy (e.g., treatment of warts by DNCB) | 15 |
| VADT | 13.59B | A.N.S. - temporary blocks - bier block with guanethidine/reserpine | 45 |
| VADT | 13.59C | Intracorporal injection | 10 |
| VADT | 13.59E | Tensilon test | 10 |

| | | | |
|---|---|---|---|
| VADT | 13.59G | Injection of myochrysine gold salts | 6 |
| ADON | 13.34A | Rotavirus Immunization | 6 |
| ADON | 13.59L | Provincial immunizations (Preamble 5.3.26) | |
| | | RO=CO19 | 6 |
| | | RO=EXEM | 6 |
| | | RO=GAIG PT=RISK | 6 |
| | | RO=HAHB PT=RISK | 6 |
| | | RO=HAIG PT=RISK | 6 |
| | | RO=HAVV PT=RISK | 6 |
| | | RO=HBIG PT=RISK | 6 |
| | | RO=HBVV (PT=RISK) | 6 |
| | | RO=HDIN (PT=RISK) | 6 |
| | | RO=HIBV (PT=RISK) | 6 |
| | | RO=HPV4 (PT=RISK) | 6 |
| | | RO=HPV9 (PT=RISK) | 6 |
| | | RO=INFL | 6 |
| | | RO=IPVV | 6 |
| | | RO=MENB PT=RISK | 6 |
| | | RO=MENC (PT=RISK) | 6 |
| | | RO=MENQ (PT=RISK) | 6 |
| | | RO=MMAR | 6 |
| | | RO=MMRT PT=RISK | 6 |
| | | RO=MMRV | 6 |
| | | RO=MPOX | 6 |
| | | RO=PENT | 6 |
| | | RO=PNEC (PT=RISK) | 6 |
| | | RO=PNEU (PT=RISK) | 6 |
| | | RO=RABI PT=RISK | 6 |
| | | RO=RABV PT=RISK | 6 |
| | | RO=RSVV (PT=RISK) | 6 |
| | | RO=RSVM (PT=RISK) | 6 |
| | | RO=SHVV | 6 |
| | | RO=TDAP | 6 |
| | | RO=TDPP | 6 |
| | | RO=TEDV (PT=RISK) | 6 |
| | | RO=TEIG PT=RISK | 6 |
| | | RO=TIPV | 6 |
| | | RO=VAIG PT=RISK | 6 |
| | | RO=VARV (PT=RISK) | 6 |
| ADON | 13.59M | Provincial immunization tray fee/maximum 4 - per multiple | 1.5 |
| VADT | 13.59N | Intravenous infusion of local anaesthetic/adrenergic drugs for chronic pain Management (e.g. lidocaine) | 45 |
| VADT | 13.59P | Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment Of opioid use disorder | 20 |
| VADT | 13.59Q | Removal of Buprenorphine Implant (e.g. Probuphine) | 20 |

| | | | |
|---|---|---|---|
| ADON | 13.59R | Evusheld injection for the prevention of COVID-19 in immune compromised adults and children ..... 6+MU | |

**HYPERBARIC OXYGENATION**

| | | | |
|---|---|---|---|
| VADT | 13.65 | Hyperbaric oxygenation - plus multiples, if applicable<br>RO=INCH ..... 27<br>RO=OTCH ..... 20 | |

**OTHER ELECTRIC COUNTERSHOCK OF HEART**

| | | | |
|---|---|---|---|
| VADT | 13.72 | Other electric countershock of heart ..... 48 | 5+T |

**OTHER MISCELLANEOUS DIAGNOSTIC & THERAPEUTIC PROCEDURES NEC**

| | | | |
|---|---|---|---|
| VADT | 13.99A | Patch test for allergens (application and reading) per series - plus multiples, if applicable ..... 28.5 | |
| VADT | 13.99B | Maximum for complete testing, allergy testing ..... 40 | |
| VADT | 13.99D | Ingestant provocation studies for high risk patients only in hospital by a qualified allergist (multiples required) ..... 60<br>(60 units first hour, 15 units for each additional 1/4 hour up to 3 hours) | |
| VADT | 13.99E | Ingestant provocation studies for low risk patients by a qualified allergist ..... 50 | |
| VEDT | 13.99F | Assessment and management of patient with Acute Stroke ..... 130<br>From activation of Acute Stroke Protocol through completion of Thrombolytic therapy (e.g. t-PA) | |

**OTHER MISCELLANEOUS ANTICOAGULANT SUPERVISION NEC**

| | | | |
|---|---|---|---|
| VADT | 13.99C | Supervision of long-term warfarin therapy (per month telephone/fax/e-mail communications) ..... 10 | |
| VADT | 13.99H | Consult with pharmacy for patient participating in CPAMS ..... 10 | |

**CISTERNAL PUNCTURE**

| | | | |
|---|---|---|---|
| VADT | 14.01 | Cisternal puncture ..... 30 | |
| VADT | 14.01A | Cisterna magna aspiration ..... 15 | |

**OTHER CRANIAL PUNCTURE**

| | | | |
|---|---|---|---|
| VADT | 14.09A | Subdural puncture - plus multiples, if applicable<br>RP=INTL ..... 35 | |
| VADT | 14.09B | Ventricular puncture ..... 35 | |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON BRAIN AND CEREBRAL MENINGES**

| | | | |
|---|---|---|---|
| VADT | 14.88A | Electrocorticogram<br>RO=SPIN ..... 100.5 | |
| VADT | 14.88B | Depth E.E.G., electrical stimulation, during thalamotomies ..... 50 | |

**IMPLANTATION OF INTRACRANIAL NEUROSTIMULATOR**

| | | | | |
|---|---|---|---|---|
| VADT | 15.93A | Percutaneous diagnostic stimulation of the brain | 170 | |
| VADT | 15.93B | Implantation or revision of stimulation packs or leads (spinal cord, brain and peripheral nerve) | 160 | 7+T |
| VADT | 15.93C | Stimulation pack, battery change | 125 | 7+T |

**INJECTION OF DESTRUCTIVE AGENT INTO SPINAL CANAL**

| | | | | |
|---|---|---|---|---|
| VADT | 16.7 | Injection of destructive agent into spinal canal | 69 | |

**SPINAL TAP**

| | | | | |
|---|---|---|---|---|
| VADT | 16.81 | Spinal tap | | 4+T |
| | | AG=ADUT | 37.5 | |
| | | AG=CH16 | 47 | |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON SPINAL CORD AND SPINAL CANAL STRUCTURES**

| | | | | |
|---|---|---|---|---|
| VADT | 16.89A | Discogram | 30 | 4+T |

**INJECTION OF ANAESTHETIC INTO SPINAL CANAL FOR ANALGESIA**

| | | | | |
|---|---|---|---|---|
| VADT | 16.91A | Chronic epidural catheter insertion, tunnelling and reservoir implantation | 100 | |
| VADT | 16.91B | Temporary trans-sacral nerve root block | 41 | |
| VADT | 16.91C | Thoracic/cervical intrathecal/epidural Injections – Temporary Block | 52 | |
| VADT | 16.91D | Differential spinal-epidural block | 80 | |
| VADT | 16.91E | Caudal block | 29 | |
| VADT | 16.91F | Insertion of permanent epidural catheter | 57 | |
| VADT | 16.91G | Insertion of permanent epidural catheter with tunnelling | 69 | |
| VADT | 16.91H | Intrathecal/epidural injections - thoracic or cervical areas Permanent Block with a sclerosing agent | 91 | |
| VADT | 16.91I | Subarachnoid block (diagnostic spinal) | 30 | |
| VADT | 16.91L | Post-op pain control performed in conjunction with anaesthesia (caudal/intercostal/ intrapleural/psoas compartment) - plus multiples, if applicable | | |
| | | SP=ANAE, SP=GENP | 10 | |
| VEDT | 16.91R | Continuous conduction anaesthesia for relief of pain in labour | | |
| | | SP=ANAE, AN=LABR | 166 | |
| | | SP= GENP, AN=LABR | 166 | |

**INJECTION OF OTHER AGENT INTO SPINAL CANAL**

| | | | |
|---|---|---|---|
| VADT | 16.92 | Injection of other agent into spinal canal (with installation of chemotherapeutic agents) ..... | 4+T |
| | | AG=ADUT ..... 56.3 | |
| | | AG=CH16 ..... 70.5 | |
| VADT | 16.92A | Epidural, single injection as with cortisone ..... 35 | |
| VADT | 16.92C | Epidural infusion of baclofen includes programming and filling of the pump ..... 15 | |

**INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR**

| | | | |
|---|---|---|---|
| VADT | 16.93A | Percutaneous diagnostic stimulation of the spinal cord ..... 170 | |
| VADT | 16.93B | Implantation or revision of stimulation packs or leads (spinal cord, brain and peripheral nerve) ..... 160 | 7+T |
| VADT | 16.93C | Stimulation pack, battery change ..... 125 | 7+T |

**SPINAL BLOOD PATCH**

| | | | |
|---|---|---|---|
| VADT | 16.95 | Spinal blood patch ..... 40 | |

**PERCUTANEOUS DENERVATION OF FACET**

| | | | |
|---|---|---|---|
| VADT | 16.96 | Percutaneous denervation of facet - plus multiples, if applicable ..... 46 | |

**DIVISION OF TRIGEMINAL NERVE**

| | | | |
|---|---|---|---|
| VADT | 17.03C | Facet nerve rhizotomy - plus multiples, if applicable ..... 34 | 4+T |

**DESTRUCTION OF CRANIAL AND PERIPHERAL NERVES**

| | | | |
|---|---|---|---|
| VADT | 17.1A | Therapeutic blocks with sclerosing solution - permanent trans-sacral nerve block ..... 69 | |
| VADT | 17.1B | Permanent coeliac plexus block with Phenol ..... 91 | |
| VADT | 17.1C | Gasserian ganglion block ..... 60 | |
| VADT | 17.1D | Transverse scapular nerve ..... 30 | |
| VADT | 17.1E | Single somatic block - plus multiples, if applicable ..... 28 | |

**PERIPHERAL NERVE INJECTION, UNQUALIFIED**

| | | | |
|---|---|---|---|
| VADT | 17.71A | Mandibular block ..... 25 | |
| VADT | 17.71B | Maxillary block ..... 25 | |

**INJECTION OF ANAESTHETIC INTO PERIPHERAL NERVE FOR ANALGESIA**

| | | | |
|---|---|---|---|
| VADT | 17.72A | Cervical plexus block ..... 30 | |

| | | | | |
|---|---|---|---|---|
| VADT | 17.72B | Sciatic block | 29 | |
| VADT | 17.72C | Temporary blocks - somatic nerve/paravertebral somatic nerve - plus multiples, if applicable | 20 | |
| VADT | 17.72D | Obturator block | 29 | |
| VADT | 17.72E | Pudendal block | 23 | |
| VADT | 17.72F | Lateral femoral cutaneous nerve block | 30 | |
| VADT | 17.72G | Brachial plexus block | 25 | |
| VADT | 17.72H | Maxillary or mandibular division of trigeminal nerve | 35 | |
| VADT | 17.72I | Superior laryngeal nerve | 60 | |
| VADT | 17.72J | Myofascial trigger point injection of therapeutic agent, regardless of the number of injections | 10 | |

**BIOPSY OF PERIPHERAL NERVE OR GANGLION**

| | | | | |
|---|---|---|---|---|
| VADT | 17.81A | Sural nerve biopsy | 50 | 4+T |

**IMPLANTATION OR REPLACEMENT OF PERIPHERAL NEUROSTIMULATOR**

| | | | |
|---|---|---|---|
| VADT | 17.92B | Sacral nerve stimulator programming inclusive of visit | 24 |

**OTHER OPERATIONS ON CRANIAL AND PERIPHERAL NERVES NEC**

| | | | |
|---|---|---|---|
| ADON | 17.99D | Sciatic nerve catheter insertion at time of amputation | 10 |

**INJECTION OF ANAESTHETIC INTO SYMPATHETIC NERVE FOR ANALGESIA**

| | | | |
|---|---|---|---|
| VADT | 18.21A | Presacral block | 25 |
| VADT | 18.21B | Lumbar sympathetic block (regions required) | 41 |
| VADT | 18.21C | Stellate ganglion block | 46 |
| VADT | 18.21D | Coeliac plexus block | 46 |
| VADT | 18.21E | Femoral nerve block | 25 |

**INJECTION OF NEUROLYTIC AGENT INTO SYMPATHETIC NERVE**

| | | | |
|---|---|---|---|
| VADT | 18.22A | Cardiac sensory nerve block | 60 |
| VADT | 18.22B | Lumbar sympathetic block | 69 |
| VADT | 18.22C | Sphenopalatine ganglion block | 30 |
| VADT | 18.22D | Stellate ganglion block | 91 |

**OTHER INJECTION INTO SYMPATHETIC NERVE OR GANGLION**

| | | | | |
|---|---|---|---|---|
| VADT | 18.29A | Paravertebral - nerve block - plus multiples, if applicable | 35 | |

**ASPIRATION OF THYROID FIELD**

| | | | | |
|---|---|---|---|---|
| VADT | 19.01 | Aspiration of thyroid field | 10 | |

**SUBCONJUNCTIVAL INJECTION**

| | | | | |
|---|---|---|---|---|
| VADT | 24.91 | Subconjunctival injection (regions required) | 15 | 4+T |

**INJECTION OF VITREOUS SUBSTITUTE**

| | | | | |
|---|---|---|---|---|
| VADT | 28.73D | Intravitreal injection of antibiotics (regions required) | 25 | |
| VADT | 28.73F | Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases | 25 | |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON MIDDLE AND INNER EAR**

| | | | | |
|---|---|---|---|---|
| VADT | 32.89A | Glycerol test - includes repeated audiometric testing same day | | |
| | | RO=INPR | 30 | |
| | | RO=INTP | 15 | |

**OPERATIONS ON EUSTACHIAN TUBE**

| | | | | |
|---|---|---|---|---|
| VADT | 32.97A | Catheterization of eustachian tube (regions required) | 5 | |

**TEMPORARY TRACHEOSTOMY**

| | | | | |
|---|---|---|---|---|
| VADT | 43.1B | Bedside percutaneous tracheostomy | 100 | 6+T |

**CONTRAST LARYNGOGRAM**

| | | | | |
|---|---|---|---|---|
| VADT | 43.83A | Laryngogram | 10 | |

**OTHER OPERATIONS ON TRACHEA**

| | | | | |
|---|---|---|---|---|
| ADON | 43.96A | Tracheal dilation - add on to rigid bronchoscopy | 50 | |

**LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF BRONCHUS**

| | | | | |
|---|---|---|---|---|
| ADON | 44.0A | Laser treatment of malignant neoplasms of esophagus, bronchi, etc. in addition to scope | 50 | 13+T |

**OTHER CONTRAST BRONCHOGRAM**

| | | | | |
|---|---|---|---|---|
| VADT | 45.86 | Other contrast bronchogram | 25.5 | 6+T |

**INSERTION OF INTERCOSTAL CATHETER (WITH WATER SEAL) FOR DRAINAGE**

| | | | | |
|---|---|---|---|---|
| VADT | 46.04B | Insertion of temporary chest tube | 40 | |

**MEDIASTINOSCOPY**

| | | | | |
|---|---|---|---|---|
| VADT | 46.82 | Mediastinoscopy | 120 | 6+T |
| VADT | 46.82A | Mediastinoscopy with flexible bronchoscopy | 140 | 6+T |
| VADT | 46.82B | Mediastinoscopy with rigid bronchoscopy | 150 | 6+T |

**PLEURAL BIOPSY**

| | | | | |
|---|---|---|---|---|
| VADT | 46.84 | Pleural biopsy | 20 | |

**THORACENTESIS**

| | | | | |
|---|---|---|---|---|
| VADT | 46.91A | Thoracentesis - therapeutic aspiration including diagnostic sample | 24 | 4+T |
| VADT | 46.91B | Thoracentesis - administration of chemotherapy including therapeutic aspiration and sample | 25 | |
| VADT | 46.91D | Thoracentesis - aspiration for diagnostic sample | 20 | |

**CLOSED HEART VALVOTOMY, UNSPECIFIED VALVE**

| | | | | |
|---|---|---|---|---|
| VADT | 47.01 | Closed heart valvotomy, unspecified valve | 250 | 15+T |

**ENLARGEMENT OF EXISTING ATRIAL SEPTAL DEFECT**

| | | | | |
|---|---|---|---|---|
| VADT | 47.42 | Enlargement of existing atrial septal defect balloon septostomy | 125 | 9+T |

**OTHER AND UNSPECIFIED REPAIR OF ATRIAL SEPTAL DEFECT**

| | | | | |
|---|---|---|---|---|
| VADT | 47.72A | Percutaneous Atrial Septal Defect Closure/Patent Foramen Ovale Closure | 200 | 8+T |

**REMOVAL OF CORONARY ARTERY OBSTRUCTION**

| | | | | |
|---|---|---|---|---|
| VADT | 48.0A | Percutaneous coronary angioplasty (including selective coronary arteriography and right heart catheterization) - plus multiples, if applicable | | 15+T |
| | | AG=ADUT | 250 | |
| | | AG=CH16 | 275 | |
| VADT | 48.0C | Directional atherectomy - includes one angioplasty (if subsequent angioplasties are performed prior to the atherectomy when the patient's condition has changed, they should be paid in addition to the atherectomy composite fee. If the patient's condition has not changed since the first angioplasty, subsequent angioplasty should not be paid. This applies whether it is the same or different cardiologist) | 300 | 15+T |

| | | | | |
|---|---|---|---|---|
| VADT | 48.0D | Arm venogram angioplasty for hemodialysis fistula (regions required) | 137.7 | |
| VADT | 48.0F | Insertion of intracoronary stent - includes one angiogram (when additional angiograms are performed prior to stenting when the patient's condition has changed, they should be paid in addition to the stenting. If the patient's condition has not changed since the first angiogram, the subsequent angiogram(s) should not be paid. This applies whether it is the same or different cardiologist. When a stentor is called in to place a stent during angioplasty by another interventional cardiologist, only 50 units is payable to the stentor. When three or more stents are placed, an additional 25 units is payable regardless of the number of additional stents) | | |
| | | - plus multiples, if applicable | 300 | 15+T |
| | | RO=SPHN | 50 | |

**OTHER CORONARY ARTERIOGRAPHY**

| | | | | |
|---|---|---|---|---|
| VADT | 48.98B | Selective coronary angiography | 121 | 5+T |

**PERICARDIOCENTESIS**

| | | | | |
|---|---|---|---|---|
| VADT | 49.0 | Pericardiocentesis | 48 | |
| VADT | 49.0A | Left ventricular puncture | 50 | 5+T |

**IMPLANT OF PULSATION BALLOON**

| | | | | |
|---|---|---|---|---|
| VADT | 49.61A | Percutaneous insertion of intra-aortic balloon pump | 175 | |

**IMPLANTATION OF HEART ASSIST SYSTEM**

| | | | | |
|---|---|---|---|---|
| VADT | 49.7A | Insertion of Implantable of Loop Recorder | 70 | 4+T |

**IMPLANTATION OF ENDOCARDIAL ELECTRODES**

| | | | | |
|---|---|---|---|---|
| VADT | 49.73 | Implantation of endocardial electrodes | 96 | |
| | | Temporary, by transvenous (percutaneous) approach | | |

**REPLACEMENT OF PULSE GENERATOR**

| | | | | |
|---|---|---|---|---|
| VADT | 49.83B | Visit and programming to a standard pacemaker | 24 | |
| VADT | 49.83C | Visit and programming to a dual chamber pacemaker | 36 | |

**REMOVAL OF CARDIAC PACEMAKER SYSTEM WITHOUT REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| VADT | 49.87A | Removal of Loop Recorder | 40 | 4+T |

**BIOPSY OF HEART**

| | | | | |
|---|---|---|---|---|
| VADT | 49.93 | Biopsy of heart | 82 | 8+T |

**BIOPSY OF PERICARDIUM**

| | | | |
|---|---|---|---|
| VADT | 49.94A | Biopsy of pericardium by needle ..... 75 | |

**RIGHT CARDIAC CATHETERIZATION**

| | | | |
|---|---|---|---|
| VADT | 49.95 | Right cardiac catheterization ..... | 8+T |
| | | AG=ADUT ..... 68 | |
| | | AG=CH16 ..... 85 | |
| ADON | 49.95A | Extra angiogram more than two - plus multiples, if applicable | |
| | | AG=ADUT ..... 22 | |
| | | AG=CH16 ..... 28 | |
| ADON | 49.95B | Assessment of pulmonary vascular resistance changes (includes all agents add on to right heart catheterization) | |
| | | AG=ADUT ..... 36 | |
| | | AG=CH16 ..... 44 | |

**LEFT CARDIAC CATHETERIZATION**

| | | | |
|---|---|---|---|
| VADT | 49.96 | Left cardiac catheterization ..... | 8+T |
| | | AG=ADUT ..... 90 | |
| | | AG=CH16 ..... 115 | |
| VADT | 49.96A | Left heart catheterization with selective coronary arteriogram ..... 156 | 8+T |
| VADT | 49.96B | Left heart catheterization with angiograms and selective coronary arteriogram. 180 | 8+T |
| ADON | 49.96C | Ergonovine provocation (for coronary artery spasm) add on to right heart catheterization | |
| | | AG=ADUT ..... 45 | |
| | | AG=CH16 ..... 55 | |
| ADON | 49.96D | Selective coronary graft angiography add on to catheterization of heart - left - plus multiples, if applicable | |
| | | AG=ADUT ..... 33 | |
| | | AG=CH16 ..... 41 | |
| VADT | 49.96E | Transeptal left heart catheterization ..... | 8+T |
| | | AG=ADUT ..... 135 | |
| | | AG=CH16 ..... 165 | |
| VADT | 49.96F | Left heart catheterization via atrial septal defect/foramen ovale | |
| | | AG=ADUT ..... 90 | |
| | | AG=CH16 ..... 110 | |
| ADON | 49.96G | Extra angiogram - more than two - plus multiples, if applicable | |
| | | AG=ADUT ..... 22 | |
| | | AG=CH16 ..... 28 | |
| VADT | 49.96H | Intracoronary ultrasound including left heart catheterization, left ventricular angiogram and selective coronary arteriography ..... 250 | |

**COMBINED RIGHT AND LEFT CARDIAC CATHETERIZATION**

| | | | |
|---|---|---|---|
| VADT | 49.97 | Combined right and left cardiac catheterization | 8+T |
| | | AG=ADUT ... 125 | |
| | | AG=CH16 ... 150 | |
| VADT | 49.97A | Combined right and left cardiac catheterization with angiograms | 8+T |
| | | AG=ADUT ... 145 | |
| | | AG=CH16 ... 180 | |
| VADT | 49.97B | Combined right and left cardiac catheterization with angiograms and either Fick or thermodilution cardiac output | 8+T |
| | | AG=ADUT ... 150 | |
| | | AG=CH16 ... 185 | |
| VADT | 49.97C | Combined right and left cardiac catheterization with selective coronary arteriogram | 8+T |
| | | AG=ADUT ... 180 | |
| | | AG=CH16 ... 220 | |
| VADT | 49.97D | Combined right and left cardiac catheterization with angiograms and selective coronary arteriogram | 8+T |
| | | AG=ADUT ... 200 | |
| | | AG=CH16 ... 250 | |
| VADT | 49.97E | Combined right and left cardiac catheterization with angiograms, selective coronary arteriogram and Fick or thermodilution cardiac output | 8+T |
| | | AG=ADUT ... 205 | |
| | | AG=CH16 ... 255 | |
| ADON | 49.97F | Extra angiogram more than two - plus multiples, if applicable | |
| | | AG=ADUT ... 22 | |
| | | AG=CH16 ... 28 | |
| ADON | 49.97G | Cardiac output ... 5 | |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON HEART AND PERICARDIUM**

| | | | |
|---|---|---|---|
| VADT | 49.98A | Electrophysiological study with programmed stimulation of the atria or ventricles | 8+T |
| | | AG=ADUT ... 180 | |
| | | AG=CH16 ... 220 | |
| VADT | 49.98B | Electrophysiological study to assess response to medication or surgery | |
| | | AG=ADUT, RP=REPT ... 90 | |
| | | AG=CH16, RP=REPT ... 110 | |
| VADT | 49.98C | Electrophysiologic study with endomyocardial mapping | 9+T |
| | | AG=ADUT ... 180 | |
| | | AG=CH16 ... 220 | |

| | | | |
|---|---|---|---|
| VADT | 49.98D | Atrial pacing and HIS bundle studies ..... | 9+T |
| | | AG=ADUT ..... 90 | |
| | | AG=CH16 ..... 110 | |
| ADON | 49.98E | Dye curves (including all curves) add on to right heart catheterization | |
| | | AG=ADUT ..... 22 | |
| | | AG=CH16 ..... 28 | |
| VADT | 49.98F | Catheter ablation therapy for cardiac arrhythmias | |
| | | RO=FPHN ..... 250 | |
| | | RO=SPHN ..... 75 | |
| VADT | 49.98G | Catheter ablation - composite fee, including endocardial mapping and electrophysiological study ..... 430 | |
| VADT | 49.98H | Atrial pacing studies | |
| | | AG=ADUT ..... 45 | 9+T |
| VADT | 49.98I | Complex cardiac ablation for atrial fibrillation and complex cardiac arrhythmias ..... 796 | 9+T |

**INCISION OF VESSEL**

| | | | |
|---|---|---|---|
| VADT | 50.0A | Percutaneous image guided retrieval of intravascular foreign body (composite fee - to include all necessary imaging studies) ..... 150 | 10+T |

**RESECTION OF VESSEL WITH REPLACEMENT**

| | | | |
|---|---|---|---|
| VEDT | 50.37D | EVAR - endovascular abdominal aortic aneurysm repair with stent graft | |
| | | RO=FPHN Vascular surgeon or Interventional radiologist only ..... 380 | 15+T |
| | | RO=SPHN Vascular surgeon or Interventional radiologist only ..... 228 | |

**PLICATION OF VENA CAVA**

| | | | |
|---|---|---|---|
| VADT | 50.6D | Percutaneous image guided IVC filter removal (composite fee - to include all necessary imaging studies) ..... 135 | 10+T |

**OTHER SURGICAL OCCLUSION OF VESSELS - ABDOMINAL ARTERIES**

| | | | |
|---|---|---|---|
| VADT | 50.76E | Uterine fibroid embolization, to include embolization of all supply arteries and necessary angiography ..... 200 | |

**OTHER SURGICAL OCCLUSION OF VESSELS - UNSPECIFIED SITE**

| | | | |
|---|---|---|---|
| ADON | 50.79A | Vascular embolization or infusion of chemotherapy - add to arteriogram ..... 51 | |

**ANGIOGRAPHY USING CONTRAST MATERIAL, SITE UNSPECIFIED**

| | | | |
|---|---|---|---|
| VADT | 50.80A | Intraoperative arteriography ..... 15 | |

**ANGIOGRAPHY OF CEREBRAL VESSELS**

| | | | |
|---|---|---|---|
| VADT | 50.81B | Carotid arteriography ..... 51 | 5+T |

**AORTOGRAPHY**

| | | | | |
|---|---|---|---|---|
| VADT | 50.82 | Aortography<br>AP=PERC | 50.5 | 5+T |
| VADT | 50.82A | Aortography, trans-lumbar | 50.5 | 5+T |
| VADT | 50.82B | Angioplasty of coarctation of the aorta | 200 | 15+T |
| VADT | 50.82C | Aortic arch study | 75 | 5+T |
| VADT | 50.82D | Aortography - exposure of major artery | 75 | 4+T |

**ANGIOGRAPHY OF PULMONARY VESSELS**

| | | | | |
|---|---|---|---|---|
| ADON | 50.83 | Angiography of pulmonary vessels add on to catheterization of heart - right<br>- plus multiples, if applicable<br>AG=ADUT<br>AG=CH16 | <br>22<br>28 | |
| VADT | 50.83A | Study of aorto-pulmonary shunts | 75 | |

**ANGIOGRAPHY OF OTHER INTRA-ABDOMINAL VESSELS**

| | | | | |
|---|---|---|---|---|
| VADT | 50.87A | Superior/inferior venacavogram | 25.5 | 5+T |
| VADT | 50.87B | Selective visceral venography - plus multiples, if applicable | 40 | 5+T |
| VADT | 50.87C | Percutaneous transhepatic portography | 150 | |
| VADT | 50.87D | Selective abdominal angiographic studies - one catheter<br>- plus multiples, if applicable | 65 | 5+T |
| VADT | 50.87E | Selective abdominal angiographic studies - two catheters<br>- plus multiples, if applicable | 75 | 5+T |

**ANGIOGRAPHY OF FEMORAL VESSELS**

| | | | | |
|---|---|---|---|---|
| VADT | 50.88A | Femoral arteriography (regions required) | 15.3 | 4+T |

**ANGIOGRAPHY OF OTHER VESSELS NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 50.89A | Digital vascular angiography<br>RO=PROC | <br>100 | |
| VADT | 50.89B | Carotid vertebral or brachial arteriography by cutdown | 75 | 8+T |
| VADT | 50.89C | Capillaroscopy | 10 | |
| ADON | 50.89D | Extra angiogram more than two - plus multiples, if applicable<br>AG=ADUT<br>AG=CH16 | <br>22<br>28 | |

| | | | | |
|---|---|---|---|---|
| VADT | 50.89E | Venogram - peripheral | 15.3 | |
| VADT | 50.89F | Vertebral arteriography | 51 | 5+T |
| VADT | 50.89G | Selective abdominal angiographic studies - one catheter<br>- plus multiples, if applicable | 65 | 5+T |
| VADT | 50.89H | Selective abdominal angiographic studies - two catheters | 75 | 5+T |

**ARTERIAL CATHETERIZATION**

| | | | | |
|---|---|---|---|---|
| VADT | 50.91 | Arterial catheterization | 25 | 4+T |

**OTHER VENOUS CATHETERIZATION**

| | | | | |
|---|---|---|---|---|
| VADT | 50.93A | Flushing of portacath<br>LO=OFFC<br>LO=HOSP, FN=INPT, FN=OTPT | 10<br>10 | |
| VADT | 50.93C | Percutaneous insertion of central venous line<br>AG=CH04 | 40 | |
| VADT | 50.93F | Insertion of central venous pressure catheter | 24 | |
| VADT | 50.93J | Insertion of a central venous line (infants under 3 kg) | 125 | 7+T |
| VADT | 50.93K | Hepatic wedge pressure | 51 | 5+T |

**VENOUS CUTDOWN**

| | | | | |
|---|---|---|---|---|
| VADT | 50.96 | Venous cutdown | 11 | |

**OTHER PUNCTURE OF ARTERY**

| | | | | |
|---|---|---|---|---|
| VADT | 50.98A | Arterial puncture - plus multiples, if applicable | 7 | |

**OTHER PUNCTURE OF VEIN**

| | | | | |
|---|---|---|---|---|
| VADT | 50.99A | Intravenous - plus multiples, if applicable | 9 | |
| VADT | 50.99B | Intravenous - by scalp vein | 14.5 | |
| VADT | 50.99C | Femoral vein puncture (regions required) | 14 | |
| VADT | 50.99D | Jugular vein puncture (regions required) | 14 | |
| VADT | 50.99E | Venesection, therapeutic | 6.5 | |
| VADT | 50.99F | Phlebotomy, therapeutic | 6.5 | |
| VADT | 50.99G | Subclavian vein puncture for hyperalimentation | 24 | |

| | | | | |
|---|---|---|---|---|
| VADT | 50.99H | Venipuncture (included in a consultation) | | |
| | | AG=CH07 | 8.8 | |
| | | AG=PR07 - plus multiples, if applicable | 3 | |
| VADT | 50.99L | Thrombolysis with urokinase (includes interpretation, angiograms, angioplasty and all re-adjustments and infusion) | 300 | |

**OTHER REPAIR OF BLOOD VESSEL NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 51.59I | Percutaneous arterial angioplasty – upper limbs | | |
| | | RG=RRUA (Radial or ulnar artery, right side) | 183.6 | 8+T |
| | | RG=LRUA (Radial or ulnar artery, left side) | 183.6 | 8+T |
| | | RG=RBRA (Brachial, right side) | 137.7 | 8+T |
| | | RG=LBRA (Brachial, left side) | 137.7 | 8+T |
| VADT | 51.59J | Percutaneous arterial angioplasty – central vessels | | |
| | | RG=INRE (Infra renal) | 137.7 | 15+T |
| | | RG=SURE (Supra renal) | 200 | 15+T |
| | | RG=GVIB (Great vessel, innominate / brachiocephalic) | 183.6 | 15+T |
| | | RG=GVCC (Great vessel, left common carotid) | 183.6 | 15+T |
| | | RG=GVSA (Great vessel, left subclavian) | 183.6 | 15+T |
| | | RG=VCEL (Visceral, celiac) | 183.6 | 8+T |
| | | RG=VSMA (Visceral, SMA) | 183.6 | 8+T |
| | | RG=VIMA (Visceral, IMA) | 183.6 | 8+T |
| | | RG=VSPL (Visceral, splenic) | 183.6 | 8+T |
| | | RG=VHEP (Visceral, hepatic) | 183.6 | 8+T |
| | | RG=RRMV (Renal - main vessel, right side) | 183.6 | 8+T |
| | | RG=LRMV (Renal – main vessel, left side) | 183.6 | 8+T |
| | | RG=RRSV (Renal – segmental vessel, right side) | 183.6 | 8+T |
| | | RG=LRSV (Renal – segmental vessel, left side) | 183.6 | 8+T |
| VADT | 51.59K | Percutaneous arterial angioplasty – lower limbs | | |
| | | RG=RPOP (Popliteal, right side) | 137.7 | 8+T |
| | | RG=LPOP (Popliteal, left side) | 137.7 | 8+T |
| | | RG=RANT (Anterior tibial, right side) | 183.6 | 8+T |
| | | RG=LANT (Anterior tibial, left side) | 183.6 | 8+T |
| | | RG=RPOT (Posterior tibial, right side) | 183.6 | 8+T |
| | | RG=LPOT (Posterior tibial, left side) | 183.6 | 8+T |
| | | RG=RPER (Peroneal, right side) | 183.6 | 8+T |
| | | RG=LPER (Peroneal, left side) | 183.6 | 8+T |
| | | RG=RCOI (Common iliac, right side) | 137.7 | 8+T |
| | | RG=LCOI (Common iliac, left side) | 137.7 | 8+T |
| | | RG=RINI (Internal iliac, right side) | 137.7 | 8+T |
| | | RG=LINI (Internal iliac, left side) | 137.7 | 8+T |
| | | RG=REXI (External iliac, right side) | 137.7 | 8+T |
| | | RG=LEXI (External iliac, left side) | 137.7 | 8+T |
| | | RG=RCSF (Common femoral / Superficial femoral, right side) | 137.7 | 8+T |
| | | RG=LCSF (Common femoral / Superficial femoral, left side) | 137.7 | 8+T |
| | | RG=RPRF (Profunda femoris, right side) | 137.7 | 8+T |
| | | RG=LPRF (Profunda femoris, left side) | 137.7 | 8+T |

| | | | | |
|---|---|---|---|---|
| VADT | 51.59L | Venous angioplasty – head | | |
| | | RG=RSIG (Sigmoid sinus, right side) | 183.6 | 10+T |
| | | RG=LSIG (Sigmoid sinus, left side) | 183.6 | 10+T |
| | | RG=RTRA (Transverse sinus, right side) | 183.6 | 10+T |
| | | RG=LTRA (Transverse sinus, left side) | 183.6 | 10+T |
| | | RG=SAGG (Saggital sinus) | 183.6 | 10+T |
| VADT | 51.59M | Venous angioplasty – upper limbs | | |
| | | RG=RRUA (Radial or ulnar, right side) | 137.7 | 8+T |
| | | RG=LRUA (Radial or ulnar, left side) | 137.7 | 8+T |
| | | RG=RBAC (Basilic or cephalic, right side) | 137.7 | 8+T |
| | | RG=LBAC (Basilic or cephalic, left side) | 137.7 | 8+T |
| | | RG=RAXI (Axillary, right side) | 137.7 | 8+T |
| | | RG=LAXI (Axillary, left side) | 137.7 | 8+T |
| VADT | 51.59N | Venous angioplasty – central vessels | | |
| | | RG=VREN (Visceral - renal) | 183.6 | 10+T |
| | | RG=VSUM (Visceral – superior mesenteric) | 183.6 | 10+T |
| | | RG=VSPL (Visceral – splenic) | 183.6 | 10+T |
| | | RG=VHEP (Visceral – hepatic) | 183.6 | 10+T |
| | | RG=VPOR (Visceral – portal) | 183.6 | 10+T |
| | | RG=IVCA (Inferior Vena Cava – IVC) | 137.7 | 10+T |
| | | RG=SVCA (Superior Vena Cava) | 137.7 | 10+T |
| | | RG=RBRC (Brachiocephalic, right side) | 137.7 | 10+T |
| | | RG=LBRC (Brachiocephalic, left side) | 137.7 | 10+T |
| | | RG=RSUB (Subclavian, right side) | 137.7 | 10+T |
| | | RG=LSUB (Subclavian, left side) | 137.7 | 10+T |
| VADT | 51.59O | Venous angioplasty – lower limbs | | |
| | | RG=RCSF (Common femoral / Superficial femoral, right side) | 137.7 | 8+T |
| | | RG=LCSF (Common femoral / Superficial femoral, left side) | 137.7 | 8+T |
| | | RG=RPRF (Profunda femoris, right side) | 137.7 | 8+T |
| | | RG=LPRF (Profunda femoris, left side) | 137.7 | 8+T |
| | | RG=RCOI (Common iliac, right side) | 137.7 | 8+T |
| | | RG=LCOI (Common iliac, left side) | 137.7 | 8+T |
| | | RG=RINI (Internal iliac, right side) | 137.7 | 8+T |
| | | RG=LINI (Internal iliac, left side) | 137.7 | 8+T |
| | | RG=REXI (External iliac, right side) | 137.7 | 8+T |
| | | RG=LEXI (External iliac, left side) | 137.7 | 8+T |
| | | RG=RPOP (Popliteal, right side) | 137.7 | 8+T |
| | | RG=LPOP (Popliteal, left side) | 137.7 | 8+T |

NOTE: Each angioplasty code is intended to include all angiography performed of the extremity region at the time of the angioplasty procedure. Each code is intended to include all angioplasties necessary within the vessel or region regardless of the length or number of vascular occlusions. The maximum number of anatomic regions that may be billed at one service encounter is 4.

| | | | |
|---|---|---|---|
| ADON | 51.59P | Subintimal recanalisation of vascular occlusion | 125 |
| ADON | 51.59Q | Non-cardiac, endovascular stent placement | 50 |
| ADON | 51.59R | Thrombolysis following non-cardiac angiography | 150 |

**INSERTION OF VESSEL-TO-VESSEL CANNULA**

| | | | | |
|---|---|---|---|---|
| VADT | 51.93A | Insertion of venovenous catheters for acute hemodialysis | 25 | |

**HEMODIALYSIS**

| | | | | |
|---|---|---|---|---|
| VADT | 51.95 | Hemodialysis | | |
| | | AG=ADUT | 35 | |
| | | RP=INTL | 288 | |
| | | RP=SUBS | 96 | |

**OTHER PERFUSION**

| | | | | |
|---|---|---|---|---|
| VADT | 51.97 | Other perfusion - regional isolation perfusion | 100 | 4+T |

**EXCISION OF DEEP CERVICAL LYMPH NODE (WITH EXCISION OF SCALENE FAT PAD)**

| | | | | |
|---|---|---|---|---|
| VADT | 52.11 | Excision of deep cervical lymph node (with excision of scalene fat pad) | 62 | 4+T |

**BIOPSY OF BONE MARROW**

| | | | | |
|---|---|---|---|---|
| VADT | 53.81 | Biopsy of bone marrow | | |
| | | AG=ADUT | 25 | 4+T |
| | | AG=CH16 | 50 | 4+T |
| | | RO=INTP | 15 | |
| VEDT | 53.81A | Bone marrow interpretation | 28.62 | |

**ASPIRATION BIOPSY OF SPLEEN**

| | | | | |
|---|---|---|---|---|
| VADT | 53.83 | Aspiration biopsy of spleen | 25 | 4+T |

**OTHER BIOPSY OF SPLEEN**

| | | | | |
|---|---|---|---|---|
| VADT | 53.84A | Splenic puncture biopsy | 25 | 4+T |

**ENDOSCOPIC EXCISION OR DESTRUCTION OF LESION OR TISSUE OF ESOPHAGUS**

| | | | | |
|---|---|---|---|---|
| ADON | 54.21A | Electrocautery of GI bleeding lesions - add on to endoscopic fees | 10 | |

**TEMPORARY GASTROSTOMY**

| | | | | |
|---|---|---|---|---|
| VADT | 55.1A | Percutaneous gastrostomy - performed under imaging control | 90 | |
| VADT | 55.1B | Percutaneous endoscopic gastrostomy (PEG) - includes the scope | 90 | 7+T |
| VADT | 55.1C | Reposition or exchange of percutaneous gastrostomy tube when performed under imaging control | 50 | |

**OTHER ENTEROSTOMY NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 58.39B | Percutaneous endoscopic jejunostomy (PEJ) - includes the scope | 120 | |

**CORRECTION OF VOLVULUS / INTUSSUSCEPTION**

| | | | | |
|---|---|---|---|---|
| VADT | 58.81A | Reduction of intussusception by barium enema | 30 | |
| VADT | 58.81B | Relief of bowel obstruction due to meconium by radiological methods | 60 | |

**INJECTION OF HEMORRHOIDS**

| | | | | |
|---|---|---|---|---|
| VADT | 61.32 | Injection of hemorrhoids | | |
| | | RP=INTL | 10 | |
| | | RP=SUBS | 5 | |

**LIGATION OF HEMORRHOIDS**

| | | | | |
|---|---|---|---|---|
| VADT | 61.35A | Banding of hemorrhoids - per session | 30 | 4+T |

**PERCUTANEOUS BIOPSY OF LIVER**

| | | | | |
|---|---|---|---|---|
| VADT | 62.81 | Percutaneous biopsy of liver | 38 | 4+T |
| | | AG=CH16 | 80 | 4+T |

**OTHER BIOPSY OF LIVER**

| | | | | |
|---|---|---|---|---|
| VADT | 62.82 | Other biopsy of liver | 100 | |
| | | AG=CH16 | 80 | 4+T |
| VADT | 62.82A | Transjugular liver biopsy | 100 | |

**PERCUTANEOUS ASPIRATION OF LIVER**

| | | | | |
|---|---|---|---|---|
| VADT | 62.91A | Percutaneous transhepatic biliary drainage | 153 | |

**OTHER CHOLECYSTOTOMY AND CHOLECYSTOSTOMY**

| | | | | |
|---|---|---|---|---|
| VADT | 63.09A | Percutaneous cholecystostomy - performed under imaging control | 120 | |

**COMMON DUCT EXPLORATION FOR REMOVAL OF CALCULUS**

| | | | | |
|---|---|---|---|---|
| VADT | 63.31B | Basket extraction for retained bile duct stones | 51 | 4+T |

**INSERTION OF CHOLEDOCHOHEPATIC TUBE FOR DECOMPRESSION**

| | | | | |
|---|---|---|---|---|
| VADT | 63.33A | Percutaneous transhepatic biliary drainage | 153 | |
| VADT | 63.33B | Percutaneous dilatation of biliary stricture and insertion of stent when performed under imaging control | 75 | |
| VADT | 63.33C | Reposition or exchange of percutaneous placed biliary drain or stent when performed under imaging control | 75 | |

**INCISION OF OTHER BILE DUCTS FOR RELIEF OF OBSTRUCTION**

| | | | | |
|---|---|---|---|---|
| VADT | 63.39A | Transhepatic biliary stone extraction when performed under imaging control | 85 | |

**PANCREATIC SPHINCTEROTOMY**

| | | | | |
|---|---|---|---|---|
| VADT | 63.82A | Esophagogastroduodenoscopy - with papillotomy | 230 | 4+T |

**OTHER OPERATIONS ON SPHINCTER OF ODDI**

| | | | | |
|---|---|---|---|---|
| VADT | 63.89A | Esophagogastroduodenoscopy - with manometry of ampulla of vater | 170 | 4+T |

**ENDOSCOPIC RETROGRADE CHOLANGIOGRAPHY (ERC)**

| | | | | |
|---|---|---|---|---|
| VADT | 63.95A | Esophagogastroduodenoscopy - with basket extraction of stones | 173.4 | 4+T |
| VADT | 63.95B | Esophagogastroduodenoscopy - with indwelling nasobiliary catheter | 170 | 4+T |
| VADT | 63.95C | Esophagogastroduodenoscopy - with biliary stents | 170 | 4+T |

**INTRA-OPERATIVE OR INTRAVENOUS CHOLANGIOGRAM OR PERCUTANEOUS HEPATIC CHOLANGIOGRAM**

| | | | | |
|---|---|---|---|---|
| VADT | 63.96 | Intra-operative or intravenous cholangiogram or percutaneous hepatic cholangiogram | 35.7 | |

**OTHER BIOPSY OF GALLBLADDER OR BILIARY TRACT**

| | | | | |
|---|---|---|---|---|
| VADT | 63.98A | Percutaneous brush or needle biopsy through drain or stent when performed under imaging control (regardless of the number of biopsies) | 40 | |

**CANNULATION OF PANCREATIC DUCT (TRANSDUODENAL)**

| | | | | |
|---|---|---|---|---|
| VADT | 64.91A | Esophagogastroduodenoscopy - with cannulation of pancreatic duct | 120 | 4+T |
| ADON | 64.91B | Choledochoscopy with associated procedure | 25 | |

**OTHER BIOPSY OF PANCREAS**

| | | | | |
|---|---|---|---|---|
| VADT | 64.96A | Esophagogastroduodenoscopy - with selective pancreatic duct cytology | 170 | 4+T |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON ABDOMINAL REGION**

| | | | | |
|---|---|---|---|---|
| VADT | 66.89A | Percutaneous biopsy of solid masses for cytology or histology using ultrasound or fluoroscopy - plus multiples, if applicable | 51+MU | |

**PERCUTANEOUS ABDOMINAL PARACENTESIS**

| | | | | |
|---|---|---|---|---|
| VADT | 66.91 | Percutaneous abdominal paracentesis | 10 | |
| VADT | 66.91A | Trocar insertion of silastic peritoneal catheter - Tenchkoff type | 40 | |
| VADT | 66.91B | Removal of trocar insertion silastic peritoneal catheter of Tenchkoff type | 20 | |
| VADT | 66.91C | Percutaneous diagnostic tap of fluid collections | 40.8 | |

| | | | | |
|---|---|---|---|---|
| VADT | 66.91D | Percutaneous insertion of drainage tube into fluid collection excluding nephrostomy | 61.2 | |
| VADT | 66.91E | Abdominal paracentesis - therapeutic aspiration including diagnostic sample | 24 | 4+T |
| VADT | 66.91F | Abdominal paracentesis - administration of chemotherapy including therapeutic aspiration and sample | 25 | |

**TUNNELED INTRAPERITONEAL CATHETER**

| | | | | |
|---|---|---|---|---|
| VEDT | 66.98E | Percutaneous insertion of tunneled intraperitoneal catheter for use in dialysis (SP=NEPH) | 125 | |
| VEDT | 66.98F | Removal of tunneled intraperitoneal catheter for use in dialysis (SP=NEPH) | 75 | |
| VEDT | 66.98G | Repositioning of tunneled intraperitoneal catheter for use in dialysis (SP=NEPH) | 75 | |

**INJECTION OF AIR INTO PERITONEAL CAVITY**

| | | | | |
|---|---|---|---|---|
| VADT | 66.96 | Injection of air into peritoneal cavity | 25 | |

**PERITONEAL DIALYSIS**

| | | | | |
|---|---|---|---|---|
| VADT | 66.98 | Peritoneal dialysis | | |
| | | AG=ADUT | 35 | |
| | | AG=CH07, RP=INTL | 168 | |
| | | AG=CH07, RP=SUBS | 112 | |
| | | AG=CH16 | 90 | |
| | | AG=PR07, RP=INTL | 150 | |
| | | AG=PR07, RP=SUBS | 96 | |
| VADT | 66.98 | Peritoneal dialysis - Home Dialysis (Program=HD) RO=HMDY, SP=NEPH | 83 | |
| VADT | 66.98A | Diagnostic peritoneal lavage | 35 | |

**NEPHROSTOMY**

| | | | | |
|---|---|---|---|---|
| VADT | 67.02C | Percutaneous nephrostomy tube insertion under ultrasound or fluoroscopy (regions required) | 81.6 | |

**PERCUTANEOUS BIOPSY OF KIDNEY**

| | | | | |
|---|---|---|---|---|
| VADT | 67.81 | Percutaneous biopsy of kidney | | |
| | | AG=ADUT | 40.8 | 4+T |
| | | AG=CH16 | 80 | 4+T |

**PERCUTANEOUS ASPIRATION OF KIDNEY**

| | | | | |
|---|---|---|---|---|
| VADT | 67.92A | Percutaneous aspiration of renal cyst under imaging guidance - plus multiples, if applicable | 40.7 | |
| VADT | 67.92B | Percutaneous aspiration of renal cyst with sclerosing injection | 51 | |

**REPLACEMENT OF NEPHROSTOMY TUBE**

| | | | | |
|---|---|---|---|---|
| VADT | 67.93A | Removal of nephrostomy tube | 10.5 | |

**OTHER OPERATIONS ON URETER NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 68.99A | Removal of J-stent including cystoscopy (regions required) | 43.6 | 4+T |
| VEDT | 68.99G | Renal access and nephroureteral stent placement for stone extraction | 160 | |
| VEDT | 68.99H | Antegrade ureteric stent insertion with or without balloon dilation | 120 | |
| VEDT | 68.99I | Balloon dilation of ureteric stricture | 100 | |

**PERCUTANEOUS ASPIRATION OF BLADDER**

| | | | | |
|---|---|---|---|---|
| VADT | 69.11 | Percutaneous aspiration of bladder | 17.5 | |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON BLADDER**

| | | | | |
|---|---|---|---|---|
| VADT | 69.89B | Induced ejaculation, vibratory and/or electrical to include catheterization and sigmoidoscopy as necessary | 100 | 4+T |

**INSERTION OF INDWELLING URINARY CATHETER**

| | | | | |
|---|---|---|---|---|
| VADT | 69.94 | Insertion of indwelling urinary catheter (stand alone procedure) | 12.5 | |

**OTHER OPERATIONS ON URETHRA AND PERIURETHRAL TISSUE NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 70.99B | Aristospan injection into the periurethral space | 10 | |

**URETERAL CATHETERIZATION**

| | | | | |
|---|---|---|---|---|
| VADT | 71.8A | Differential renal function test (Stamey) | 100 | 4+T |
| VADT | 71.8B | Cystoscopy with bilateral sodium excretion estimation (Howard Test) | 50 | 4+T |

**NEEDLE BIOPSY OF PROSTATE**

| | | | | |
|---|---|---|---|---|
| VADT | 72.91A | Biopsy of prostate, perineal needle | 35 | 4+T |
| VADT | 72.91B | Needle biopsy, perineal, with cystoscopy | 54.4 | 4+T |
| VADT | 72.91C | Ultrasound guided biopsy of the prostate | 45 | |

**PERCUTANEOUS ASPIRATION OF TUNICA VAGINALIS**

| | | | |
|---|---|---|---|
| VADT | 73.91A | Aspiration of hydrocoele | 10 |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON PENIS**

| | | | | |
|---|---|---|---|---|
| VADT | 76.89A | Corpus cavernosagram | 26 | 4+T |

**INSERTION OF THERAPEUTIC DEVICE INTO UTERUS**

| | | | |
|---|---|---|---|
| VADT | 81.91A | Insertion of intrauterine catheter | |
| | | RO=INPR | 15 |

**CULDOSCOPY**

| | | | |
|---|---|---|---|
| VADT | 82.81A | Colposcopy | 8.5 |

**AMNIOCENTESIS**

| | | | |
|---|---|---|---|
| VADT | 87.3A | Therapeutic amniocentesis | 75 |

**INTRAUTERINE TRANSFUSION**

| | | | |
|---|---|---|---|
| VADT | 87.4A | Transabdominal amnioinfusion | |
| | | RO=FPHN | 100 |
| VADT | 87.4B | Intrauterine intravascular fetal transfusion | 200 |

**FETAL BLOOD SAMPLING AND BIOPSY**

| | | | |
|---|---|---|---|
| VADT | 87.53 | Fetal blood sampling and biopsy - plus multiples, if applicable | 15 |
| VADT | 87.53A | Percutaneous umbilical blood sampling | |
| | | RO=FPHN | 100 |
| | | RO=SPHN | 100 |

**FETAL MONITORING, UNQUALIFIED**

| | | | |
|---|---|---|---|
| VADT | 87.54A | Oxytocin challenge test | |
| | | RO=INPR | 15 |

**OTHER DIAGNOSTIC PROCEDURES ON FETUS AND AMNION**

| | | | |
|---|---|---|---|
| VADT | 87.55A | Chorionic villus sampling (CVS) | 50 |

**OTHER INTRAUTERINE OPERATIONS ON FETUS AND AMNION NEC**

| | | | |
|---|---|---|---|
| VADT | 87.59A | Transabdominal fetal thoracocentesis | |
| | | RO=FPHN (regions required) | 100 |
| VADT | 87.59B | Fetal therapeutic shunts pleural-amniotic or urinary-amniotic | |

| | | | | |
|---|---|---|---|---|
| | | RO=FPHN | 150 | |

**EXCISION OF INTERVERTEBRAL DISC**

| | | | | |
|---|---|---|---|---|
| VADT | 92.31A | Chemonucleolysis - placement of needle under imaging - plus multiples, if applicable | 50 | 7+T |
| VADT | 92.31B | Chemonucleolysis - injection of lysing material | 50 | 7+T |
| VADT | 92.31C | Chemonucleolysis - placement of needle under imaging and injection of lysing material (same physician) | 100 | 7+T |

**CONTRAST ARTHROGRAM, OTHER SPECIFIED SITE, SPINE**

| | | | | |
|---|---|---|---|---|
| VADT | 92.78A | Injection of cervical posterior intervertebral joints (facet joints) under imaging control - plus multiples, if applicable | 40 | |

**BIOPSY OF JOINT STRUCTURE, UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| VADT | 92.99A | Needle biopsy - synovial tissue | 25 | |

**ARTHROCENTESIS**

| | | | | |
|---|---|---|---|---|
| VADT | 93.91 | Arthrocentesis - plus multiples, if applicable | 13 | |

**INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT**

| | | | | |
|---|---|---|---|---|
| VADT | 93.92A | Injection of therapeutic substance into joint or ligament including aspiration if necessary - plus multiples, if applicable | 13 | 4+T |
| VADT | 93.92B | Facet joint injection - plus multiples, if applicable | 23 | |

**BIOPSY OF MUSCLE, TENDON, FASCIA, AND BURSA**

| | | | | |
|---|---|---|---|---|
| VADT | 95.81A | Percutaneous muscle biopsy | 30 | |

**INJECTION OF THERAPEUTIC SUBSTANCE INTO TENDON**

| | | | | |
|---|---|---|---|---|
| VADT | 95.92A | Injection of therapeutic substance into tendon including aspiration if necessary - plus multiples, if applicable | 13 | 4+T |

**INJECTION OF THERAPEUTIC SUBSTANCE INTO BURSA**

| | | | | |
|---|---|---|---|---|
| VADT | 95.93A | Injection of therapeutic substance into bursa including aspiration if necessary - plus multiples, if applicable | 13 | 4+T |

**INJECTION OF THERAPEUTIC SUBSTANCE INTO OTHER SOFT TISSUE**

| | | | | |
|---|---|---|---|---|
| VADT | 95.94A | Injection of therapeutic substance into other soft tissue including aspiration if necessary - plus multiples, if applicable | 13 | 4+T |

| | | | | |
|---|---|---|---|---|
| VADT | 95.94B | Injection for pruritus ani/fissure | 10 | |

**ASPIRATION OF BURSA**

| | | | | |
|---|---|---|---|---|
| VADT | 95.95 | Aspiration of bursa - plus multiples, if applicable | 13 | 4+T |

**CONTRAST MAMMARY DUCTOGRAM**

| | | | | |
|---|---|---|---|---|
| VADT | 97.83 | Contrast mammary ductogram | 10 | |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON BREAST**

| | | | | |
|---|---|---|---|---|
| VADT | 97.89A | Breast biopsy after localization of mammographic abnormality by Radiologist - plus multiples, if applicable | 80 | 4+T |

**ASPIRATION OF BREAST (CYST)**

| | | | | |
|---|---|---|---|---|
| VADT | 97.91 | Aspiration of breast (cyst) - plus multiples, if applicable | 10 | |

**OTHER OPERATIONS OF THE BREAST**

| | | | | |
|---|---|---|---|---|
| VEDT | 97.99A | MRI guided placement of MRI compatible clip to locate a breast abnormality, with or without biopsy, to include all necessary imaging | 70 | |

**OTHER INCISION WITH DRAINAGE OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| VADT | 98.03 | Other incision with drainage of skin and subcutaneous tissue<br>- plus multiples, if applicable<br>AN=LOCL | 6<br>6 | |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| VADT | 98.89B | Scratch/intradermal tests for allergens per series<br>- plus multiples, if applicable | 18 | |
| VADT | 98.89C | Skin scrapings when direct microscopic examination is carried out, using KOH, immediately following the scraping of the lesions | 7.7 | |

**INSERTION OF TISSUE EXPANDER(S)**

| | | | | |
|---|---|---|---|---|
| MASG | 98.98 | Insertion of tissue expander(s) - plus multiples, if applicable | 100 | 4+T |
| VADT | 98.98A | Percutaneous expansion/inflation of a tissue expander<br>- plus multiples, if applicable | 13 | |

# FAMILY PRACTICE

(Includes SP=GENP, EMMD, COMD)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|

## CONSULTATIONS

| | | | |
|---|---|---|---|
| CONS | 03.08 | Consultation | |
| | | RF=REFD (ME=TELE) | 30 |
| | | RF=REFD, US=PREM (ME=TELE) | 48 |
| | | RF=REFD, US=PR50 (ME=TELE) | 48 |
| | | RF=REFD, RO=DETE (ME=TELE) | 30+MU |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 48+MU |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 48+MU |
| CONS | 03.07 | Repeat Consultation | |
| | | RF=REFD, RP=REPT (ME=TELE) | 13 |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 31 |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 31 |
| | | RF=REFD, RP=REPT, RO=DETE (ME=TELE) | 13+MU |
| | | RF=REFD, RP=REPT, RO=DETE, US=PREM (ME=TELE) | 31+MU |
| | | RF=REFD, RP=REPT, RO=DETE, US=PR50 (ME=TELE) | 31+MU |

## OFFICE

| | | | |
|---|---|---|---|
| VIST | 03.04 | Complete Examination | |
| | | LO=OFFC (RF=REFD) | 24 |
| | | LO-OFFC, TI=GPEW | 30 |
| VIST | 03.04C | Adults with developmental disabilities complete examination | |
| | | LO=OFFC, AG=ADUT | 36 |
| | | LO-OFFC, AG=ADUT, TI=GPEW | 45 |
| VIST | 03.04K | Gender transition readiness assessment, follow up of patients undergoing Medical transition, and follow up of patients undergoing surgical transition where the primary care provider is required to provide postoperative care | |
| | | LO=OFFC | 40+MU |
| | | LO-OFFC, TI=GPEW | 50+MU |
| | | *Physician Restrictions in Place (See Appendix J) | |
| VIST | 03.03 | Office Visit | |
| | | LO-OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 |
| | | LO-OFFC, RP=SUBS, ME=CARE | 17+MU |
| | | LO-OFFC, RP=SUBS, ME=CARE, TI=GPEW | 21.25+MU |
| | | LO-OFFC, RP=SUBS, TI=GPEW | 16.25 |
| | | *Physician Restrictions in Place (See Appendix J) | |

| | | | |
|---|---|---|---|
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 16.5 |
| | | LO=OFFC, ME=CARE | 20.99+MU |
| | | LO-OFFC, ME=CARE, TI=GPEW | 26.24+MU |
| | | LO=OFFC, TI=GPEW | 20.63 |
| | | *Physician Restrictions in Place (See Appendix J) | |
| VIST | 03.03B | Complex Care Visit | |
| | | LO=OFFC (RF=REFD) | 21 |
| | | LO=OFFC, TI=GPEW | 26.25 |
| VIST | 03.03E | Adults with developmental disabilities visit | |
| | | LO=OFFC, AG=ADUT | 19.5 |
| | | LO=OFFC, AG=ADUT, TI=GPEW | 24.38 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000) | |
| | | LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD). | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359) | |
| | | LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD). | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800) | |
| | | LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD). | 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Extra Patient to: Urgent Care Codes | |
| | | LO=OFFC, PT=EXPT (RF=REFD) | 10.5 |
| | | LO=OFFC, PT=EXPT, ME=CARE | 11.92 |
| VIST | 03.04 | Complete Pregnancy Exam | |
| | | LO=OFFC, RO=ANTL, RP=INTL (RF=REFD) | 29.7 |
| | | LO=OFFC, RO=ANTL, RP=INTL, TI=GPEW | 37.13 |
| VIST | 03.03 | Routine Pre Natal Visit | |
| | | LO=OFFC, RO=ANTL, RP=SUBS (RF=REFD) | 13 |
| | | LO=OFFC, RO=ANTL, RP=SUBS, ME=CARE | 16.96 |
| | | LO=OFFC, RO=ANTL, RP=SUBS, ME=CARE, TI=GPEW | 21.2 |
| | | LO=OFFC, RO=ANTL, RP=SUBS, TI=GPEW | 16.25 |
| VIST | 03.03 | Post Natal Care Visit | |
| | | LO=OFFC, RO=PTNT (RF=REFD) | 19 |
| | | LO=OFFC, RO=PTNT, TI=GPEW | 23.75 |

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| VIST | 03.03 | Comprehensive Well Infant/Child Visit Using the Rourke Baby Record |
| | | LO=OFFC, CT=RKBR, RO=WBCR ..... 24 |
| | | LO=OFFC, CT=RKBR, RO=WBCR, TI=GPEW ..... 30 |
| VIST | 03.03 | Well Baby Care |
| | | LO=OFFC, RO=WBCR (RF=REFD) ..... 13 |
| | | LO=OFFC, RO=WBCR, ME=CARE ..... 16.96 |
| | | LO=OFFC, RO=WBCR, ME=CARE, TI=GPEW ..... 21.2 |
| | | LO=OFFC, RO=WBCR, TI=GPEW ..... 16.25 |
| ADON | 03.03P | First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care |
| | | LO=OFFC ..... 10 |
| ADON | 03.03S | First Visit after Acute Care In-Patient Hospital Discharge – Complex Care |
| | | LO=OFFC ..... 10 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT, DTOX or EMCC)

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| VIST | 03.04 | Complete Examination |
| | | LO=HOSP, FN=EMCC, FN=OTPT, FN=DTOX (RF=REFD) ..... 24 |
| | | LO=HOSP, FN=EMCC, FN=OTPT, FN=DTOX, RO=DETE (RF=REFD) ..... 24+MU |
| VIST | 03.04 | Trauma Team Leader |
| | | LO=HOSP, FN=EMCC, RO=TRTL, SP=EMMD, SP=GENP (RF=REFD) ..... 60 |
| VIST | 03.04 | First Examination |
| | | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 30 |
| | | LO=HOSP, FN=INPT, RO=DETE, RP=INTL (RF=REFD) ..... 30+MU |
| VIST | 03.04C | Adults with developmental disabilities complete examination |
| | | LO=HOSP, AG=ADUT ..... 36 |
| VIST | 03.04E | Initial Geriatric Inpatient Medical Assessment |
| | | LO=HOSP, FN=INPT ..... 38.1 |
| VIST | 03.03E | Adults with developmental disabilities visit |
| | | LO=HOSP, AG=ADUT ..... 19.5 |
| VIST | 03.03G | Examination of a victim of an alleged sexual assault and evidence collection |
| | | LO=HOSP ..... 245+MU |
| | | (15 units per 15 min. after 3 hours to a maximum of six 15 minute time intervals) |

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| VIST | 03.03 | Subsequent Daily Hospital Visit (first days out of ICU) | | |
| | | LO=HOSP, FN=INPT, DA=DA23 | 26.43 | |
| | | LO=HOSP, FN=INPT, DA=DA47 | 21.84 | |
| VIST | 03.03 | Subsequent Visit - Daily up to 56 days | | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 18.39 | |
| | | LO=HOSP, FN=INPT, DA=DALY, RO=DETE, RP=SUBS (RF=REFD) | 18.39+MU | |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 days - Maximum 80 units per week | | |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) | 18.39 | |
| | | LO=HOSP, FN=INPT, DA=WKLY, RO=DETE, RP=SUBS (RF=REFD) | 18.39+MU | |
| VIST | 03.03 | Supportive Care | | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=SPCR (RF=REFD) | 15 | |
| ADON | 03.02A | Hospital Discharge Fee | | |
| | | LO=HOSP, FN=INPT | 10 | |
| VIST | 03.04F | Complex comprehensive acute care hospital discharge | | |
| | | LO=HOSP, FN=INPT | 45 | |
| VIST | 03.03 | Urgent Hospital Visit | | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD) | 35.2 | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DETE, US=UNOF (RF=REFD) | 35.2+MU | |
| VIST | 03.03 | Hospital Emergency Visit | | |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD) | 35.2 | |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD) | 35.2+MU | |
| VIST | 03.04A | Transfer During Labour | | |
| | | LO=HOSP, FN=INPT (RF=REFD) | 100 | |
| | | LO=HOSP, FN=INPT, RO=DETE (RF=REFD) | 100+MU | |
| OBST | 87.98 | Delivery NEC | | |
| | | RF=REFD | 282.24 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 91.73 | |
| ADON | 87.98A | Detention during obstetrical delivery (for attendance beyond three hours) | | |
| | | RO=DETE | 15+MU | |
| VIST | 03.03 | Post-Partum Visit | | |
| | | LO=HOSP, FN=INPT, RO=PTPP, DA=DA23 | 26.43 | |
| | | LO=HOSP, FN=INPT, RO=PTPP, DA=DA47 | 21.84 | |
| | | LO=HOSP, FN=INPT, RO=PTPP (RF=REFD) | 16 | |
| VIST | 03.03 | Resuscitation of Newborn | | |
| | | LO=HOSP, FN=INPT, RO=RESC (RF=REFD) | 50 | |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD) | 68 | |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD) | 75 | |
| | | LO=HOSP, FN=INPT, RO=RNDT (RF=REFD) | 50+MU | |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD) | 68+MU | |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD) | 75+MU | |

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| VIST | 03.04 | First Examination - Newborn Care Healthy Infant<br>LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD) ..... 24 |
| VIST | 03.03 | Subsequent Care - Newborn Healthy Infant<br>LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA=DA23 ..... 26.43<br>LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA=DA45..... 19<br>LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD) ..... 16 |
| VIST | 03.03 | Emergency Care Centre (0801 - 1200)<br>LO=HOSP, FN=EMCC, TI=AMNN, SP=EMMD, SP=GENP (RF=REFD)..... 10.5<br>LO=HOSP, FN=EMCC, TI=AMNN, RO=DETE, SP=EMMD, SP=GENP (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Emergency Care Centre (1201 - 1700)<br>LO=HOSP, FN=EMCC, TI=NNEV, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5<br>LO=HOSP, FN=EMCC, TI=NNEV, RO=DETE, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5+MU |
| VIST | 03.03 | Emergency Care Centre (1701 - 2000)<br>LO=HOSP, FN=EMCC, TI=EVNT, SP=EMMD, SP=GENP (RF=REFD)..... 10.5<br>LO=HOSP, FN=EMCC, TI=EVNT, RO=DETE, SP=EMMD, SP=GENP (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Emergency Care Centre (2001 - 2359)<br>LO=HOSP, FN=EMCC, TI=ETMD, SP=EMMD, SP=GENP (RF=REFD)..... 15.5<br>LO=HOSP, FN=EMCC, TI=ETMD, RO=DETE, SP=EMMD, SP=GENP (RF=REFD)..... 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (0000 - 0800)<br>LO=HOSP, FN=EMCC, TI=MDNT, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5<br>LO=HOSP, FN=EMCC, TI=MDNT, RO=DETE, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (0801 - 1200) Sundays and Holidays<br>LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN, SP=EMMD, SP=GENP<br>(RF=REFD) ..... 15.5<br>LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN, RO=DETE, SP=EMMD,<br>SP=GENP (RF=REFD)..... 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (1201 - 1700) Sundays and Holidays<br>LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV, SP=EMMD, SP=GENP<br>(RF=REFD) ..... 15.5<br>LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV, RO=DETE, SP=EMMD,<br>SP=GENP (RF=REFD)..... 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (1701 - 2000) Sundays and Holidays<br>LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT, SP=EMMD, SP=GENP<br>(RF=REFD) ..... 15.5<br>LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT, RO=DETE, SP=EMMD,<br>SP=GENP (RF=REFD)..... 15.5+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)..... 13.5+MU |

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| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU |

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| VIST | 03.03 | Outpatient Visit-Doctor on Duty | |
| | | LO=HOSP, FN=OTPT, RO=DUTY (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, RO=DYDT (RF=REFD) | 7+MU |
| VIST | 03.03 | Detox Centre (0800 - 1700) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT (RF=REFD) | 21.3 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, RO=DETE (RF=REFD) | 21.3+MU |
| VIST | 03.03 | Detox Centre (1701 - 2000) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Detox Centre (2001 - 2359) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Detox Centre (0000 - 0800) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 38.3 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 38.3+MU |
| VIST | 03.03 | Detox Centre (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 28.3 |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Detox Centre (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 28.3 |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Detox Centre (0800 - 1200) Extra Patient | |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN (RF=REFD) | 15.8 |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 15.8+MU |
| VIST | 03.03 | Detox Centre (1201 - 1700) Extra Patient | |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV (RF=REFD) | 15.8 |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 15.8+MU |
| VIST | 03.03 | Detox Centre (1701 - 2000) Extra Patient | |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Detox Centre (2001 - 2359) Extra Patient | |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) | 10.5+MU |

VIST 03.03 Detox Centre (0000 - 0800) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT (RF=REFD) ..... 10.5
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 10.5+MU

VIST 03.03 Detox Centre (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) ..... 10.5
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 10.5+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

**INSTITUTIONAL VISITS**

VIST 03.04 Complete Examination (Not to be used for admission to Nursing Home)
LO=NRHM (RF=REFD) ..... 24
LO=NRHM, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04C Adults with developmental disabilities complete examination
LO=NHRM, AG=ADUT ..... 36

VIST 03.03E Adults with developmental disabilities visit
LO=NHRM, AG=ADUT ..... 19.5

VIST 03.03 Nursing Home Visit (0800 - 1700)
LO=NRHM (RF=REFD) ..... 21.3+MU
LO=NRHM, RO=DETE (RF=REFD) ..... 21.3+MU

VIST 03.03 Nursing Home Visit (1701 - 2000)
LO=NRHM, TI=EVNT (RF=REFD) ..... 28.3+MU
LO=NRHM, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Nursing Home Visit (2001 - 2359)
LO=NRHM, TI=ETMD (RF=REFD) ..... 28.3+MU
LO=NRHM, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Nursing Home Visit (0000 - 0800)
LO=NRHM, TI=MDNT (RF=REFD) ..... 38.3+MU
LO=NRHM, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU

VIST 03.03 Nursing Home Visit (0801 - 1200) Sat., Sun., Holidays
LO=NRHM, DA=RGE1, TI=AMNN, US=UNOF (RF=REFD) ..... 28.3+MU
LO=NRHM, DA=RGE1, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Nursing Home Visit (1201 - 1700) Sat., Sun., Holidays
LO=NRHM, DA=RGE1, TI=NNEV, US=UNOF (RF=REFD) ..... 28.3+MU
LO=NRHM, DA=RGE1, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Nursing Home - Emergency Visit
LO=NRHM, US=UIOH (RF=REFD) ..... 35.2
LO=NRHM, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU

**HOME**

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|---|---|---|
| VIST | 03.04 | Complete Examination<br>LO=HOME (RF=REFD) ..... 40.6<br>LO=HOME, RO=DETE (RF=REFD) ..... 40.6+MU |
| VIST | 03.04C | Adults with developmental disabilities complete examination<br>LO=HOME, AG=ADUT ..... 36 |
| VIST | 03.03E | Adults with developmental disabilities visit<br>LO=HOME, AG=ADUT ..... 19.5 |
| VIST | 03.03 | Home Visit (0800 - 1700)<br>LO=HOME, PT=FTPT (RF=REFD) ..... 36<br>LO=HOME, PT=FTPT, RO=DETE (RF=REFD) ..... 36+MU |
| VIST | 03.03 | Home Visit (1701 - 2000)<br>LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 47.8<br>LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 47.8+MU |
| VIST | 03.03 | Home Visit (2001 - 2359)<br>LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 47.8<br>LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 47.8+MU |
| VIST | 03.03 | Home Visit (0000 - 0800)<br>LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 64.7<br>LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 64.7+MU |
| VIST | 03.03 | Home Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) ..... 47.8<br>LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 47.8+MU |
| VIST | 03.03 | Home Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 47.8<br>LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 47.8+MU |
| VIST | 03.03 | Home Visit - Extra Patient<br>LO=HOME, PT=EXPT (RF=REFD) ..... 13 |
| VIST | 03.03 | Home- Emergency Visit<br>LO=HOME, US=UIOH (RF=REFD) ..... 59.5<br>LO=HOME, US=UIOH, RO=DETE (RF=REFD) ..... 59.5+MU |
| VIST | 03.03 | Home Visit – Visit of Convenience (not homebound)<br>LO=HOME, ME=CONV, PT=FTPT ..... 13<br>LO=HOME, ME=CONV, PT=FTPT, AG=OV65 ..... 16.5 |
| ADON | HOVM1 | Blended Mileage and travel detention for Home Visits ..... 0.46+ MU<br>1 multiple per kilometer |
| ADON | 03.03P | First Visit after In-Patient Hospital Discharge – Maternal Care<br>LO=HOME ..... 10 |

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| ADON | 03.03S | First Visit after Acute Care In-Patient Hospital Discharge – Complex Care<br>LO=HOME ..... 10 |

**HOME CARE**

| | | |
|---|---|---|
| VIST | 03.04 | Direct Admission to Home Care from Home (0800 - 1700)<br>LO=HMHC, OL=HOME, SP=GENP (RF=REFD) ..... 46.3<br>LO=HMHC, OL=HOME, SP=GENP RO=DETE (RF=REFD) ..... 46.3+MU |
| VIST | 03.04 | Direct Admission to Home Care from Home (1701 - 2000)<br>LO=HMHC, OL=HOME, TI=EVNT, SP=GENP (RF=REFD)..... 53.3<br>LO=HMHC, OL=HOME, TI=EVNT, RO=DETE, SP=GENP (RF=REFD)..... 53.3+MU |
| VIST | 03.04 | Direct Admission to Home Care from Home (2001 - 2359)<br>LO=HMHC, OL=HOME, TI=ETMD, SP=GENP (RF=REFD)..... 53.3<br>LO=HMHC, OL=HOME, TI=ETMD, RO=DETE, SP=GENP (RF=REFD)..... 53.3+MU |
| VIST | 03.04 | Direct Admission to Home Care from Home (0000 - 0800)<br>LO=HMHC, OL=HOME, TI=MDNT, SP=GENP (RF=REFD) ..... 63.3<br>LO=HMHC, OL=HOME, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) ..... 63.3+MU |
| VIST | 03.04 | Direct Admission to Home Care from Home (0801 - 1200) Sat., Sun., Holidays<br>LO=HMHC, DA=RGE1, OL=HOME, TI=AMNN, SP=GENP (RF=REFD) ..... 53.3<br>LO=HMHC, DA=RGE1, OL=HOME, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) ..... 53.3+MU |
| VIST | 03.04 | Direct Admission to Home Care from Home (1201 - 1700) Sat., Sun., Holidays<br>LO=HMHC, DA=RGE1, OL=HOME, TI=NNEV, SP=GENP (RF=REFD)..... 53.3<br>LO=HMHC, DA=RGE1, OL=HOME, TI=NNEV, RO=DETE, SP=GENP (RF=REFD)..... 53.3+MU |
| VIST | 03.04 | Direct Admission to Home Care from Office<br>LO=HMHC, OL=OFFC, SP=GENP (RF=REFD) ..... 35.5 |
| VIST | 03.04 | Direct Admission to Home Care from Emergency<br>LO=HMHC, OL=USEM, SP=GENP (RF=REFD)..... 59.91<br>LO=HMHC, OL=USEM, RO=DETE, SP=GENP (RO=REFD) ..... 59.91+MU |
| VIST | 03.04 | Direct Admission to Home Care from Outpatient (0801 - 1200)<br>LO=HMHC, OL=OTPT, TI=AMNN, SP=GENP (RF=REFD) ..... 35.4<br>LO=HMHC, OL=OTPT, TI=AMNN, RO=DETE, SP=GENP (RF=REFD)..... 35.4+MU |
| VIST | 03.04 | Direct Admission to Home Care from Outpatient (1201 - 1700)<br>LO=HMHC, OL=OTPT, TI=NNEV, SP=GENP (RF=REFD)..... 35.4<br>LO=HMHC, OL=OTPT, TI=NNEV, RO=DETE, SP=GENP (RF=REFD)..... 35.4+MU |
| VIST | 03.04 | Direct Admission to Home Care from Outpatient (1701 - 2000)<br>LO=HMHC, OL=OTPT, TI=EVNT, SP=GENP (RF=REFD)..... 35.4<br>LO=HMHC, OL=OTPT, TI=EVNT, RO=DETE, SP=GENP (RF=REFD)..... 35.4+MU |
| VIST | 03.04 | Direct Admission to Home Care from Outpatient (2001 - 2359)<br>LO=HMHC, OL=OTPT, TI=ETMD, SP=GENP (RF=REFD)..... 40.5<br>LO=HMHC, OL=OTPT, TI=ETMD, RO=DETE, SP=GENP (RF=REFD)..... 40.5+MU |

| | | | |
|---|---|---|---|
| VIST | 03.04 | Direct Admission to Home Care from Outpatient (0000 - 0800) | |
| | | LO=HMHC, OL=OTPT, TI=MDNT, SP=GENP (RF=REFD) | 40.5 |
| | | LO=HMHC, OL=OTPT, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) | 40.5+MU |
| VIST | 03.04 | Direct Admission to Home Care from Outpatient, Sundays and Holidays | |
| | | LO=HMHC, DA=RGE2, OL=OTPT, SP=GENP (RF=REFD) | 40.5 |
| | | LO=HMHC, DA=RGE2, OL=OTPT, RO=DETE, SP=GENP (RF=REFD) | 40.5+MU |
| VIST | 03.04 | Transfer to Home Care from Inpatient | |
| | | LO=HMHC, OL=INPT, SP=GENP, SP=EMMD, SP=COMD (RF=REFD) | 28.6 |
| | | LO=HMHC, OL=INPT, RO=DETE, SP=GENP, SP=EMMD, SP=COMD (RF=REFD) | 28.6+MU |
| VIST | 03.03 | Home Care - Home Visit (0800 - 1700) | |
| | | LO=HMHC, SP=GENP (RF=REFD) | 21.3 |
| | | LO=HMHC, SP=GENP, RO=DETE (RF=REFD) | 21.3+MU |
| VIST | 03.03 | Home Care - Home Visit (1701 - 2000) | |
| | | LO=HMHC, TI=EVNT, SP=GENP (RF=REFD) | 28.3 |
| | | LO=HMHC, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Home Care - Home Visit (2001 - 2359) | |
| | | LO=HMHC, TI=ETMD, SP=GENP (RF=REFD) | 28.3 |
| | | LO=HMHC, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Home Care - Home Visit (0000 - 0800) | |
| | | LO=HMHC, TI=MDNT, SP=GENP (RF=REFD) | 38.3 |
| | | LO=HMHC, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) | 38.3+MU |
| VIST | 03.03 | Home Care - Home Visit (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HMHC, DA=RGE1, TI=AMNN, SP=GENP (RF=REFD) | 28.3 |
| | | LO=HMHC, DA=RGE1, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Home Care - Home Visit (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HMHC, DA=RGE1, TI=NNEV, SP=GENP (RF=REFD) | 28.3 |
| | | LO=HMHC, DA=RGE1, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Home Care - Urgent Callback By Staff | |
| | | LO=HMHC, US=UCHH, SP=GENP (RF=REFD) | 35.2 |
| | | LO=HMHC, US=UCHH, RO=DETE, SP=GENP (RF=REFD) | 35.2+MU |
| VIST | 03.03 | Home Care - Outpatient Visit (0801 - 1200) | |
| | | LO=HOSP, FN=OTPT, OL=HMHC, TI=AMNN, SP=GENP (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, OL=HMHC, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Home Care - Outpatient Visit (1201 - 1700) | |
| | | LO=HOSP, FN=OTPT, OL=HMHC, TI=NNEV, SP=GENP (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, OL=HMHC, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Home Care - Outpatient Visit (1701 - 2000) | |
| | | LO=HOSP, FN=OTPT, OL=HMHC, TI=EVNT, SP=GENP (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, OL=HMHC, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) | 10.5+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Home Care - Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, OL=HMHC, TI=ETMD, SP=GENP (RF=REFD) ..... 15.5<br>LO=HOSP, FN=OTPT, OL=HMHC, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) ..... 15.5+MU |
| VIST | 03.03 | Home Care - Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, OL=HMHC, TI=MDNT, SP=GENP (RF=REFD)..... 15.5<br>LO=HOSP, FN=OTPT, OL=HMHC, TI=MDNT, RO=DETE, SP=GENP (RF=REFD)..... 15.5+MU |
| VIST | 03.03 | Home Care - Outpatient Visit, Sunday and Holidays<br>LO=HOSP, FN=OTPT, DA=RGE2, OL=HMHC, SP=GENP (RF=REFD)..... 15.5<br>LO=HOSP, FN=OTPT, DA=RGE2, OL=HMHC, RO=DETE, SP=GENP (RF=REFD)..... 15.5+MU |
| VIST | 03.03 | Home Care, Medical Chart Review and/or Telephone<br>Call, Fax or E-mail Advice - up to three per day per patient<br>LO=HMHC, RO=HMTE, SP=GENP (RF=REFD) ..... 11.5<br>**Note**: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 MSU |
| ADON | HHCMI | Blended Mileage/Detention Time for Home Care..... 0.46+ MU<br>(1 multiple = 1 km) |
| VIST | 03.03 | Home Care Emergency Visit<br>LO=HMHC, US=UIOH, SP=GENP, SP=EMMD, SP=COMD (RF=REFD)..... 35.2<br>LO=HMHC, US=UIOH, RO=DETE, SP=GENP, SP=EMMD, SP=COMD (RF=REFD)..... 35.2+MU |

**CORRECTIONAL CENTRE**

| | | |
|---|---|---|
| VIST | 03.04 | Complete Examination<br>LO=CCNT (RF=REFD) ..... 24 |
| VIST | 03.03 | Office Visit<br>LO=CCNT, RP=SUBS (RF=REFD) ..... 12.5 |
| VIST | 03.03 | Urgent Visit - Request by Patient (1701 - 2000)<br>LO=CCNT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Visit - Request by Patient (2001 - 2359)<br>LO=CCNT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Visit - Request by Patient (0000 - 0800)<br>LO=CCNT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 38.3 |
| VIST | 03.03 | Urgent Visit - Request by Patient (0801 - 1200) Sat., Sun., Holidays<br>LO=CCNT, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Visit - Request by Patient (1201 - 1700) Sat., Sun., Holidays<br>LO=CCNT, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)..... 28.3 |
| VIST | 03.03 | Urgent Visit - Request by Patient, Extra Patient<br>LO=CCNT, PT=EXPT (RF=REFD)..... 10.5 |

VIST 03.03 Correctional Centre - Emergency Visit
LO=CCNT, US=UIOH (RF=REFD) ..... 35.2
LO=CCNT, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU

VIST 03.04 Complete Pregnancy Exam
LO=CCNT, RO=ANTL, RP=INTL (RF=REFD) ..... 29.7

VIST 03.03 Routine Pre-Natal Visit
LO=CCNT, RO=ANTL, RP=SUBS (RF=REFD) ..... 13

**OTHER**

VIST 03.04 Complete Examination
LO=OTHR (RF=REFD) ..... 24
LO=OTHR, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.03 Unspecified Emergency Visit
LO=OTHR, US=UIOH (RF=REFD) ..... 35.2
LO=OTHR, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU

VIST 03.03 Unspecified Location (0800 - 1700)
LO=OTHR, PT=FTPT (RF=REFD) ..... 21.3
LO=OTHR, PT=FTPT, RO=DETE (RF=REFD) ..... 21.3+MU

VIST 03.03 Unspecified Location (1701 - 2000)
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location (2001 - 2359)
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location (0000 - 0800)
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU

VIST 03.03 Unspecified Location (0801 - 1200) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) ..... 28.3
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location (1201 - 1700) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 28.3
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location - Extra Patient
LO=OTHR, PT=EXPT (RF=REFD) ..... 10.5

**PALLIATIVE CARE**

CONS 03.09C Palliative Care Consultation ..... 62+MU
RF=REFD, TI=GPEW ..... 77.5+MU
(Once per patient per physician)

VIST 03.03C Palliative Care Support Visit
RO=PCSV ..... 30 per 30 min
(15 units per 15 min. thereafter, maximum of 60 min. per patient per day)
RO=PCSV, TI=GPEW ..... 37.5 per 30 min
(18.75 units per 15 min. thereafter, maximum of 60 min. per patient per day)

VIST 03.03 Palliative Care Medical Chart Review and/or Telephone Call, Fax or E-mail initiated by a health care professional - up to three telephone calls/faxes or e-mails per day per patient
RO=CRTC ..... 11.5
**Note**: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 units

## PROCEDURES

**IMPLANT FOR OPIOID USE DISORDER**

VADT 13.59P Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment Of opioid use disorder ..... 20

VADT 13.59Q Removal of Buprenorphine Implant (e.g. Probuphine) ..... 20

**ACUTE STROKE PROTOCOL**

VEDT 13.99F Assessment and management of patient with Acute Stroke ..... 130
From activation of Acute Stroke Protocol through completion of Thrombolytic therapy (e.g. t-PA)

**SUTURES**

MISG 98.22 Suture of skin and subcutaneous tissue of other sites ..... 20

MISG 98.22A Suture of simple wounds or lacerations – child's face ..... 25

MISG 98.22D Suture minor laceration or foreign body wound ..... 20

VADT 98.03 Other incision with drainage of skin and subcutaneous tissue
AN-LOCL ..... 10

**PSYCHIATRIC SERVICES**

Refer to the Preamble for billing Psychiatric Health Service Codes (5.2.131).

VIST 03.04I Practice Support Program Mental Health Comprehensive Visit* ..... 50 per 30 min.
(25 units per 15 min. thereafter to a maximum 1 hour)
TI=GPEW ..... 62.50 per 30 min.
(31.25 units per 15 min. thereafter to a maximum 1 hour)
*Physician Restrictions in Place (See Appendix J)

| | | | |
|---|---|---|---|
| PSYC | 08.41 | Hypnotherapy* | 30 per 30 min. |
| | | (15 units per 15 min. thereafter) | |
| | | TI=GPEW | 37.50 per 30 min. |
| | | (18.75 units per 15 min. thereafter) | |
| | | *Physician Restrictions in Place (See Appendix J) | |
| PSYC | 08.44 | Group therapy | |
| | | Group psychotherapy per patient (4 - 8 members) | 7.6 per 30 min. |
| | | (3.2 units per 15 min. thereafter) | |
| | | TI=GPEW | 9.50 per 30 min. |
| | | (4.75 units per 15 min. thereafter) | |
| PSYC | 08.44A | Mindfulness-Based Cognitive Therapy (MBCT)* (min 8 – max 12 patients) | |
| | | Group therapy fee per patient per two-hour session | 14.3 |
| | | *Physician Restrictions in Place (See Appendix J) | |
| PSYC | 08.45 | Family therapy (2 or more members) | 30 per 30 min. |
| | | (15 units per 15 min. thereafter) | |
| | | TI=GPEW | 37.50 per 30 min. |
| | | (18.75 units per 15 min. thereafter) | |
| PSYC | 08.49A | Counselling | 30 per 30 min. |
| | | (15 units per 15 min. thereafter) | |
| | | TI=GPEW | 18.75 per 15 min. |
| PSYC | 08.49B | Psychotherapy | 30 per 30 min. |
| | | (15 units per 15 min. thereafter) | |
| | | TI=GPEW | 37.50 per 30 min. |
| | | (18.75 units per 15 min. thereafter) | |
| PSYC | 08.49C | Lifestyle counselling | 15 per 15 min. |
| | | TI=GPEW | 18.75 per 15 min. |

**ADDITIONAL SERVICES**

For further information refer to the Preamble.

| | | | |
|---|---|---|---|
| MAAS | EC | Exceptional Circumstances | EC |
| MAAS | IC | Independent Consideration | IC |
| MAAS | IF | Interim Fee | IF |

**COMMUNITY SERVICES (See Community Services Medical Assessment (2.5.11) of Preamble)**

| | | | |
|---|---|---|---|
| DEFT | C9999 | Community Services Medical Assessment Form and request for Essential Medical Treatments Form | $40.00 |

**OTHER DENTAL OPERATIONS NEC**

| | | | |
|---|---|---|---|
| MAAS | 36.99A | Assistant for dental surgery performed by a dentist | |
| | | (RO=DTAS) | IC |

**OPIOID AGONIST TREATMENT (OAT)**

| | | | |
|---|---|---|---|
| VIST | 03.03J | Initial Opioid Use Disorder Assessment for Initiation of OAT<br>Community Primary Care Setting Only (30 minutes) | 50 + MU |
| | | TI=GPEW | 62.5 + MU |
| VIST | 03.03K | Initial Opioid Use Disorder Assessment for Initiation of OAT | 50 |
| | | Transfer from Opioid Use Disorder Treatment Program to Community Primary Care Provider | |
| | | TI=GPEW | 62.5 |
| VIST | 03.03L | Permanent Transfer of a Patient on Active OAT for Opioid Use Disorder<br>Full Acceptance of Responsibility for Ongoing Care<br>Initial Visit with Accepting Health Care Provider | 50 |
| | | TI=GPEW | 62.5 |
| DEFT | OAT1 | OAT Monthly Management Fee – Primary Care Provider Only | |
| | | ME=CARE | 60 |
| DEFT | OAT2 | OAT Monthly Management Fee for provision of OAT only<br>Patient Referred by another health care provider with written progress updates supplied the primary care provider at least quarterly | 45 |
| ADON | UDS1 | Urine Drug Screen Tray Fee | 2.3 |

**INCENTIVE PROGRAMS**

| | | | |
|---|---|---|---|
| DEFT | CDM1 | Family Physician Chronic Disease Management Incentive Program -<br>(First qualifying condition) | $100.00 |
| | | RP=CON2 (Second qualifying condition) | $75.00 |
| | | (Can be claimed once per fiscal year per condition) | |
| | | RP=CON3 (Third qualifying condition) | $50.00 |
| | | (Can be claimed once per fiscal year per condition) | |
| DEFT | ENH1 | Long Term Care Medication Review | 11.95 |
| | | (Can be claimed twice per fiscal year) | |
| DEFT | CGA1 | Long Term Care Clinical Geriatric Assessment | 26.32 |
| | | (Can be claimed twice per fiscal year) | |

**WORKERS' COMPENSATION BOARD**

| | | | |
|---|---|---|---|
| DEFT | WCB12 | EPS Physician Assessment Service<br>Combined office visit and completion of Form 8/10 | |
| | | RO=EPS1, RP=INTL | $230.35 +MU |
| | | RO=EPS1, RP=SUBS | $230.35 |
| DEFT | WCB13 | Chart Summaries / Written Reports. Detailed reports billed | |
| | | - plus multiples, if applicable | $56.42 per 15 min |
| | | RO=EPS1 | $67.43 per 15 min |

| | | |
|---|---|---|
| DEFT | WCB15 | Case Conferencing and Teleconferencing (Treating Physician)<br>Conferencing billed by the Treating Physician - plus multiples, if applicable..... $56.42 per 15 min<br>RO=EPS1..... $67.43 per 15 min |
| DEFT | WCB17 | Photocopying of charts. Photocopying of chart notes<br>ME=UP10 ..... $33.80<br>ME=UP25 ..... $67.43<br>ME=UP50 ..... $134.65<br>ME=OV50..... $201.78 |
| DEFT | WCB20 | Carpal Tunnel Syndrome (CTS) Form Payment<br>This form is only to be used upon request form the WCB case worker ..... $86.43 |
| DEFT | WCB21 | Follow-up visit report ..... $50.62 |
| DEFT | WCB22 | Completed Mandatory Generic Exemption Request Form ..... $16.99 per form |
| DEFT | WCB23 | Completed Non-Opioid Special Authorization Request Form ..... $16.99 per form |
| DEFT | WCB24 | Completed Opioid Special Authorization Request Form ..... $56.71 per form |
| DEFT | WCB25 | Completed WCB Substance Abuse Assessment Form..... $37.86 |
| DEFT | WCB26 | Return to Work Report – Physician's Report Form 8/10..... $86.43 |
| DEFT | WCB27 | Eye Report ..... $75.86 |
| DEFT | WCB28 | Comprehensive Visit for Work Related Injury or Illness..... $86.96 |
| DEFT | WCB29 | Initial request form for Medical Cannabis ..... $93.83 |
| DEFT | WCB30 | Extension request form for Medical Cannabis ..... $56.42 |
| DEFT | WCB31 | WCB Interim Fee- Comprehensive Visit for Work Related Injury or Illness<br>When Condition has Changed. ..... $86.99 |

# INTENSIVE CARE UNIT

(Includes Critical Care, Ventilatory Care, Comprehensive Care, Intensive Care and Neonatal Intensive Care)

For further details refer to the Preamble.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CRITICAL CARE** | | | | |
| CRCR | 03.05 | First Day<br>LO=HOSP, IN=CC01, FN=INCU | 105.8 | |
| CRCR | 03.05 | Day 2 - 10 Inclusive<br>LO=HOSP, IN=CC10, FN=INCU | 52.9 | |
| CRCR | 03.05 | Eleventh Day Onward<br>LO=HOSP, IN=CC11, FN=INCU | 26.45 | |
| **VENTILATORY CARE** | | | | |
| CRCR | 03.05 | First Day<br>LO=HOSP, IN=VC01, FN=INCU | 100 | |
| CRCR | 03.05 | Day 2 - 10 Inclusive<br>LO=HOSP, IN=VC10, FN=INCU | 50 | |
| CRCR | 03.05 | Eleventh Day Onward<br>LO=HOSP, IN=VC11, FN=INCU | 25 | |
| **COMPREHENSIVE CARE** | | | | |
| CRCR | 03.05 | First Day<br>LO=HOSP, IN=CP01, FN=INCU | 155.8 | |
| CRCR | 03.05 | Day 2 - 10 Inclusive<br>LO=HOSP, IN=CP10, FN=INCU | 77.9 | |
| CRCR | 03.05 | Eleventh Day Onward<br>LO=HOSP, IN=CP11, FN=INCU | 38.95 | |
| **COMPREHENSIVE CARE** (for patient requiring extracorporeal membrane oxygenation ECMO) | | | | |
| CRCR | 03.05 | First Day<br>LO=HOSP, IN=CP01, FN=INCU, ME=ECMO | 205.08 | |
| CRCR | 03.05 | Day 2 - 10 Inclusive<br>LO=HOSP, IN=CP10, FN=INCU, ME=ECMO | 102.9 | |
| CRCR | 03.05 | Eleventh Day Onward<br>LO=HOSP, IN=CP11, FN=INCU, ME=ECMO | 51.45 | |

**INTENSIVE CARE**

CRCR 03.05 Intensive Care, Per Day
LO=HOSP, IN=INCR, FN=INCU, FN=NICU..... 19.3

CRCR 03.05 Requiring Detention, Per Hour
LO=HOSP, IN=INPH, FN=INCU..... 45

CRCR 03.05A Continuous Attendance for Support of a Beating Donor, maximum 36 hours
LO=HOSP, FN=INCU ..... 15+MU

**NEONATAL INTENSIVE CARE** - with respiratory insufficiency requiring ventilatory assistance

CRCR 03.05 First Day
LO=HOSP, IN=NIC1, FN=NICU ..... 150

CRCR 03.05 2nd, 3rd and 4th Day
LO=HOSP, IN=NIC4, FN=NICU ..... 75

CRCR 03.05 5th Day Onward
LO=HOSP, IN=NIC5, FN=NICU ..... 50

# MEDICINE

(Includes SP=INMD, CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD)

For further details refer to the Preamble.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation (Prolonged) | | |
| | | RF=REFD (ME=TELE) | 62+MU | |
| | | RF=REFD, US=PREM (ME=TELE) | 83.7 +MU | |
| | | RF=REFD, US=PR50 (ME=TELE) | 93+MU | |
| | | RF=REFD, RO=DETE (ME=TELE) | 62+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 83.7 +MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 93+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 37 | |
| | | RF=REFD, US=PREM (ME=TELE) | 55 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 55.5 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 37+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 55+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 55.5+MU | |
| CONS | 03.07 | Repeat Consultation (Prolonged) | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 27.4+MU | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 45.4+MU | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 45.4+MU | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 27.4+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 45.4+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 45.4+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.04 | Subsequent Visit with Complete Re-Examination | | |
| | | LO=OFFC, RP=SUBS (RF=REFD) | 12 | |
| VIST | 03.04D | Geriatrician's Initial Comprehensive Geriatric Consultation to include CGA* (Comprehensive Geriatric Assessment) | | |
| | | LO=OFFC | 150 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |
| VIST | 03.03 | Subsequent Visit with Regional Exam | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 17 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

VIST 03.03A Geriatric Office Visit (for patients aged 65+)
LO=OFFC (ME=VTCR*) (RF=REFD) ..... 21
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD ..... 17
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 21

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD ..... 17
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 21

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 25
LO=HOSP, FN=INPT, RP=INTL, SP=INMD (RF=REFD) ..... 30
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.04B Screening for Potential Organ / Tissue Donor and Family Approach for Consent
..... 35

VIST 03.04D Geriatrician's Initial Comprehensive Geriatric Consultation to include CGA* (Comprehensive Geriatric Assessment)
LO=HOSP ..... 150
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Continuing Care
LO=HOSP, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 15
LO=HOSP, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

| | | | |
|---|---|---|---|
| VIST | 03.03 | Continuing Care | |
| | | LO=HOSP, FN=INPT, RO=CNTC, RF=REFD | 18.39 |
| | | LO=HOSP, FN=INPT, DA=DA23, RO=CNTC, RF=REFD | 26.43 |
| | | LO=HOSP, FN=INPT, DA=DA47, RO=CNTC, RF=REFD | 21.84 |
| VIST | 03.03 | Directive Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, RO=DIRC, SP=INMD, RF=REFD | 18.39 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD | 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, SP=INMD (RF=REFD) | 18.39 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week | |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, SP=INMD (RF=REFD) | 18.39 |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |
| ADON | 03.02A | Hospital Discharge Fee | |
| | | LO=HOSP, FN=INPT | 10 |
| VIST | 03.03 | Urgent Hospital Visit | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD) | 22 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD) | 22+MU |
| VIST | 03.03 | Hospital Emergency Visit | |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD) | 35.2 |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD) | 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) | 13.5 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) | 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 26 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 20+MU |

VIST 03.03 Outpatient Visit (1201 - 1700) Sat., Sun., Holidays
LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20
LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU

VIST 03.03 Outpatient Visit (0801 - 1200) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7
LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU

VIST 03.03 Outpatient Visit (1201 - 1700) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7
LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU

VIST 03.03 Outpatient Visit (1701 - 2000) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5

VIST 03.03 Outpatient Visit (2001 - 2359) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5
LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU

VIST 03.03 Outpatient Visit (0000 - 0800) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4
LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU

VIST 03.03 Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU

VIST 03.03 Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

**CANCER PATIENT**

VIST 03.04 Comprehensive reassessment of a cancer patient
RO=CAPT RP=SUBS..... 25

VIST 03.03 Telephone advice and medical chart review of a cancer patient by the Oncologist
RO=TCCP ..... 11.5

## PROCEDURES

**OTHER NONOPERATIVE BRONCHOSCOPY**

VADT 01.09D Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of one or two mediastinal nodal stations and or hilar nodal stations or structures..... 125

VADT 01.09E Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of three or more nodal stations and or hilar nodal stations or structures..... 150

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC**

VADT 03.19C Sleep studies - plus multiples, if applicable
RO=INTP, SP=RSMD ..... 60

VADT 03.19F Level II Sleep Apnea Testing Interpretation
(SP=INMD) (SP=RSMD) ..... 35

VADT 03.19G Level III Sleep Apnea Testing Interpretation
(SP=INMD) (SP=RSMD) ..... 25

**CARDIOVASCULAR STRESS TEST USING BICYCLE ERGOMETER**

VADT 03.43 Cardiovascular stress test using bicycle ergometer ..... 38

**OTHER CARDIOVASCULAR STRESS TEST**

VADT 03.44A Myocardial perfusion study includes IV set-up and medication ..... 48

VADT 03.44B Graded testing utilizing treadmill with continuous ECG monitoring ..... 38

**OTHER ASTHMA ASSESSMENT**

VEDT 03.38A Bronchial challenge testing with methacholine or similar compounds-
Includes baseline spirometry and all spirometric determinations post
Administration of agent(s) RO=INTP ..... 19

VEDT 03.38B Exercise Induced Asthma Assessment, interpretation.
Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation
responsiveness, and oximetry required to assess the patient. ..... 20

VEDT 03.38C Interpretation of spirometry pre and post bronchodilator ..... 10

VEDT 03.38D Six Minute Walk Test, interpretation, when this is the sole procedure ..... 2

**ACUTE STROKE PROTOCOL**

VEDT 13.99F Assessment and management of patient with Acute Stroke ..... 130
From activation of Acute Stroke Protocol through completion of
Thrombolytic therapy (e.g., t-PA)

**OTHER REPLACEMENT OF AORTIC VALVE**

VEDT 47.25C Transcutaneous Aortic Valve Implantation/Replacement (TAVI)
RO=FPHN ..... 611
RO=SPHN ..... 611

**CHRONIC DIALYSIS** *Physician Restrictions in Place (See Appendix J)

VEDT 51.95A Chronic Dialysis – treatment and supervision of care for a patient with
end stage kidney disease, in hospital (hemodialysis or peritoneal dialysis)
or in central outpatient hemodialysis units for a 24-hour period. ..... 12.11

VEDT 51.95B Chronic Hemodialysis – treatment and supervision of care for the patient
with end stage kidney disease, in an urban satellite hemodialysis unit as
designated by the Health Authority for a 24-our period ..... 12.11

| | | | |
|---|---|---|---|
| VEDT | 51.95C | Chronic hemodialysis – treatment and supervision of care, in a rural satellite hemodialysis unit as designated by the Health Authority for a 24-hour period | 12.11 |
| VEDT | 51.95D | Chronic Dialysis – treatment and supervision of care for the patient on home peritoneal dialysis or home hemodialysis for a 24-hour period ME=PERI, ME=HEMO | 12.11 |

## INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

These codes must be claimed from LO=HOSP[1]

**ELECTRO DIAGNOSTICS**

| | | | |
|---|---|---|---|
| BULK | I1168 | Electrocardiogram - interpretation | 4.60 |
| BULK | I1171 | Electroencephalogram – interpretation only | 10.50 |
| BULK | I6208 | Holter monitoring – interpretation only | 25 |

**PULMONARY FUNCTIONS**

| | | | |
|---|---|---|---|
| BULK | I1110 | Simple Spirometry | 5 |
| BULK | I1140 | Flow/volume loops | 5 |
| BULK | I1210 | Helium dilution | 5 |
| BULK | I1410 | Carbon monoxide single breath | 5 |
| BULK | I1710 | Pulmonary stress test | 20 |
| BULK | I1120 | Bedside spirometry | 5 |
| BULK | I1230 | Body plethysmography | 5 |

**ECHOCARDIOGRAPHY**

| | | | |
|---|---|---|---|
| BULK | I1311 | M – mode | 25.44 |
| BULK | I1310 | Two dimensional | 47.56 |
| BULK | I1312 | Doppler – quantitative | 30.45 |
| BULK | I1313 | Doppler – qualitative | 15.23 |

[1] Specialties SP=INMD and SP=RSMD may claim health service codes I1110 and I1140 from locations LO=OFFC, LO=OTHER or LO=HOME. These locations are restricted to the mobile INSPIRED program and physicians are required to enter 'INSPIRED' in the text field of the MSI claim when submitting claims for this program.

# NEUROLOGY

(SP=NEUR)

For further details refer to the Preamble.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation (Prolonged) | | |
| | | RF=REFD (ME=TELE) | 62+MU | |
| | | RF=REFD, US=PREM (ME=TELE) | 83.7+MU | |
| | | RF=REFD, US=PR50 (ME=TELE) | 93+MU | |
| | | RF=REFD, RO=DETE (ME=TELE) | 62+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 83.7+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 93+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 37 | |
| | | RF=REFD, US=PREM (ME=TELE) | 55 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 55.5 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 37+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 55+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 55.5+MU | |
| CONS | 03.07 | Repeat Consultation (Prolonged) | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 27.1+MU | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 45.1+MU | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 45.1+MU | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 27.1+MU | |
| | | RF=REFD, RO=DETE, RP=REPT US=PREM, (ME=TELE) | 45.1+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 45.1+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.04 | Subsequent Visit with Complete Re-Examination | | |
| | | LO=OFFC, RP=SUBS (RF=REFD) | 12 | |
| VIST | 03.03 | Subsequent Visit with Regional Exam | | |
| | | LO=OFFC, RP=SUBS (RF=REFD) | 17 | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (RF=REFD) | 21 | |
| VIST | 03.03 | Continuing Care | | |
| | | LO=OFFC, RO=CNTC, RF=REFD | 17 | |
| | | LO=OFFC, AG=OV65, RO=CNTC, RF=REFD | 21 | |

| | | |
|---|---|---|
| VIST | 03.03 | Directive Care<br>LO=OFFC, RO=DIRC, RF=REFD ..... 17<br>LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 21 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000)<br>LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359)<br>LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800)<br>LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays<br>LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays<br>LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient<br>LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | |
|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination<br>LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 24<br>LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU |
| VIST | 03.04 | Initial Visit<br>LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 30<br>LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 30+MU |
| VIST | 03.03 | Continuing Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 15<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU |
| VIST | 03.03 | Directive Care<br>LO=HOSP, FN=INPT, RO=DIRC, RF=REFD ..... 18.39<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 18.39<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 18.39+MU |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 18.39<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 18.39+MU |
| ADON | 03.02A | Hospital Discharge Fee<br>LO=HOSP, FN=INPT ..... 10 |

| | | |
|---|---|---|
| VIST | 03.03 | Urgent Hospital Visit<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Hospital Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE<br>(RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE<br>(RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU |

## PROCEDURES

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC**

| | | |
|---|---|---|
| VADT | 03.19C | Sleep studies - plus multiples, if applicable<br>RO=INTP..... 60 |
| VADT | 03.19F | Level II Sleep Apnea Testing Interpretation..... 35 |
| VADT | 03.19G | Level III Sleep Apnea Testing Interpretation..... 25 |

**INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC**

| | | |
|---|---|---|
| VEDT | 13.59O | Injection of onabotulinumtoxinA for treatment of chronic migraine ..... 70<br>(Prior Approval) |

**ACUTE STROKE PROTOCOL**

| | | |
|---|---|---|
| VEDT | 13.99F | Assessment and management of patient with Acute Stroke ..... 130<br>From activation of Acute Stroke Protocol through completion of Thrombolytic therapy (e.g., t-PA) |
| VEDT | 13.99G | Assessment and management of patient with Acute Stroke ..... 170<br>From activation of Acute Stroke Protocol through receiving endovascular Thrombectomy (EVT) with or without administration of thrombolytic therapy |

## INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

Code must be claimed from LO=HOSP

**ELECTRO DIAGNOSTICS**

| | | |
|---|---|---|
| BULK | I6208 | Holter monitoring – interpretation only..... 25 |

# NEUROSURGERY

(SP=NUSG)

For further details refer to the Preamble.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 40.3 | |
| | | RF=REFD, US=PREM (ME=TELE) | 58.3 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 60.45 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 40.3+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 58.3+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 60.45+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 24.5 | |
| | | RF=REFD, US=PREM (ME=TELE) | 42.5 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 42.5 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 24.5+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 42.5+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 42.5+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 22.5 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 40.5 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 40.5 | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 22.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 40.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 40.5+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 16.5 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Continuing Care | |
| | | LO=OFFC, RO=CNTC, RF=REFD | 13.5 |
| | | LO=OFFC, AG=OV65, RO=CNTC, RF=REFD | 16.5 |
| VIST | 03.03 | Directive Care | |
| | | LO=OFFC, RO=DIRC, RF=REFD | 13.5 |
| | | LO=OFFC, AG=OV65, RO=DIRC, RF=REFD | 16.5 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000) | |
| | | LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359) | |
| | | LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800) | |
| | | LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient | |
| | | LO=OFFC, PT=EXPT (RF=REFD) | 10.5 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | | |
|---|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=HOSP, FN=EMCC FN=OTPT (RF=REFD) | 24 |
| | | LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) | 24+MU |
| VIST | 03.04 | Closed Head Injury - Initial Examination and Recommendation Re Further Management | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC, RO=CLHD, RP=INTL (RF=REFD) | 30 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC, RO=CHDT, RP=INTL (RF=REFD) | 30+MU |
| VIST | 03.03 | Daily Management in Hospital, Per Day | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CLHD (RF=REFD) | 7 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CHDT (RF=REFD) | 7+MU |
| VIST | 03.04 | Initial Visit | |
| | | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | 25 |
| | | LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) | 25+MU |
| VIST | 03.03 | Continuing Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD | 15+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Directive Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU |
| ADON | 03.02A | Hospital Discharge Fee<br>LO=HOSP, FN=INPT ..... 10 |
| VIST | 03.03 | Urgent Hospital Visit<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DETE, US=UNOF (RF=REFD)..... 22+MU |
| VIST | 03.03 | Hospital Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE<br>(RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE<br>(RF=REFD) ..... 20+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) | 11.4 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) | 11.4+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 10.5+MU |

## PROCEDURES

**APPLICATION OF PLASTER JACKET**

| | | | |
|---|---|---|---|
| MISG | 07.51A | Vertebral fracture/other trauma without cord injury - body plaster | 25 |

**APPLICATION OF NECK SUPPORT**

| | | | |
|---|---|---|---|
| MISG | 07.52A | Vertebral fracture/other trauma without cord injury - Minerva plaster jacket | 40 |
| MISG | 07.52B | Vertebral fracture/other trauma without cord injury - plaster collar | 30 |

**OTHER CRANIOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 14.13A | Skull trauma - decompression craniectomy - subtemporal (regions required) | 300 | 14+T |
| MASG | 14.13B | Skull trauma - decompression craniectomy - suboccipital (regions required) | 524 | 14+T |
| MASG | 14.13C | Burr holes - diagnostic - plus multiples, if applicable | 141 | 9+T |
| MASG | 14.13D | Craniotomy for craniofacial repair | 675 | 14+T |

| | | | | |
|---|---|---|---|---|
| MASG | 14.13E | Extradural with burr holes | 269 | 9+T |
| MASG | 14.13F | Extradural with craniotomy | 423 | 14+T |
| MASG | 14.13G | Trephine/burr hole with cerebral needling for aspiration or injection or biopsy | 212 | 9+T |
| MASG | 14.13H | Surgical management of brain abscess by craniotomy - to include multiple taps or procedures | 564 | 14+T |

**OTHER CRANIECTOMY**

| | | | | |
|---|---|---|---|---|
| MAAS | 14.14A | Craniectomy for osteomyelitis | IC | 14+T |
| MASG | 14.14B | Removal of infected bone flap | 175 | 14+T |

**INCISION OF CEREBRAL MENINGES**

| | | | | |
|---|---|---|---|---|
| MASG | 14.21A | Subdural with burr holes | 269 | 9+T |
| MASG | 14.21B | Subdural with craniotomy | 423 | 14+T |
| MASG | 14.21C | Subdural by repeated aspiration AG=CH16 | 150 | 9+T |

**LOBOTOMY AND TRACTOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 14.22 | Lobotomy and tractotomy (regions required) | 200 | 14+T |
| MASG | 14.22A | Craniotomy for medullary or mesencephalic tractotomy | 652 | 14+T |

**OTHER INCISION OF BRAIN**

| | | | | |
|---|---|---|---|---|
| MASG | 14.29A | Surgical management of brain abscess by burr hole to include multiple taps or procedures | 564 | 9+T |
| MASG | 14.29B | Craniotomy - removal of foreign body | 467 | 14+T |
| MASG | 14.29C | Craniotomy for removal cyst, tumour, pituitary tumour, intracerebral hematoma, lobectomy - plus multiples, if applicable | 608 | 14+T |

**OPERATIONS ON THALAMUS AND GLOBUS PALLIDUS (INCLUDING ANSA AND CINGULUS)**

| | | | | |
|---|---|---|---|---|
| MASG | 14.3B | Stereotactic thalamotomy, pallidotomy, cingulotomy with depth recording and stimulation | 400 | 14+T |
| MASG | 14.3C | CT-Guided stereotactic surgery includes biopsy, chemotherapy, radiotherapy, draining abscess, deep brain stimulation, includes attendance by Neurosurgeon at imaging localization | 662 | 9+T |

**HEMISPHERECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 14.42 | Hemispherectomy (regions required) | 765 | 14+T |

**LOBECTOMY OF BRAIN**

| | | | | |
|---|---|---|---|---|
| MASG | 14.43 | Lobectomy of brain - plus multiples, if applicable | 608 | 14+T |

**OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF BRAIN**

| | | | | |
|---|---|---|---|---|
| MASG | 14.49A | Craniotomy for removal of acoustic neuroma | 961 | 14+T |
| MASG | 14.49B | Craniotomy for excision of cortical scar for epilepsy | 890 | 14+T |
| MASG | 14.49C | Craniotomy for excisional brain biopsy | 410 | 14+T |
| MASG | 14.49D | Craniotomy for obliteration of cerebral aneurysm | 809 | 14+T |
| MASG | 14.49E | Craniotomy for arteriovenous malformation | 809 | 14+T |
| MASG | 14.49F | Craniotomy with clipping of internal carotid intracranially or of feeding blood vessel to arteriovenous malformation | 375 | 14+T |
| MASG | 14.49G | Craniotomy for carotid-cavernous fistula | 550 | 14+T |
| MASG | 14.49H | Craniotomy - by direct attack | 800 | 14+T |
| MASG | 14.49I | Craniotomy - by embolization | 400 | 14+T |
| MASG | 14.49J | Posterior fossa craniotomy | 975 | 14+T |

**EXCISION OF LESION OF SKULL**

| | | | | |
|---|---|---|---|---|
| MASG | 14.5A | Linear craniectomy for craniosynostosis excision of skull tumour | 170 | 14+T |

**OTHER CONTRAST RADIOGRAM OF BRAIN AND SKULL**

| | | | | |
|---|---|---|---|---|
| MASG | 14.85 | Other contrast radiogram of brain and skull<br>AP=PERC | 75 | 7+T |
| MISG | 14.85A | Ventriculogram by drill or burr hole | 45 | 7+T |

**OPENING OF CRANIAL SUTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 15.01A | Linear craniectomy for craniosynostosis - one suture | 229 | 14+T |
| MASG | 15.01B | Linear craniectomy for craniosynostosis - more than one suture | 350 | 14+T |

**ELEVATION OF SKULL FRACTURE FRAGMENTS**

| | | | | |
|---|---|---|---|---|
| MASG | 15.02A | Simple depressed fracture of skull - dura lacerated | 268 | 14+T |
| MASG | 15.02B | Simple depressed fracture of skull - dura intact | 198 | 10+T |
| MASG | 15.02C | Compound depressed fracture of skull - dura intact | 269 | 14+T |
| MASG | 15.02D | Compound depressed fracture of skull - dura lacerated | 339 | 14+T |

| | | | | |
|---|---|---|---|---|
| MASG | 15.02E | Compound depressed fracture of skull - sinus involvement/serious brain damage (foreign body, hematoma, etc) | 339 | 14+T |
| MASG | 15.02F | Simple depressed fracture of skull - serious brain damage | 300 | 14+T |

**OTHER CRANIAL OSTEOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 15.06 | Other cranial osteoplasty | 298 | 14+T |
| MASG | 15.06B | Craniotomy - replacement of bone flap | 220 | 14+T |

**OTHER REPAIR OF CEREBRAL MENINGES**

| | | | | |
|---|---|---|---|---|
| ADON | 15.12B | Duraplasty | 125 | |
| MASG | 15.12C | Repair of cerebro-spinal fluid leak by craniotomy (regions required) | 564 | 14+T |

**VENTRICULOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 15.2 | Ventriculostomy (regions required) | 251 | 14+T |
| MASG | 15.2A | Endoscopic third ventriculostomy | 250 | 14+T |

**VENTRICULAR SHUNT TO CIRCULATORY SYSTEM**

| | | | | |
|---|---|---|---|---|
| MASG | 15.32A | Ventriculoatrial shunt (Holter or Pudenz valve) | 251 | 14+T |

**VENTRICULAR SHUNT TO ABDOMINAL CAVITY AND ORGANS**

| | | | | |
|---|---|---|---|---|
| MASG | 15.34 | Ventricular shunt to abdominal cavity and organs | 251 | 14+T |

**OTHER OPERATIONS TO ESTABLISH DRAINAGE OF VENTRICLE**

| | | | | |
|---|---|---|---|---|
| MASG | 15.39 | Other operations to establish drainage of ventricle (continuous) | 114 | 14+T |

**REPLACEMENT OF VENTRICULAR SHUNT**

| | | | | |
|---|---|---|---|---|
| MASG | 15.42A | Revision of shunt | 177 | 14+T |
| | | CO=UN5K | | 19+T |
| MASG | 15.42B | Exteriorization of distal end cerebro-spinal fluid shunt | 55 | 8+T |

**REMOVAL OF VENTRICULAR SHUNT**

| | | | | |
|---|---|---|---|---|
| MASG | 15.43 | Removal of ventricular shunt | 110 | 14+T |

**INSERTION OF INTRACRANIAL PRESSURE MONITOR**

| | | | | |
|---|---|---|---|---|
| MASG | 15.94 | Insertion of intracranial pressure monitor | 168 | |

**OTHER EXPLORATION AND DECOMPRESSION OF SPINAL CANAL**

| | | | | |
|---|---|---|---|---|
| MASG | 16.09A | Laminectomy for decompression of spinal cord anterior or posterior | | |
| | | AP=CERV | 322 | 8+T |
| | | AP=DRSL | 236 | 7+T |
| | | AP=LMBR | 236 | 7+T |

| | | | | |
|---|---|---|---|---|
| MASG | 16.09B | Laminectomy for treatment of epidural abscess | 300 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.09C | Laminectomy for exploration of syringomyelic cavity | 423 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.09D | Laminectomy for excision of hematoma of spinal cord or nerve roots | 467 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.09F | Neural arch with nerve root exploration - unilateral or bilateral - with or without discectomy to include laminectomy, laminotomy or foraminotomy - 1 level | 240 | 7+T |
| MASG | 16.09G | Neural arch with nerve root exploration - unilateral or bilateral - with or without discectomy to include laminectomy, laminotomy or foraminotomy - 2 levels | 280 | 7+T |
| MASG | 16.09H | Neural arch with nerve root exploration - unilateral or bilateral - with or without discectomy to include laminectomy, laminotomy or foraminotomy - 3 or more levels | 325 | 7+T |
| MASG | 16.09I | Multiple level anterior decompression (vertebrectomy) to include fusion and/or internal fixation and harvesting of graft | 600 | 11+T |
| MASG | 16.09J | Cervical laminoplasty | 500 | 8+T |

**DIVISION OF INTRASPINAL NERVE ROOT**

| | | | | |
|---|---|---|---|---|
| MASG | 16.1A | Laminectomy for anterior or posterior rhizotomy | 456 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.1B | Laminectomy for rhizotomy torticollis including spinal accessory nerve | 350 | 6+T |

**CHORDOTOMY**

| | | | | |
|---|---|---|---|---|
| MAAS | 16.2 | Chordotomy | | |
| | | AP=PERC | IC | 9+T |
| MASG | 16.2A | Laminectomy for spinothalamic tractotomy (cordotomy) - unilateral (Regions required) | 510 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

| | | | | |
|---|---|---|---|---|
| MASG | 16.2B | Laminectomy for spinothalamic tractotomy (cordotomy) - bilateral | 510 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

**EXCISION OR DESTRUCTION OF LESION OF SPINAL CORD AND SPINAL MENINGES**

| | | | | |
|---|---|---|---|---|
| MASG | 16.3A | Laminectomy for opening of dura and exploration or biopsy of cord or nerve roots or section of dentate ligaments | 350 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.3B | Laminectomy for excision of neoplasm, vascular anomaly, constrictive pachymeningitis of spinal cord or nerve roots | 467 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.3C | Dorsal root entry zone lesions (DREZ) | 543 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

**REPAIR OF (SPINAL) MENINGOCELE**

| | | | | |
|---|---|---|---|---|
| MASG | 16.41 | Repair of (spinal) meningocele | 228 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.41A | Gardner Procedure operation for syringomyelia | 575 | 14+T |

**REPAIR OF (SPINAL) MYELOMENINGOCELE**

| | | | | |
|---|---|---|---|---|
| MASG | 16.42 | Repair of (spinal) myelomeningocele or encephalocele | | |
| | | AP=CERV | 310 | 11+T |
| | | AP=DRSL | 310 | 11+T |
| | | AP=LMBR | 310 | 11+T |
| MASG | 16.42A | Bischoff's tractotomy or modifications | 510 | 7+T |
| MASG | 16.42B | Rickham Reservoir | 150 | 11+T |

**REPAIR OF VERTEBRAL FRACTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 16.43A | Open reduction without cord injury | 200 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43B | Open reduction with internal fixation without cord injury | 285 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

| | | | | |
|---|---|---|---|---|
| MASG | 16.43C | Open reduction and fusion in conjunction with Orthopaedic Surgeon | | |
| | | SP=NUSG | 225 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43D | Injury - antero-lateral decompression of thoracic spinal cord | 425 | 7+T |
| MASG | 16.43E | Open reduction with cord injury | 250 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43F | Open reduction with internal fixation with cord injury | 275 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43G | Open reduction and fusion in conjunction with Orthopaedic Surgeon | | |
| | | SP=NUSG | 200 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MAFR | 16.43H | Spine fracture or fracture dislocation - anterior cervical decompression and/or fusing | 300 | 7+T |
| MAFR | 16.43I | Spine fracture or fracture dislocation - open reduction with decompression of cord or nerve roots | 300 | 7+T |
| MAFR | 16.43J | Spine fracture or fracture dislocation - open reduction | 200 | 7+T |
| MASG | 16.43K | Reduction, internal fixation C1-C2 including harvesting of bone graft if by same surgeon | 365 | 11+T |

**OTHER REPAIR AND PLASTIC OPERATION ON SPINAL CORD STRUCTURES**

| | | | | |
|---|---|---|---|---|
| MASG | 16.49A | Laminectomy for repair of disastematomyelia | 460 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

**FREEING OF ADHESIONS OF SPINAL CORD AND NERVE ROOTS**

| | | | | |
|---|---|---|---|---|
| MASG | 16.5A | Laminectomy for repair of spinal lipomeningocele (To include release of tethered spinal cord) | 554 | 11+T |
| MASG | 16.5B | Laminectomy for intradural section of tethered conus | 424 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

**SPINAL SUBARACHNOID-PERITONEAL SHUNT**

| | | | | |
|---|---|---|---|---|
| MASG | 16.61 | Spinal subarachnoid-peritoneal shunt | 251 | 14+T |

**SPINAL SUBARACHNOID-URETERAL SHUNT**

| | | | | |
|---|---|---|---|---|
| MASG | 16.62A | Lumboureteral shunt | 300 | 14+T |

**CONTRAST MYELOGRAM**

| | | | | |
|---|---|---|---|---|
| MISG | 16.83 | Contrast myelogram | | |
| | | AP=CERV | 40.8 | 5+T |
| | | AP=LMBR | 30.6 | 4+T |

**INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR**

| | | | | |
|---|---|---|---|---|
| MASG | 16.93D | Laminectomy for implantation of spinal cord stimulating electrode | 307 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.93E | Implantation of stimulation pack for cord stimulation system | 140 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

**REMOVAL OF NEUROSTIMULATOR FROM SPINAL CANAL**

| | | | | |
|---|---|---|---|---|
| MASG | 16.94 | Removal of neurostimulator from spinal canal or revision | 120 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

**DIVISION OF TRIGEMINAL NERVE**

| | | | | |
|---|---|---|---|---|
| MASG | 17.03A | Percutaneous trigeminal rhizotomy (regions required) | 217 | 6+T |
| MASG | 17.03B | Subtemporal craniectomy and rhizotomy of V nerve (regions required) | 275 | 14+T |

**DIVISION OR CRUSHING OF Other CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.04A | Rhizotomy including MacKenzie Procedure | 510 | 14+T |

**OTHER INCISION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.05A | Extracranial section of spinal accessory, nerve and/or other peripheral nerves for treatment of spasmodic torticollis | 100 | 6+T |
| MASG | 17.05B | Exploration of brachial plexus (regions required) | 315 | 6+T |
| MASG | 17.05C | Sciatic nerve exploration and neurolysis | 200 | 4+T |
| MASG | 17.05D | Explore peripheral nerve transplant or transposition with/without neurolysis (Excluding median nerve at the carpal tunnel) | 100 | 4+T |

**OTHER EXCISION OR AVULSION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.08B | Neurectomy, major nerve | 85 | 4+T |
| MASG | 17.08C | Avulsion of mandibular, supraorbital, infraorbital occipital nerves (Regions required) | 85 | 4+T |
| MASG | 17.08D | Excision of nerve tumour | 190 | 4+T |
| MASG | 17.08E | Excision of Morton's neuroma (regions required) | 76 | 4+T |
| MASG | 17.08F | Inguinal neurectomy (regions required) | 130 | 4+T |
| MASG | 17.08G | Retroperitoneal neurectomy | 160 | 6+T |

**DESTRUCTION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MISG | 17.1F | Chemical destruction | 35 | |

**SUTURE OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.2A | Peripheral nerves - primary suture, major nerve | 100 | 4+T |

**DECOMPRESSION OF TRIGEMINAL NERVE ROOT**

| | | | | |
|---|---|---|---|---|
| MASG | 17.31A | Decompression of Gasserian ganglion | 255 | 14+T |

**OTHER CRANIAL NERVE DECOMPRESSION**

| | | | | |
|---|---|---|---|---|
| MASG | 17.32 | Other cranial nerve decompression | 570 | 14+T |

**OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS**

| | | | | |
|---|---|---|---|---|
| MASG | 17.39A | Entrapment syndrome | 85 | 4+T |
| MASG | 17.39B | Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm),posterior interosseus nerve (radial nerve in forearm wrist) (regions required) | 125 | 4+T |
| MASG | 17.39C | Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required) | 125 | 4+T |

**CRANIAL OR PERIPHERAL NERVE GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 17.4A | Grafting of VII cranial nerve | 350 | 14+T |

**TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.5A | Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis (excluding median nerve at carpal tunnel) | 100 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 17.5B | Ulnar nerve release at the elbow (cubital tunnel) (regions required) | 125 | 4+T |
| | | RP=REPT | 200 | 4+T |

**ANASTOMOSIS OF CRANIAL OR PERIPHERAL NERVE**

| | | | | |
|---|---|---|---|---|
| MASG | 17.61A | Facial hypoglossal or facial accessory nerve anastomosis | 304 | 6+T |
| MASG | 17.61C | Repair of peripheral nerve - major primary suture (regions required) | 100 | 4+T |

**IMPLANTATION OR REPLACEMENT OF PERIPHERAL NEUROSTIMULATOR**

| | | | | |
|---|---|---|---|---|
| MASG | 17.92C | Vagal nerve stimulator implantation | 200 | 7+T |
| MASG | 17.92D | Vagal nerve stimulator battery change | 100 | 7+T |

**CERVICAL SYMPATHECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 18.12 | Cervical sympathectomy | 200 | 6+T |
| MASG | 18.12A | Cervical - dorsal sympathectomy (regions required) | 150 | 10+T |

**LUMBAR SYMPATHECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 18.13 | Lumbar sympathectomy (regions required) | 200 | 6+T |

**OTHER SYMPATHECTOMY AND GANGLIONECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 18.19A | Thoracolumbar - complete (Smithwick) | 400 | 3+T |
| MASG | 18.19B | Sympathectomy - dorsal (regions required) | 150 | 10+T |

**PARTIAL EXCISION OF PITUITARY GLAND, TRANSFRONTAL APPROACH**

| | | | | |
|---|---|---|---|---|
| MASG | 20.51 | Partial excision of pituitary gland, transfrontal approach - plus multiples, if applicable | 608 | 14+T |
| MASG | 20.51A | Craniotomy for hypophysectomy | 365 | 14+T |

**PARTIAL EXCISION OF PITUITARY GLAND, TRANSSPHENOIDAL APPROACH**

| | | | | |
|---|---|---|---|---|
| MASG | 20.52A | Transphenoidal microsurgery of pituitary fossa for removal of tumour | 651 | 14+T |

**TOTAL EXCISION OF PITUITARY GLAND, TRANSSPHENOIDAL APPROACH**

| | | | | |
|---|---|---|---|---|
| MASG | 20.55A | Transphenoidal hypophysectomy | 400 | 15+T |

**OTHER ORBITOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 29.09A | Skull trauma - craniotomy for orbital decompression (regions required) | 554 | 14+T |

**ENDARTERECTOMY OF OTHER VESSELS OF HEAD AND NECK**

| | | | | |
|---|---|---|---|---|
| MASG | 50.12 | Endarterectomy of other vessels of head and neck (regions required) | 271 | 10+T |
| MASG | 50.12B | Vertebral endarterectomy with patch graft | 300 | 14+T |
| MASG | 50.12C | Carotid endarterectomy - with graft and by-pass shunt (regions required) | 300 | 10+T |
| MASG | 50.12D | Carotid endarterectomy - with patch graft (regions required) | 300 | 10+T |

**RESECTION OF INTRACRANIAL VESSELS WITH ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.21A | Superficial temporal to middle cerebral branch anastomosis (regions required) | 625 | 14+T |

**RESECTION OF INTRACRANIAL VESSELS WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 50.31A | Intracranial arterial reconstructive surgery | 400 | 14+T |

**OTHER SURGICAL OCCLUSION OF INTRACRANIAL VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.71C | Cerebral embolization - intracranial | 350 | 14+T |
| MASG | 50.71D | Embolization of intracranial arteriovenous malformations with glue - congenital and acquired - 1st pedicle - plus multiples, if applicable | 350 | 14+T |
| | | (each additional pedicle) | 175 | |

**OTHER SURGICAL OCCLUSION OF OTHER VESSELS OF HEAD AND NECK**

| | | | | |
|---|---|---|---|---|
| MASG | 50.72B | Cerebral embolization - extracranial | 250 | 14+T |
| MASG | 50.72C | Ligation of carotid (regions required) | 150 | 5+T |

**BIOPSY OF BLOOD VESSEL**

| | | | | |
|---|---|---|---|---|
| MISG | 50.97A | Biopsy of temporal artery (regions required) | 35 | 4+T |

**CLIPPING OF ANEURYSM**

| | | | | |
|---|---|---|---|---|
| MASG | 51.51 | Clipping of aneurysm (Silverstone clamp) | 168 | 10+T |

**OTHER REPAIR OF ANEURYSM**

| | | | | |
|---|---|---|---|---|
| MASG | 51.52A | Endovascular occlusion of cerebral aneurysm | 809 | 14+T |

**OTHER PARTIAL OSTECTOMY, OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.78A | Spinal trauma - fracture of spinous process (surgical removal) | 75 | 5+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION), OTHER SPECIFIED BONE**

| | | | | |
|---|---|---|---|---|
| MASG | 91.08L | Spinal trauma without cord injury cranio-skeletal traction tongs | 85 | 5+T |
| | | AN=GENL | 110 | 5+T |
| MASG | 91.08M | Spinal trauma with cord injury cranio-skeletal traction tongs | 85 | 5+T |
| | | AN=GENL | 110 | 5+T |

**EXCISION OF INTERVERTEBRAL DISC**

| | | | | |
|---|---|---|---|---|
| MASG | 92.31 | Excision or destruction of intervertebral disc | | |
| | | AP=CERV (regions required) | 303 | 8+T |
| | | AP=LMBR (regions required) | 212 | 7+T |
| MASG | 92.31D | Discectomy - cervical or dorsal | | |
| | | AP=ANTE | 573 | |
| | | AP=POST | 250 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 92.31E | Discectomy - bilateral - recurrent or multiple levels | | |
| | | AP=LMBR | 246 | 7+T |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| MASG | 92.31F | Removal of protruded disc - bilateral or multiple | | |
| | | AP=CERV | 425 | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 92.31G | Removal of protruded lumbar disc to include fusion and/or internal fixation if indicated | | |
| | | AP=ANTE | 350 | 11+T |

**OTHER CERVICAL SPINAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.02A | Removal of anterior cervical disc and fusion - one space | 366 | 8+T |
| MASG | 93.02B | Removal of anterior cervical disc and fusion - two spaces | 548 | 8+T |

**OTHER SPINAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.09A | Removal of lumbar disc or laminectomy in conjunction with Orthopaedic Surgeon for fusion | | |
| | | SP=NUSG (regions required) | 210 | 7+T |

**OTHER REPAIR OF JOINT**

| | | | | |
|---|---|---|---|---|
| MASG | 93.96A | Cervical Total Disc Arthroplasty (artificial disc) | 750 | 8+T |

**SUTURE OF SKIN AND SUBCUTANEOUS TISSUE OF OTHER SITES**

| | | | | |
|---|---|---|---|---|
| MISG | 98.22 | Suture of skin and subcutaneous tissue of other sites<br>- plus multiples, if applicable | | |
| | | ME=SIMP, AN=LOCL | 11 | |
| | | ME=SIMP | 11 | |
| MAAS | 98.22C | Scalp laceration - extensive, multiple or complicated | IC | 4+T |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

# OBSTETRICS & GYNAECOLOGY

(SP=OBGY)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation (Prolonged) | | |
| | | RF=REFD (ME=TELE) | 40.1+MU | |
| | | RF=REFD, US=PREM (ME=TELE) | 58.1+MU | |
| | | RF=REFD, US=PR50 (ME=TELE) | 60.15+MU | |
| | | RF=REFD, RO=DETE (ME=TELE) | 35.1+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 53.1+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 53.1+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 29.5 | |
| | | RF=REFD, US=PREM (ME=TELE) | 47.5 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 47.5 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 24.5+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 42.5+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 42.5+MU | |
| CONS | 03.07 | Repeat Consultation (Prolonged) | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 27.5+MU | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 45.5+MU | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 45.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 22.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 40.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 40.5+MU | |
| CONS | 03.09G | Medical Management of Ectopic Pregnancy | | |
| | | RF=REFD | 56 | |
| | | RF=REFD, US=PREM | 75.6 | |
| | | RF=REFD, US=PR50 | 84 | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

| | | |
|---|---|---|
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+)<br>LO=OFFC (ME=VTCR*) (RF=REFD) ..... 16.5<br>*Physician Restrictions in Place (See Appendix J) |
| VIST | 03.03 | Continuing Care<br>LO=OFFC, RO=CNTC, RF=REFD ..... 13.5<br>LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 16.5 |
| VIST | 03.03 | Directive Care<br>LO=OFFC, RO=DIRC, RF=REFD ..... 13.5<br>LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 16.5 |
| VIST | 03.04 | Complete Pregnancy Exam<br>LO=OFFC, RO=ANTL, RP=INTL (RF=REFD) ..... 29.7 |
| VIST | 03.03 | Pre Natal Visit<br>LO=OFFC, RO=ANTL, RP=SUBS (RF=REFD) ..... 15.5 |
| VIST | 03.03 | Routine Pre Natal Visit<br>LO=OFFC, RO=ANTL, RP=SUBS ..... 13 |
| VIST | 03.03 | Post Natal Visit<br>LO=OFFC, RO=PTNT, RF=REFD ..... 22.6 |
| VIST | 03.03 | Post Natal Care Visit<br>LO=OFFC, RO=PTNT ..... 19 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000)<br>LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359)<br>LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800)<br>LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays<br>LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays<br>LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient<br>LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | | |
|---|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) | 24 |
| | | LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) | 24+MU |
| VIST | 03.04 | Initial Visit | |
| | | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | 25 |
| | | LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) | 25+MU |
| VIST | 03.03 | Continuing Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD | 15+MU |
| VIST | 03.03 | Directive Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD | 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week | |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |
| ADON | 03.02A | Hospital Discharge Fee | |
| | | LO=HOSP, FN=INPT | 10 |
| VIST | 03.03 | Urgent Hospital Visit | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD) | 22 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD) | 22+MU |
| VIST | 03.03 | Post Partum Care; Per Visit | |
| | | LO=HOSP, FN=INPT, RO=PTPP, DA=DA23 | 23 |
| | | LO=HOSP, FN=INPT, RO=PTPP, DA=DA47 | 19 |
| | | LO=HOSP, FN=INPT, RO=PTPP (RF=REFD) | 16 |
| VIST | 03.03 | Resuscitation of Newborn | |
| | | LO=HOSP, FN=INPT, RO=RESC (RF=REFD) | 50 |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD) | 68 |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD) | 75 |
| | | LO=HOSP, FN=INPT, RO=RNDT (RF=REFD) | 50+MU |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD) | 68+MU |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD) | 75+MU |
| VIST | 03.04 | First Examination - Newborn Care | |
| | | LO=HOSP, FN=INPT, RP=INTL, RO=NBCR (RF=REFD) | 16 |
| VIST | 03.03 | Subsequent Care - Newborn | |
| | | LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD) | 16 |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Emergency Visit | |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD) | 35.2 |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD) | 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) | 13.5 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) | 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 26 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (0000 – 0800) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) | 11.4 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) | 11.4+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU | |

**CANCER PATIENT**

| | | | |
|---|---|---|---|
| VIST | 03.04 | Comprehensive reassessment of a cancer patient<br>RO=CAPT, RP=SUBS ..... 25 | |

## PROCEDURES

**VAGINOSCOPY**

| | | | |
|---|---|---|---|
| MISG | 01.36 | Vaginoscopy..... 50 | 4+T |

**GYNECOLOGICAL EXAMINATION**

| | | | |
|---|---|---|---|
| MISG | 03.26 | Gynaecological examination and/or dilation<br>AN=GENL..... 19 | 4+T |

**IMPLANTATION OR INSERTION OF RADIOACTIVE ELEMENTS**

| | | | |
|---|---|---|---|
| MASG | 06.34A | Gold seed implants ..... 90 | |
| MASG | 06.34B | Caesium needle implants..... 90 | |

**INJECTION OR INSTILLATION OF RADIOISOTOPES**

| | | | |
|---|---|---|---|
| MISG | 06.35A | Strontium 90 treatment..... 15 | |

**INSERTION OF VAGINAL DIAPHRAGM**

| | | | |
|---|---|---|---|
| COCR | 10.15 | Insertion of vaginal diaphragm ..... 15 | |

**INSERTION OF OTHER VAGINAL PESSARY**

| | | | |
|---|---|---|---|
| VADT | 10.16 | Insertion of other vaginal pessary examination and insertion of pessary<br>And 1 follow-up visit ..... 33.16 | |

**REMOVAL OF INTRAUTERINE CONTRACEPTIVE DEVICE (IUD)**

| | | | |
|---|---|---|---|
| MISG | 11.71 | Removal of intrauterine contraceptive device (IUD)<br>AN=GENL..... 50 | 4+T |

**PRESACRAL SYMPATHECTOMY**

| | | | |
|---|---|---|---|
| MASG | 18.14A | Presacral neurectomy..... 180 | 6+T |

**INCISION OF LYMPHATIC STRUCTURES**

| | | | |
|---|---|---|---|
| MISG | 52.0A | Superficial lymph node aspiration for diagnostic purposes ..... 10 | |

**OTHER OPERATIONS ON LYMPHATIC STRUCTURES**

| | | | | |
|---|---|---|---|---|
| MISG | 52.9D | Drainage of pelvic lymphocyst with insertion of suction catheter (With or without installation of sclerosing agents) | 40.8 | 4+T |
| MASG | 52.9E | Drainage of pelvic lymphocyst with laparotomy for pelvic lymphocyst with window format/insertion of omental pedicle | 200 | 7+T |

**OTHER REPAIR OF ANUS AND ANAL SPHINCTER**

| | | | | |
|---|---|---|---|---|
| MASG | 61.69G | Comprehensive anal sphincteroplasty for the treatment of anal incontinence | 220 | 4+T |

**EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PERITONEUM**

| | | | | |
|---|---|---|---|---|
| MASG | 66.3E | Infracolic omentectomy | 75 | 6+T |
| MASG | 66.3F | Infragastric omentectomy | 140 | 6+T |

**CLOSURE OF OTHER FISTULA OF URETER**

| | | | | |
|---|---|---|---|---|
| MASG | 68.84 | Closure of other fistula of ureter | 240 | 6+T |
| MASG | 68.84A | Repair - uretero-vaginal fistula (regions required) | 240 | 6+T |

**REPAIR OF OTHER FISTULA OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.73B | Closure of fistula, vesico-vaginal | 205 | 6+T |
| MASG | 69.73C | Repair of vesico-vaginal fistula with omental graft | 300 | 6+T |

**EXCISION OR DESTRUCTION OF URETHRAL LESION OR TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 70.2A | Urethral caruncle or prolapse of mucosa | 40 | 4+T |

**SUPRAPUBIC SLING OPERATION**

| | | | | |
|---|---|---|---|---|
| MASG | 71.4C | Synthetic mid urethral sling for urinary incontinence, any approach | 150 | 4+T |
| MASG | 71.4D | Pubo-vaginal sling with autologous fascia for urinary incontinence, includes Cystoscopy as required (If skin to skin time exceeds 4 hours it shall be paid IC) | 350 | 6+T |

**RETROPUBIC URETHRAL SUSPENSION**

| | | | | |
|---|---|---|---|---|
| MASG | 71.5B | Paravaginal repair - includes the repair of cystocoele and Burch Sling or Marshall Marchetti AP=ABDO | 200 | 6+T |
| MASG | 71.5C | Paravaginal repair of cystocoele AP=ABDO or AP=VAGN | 150 | 6+T |
| MASG | 71.7F | Cystoscopy with intravesicular injection(s) of chemodenervating agent | 90 | 4+T |

**OOPHOROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 77.0 | Oophorotomy (regions required) | 130 | 6+T |

**WEDGE RESECTION OF OVARY**

| | | | | |
|---|---|---|---|---|
| MASG | 77.12 | Wedge resection of ovary (regions required) | 130 | 6+T |

**OTHER LOCAL EXCISION OR DESTRUCTION OF OVARY**

| | | | | |
|---|---|---|---|---|
| MASG | 77.19A | Salpingectomy and salpingo-oophorectomy (regions required) | 183.45 | 6+T |
| MASG | 77.19B | Excision of ovarian cyst (regions required) | 130 | 6+T |
| MASG | 77.19C | Laparoscopic ovarian cystectomy (regions required) | 211.68 | 6+T |

**UNILATERAL OOPHORECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 77.2 | Unilateral oophorectomy (regions required) | 130 | 6+T |

**UNILATERAL SALPINGO-OOPHORECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 77.3 | Unilateral salpingo-oophorectomy (regions required) | 130 | 6+T |

**REMOVAL OF BOTH OVARIES (AT SAME OPERATIVE EPISODE)**

| | | | | |
|---|---|---|---|---|
| MASG | 77.41 | Removal of both ovaries (at same operative episode) | 195 | 6+T |

**REMOVAL OF REMAINING OVARY**

| | | | | |
|---|---|---|---|---|
| MASG | 77.42 | Removal of remaining ovary (regions required) | 130 | 6+T |

**REMOVAL OF BOTH OVARIES AND TUBES (AT SAME OPERATIVE EPISODE)**

| | | | | |
|---|---|---|---|---|
| MASG | 77.51 | Removal of both ovaries and tubes (at same operative episode) | 275.18 | 6+T |

**REMOVAL OF REMAINING OVARY AND TUBE**

| | | | | |
|---|---|---|---|---|
| MASG | 77.52 | Removal of remaining ovary and tube (regions required) | 130 | 6+T |

**ASPIRATION BIOPSY OF OVARY**

| | | | | |
|---|---|---|---|---|
| MISG | 77.81A | Transvaginal ultrasound - guided needle aspiration of endometrium or simple ovarian cyst | | |
| | | SP=GNSG | 35 | |
| | | SP=OBGY | 35 | |

**TOTAL SALPINGECTOMY (UNILATERAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 78.1A | Salpingectomy for morbidity, not for sterilization (regions required) | 183.45 | 6+T |

**OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES**

| | | | | |
|---|---|---|---|---|
| MASG | 78.39A | Interruption or removal of fallopian tubes for purposes of sterilization: Abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral) | 148.18 | 6+T |

**OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES (NEC)**

| | | | | |
|---|---|---|---|---|
| MASG | 78.49A | Sterilisation by transcervical tubal occlusion (both tubes). Includes access (eg. Hysteroscopy) and any necessary imaging | 90 | 4+T |

**BILATERAL PARTIAL SALPINGECTOMY, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| ADON | 78.53B | Tubal ligation, unilateral or bilateral (in addition to General Practice delivery fee as assist at c-section) (regions required) | 10 | |

**OTHER REPAIR OF FALLOPIAN TUBE**

| | | | | |
|---|---|---|---|---|
| MASG | 78.69A | Salpingoplasty | 141 | 6+T |

**INSUFFLATION OF FALLOPIAN TUBE**

| | | | | |
|---|---|---|---|---|
| MISG | 78.7 | Insufflation of fallopian tube - Rubin's test | 19 | 4+T |
| MISG | 78.7A | Insufflation with endometrial biopsy | 28.5 | 4+T |

**CONIZATION OF CERVIX**

| | | | | |
|---|---|---|---|---|
| MASG | 79.1 | Conization of cervix including colposcopy | 71.97 | 4+T |

**DESTRUCTION OF LESION OF CERVIX BY CAUTERIZATION**

| | | | | |
|---|---|---|---|---|
| MISG | 79.22 | Destruction of lesion of cervix by cauterization | 13.5 | |
| | | AN=GENL | 23.5 | 4+T |
| MISG | 79.22A | Laser vaporization of the cervix | 28.5 | 4+T |
| MISG | 79.22B | Cryosurgery of cervix | 13.5 | |

**DESTRUCTION OF LESION OF CERVIX BY CRYOSURGERY**

| | | | | |
|---|---|---|---|---|
| MISG | 79.23A | Laser vaporization of the cervix including colposcopy | 28.5 | 4+T |

**OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF CERVIX NEC**

| | | | | |
|---|---|---|---|---|
| MAAS | 79.29A | Debulking of tumour | IC | 6+T |
| MISG | 79.29B | Excision of cervical polyp, without D&C | 14.1 | 4+T |

**AMPUTATION OF CERVIX**

| | | | | |
|---|---|---|---|---|
| MASG | 79.3 | Amputation of cervix | 90 | 4+T |
| | | AP=ABDO | 150 | 6+T |
| | | AP=VAGN | 120 | 4+T |

**REPAIR OF INTERNAL CERVICAL OS**

| | | | | |
|---|---|---|---|---|
| MASG | 79.4 | Repair of internal cervical os (incompetent cervix, any suture repair) | 75 | 4+T |
| OBST | 79.4A | Suture of incompetent cervix during pregnancy | 75 | 4+T |
| MASG | 79.4B | Rescue cerclage suture | 120 | 4+T |
| MISG | 79.4C | Removal cerclage suture | | |
| | | AN=GENL | 50 | 4+T |
| | | AN=REGL | 50 | 4+T |

**ENDOCERVICAL BIOPSY**

| | | | | |
|---|---|---|---|---|
| MISG | 79.81 | Endocervical biopsy | 13.5 | |
| | | AN=GENL | 23.5 | 4+T |

**OTHER CERVICAL BIOPSY**

| | | | | |
|---|---|---|---|---|
| MISG | 79.82 | Other cervical biopsy | | |
| | | AN=GENL | 23.5 | 4+T |

**HYSTEROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 80.0 | Hysterotomy | 150 | 6+T |

**INCISION OR EXCISION OF CONGENITAL SEPTUM OF UTERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 80.12 | Incision or excision of congenital septum of uterus | 200 | 4+T |
| MASG | 80.12A | Uterine unification procedure | 200 | 6+T |

**OTHER EXCISION OR DESTRUCTION OF LESION OF UTERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 80.19 | Other excision or destruction of lesion of uterus myomectomy | 180 | 6+T |
| MASG | 80.19A | Endometrial ablation including D&C | 225.79 | 6+T |
| MASG | 80.19B | Endometrial polypectomy using resectoscope | 80 | 4+T |

**SUBTOTAL ABDOMINAL HYSTERECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 80.2A | Subtotal abdominal hysterectomy | 338.69 | 6+T |
| MASG | 80.2B | Subtotal abdominal hysterectomy with rectocoele and/or cystocoele repair | 287 | 6+T |

**TOTAL ABDOMINAL HYSTERECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 80.3 | Total abdominal hysterectomy | 338.69 | 6+T |
| MASG | 80.3A | Uterus-total abdominal with rectocoele and/or cystocoele repair | 405.01 | 6+T |
| MASG | 80.3B | Total abdominal hysterectomy with retropubic incontinence repair | 287 | 6+T |
| MASG | 80.3C | Abdominal hysterectomy with salpingo-ophorectomy including bilateral selective pelvic lymphadenectomies, omental biopsy and selective periaortic lymphadenectomy | 564.48 | 6+T |

**VAGINAL HYSTERECTOMY (SUBTOTAL) (TOTAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 80.4 | Vaginal hysterectomy (subtotal) (total) | 338.69 | 6+T |
| MASG | 80.4A | Uterus-total vaginal with rectocoele and/or cystocoele repair | 405.01 | 6+T |
| MASG | 80.4C | Laparoscopic hysterectomy – Total, subtotal, or laparoscopically assisted | 423.36 | 6+T |

**RADICAL ABDOMINAL HYSTERECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 80.5A | Radical abdominal hysterectomy-Wertheim | 356 | 8+T |
| MASG | 80.5B | Modified radical abdominal hysterectomy | 306 | 8+T |
| MASG | 80.5C | Radical abdominal hysterectomy with pelvic para-aortic lymphadenectomy | 440 | 8+T |

**HYSTEROSCOPY**

| | | | | |
|---|---|---|---|---|
| MISG | 80.81 | Hysteroscopy | 59.98 | 4+T |

**OPAQUE DYE CONTRAST HYSTEROSALPINGOGRAPHY**

| | | | | |
|---|---|---|---|---|
| MISG | 80.85 | Opaque dye contrast hysterosalpingography | 25.5 | 4+T |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON UTERUS AND SUPPORTS NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 80.89A | Abortion - incomplete; examination of the uterus without D&C or anaesthesia (in hospital procedure only) | | |
| | | FN=EMCC, LO=HOSP | 35.28 | |
| | | FN=INPT, LO=HOSP | 35.28 | |
| | | FN=OTPT, LO=HOSP | 35.28 | |

**DILATION AND CURETTAGE FOLLOWING DELIVERY OR ABORTION**

| | | | | |
|---|---|---|---|---|
| MASG | 81.01 | Dilation and curettage following delivery or abortion | 80.44 | 4+T |

**OTHER DILATION AND CURETTAGE**

| | | | | |
|---|---|---|---|---|
| MISG | 81.09 | Other dilation and curettage | 59.98 | 4+T |
| MISG | 81.09A | Endocervical curettage | 14.11 | |

**OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF UTERINE SUPPORTS**

| | | | | |
|---|---|---|---|---|
| MASG | 81.29A | Hydrocoele of canal of Nuck | 60 | 4+T |
| MASG | 81.29B | Excision of paraovarian cyst (regions required) | 150 | 6+T |

**INTERPOSITION OPERATION**

| | | | | |
|---|---|---|---|---|
| MASG | 81.31 | Interposition operation | 200 | 5+T |

**OTHER UTERINE SUSPENSION**

| | | | | |
|---|---|---|---|---|
| MASG | 81.32 | Other uterine suspension hysteropexy | 103 | 6+T |
| MASG | 81.32A | Hysteropexy with rectocoele and cystocoele repair | 200 | 6+T |
| MASG | 81.32B | Hysteropexy with D&C | 180 | 6+T |

**PARACERVICAL UTERINE DENERVATION**

| | | | | |
|---|---|---|---|---|
| MASG | 81.4 | Paracervical uterine denervation | 75 | 6+T |

**ASPIRATION CURETTAGE FOLLOWING DELIVERY OR ABORTION**

| | | | | |
|---|---|---|---|---|
| MASG | 81.61 | Aspiration curettage following delivery or abortion | 80.44 | 4+T |

**OTHER ASPIRATION CURETTAGE OF UTERUS**

| | | | | |
|---|---|---|---|---|
| MISG | 81.69A | Endometrial biopsy | 26.81 | |

**INSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE**

| | | | | |
|---|---|---|---|---|
| COCR | 81.8 | Insertion of intrauterine contraceptive device | 45.16 | |

**INSERTION OF THERAPEUTIC DEVICE INTO UTERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 81.91 | Insertion of therapeutic device into uterus | 76 | 4+T |
| | | Insertion of radium (per application) | | |
| MASG | 81.91B | Intrauterine balloon for PPH tamponade | 70 | 4+T |

**INSERTION OF LAMINARIA**

| | | | | |
|---|---|---|---|---|
| MISG | 81.93 | Insertion of laminaria | 14.1 | |

**HYMENOTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 82.11 | Hymenotomy | 15 | |
| | | AN=GENL | 25 | 4+T |
| | | AN=LOCL | 15 | |

**COLPOTOMY OR CULDOTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 82.12 | Colpotomy or culdotomy | 40 | 4+T |

**OTHER VAGINOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 82.14 | Other vaginotomy - repair of double vagina | 90 | 4+T |

**EXCISION OR DESTRUCTION OF LESION OR TISSUE OF VAGINA**

| | | | | |
|---|---|---|---|---|
| MISG | 82.23 | Excision or destruction of lesion or tissue of vagina | 14.1 | |
| | | AN=GENL | 23.5 | 4+T |
| | | AN=LOCL | 14.1 | |
| MISG | 82.23A | True cut needle biopsy of transvaginal mass | 25 | 4+T |
| MASG | 82.23C | Local excision of cyst | 70 | 4+T |

**OBLITERATION AND TOTAL EXCISION OF VAGINA**

| | | | | |
|---|---|---|---|---|
| MASG | 82.3 | Obliteration and total excision of vagina | | |
| | | PO=RADI | 260 | 6+T |
| MASG | 82.3A | Total vaginectomy with replacement skin graft | 300 | 6+T |
| MASG | 82.3B | Vaginectomy | | |
| | | PO=SEGM | 200 | 4+T |
| MASG | 82.3C | Colpocleisis (Lefort) | 180 | 5+T |

**REPAIR OF CYSTOCOELE**

| | | | | |
|---|---|---|---|---|
| MASG | 82.41 | Repair of cystocoele - paravaginal repair | 85 | 4+T |

**REPAIR OF RECTOCOELE**

| | | | | |
|---|---|---|---|---|
| MASG | 82.42 | Repair of rectocoele - paravaginal repair | 85 | 4+T |
| MASG | 82.42A | Rectocoele and repair of anal sphincter | 180 | 4+T |

**REPAIR OF CYSTOCOELE AND RECTOCOELE**

| | | | | |
|---|---|---|---|---|
| MASG | 82.43 | Repair of cystocoele and rectocoele or paravaginal repair | 151 | 4+T |
| MASG | 82.43A | Cystocoele, (paravaginal repair), rectocoele and prolapse (Fothergill) | 200 | 5+T |
| MASG | 82.43B | Cystocoele, (paravaginal repair), rectocoele and excision of cervical stump | 200 | 5+T |

**VAGINAL RECONSTRUCTION**

| | | | | |
|---|---|---|---|---|
| MASG | 82.52 | Vaginal reconstruction | 200 | 4+T |

**REPAIR OF FISTULA OF VAGINA**

| | | | | |
|---|---|---|---|---|
| MASG | 82.62 | Repair of fistula of vagina | 200 | 6+T |

**VAGINAL SUSPENSION AND FIXATION**

| | | | | |
|---|---|---|---|---|
| MISG | 82.64A | Resuturing vaginal cuff of vault - post hysterectomy | | |
| | | AP=ABDO | 50 | 6+T |
| | | AP=VAGN | 50 | 4+T |
| MASG | 82.64B | Repair - vaginal vault prolapse (post hysterectomy, vaginal or abdominal) | 200 | 6+T |
| MASG | 82.64D | Abdominal Sacral Colpopexy | 350 | 6+T |
| MASG | 82.64E | Laparoscopic Sacral Colpopexy (IC) | 140MSU/hr | 6+T |
| MASG | 82.64F | Colpopexy, vaginal; fixation to sacrospinous ligament(s) | 200 | 6+T |

**OTHER REPAIR OF VAGINA NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 82.69A | Vaginoplasty - low perineal construction | 240 | 5+T |
| MASG | 82.69B | Vaginoplasty - high perineal construction | 350 | 8+T |

**OBLITERATION OF VAGINAL VAULT**

| | | | | |
|---|---|---|---|---|
| MASG | 82.7 | Obliteration of vaginal vault enterocele | 151 | 4+T |

**CULDOSCOPY**

| | | | | |
|---|---|---|---|---|
| VADT | 82.81A | Colposcopy | 12 | |

**MARSUPIALIZATION OF BARTHOLIN'S GLAND (CYST)**

| | | | | |
|---|---|---|---|---|
| MISG | 83.13 | Marsupialization of Bartholin's gland (cyst) | 25 | 4+T |

**EXCISION OR OTHER DESTRUCTION OF BARTHOLIN'S GLAND (CYST)**

| | | | | |
|---|---|---|---|---|
| MASG | 83.14 | Excision or other destruction of Bartholin's gland (cyst) | | |
| | | (Regions required) | 60 | 4+T |

**OTHER LOCAL EXCISION OR DESTRUCTION OF VULVA AND PERINEUM**

| | | | | |
|---|---|---|---|---|
| MISG | 83.2B | Ablation of vin, vain, cin, condylomata, regardless of the method | 50 | 4+T |
| COCR | 83.2C | Abscess of vulva - Bartholin's or Skene's gland (regions required) | 25 | |
| | | AN=GENL (regions required) | 25 | 4+T |
| | | AN=LOCL (regions required) | 25 | |
| MISG | 83.2D | Excision of condylomata | 42.5 | 4+T |

**OPERATIONS ON CLITORIS**

| | | | | |
|---|---|---|---|---|
| MASG | 83.3A | Clitoroplasty | 100 | 4+T |
| MASG | 83.3B | Clitoris amputation | 60 | 6+T |

**RADICAL VULVECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 83.4A | Radical vulvectomy without gland dissection | 175 | 6+T |
| MASG | 83.4B | Radical vulvectomy with complete bilateral gland dissection | 300 | 6+T |
| MASG | 83.4C | Radical vulvectomy with inguinal and deep pelvic lymphadenectomy | 400 | 10+T |

**UNILATERAL VULVECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 83.51 | Unilateral vulvectomy (regions required) | 120 | 4+T |
| MASG | 83.51A | Segmental vulvectomy (without reconstruction) (regions required) | 85 | 4+T |
| MASG | 83.51B | Skinning vulvectomy P.A.I.N. excision without skin graft | 100 | 4+T |

**BILATERAL VULVECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 83.52 | Bilateral vulvectomy | | |
| | | ME=SIMP | 180 | 4+T |

**SUTURE OF VULVA AND PERINEUM**

| | | | | |
|---|---|---|---|---|
| MASG | 83.61 | Suture of vulva and perineum (a perineorrhaphy is included in the fee for a posterior repair) | 60 | 4+T |

**OTHER REPAIR OF VULVA AND PERINEUM**

| | | | | |
|---|---|---|---|---|
| MISG | 83.69A | Third degree laceration - consultation and procedure | 50 | 4+T |

**LOW FORCEPS DELIVERY WITHOUT EPISIOTOMY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.0 | Low forceps delivery (without episiotomy) | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**LOW FORCEPS DELIVERY WITH EPISIOTOMY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.1 | Low forceps delivery (with episiotomy) | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**MID FORCEPS DELIVERY WITH EPISIOTOMY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.21 | Mid forceps delivery with episiotomy | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**OTHER MID FORCEPS DELIVERY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.29 | Other mid forceps delivery | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**HIGH FORCEPS DELIVERY WITH EPISIOTOMY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.31 | High forceps delivery with episiotomy | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**OTHER HIGH FORCEPS DELIVERY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.39 | Other high forceps delivery | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**BREECH EXTRACTION, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| OBST | 84.51 | Breech extraction, unqualified | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**PARTIAL BREECH EXTRACTION**

| | | | | |
|---|---|---|---|---|
| OBST | 84.52 | Partial breech extraction | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**TOTAL BREECH EXTRACTION**

| | | | | |
|---|---|---|---|---|
| OBST | 84.53 | Total breech extraction | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**PARTIAL BREECH EXTRACTION WITH FORCEPS TO AFTERCOMING HEAD**

| | | | | |
|---|---|---|---|---|
| OBST | 84.61 | Partial breech extraction with forceps to aftercoming head | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**TOTAL BREECH EXTRACTION WITH FORCEPS TO AFTERCOMING HEAD**

| | | | | |
|---|---|---|---|---|
| OBST | 84.62 | Total breech extraction with forceps to aftercoming head | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**OTHER FORCEPS APPLICATION TO AFTERCOMING HEAD**

| | | | | |
|---|---|---|---|---|
| OBST | 84.69 | Other forceps application to aftercoming head | | |
| | | RF=REFD (SP=OBGY) | 260 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**VACUUM EXTRACTION WITH EPISIOTOMY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.71 | Vacuum extraction with episiotomy | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**OTHER VACUUM EXTRACTION**

| | | | | |
|---|---|---|---|---|
| OBST | 84.79 | Other vacuum extraction | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**OTHER SPECIFIED INSTRUMENTAL DELIVERY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.8 | Other specified instrumental delivery | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**UNSPECIFIED INSTRUMENTAL DELIVERY**

| | | | | |
|---|---|---|---|---|
| OBST | 84.9 | Unspecified instrumental delivery | | |
| | | RF=REFD (SP=OBGY) | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 65 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 68 | |
| | | RO=OBDA, SP=OBGY | 68 | |

**INDUCTION OF LABOUR BY ARTIFICIAL RUPTURE OF MEMBRANES**

| | | | | |
|---|---|---|---|---|
| OBST | 85.01 | Induction of labour by artificial rupture of membranes<br>Consultation and procedure | 23.5 | 4+T |

**EXTERNAL VERSION**

| | | | | |
|---|---|---|---|---|
| MISG | 85.91A | External cephalic version under ultrasound control | 50 | 4+T |

**CERVICAL CAESAREAN SECTION**

| | | | | |
|---|---|---|---|---|
| OBST | 86.1 | Cervical Caesarean section | | |
| | | SP=GNSG | 366.91 | 7+T |
| | | SP=OBGY | 366.91 | 7+T |
| | | -plus multiples, if applicable | 49.39 | |
| | | CO=INFE | | 10+T |
| OBST | 86.1A | Caesarean section with tubal ligation | | |
| | | SP=GNSG | 395.13 | 7+T |
| | | SP=OBGY | 395.13 | 7+T |
| | | -plus multiples, if applicable | 49.39 | |
| | | CO=INFE | | 10+T |

**REMOVAL OF INTRAPERITONEAL EMBRYO**

| | | | | |
|---|---|---|---|---|
| MASG | 86.3 | Removal of intraperitoneal embryo (regions required) | 130 | 6+T |
| MASG | 86.3A | Surgical removal of extrauterine (ectopic) pregnancy - by any means (regions required) | 183.45 | 6+T |

**INTRA-AMNIOTIC INJECTION FOR TERMINATION OF PREGNANCY**

| | | | | |
|---|---|---|---|---|
| MASG | 87.0 | Intra-amniotic injection for termination of pregnancy | 71 | 4+T |

**VACUUM ASPIRATION FOR TERMINATION OF PREGNANCY**

| | | | | |
|---|---|---|---|---|
| MASG | 87.1 | Vacuum aspiration for treatment of pregnancy | 71 | 4+T |

**DILATION AND CURETTAGE FOR TERMINATION OF PREGNANCY**

| | | | | |
|---|---|---|---|---|
| MASG | 87.21 | Dilation and curettage for termination of pregnancy | 100.19 | 4+T |

**OTHER TERMINATION OF PREGNANCY NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 87.29 | Other termination of pregnancy NEC | 71 | 4+T |

**AMNIOCENTESIS**

| | | | | |
|---|---|---|---|---|
| MISG | 87.3 | Amniocentesis | 18 | |

**INTRAUTERINE TRANSFUSION**

| | | | | |
|---|---|---|---|---|
| OBST | 87.4 | Intrauterine transfusion | 125 | |
| MISG | 87.4C | Amniocentesis for erythroblastosis | 21 | |

**REMOVAL OF RETAINED PLACENTA**

| | | | | |
|---|---|---|---|---|
| MISG | 87.6 | Removal of retained placenta - consultation and procedure | 70 | 4+T |

**REPAIR OF OBSTETRIC LACERATION OF SPHINCTER ANI**

| | | | | |
|---|---|---|---|---|
| MASG | 87.82A | Obstetrical trauma – Repair 3rd degree laceration - consultation and procedure | 75 | 4+T |
| MASG | 87.82B | Obstetrical trauma – Repair 4th degree laceration - consultation and procedure | 100 | 4+T |

**MANUAL REPLACEMENT OF INVERTED UTERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 87.94 | Manual replacement of inverted uterus | 75 | 4+T |
| MASG | 87.94A | Operative repair of inversion of uterus | 180 | 4+T |

**DELIVERY NEC**

| | | | | |
|---|---|---|---|---|
| OBST | 87.98 | Delivery NEC | 282.24 | 4+T |
| | | RF=REFD, SP=OBGY | 366.91 | 4+T |
| | | Multiple vaginal births - each additional - plus multiples, if applicable | 91.73 | |
| | | AN=DFED | | Time Only |
| | | CO=INFE | | 7+T |
| | | RO=OBDA, RF=REFD, SP=OBGY | 95.40 | |
| | | RO=OBDA, SP=OBGY | 95.40 | |

**OTHER OBSTETRIC OPERATIONS NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 87.99B | Application of Uterine Compression Sutures | 200 | 6+T |

**LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.12V | Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic Granulomata, etc., for malignant or recognized pre-malignant condition -includes clinical suspicion of malignancy – plus multiples, if applicable | 16.93 | 4+T |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

# OPHTHALMOLOGY

(SP=OPHT)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 37.6 | |
| | | RF=REFD, US=PREM (ME=TELE) | 55.6 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 56.4 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 37.6+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 55.6+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 56.4+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 24.1 | |
| | | RF=REFD, US=PREM (ME=TELE) | 42.1 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 42.1 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 24.1+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 42.1+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 42.1+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 22.5 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 40.5 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 40.5 | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 22.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 40.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 40.5+MU | |
| CONS | 09.02E | Oculogenetic Consultation for Patients with Congenital or Hereditary Visual Problems | | |
| | | RF=REFD | 50 | |
| | | **Note**: Refer to Diagnostic & Therapeutic Section for complete eye examination codes | | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 20.3 | |
| VIST | 03.03 | Initial Visit Not Requiring Complete Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (RF=REFD) | 13 | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (RF=REFD) | 16.5 | |

| | | |
|---|---|---|
| VIST | 03.03 | Continuing Care<br>LO=OFFC, RO=CNTC, RF=REFD ..... 13.5<br>LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 16.5 |
| VIST | 03.03 | Directive Care<br>LO=OFFC, RO=DIRC, RF=REFD ..... 13.5<br>LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 16.5 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000)<br>LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359)<br>LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800)<br>LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays<br>LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays<br>LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient<br>LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | |
|---|---|---|
| VIST | 03.04 | Initial Visit<br>LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 25<br>LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU |
| VIST | 03.03 | Continuing Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 15<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU |
| VIST | 03.03 | Directive Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU |
| ADON | 03.02A | Hospital Discharge Fee<br>LO=HOSP, FN=INPT ..... 10 |

| | | |
|---|---|---|
| VIST | 03.03 | Urgent Hospital Visit<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Hospital Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU |

## PROCEDURES

**OTHER TOMOGRAPHY OF HEAD**

| | | |
|---|---|---|
| VADT | 02.02B | Optic Nerve Imaging ..... 8 |

**OTHER BIOMETRY**

| | | |
|---|---|---|
| VADT | 02.02C | Ophthalmic Biometry by partial coherence interferometry with IOL (intraocular lens) power calculation, unilateral or bilateral ..... 25.44 |

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC**

| | | |
|---|---|---|
| VADT | 03.19E | Interpretation by Ophthalmologists of Orthoptic Evaluation including measurements of all of the following: visual acuity (distance and near), ocular alignment (distance and near), binocularity including stereopis and vergences and ductions.<br>RO=INPR..... 10 |
| VADT | 03.19H | Corneal Topography of both eyes for corneal disease (not refractive eye surgery)<br>RO=INTP..... 5.8 |

**COMPREHENSIVE EYE EXAMINATION**

| | | |
|---|---|---|
| VEDT | 09.02 | Comprehensive eye examination including refraction..... 20.3 |
| VEDT | 09.02A | Low vision clinic fees (for prolonged visits beyond one hour, a rate of 13.7 units per 15 minutes applies) - plus multiples, if applicable<br>RP=INTL..... 50 |
| VEDT | 09.02B | Reduced payment for uninsured service..... 10.4 |
| VEDT | 09.02D | Low vision clinic fees - follow-up after 30 days ..... 25 |
| CONS | 09.02E | Oculogenetic consultation for patients with congenital or hereditary visual problems<br>SP=OPHT, RF=REFD..... 50 |
| VEDT | 09.02H | Comprehensive Eye Examination of both eyes including refraction ..... 29 |
| VADT | 09.03A | Examination for Retinopathy of Prematurity ..... 15 |

**EYE EXAMINATION UNDER ANAESTHESIA**

| | | | | |
|---|---|---|---|---|
| VEDT | 09.04 | Eye examination under anaesthesia | 27 | 4+T |
| | | Prolonged eye examinations under general anaesthesia for children (50 units per half hour) - plus multiples, if applicable | | |
| | | AG=CH16 | 50 | 4+T |

**FLUORESCEIN ANGIOGRAPHY OR ANGIOSCOPY OF EYE**

| | | | | |
|---|---|---|---|---|
| VADT | 09.12 | Fluorescein angiography or angioscopy of eye | 22 | |

**REMOVAL OF PENETRATING FOREIGN BODY FROM EYELID OR CONJUNCTIVA WITHOUT INCISION**

| | | | | |
|---|---|---|---|---|
| MISG | 12.32 | Removal of penetrating foreign body from eyelid or conjunctiva without incision | | |
| | | AN=GENL (regions required) | 25 | 4+T |
| | | No anaesthetic (regions required) | 10.4 | |

**DILATION OF LACRIMAL PUNCTUM**

| | | | | |
|---|---|---|---|---|
| MISG | 21.31 | Dilation of lacrimal punctum (regions required) | 35 | 4+T |

**PROBING OF NASOLACRIMAL DUCT**

| | | | | |
|---|---|---|---|---|
| MISG | 21.33 | Probing of nasolacrimal duct (regions required) | | |
| | | AN=LOCL, RP=INTL | 12.5 | |
| | | AN=LOCL, RP=REPT | 5 | |
| | | RP=INTL | 12.5 | |
| | | RP=REPT | 5 | |
| MISG | 21.33A | Probing and dilation of nasolacrimal duct - initial or repeat, unilateral or bilateral | | |
| | | AN=GENL | 20 | 4+T |

**INTUBATION OF NASOLACRIMAL DUCT**

| | | | | |
|---|---|---|---|---|
| MISG | 21.34 | Intubation of nasolacrimal duct (regions required) | 35 | 4+T |

**INCISION OF LACRIMAL SAC**

| | | | | |
|---|---|---|---|---|
| MISG | 21.41A | Dacryocystotomy (regions required) | | |
| | | AN=GENL | 25 | 4+T |

**EXCISION OF LACRIMAL SAC OR LESION**

| | | | | |
|---|---|---|---|---|
| MASG | 21.5 | Excision of lacrimal sac or lesion (regions required) | 125 | 4+T |
| MASG | 21.5A | Excision of lacrimal gland (regions required) | 200 | 4+T |

**OTHER REPAIR OF CANALICULUS AND PUNCTUM**

| | | | | |
|---|---|---|---|---|
| MASG | 21.69A | Repair wounds involving canaliculi (regions required) | 100 | 4+T |

**DACRYOCYSTORHINOSTOMY (DCR)**

| | | | | |
|---|---|---|---|---|
| MASG | 21.71 | Dacryocystorhinostomy (DCR) (regions required) | 325 | 4+T |

**BIOPSY OF LACRIMAL GLAND**

| | | | | |
|---|---|---|---|---|
| MISG | 21.81 | Biopsy of lacrimal gland (regions required) | 50 | 4+T |

**OTHER EXCISION OF SINGLE LESION OF EYELID**

| | | | | |
|---|---|---|---|---|
| COCR | 22.13A | Excision of chalazion or tarsal cyst - single or multiple - one lid | | |
| | | AN=GENL (regions required) | 30 | 4+T |
| | | AN=LOCL (regions required) | 24 | |
| | | No anaesthetic (regions required) | 24 | |
| MASG | 22.13B | Excision of malignant eyelid lesion with reconstruction (regions required) | 200 | 4+T |

**OTHER CORRECTION OF ENTROPION OR ECTROPION**

| | | | | |
|---|---|---|---|---|
| MASG | 22.39 | Other correction of entropion or ectropion (regions required) | 147 | 4+T |
| MASG | 22.39B | Quickert suture repair of entropion (regions required) | 65 | 4+T |

**FRONTALIS MUSCLE TECHNIQUE WITH SUTURE FOR CORRECTION OF BLEPHAROPTOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 22.41 | Frontalis muscle technique with suture for correction of blepharoptosis (Regions required) | 137 | 4+T |

**BLEPHARORRHAPHY**

| | | | | |
|---|---|---|---|---|
| MASG | 22.5A | Skin or mucous membrane grafts - eyelid (regions required) | 100 | 4+T |
| MASG | 22.5B | Tarsorrhaphy (regions required) | 60 | 4+T |
| MASG | 22.5C | Plastic repair (without skin graft) eyelid (regions required) - prior approval required other than trauma related conditions | 65 | 4+T |
| MASG | 22.5D | Plastic repair with graft - eyelid (regions required) | 85 | 4+T |

**OTHER EYELID REPAIR**

| | | | | |
|---|---|---|---|---|
| MISG | 22.69A | Punctal occlusion (regions required) | 25 | 4+T |

**ELECTROSURGICAL EPILATION**

| | | | | |
|---|---|---|---|---|
| MISG | 22.71A | Cryotherapy to eyelid margins (regions required) | 25 | |
| MISG | 22.71B | Epilation of eyelashes by electrolysis - per lid (regions required) - plus multiples, if applicable | 25 | 4+T |

**ADVANCEMENT OR RECESSION OF OCULAR MUSCLES**

| | | | | |
|---|---|---|---|---|
| ADON | 23.2A | Posterior fixation of extraocular muscles (Faden Procedure) in addition to strabismus repair | 200 | |
| MASG | 23.2B | Strabismus repair one or two muscles same or different eye | | |
| | | AG=ADUT | 190 | 6+T |
| | | AG=CH16 | 180 | 6+T |
| ADON | 23.2C | Strabismus repair (additional muscles over two) - plus multiples, if applicable | | |
| | | AG=ADUT | 30 | |
| | | AG=CH16 | 50 | |

**OTHER SHORTENING OF OCULAR MUSCLES**

| | | | | |
|---|---|---|---|---|
| MASG | 23.4A | Superior oblique muscle tuck (regions required) | 200 | 6+T |

**REPAIR OF (TRAUMATIC) LACERATION OF MUSCLE, TENDON, OR TENON'S CAPSULE**

| | | | | |
|---|---|---|---|---|
| MASG | 23.91A | Surgical exploration and repair of two or more extraocular muscles (Regions required) | 200 | 6+T |

**OTHER OPERATIONS ON OCULAR MUSCLES OR TENDONS NEC**

| | | | | |
|---|---|---|---|---|
| ADON | 23.99A | Adjustable suture in addition to strabismus repair (regions required) | 100 | |
| MISG | 23.99B | Injection of chemodenervating agent into extraocular muscle(s) for strabismus | | |
| | | AG=CH03 | 25 | 4+T |

**EXCISION OF LESION OR TISSUE OF CONJUNCTIVA**

| | | | | |
|---|---|---|---|---|
| MISG | 24.22 | Excision of lesion or tissue of conjunctiva biopsy (regions required) | 15 | 4+T |
| MISG | 24.22A | Excision of conjunctival tumour malignant (regions required) | 50 | 4+T |

**CONJUNCTIVAL FLAP**

| | | | | |
|---|---|---|---|---|
| MASG | 24.35 | Conjunctival flap Gunderson (total conjunctival) flap (regions required) | 200 | 4+T |

**OTHER CONJUNCTIVOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 24.39B | Excision of conjunctival tumour malignant - with plastic repair (Regions required) | 125 | 4+T |
| MASG | 24.39C | Excision of conjunctival tumour requiring graft (regions required) | 150 | 4+T |

**SUTURE OF CONJUNCTIVA**

| | | | | |
|---|---|---|---|---|
| MISG | 24.5 | Suture of conjunctiva (regions required) | 20 | 4+T |
| MISG | 24.5A | Suture repair of a conjunctional wound or bleb leak (regions required) | 25 | 4+T |

**OTHER OPERATIONS ON CONJUNCTIVA NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 24.99A | Laser treatment of conjunctival bleb (regions required) | 50 | 4+T |
| MISG | 24.99B | Autologous blood injection (regions required) | 25 | |
| MISG | 24.99C | Needling of Bleb - office procedure (regions required) | 50 | |
| MASG | 24.99D | Needling of Bleb - OR setting (regions required) | 100 | 6+T |

**INCISION OF CORNEA**

| | | | | |
|---|---|---|---|---|
| MISG | 25.1A | Removal embedded foreign body cornea | | |
| | | AN=GENL (regions required) | 25 | 4+T |
| | | No anaesthetic (regions required) | 20 | |

**OTHER EXCISION OF PTERYGIUM**

| | | | | |
|---|---|---|---|---|
| MISG | 25.29 | Other excision of pterygium (regions required) | 49 | 4+T |
| MASG | 25.29A | Excision of pterygium with conjunctival flap (regions required) | 65 | 4+T |

**THERMOCAUTERIZATION OF CORNEAL LESION**

| | | | | |
|---|---|---|---|---|
| MISG | 25.32 | Thermocauterization of corneal lesion or corneal ulcer (regions required) | 10 | 4+T |

**OTHER REMOVAL OR DESTRUCTION OF CORNEAL LESION**

| | | | | |
|---|---|---|---|---|
| MISG | 25.39B | Excision of corneal scar or debridement of cornea (regions required) | 50 | 4+T |
| MASG | 25.39C | Excision of dermoid cyst of cornea (regions required) | 75 | 4+T |
| MASG | 25.39D | Excision of malignant tumour of cornea (regions required) | 150 | 4+T |
| MASG | 25.39E | Superficial keratectomy cornea (regions required) | 196 | 7+T |

**SUTURE OF CORNEA**

| | | | | |
|---|---|---|---|---|
| MASG | 25.4A | Suture of cornea with excision of iris (regions required) | 160 | 6+T |
| MASG | 25.4B | Suture of cornea without excision of iris (regions required) | 120 | 6+T |

**LAMELLAR KERATOPLASTY (WITH HOMOGRAFT)**

| | | | | |
|---|---|---|---|---|
| MASG | 25.53 | Lamellar keratoplasty (with homograft) (regions required) | 250 | 8+T |

**PENETRATING KERATOPLASTY (WITH HOMOGRAFT)**

| | | | | |
|---|---|---|---|---|
| MASG | 25.55 | Penetrating keratoplasty (with homograft) (regions required) | 345 | 8+T |

**SCRAPING OF CORNEA FOR SMEAR OR CULTURE**

| | | | | |
|---|---|---|---|---|
| MISG | 25.81 | Scraping of cornea for smear or culture (regions required) | 20 | |

**DIVISION OF CORNEAL BLOOD VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 25.91 | Division of corneal blood vessels (regions required) | 100 | 6+T |

**TATTOOING OF CORNEA**

| | | | | |
|---|---|---|---|---|
| MISG | 25.92A | Microperforations of corneal stroma (regions required) | 20 | 4+T |

**OTHER OPERATIONS ON CORNEA NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 25.99C | Application of glue for corneal perforation (regions required) | 50 | |
| MISG | 25.99D | Corneal measurement for congenital glaucoma (regions required) | 20 | 4+T |
| MASG | 25.99F | Procurement of Ocular Tissue for Eye Bank (regions required) | 100 | |

**OTHER SCLERAL FISTULIZATION WITH IRIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 26.23A | Iridocyclectomy | 250 | 4+T |

**TRABECULECTOMY AB EXTERNO**

| | | | | |
|---|---|---|---|---|
| MASG | 26.25 | Trabeculectomy ab externo (regions required) | 225 | 6+T |
| MASG | 26.25B | Corneoscleral filtering (regions required) | 160 | 4+T |
| MASG | 26.25C | Trabeculectomy on an eye with a previous major ocular surgical procedure with or without post op laser suture lysis (regions required) | 292 | 6+T |
| MASG | 26.25D | Trabeculectomy with the use of anti-metabolites with or without post-op laser suture lysis (regions required) | 292 | 6+T |

**OTHER RELIEF OF INTRAOCULAR TENSION**

| | | | | |
|---|---|---|---|---|
| MASG | 26.29A | Laser cyclodestructive procedure (regions required) | 80 | 4+T |
| MASG | 26.29D | Trabeculoplasty (regions required) | 250 | 6+T |
| MASG | 26.29E | Placement of glaucoma tube shunt (regions required) | 300 | 6+T |
| MASG | 26.29G | Glaucoma surgery (such as stent insertion) ab interno approach, for the relief of intraocular pressure through drainage of aqueous humor to the subconjunctival space (regions required) | 175 | 6+T |

**GONIOTOMY WITH GONIOPUNCTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 26.33 | Goniotomy with goniopuncture (regions required) | 160 | 4+T |

**TRABECULOTOMY AB EXTERNO**

| | | | | |
|---|---|---|---|---|
| MASG | 26.34 | Trabeculotomy ab externo (regions required) | 225 | 6+T |

**CYCLODIALYSIS (INITIAL) (SUBSEQUENT)**

| | | | | |
|---|---|---|---|---|
| MASG | 26.35 | Cyclodialysis (initial) (subsequent) (regions required) | 100 | 4+T |

**CYCLOCRYOTHERAPY**

| | | | | |
|---|---|---|---|---|
| MASG | 26.37 | Cyclocryotherapy (regions required) | 70 | 4+T |

**DESTRUCTION OF LESION OF CILIARY BODY, NONEXCISIONAL**

| | | | | |
|---|---|---|---|---|
| MASG | 26.44 | Destruction of lesion of ciliary body, nonexcisional (regions required) | 100 | 4+T |

**OTHER IRIDOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 26.52 | Other iridotomy (regions required) | 113 | 4+T |

**IRIDECTOMY (BASAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 26.53 | Iridectomy (basal) (regions required) | 113 | 4+T |
| MISG | 26.53A | Ziegler puncture for correction of entropion or ectropion (regions required) | 15 | 4+T |

**FREEING OF OTHER ANTERIOR SYNECHIAE**

| | | | | |
|---|---|---|---|---|
| MASG | 26.62 | Freeing of other anterior synechiae (regions required) | 90 | 6+T |
| MASG | 26.62B | Intraocular synechiolysis with or without surgery to the pupil and iris (Regions required) | 90 | 6+T |

**SUTURE OF (TRAUMATIC) LACERATION OF SCLERA**

| | | | | |
|---|---|---|---|---|
| MASG | 26.71A | Suture uncomplicated wound without prolapse (regions required) | 110 | 6+T |
| MASG | 26.71B | Suture complicated wound with prolapse (regions required) | 170 | 6+T |

**OTHER SCLEROPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 26.79A | Scleral transplant for reconstruction (regions required) | 200 | 6+T |

**ASPIRATION OF ANTERIOR CHAMBER**

| | | | | |
|---|---|---|---|---|
| MISG | 26.91 | Aspiration of anterior chamber (regions required) | 30 | 4+T |

**OTHER OPERATIONS ON IRIS**

| | | | | |
|---|---|---|---|---|
| MASG | 26.95A | Suture repair of iris in conjunction with intraocular surgery (regions required) | 100 | 4+T |

**OTHER OPERATIONS ON SCLERA**

| | | | | |
|---|---|---|---|---|
| MASG | 26.97A | Sclerotomy<br>AP=POST (regions required) | 75 | 4+T |

**DISCISSION OF LENS AND CAPSULOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 27.3 | Discission of lens and capsulotomy (regions required) | 88 | 4+T |
| MASG | 27.3A | Needling of capsule (regions required) | 100 | 5+T |

**OTHER INTRACAPSULAR EXTRACTION**

| | | | | |
|---|---|---|---|---|
| MASG | 27.49A | Excision - crystalline lens - senile or others (regions required) | 172.5 | 4+T |
| MASG | 27.49B | Excision - crystalline lens - senile or others, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required) | 172.5 | 4+T |

**OTHER EXTRACAPSULAR EXTRACTION (See Cataract Fee Revisions**

| | | | | |
|---|---|---|---|---|
| MASG | 27.59A | Excision - crystalline lens - senile or others (regions required) | 172.5 | 4+T |
| MASG | 27.59B | Excision - crystalline lens - senile or others, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required) | 172.5 | 4+T |

**INSERTION OF PSEUDOPHAKOS, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 27.71A | Repositioning of dislocated intra-ocular lens (regions required) | 65 | 4+T |
| MASG | 27.71B | Repositioning of dislocated intra-ocular lens, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required) | 65 | 4+T |

**INSERTION OF INTRAOCULAR LENS PROSTHESIS WITH CATARACT EXTRACTION, ONE STAGE**

| | | | | |
|---|---|---|---|---|
| MASG | 27.72 | Insertion of intraocular lens prosthesis with cataract extraction, one stage (Regions required) | 225 | 4+T |
| MASG | 27.72B | Insertion of intraocular lens prosthesis with cataract extraction, high risk patients, monocular patients or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required) | 244 | 4+T |

**SECONDARY INSERTION OF INTRAOCULAR LENS PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 27.73 | Secondary insertion of intraocular lens prosthesis (regions required) | 150 | 6+T |
| MASG | 27.73A | Transcleral suturing of secondary posterior chamber intraocular lens (Regions required) | 250 | 6+T |
| MASG | 27.73B | Secondary insertion of intraocular lens prosthesis, high risk patients, monocular patients or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required) | 150 | 6+T |

**REMOVAL OF IMPLANTED LENS**

| | | | | |
|---|---|---|---|---|
| MASG | 27.8 | Removal of implanted lens (regions required) | 120 | 6+T |

| | | | | |
|---|---|---|---|---|
| MASG | 27.8A | Removal of implanted lens, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation, or serious complications of previous cataract surgery (regions required) | 120 | 6+T |

**SCLERAL BUCKLING WITH IMPLANT**

| | | | | |
|---|---|---|---|---|
| MASG | 28.2A | Non-circling tube or buckle procedure (regions required) | 250 | 7+T |
| MASG | 28.2B | Scleral buckle for circling tube | | |
| | | RP=INTL (regions required) | 294 | 7+T |
| | | RP=SUBS (regions required) | 392 | 7+T |

**OTHER SCLERAL BUCKLING**

| | | | | |
|---|---|---|---|---|
| MASG | 28.3 | Other scleral buckling scleral resection (regions required) | 250 | 6+T |
| MASG | 28.3A | Scleral resection with cryosurgery or electrocoagulation (regions required) | 250 | 7+T |

**REPAIR OF RETINAL DETACHMENT WITH DIATHERMY**

| | | | | |
|---|---|---|---|---|
| MASG | 28.41 | Repair of retinal detachment with diathermy (regions required) | 200 | 6+T |
| MASG | 28.41A | Diathermy or electrocoagulation repair of retina (regions required) | 200 | 7+T |

**REPAIR OF RETINAL DETACHMENT WITH CRYOTHERAPY**

| | | | | |
|---|---|---|---|---|
| MASG | 28.42 | Repair of retinal detachment with cryotherapy (regions required) | 200 | 6+T |
| MASG | 28.42A | Cryosurgical repair of retina without scleral resection (regions required) | 196 | 7+T |

**REPAIR OF RETINAL DETACHMENT WITH LASER PHOTOCOAGULATION**

| | | | | |
|---|---|---|---|---|
| MASG | 28.44A | Re-attachment of retina and choroid by photocoagulation - retinal disease | | |
| | | RP=INTL (regions required) | 171 | 7+T |
| | | RP=REPT (regions required) repeat same eye - within 30 days | 80 | 6+T |
| MASG | 28.44B | Laser photocoagulation retinal or vascular | | |
| | | RP=INTL (regions required) | 147 | 6+T |
| | | RP=REPT (regions required) repeat same eye - within 30 days | 73 | 6+T |
| MASG | 28.44C | Re-attachment of retina and choroid by photocoagulation - vascular | | |
| | | RP=INTL (regions required) | 125 | 7+T |
| | | RP=REPT (regions required) repeat same eye - within 30 days | 65 | 6+T |

**OTHER OPERATIONS FOR REPAIR OF RETINA NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 28.49A | Pneumatic retinopexy (regions required) | 250 | 6+T |
| MASG | 28.54A | Laser Photocoagulation for the treatment of Retinopathy of Prematurity | 160 | 6+T |

**OTHER DESTRUCTION OF LESION OF RETINA OR CHOROID**

| | | | | |
|---|---|---|---|---|
| MASG | 28.59A | Coagulation with scleral flap (regions required) | 250 | 7+T |

**REMOVAL OF IMPLANTED MATERIAL FROM POSTERIOR SEGMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 28.61B | Removal of scleral buckle (regions required) | 90 | 5+T |

**OTHER OPERATIONS ON RETINA**

| | | | | |
|---|---|---|---|---|
| MASG | 28.63A | Membrane peeling (regions required) | 200 | 6+T |
| MASG | 28.63B | Retinotomy (regions required) | 100 | 6+T |

**REMOVAL OF VITREOUS, ANTERIOR APPROACH (PARTIAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 28.71 | Removal of vitreous, anterior approach (partial) (regions required) | 147 | 8+T |
| MASG | 28.71A | Anterior vitrectomy or anterior chamber washout (regions required) | 147 | 8+T |

**REMOVAL OF VITREOUS, OTHER APPROACH**

| | | | | |
|---|---|---|---|---|
| MASG | 28.72 | Removal of vitreous, other approach<br>AP=POST (regions required) | 367 | 8+T |

**INJECTION OF VITREOUS SUBSTITUTE**

| | | | | |
|---|---|---|---|---|
| MASG | 28.73A | Silicone oil injection (regions required) | 100 | 6+T |
| MASG | 28.73B | Air/fluid/gas exchange (regions required) | 200 | 6+T |
| MASG | 28.73C | Intraocular or intravitreal injection of air (regions required) | 60 | 4+T |
| VADT | 28.73D | Intravitreal injection of antibiotics (regions required) | 25 | |
| MASG | 28.73E | Scleral resection - with vitreous implant (regions required) | 275 | 6+T |
| VADT | 28.73F | Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases | 25 | |

**DISCISSION OF VITREOUS STRANDS**

| | | | | |
|---|---|---|---|---|
| MASG | 28.74A | Laser lysis of vitreous strands (regions required) | 100 | 6+T |

**OTHER OPERATIONS ON VITREOUS**

| | | | | |
|---|---|---|---|---|
| MASG | 28.79A | Scleral resection with vitreous injection of implant (regions required) | 275 | 7+T |

**OTHER ORBITOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 29.09B | Orbital exploration for foreign body (regions required) | 100 | 6+T |
| MASG | 29.09C | Orbital exploration for foreign body and decompression (regions required) | 225 | 6+T |
| MASG | 29.09D | Incision drainage of abscess of the orbit (regions required) | 100 | 6+T |

**REMOVAL OF PENETRATING FOREIGN BODY FROM UNSPECIFIED STRUCTURE OF EYE**

| | | | | |
|---|---|---|---|---|
| MASG | 29.1 | Removal of penetrating foreign body from unspecified structure of eye | | |
| | | AP=POST (regions required) | 200 | 4+T |
| | | AP=ANTE (regions required) | 125 | 4+T |
| MASG | 29.1A | Foreign body non-magnetic | | |
| | | AP=POST (regions required) | 250 | 4+T |
| | | AP=ANTE (regions required) | 125 | 4+T |

**REMOVAL OF OCULAR CONTENTS WITH IMPLANT INTO SCLERAL SHELL**

| | | | | |
|---|---|---|---|---|
| MASG | 29.21 | Removal of ocular contents with implant into scleral shell (regions required) | 200 | 6+T |

**OTHER EVISCERATION OF EYEBALL**

| | | | | |
|---|---|---|---|---|
| MASG | 29.29 | Other evisceration of eyeball (regions required) | 150 | 6+T |

**ENUCLEATION OF EYEBALL WITH IMPLANT INTO TENON'S CAPSULE WITH ATTACHMENT OF MUSCLES**

| | | | | |
|---|---|---|---|---|
| MASG | 29.31 | Enucleation of eyeball with implant into tenon's capsule with muscles (Regions required) | 200 | 6+T |

**OTHER ENUCLEATION OF EYEBALL**

| | | | | |
|---|---|---|---|---|
| MASG | 29.39 | Other enucleation of eyeball (regions required) | 130 | 6+T |
| | | (PT=CDDR) (regions required) | 125 | |
| MASG | 29.39A | Secondary operation after enucleation of eyeball to replace implant (Regions required) | 100 | 4+T |

**OTHER EXENTERATION OF ORBIT**

| | | | | |
|---|---|---|---|---|
| MASG | 29.49A | Exenteration and skin graft (regions required) | 350 | 6+T |

**RETROBULBAR INJECTION OF THERAPEUTIC AGENT**

| | | | | |
|---|---|---|---|---|
| MISG | 29.91 | Retrobulbar injection of therapeutic agent (regions required) | 15 | |
| MISG | 29.91B | Retrobulbar injection with alcohol (regions required) | 25 | |

**EXCISION OF LESION OF ORBIT**

| | | | | |
|---|---|---|---|---|
| MASG | 29.94A | Excision of tumour, Kronlein Procedure (regions required) | 400 | 6+T |
| MASG | 29.94B | Tumour - removal by anterior route (regions required) | 300 | 6+T |
| MASG | 29.94C | Tumour - removal by intracranial route (regions required) | 300 | 6+T |

**OTHER OPERATIONS ON EYEBALL**

| | | | | |
|---|---|---|---|---|
| MASG | 29.98A | Laser gonioplasty (regions required) | 125 | 4+T |

**OPEN REDUCTION OF ORBITAL FRACTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 88.16 | Open reduction of orbital fracture (regions required) | 216 | 6+T |

# ORTHOPAEDICS

(SP=ORTH)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 38.2 | |
| | | RF=REFD, US=PREM (ME=TELE) | 56.2 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 57.3 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 38.2+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 56.2+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 57.3+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 27.5 | |
| | | RF=REFD, US=PREM (ME=TELE) | 45.5 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 45.5 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 27.5+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 45.5+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 45.5+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 25.5 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 43.5 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 43.5 | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 25.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 43.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 43.5+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 16.5 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

| | | |
|---|---|---|
| ADON | 03.02A | Hospital Discharge Fee<br>LO=HOSP, FN=INPT ..... 10 |
| VIST | 03.03 | Urgent Hospital Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE<br>(RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE<br>(RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU | |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU | |

## PROCEDURES

**MANUAL RUPTURE OF JOINT ADHESIONS**

| | | | |
|---|---|---|---|
| MISG | 07.27A | Manipulation - shoulder including application of cast or traction<br>AN=GENL (regions required)..... 25 | 4+T |
| MISG | 07.27B | Manipulation - elbow including application of cast or traction<br>AN=GENL (regions required)..... 25 | 4+T |
| MISG | 07.27C | Manipulation - wrist including application of cast or traction<br>AN=GENL (regions required)..... 25 | 4+T |
| MISG | 07.27D | Manipulation - hip including application of cast or traction<br>AN=GENL (regions required)..... 25 | 4+T |
| MISG | 07.27E | Manipulation - knee including application of cast or traction<br>AN=GENL (regions required)..... 25 | 4+T |
| MISG | 07.27F | Manipulation - ankle including application of cast or traction<br>AN=GENL (regions required)..... 25 | 4+T |
| MISG | 07.27G | Manipulation - vertebral column including application of cast or traction<br>AN=GENL..... 25 | 5+T |

**OTHER FORCIBLE CORRECTION OF DEFORMITY**

| | | | |
|---|---|---|---|
| MISG | 07.29A | Congenital foot deformity - manipulation and casts - initial - unilateral ..... 25<br>(Regions required) | |
| MISG | 07.29B | Congenital foot deformity - manipulation and casts - subsequent - unilateral..... 15<br>(Regions required) | |
| MISG | 07.29C | Congenital foot deformity - manipulation and casts - initial - bilateral..... 35 | |
| MISG | 07.29D | Congenital foot deformity - manipulation and casts - subsequent - bilateral..... 23.8 | |
| MISG | 07.29E | Congenital foot deformity - manipulation and casts<br>AN=GENL (regions required)..... 25 | 4+T |

**SPINAL TRACTION USING SKULL DEVICE**

| | | | | |
|---|---|---|---|---|
| MIFR | 07.41 | Spinal traction using skull device | 50 | 5+T |

**APPLICATION OF PLASTER JACKET**

| | | | | |
|---|---|---|---|---|
| MISG | 07.51 | Application of plaster jacket<br>AN=GENL | 50 | 4+T |
| CASP | 07.51B | Application of plaster casts, body - shoulder to hips | 25 | |
| CASP | 07.51C | Application of plaster casts, body - including head | 35 | |

**APPLICATION OF NECK SUPPORT**

| | | | | |
|---|---|---|---|---|
| CASP | 07.52 | Application of neck support | 10 | |

**APPLICATION OF OTHER CAST**

| | | | | |
|---|---|---|---|---|
| CASP | 07.53A | Application of plaster cast, bilateral wedging | 15 | |
| CASP | 07.53B | Molded plaster to forearm (regions required) | 12.5 | |
| CASP | 07.53C | Application of plaster cast, elbow to finger (regions required) | 12.5 | |
| CASP | 07.53D | Application of plaster cast, hand to wrist (regions required) | 12.5 | |
| CASP | 07.53E | Application of plaster cast, shoulder to hand (regions required) | 12.5 | |
| CASP | 07.53F | Shoulder spica (regions required) | 25 | |
| CASP | 07.53G | Application of plaster cast, ankle (foot to mid-leg) (regions required) | 12.5 | |
| CASP | 07.53H | Application of plaster cast, knee (foot to thigh) (regions required) | 15 | |
| CASP | 07.53I | Ambulatory leg cast (regions required) | 15 | |
| CASP | 07.53J | Molded plaster to leg (regions required) | 15 | |
| CASP | 07.53K | Spica (rib margin to toe) (regions required) | 25 | |

**APLICATION OF SPLINT**

| | | | | |
|---|---|---|---|---|
| CASP | 07.54A | Unna Boot (regions required) | 5 | |
| CASP | 07.54B | Application of corrective splints, fingers, hand, wrist (regions required) | 10 | |
| CASP | 07.54C | Application of splints, elbow (regions required) | 10 | |
| CASP | 07.54D | Application of corrective splints, shoulder (regions required) | 10 | |
| CASP | 07.54E | Application of corrective splints, below knee (including foot) (regions required) | 10 | |
| CASP | 07.54F | Application of corrective splints knee (regions required) | 10 | |
| CASP | 07.54G | Application of corrective splints whole leg (mid-thigh to toe) (regions required) | 10 | |

**OTHER EXPLORATION AND DECOMPRESSION OF SPINAL CANAL**

| | | | | |
|---|---|---|---|---|
| MASG | 16.09J | Cervical laminoplasty | 500 | 8+T |

**REPAIR OF VERTEBRAL FRACTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 16.43A | Open reduction without cord injury | 200 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43B | Open reduction with internal fixation without cord injury | 285 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43C | Open reduction and fusion in conjunction with Orthopaedic Surgeon | | |
| | | SP=NUSG | 225 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43D | Injury - antero-lateral decompression of thoracic spinal cord | 425 | 7+T |
| MASG | 16.43E | Open reduction with cord injury | 250 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43F | Open reduction with internal fixation with cord injury | 275 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 16.43G | Open reduction and fusion in conjunction with Orthopaedic Surgeon | | |
| | | SP=NUSG | 200 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MAFR | 16.43H | Spine fracture or fracture dislocation - anterior cervical decompression and/or fusing | 300 | 7+T |
| MAFR | 16.43I | Spine fracture or fracture dislocation - open reduction with decompression of cord or nerve roots | 300 | 7+T |
| MAFR | 16.43J | Spine fracture or fracture dislocation - open reduction | 200 | 7+T |
| MASG | 16.43K | Reduction, internal fixation C1-C2 including harvesting of bone graft if by same surgeon | 365 | 11+T |

**OTHER EXCISION OR AVULSION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.08H | Neurectomy - elbow or knee (regions required) | 150 | 4+T |
| MASG | 17.08I | Neurectomy - hip (regions required) | 175 | 5+T |

**RELEASE OF CARPAL TUNNEL**

| | | | | |
|---|---|---|---|---|
| MASG | 17.33A | Decompression including neurolysis if medically indicated (regions required) | 85 | 4+T |
| | | RP=REPT (regions required) | 137.5 | |

**OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS**

| | | | | |
|---|---|---|---|---|
| MASG | 17.39B | Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm), posterior interosseus nerve (radial nerve in forearm wrist) (regions required) | 125 | 4+T |
| MASG | 17.39C | Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required) | 125 | 4+T |

**TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.5B | Ulnar nerve release at the elbow (cubital tunnel) (regions required) | 125 | 4+T |
| | | RP=REPT | 200 | 4+T |

**OTHER INCISION OF FACIAL BONE WITHOUT DIVISION**

| | | | | |
|---|---|---|---|---|
| MISG | 88.29 | Other incision of facial bone without division | 25 | 7+T |

**TEMPOROMANDIBULAR ARTHROPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 88.6 | Temporomandibular arthroplasty | 175 | 10+T |
| MASG | 88.6A | Arthrotomy (meniscectomy or condylectomy) | 150 | 8+T |
| MASG | 88.6B | Temporomandibular joint - meniscectomy (regions required) | 150 | 5+T |

**CLOSED REDUCTION OF TEMPOROMANDIBULAR DISLOCATION**

| | | | | |
|---|---|---|---|---|
| DISL | 88.92 | (Closed) reduction of temporomandibular dislocation (regions required) | 15 | |
| | | AN=GENL (regions required) | 25 | 4+T |
| | | AN=LOCL (regions required) | 25 | |
| | | AN=REGL (regions required) | 25 | |

**OPEN REDUCTION OF TEMPOROMANDIBULAR DISLOCATION**

| | | | | |
|---|---|---|---|---|
| DISL | 88.93 | Open reduction of temporomandibular dislocation (regions required) | 125 | 5+T |

**SEQUESTRECTOMY, OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.08 | Sequestrectomy, other specified site | | |
| | | ME=SIMP | 200 | 4+T |

| | | | | |
|---|---|---|---|---|
| MISG | 89.08A | Pelvis | 25 | 4+T |
| MASG | 89.08B | Vertebrae incision and drainage | 250 | 4+T |

**SEQUESTRECTOMY, UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.09C | Large bones - secondary closure | 100 | 4+T |
| MASG | 89.09D | Small bones - secondary closure | 75 | 4+T |
| MASG | 89.09E | Sequestrectomy - large bones | 150 | 4+T |
| MASG | 89.09F | Sequestrectomy - small bones | 150 | 4+T |

**OTHER INCISION OF BONE WITHOUT DIVISION, OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.18A | Forage of hip (regions required) | 175 | 6+T |
| MISG | 89.18B | Skull and facial bones | 25 | 7+T |

**OTHER INCISION OF BONE WITHOUT DIVISION, UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MISG | 89.19A | Incision of subperiosteal abscess | 25 | 4+T |
| MASG | 89.19B | Foraging of os calcis (regions required) | 75 | 4+T |
| MISG | 89.19D | Large bones - incision and drainage | 25 | 4+T |

**OTHER DIVISION OF BONE - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| MASG | 89.30A | Sternal split (when billed alone) | 200 | 20+T |
| MASG | 89.30B | Osteotomy - clavicle | 125 | 4+T |
| MASG | 89.30C | Glenoid osteotomy (regions required) | 300 | 7+T |

**OTHER DIVISION OF BONE - HUMERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.31A | Osteotomy - humerus (regions required) | 150 | 4+T |

**OTHER DIVISION OF BONE - RADIUS AND ULNA**

| | | | | |
|---|---|---|---|---|
| MASG | 89.32 | Other division of bone, radius and ulna (regions required) | 200 | 4+T |
| MASG | 89.32A | Osteotomy - radius (regions required) | 150 | 4+T |
| MASG | 89.32B | Osteotomy - ulna (regions required) | 150 | 4+T |

**OTHER DIVISION OF BONE - CARPALS AND METACARPALS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.33A | Osteotomy - metacarpal or metatarsal - with or without internal fixation (Regions required) - plus multiples, if applicable | 95 | 4+T |

**OTHER DIVISION OF BONE - FEMUR**

| | | | | |
|---|---|---|---|---|
| MASG | 89.34A | Osteotomy - femur, neck, intertrochanteric or shaft (regions required) | 200 | 6+T |
| MASG | 89.34B | Osteotomy - femur, supracondylar, bilateral | 300 | 6+T |
| MASG | 89.34C | Osteotomy - femur, supracondylar and tibia, fibula (regions required) | 300 | 6+T |

**OTHER DIVISION OF BONE - TIBIA AND FIBULA**

| | | | | |
|---|---|---|---|---|
| MASG | 89.36A | Osteotomy - tibia (with or without fibula) (regions required) | 190 | 4+T |

**OTHER DIVISION OF BONE - TARSALS AND METATARSALS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.37A | Osteotomy - with or without internal fixation (regions required)<br>- plus multiples, if applicable | 95 | 4+T |

**OTHER DIVISION OF BONE - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.38A | Osteotomy - phalanx, single (regions required)<br>- plus multiples, if applicable | 75 | 4+T |
| MAAS | 89.38B | Osteotomy - spine | IC | 7+T |
| MASG | 89.38C | Pelvis - innominate osteotomy | 200 | 4+T |
| MASG | 89.38D | Pelvis - osteotomy - with iliopsoas transfer | 250 | 7+T |
| DISL | 89.38E | Dislocation hip - congenital - Chiari osteotomy (regions required) | 350 | 8+T |
| DISL | 89.38F | Dislocation hip - congenital - open reduction with limbectomy or derotation osteotomy (regions required) | 250 | 9+T |
| DISL | 89.38G | Dislocation hip - congenital - open reduction with innominate osteotomy (Regions required) | 350 | 9+T |

**OTHER DIVISION OF BONE - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.39A | Osteotomy - os calcis (regions required) | 150 | 4+T |

**BUNIONECTOMY WITH SOFT TISSUE CORRECTION AND OSTEOTOMY OF THE FIRST METATARSAL**

| | | | | |
|---|---|---|---|---|
| MASG | 89.41 | Bunionectomy with soft tissue correction and osteotomy of the first metatarsal (regions required) | 114 | 4+T |

**OTHER BUNIONECTOMY WITH SOFT TISSUE CORRECTION**

| | | | | |
|---|---|---|---|---|
| MASG | 89.43 | Other bunionectomy with soft tissue correction (regions required) | 100 | 4+T |
| MASG | 89.43A | Foot reconstruction - Joplin, Lapidus (regions required) | 150 | 4+T |

**OTHER EXCISION OF BUNION**

| | | | | |
|---|---|---|---|---|
| MASG | 89.49A | Keller's Procedure (regions required) | 95 | 4+T |

**LOCAL EXCISION OF LESION OR TISSUE OF BONE - HUMERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.51A | Upper limb resection of malignant musculoskeletal tumour of bone (Regions required) | 400 | 15+T |
| MASG | 89.51B | Upper limb resection of malignant musculoskeletal tumour of bone - with allograft reconstruction with or without ligament or tendon reconstruction (Regions required) | 550 | 15+T |

**LOCAL EXCISION OF LESION OR TISSUE OF BONE - RADIUS AND ULNA**

| | | | | |
|---|---|---|---|---|
| MASG | 89.52A | Upper limb resection of malignant musculoskeletal tumour of bone (Regions required) | 400 | 15+T |
| MASG | 89.52B | Upper limb resection of malignant musculoskeletal tumour of bone - with allograft reconstruction with or without ligament or tendon reconstruction (Regions required) | 550 | 15+T |

**LOCAL EXCISION OF LESION OR TISSUE OF BONE - FEMUR**

| | | | | |
|---|---|---|---|---|
| MASG | 89.54A | Resection of femoral malignant bone tumour (regions required) | 500 | 15+T |
| MASG | 89.54B | Resection of femoral malignant bone tumour with allograft reconstruction with or without ligament or tendon reconstruction (regions required) | 650 | 15+T |

**LOCAL EXCISION OF LESION OR TISSUE OF BONE - TIBIA AND FIBULA**

| | | | | |
|---|---|---|---|---|
| MASG | 89.56A | Resection of tibial malignant bone tumour (regions required) | 500 | 15+T |
| MASG | 89.56B | Resection of tibial malignant bone tumour with allograft reconstruction with or without ligament or tendon reconstruction (regions required) | 650 | 15+T |

**LOCAL EXCISION OF LESION OR TISSUE OF BONE - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.58A | Bone biopsy - vertebrae - open | 150 | 7+T |
| MASG | 89.58B | Vertebrae - saucerization (costotransversectomy) with graft as necessary | 250 | 7+T |
| MASG | 89.58C | Pelvic resection for malignant tumour (internal as part of limb salvage procedure) | 700 | 20+T |
| MASG | 89.58D | Pelvic resection for malignant tumour (internal as part of limb salvage procedure) - with allograft reconstruction with or without ligament or tendon reconstruction | 850 | 20+T |

**LOCAL EXCISION OF LESION OR TISSUE OF BONE - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.59A | Large bones - saucerization | 150 | 4+T |
| MASG | 89.59B | Small bones - saucerization | 100 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 89.59C | Small bones - saucerization and bone graft | 200 | 4+T |
| MASG | 89.59D | Bone biopsy - superficial | 75 | 4+T |
| MASG | 89.59E | Bone biopsy - open | 95 | 4+T |
| MASG | 89.59F | Major bone - excision bone tumours, bone cyst, exostosis | 119 | 4+T |
| | | RG=FEMR | | 5+T |
| MASG | 89.59G | Excision bone tumours, bone cyst, exostosis - major bone - with bone graft | 175 | 4+T |
| | | RG=FEMR | | 5+T |
| MASG | 89.59H | Excision bone tumours, bone cyst, exostosis - minor bone | 95 | 4+T |
| | | RG=FEMR | | 5+T |
| MASG | 89.59I | Excision bone tumours, bone cyst, exostosis - minor bone - with bone graft | 125 | 4+T |
| | | RG=FEMR | | 5+T |
| MASG | 89.59J | Saucerization and bone graft major bones | 200 | 4+T |

**EXCISION OF BONE FOR GRAFT - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MAAS | 89.69B | Removal of malignant bone tumour - to include excision of bone, excision of soft tissue including nerves, vessels, muscles, ligaments and tendons. Includes removal of existing hardware and the application of internal or external hardware. To include bone graft of any type and prosthesis if needed | IC | IC+T |

**OTHER PARTIAL OSTECTOMY - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| MASG | 89.70A | Acromion or outer end of clavicle included in composite rotator cuff repair (Regions required) | 95 | 4+T |

**OTHER PARTIAL OSTECTOMY - HUMERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.71A | Humerus - head (regions required) | 175 | 4+T |
| MASG | 89.71B | Humerus - head, with replacement (regions required) | 250 | 4+T |
| MAAS | 89.71C | Humerus - head, with extensive reconstruction (regions required) | IC | 4+T |

**OTHER PARTIAL OSTECTOMY - RADIUS AND ULNA**

| | | | | |
|---|---|---|---|---|
| MASG | 89.72A | Radius - head (regions required) | 100 | 4+T |
| MASG | 89.72B | Radius - styloid (regions required) | 100 | 4+T |
| MASG | 89.72C | Radius - head, with prosthetic replacement (regions required) | 150 | 4+T |
| MASG | 89.72D | Ulna - olecranon and repair (regions required) | 125 | 4+T |
| MASG | 89.72E | Ulna - excision of distal end (regions required) | 100 | 4+T |
| ADON | 89.72F | Ulna - excision of distal end in combination with other procedure – Darroch Procedure (regions required) | 50 | |

**OTHER PARTIAL OSTECTOMY - CARPALS AND METACARPALS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.73A | Metatarsal head (regions required) - plus multiples, if applicable | 75 | 4+T |

**OTHER PARTIAL OSTECTOMY - FEMUR**

| | | | | |
|---|---|---|---|---|
| MASG | 89.74A | Femur - head and neck (regions required) | 200 | 5+T |

**OTHER PARTIAL OSTECTOMY - PATELLA**

| | | | | |
|---|---|---|---|---|
| MASG | 89.75 | Other partial ostectomy, patella (regions required) | 150 | 4+T |

**OTHER PARTIAL OSTECTOMY - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MAAS | 89.79C | Bone tumours - major bone radical excision and reconstruction | IC | 4+T |
| | | RG=FEMR | | 5+T |
| MAAS | 89.79D | Bone tumours - minor bone radical excision and reconstruction | IC | 4+T |
| | | RG=FEMR | | 5+T |

**TOTAL OSTECTOMY - SCAPULA, CLAVICLE AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| MASG | 89.80B | Claviculectomy (regions required) | 150 | 4+T |
| MASG | 89.80C | Cervical rib (regions required) | 150 | 10+T |

**TOTAL OSTECTOMY - CARPALS AND METACARPALS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.83 | Total ostectomy, carpals and metacarpals (regions required) - plus multiples, if applicable | 125 | 4+T |
| MASG | 89.83A | Carpectomy (regions required) - plus multiples, if applicable | 125 | 4+T |
| MASG | 89.83B | Scaphoid, accessory (regions required) | 100 | 4+T |

**TOTAL OSTECTOMY - PATELLA**

| | | | | |
|---|---|---|---|---|
| MASG | 89.85 | Total ostectomy, patella (regions required) | 150 | 4+T |

**TOTAL OSTECTOMY - TARSALS AND METATARSALS**

| | | | | |
|---|---|---|---|---|
| MASG | 89.87A | Tarsal bar (regions required) | 100 | 4+T |
| MASG | 89.87B | Talus (regions required) | 150 | 4+T |

**TOTAL OSTECTOMY - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.88A | Sesamoids one or more (regions required) | 100 | 4+T |
| MASG | 89.88B | Phalanx (regions required) - plus multiples, if applicable | 71 | 4+T |
| MAAS | 89.88C | Radical excision and reconstruction bone tumours - vertebral column | IC | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |

**TOTAL OSTECTOMY - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.89A | Coccygectomy | 75 | 5+T |

**BIOPSY OF BONE - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.98A | Punch biopsy of vertebra | 75 | 4+T |

**BIOPSY OF BONE - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MISG | 89.99A | Punch biopsy - without x-ray control | 38 | 4+T |
| MASG | 89.99B | Punch biopsy - with x-ray control | 65 | 4+T |

**BONE GRAFT - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.00A | Bone graft - clavicle (for primary bone grafts in a fresh fracture, add 50% of the code to the primary procedure) (regions required) | 175 | 4+T |

**BONE GRAFT - HUMERUS**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.01 | Bone graft, humerus (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure (regions required) | 200 | 4+T |

**BONE GRAFT - RADIUS AND ULNA**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.02 | Bone graft, radius and ulna (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required) | 200 | 4+T |
| BOGR | 90.02A | Bone graft - radius or ulna (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required) | 175 | 4+T |

**BONE GRAFT - CARPALS AND METACARPALS**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.03 | Bone graft, carpals and metacarpals (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (Regions required) - plus multiples, if applicable | 100 | 4+T |
| BOGR | 90.03A | Bone graft, scaphoid (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required) | 175 | 4+T |

**BONE GRAFT - FEMUR**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.04A | Bone graft - femur - neck or shaft (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (Regions required) | 190 | 6+T |

**BONE GRAFT - TIBIA AND FIBULA**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.06A | Bone graft - tibia (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required) | 190 | 4+T |
| ADON | 90.06B | Fixation of vascularized fibula graft for limb salvage - not eligible for premium fees (patient specific) | 150 | |

**BONE GRAFT - TARSALS AND METATARSALS+**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.07 | Bone graft, tarsals and metatarsals (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (Regions required) - plus multiples, if applicable | 100 | 4+T |
| BOGR | 90.07A | Bone graft - talus (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required) | 200 | 4+T |

**BONE GRAFT - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| BOGR | 90.08A | Bone graft - phalanx (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required) - plus multiples, if applicable | 75 | 4+T |
| MAAS | 90.08B | Bone graft - pelvis (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) | IC | 7+T |

**BONE GRAFT - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| ADON | 90.09A | Morselized allograft | 50 | |

**EPIPHYSEAL STAPLING - FEMUR**

| | | | | |
|---|---|---|---|---|
| MASG | 90.24 | Epiphyseal stapling, femur (regions required) | 150 | 4+T |
| MASG | 90.24A | Epiphysiodesis (regions required) | 150 | 4+T |

**EPIPHYSEAL STAPLING - TIBIA AND FIBULA**

| | | | | |
|---|---|---|---|---|
| MASG | 90.26 | Epiphyseal stapling, tibia and fibula (regions required) | 150 | 4+T |
| MASG | 90.26A | Epiphysiodesis (regions required) | 150 | 4+T |

**EPIPHYSEAL STAPLING - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 90.28A | Tibia and femur (regions required) | 200 | 4+T |
| MASG | 90.28B | Epiphysiodesis - tibia and femur (regions required) | 200 | 4+T |

**OTHER CHANGE IN BONE LENGTH - HUMERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 90.31A | Shortening of humerus with or without bone graft (regions required) | 250 | 4+T |

**OTHER CHANGE IN BONE LENGTH - RADIUS AND ULNA**

| | | | | |
|---|---|---|---|---|
| MASG | 90.32A | Shortening of radius and ulna (regions required) | 150 | 4+T |

**OTHER CHANGE IN BONE LENGTH - FEMUR**

| | | | | |
|---|---|---|---|---|
| MASG | 90.34A | Shortening of femur with or without bone graft (regions required) | 250 | 4+T |

**OTHER CHANGE IN BONE LENGTH - TIBIA AND FIBULA**

| | | | | |
|---|---|---|---|---|
| MASG | 90.36A | Shortening of tibia with or without bone graft (regions required) | 250 | 4+T |
| MASG | 90.36B | Lengthening of tibia (regions required) | 250 | 4+T |

**OTHER CHANGE IN BONE LENGTH - TARSALS AND METATARSALS**

| | | | | |
|---|---|---|---|---|
| MASG | 90.37A | Osteoplasty of metatarsal - single (regions required) | 125 | 4+T |
| MASG | 90.37B | Osteoplasty of metatarsal - more than one (regions required) | 175 | 4+T |

**OTHER CHANGE IN BONE LENGTH - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 90.39A | Lengthening of major bone | 300 | 4+T |

**OTHER REPAIR OR PLASTIC OPERATION ON BONE - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| MASG | 90.40A | Scapulopexy | 250 | 6+T |

**OTHER REPAIR OR PLASTIC OPERATION ON BONE OTHER REPAIR OR PLASTIC OPERATION ON BONE, SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| MASG | 90.40B | Repair of Sternal Non-union | 750 | 20+T |

**OTHER REPAIR OR PLASTIC OPERATION ON BONE - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MISG | 90.49A | Electromagnetic bone stimulator with external generator | 40 | |

**REMOVAL OF INTERNAL FIXATION DEVICE**

| | | | | |
|---|---|---|---|---|
| MASG | 90.6A | Removal of Harrington Rod apparatus | 125 | 6+T |

**REMOVAL OF INTERNAL FIXATION DEVICE - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 90.69B | Removal of internal fixation - metal plate, band, screw or nail (Regions required) | 71 | 4+T |
| MISG | 90.69C | Removal of percutaneous k-wire (when the fee for removal of multiple k-wires exceeds 50 units, the surgical rules apply) - plus multiples, if applicable | 10 | 4+T |
| MASG | 90.69D | Removal of Complex Internal Fixation Device(s) (IM nail, locking plate) as sole Operative procedure | 110 | 4+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - HUMERUS**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.00A | Fractured humerus neck without dislocation of head - closed reduction (Regions required) | 100 | 4+T |
| MAFR | 91.00B | Fractured humerus shaft - closed reduction (regions required) | 95 | 4+T |
| MAFR | 91.00C | Fractured humerus - epicondyle - medial - closed reduction (Regions required) | 75 | 4+T |
| MAFR | 91.00D | Fractured humerus - epicondyle - lateral - closed reduction (Regions required) | 75 | 4+T |
| MAFR | 91.00E | Fractured humerus tuberosity - closed reduction (regions required) | 75 | 4+T |

| | | | | |
|---|---|---|---|---|
| MAFR | 91.00F | Fractured humerus neck with dislocation of head - closed reduction<br>(Regions required) | 100 | 4+T |
| MAFR | 91.00G | Fractured humerus - supra or transcondylar - closed reduction<br>(Regions required) | 100 | 4+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - RADIUS AND ULNA**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.01 | Closed reduction of fracture (without internal fixation), radius and ulna<br>(Regions required) | 95 | 4+T |
| MIFR | 91.01A | Closed reduction fractured radius - head or neck (regions required) | 50 | 4+T |
| MAFR | 91.01B | Closed reduction fractured radius or ulna - shaft (regions required) | 71 | 4+T |
| MAFR | 91.01C | Colles' or Smith's fracture - closed reduction (regions required) | 57 | 4+T |
| MAFR | 91.01D | Monteggia's or Galleazzi's fracture - closed reduction (regions required) | 100 | 4+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - CARPALS AND METACARPALS**

| | | | | |
|---|---|---|---|---|
| MIFR | 91.02A | Closed reduction - carpus (excluding scaphoid) (regions required) | 50 | 4+T |
| MIFR | 91.02B | Closed reduction metacarpal (regions required)<br>- plus multiples, if applicable | 50 | 4+T |
| MIFR | 91.02C | Closed reduction Bennett's fracture (regions required) | 50 | 4+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - PHALANGES OF HAND**

| | | | | |
|---|---|---|---|---|
| MIFR | 91.03A | Closed reduction phalanx, terminal - upper extremity (regions required)<br>- plus multiples, if applicable | 35 | 4+T |
| MIFR | 91.03B | Closed reduction phalanx - middle or proximal (regions required)<br>- plus multiples, if applicable | 35 | 4+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - FEMUR**

| | | | | |
|---|---|---|---|---|
| MISG | 91.04A | Fractured femur - shaft or transcondylar - cast bracing of the femoral shaft<br>(Regions required) | 50 | 4+T |
| MAFR | 91.04B | Fractured femur neck - closed reduction with external fixation<br>(Regions required) | 150 | 6+T |
| MAFR | 91.04C | Fractured femur - pertrochanteric - closed reduction with external fixation<br>(Regions required) | 150 | 6+T |
| MAFR | 91.04D | Fractured femur - shaft or transcondylar- closed reduction<br>(Regions required) | 142 | 6+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - TIBIA AND FIBULA**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.05A | Fracture - tibia with or without fibula - closed reduction (regions required) | 119 | 4+T |
| MAFR | 91.05B | Fractured ankle - medial malleolus - closed reduction (regions required) | 75 | 4+T |
| MIFR | 91.05C | Fracture fibula - closed reduction (regions required) | 35 | 4+T |
| MIFR | 91.05D | Fractured ankle - lateral malleolus - closed reduction (regions required) | 50 | 4+T |
| MAFR | 91.05E | Fractured ankle - bimalleolar (including Pott's) - closed reduction (Regions required) | 100 | 4+T |
| MAFR | 91.05F | Fractured ankle - trimalleolar - closed reduction (regions required) | 100 | 4+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - TARSALS AND METATARSALS**

| | | | | |
|---|---|---|---|---|
| MIFR | 91.06A | Fracture tarsus except os calcis - closed reduction (regions required) | 50 | 4+T |
| MIFR | 91.06B | Fractured talus - closed reduction (regions required) | 50 | 4+T |
| MAFR | 91.06C | Fracture os calcis - closed reduction (regions required) | 75 | 4+T |
| MAFR | 91.06D | Fracture os calcis - closed reduction with external pin fixation (Regions required) | 100 | 4+T |
| MIFR | 91.06E | Closed reduction metatarsal (regions required) - plus multiples, if applicable | 35 | 4+T |

**CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - OTHER SPECIFIED BONE**

| | | | | |
|---|---|---|---|---|
| MIFR | 91.08A | Fractured olecranon - closed reduction (regions required) | 50 | 4+T |
| MAFR | 91.08B | Spine fracture or fracture dislocation - closed reduction with cast, frame or brace | 150 | 5+T |
| MIFR | 91.08C | Fracture - clavicle - closed reduction (regions required) | 50 | 4+T |
| MAFR | 91.08D | Fracture - scapula - body, neck or glenoid - closed reduction (Regions required) | 75 | 4+T |
| MAAS | 91.08E | Fracture sternum - closed reduction | IC | |
| | | AP=WPLC | | 4+T |
| | | AP=WPLO | | 9+T |
| MAAS | 91.08F | Fracture - ribs - complicated | IC | |
| | | AP=WPLC | | 4+T |
| | | AP=WPLO | | 9+T |
| MAFR | 91.08G | Fracture - pelvis - closed reduction - manipulation with x-ray control | 150 | 4+T |
| MAFR | 91.08H | Fracture - acetabulum, with or without pelvic fracture - closed reduction | 75 | 4+T |

| | | | | |
|---|---|---|---|---|
| MAFR | 91.08I | Pelvis - central fracture - dislocation - closed reduction | 150 | 4+T |
| MIFR | 91.08J | Fracture patella - closed reduction (regions required) | 35 | 4+T |
| MAFR | 91.08K | Spine fracture or fracture dislocation - halo pelvic traction | 115 | 5+T |

**CLOSED REDUCTION OF FRACTURE WITH PERCUTANEOUS FIXATION**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.11A | External skeletal pin fixation - Radius and Ulna (regions required) | | |
| | | AG=ADUT | 100 | 4+T |
| | | AG=CH16 | 75 | 4+T |
| MAFR | 91.12A | External skeletal pin fixation – Carpals and Metacarpals (regions required) -plus multiples, if applicable | | |
| | | AG=ADUT | 100+MU | 4+T |
| | | AG=CH16 | 75+MU | 4+T |
| MAFR | 91.13A | External skeletal pin fixation – Phalanges of hand (regions required) - plus multiples, if applicable | | |
| | | AG=ADUT | 100+MU | 4+T |
| | | AG=CH16 | 75+MU | 4+T |
| MAFR | 91.16A | External skeletal pin fixation – Tarsals and Metatarsals (regions required) - plus multiples, if applicable | | |
| | | AG=ADUT | 100+MU | 4+T |
| | | AG=CH16 | 75+MU | 4+T |
| MAFR | 91.17A | External skeletal pin fixation – Phalanges of the foot (regions required) -plus multiples, if applicable | | |
| | | AG=ADUT | 100+MU | 4+T |
| | | AG=CH16 | 75+MU | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - HUMERUS**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.30A | Fractured humerus neck without dislocation of head - open reduction (Regions required) | 200 | 4+T |
| MAFR | 91.30B | Fractured humerus shaft - open reduction | 175 | 4+T |
| MAFR | 91.30C | Fractured humerus - epicondyle - medial - open reduction (Regions required) | 100 | 4+T |
| MAFR | 91.30D | Fractured humerus - epicondyle - lateral - open reduction (Regions required) | 125 | 4+T |
| MAFR | 91.30E | Fractured humerus tuberosity - open reduction (regions required) | 150 | 4+T |
| MAFR | 91.30F | Fractured humerus neck with dislocation of head - open reduction (Regions required) | 200 | 4+T |
| MAFR | 91.30G | Fractured humerus - supra or transcondylar - open reduction (Regions required) | 175 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - RADIUS AND ULNA**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.31 | Open reduction of fracture with internal fixation, radius and ulna (Regions required) | 150 | 4+T |
| MAFR | 91.31A | Open reduction - fractured olecranon (regions required) | 119 | 4+T |
| MAFR | 91.31B | Open reduction - radius - head or neck (regions required) | 100 | 4+T |
| MAFR | 91.31C | Open reduction fractured radius or ulna - shaft (regions required) | 125 | 4+T |
| MAFR | 91.31D | Colles' or Smith's fracture - open reduction (regions required) | 75 | 4+T |
| MAFR | 91.31E | Monteggia's or Galleazzi's fracture - open reduction (regions required) | 175 | 4+T |
| MAFR | 91.31F | External skeletal pin fixation (regions required) | | |
| | | AG=ADUT | 100 | 4+T |
| | | AG=CH16 | 75 | 4+T |
| MAFR | 91.31G | Distal comminuted intra-articular fracture of radius (to include distal ulna) due to high energy trauma. To include open reduction, internal/external fixation as required when performed in conjunction with remote donor site bone graft (regions required) | 200 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - CARPALS AND METACARPALS**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.32A | Open reduction - carpus (excluding scaphoid) (regions required) | 100 | 4+T |
| MAFR | 91.32B | Open reduction - metacarpal (regions required) | | |
| | | - plus multiples, if applicable | 96 | 4+T |
| MAFR | 91.32C | Open reduction - scaphoid (regions required) | 100 | 4+T |
| MAFR | 91.32D | External skeletal pin fixation (regions required) | | |
| | | AG=ADUT | 100+MU | 4+T |
| | | AG=CH16 | 75+MU | 4+T |
| MAFR | 91.32E | Open reduction and internal fixation using plates and/or screws - phalangeal or metacarpal fractures (regions required) | 105 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - PHALANGES OF HAND**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.33A | Upper extremity - phalanx, terminal - open reduction (regions required) | | |
| | | - plus multiples, if applicable | 75 | 4+T |
| MAFR | 91.33B | Open reduction - Bennett's fracture (regions required) | 100 | 4+T |
| MAFR | 91.33C | Fracture scaphoid - excision (regions required) | 125 | 4+T |
| MAFR | 91.33D | Open reduction phalanx - middle or proximal (regions required) | | |
| | | - plus multiples, if applicable | 72 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - FEMUR**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.34A | Fracture femur neck - open reduction with internal fixation (Regions required) | 214 | 9+T |
| MAFR | 91.34B | Fractured femur - pertrochanteric - open reduction (regions required) | 214 | 9+T |
| MAFR | 91.34C | Fractured femur - shaft or transcondylar - open reduction (Regions required) | 190 | 9+T |
| MAFR | 91.34D | Fracture femur neck - prosthetic replacement (regions required) | 214 | 9+T |
| MAFR | 91.34E | Locked femoral I.M. nails - regular (regions required) | 250 | 9+T |
| MAFR | 91.34F | Locked femoral I.M. nails - reconstruction nail (regions required) | 300 | 9+T |
| MASG | 91.34G | Locked tibial I.M. nails (regions required) | 250 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - TIBIA AND FIBULA**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.35A | Fracture - tibia with or without fibula - shaft - open reduction (Regions required) | 166 | 4+T |
| MAFR | 91.35C | Fractured tibia with or without fibula - plateau - open reduction (Regions required) | 166 | 4+T |
| MAFR | 91.35D | Fractured ankle - single malleolus - open reduction (regions required) | 95 | 4+T |
| MAFR | 91.35E | Fracture fibula - open reduction (regions required) | 75 | 4+T |
| MAFR | 91.35F | Fractured ankle - bi or trimalleolar - open reduction (regions required) | 142 | 4+T |
| MAFR | 91.35G | Open Reduction and Internal Fixation (ORIF) Bicondylar Tibial Plateau Fracture | 250 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - TARSALS AND METATARSALS**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.36A | Fracture talus - excision (regions required) | 150 | 4+T |
| MAFR | 91.36B | Fracture os calcis - open reduction and primary arthrodesis (Regions required) | 200 | 4+T |
| MAFR | 91.36C | Fracture tarsus except os calcis - open reduction (regions required) | 150 | 4+T |
| MAFR | 91.36D | Fractured talus - open reduction (regions required) | 150 | 4+T |
| MAFR | 91.36E | Fracture os calcis - open reduction (regions required) | 150 | 4+T |
| MAFR | 91.36F | Fractured metatarsal - open reduction (regions required) - plus multiples, if applicable | 100 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - PHALANGES OF FOOT**

| | | | | |
|---|---|---|---|---|
| MIFR | 91.37A | Fractured phalanx - lower extremity - open reduction (regions required) - plus multiples, if applicable | 35 | 4+T |

**OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - OTHER SPECIFIED BONE**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.38A | Fracture - clavicle - open reduction (regions required) | 100 | 4+T |
| MAFR | 91.38B | Fracture - scapula - body, neck or glenoid - open reduction (Regions required) | 150 | 4+T |
| MAAS | 91.38C | Fracture - sternum - open reduction | IC | |
| | | AP=WPLC | | 4+T |
| | | AP=WPLO | | 9+T |
| MAFR | 91.38G | Fracture - acetabulum, with or without pelvic fracture - open reduction | 250 | 4+T |
| MAFR | 91.38H | Pelvis - central fracture - dislocation - open reduction | 250 | 4+T |
| MAFR | 91.38I | Fracture patella - excision and simple repair (regions required) | 150 | 4+T |
| MAFR | 91.38J | Fracture patella - excision and fascial repair (regions required) | 175 | 4+T |
| MAFR | 91.38K | Fracture patella - open reduction with tension band wiring (Regions required) | 166 | 4+T |
| MAFR | 91.38L | Open reduction pelvis for traumatic disruption - one pillar - all inclusive to include acetabulum if required | 500 | 11+T |
| MAFR | 91.38M | Pelvis - open reduction for traumatic disruption - 2 pillars - all inclusive to include acetabulum if required | 700 | 11+T |

**CLOSED REDUCTION OF SEPARATED (SLIPPED) EPIPHYSIS - FEMUR**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.44 | (Closed) reduction of separated (slipped) epiphysis, femur (Regions required) | 175 | 6+T |

**OPEN REDUCTION OF SEPARATED (SLIPPED) EPIPHYSIS - FEMUR**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.54 | Open reduction of separated (slipped) epiphysis, femur (Regions required) | 225 | 9+T |

**CLOSED REDUCTION OF DISLOCATION OF SHOULDER**

| | | | | |
|---|---|---|---|---|
| DISL | 91.70 | Closed reduction of dislocation of shoulder (regions required) | 50 | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF ELBOW**

| | | | | |
|---|---|---|---|---|
| DISL | 91.71 | Closed reduction of dislocation of elbow (regions required) | 50 | 4+T |
| MAAS | 91.71A | Repair of recurrent dislocation of elbow (regions required) | IC | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF WRIST**

| | | | | |
|---|---|---|---|---|
| DISL | 91.72A | Dislocation of wrist and carpal bones - closed reduction (Regions required) | 50 | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF HAND AND FINGER**

| | | | | |
|---|---|---|---|---|
| DISL | 91.73A | Dislocation - metacarpophalangeal joint - closed reduction (Regions required) - plus multiples, if applicable | 25 | 4+T |
| DISL | 91.73B | Dislocation - interphalangeal joint - upper extremity - closed reduction (Regions required) | 15 | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF HIP**

| | | | | |
|---|---|---|---|---|
| DISL | 91.74 | Closed reduction of dislocation of hip (regions required) | 75 | 4+T |
| DISL | 91.74A | Congenital dislocation - closed reduction (regions required) | 150 | 4+T |
| DISL | 91.74B | Central dislocation - closed reduction (regions required) | 150 | 4+T |
| DISL | 91.74C | Congenital - repeat - manipulation and plaster (regions required) | 60 | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF KNEE**

| | | | | |
|---|---|---|---|---|
| DISL | 91.75 | Closed reduction of dislocation of knee (regions required) | 75 | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF ANKLE**

| | | | | |
|---|---|---|---|---|
| DISL | 91.76 | Closed reduction of dislocation of ankle (regions required) | 75 | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF FOOT AND TOE**

| | | | | |
|---|---|---|---|---|
| DISL | 91.77A | Dislocation - tarsal - closed reduction (regions required) - plus multiples, if applicable | 50 | 4+T |
| DISL | 91.77B | Dislocation - metatarsophalangeal joint - closed reduction (Regions required) - plus multiples, if applicable | 25 | 4+T |
| DISL | 91.77C | Dislocation - interphalangeal joint - lower extremity - closed reduction (Regions required) | 10 | 4+T |

**CLOSED REDUCTION OF DISLOCATION OF OTHER SPECIFIED SITES**

| | | | | |
|---|---|---|---|---|
| DISL | 91.78A | Dislocation spine-intervertebral - closed reduction including traction, etc | 150 | 5+T |
| DISL | 91.78B | Dislocation - sternoclavicular - closed reduction (regions required) | 25 | 4+T |
| DISL | 91.78C | Dislocation - acromioclavicular - closed reduction (regions required) | 25 | 4+T |
| DISL | 91.78D | Dislocation - patella - closed reduction (regions required) | 25 | 4+T |
| DISL | 91.78E | Dislocation - sacroiliac - closed reduction including traction, etc | 75 | 5+T |

**OPEN REDUCTION OF DISLOCATION OF SHOULDER**

| | | | | |
|---|---|---|---|---|
| DISL | 91.80 | Open reduction of dislocation of shoulder (regions required) | 175 | 4+T |

**OPEN REDUCTION OF DISLOCATION OF ELBOW**

| | | | | |
|---|---|---|---|---|
| DISL | 91.81 | Open reduction of dislocation of elbow (regions required) | 150 | 4+T |
| MAAS | 91.81A | Repair of recurrent dislocation of elbow (regions required) | IC | 4+T |

**OPEN REDUCTION OF DISLOCATION OF WRIST**

| | | | | |
|---|---|---|---|---|
| DISL | 91.82A | Dislocation of wrist and carpal bones - open reduction (regions required) | 150 | 4+T |

**OPEN REDUCTION OF DISLOCATION OF HAND AND FINGER**

| | | | | |
|---|---|---|---|---|
| DISL | 91.83A | Dislocation - metacarpophalangeal joint - open reduction (Regions required) - plus multiples, if applicable | 75 | 4+T |
| DISL | 91.83B | Dislocation - interphalangeal joint - upper extremity - open reduction (Regions required) | 50 | 4+T |
| DISL | 91.83C | Dislocation thumb - open reduction (regions required) | 75 | 4+T |

**OPEN REDUCTION OF DISLOCATION OF HIP**

| | | | | |
|---|---|---|---|---|
| DISL | 91.84 | Open reduction of dislocation of hip (regions required) | 175 | 7+T |
| DISL | 91.84A | Central dislocation - open reduction (regions required) | 200 | 7+T |
| DISL | 91.84B | Congenital dislocation - open reduction (regions required) ME=SIMP | 225 | 9+T |
| DISL | 91.84C | Congenital dislocation - open reduction with acetabuloplasty (Regions required) | 250 | 9+T |

**OPEN REDUCTION OF DISLOCATION OF KNEE**

| | | | | |
|---|---|---|---|---|
| DISL | 91.85 | Open reduction of dislocation of knee (regions required) | 175 | 4+T |
| DISL | 91.85A | Patella - repair of recurrent dislocation (regions required) | 142 | 4+T |

**OPEN REDUCTION OF DISLOCATION OF ANKLE**

| | | | | |
|---|---|---|---|---|
| DISL | 91.86 | Open reduction of dislocation of ankle (regions required) | 125 | 4+T |

**OPEN REDUCTION OF DISLOCATION OF FOOT AND TOE**

| | | | | |
|---|---|---|---|---|
| DISL | 91.87A | Dislocation - tarsal - open reduction (regions required) - plus multiples, if applicable | 125 | 4+T |
| DISL | 91.87B | Dislocation - metatarsophalangeal joint - open reduction (Regions required) - plus multiples, if applicable | 75 | 4+T |
| DISL | 91.87C | Dislocation - interphalangeal joint - lower extremity - open reduction (Regions required) | 50 | 4+T |

**OPEN REDUCTION OF DISLOCATION OF OTHER SPECIFIED SITES**

| | | | | |
|---|---|---|---|---|
| DISL | 91.88A | Dislocation spine - intervertebral - open reduction | 200 | 7+T |
| | | AP=CERV | | 8+T |
| DISL | 91.88B | Dislocation - spine - intervertebral - open reduction and fusion | 300 | 7+T |
| | | AP=CERV | | 8+T |
| DISL | 91.88C | Dislocation - sternoclavicular - open reduction (regions required) | 100 | 4+T |
| DISL | 91.88D | Dislocation - acromioclavicular - open reduction (regions required) | 125 | 4+T |
| DISL | 91.88E | Dislocation - patella - open reduction (regions required) | 100 | 4+T |
| DISL | 91.88F | Dislocation - sacroiliac - open reduction | 150 | 5+T |

**OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - HUMERUS**

| | | | |
|---|---|---|---|
| MIFR | 91.90A | Fractured humerus shaft - no reduction (regions required) | 50 |
| MIFR | 91.90B | Fractured humerus neck without dislocation of head - no reduction (Regions required) | 50 |
| MIFR | 91.90C | Fractured humerus tuberosity - no reduction (regions required) | 50 |
| MIFR | 91.90D | Fractured humerus neck with dislocation of head - no reduction (Regions required) | 50 |
| MIFR | 91.90E | Fractured humerus supra or transcondylar - no reduction (Regions required) | 50 |

**OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - FEMUR**

| | | | |
|---|---|---|---|
| MAFR | 91.94A | Fractured femur shaft or transcondylar - no reduction (regions required) | 75 |
| MAFR | 91.94B | Fracture femur - pertrochanteric - no reduction (regions required) | 75 |
| MAFR | 91.94C | Fracture femur - neck - no reduction (regions required) | 75 |

**OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - TIBIA AND FIBULA**

| | | | |
|---|---|---|---|
| MAFR | 91.95A | Fracture tibia with or without fibula - no reduction (regions required) | 75 |

**PLAFOND FRACTURE PROCEDURES**

| | | | | |
|---|---|---|---|---|
| MAFR | 91.35B | Fractured tibial plafond, with or without fibula, open reduction and internal fixation -including removal of pre-existing internal or external fixation devices (Regions required) | 200 | 4+T |
| MAFR | 91.95C | External fixation of tibial plafond fracture (regions required) | 150 | 4+T |
| MAFR | 91.95D | External fixation of tibial plafond fracture, with open reduction and internal fixation of fibular fracture (regions required) | 175 | 4+T |

**OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - OTHER SPECIFIED BONE**

| | | | | |
|---|---|---|---|---|
| MIFR | 91.98B | No reduction of fractured malleolus | 35 | |
| MIFR | 91.98C | Fracture tarsus except os calcis - no reduction (regions required) | 50 | |

**OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - UNSPECIFIED BONE**

| | | | | |
|---|---|---|---|---|
| ADON | 91.99A | Fractures requiring cement | 25 | |

**OTHER ARTHROTOMY - SHOULDER**

| | | | | |
|---|---|---|---|---|
| MASG | 92.10 | Other arthrotomy, shoulder (regions required) | 150 | 4+T |

**OTHER ARTHROTOMY - ELBOW**

| | | | | |
|---|---|---|---|---|
| MASG | 92.11 | Other arthrotomy, elbow (regions required) | 100 | 4+T |

**OTHER ARTHROTOMY - WRIST**

| | | | | |
|---|---|---|---|---|
| MASG | 92.12 | Other arthrotomy, wrist (regions required) | 100 | 4+T |

**OTHER ARTHROTOMY - HAND AND FINGER**

| | | | | |
|---|---|---|---|---|
| MASG | 92.13A | Arthrotomy - metacarpophalangeal joint (regions required) - plus multiples, if applicable | 75 | 4+T |
| MISG | 92.13B | Arthrotomy - interphalangeal joint (regions required) - plus multiples, if applicable | 50 | 4+T |

**OTHER ARTHROTOMY - HIP**

| | | | | |
|---|---|---|---|---|
| MASG | 92.14 | Other arthrotomy, hip (regions required) | 166 | 5+T |

**OTHER ARTHROTOMY - KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.15 | Other arthrotomy, knee (regions required) | 95 | 4+T |
| MISG | 92.15A | Shaving patella (regions required) | 25 | 4+T |

**OTHER ARTHROTOMY - ANKLE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.16 | Other arthrotomy, ankle (regions required) | 100 | 4+T |

**OTHER ARTHROTOMY - FOOT AND TOE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.17A | Arthrotomy - metatarsophalangeal joint (regions required) - plus multiples, if applicable | 75 | 4+T |
| MISG | 92.17B | Arthrotomy - interphalangeal joint (regions required) - plus multiples, if applicable | 50 | 4+T |

**OTHER ARTHROTOMY - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.18A | Arthrotomy - temporomandibular joint (regions required) | 125 | 5+T |

**DIVISION OF JOINT CAPSULE, LIGAMENT, OR CARTILAGE - KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.25A | Arthroscopy and open lateral retinacular release (regions required) | 122 | 4+T |

**EXCISION OF INTERVERTEBRAL DISC**

| | | | | |
|---|---|---|---|---|
| MASG | 92.31 | Excision or destruction of intervertebral disc | | |
| | | AP=CERV (regions required) | 303 | 8+T |
| | | AP=LMBR (regions required) | 212 | 7+T |
| MASG | 92.31D | Discectomy - cervical or dorsal | | |
| | | AP=ANTE | 573 | |
| | | AP=POST | 250 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 92.31E | Discectomy - bilateral - recurrent or multiple levels | 246 | |
| | | AP=LMBR | | 7+T |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| MASG | 92.31F | Removal of protruded disc - bilateral or multiple | 425 | |
| | | AP=CERV | | 8+T |
| | | AP=DRSL | | 7+T |
| | | AP=LMBR | | 7+T |
| MASG | 92.31G | Removal of protruded lumbar disc to include fusion and/or internal fixation if indicated | | |
| | | AP=ANTE | 350 | 11+T |

**EXCISION OF SEMILUNAR CARTILAGE OF KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.32A | Meniscectomy - knee (regions required) | 119 | 4+T |

**SYNOVECTOMY - ELBOW**

| | | | | |
|---|---|---|---|---|
| MASG | 92.41 | Synovectomy, elbow (regions required) | 175 | 4+T |

**SYNOVECTOMY - WRIST**

| | | | | |
|---|---|---|---|---|
| MASG | 92.42 | Synovectomy, wrist (regions required) | 144 | 4+T |

**SYNOVECTOMY - HIP**

| | | | | |
|---|---|---|---|---|
| MASG | 92.44 | Synovectomy, hip (regions required) | 250 | 5+T |

**SYNOVECTOMY - KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.45 | Synovectomy, knee (regions required) | 142 | 4+T |

**SYNOVECTOMY - ANKLE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.46 | Synovectomy, ankle (regions required) | 150 | 4+T |

**OTHER EXCISION OF JOINT - SHOULDER**

| | | | | |
|---|---|---|---|---|
| MASG | 92.60 | Other excision of joint, shoulder (regions required) | 175 | 4+T |

**OTHER EXCISION OF JOINT - WRIST**

| | | | | |
|---|---|---|---|---|
| MASG | 92.62A | Meniscectomy - wrist (regions required) | 125 | 4+T |

**OTHER EXCISION OF JOINT - HAND AND FINGER**

| | | | | |
|---|---|---|---|---|
| MASG | 92.63A | Excision (capsulectomy, synovectomy, debridement) metacarpophalangeal joint (regions required) - plus multiples, if applicable | 100 | 4+T |
| MASG | 92.63B | Excision (capsulectomy, synovectomy, debridement) interphalangeal joint (Regions required) - plus multiples, if applicable | 100 | 4+T |

**OTHER EXCISION OF JOINT - FOOT AND TOE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.67A | Excision (capsulectomy, synovectomy, debridement) metatarsophalangeal joint (regions required) - plus multiples, if applicable | 100 | 4+T |
| MASG | 92.67B | Excision (capsulectomy, synovectomy, debridement) interphalangeal joint (Regions required) - plus multiples, if applicable | 100 | 4+T |

**CONTRAST ARTHROGRAM - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MISG | 92.79 | Contrast arthrogram, unspecified site | 15 | |
| MISG | 92.79A | Arthrogram, double contrast | 25.5 | |

**ARTHROSCOPY - KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.85A | Arthroscopy and open lateral retinacular release (regions required) | 122 | 4+T |

**ARTHROSCOPY - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 92.89 | Arthroscopy, unspecified site (regions required) | 71 | 4+T |
| MASG | 92.89A | Arthroscopy and open lateral retinacular release (regions required) | 122 | 4+T |
| MASG | 92.89B | Arthroscopic removal of osteochondral fragment and drilling of femoral condyle (regions required) | 162 | 4+T |
| MASG | 92.89C | Arthroscopic pinning of osteochondral defect (regions required) | 162 | 4+T |
| MASG | 92.89D | Arthroscopic resection of plica and/or biopsies of synovium (regions required) | 107 | 4+T |
| MASG | 92.89E | Arthroscopy and removal of loose body arthroscopically (regions required) | 137 | 4+T |
| MASG | 92.89F | Arthroscopic meniscectomy (regions required) | 162 | 4+T |
| MASG | 92.89G | Arthroscopic trimming of meniscus and minor debridement (regions required) | 117 | 4+T |
| MASG | 92.89H | Arthroscopic synovectomy - partial removal (one compartment) (Regions required) | 137 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 92.89I | Arthroscopic synovectomy - total removal (one compartment) (Regions required) | 162 | 4+T |
| MASG | 92.89J | Arthroscopic synovectomy - total anterior (more than one compartment) (Regions required) | 187 | 4+T |
| MASG | 92.89K | Arthroscopic synovectomy - total anterior and posterior (more than one compartment) (regions required) | 187 | 4+T |
| MASG | 92.89L | Arthroscopic debridement - (one compartment) | | |
| | | ME=MAJO (regions required) | 137 | 4+T |
| | | ME=MINO (regions required) | 117 | 4+T |
| MASG | 92.89M | Arthroscopic debridement of the knee - major (tricompartmental) (Regions required) | 187 | 4+T |
| MASG | 92.89N | Arthroscopic meniscal repair (regions required) | 212 | 4+T |

**BIOPSY OF JOINT STRUCTURE - OTHER SPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MISG | 92.98A | Punch biopsy of synovial membrane | 25 | 4+T |

**DORSOLUMBAR SPINAL FUSION WITH HARRINGTON ROD**

| | | | | |
|---|---|---|---|---|
| MASG | 93.04 | Dorsolumbar spinal fusion with Harrington Rod | 700 | 11+T |
| MAAS | 93.04A | Spinal fusion for scoliosis with spinal osteotomy | IC | 8+T |

**OTHER DORSOLUMBAR SPINAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.05A | Spinal fusion - Luque Procedure | 665 | 11+T |
| MAFR | 93.05B | Fracture spine - open reduction and fusion | 300 | 7+T |

**OTHER SPINAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.09B | Spinal fusion from four to seven spaces | 300 | 7+T |
| MASG | 93.09C | Spinal fusion - Dwyer Procedure | 600 | 13+T |
| MASG | 93.09D | Spinal fusion - one stage | 200 | 7+T |
| MASG | 93.09E | Spinal fusion from eight to fifteen spaces | 350 | 7+T |
| MASG | 93.09F | Spinal fusion - two spaces | 285 | 7+T |
| MASG | 93.09G | Spinal fusion - three spaces | 300 | 7+T |
| MASG | 93.09H | Spinal fusion with pedicle fixation and metal rod support (not Luque or Harrington Procedure) two or more levels as indicated without decompression | 500 | 11+T |
| MASG | 93.09I | Spinal fusion with pedicle fixation and metal rod support (not Luque or Harrington Procedure) two or more levels as indicated, with decompression of nerve roots and/or disc excision | 550 | 11+T |

**ANKLE FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.11 | Ankle fusion (regions required) | 200 | 4+T |
| MASG | 93.11A | Bone block stabilization - ankle (regions required) | 150 | 5+T |

**TRIPLE ARTHRODESIS (AND STRIPPING)**

| | | | | |
|---|---|---|---|---|
| MASG | 93.12 | Triple arthrodesis (and stripping) (regions required) | 190 | 4+T |

**SUBTALAR FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.13 | Subtalar fusion (regions required) | 190 | 4+T |

**MIDTARSAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.14 | Midtarsal fusion (regions required) | 190 | 4+T |

**METATARSOPHALANGEAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.16 | Metatarsophalangeal fusion (regions required) | 71 | 4+T |
| MASG | 93.16A | MP joint fusion great toe (Marin fusion, etc.) (regions required) | 150 | 4+T |

**OTHER FUSION OF FOOT**

| | | | | |
|---|---|---|---|---|
| MASG | 93.17A | Arthrodesis - foot - pantalar (regions required) | 250 | 4+T |

**ARTHRODESIS OF HIP**

| | | | | |
|---|---|---|---|---|
| MASG | 93.21 | Arthrodesis of hip (regions required) | 300 | 5+T |

**ARTHRODESIS OF KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 93.22 | Arthrodesis of knee (regions required) | 200 | 4+T |

**ARTHRODESIS OF SHOULDER**

| | | | | |
|---|---|---|---|---|
| MASG | 93.23 | Arthrodesis of shoulder (regions required) | 250 | 4+T |

**ARTHRODESIS OF ELBOW**

| | | | | |
|---|---|---|---|---|
| MASG | 93.24 | Arthrodesis of elbow (regions required) | 200 | 4+T |

**CARPORADIAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.25 | Carporadial fusion (regions required) | 200 | 4+T |

**METACARPOCARPAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.26A | Bone block stabilization - wrist (regions required) | 150 | 5+T |

**METACARPOPHALANGEAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.27 | Metacarpophalangeal fusion (regions required)<br>- plus multiples, if applicable | 100 | 4+T |

**INTERPHALANGEAL FUSION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.28 | Interphalangeal fusion (regions required) | 100 | 4+T |

**ARTHRODESIS OF OTHER AND UNSPECIFIED JOINTS**

| | | | | |
|---|---|---|---|---|
| MASG | 93.29A | Arthrodesis - sacroiliac or symphysis pubis | 200 | 5+T |

**ARTHROPLASTY OF FOOT AND TOE WITH SYNTHETIC PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 93.31A | Prosthetic arthroplasty - toe (regions required)<br>- plus multiples, if applicable | 150 | 4+T |

**OTHER ARTHROPLASTY OF FOOT AND TOE**

| | | | | |
|---|---|---|---|---|
| MASG | 93.39A | Hoffman Procedure - reconstruction of rheumatic foot (regions required) | 176 | 4+T |
| MASG | 93.39B | Arthroplasty - toe (except great toe) (regions required)<br>- plus multiples, if applicable | 71 | 4+T |

**TOTAL KNEE REPLACEMENT (GEOMEDIC) (POLYCENTRIC)**

| | | | | |
|---|---|---|---|---|
| MASG | 93.41 | Total knee replacement (Geomedic) (Polycentric) (regions required) | 299 | 6+T |

**PATELLAR STABILIZATION**

| | | | | |
|---|---|---|---|---|
| MASG | 93.44A | Roux-Goldthwaite Procedure (regions required) | 150 | 4+T |
| MASG | 93.44B | Patellar advancement (regions required) | 104 | 4+T |

**OTHER REPAIR OF THE CRUCIATE LIGAMENTS**

| | | | | |
|---|---|---|---|---|
| MASG | 93.45A | Suture of torn, ruptured or severed cruciate ligaments (fresh)<br>(Regions required) | 150 | 4+T |

**OTHER REPAIR OF THE COLLATERAL LIGAMENTS**

| | | | | |
|---|---|---|---|---|
| MASG | 93.46 | Other repair of the collateral ligaments (regions required) | 120 | 4+T |

**OTHER REPAIR OF KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 93.47A | Arthroplasty - knee (regions required) | 190 | 4+T |
| MASG | 93.47B | Composite ligamentous reconstruction of knee (regions required) | 214 | 4+T |
| MASG | 93.47C | LSOT reconstruction (regions required) | 214 | 4+T |
| MASG | 93.47D | Revision of total knee replacement (regions required) | 500 | 6+T |
| MASG | 93.47E | Reconstruction - knee - early (regions required) | 175 | 4+T |
| MASG | 93.47F | Reconstruction - knee - late (regions required) | 200 | 4+T |

**TOTAL ANKLE REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 93.48A | Total ankle arthroplasty with prosthesis (regions required) | 350 | 4+T |

**OTHER REPAIR OF ANKLE**

| | | | | |
|---|---|---|---|---|
| MASG | 93.49 | Other repair of ankle<br>RP=INTL (regions required) | 125 | 4+T |
| MASG | 93.49A | Arthroplasty - ankle (regions required) | 190 | 4+T |
| DISL | 93.49B | Repair of recurrent subluxation - ankle (regions required) | 175 | 4+T |
| MASG | 93.49C | Reconstruction - ankle - late (regions required) | 175 | 4+T |

**OTHER TOTAL HIP REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| ADON | 93.59A | Bone graft with revision of total hip replacement (regions required) | 50 | |
| MASG | 93.59B | Arthroplasty - hip - cup or total (regions required) | 299 | 9+T |
| MASG | 93.59C | Arthroplasty - revision of total hip (regions required) | 380 | 9+T |
| MASG | 93.59D | Exeter/Ling hip system to include impacted cancellous allograft and all other technical variations or additions (to include acetabular and/or femoral components) | 450 | 9+T |
| MASG | 93.59E | Revision of total hip with allograft reconstruction with or without ligament or tendon reconstruction (regions required) | 530 | 15+T |

**REPLACEMENT OF HEAD OF FEMUR WITH USE OF METHYL METHACRYLATE**

| | | | | |
|---|---|---|---|---|
| MASG | 93.61A | Arthroplasty - hip - simple prosthesis or excision of head and neck<br>(Regions required) | 250 | 7+T |

**OTHER REPAIR OF HAND AND FINGER**

| | | | | |
|---|---|---|---|---|
| MASG | 93.79A | Reconstruction of rheumatoid joints - multiple (regions required) | 211 | 4+T |
| MASG | 93.79B | Arthroplasty - interphalangeal or metacarpophalangeal - single<br>(Regions required) | 100 | 4+T |
| MASG | 93.79C | Reconstruction - both interphalangeal or metacarpophalangeal ligaments<br>(Regions required) | 125 | 4+T |
| MASG | 93.79D | Arthroplasty - wrist (regions required) | 190 | 4+T |
| MASG | 93.79E | Arthroplasty - interphalangeal or metacarpophalangeal - multiple<br>(Regions required) | 200 | 4+T |
| MASG | 93.79F | Thumb CMC joint tendon interpositional Arthoplasty<br>(Regions required) | 190 | 4+T |

**ARTHROPLASTY OF SHOULDER WITH SYNTHETIC PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 93.81 | Arthroplasty of shoulder with synthetic prosthesis (regions required) | 350 | 10+T |
| MASG | 93.81A | Total shoulder replacement (regions required) | 380 | 8+T |

**REPAIR OF RECURRENT DISLOCATION OF SHOULDER**

| | | | | |
|---|---|---|---|---|
| DISL | 93.82 | Repair of recurrent dislocation of shoulder (regions required) | 190 | 4+T |

**OTHER REPAIR OF SHOULDER**

| | | | | |
|---|---|---|---|---|
| MASG | 93.83A | Arthroplasty - shoulder (regions required) | 190 | 4+T |
| MASG | 93.83B | Arthroplasty - acromio or sternoclavicular (regions required) | 119 | 4+T |
| MASG | 93.83C | Reconstruction - acromio - or sterno-clavicular (regions required) | 125 | 4+T |
| MASG | 93.83E | Total shoulder revision arthroplasty of prior unipolar shoulder arthroplasty to include cancellous or structural bone graft including all other technical variations or additions (regions required) | 400 | 10+T |
| MASG | 93.83F | Total shoulder revision arthroplasty of prior shoulder arthroplasty to include cancellous or structural bone graft including all other technical variations or additions (regions required) | 425 | 10+T |

**ARTHROPLASTY OF ELBOW WITH SYNTHETIC PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 93.84 | Arthroplasty of elbow with synthetic prosthesis (regions required) | 315 | 6+T |

**OTHER REPAIR OF ELBOW**

| | | | | |
|---|---|---|---|---|
| MASG | 93.85A | Revision of total elbow replacement including decompression of ulnar nerve (Regions required) | 396 | 6+T |
| MASG | 93.85B | Arthroplasty - elbow (regions required) | 190 | 4+T |
| MASG | 93.85C | Flexorplasty of elbow (regions required) | 150 | 4+T |
| MASG | 93.85D | Reconstruction elbow - late (regions required) | 100 | 4+T |

**OTHER REPAIR OF WRIST**

| | | | | |
|---|---|---|---|---|
| MASG | 93.87A | Reconstruction - wrist - late (regions required) | 100 | 4+T |

**INCISION OF TENDON SHEATH OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.01A | Acute tenosynovitis of finger - drainage (regions required) - plus multiples, if applicable | 75 | 4+T |
| MASG | 94.01B | Incision of tendon sheath - simple ganglion or Dequervain's (Regions required) | 60 | 4+T |
| MASG | 94.01C | Exploration - tendon or tendon sheath (regions required) | 58 | 4+T |

**TENOTOMY OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.11A | Incision - tendon sheath - release - finger (regions required) - plus multiples, if applicable | 58 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 94.11B | Tenotomy - including lengthening or section of tendon of hand (Regions required) | 71 | 4+T |
| MASG | 94.11C | Tenotomy with capsulotomy (regions required) - plus multiples, if applicable | 95 | 4+T |

**FASCIOTOMY OF HAND FOR DIVISION**

| | | | | |
|---|---|---|---|---|
| MASG | 94.13 | Fasciotomy of hand for division AP=SUBC (regions required) | 60 | 4+T |
| MASG | 94.13B | Partial excision fascia (open) – Palmar Dupuytren's Disease PO=PART (regions required) | 100 | 4+T |
| MASG | 94.13C | Complex palmar fasciectomy for Dupuytren's Disease (regions required) | 180 | 4+T |
| ADON | 94.13D | Release of each additional digit including proximal interphalangeal joint release (Add on to complex palmar fasciectomy) - plus multiples, if applicable | 70 | |
| MASG | 94.13E | Release of a single digit including the interphalangeal joint(s) for Dupuytren's disease (regions required) | 120 | 4+T |

**EXCISION OF LESION OF TENDON (SHEATH) OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.21A | Excision of tendon sheath - simple ganglion or Dequervain's (Regions required) | 60 | 4+T |
| MASG | 94.21D | Biopsy through incision, tendon sheath (regions required) | 75 | 4+T |

**OTHER EXCISION OF TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.32 | Other excision of tendon of hand (regions required) | 100 | 4+T |
| | | ME=RADI (regions required) | 150 | 4+T |
| MASG | 94.32A | Excision of tendon of finger (regions required) - plus multiples, if applicable | 100 | 4+T |

**EXCISION OF BURSA OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.36 | Excision of bursa of hand (regions required) | 150 | 4+T |

**OTHER TRANSFER OR TRANSPLANTATION OF TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.55A | Hand and forearm - opponens transfer (regions required) | 125 | 4+T |
| MASG | 94.55B | Tendon transplant - hand and forearm - single (regions required) | 100 | 4+T |
| MASG | 94.55C | Tendon transplant - hand and forearm - multiple (regions required) | 175 | 4+T |

**OTHER CHANGE IN LENGTH OF MUSCLE, TENDON, AND FASCIA OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.82 | Other change in length of muscle, tendon, and fascia of hand ME=SIMP (regions required) | 100 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 94.82A | Tenotomy, including lengthening or section of tendon of hand (Regions required) | 71 | 4+T |

**REPAIR OF MALLET FINGER**

| | | | | |
|---|---|---|---|---|
| MASG | 94.85 | Repair of mallet finger (regions required) - plus multiples, if applicable | | |
| | | AP=OPEN | 72 | 4+T |
| MISG | 94.85 | Repair of mallet finger | | |
| | | AP=CLSD | 25 | 4+T |

**INCISION OF TENDON SHEATH**

| | | | | |
|---|---|---|---|---|
| MASG | 95.01 | Incision of tendon sheath | 75 | 4+T |
| MASG | 95.01A | Incision of tendon sheath - simple ganglion | 60 | 4+T |
| MASG | 95.01B | Exploration - tendon or tendon sheath | 58 | 4+T |

**MYOTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 95.02A | Incision - muscle - intramuscular abscess | 25 | 4+T |
| MISG | 95.02B | Incision - muscle - removal of foreign body | | |
| | | AN=GENL, ME=COMP | 50 | IC+T |
| | | AN=GENL, ME=SIMP | 25 | 4+T |
| | | ME=COMP | 50 | IC+T |
| | | ME=SIMP | 25 | 4+T |

**BURSOTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 95.03 | Bursotomy | 25 | 4+T |
| MASG | 95.03A | Removal of subtrochanteric calcium (regions required) | 125 | 4+T |
| MASG | 95.03B | Removal of subdeltoid calcium (regions required) | 100 | 4+T |
| MASG | 95.03C | Ulnar or radial bursa - drainage (regions required) | 60 | 4+T |

**OTHER TENOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 95.13A | Tenotomy for congenital torticollis | 70 | 5+T |
| MASG | 95.13B | Incision - tendon sheath - release - wrist (regions required) | 60 | 4+T |
| MASG | 95.13C | Tenotomy, including lengthening or section of tendon | 71 | 4+T |
| MASG | 95.13E | Hip adductors - open (regions required) | 75 | 4+T |
| MISG | 95.13F | Hip adductors - closed (regions required) | 25 | 4+T |
| MASG | 95.13G | Hip adductors - with peripheral obturator neurectomy (regions required) | 100 | 4+T |

| | | | | |
|---|---|---|---|---|
| MISG | 95.13H | Tenotomy - toe (regions required) - plus multiples, if applicable | 25 | 4+T |
| MASG | 95.13I | Incision muscle - myotomy for tennis elbow (regions required) | 95 | 4+T |
| MASG | 95.13J | Tenotomy with capsulotomy of the foot (regions required) - plus multiples, if applicable | 95 | 4+T |

**MYOTOMY FOR DIVISION**

| | | | | |
|---|---|---|---|---|
| MASG | 95.14A | Psoas muscle release | 75 | 4+T |
| MASG | 95.14B | Scalenus anticus, without resection of cervical or first rib | 100 | 5+T |
| MASG | 95.14C | Scalenus anticus, with resection of cervical or first rib | 200 | 5+T |
| MASG | 95.14D | Incision - muscles - sternomastoid - unipolar | 70 | 5+T |
| MASG | 95.14E | Incision - muscles - sternomastoid - bipolar | 75 | 5+T |
| MASG | 95.14F | Major muscle release | 100 | 5+T |

**FASCIOTOMY FOR DIVISION**

| | | | | |
|---|---|---|---|---|
| MASG | 95.15 | Fasciotomy for division AP=SUBC | 60 | 4+T |
| MASG | 95.15A | Plantar fasciotomy at multiple levels (regions required) | 75 | 4+T |
| MASG | 95.15B | Plantar fasciectomy – open (regions required) | 100 | 4+T |
| MASG | 95.15C | Removal of calcaneal spur and plantar fasciotomy (regions required) | 100 | 4+T |
| MASG | 95.15D | Fasciotomy for compartment syndrome | 100 | 4+T |
| MISG | 95.15E | Incision – plantar fascia (regions required) | 35 | 4+T |
| ADON | 95.15F | Plantar fasciotomy with other procedure, add to procedure (regions required) | 25 | |

**EXCISION OF LESION OF TENDON (SHEATH)**

| | | | | |
|---|---|---|---|---|
| MASG | 95.21A | Excision of tendon sheath – simple ganglion | 60 | 4+T |
| MASG | 95.21B | Biopsy through incision – tendon sheath | 75 | 4+T |

**EXCISION OF LESION OF MUSCLE**

| | | | | |
|---|---|---|---|---|
| MAAS | 95.22A | Excision - tumour, etc. | IC | IC+T |
| MISG | 95.22B | Biopsy of muscle | 25 | 4+T |

**EXCISION OF LESION OF OTHER SOFT TISSUE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.29A | Excision of Baker's cyst of knee (regions required) | 100 | 4+T |
| MASG | 95.29C | Resection of subfascial benign lesion over 5 cm. in size excluding lipoma | 100 | 4+T |

**OTHER EXCISION OF TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.32A | Excision - tendon sheath | | |
| | | ME=RADI | 150 | 4+T |

**OTHER EXCISION OF FASCIA**

| | | | | |
|---|---|---|---|---|
| MASG | 95.35A | Fasciotomy, single, of sole (regions required) | | |
| | | AP=SUBC | 60 | 4+T |

**OTHER EXCISION OF OTHER SOFT TISSUE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.39A | Resection of malignant soft tissue sarcoma over 5 cm. in diameter | 250 | 8+T |

**EXCISION OF BURSA**

| | | | | |
|---|---|---|---|---|
| MASG | 95.4A | Excision - bursa - olecranon or prepatellar (regions required) | 71 | 4+T |
| MASG | 95.4B | Excision - bursa - forearm (regions required) | 150 | 4+T |
| MASG | 95.4C | Excision - bursa - ischial or subtrochanteric (regions required) | 125 | 4+T |

**REPAIR OF MUSCULOTENDINOUS CUFF**

| | | | | |
|---|---|---|---|---|
| MASG | 95.53A | Reconstruction - rotator cuff repair (regions required) | | |
| | | ME=CMST | 190 | 4+T |
| | | ME=SIMP | 100 | 4+T |

**OTHER SUTURE OF TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.54E | Tendon transplant - Achilles or biceps repair (regions required) | 100 | 4+T |

**OTHER SUTURE OF MUSCLE**

| | | | | |
|---|---|---|---|---|
| MAAS | 95.55A | Repair of muscle laceration or rupture | IC | IC+T |

**OTHER TRANSFER OR TRANSPLANTATION OF TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.65A | Tendon transplant - knee - single or multiple (regions required) | 150 | 4+T |
| MASG | 95.65C | Tendon transplant - foot and ankle - single (regions required) | 100 | 4+T |
| MASG | 95.65D | Tendon transplant - hip - iliopsoas (regions required) | 250 | 5+T |
| MASG | 95.65E | Tendon transplant - foot and ankle - multiple (regions required) | 175 | 4+T |

**OTHER TRANSFER OR TRANSPLANTATION OF MUSCLE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.66 | Other transfer or transplantation of muscle | 200 | 6+T |

**PLASTIC OPERATION WITH GRAFT OF TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.72A | Fascial repair or tendon graft for rupture | 150 | 4+T |

**RELEASE OF CLUBFOOT NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 95.75A | Congenital foot deformity - operative - arthrodesis and tendon transfer (Regions required) | 250 | 4+T |
| MASG | 95.75B | Composite club foot reconstruction - Turco Procedure (regions required) | 250 | 4+T |
| MASG | 95.75C | Congenital foot deformity - operative - medial release and tendon lengthening. (Regions required) | 150 | 4+T |

**OTHER CHANGE IN LENGTH OF MUSCLE, TENDON, AND FASCIA**

| | | | | |
|---|---|---|---|---|
| MASG | 95.76A | Recession of muscle | 100 | 4+T |
| MASG | 95.76B | Ober or Yount and spica, skeletal pins, etc. | 150 | 4+T |
| MASG | 95.76C | Tenotomy, including heel cord lengthening and lengthening or section of tendon of hand or foot<br>AP=PERC (regions required) | 71 | 4+T |
| MASG | 95.76D | Tenoplasty - shortening, lengthening of any tendon any location<br>(Regions required) - plus multiples, if applicable | 95 | 4+T |
| MASG | 95.76E | Fasciotomy and fasciectomy simple lengthening | 100 | 4+T |

**OTHER PLASTIC OPERATIONS ON TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.77B | Tendon transplant - foot - tenodesis (regions required) | 100 | 4+T |

**OTHER PLASTIC OPERATIONS ON MUSCLE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.78A | Quadricepsplasty (regions required) | 150 | 6+T |
| MASG | 95.78B | Tendon transplant - shoulder - pectoralis minor included in composite rotator cuff repair (regions required) | 100 | 4+T |
| MASG | 95.78C | Tendon transplant - shoulder - trapezius (regions required) | 175 | 4+T |
| MASG | 95.78D | Tendon transplant - hip - abdomen (regions required) | 200 | 5+T |
| MASG | 95.78E | Tendon transplant - quadriceps, muscle or tendon (regions required) | 125 | 4+T |

**AMPUTATION AND DISARTICULATION OF FINGER(S), EXCEPT THUMB**

| | | | | |
|---|---|---|---|---|
| MAAS | 96.01 | Amputation and disarticulation of finger(s), except thumb (regions required)<br>ME=COMP | IC | 4+T |
| MISG | 96.01 | Amputation and disarticulation of finger(s), except thumb (regions required) - plus multiples, if applicable<br>ME=SIMP | 30 | 4+T |

**AMPUTATION AND DISARTICULATION OF THUMB**

| | | | | |
|---|---|---|---|---|
| MAAS | 96.02 | Amputation and disarticulation of thumb (regions required)<br>ME=COMP | IC | 4+T |
| MISG | 96.02 | Amputation and disarticulation of thumb<br>ME=SIMP | 30 | 4+T |

**AMPUTATION THROUGH HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 96.03 | Amputation through hand (regions required) | 100 | 4+T |

**DISARTICULATION OF WRIST**

| | | | | |
|---|---|---|---|---|
| MASG | 96.04 | Disarticulation of wrist (regions required) | 100 | 4+T |

**AMPUTATION THROUGH FOREARM**

| | | | | |
|---|---|---|---|---|
| MASG | 96.05 | Amputation through forearm (regions required) | 125 | 4+T |

**DISARTICULATION OF ELBOW OR AMPUTATION THROUGH HUMERUS**

| | | | | |
|---|---|---|---|---|
| MASG | 96.06 | Disarticulation of elbow or amputation through humerus (regions required) | 125 | 4+T |
| MASG | 96.06A | Amputation of humerus (regions required) | 125 | 4+T |

**DISARTICULATION OF SHOULDER**

| | | | | |
|---|---|---|---|---|
| MASG | 96.07 | Disarticulation of shoulder (regions required) | 175 | 9+T |

**INTERTHORACOSCAPULAR AMPUTATION**

| | | | | |
|---|---|---|---|---|
| MASG | 96.08 | Interthoracoscapular amputation | 275 | 15+T |

**AMPUTATION AND DISARTICULATION OF TOE(S)**

| | | | | |
|---|---|---|---|---|
| MAAS | 96.11A | Amputations - lower extremity - metatarsal or metatarsophalangeal joint<br>ME=COMP (regions required) | IC | 4+T |
| MASG | 96.11A | Amputations - lower extremity - metatarsal or metatarsophalangeal joint<br>(Regions required) | 75 | 4+T |
| MISG | 96.11B | Amputations - lower extremity - phalanx (regions required) | 30 | 4+T |

**AMPUTATION AND DISARTICULATION OF FOOT**

| | | | | |
|---|---|---|---|---|
| MASG | 96.12 | Amputation and disarticulation of foot (regions required) | 150 | 5+T |
| MASG | 96.12A | Amputations - lower extremity - transmetatarsal (regions required)<br>- plus multiples, if applicable | 125 | 4+T |

**AMPUTATION AND DISARTICULATION OF ANKLE**

| | | | | |
|---|---|---|---|---|
| MASG | 96.13 | Amputation and disarticulation of ankle (regions required) | 150 | 5+T |

**AMPUTATION OF LOWER LEG**

| | | | | |
|---|---|---|---|---|
| MASG | 96.14 | Amputation of lower leg (regions required) | 145 | 5+T |

**AMPUTATION OF THIGH AND DISARTICULATION OF KNEE**

| | | | | |
|---|---|---|---|---|
| MASG | 96.15 | Amputation of thigh and disarticulation of knee (regions required) | 145 | 5+T |
| MASG | 96.15A | Amputations - lower extremity - knee, including Gritti-Stokes or Callander (Regions required) | 125 | 5+T |

**DISARTICULATION OF HIP**

| | | | | |
|---|---|---|---|---|
| MASG | 96.16 | Disarticulation of hip (regions required) | 250 | 10+ |

**ABDOMINOPELVIC AMPUTATION**

| | | | | |
|---|---|---|---|---|
| MASG | 96.17 | Abdominopelvic amputation | 350 | 15+T |

**OTHER REATTACHMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 96.39A | Debridement and plastic repair of traumatically amputated extremities (Regions required) | IC | IC+T |

**OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 96.99A | Open biopsy of musculoskeletal neoplasm | 100 | 4+T |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

# OTOLARYNGOLOGY

(SP=OTOL)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 35.1 | |
| | | RF=REFD, US=PREM (ME=TELE) | 53.1 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 53.1 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 35.1 | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 53.1 | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 53.1 | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 24.5 | |
| | | RF=REFD, US=PREM (ME=TELE) | 42.5 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 42.5 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 24.5+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 42.5+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 42.5+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 22.5 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 40.5 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 40.5 | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 22.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 40.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 40.5+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit Not Requiring a Complete Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (RF=REFD) | 13 | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (RF=REFD) | 16.5 | |
| VIST | 03.03 | Continuing Care | | |
| | | LO=OFFC, RO=CNTC, RF=REFD | 13.5 | |
| | | LO=OFFC, AG=OV65, RO=CNTC, RF=REFD | 16.5 | |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Directive Care | |
| | | LO=OFFC, RO=DIRC, RF=REFD | 13.5 |
| | | LO=OFFC, AG=OV65, RO=DIRC, RF=REFD | 16.5 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000) | |
| | | LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359) | |
| | | LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800) | |
| | | LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient | |
| | | LO=OFFC, PT=EXPT (RF=REFD) | 10.5 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | | |
|---|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) | 24 |
| | | LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) | 24+MU |
| VIST | 03.04 | Initial Visit | |
| | | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | 25 |
| | | LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) | 25+MU |
| VIST | 03.03 | Continuing Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD | 15+MU |
| VIST | 03.03 | Directive Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD | 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week | |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |
| ADON | 03.02A | Hospital Discharge Fee | |
| | | LO=HOSP, FN=INPT | 10 |

| | | |
|---|---|---|
| VIST | 03.03 | Urgent Hospital Visit<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Hospital Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 – 2000) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU |

| | | | | |
|---|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient | | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) | 11.4 | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) | 11.4+MU | |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays | | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) | 10.5 | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays | | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) | 10.5 | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 10.5+MU | |

## PROCEDURES

**DIRECT LARYNGOSCOPY**

| | | | | |
|---|---|---|---|---|
| MASG | 01.03A | Endoscopy with removal of benign growth - larynx | 90 | 6+T |
| MASG | 01.03B | Endoscopy with removal of foreign body - larynx | 75 | 6+T |

**PHARYNGOSCOPY**

| | | | | |
|---|---|---|---|---|
| MISG | 01.05 | Pharyngoscopy | 25 | 4+T |

**OTHER NONOPERATIVE ENDOSCOPY NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 01.39A | Maxillary sinusoscopy | 50 | 4+T |

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC**

| | | | | |
|---|---|---|---|---|
| VADT | 03.19F | Level II Sleep Apnea Testing Interpretation | 35 | |
| VADT | 03.19G | Level III Sleep Apnea Testing Interpretation | 25 | |

**OTHER RADIOTHERAPEUTIC PROCEDURE**

| | | | | |
|---|---|---|---|---|
| MISG | 06.39C | Radium application to nasopharynx | 10 | 5+T |

**OTHER INTUBATION OF RESPIRATORY TRACT**

| | | | | |
|---|---|---|---|---|
| MISG | 10.05A | Intubation of larynx | 25 | |

**IRRIGATION OF EAR**

| | | | | |
|---|---|---|---|---|
| MISG | 10.62 | Irrigation of ear | | |
| | | AN=GENL (regions required) | 27 | 4+T |

**REMOVAL OF INTRALUMINAL FOREIGN BODY FROM NOSE WITHOUT INCISION**

| | | | | |
|---|---|---|---|---|
| MISG | 12.01 | Removal of intraluminal foreign body from nose without incision | | |
| | | AN=GENL, ME=COMP | 35 | 4+T |
| | | ME=SIMP | 20 | |

**REMOVAL OF INTRALUMINAL FOREIGN BODY FROM EAR WITHOUT INCISION**

| | | | | |
|---|---|---|---|---|
| MISG | 12.21 | Removal of intraluminal foreign body from ear without incision | | |
| | | AN=GENL, ME=COMP (regions required) | 30 | 4+T |
| | | ME=SIMP (regions required) | 15 | |

**OTHER REPAIR OF CEREBRAL MENINGES**

| | | | | |
|---|---|---|---|---|
| MASG | 15.12A | Rhinoplasty - rhinorrhoea - CSF leak | 300 | 7+T |

**OTHER EXCISION OR AVULSION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.08A | Retro-labyrinthine vestibular neurectomy | | |
| | | SP=NUSG (regions required) | 375 | 14+T |
| | | SP=OTOL (regions required) | 375 | 14+T |

**OTHER CRANIAL NERVE DECOMPRESSION**

| | | | | |
|---|---|---|---|---|
| MASG | 17.32A | Repair - facial nerve decompression | 350 | 6+T |
| MASG | 17.32B | Repair facial nerve decompression with graft | 300 | 6+T |

**EXCISION OF THYROGLOSSAL DUCT OR TRACT**

| | | | | |
|---|---|---|---|---|
| MASG | 19.6 | Excision of thyroglossal duct or tract | 120 | 4+T |
| MASG | 19.6A | Excision of thyroglossal duct - cyst and sinus | 200 | 5+T |

**TOTAL EXCISION OF PITUITARY GLAND, TRANSSPHENOIDAL APPROACH**

| | | | | |
|---|---|---|---|---|
| MASG | 20.55A | Transphenoidal hypophysectomy | 400 | 15+T |

**EXCISION OF PREAURICULAR SINUS/CYST**

| | | | | |
|---|---|---|---|---|
| MASG | 30.11 | Excision of preauricular sinus/cyst | 100 | 4+T |
| MASG | 30.11A | Excision of perilymph fistula | 200 | 4+T |

**EXCISION OR DESTRUCTION OF OTHER LESION OF EXTERNAL EAR**

| | | | | |
|---|---|---|---|---|
| MISG | 30.19A | Excision of polyp of external ear (regions required) | 25 | 4+T |
| | | AN=GENL | 30 | 4+T |
| | | AN=LOCL | 25 | |
| MASG | 30.19B | Partial excision of ear (regions required) | 75 | 4+T |
| MASG | 30.19C | Removal of ear canal exostosis - single (regions required) | 150 | 5+T |
| MASG | 30.19D | Removal of ear canal exostosis with skin graft (regions required) | 300 | 5+T |
| MASG | 30.19E | Removal of ear canal exostosis - multiple (regions required) | 225 | 5+T |

**AMPUTATION OF EXTERNAL EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 30.22 | Amputation of external ear (regions required) | 125 | 5+T |

**SURGICAL CORRECTION OF PROMINENT EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 30.4 | Surgical correction of prominent ear - congenital deformity | 96 | 5+T |

**RECONSTRUCTION OF EXTERNAL AUDITORY CANAL**

| | | | | |
|---|---|---|---|---|
| MASG | 30.5A | Repair congenital atresia of canal (including necessary mastoid surgery) (Regions required) | 330 | 5+T |
| MASG | 30.5B | Meatoplasty for external auditory canal stenosis (regions required) | 100 | 4+T |

**CONSTRUCTION OF AURICLE OF EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 30.61A | External ear otoplasty, exclusive of simple lacerations - prior approval | | |
| | | ME=MAJO (regions required) | 125 | 5+T |
| MISG | 30.61A | External ear otoplasty, exclusive of simple lacerations - prior approval | | |
| | | ME=MINO (regions required) | 50 | 5+T |
| MASG | 30.61B | Total reconstruction of ear (pinna) (regions required) - prior approval | 125 | 5+T |

**STAPES MOBILIZATION**

| | | | | |
|---|---|---|---|---|
| MASG | 31.0A | Middle ear stapes mobilization (regions required) | 200 | 6+T |

**STAPEDECTOMY WITH INCUS REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 31.11 | Stapedectomy with incus replacement (regions required) | 375 | 6+T |

**OTHER OPERATIONS ON OSSICULAR CHAIN**

| | | | | |
|---|---|---|---|---|
| MASG | 31.3A | Ossiculoplasty without tympanic repair (regions required) | 250 | 6+T |

**MYRINGOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 31.4 | Myringoplasty (regions required) | 135 | 4+T |
| MISG | 31.4A | Cauterization of perforated ear drum (regions required) | 15 | 4+T |
| | | AN=GENL (regions required) | 20 | 4+T |
| | | AN=LOCL (regions required) | 15 | |
| MASG | 31.4B | Tympanoplasty (type one) with graft only (regions required) | 250 | 6+T |

**TYPE II TYMPANOPLASTY**

| | | | | |
|---|---|---|---|---|
| MISG | 31.51A | Other tympanoplasty applying plastic plate for perforated ear drum (Regions required) | 10 | 4+T |

**TYPE V TYMPANOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 31.54A | Tympanoplasty with graft and canaloplasty (regions required) | 300 | 6+T |

**OTHER TYMPANOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 31.59A | Tympanoplasty and ossiculoplasty with/without canaloplasty (Regions required) | 350 | 6+T |

**OTHER REPAIR OF MIDDLE EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 31.9A | Repair mastoid fistula, closure (regions required) | 125 | 4+T |

**MYRINGOTOMY WITH INSERTION OF TUBE**

| | | | | |
|---|---|---|---|---|
| MISG | 32.01 | Myringotomy with insertion of tube (regions required) | 48 | 4+T |

**OTHER MYRINGOTOMY**

| | | | | |
|---|---|---|---|---|
| COCR | 32.09A | Middle ear myringotomy (regions required)<br>AN=GENL | 30 | 4+T |
| MISG | 32.09A | Middle ear myringotomy (regions required)<br>AN=LOCL | 20 | |
| MASG | 32.09B | Tympanotomy with insertion of plastic or silastic sheeting<br>(Regions required) | 200 | 6+T |
| MISG | 32.09C | Tympanocentesis (regions required) | 18 | |
| MISG | 32.09D | Aspiration for serous otitis (regions required) | 10 | 4+T |
| MISG | 32.09E | Microscopic aspiration of ears (regions required) | 10 | 4+T |

**REMOVAL OF TYMPANOSTOMY TUBE**

| | | | | |
|---|---|---|---|---|
| MISG | 32.1 | Removal of tympanostomy tube (regions required)<br>AN=GENL, LO=HOSP | 20 | 4+T |
| | | LO=OFFC | 5 | |

**INCISION OF MIDDLE EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 32.23A | Repair - exploration middle ear (regions required) | 100 | 4+T |

**SIMPLE MASTOIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 32.31 | Simple mastoidectomy (regions required) | 125 | 4+T |

**RADICAL MASTOIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 32.32 | Radical mastoidectomy (regions required) | 224.8 | 4+T |

**OTHER MASTOIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 32.39A | Cleaning mastoid cavity (regions required) | 13.5 | |

**EXCISION OF LESION OF MIDDLE EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 32.41A | Intratympanic microscopic excision of aural lesion (regions required) | 90 | 4+T |

**FENESTRATION OF INNER EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 32.5 | Fenestration of inner ear (regions required) | 300 | 6+T |

**ENDOLYMPHATIC SHUNT**

| | | | | |
|---|---|---|---|---|
| MASG | 32.71 | Endolymphatic shunt (regions required) | 350 | 7+T |
| MASG | 32.71A | Placement of Silverstein ventilating tube (regions required) | 150 | 4+T |
| MASG | 32.71B | Endolymphatic sac decompression or shunting (regions required) | 350 | 6+T |

**OTHER INCISION, EXCISION, AND DESTRUCTION OF INNER EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 32.79A | Trans-mastoid labyrinthectomy (regions required) | 300 | 6+T |
| MASG | 32.79C | Total labyrinthectomy, trans-canal (regions required) | 250 | 6+T |
| MASG | 32.79D | Endolymphatic decompression inner ear (regions required) | 350 | 6+T |

**IMPLANTATION OF ELECTRO-MAGNETIC HEARING AID**

| | | | | |
|---|---|---|---|---|
| MASG | 32.95B | Cochlear implant - to include mastoidectomy and facial nerve decompression (Regions required) | 400 | 6+T |
| MASG | 32.95C | Insertion of Bone-Anchored Hearing Aid (BAHA) single stage (Regions required) | 225 | 6+T |
| MASG | 32.95D | Insertion of Bone-Anchored Hearing Aid (BAHA) two-stage: implantation of fixture (regions required) | 225 | 6+T |
| MISG | 32.95E | Insertion of Bone-Anchored Hearing Aid (BAHA) two-stage: loading of abutment (regions required) | 50 | 4+T |

**OTHER OPERATIONS ON MIDDLE AND INNER EAR**

| | | | | |
|---|---|---|---|---|
| MAAS | 32.96A | Excision of glomus jugular tumour | IC | 6+T |

**CONTROL OF EPISTAXIS BY ANTERIOR NASAL PACKING**

| | | | | |
|---|---|---|---|---|
| MISG | 33.01 | Control of epistaxis by anterior nasal packing | 20 | |

**CONTROL OF EPISTAXIS BY POSTERIOR (AND ANTERIOR) PACKING**

| | | | | |
|---|---|---|---|---|
| MISG | 33.02A | Treatment of epistaxis posterior packing | 30 | 4+T |

**CONTROL OF EPISTAXIS BY LIGATION OF ETHMOIDAL ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 33.04 | Control of epistaxis by ligation of ethmoidal arteries | 51 | 4+T |

**CONTROL OF EPISTAXIS BY (TRANSANTRAL) LIGATION OF THE MAXILLARY ARTERY**

| | | | | |
|---|---|---|---|---|
| MASG | 33.05 | Control of epistaxis by (transantral) ligation of the maxillary artery | 225 | 7+T |

**INCISION OF NOSE**

| | | | | |
|---|---|---|---|---|
| COCR | 33.1A | Drainage of abscess or hematoma of septum | 25 | 4+T |

**EXCISION OF LESION OF NOSE, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 33.21A | Excision of choanal atresia - bony | 200 | 6+T |
| MASG | 33.21B | Excision of choanal atresia - membranous | 200 | 6+T |

**LOCAL EXCISION OR DESTRUCTION OF INTRANASAL LESION**

| | | | | |
|---|---|---|---|---|
| MISG | 33.22A | Excision of nasal polyp (regions required) | 25 | 4+T |
| MISG | 33.22B | Excision of single choanal polyp | 40 | 4+T |

| | | | | |
|---|---|---|---|---|
| MISG | 33.22C | Biopsy of nasal septum | 15 | |
| | | AN=GENL | 30 | 4+T |
| | | AN=LOCL | 15 | |

**SUBMUCOUS RESECTION OF NASAL SEPTUM**

| | | | | |
|---|---|---|---|---|
| MASG | 33.4 | Submucous resection of nasal septum | 125 | 4+T |
| MASG | 33.4A | SMR including submucous resection of inferior turbinates | 134.9 | 4+T |

**TURBINECTOMY BY DIATHERMY OR CRYOSURGERY**

| | | | | |
|---|---|---|---|---|
| MISG | 33.51 | Turbinectomy by diathermy or cryosurgery - single or bilateral | 27 | 4+T |
| | | AN=GENL | 40.5 | 4+T |
| | | AN=LOCL | 27 | |

**OTHER TURBINECTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 33.59A | Submucous resection of turbinates (regions required) | 50 | 4+T |

**RHINOPLASTY WITH BONE OR CARTILAGE GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 33.74 | Rhinoplasty with bone or cartilage graft - prior approval | | |
| | | PO=COML | 192 | 7+T |
| | | PO=PART | 75 | 7+T |

**OTHER RHINOPLASTY OR SEPTOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 33.76A | Septal reconstruction | 150 | 4+T |
| MASG | 33.76B | Complete rhinoplasty with submucous resection without skin grafting - prior approval | 254 | 7+T |
| MISG | 33.76C | Insertion of nasal septal button | 30 | 4+T |

**FREEING OF ADHESIONS OF NOSE**

| | | | | |
|---|---|---|---|---|
| MISG | 33.91A | Repair - lysis of synechiae of nose with insertion of plastic stent | 50 | 4+T |

**OTHER OPERATIONS ON NOSE NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 33.99A | Repair - choanal atresia - dilation | 25 | 4+T |
| | | RP=REPT | 10 | 6+T |

**PUNCTURE OF NASAL SINUS**

| | | | | |
|---|---|---|---|---|
| MISG | 34.0 | Puncture of nasal sinus (regions required) | | |
| | | LO=HOSP | 37.8 | 4+T |
| | | LO=OFFC | 35 | |
| MISG | 34.0A | Lavage-maxillary sinus antrum (regions required) | 10 | 4+T |
| MISG | 34.0C | Proetz displacement lavage | 5 | 4+T |

**INTRANASAL ANTROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.1A | Removal accessory maxillary, intranasal sinus (regions required) | 75 | 4+T |

**RADICAL MAXILLARY ANTROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.21 | Radical maxillary antrotomy (regions required) | 134.9 | 4+T |

**FRONTAL SINUSECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.31 | Frontal sinusectomy (regions required) | 75 | 4+T |

**FRONTAL SINUSECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.32 | Frontal sinusectomy, radical (regions required) | 250 | 6+T |

**ETHMOIDOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.42 | Ethmoidotomy (regions required) | 69.2 | 4+T |
| MASG | 34.42A | Ethmoidotomy and widening middle meatus with or without maxillary sinusoscopy (regions required) | 75 | 4+T |

**SPHENOIDOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.43A | Sphenoidostomy with sinusoscopy control | 75 | 4+T |

**ETHMOIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.54A | Removal of external fronto-ethmoidal with sphenoid if necessary (Regions required) | 250 | 6+T |
| MASG | 34.54B | Intranasal anterior & posterior ethmoidectomy traversing the ground lamella (Regions required) | 100 | 4+T |

**SPHENOIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 34.55 | Sphenoidectomy (regions required) | 102 | 4+T |

**CLOSURE OF SINUS FISTULA (OROANTRAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 34.61 | Closure of sinus fistula (oroantral) | 150 | 4+T |

**OTHER REPAIR AND PLASTIC OPERATIONS ON SALIVARY GLAND**

| | | | | |
|---|---|---|---|---|
| MASG | 38.39C | Resection of salivary gland malignancy with lymphadectomy<br>*Physician Restrictions in place (See Appendix J) | 640 | 10+T |

**INCISION AND DRAINAGE OF TONSIL AND PERITONSILLAR STRUCTURES**

| | | | | |
|---|---|---|---|---|
| MISG | 40.0 | Incision and drainage of tonsil and peritonsillar structures | 5 | |
| | | AN=GENL | 30 | 4+T |
| | | AN=LOCL | 30 | |
| COCR | 40.0A | Drainage of retropharyngeal abscess - intraoral | 30 | 4+T |
| MASG | 40.0B | Drainage of lateral pharyngeal abscess | 75 | 4+T |

**TONSILLECTOMY WITH ADENOIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 40.2A | Tonsillectomy only or tonsillectomy and adenoidectomy hospital location only | | |
| | | AG=ADUT, AN=GENL | 95 | 4+T |
| | | AG=ADUT, AN=LOCL | 95 | |
| | | AG=CH16 | 95 | 4+T |

**ADENOIDECTOMY WITHOUT TONSILLECTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 40.5 | Adenoidectomy without tonsillectomy | 28.8 | 4+T |

**CONTROL OF HEMORRHAGE AFTER TONSILLECTOMY AND ADENOIDECTOMY - SAME SURGEON**

| | | | | |
|---|---|---|---|---|
| MISG | 40.7 | Control of hemorrhage after tonsillectomy and adenoidectomy – same surgeon | 30 | 4+T |
| MASG | 40.7A | Post-operative hemorrhage tonsillectomy - adenoidectomy referred consult and procedure | 55 | 4+T |

**PHARYNGOTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 41.0A | Removal foreign body of pharynx | 35 | 4+T |

**OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PHARYNX**

| | | | | |
|---|---|---|---|---|
| MASG | 41.2 | Excision or destruction of lesion or tissue of nasopharynx | 200 | 4+T |
| MISG | 41.2A | Biopsy of pharynx | 35 | 4+T |

**PLASTIC OPERATION ON PHARYNX**

| | | | | |
|---|---|---|---|---|
| MASG | 41.3A | Palatopharyngouvuloplasty | 200 | 5+T |

**CLOSURE OF BRANCHIAL CLEFT FISTULA**

| | | | | |
|---|---|---|---|---|
| MASG | 41.42A | Excision branchial cyst | 150 | 4+T |
| MASG | 41.42B | Excision branchial sinus | 150 | 5+T |

**OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF LARYNX**

| | | | | |
|---|---|---|---|---|
| MASG | 42.09 | Other excision or destruction of lesion or tissue of larynx | 89.9 | 6+T |

**HEMILARYNGECTOMY (ANTERIOR) (LATERAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 42.1 | Hemilaryngectomy (anterior) (lateral) | 325 | 9+T |

**OTHER PARTIAL LARYNGECTOMY NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 42.29 | Other partial laryngectomy NEC | 400 | 8+T |
| MASG | 42.29A | Supra glottic laryngectomy | 350 | 10+T |
| MASG | 42.29B | Excision of laryngofissure | 200 | 6+T |
| MASG | 42.29C | Arytenoidectomy | 200 | 6+T |

**COMPLETE LARYNGECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 42.3 | Complete laryngectomy | 269.7 | 8+T |
| MASG | 42.3A | Excision by laryngofissure - with block dissection | 400 | 6+T |
| MASG | 42.3B | Pharyngolaryngectomy | 343 | 8+T |

**INJECTION OF LARYNX**

| | | | | |
|---|---|---|---|---|
| MAAS | 43.0A | Teflon injection vocal cord | IC | 6+T |

**TEMPORARY TRACHEOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 43.1 | Temporary tracheostomy | 100 | 6+T |
| MASG | 43.1A | Placement of Montgomery T-tube | 100 | 6+T |

**OTHER REPAIR OF LARYNX**

| | | | | |
|---|---|---|---|---|
| MAAS | 43.59A | Laryngoplasty | IC | 6+T |
| MASG | 43.59B | Arytenoidopexy | 200 | 6+T |

**RADICAL NECK DISSECTION, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 52.31A | Resection of upper aerodigestive tract malignancy with lymphadectomy<br>*Physician Restrictions in Place (See Appendix J) | 800 | 10+T |

**INJECTION OR LIGATION OF ESOPHAGEAL VARICES**

| | | | | |
|---|---|---|---|---|
| MASG | 54.91A | Esophageal varices with esophagoscopy | 90 | 4+T |

**OTHER PARTIAL OSTECTOMY - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.79A | Excision elongated styloid process via tonsillar fossa | 80 | 4+T |
| MASG | 89.79B | Excision elongated styloid process via neck exploration (external) | 150 | 4+T |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

# PAEDIATRICS

(Includes SP=PEDI, HUGE, MEGE, NEPE)

For further details refer to the Preamble.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation (Prolonged) | | |
| | | RF=REFD (ME=TELE) | 71+MU | |
| | | RF=REFD, US=PREM (ME=TELE) | 95.85+MU | |
| | | RF=REFD, US=PR50 (ME=TELE) | 106.5+MU | |
| | | RF=REFD, RO=DETE (ME=TELE) | 71+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 95.85+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 106.5+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 42 | |
| | | RF=REFD, US=PREM (ME=TELE) | 60 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 63 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 42+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 60+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 63+MU | |
| CONS | 03.07 | Repeat Consultation (Prolonged) | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 37.3+MU | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 55.3+MU | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 55.95+MU | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 37.3+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 55.3+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 55.95+MU | |
| **OTHER CONSULTATION** | | | | |
| CONS | 03.09A | Complex Genetic Counselling Consultation | | |
| | | RF=REFD, SP=HUGE or MEGE (ME=VTCR) | 125+MU | |
| | | (Fee to be billed once per physician per patient) | | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 53 | |
| VIST | 03.04 | Follow-up Visit with Complete Examination | | |
| | | LO=OFFC, RP=SUBS (RF=REFD) | 39 | |
| VIST | 03.04J | Comprehensive Diagnostic Evaluation of Suspected Autism Spectrum Disorder | | |
| | | LO=OFFC (restricted to IWK) | 284 | |

VIST 03.03 Initial Visit with Regional Examination
LO=OFFC, RP=INTL (RF=REFD) ..... 26.4

VIST 03.03 Subsequent Visit
LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) ..... 13
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Comprehensive Well Infant/Child Visit Using the Rourke Baby Record
LO=OFFC, CT=RKBR, RO=WBCR ..... 24

VIST 03.03 Well Baby Care
LO=OFFC, RO=WBCR (RF=REFD) ..... 8

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD ..... 15

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD ..... 15

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 53
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 53+MU

VIST 03.04 Closed Head Injury - Initial Examination and Recommendation Re Further Management
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC, RO=CLHD,
RP=INTL (RF=REFD) ..... 30
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC, RO=CHDT,
RP=INTL (RF=REFD) ..... 30+MU

VIST 03.04J Comprehensive Diagnostic Evaluation of Suspected Autism Spectrum Disorder
LO=HOSP (restricted to IWK) ..... 284

| | | |
|---|---|---|
| VIST | 03.03 | Daily Management - Per Day<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CLHD (RF=REFD) ..... 7<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CHDT (RF=REFD)..... 7+MU |
| VIST | 03.04 | Complete Examination<br>LO=HOSP, FN=INPT (RF=REFD) ..... 53<br>LO=HOSP, FN=INPT, RO=DETE (RF=REFD) ..... 53+MU |
| VIST | 03.04 | First Examination – Newborn Care Healthy Infant<br>LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD) ..... 16 |
| VIST | 03.03 | Subsequent Care – Newborn Healthy Infant<br>LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA23 ..... 23<br>LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA45 ..... 19<br>LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD) ..... 16 |
| VIST | 03.03 | Continuing Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 16.5<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 16.5+MU |
| VIST | 03.03 | Directive Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 16.5<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 16.5+MU |
| VIST | 03.03 | Subsequent Visit - Daily<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 13<br>LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 13+MU |
| VIST | 03.03 | Supportive Care<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=SPCR (RF=REFD)..... 11.5 |
| VIST | 03.03W | Medical Geneticist Virtual Care Follow Up Visit – Per 15 minutes<br>LO=HOSP, ME=VTCR ..... 16.3 |
| ADON | 03.02A | Hospital Discharge Fee<br>LO=HOSP, FN=INPT ..... 10 |
| VIST | 03.03 | Urgent Hospital Visit<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 40<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 40+MU |
| VIST | 03.03 | Hospital Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Emergency Care Centre (0801 - 1200)<br>LO=HOSP, FN=EMCC, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=EMCC, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Emergency Care Centre (1201 - 1700)<br>LO=HOSP, FN=EMCC, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=EMCC, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Emergency Care Centre (1701 - 2000) | |
| | | LO=HOSP, FN=EMCC, TI=EVNT (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=EMCC, TI=EVNT, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Emergency Care Centre (0801 - 1200) Sundays and Holidays | |
| | | LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN (RF=REFD) | 15.5 |
| | | LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN, RO=DETE (RF=REFD) | 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (1201 - 1700) Sundays and Holidays | |
| | | LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV (RF=REFD) | 15.5 |
| | | LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV, RO=DETE (RF=REFD) | 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (1701 - 2000) Sundays and Holidays | |
| | | LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT (RF=REFD) | 15.5 |
| | | LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT, RO=DETE, (RF=REFD) | 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (2001 - 2359) | |
| | | LO=HOSP, FN=EMCC, TI=ETMD (RF=REFD) | 15.5 |
| | | LO=HOSP, FN=EMCC, TI=ETMD, RO=DETE (RF=REFD) | 15.5+MU |
| VIST | 03.03 | Emergency Care Centre (0000 - 0800) | |
| | | LO=HOSP, FN=EMCC, TI=MDNT (RF=REFD) | 15.5 |
| | | LO=HOSP, FN=EMCC, TI=MDNT, RO=DETE, (RF=REFD) | 15.5+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) | 13.5 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) | 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 26 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) | 20+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) | 11.4 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) | 11.4+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 10.5+MU |

**HOME**

| | | | |
|---|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=HOME (RF=REFD) | 23 |
| | | LO=HOME, RO=DETE (RF=REFD) | 23+MU |
| VIST | 03.03 | Initial Visit with Regional Examination | |
| | | LO=HOME, RP=INTL (RF=REFD) | 20 |
| | | LO=HOME, RP=INTL, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Home Visit (0800 - 1700) | |
| | | LO=HOME, PT=FTPT (RF=REFD) | 21.3 |
| | | LO=HOME, PT=FTPT, RO=DETE (RF=REFD) | 21.3+MU |
| VIST | 03.03 | Home Visit (1701 - 2000) | |
| | | LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 |
| | | LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU |
| VIST | 03.03 | Home Visit (2001 - 2359) | |
| | | LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 |
| | | LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 28.3+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Home Visit (0000 - 0800)<br>LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3<br>LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU |
| VIST | 03.03 | Home Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) ..... 28.3<br>LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU |
| VIST | 03.03 | Home Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 28.3<br>LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU |
| VIST | 03.03 | Home Visit - Extra Patient<br>LO=HOME, PT=EXPT (RF=REFD) ..... 10.5 |
| VIST | 03.03 | Home Emergency Visit<br>LO=HOME, US=UIOH (RF=REFD) ..... 35.2<br>LO=HOME, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU |
| VIST | 03.03 | Continuing Care<br>LO=HOME, RO=CNTC, RF=REFD ..... 15<br>LO=HOME, RO=CCDT, RF=REFD ..... 15+MU |
| VIST | 03.03 | Directive Care<br>LO=HOME, RO=DIRC, RF=REFD ..... 15<br>LO=HOME, RO=DRDT, RF=REFD ..... 15+MU |

**PALLIATIVE CARE**

| | | |
|---|---|---|
| CONS | 03.09C | Palliative Care Consultation ..... 62+MU<br>(Once per patient per physician) |
| CONS | 03.09H | Antenatal Palliative Care Consultation (Limited)<br>RF=REFD ..... 42<br>*Physician Restrictions in Place (See Appendix J) |
| VIST | 03.03C | Palliative Care Support Visit<br>RO=PCSV ..... 30 per 30 min<br>(15 units per 15 min. thereafter, maximum of 60 min. per patient per day) |
| VIST | 03.03H | Antenatal Palliative Care follow up visit ..... 13<br>*Physician Restrictions in Place (See Appendix J) |
| VIST | 03.03 | Palliative Care Medical Chart Review and/or Telephone Call, Fax or E-mail initiated by a health care professional - up to three telephone calls/faxes or e-mails per day per patient<br>RO=CRTC ..... 11.5<br>**Note**: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 units |

# PROCEDURES

**BEHAVIORAL THERAPY**

| | | | |
|---|---|---|---|
| PSYC | 08.43A | Behavioural Management<br>(16.7 units per 15 minutes thereafter, maximum one hour per day) | 33.4+MU per ½ hour |

**OTHER ASTHMA ASSESSMENT**

| | | | |
|---|---|---|---|
| VEDT | 03.38A | Bronchial challenge testing with methacholine or similar compounds- Includes baseline spirometry and all spirometric determinations post administration of agent(s) RO=INTP | 19 |
| VEDT | 03.38B | Exercise induced asthma assessment. Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient. | 20 |
| VEDT | 03.38C | Interpretation of spirometry pre and post bronchodilator | 10 |

**OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS**

| | | | |
|---|---|---|---|
| VEDT | 03.39T | Clinical Interpretation of complex genetics tests (e.g., microarray analysis, next generation sequencing, and exome sequencing) by geneticist – findings must be recorded in health record and recommendations made in writing to the referring physician. Per 15 minutes<br>RO=INTP, LO=OFFC, LO=HOSP | 15 |

**GENETECIST REVIEW OF PATIENT ENCOUNTER**

| | | | |
|---|---|---|---|
| VEDT | RGN1 | Review by Geneticist of Patient encounter with Genetics Counsellor<br>LO=OFFC, LO=HOSP | 30 |

# INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

These codes must be claimed from LO=HOSP

**ELECTRO DIAGNOSTICS**

| | | | |
|---|---|---|---|
| BULK | I1168 | Electrocardiogram - interpretation | 4.60 |
| BULK | I1171 | Electroencephalogram – interpretation only | 10.50 |
| BULK | I6208 | Holter monitoring – interpretation only | 25 |

**PULMONARY FUNCTIONS**

| | | | |
|---|---|---|---|
| BULK | I1110 | Simple Spirometry | 5 |
| BULK | I1140 | Flow/volume loops | 5 |
| BULK | I1410 | Carbon monoxide single breath | 5 |
| BULK | I1230 | Body plethysmography | 5 |

**ECHOCARDIOGRAPHY**

| | | | |
|---|---|---|---|
| BULK | I1311 | M – mode | 25.44 |
| BULK | I1310 | Two dimensional | 47.56 |
| BULK | I1312 | Doppler – quantitative | 30.45 |
| BULK | I1313 | Doppler – qualitative | 15.23 |

# PATHOLOGY

(Includes SP=PATH, ANPA, HAPA, MEBI, NEPA)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|

**CONSULTATIONS**

| | | | | |
|---|---|---|---|---|
| CONS | 03.08 | Operating Room Consultation, Without Frozen Section | | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD (ME=TELE) | 36 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PREM (ME=TELE) | 54 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PR50 (ME=TELE) | 54 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD (ME=TELE) | 36+MU | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PREM (ME=TELE) | 54+MU | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PR50 (ME=TELE) | 54+MU | |
| CONS | 03.08 | Initial Consultation, Total Care | | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD (ME=TELE) | 36 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PREM (ME=TELE) | 54 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PR50 (ME=TELE) | 54 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD (ME=TELE) | 36+MU | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PREM (ME=TELE) | 54+MU | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PR50 (ME=TELE) | 54+MU | |
| CONS | 03.08 | Initial Consultation, Pathology Material Only | | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=PAMO, RF=REFD (ME=TELE) | 30 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=PAMO, RF=REFD, US=PREM (ME=TELE) | 48 | |
| | | SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=PAMO, RF=REFD, US=PR50 (ME=TELE) | 48 | |
| CONS | 03.09I | Anatomic Pathology Consultation | | |
| | | Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere | 45 | |
| CONS | 03.09J | Anatomic Pathology Consultation | | |
| | | Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests | 60 | |

**MICROSCOPIC EXAMINATION OF SPECIMEN FROM UNSPECIFIED SITE**

| | | | |
|---|---|---|---|
| VEDT | 05.99A | Immunofluorescence, interpretation of any and all markers required for Diagnosis; any method | 30 |
| VEDT | 05.99B | Molecular testing, interpretation of any and all analyses/test required for Diagnosis; any method | 40 |
| VEDT | 05.9A | Complex, small surgical specimens, gross and microscopic | 60 |
| | | US=PREM | 81 |
| | | US=PR50 | 90 |
| VEDT | 03.8A | Complete autopsy, non-complex, gross and microscopic – all ages | 500 |
| | | US=PREM | 675 |
| | | US=PR50 | 750 |
| VEDT | 03.8B | Limited autopsy, non-complex, gross and microscopic – all ages (Regions required) | 332.5 |
| | | US=PREM | 448.88 |
| | | US=PR50 | 498.75 |
| VEDT | 03.8C | Complex autopsy, gross and microscopic – all ages | 665 |
| | | US=PREM | 897.75 |
| | | US=PR50 | 997.5 |
| VEDT | 03.8D | Autopsy, brain and/or spinal cord only with detailed neuropathologic examination as part of a full autopsy, gross and microscopic – all ages | 200 |
| | | US=PREM | 270 |
| | | US=PR50 | 300 |
| VEDT | 03.8E | Autopsy, removal of brain and/or spinal cord only for detailed neuropathologic examination | 75 |
| | | US=PREM | 101.25 |
| | | US=PR50 | 112.5 |

## INTERPRETATIONS

Must be claimed from LO=HOSP

Pathology interpretation billing and service date must be the date the patient was seen in hospital and had specimens removed. The date the report was completed is not the correct service date

| | | | |
|---|---|---|---|
| BULK | P2324 | Surigcals, gross | 7.30 |
| | | US=PREM, US=PR50 | 16.30 |
| BULK | P2325 | Surgicals, gross and microscopic | 23.85 +MU |
| | | US=PREM | 32.85 +MU |
| | | US=PR50 | 35.78 +MU |
| BULK | P2326 | Frozen sections | 31.99 +MU |
| | | US=PREM | 43.19 +MU |
| | | US=PR50 | 47.99 +MU |
| BULK | P2328 | Interpretation – fine needle aspiration biopsy | 18.75 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |

| | | | |
|---|---|---|---|
| BULK | P2329 | Cell block | 14.60 |
| | | US=PREM, US=PR50 | 23.60 |
| BULK | P2330 | Cytology (with a screener) | 1 |
| | | US=PREM, US=PR50 | 10 |
| BULK | P2331 | Interpretation and report (GYN cytology slides) | 5 |
| | | US=PREM, US=PR50 | 14 |
| | | CT=CYSR | 4 |
| | | CT=CYSR, US=PREM, US=PR50 | 13 |
| BULK | P2332 | Interpretation and report (non GYN cytology slides) | 7.01 |
| | | US=PREM, US=PR50 | 16.01 |
| BULK | P2333 | Sex chromatin analysis | 5.61 |
| BULK | P2334 | Karyotype Test A – five cells and two karyotypes | 16.84 |
| | | US=PREM, US=PR50 | 25.84 |
| BULK | P2335 | Karyotype Test B – 30 cells and four karyotypes | 22.46 |
| | | US=PREM | 31.46 |
| | | US=PR50 | 33.69 |
| BULK | P2336 | Electron microscopy - Anatomical pathology only | 52.90 |
| BULK | P2337 | *Immunohistochemistry – head and neck | 10 |
| BULK | P2338 | *Immunohistochemistry – anterior torso | 10 |
| BULK | P2339 | *Immunohistochemistry – posterior torso | 10 |
| BULK | P2340 | *Immunohistochemistry – right arm | 10 |
| BULK | P2341 | *Immunohistochemistry – left arm | 10 |
| BULK | P2342 | *Immunohistochemistry – right leg | 10 |
| BULK | P2343 | *Immunohistochemistry – left leg | 10 |

* Immunohistochemistry – Staining and Interpretation of Surgical (Anatomic) Pathology Specimens

| | | | |
|---|---|---|---|
| BULK | P2344 | Liquid based preparation (thin prep) non GYN cytology (per slide) | 15 +MU |
| BULK | P2345 | Surgicals, gross and microscopic – three or more separate surgical specimens | 37.03 +MU |
| BULK | P2346 | Surgicals, gross and microscopic – single large complex CA specimen – Including lymph nodes | 37.03 |
| | | US=PREM | 49.99 |
| | | US=PR50 | 55.55 |

**Note**: The multiples permitted for HSC P2345 or P2325 may not be the same as the number of specimens received and examined. Please ensure the multiples claimed are submitted correctly.

# PHYSICAL MEDICINE

(SP=PHMD)

For further details refer to the Preamble.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|

**CONSULTATIONS**

| | | | |
|---|---|---|---|
| CONS | 03.08 | Comprehensive Consultation (Prolonged) | |
| | | RF=REFD (ME=TELE) | 62+MU |
| | | RF=REFD, US=PREM (ME=TELE) | 83.7+MU |
| | | RF=REFD, US=PR50 (ME=TELE) | 93+ MU |
| | | RF=REFD, RO=DETE (ME=TELE) | 62+MU |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 83.7+MU |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 93+MU |
| CONS | 03.07 | Limited Consultation | |
| | | RF=REFD (ME=TELE) | 37 |
| | | RF=REFD, US=PREM (ME=TELE) | 55 |
| | | RF=REFD, US=PR50 (ME=TELE) | 55.5 |
| | | RF=REFD, RO=DETE (ME=TELE) | 37+MU |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 55+MU |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 55.5+MU |
| CONS | 03.07 | Repeat Consultation (Prolonged) | |
| | | RF=REFD, RP=REPT (ME=TELE) | 27.1+MU |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 45.1+MU |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 45.1+MU |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 27.1+MU |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 45.1+MU |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 45.1+MU |

**OFFICE**

| | | | |
|---|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=OFFC (RF=REFD) | 24 |
| VIST | 03.03 | Initial Visit with Regional Exam | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 |
| VIST | 03.03 | Subsequent Visit | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 17 |
| | | *Physician Restrictions in Place (See Appendix J) | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 21 |
| | | *Physician Restrictions in Place (See Appendix J) | |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Continuing Care | |
| | | LO=OFFC, RO=CNTC, RF=REFD | 17 |
| | | LO=OFFC, AG=OV65, RO=CNTC, RF=REFD | 21 |
| VIST | 03.03 | Directive Care | |
| | | LO=OFFC, RO=DIRC, RF=REFD | 17 |
| | | LO=OFFC, AG=OV65, RO=DIRC, RF=REFD | 21 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000) | |
| | | LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359) | |
| | | LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800) | |
| | | LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient | |
| | | LO=OFFC, PT=EXPT (RF=REFD) | 10.5 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | | |
|---|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) | 24 |
| | | LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) | 24+MU |
| VIST | 03.04 | Initial Visit | |
| | | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | 30 |
| | | LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) | 25+MU |
| VIST | 03.03 | Continuing Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD | 15+MU |
| VIST | 03.03 | Directive Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, RO=DIRC, RF=REFD | 18.39 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD | 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 18.39 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) | 18.39+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 18.39<br>LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 18.39+MU |
| ADON | 03.02A | Hospital Discharge Fee<br>LO=HOSP, FN=INPT ..... 10 |
| VIST | 03.03 | Urgent Hospital Visit<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Hospital Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... .20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE<br>(RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE<br>(RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) ..... 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU |

# PLASTIC SURGERY

(SP=PLAS)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 38.1 | |
| | | RF=REFD, US=PREM (ME=TELE) | 56.1 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 57.15 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 38.1+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 56.1+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 57.15+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 27 | |
| | | RF=REFD, US=PREM (ME=TELE) | 45 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 45 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 27+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 45+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 45+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 24.9 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 42.9 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 42.9 | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 24.9+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 42.9+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 42.9+MU | |
| CONS | 03.09M | Preoperative Comprehensive Assessment for Gender Affirming Surgery | 24.9 | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 16.5 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Continuing Care | |
| | | LO=OFFC, RO=CNTC, RF=REFD | 13.5 |
| | | LO=OFFC, AG=OV65, RO=CNTC, RF=REFD | 16.5 |
| VIST | 03.03 | Directive Care | |
| | | LO=OFFC, RO=DIRC, RF=REFD | 13.5 |
| | | LO=OFFC, AG=OV65, RO=DIRC, RF=REFD | 16.5 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000) | |
| | | LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359) | |
| | | LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800) | |
| | | LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 38.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) | 28.3 |
| VIST | 03.03 | Urgent Care - Extra Patient | |
| | | LO=OFFC, PT=EXPT (RF=REFD) | 10.5 |
| VIST | 03.03Y | Post Operative Care – Gender Affirming Surgery | |
| | | LO=OFFC | 36 |

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

| | | | |
|---|---|---|---|
| VIST | 03.04 | Initial Visit with Complete Examination | |
| | | LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) | 24 |
| | | LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) | 24+MU |
| VIST | 03.04 | Initial Visit | |
| | | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | 25 |
| | | LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) | 25+MU |
| VIST | 03.03 | Continuing Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD | 15+MU |
| VIST | 03.03 | Directive Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD | 15 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD | 15+MU |
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 15 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) | 15+MU |

| | | |
|---|---|---|
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15 |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU |
| ADON | 03.02A | Hospital Discharge Fee |
| | | LO=HOSP, FN=INPT ..... 10 |
| VIST | 03.03 | Urgent Hospital Visit |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Emergency Visit |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU | |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU | |

## PROCEDURES

**APPLICATION OF OTHER WOUND DRESSING**

| | | | |
|---|---|---|---|
| MISG | 07.57 | Application of other wound dressing (applicable to burn wounds only)<br>AN=GENL..... 20 | 4+T |

**REPAIR OF SKULL WITH FLAP OR GRAFT**

| | | | |
|---|---|---|---|
| MASG | 15.03 | Repair of skull with flap or graft ..... 150 | 4+T |

**REPAIR OF (SPINAL) MENINGOCELE**

| | | | |
|---|---|---|---|
| MASG | 16.41B | Meningocele multiple flaps with or without skin grafts..... 175 | 7+T |
| MASG | 16.41C | Meningocele single flap with skin graft ..... 125 | 7+T |
| MASG | 16.41D | Meningocele single flap without skin graft ..... 100 | 7+T |

**OTHER INCISION OF CRANIAL AND PERIPHERAL NERVES**

| | | | |
|---|---|---|---|
| MASG | 17.05D | Explore peripheral nerve transplant or transposition with/without neurolysis<br>(Excluding median nerve at the carpal tunnel)..... 100 | 4+T |

**SUTURE OF CRANIAL AND PERIPHERAL NERVES**

| | | | |
|---|---|---|---|
| MASG | 17.2A | Peripheral nerves - primary suture, major nerve ..... 100 | 4+T |
| MASG | 17.2B | Peripheral nerves - secondary suture, major nerve ..... 150 | 4+T |

**OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS**

| | | | |
|---|---|---|---|
| MASG | 17.39B | Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm),posterior interosseus nerve (radial nerve in forearm wrist) (regions required) ..... 125 | 4+T |
| MASG | 17.39C | Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required)..... 125 | 4+T |

**CRANIAL OR PERIPHERAL NERVE GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 17.4B | Bilateral exploration of facial nerve and trans-facial nerve grafting with unilateral repair (microneural) | 750 | 6+T |
| MASG | 17.4C | Bilateral exploration of facial nerve and trans-facial nerve grafting with bilateral repair of facial nerve (microneural) | 1020 | 6+T |
| MASG | 17.4D | Exploration and grafting of facial nerve with microneural repair | 600 | 6+T |
| MASG | 17.4E | Peripheral nerve graft - major nerve with microneural repair | 450 | 4+T |
| MASG | 17.4F | Peripheral nerve graft - minor nerve with microneural repair | 225 | 4+ |

**TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.5A | Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis (excluding median nerve at carpal tunnel) | 100 | 4+T |
| MASG | 17.5B | Ulnar nerve release at the elbow (cubital tunnel) (regions required) | 125 | 4+T |
| | | RP=REPT | 200 | 4+T |
| MASG | 17.5C | Nerve Transfer with Microneural coaptation for the treatment of proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve IC | 130/hr | 4+T |

**ANASTOMOSIS OF CRANIAL OR PERIPHERAL NERVE**

| | | | | |
|---|---|---|---|---|
| MASG | 17.61B | Repair of palmar nerve (regions required) - plus multiples, if applicable | 84.5 | 4+T |
| MASG | 17.61C | Repair of peripheral nerve - major primary suture (regions required) | 100 | 4+T |
| MASG | 17.61D | Repair of peripheral nerve - minor digital, primary suture (regions required) - plus multiples, if applicable | 84.5 | 4+T |

**OTHER OPERATIONS ON CRANIAL AND PERIPHERAL NERVES NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 17.99A | Exploration and microneural repair - major nerve | 250 | 4+T |
| MASG | 17.99B | Exploration and microneural repair - minor nerve | 125 | 4+T |

**WEDGE RESECTION OR HALVING PROCEDURE OF EYELID**

| | | | | |
|---|---|---|---|---|
| MISG | 22.12A | Excision of benign tumour of eyelids (regions required) | 15 | 4+T |
| MISG | 22.12B | Excision of benign tumour of eyelid margins of conjunctiva (regions required) | 25 | 4+T |

**CANTHOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 22.23 | Canthoplasty (regions required) | 100 | 6+T |
| MASG | 22.23A | Medial transnasal canthopexy (regions required) | 230 | 6+T |

**OTHER OPERATIONS ON CANTHUS AND TARSUS**

| | | | | |
|---|---|---|---|---|
| MASG | 22.29A | Hypertelorism correction, intracranial approach | 1250 | 14+T |

**CORRECTION BY EXTENSIVE BLEPHAROPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 22.32A | Split thickness grafts - ectropion/entropion - complicated, including neoplasms and plastic repair (regions required) | 125 | 4+T |

**FRONTALIS MUSCLE TECHNIQUE WITH SUTURE FOR CORRECTION OF BLEPHAROPTOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 22.41 | Frontalis muscle technique with suture for correction of blepharoptosis (Regions required) | 137 | 4+T |

**FRONTALIS MUSCLE TECHNIQUE WITH FASCIAL SLING FOR CORRECTION OF BLEPHAROPTOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 22.42A | Ptosis - lid suspension living tissue sutures (regions required) | 200 | 4+T |

**TARSOLEVATOR RESECTION FOR CORRECTION OF BLEPHAROPTOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 22.43 | Tarsolevator resection for correction of blepharoptosis (regions required) | 196 | 4+T |

**OTHER EYELID REPAIR**

| | | | | |
|---|---|---|---|---|
| MASG | 22.69B | Direct flap to eyebrow - 1st stage (regions required) | 150 | 4+T |
| MASG | 22.69C | Direct flap to eyebrow - 2nd stage (regions required) | 75 | 4+T |
| MASG | 22.69D | Repair of avulsed and complicated wounds of eyelids (regions required) | 96 | 4+T |

**INSERTION OF ORBITAL IMPLANT**

| | | | | |
|---|---|---|---|---|
| MASG | 29.56A | Orbital floor reconstruction with bone graft (regions required) | 216 | 5+T |

**REPAIR OR MODIFICATION OF ORBITAL SOCKET**

| | | | | |
|---|---|---|---|---|
| MASG | 29.7A | Late correction traumatic enophthalmos (Tessier Technique) (Regions required) | 815 | 10+T |

**OTHER OPERATIONS ON ORBIT**

| | | | | |
|---|---|---|---|---|
| MASG | 29.97A | Cavity grafting - eye socket (regions required) | 200 | 4+T |
| MASG | 29.97B | Cavity grafting - eye socket with mucosa (regions required) | 250 | 4+T |

**SURGICAL CORRECTION OF PROMINENT EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 30.4 | Surgical correction of prominent ear congenital deformity (Regions required) - prior approval required if age over 17 years | 96 | 5+T |

**CONSTRUCTION OF AURICLE OF EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 30.61C | Loss of ear - major stage (total account not to exceed 400 units) PO=COML (regions required) | 150 | 5+T |
| MASG | 30.61D | Loss of ear - per stage (total account not to exceed 400 units) PO=PART (regions required) | 100 | 5+T |
| MASG | 30.61E | Loss of ear - minor stage (total account not to exceed 400 units) PO=COML (regions required) | 100 | 5+T |
| MASG | 30.61F | Total ear reconstruction (regions required) | 400 | 9+T |

**OTHER PLASTIC REPAIR OF EXTERNAL EAR**

| | | | | |
|---|---|---|---|---|
| MASG | 30.69 | Other plastic repair of external ear<br>ME=COMP (regions required) | 72 | 4+T |

**REDUCTION (CLOSED) OF NASAL FRACTURE**

| | | | | |
|---|---|---|---|---|
| MIFR | 33.61 | Reduction (closed) of nasal fracture | 25 | 4+T |
| MIFR | 33.61A | Compound fracture of nasal bones requiring reduction and internal fixation | 48 | 4+T |

**OPEN REDUCTION OF NASAL FRACTURE**

| | | | | |
|---|---|---|---|---|
| MAFR | 33.62 | Open reduction of nasal fracture | 100 | 4+T |

**SUTURE OF (TRAUMATIC) LACERATION OF NOSE**

| | | | | |
|---|---|---|---|---|
| MASG | 33.71 | Suture of (traumatic) laceration of nose<br>ME=COMP | 72 | 4+T |

**RHINOPLASTY WITH BONE OR CARTILAGE GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 33.74 | Rhinoplasty with bone or cartilage graft - prior approval<br>PO=COML | 192 | 7+T |
| | | PO=PART | 75 | 7+T |

**OTHER RHINOPLASTY OR SEPTOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 33.76B | Complete rhinoplasty with submucous resection without skin grafting - prior approval | 254 | 7+T |
| MASG | 33.76D | Rhinoplasty - removal of hump - prior approval | 150 | 7+T |
| MASG | 33.76E | Scalping rhinoplasty - two stages - prior approval | 350 | 7+T |
| MASG | 33.76F | Rhinoplasty composite graft | 125 | 7+T |
| MASG | 33.76G | Rhinophyma | 100 | 4+T |

**OTHER REPAIR AND PLASTIC OPERATIONS ON NOSE**

| | | | | |
|---|---|---|---|---|
| MASG | 33.79A | Nasal refracture | 150 | 7+T |
| MASG | 33.79B | Reconstruction of nasal tip, ala and columella - prior approval | 168 | 7+T |
| ADON | 33.79C | Lowering of floor of nose | 50 | |

**OTHER REPAIR AND PLASTIC OPERATIONS ON SALIVARY GLAND**

| | | | | |
|---|---|---|---|---|
| MASG | 38.39 | Other repair and plastic operations on salivary gland | 120 | 5+T |
| MASG | 38.39A | Salivary fistula - plastic to Stenson's duct (regions required) | 150 | 5+T |

**OTHER REPAIR OF MOUTH**

| | | | | |
|---|---|---|---|---|
| MASG | 39.49A | Cavity grafting - mouth | 200 | 4+T |

**CORRECTION OF CLEFT PALATE**

| | | | | |
|---|---|---|---|---|
| MASG | 39.52 | Correction of cleft palate | 150 | 8+T |
| MASG | 39.52A | Push-back of palate with pharyngeal flap or similar procedure | 225 | 8+T |

**PLASTIC OPERATION ON PHARYNX**

| | | | | |
|---|---|---|---|---|
| MASG | 41.3 | Plastic operation on pharynx or pharyngeal flap | 150 | 8+T |

**OTHER OPERATIONS ON LYMPHATIC STRUCTURES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.9B | Radical sleeve excision | 300 | 6+T |
| MASG | 52.9C | Lymphovenous anastomosis | 250 | 6+T |
| MASG | 52.9F | Lymphedema of limbs - modified Kondoleon- excision and grafting (Regions required) | 180 | 5+T |
| MASG | 52.9G | Lymphedema - entire lower limb (regions required) | 250 | 5+T |

**REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL**

| | | | | |
|---|---|---|---|---|
| MASG | 65.59D | Total Abdominal Wall Reconstruction with myofascial advancement flaps IC | 130/hr | 8+T |

**VAGINAL CONSTRUCTION (ABBE) (MCINDOE) (WILLIAMS)**

| | | | | |
|---|---|---|---|---|
| MASG | 82.51 | Vaginal construction (Abbe) (McIndoe) (Williams) | 300 | 4+T |

**(CLOSED) REDUCTION ON MALAR AND ZYGOMATIC FRACTURE**

| | | | | |
|---|---|---|---|---|
| MAFR | 88.02A | Fractured malar bone - simple elevation - open or closed | 58 | 5+T |

**(CLOSED) REDUCTION OF MANDIBULAR FRACTURE**

| | | | | |
|---|---|---|---|---|
| MAFR | 88.04A | Fractured mandible - simple, interdental and intermaxillary wiring | 100 | 8+T |

**OPEN REDUCTION OF FACIAL FRACTURE, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 88.11A | Nasoethmoid fracture - open reduction and internal fixation | 300 | 10+T |

**OPEN REDUCTION OF MALAR AND ZYGOMATIC FRACTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 88.12 | Open reduction of malar and zygomatic fracture with rigid three or four plate fixation | 250 | 5+T |
| MAFR | 88.12A | Fractured malar bone - open reduction with pinning | 100 | 5+T |
| MAFR | 88.12B | Fractured malar bone - open reduction with interosseous wiring | 144 | 5+T |

**OPEN REDUCTION OF MAXILLARY FRACTURE**

| | | | | |
|---|---|---|---|---|
| MAFR | 88.13A | Fractured maxilla - compound - requiring reduction and soft tissue repair | 200 | 10+T |
| MAFR | 88.13B | Fractured maxilla - requiring a radical antrostomy | 150 | 8+T |

**OPEN REDUCTION OF MANDIBULAR FRACTURE**

| | | | | |
|---|---|---|---|---|
| MAFR | 88.14A | Open reduction and rigid internal fixation of fractured mandible | 240 | 10+T |
| MAFR | 88.14B | Mandible - compound and comminuted fracture - interosseous external fixation by pinning | 175 | 10+T |

**OPEN REDUCTION OF OTHER FACIAL FRACTURE**

| | | | | |
|---|---|---|---|---|
| MAFR | 88.19A | Major fracture in middle third of face - LeFort type III | 300 | 10+T |
| MASG | 88.19B | Complex facial maxillary fracture - open reduction and rigid mini-plate fixation | 400 | 10+T |

**PARTIAL OSTECTOMY, MANDIBLE**

| | | | | |
|---|---|---|---|---|
| MASG | 88.51A | Resection of mandible | 150 | 7+T |

**TOTAL MANDIBULECTOMY WITH RECONSTRUCTION**

| | | | | |
|---|---|---|---|---|
| MASG | 88.52A | Tumours - enucleation, partial or complete resection with bone graft | 225 | 5+T |
| MASG | 88.52B | Reconstruction mandible with bone grafts and/or reconstruction plate | 400 | 10+T |
| MASG | 88.52C | Tumours - enucleation, partial or complete resection | 150 | 5+T |

**TEMPOROMANDIBULAR ARTHROPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 88.6 | Temporomandibular arthroplasty | 175 | 10+T |
| MASG | 88.6A | Arthrotomy (meniscectomy or condylectomy) | 150 | 8+T |

**AUGMENTATION GENIOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 88.74 | Augmentation genioplasty | 250 | 8+T |

**PROGNATHIC RECESSION**

| | | | | |
|---|---|---|---|---|
| MASG | 88.75 | Prognathic recession | 250 | 8+T |

**RECONSTRUCTION OF OTHER FACIAL BONE WITHOUT ASSOCIATED RESECTION**

| | | | | |
|---|---|---|---|---|
| MASG | 88.77A | Jaw or face bone graft | 168 | 5+T |

**SEQUESTRECTOMY - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.09A | Saucerization, muscle flap or bone graft | 200 | 4+T |
| MASG | 89.09B | Sequestrectomy and saucerization | 150 | 4+T |

**EXCISION OF BONE FOR GRAFT - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| ADON | 89.69A | Harvesting of bone graft for facial reconstruction | 100 | 4+T |

**BONE GRAFT - UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 90.09B | Elevation of a free vascularized bone transplant and closure of the donor site | 340 | 6+T |
| MASG | 90.09C | Preparation of a microvascular recipient site for a free vascularized bone transplant | 340 | 6+T |
| MASG | 90.09D | Transplantation of a free vascularized bone transplant with microvascular anastomoses and bony fixation | 375 | 6+T |
| MASG | 90.09E | Elevation of a free vascularized osteocutaneous or osteomuscular tissue transplant with closure of donor site | 410 | 6+T |
| MASG | 90.09F | Preparation of a microvascular recipient site for a free vascularized osteocutaneous or osteomuscular tissue transplant | 410 | 6+T |
| MASG | 90.09G | Transplantation of a free vascularized osteocutaneous or osteomuscular tissue transplant with microvascular anastomoses, osteotomies and bony fixation | 410 | 6+T |

**ARTHROPLASTY OF HAND AND FINGER WITH SYNTHETIC PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 93.71A | Replacement of metacarpophalangeal or interphalangeal joint of hand by synthetic prosthesis - single (regions required) - plus multiples, if applicable | 150 | 4+T |

**OTHER REPAIR OF HAND AND FINGER**

| | | | | |
|---|---|---|---|---|
| MASG | 93.79A | Reconstruction of rheumatoid joints- multiple (regions required) | 211 | 4+T |
| MASG | 93.79F | Thumb CMC joint tendon interpositional Arthoplasty (regions required) | 190 | 4+T |

**INCISION OF TENDON SHEATH OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.01A | Acute tenosynovitis of finger - drainage (regions required) - plus multiples, if applicable | 75 | 4+T |
| MASG | 94.01B | Incision of tendon sheath - simple ganglion or Dequervain's (Regions required) | 60 | 4+T |

**FASCIOTOMY OF HAND FOR DIVISION**

| | | | | |
|---|---|---|---|---|
| MASG | 94.13B | Excision fascia - Dupuytren's PO=PART (regions required) | 100 | 4+T |
| MASG | 94.13C | Complex palmar fasciectomy for Dupuytren's Disease (regions required) | 180 | 4+T |
| ADON | 94.13D | Release of each additional digit including proximal interphalangeal joint release (Add on to complex palmar fasciectomy) - plus multiples, if applicable | 70 | |

| | | | | |
|---|---|---|---|---|
| MASG | 94.13E | Release of a single digit including the interphalangeal joint(s) for Dupuytren's disease (regions required) | 120 | 4+T |

**EXCISION OF LESION OF TENDON (SHEATH) OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.21A | Excision of tendon sheath - simple ganglion or Dequervain's (regions required) | 60 | 4+T |
| MASG | 94.21B | Ganglion of the wrist | | |
| | | AN=GENL (regions required) | 100 | 4+T |
| | | AN=REGL (regions required) | 100 | |
| MASG | 94.21C | Excision of giant cell tumour of tendon sheath (regions required) | 96 | 4+T |

**OTHER EXCISION OF TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.32 | Other excision of tendon of hand (regions required) | 100 | 4+T |
| | | ME=RADI (regions required) | 150 | 4+T |
| MASG | 94.32A | Excision of tendon of finger (regions required) - plus multiples, if applicable | 100 | 4+T |

**DELAYED SUTURE OF OTHER TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.43A | Correction boutonniere deformity (regions required) - plus multiples, if applicable | 100 | 4+T |

**OTHER SUTURE OF FLEXOR TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.44A | Suture flexor tendon - single (regions required) - plus multiples, if applicable | 106 | 4+T |

**OTHER SUTURE OF OTHER TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MISG | 94.45A | Suture extensor tendon - single (regions required) -plus multiples, if applicable | 50 | 4+T |

**OTHER TRANSFER OR TRANSPLANTATION OF TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.55D | Tendon transfer - single (regions required) - plus multiples, if applicable | 96 | 4+T |

**POLLICIZATION (OPERATION) WITH NEUROVASCULAR BUNDLE CARRYOVER**

| | | | | |
|---|---|---|---|---|
| MASG | 94.61 | Pollicization (operation) with neurovascular bundle carryover (Regions required) | 300 | 4+T |

**PLASTIC OPERATION ON HAND WITH GRAFT OF TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 94.72A | Tendon graft - autogenous (regions required) | 192 | 4+T |

**TRANSFER OF FINGER EXCEPT THUMB**

| | | | | |
|---|---|---|---|---|
| MASG | 94.81 | Transfer of finger except thumb digital transplant (regions required) - plus multiples, if applicable | 200 | 4+T |

**OTHER PLASTIC OPERATIONS ON TENDON OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.86A | Reconstruction of flexor sheath finger by silicone tendon graft - single (Regions required) | 150 | 4+T |
| MASG | 94.86B | Tenodesis (regions required) | 85 | 4+T |
| MASG | 94.86C | Reconstruction of flexor sheath of finger by silicone tendon graft - multiple (Regions required) | 300 | 4+T |

**FREEING OF ADHESIONS OF MUSCLE, TENDON, FASCIA, AND BURSA OF HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 94.91A | Tenolysis - single (regions required) | 96 | 4+T |

**INCISION OF TENDON SHEATH**

| | | | | |
|---|---|---|---|---|
| MASG | 95.01 | Incision of tendon sheath | 75 | 4+T |
| MASG | 95.01A | Incision of tendon sheath - simple ganglion | 60 | 4+T |

**BURSOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 95.03C | Ulnar or radial bursa - drainage (regions required) | 60 | 4+T |

**OTHER TENOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 95.13A | Tenotomy for congenital torticollis | 70 | 5+T |

**MYOTOMY FOR DIVISION**

| | | | | |
|---|---|---|---|---|
| MASG | 95.14D | Incision - muscles - sternomastoid - unipolar | 70 | 5+T |
| MASG | 95.14E | Incision - muscles - sternomastoid - bipolar | 75 | 5+T |

**EXCISION OF LESION OF TENDON (SHEATH)**

| | | | | |
|---|---|---|---|---|
| MASG | 95.21A | Excision of tendon sheath - simple ganglion | 60 | 4+T |

**OTHER EXCISION OF TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.32B | Ganglion of the foot or major joint | | |
| | | AN=GENL (regions required) | 100 | 4+T |
| | | AN=REGL (regions required) | 100 | |

**OTHER EXCISION OF MUSCLE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.34A | Tenotomy for congenital torticollis - resection of sternomastoid - total | 150 | 5+T |

**OTHER SUTURE OF TENDON**

| | | | | |
|---|---|---|---|---|
| MISG | 95.54A | Suture extensor tendon - plus multiples if applicable | 50 | 4+T |
| MASG | 95.54B | Suture flexor tendon - plus multiples if applicable | 106 | 4+T |
| MASG | 95.54C | Achilles or biceps, repair of tendon rupture (regions required) | 100 | 4+T |
| MASG | 95.54D | Distal biceps repair (regions required) | 150 | 4+T |

**OTHER TRANSFER OR TRANSPLANTATION OF TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.65F | Tendon transfer - plus multiples if applicable | 96 | 4+T |

**OTHER TRANSPOSITION OF MUSCLE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.68A | Major muscle and myocutaneous flaps | 384 | 8+T |

**PLASTIC OPERATION WITH GRAFT OF MUSCLE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.73A | Elevation of a free vascularized muscle or musculocutaneous tissue transplant and closure of the donor site | 340 | 6+T |
| MASG | 95.73B | Preparation of a microvascular recipient site for a free vascularized muscle or musculocutaneous tissue transplant | 340 | 6+T |
| MASG | 95.73C | Transplantation of a free vascularized muscle or musculocutaneous tissue transplant with microvascular anastomoses | 340 | 6+T |
| MASG | 95.73D | Transplantation of a free vascularized muscle or musculocutaneous tissue transplant with microvascular anastomoses, microneural repair and tendon repairs | 460 | 8+T |

**PLASTIC OPERATION WITH GRAFT OF FASCIA**

| | | | | |
|---|---|---|---|---|
| MASG | 95.74A | Elevation of a free vascularized muscle or musculocutaneous tissue transplant with tendon and nerve and closure of the donor site | 460 | 8+T |
| MASG | 95.74B | Preparation of a microvascular recipient site for a free vascularized muscle or musculocutaneous transplant with tendon and nerve repairs | 460 | 8+T |

**OTHER CHANGE IN LENGTH OF MUSCLE, TENDON, AND FASCIA**

| | | | | |
|---|---|---|---|---|
| MASG | 95.76D | Tenoplasty - shortening, lengthening of any tendon any location (Regions required) - plus multiples, if applicable | 95 | 4+T |

**OTHER PLASTIC OPERATIONS ON TENDON**

| | | | | |
|---|---|---|---|---|
| MASG | 95.77A | Tenodesis | 85 | 4+T |

**FREEING OF ADHESIONS OF MUSCLE, TENDON, FASCIA, AND BURSA**

| | | | | |
|---|---|---|---|---|
| MASG | 95.91A | Tenolysis - single | 96 | 4+T |

**REATTACHMENT OF FINGER(S)**

| | | | | |
|---|---|---|---|---|
| MASG | 96.31A | Elevation of a free vascularized finger transplant and closure of donor site (Regions required) - plus multiples, if applicable | 410 | 6+T |
| MASG | 96.31B | Preparation of a microvascular recipient site for a free vascularized finger transplant (regions required) - plus multiples, if applicable | 410 | 6+T |
| MASG | 96.31C | Transplantation of a free vascularized finger transplant with microvascular anastomoses, tendon, nerve and bone repair (regions required) - plus multiples, if applicable | 410 | 6+T |
| MASG | 96.31D | Replantation of a single digit (regions required) - plus multiples, if applicable | 550 | 8+T |

**REATTACHMENT OF TOE(S)**

| | | | | |
|---|---|---|---|---|
| MASG | 96.35A | Elevation of a free vascularized toe transplant and closure of donor site (Regions required) - plus multiples, if applicable | 410 | 6+T |
| MASG | 96.35B | Preparation of a microvascular recipient site for a free vascularized toe transplant (regions required) - plus multiples, if applicable | 410 | 6+T |
| MASG | 96.35C | Transplantation of a free vascularized toe transplant with microvascular anastomoses, tendon, nerve and bone repair (regions required) - plus multiples, if applicable | 410 | 6+T |
| MASG | 96.35D | Replantation of a single digit (regions required) - plus multiples, if applicable | 550 | 8+T |

**OTHER REATTACHMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 96.39 | Other reattachment of limbs (regions required) | IC | 6+T |

**UNILATERAL REDUCTION MAMMOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.31A | Unilateral mammoplasty with nipple transplantation (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | 163 | 8+T |
| MASG | 97.31C | Unilateral functional pedicled breast reduction (regions required) - prior approval unless performed for malignant or pre-malignant conditions | 250 | 8+T |

**BILATERAL REDUCTION MAMMOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.32 | Bilateral reduction mammoplasty - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | 244.5 | 8+T |
| MASG | 97.32B | Bilateral functional pedicled breast reduction - prior approval unless performed for malignant or pre-malignant conditions | 375 | 8+T |

**UNILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 97.43 | Unilateral augmentation mammoplasty by implant or graft (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | 128 | 5+T |

**BILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 97.44 | Bilateral augmentation mammoplasty by implant or graft - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | 192 | 5+T |

**TOTAL RECONSTRUCTION OF BREAST**

| | | | | |
|---|---|---|---|---|
| MASG | 97.6B | Breast reconstruction by myocutaneous flap and breast prosthesis (Regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | 400 | 6+T |
| MASG | 97.6C | Breast reconstruction using rectus abdominis flap, including reconstruction of the rectus sheath as required (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | 600 | 6+T |

| | | | | |
|---|---|---|---|---|
| MASG | 97.6D | Deep inferior epigastric perforator (DIEP) free flap breast reconstruction - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition<br>RO=FPHN ..... 900<br>RO=SPHN ..... 400<br>**Note**: No assistant fee will be allowed if the second surgeon code is used. | | 8+T |
| MASG | 97.6E | Post Mastectomy Breast Reconstruction with tissue expander or implant, immediate or delayed..... 140 | | 4+T |

**MUSCLE FLAP GRAFT TO BREAST**

| | | | | |
|---|---|---|---|---|
| MASG | 97.75A | Breast reconstruction by myocutaneous flap and prosthesis (Regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition ..... 400 | | 6+T |

**OTHER REPAIR OR RECONSTRUCTION OF NIPPLE**

| | | | | |
|---|---|---|---|---|
| MASG | 97.77 | Other repair or reconstruction of nipple (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition..... 150 | | 4+T |

**REMOVAL OF IMPLANT**

| | | | | |
|---|---|---|---|---|
| MISG | 97.94A | Removal of breast prosthesis (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition..... 50 | | 4+T |
| MASG | 97.94B | Removal of breast prosthesis with capsulectomy (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition ..... 100 | | 4+T |

**INSERTION OF BREAST TISSUE EXPANDER(S)**

| | | | | |
|---|---|---|---|---|
| MASG | 97.95 | Insertion of breast tissue expander(s) (regions required)..... 100 | | 4+T |

**POST MASTECTOMY OR LUMPECTOMY FAT GRAFTING**

| | | | | |
|---|---|---|---|---|
| MISG | 97.6F | Minor Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat ≤100ml (regions required)..... 100 | | 4+T |
| MISG | 97.6G | Major Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat >100ml (regions required)..... 150 | | 4+T |

**GENDER AFFIRMING SURGERY (Prior Approval)**

| | | | | |
|---|---|---|---|---|
| MASG | 97.44A | Feminization of Chest Wall (Prior Approval) ..... 350 | | 4+T |
| MASG | 97.79B | Masculinization of Chest Wall (Prior approval) ..... 425 | | 4+T |
| MISG | 97.99B | Revision of gender affirming chest surgery (Prior Approval) (regions required) .. 150 | | 4+T |

**INCISION WITH REMOVAL OF FOREIGN BODY OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.04B | Removal of complicated foreign body - plus multiples, if applicable<br>AN=GENL..... 50 | | 4+T |

**DEBRIDEMENT OF WOUND OR INFECTED TISSUE**

| | | | | |
|---|---|---|---|---|
| MAAS | 98.11 | Debridement of wound or infected tissue | | |
| | | ME=COMP | IC | IC+T |
| ADON | 98.11B | Surgical debridement of burns - for each 5% of body surface - plus multiples, if applicable | | |
| | | AN=GENL | 20 | |
| | | PO=ONTW | | 4+T |
| | | PO=TOTF | | 6+T |
| | | PO=TSOV | | 8+T |
| ADON | 98.11C | Surgical excision of burn tissue prior to immediate skin grafting - each 5% of body surface - plus multiples, if applicable | | |
| | | AN=GENL | 50 | |
| | | PO=ONTW | | 4+T |
| | | PO=TOTF | | 6+T |
| | | PO=TSOV | | 8+T |

**LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.12Q | Wedge resection of lip, vermillion | 33.6 | 4+T |
| MISG | 98.12R | Destruction (dermabrasion) of single area (e.g., trauma scar) (Prior-Approval Required) | 35 | 4+T |
| MAAS | 98.12S | Extensive and complicated lesions | IC | 4+T |

**RADICAL EXCISION OF SKIN LESION**

| | | | | |
|---|---|---|---|---|
| MASG | 98.13F | Wedge resection of lip, vermilion to sulcus | 90 | 4+T |

**SUTURE OF SKIN AND SUBCUTANEOUS TISSUE OF OTHER SITES**

| | | | | |
|---|---|---|---|---|
| MISG | 98.22 | Suture of skin and subcutaneous tissue of other sites - plus multiples, if applicable | | |
| | | ME=SIMP, AN=LOCL | 11 | |
| | | ME=SIMP | 11 | |
| MISG | 98.22A | Suture of simple wounds or lacerations - child's face - plus multiples, if applicable | 17 | 4+T |
| MASG | 98.22B | Complicated lacerations of the scalp, cheek and neck | 96 | 4+T |
| MISG | 98.22D | Suture minor laceration or foreign body wound - plus multiples, if applicable | 20 | |
| | | AN=GENL | 20 | 4+T |
| MISG | 98.22F | Suture extensive laceration or foreign body wound - plus multiples, if applicable | 50 | |
| | | AN=GENL | 50 | 4+T |

**FULL THICKNESS SKIN GRAFT TO HAND**

| | | | | |
|---|---|---|---|---|
| MISG | 98.42A | Full thickness grafts - finger tip (regions required) - plus multiples, if applicable | 40 | 4+T |
| MASG | 98.42B | Full thickness grafts - palm (regions required) | 125 | 4+T |

**OTHER FREE SKIN GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 98.43A | Split thickness grafts - functional areas - late with scar excision graft (Regions required) | 144 | 4+T |
| MASG | 98.43B | Elevation of a free vascularized skin and subcutaneous tissue transplant and closure of the donor site (regions required) | 340 | 6+T |
| MASG | 98.43C | Preparation of a microvascular recipient site free vascularized skin and subcutaneous tissue transplant (regions required) | 340 | 6+T |
| MASG | 98.43D | Transplantation of a free vascularized skin and subcutaneous tissue transplant with microvascular anastomoses (regions required) | 340 | 6+T |
| MASG | 98.43E | Elevation of free vascularized innervated skin and subcutaneous tissue transplant and closure of the donor site (regions required) | 375 | 6+T |
| MASG | 98.43F | Preparation of a microvascular recipient site for a free vascularized innervated skin and subcutaneous tissue transplant (regions required) | 375 | 6+T |
| MASG | 98.43G | Transplantation of a free vascularized innervated skin and subcutaneous tissue transplant with microvascular anastomoses and microneural nerve repair (regions required) | 375 | 6+T |
| MASG | 98.43H | Split thickness grafts - early (regions required) | 144 | 4+T |

**FULL THICKNESS SKIN GRAFT TO OTHER SITES**

| | | | | |
|---|---|---|---|---|
| MASG | 98.44A | Free skin grafts (including mucosa) full thickness grafts - eyelid, nose, lips | 150 | 4+T |
| MASG | 98.44B | Full thickness grafts - finger, more than one phalanx (regions required) - plus multiples, if applicable | 125 | 4+T |
| MASG | 98.44C | Full thickness grafts - sole (regions required) | 125 | 4+T |
| MISG | 98.44D | Full thickness grafts - toe pulp graft (regions required) - plus multiples, if applicable | 50 | 4+T |

**OTHER FREE GRAFTS TO OTHER SITES**

| | | | | |
|---|---|---|---|---|
| MISG | 98.49A | Split thickness grafts - non functional areas - less than 1 square inch | 25 | 4+T |
| MISG | 98.49B | Split thickness grafts - non functional areas - less than 10 square inches | 50 | 4+T |
| MASG | 98.49C | Split thickness grafts - non functional areas - less than 100 square inches | 96 | 4+T |
| ADON | 98.49D | Split thickness grafts - non functional areas - for each square inch over 100 square inches - plus multiples, if applicable | 1 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 98.49E | Split thickness grafts - functional areas - major joints - early (regions required) | 144 | 4+T |
| MASG | 98.49F | Split thickness grafts - functional areas - major joints - late with scar excision graft (regions required) | 144 | 4+T |
| MASG | 98.49G | Split thickness grafts - functional areas - head and neck - less than 10 square inches | 100 | 4+T |
| MASG | 98.49H | Split thickness grafts - functional areas - head and neck - in excess of 10 square inches | 150 | 4+T |
| MASG | 98.49I | Split thickness grafts - functional areas - head and neck - in excess of 30 square inches | 350 | 4+T |
| MASG | 98.49J | Cavity grafting - nose | 150 | 4+T |
| MASG | 98.49K | Cavity grafting - lining pedicle flaps | 100 | 4+T |
| MASG | 98.49L | Bone cavity grafting over 3 inches diameter in large bone; e.g., femur (Regions required) | 250 | 4+T |
| MASG | 98.49M | Bone cavity grafting up to 3 inches in large bone (regions required) | 150 | 4+T |
| MASG | 98.49N | Bone cavity grafting in small bone; e.g., hand or foot (regions required) | 75 | 4+T |
| MASG | 98.49O | Elevation of a free vascularized skin and subcutaneous tissue transplant and closure of the donor site | 340 | 6+T |
| MASG | 98.49P | Preparation of a microvascular recipient site free vascularized skin and subcutaneous tissue transplant | 340 | 6+T |
| MASG | 98.49Q | Transplantation of a free vascularized skin and subcutaneous tissue transplant with microvascular anastomoses | 340 | 6+T |
| MASG | 98.49R | Elevation of free vascularized innervated skin and subcutaneous tissue transplant and closure of the donor site | 375 | 6+T |
| MASG | 98.49S | Preparation of a microvascular recipient site for a free vascularized innervated skin and subcutaneous tissue transplant | 375 | 6+T |
| MASG | 98.49T | Transplantation of a free vascularized innervated skin and subcutaneous tissue transplant with microvascular anastomoses and microneural nerve repair | 375 | 6+T |

**FLAP OR PEDICLE GRAFT, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 98.51B | Local tissue shifts with free skin graft to secondary defect - single | 125 | 4+T |
| MASG | 98.51C | Local tissue shifts - advancements, rotations, transpositions, 'Z' plasty - single | 96 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 98.51D | Local tissue shifts - advancements, rotations, transpositions, 'Z' plasty - multiple | 144 | 4+T |
| MASG | 98.51E | Local tissue shifts with free skin graft to secondary defect - multiple | 225 | 4+T |
| MASG | 98.51F | Neurovascular pedicle repair | 200 | 4+T |

**CUTTING AND PREPARATION OF FLAP OR PEDICLE GRAFT**

| | | | | |
|---|---|---|---|---|
| MISG | 98.52 | Cutting and preparation of flap or pedicle graft | 30 | 4+T |

**ADVANCEMENT OF FLAP OR PEDICLE GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 98.53A | Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose - single | 96 | 4+T |
| MASG | 98.53B | Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose - two stages | 200 | 4+T |
| MASG | 98.53C | Flaps from a distance - indirect - tubes, jumps - minor stage - per operation | 100 | 4+T |
| MASG | 98.53D | Flaps from a distance - indirect - tubes, jumps - major stage - per operation | 150 | 4+T |

**ATTACHMENT OF FLAP OR PEDICLE GRAFT TO HAND**

| | | | | |
|---|---|---|---|---|
| MASG | 98.54A | Flaps from distance - direct (2 stages) - upper extremity | 150 | 4+T |
| MASG | 98.54B | Flaps from distance - direct (2 stages) - upper extremity with free skin graft to secondary defect | 175 | 4+T |
| MASG | 98.54C | Direct flap to finger for covering bare bone/tendon - 2 stages (Regions required) - plus multiples, if applicable | 125 | 4+T |

**ATTACHMENT OF FLAP OR PEDICLE GRAFT TO OTHER SITES**

| | | | | |
|---|---|---|---|---|
| MASG | 98.55A | Flaps from distance - direct (2 stages) - lower extremity | 200 | 4+T |
| MASG | 98.55B | Decubitus ulcers, excision and treatment of bone rotation flaps and skin graft to secondary defect | 216 | 7+T |

**ATTACHMENT OF FLAP OR PEDICLE GRAFT TO LIP AND EXTERNAL MOUTH**

| | | | | |
|---|---|---|---|---|
| MASG | 98.63C | Abbe operation - 2 stages | 250 | 8+T |
| MASG | 98.63D | Full lip thickness transfer by rotation flap | 200 | 8+T |

**OTHER PLASTIC OPERATIONS ON LIP AND EXTERNAL MOUTH**

| | | | | |
|---|---|---|---|---|
| MASG | 98.69A | Repair of harelip (regions required) | 158 | 8+T |
| MASG | 98.69B | Repair of avulsed and complicated wounds of the lips | 96 | 4+T |

**CORRECTION OF SYNDACTYLY**

| | | | | |
|---|---|---|---|---|
| MASG | 98.71A | Syndactyly - local flaps (regions required) - plus multiples, if applicable | 100 | 4+T |
| MASG | 98.71B | Syndactyly - local flaps with skin graft (regions required) - plus multiples, if applicable | 150 | 4+T |

**REPAIR FOR FACIAL WEAKNESS**

| | | | | |
|---|---|---|---|---|
| MASG | 98.73A | Fascial slings or muscle transfer (regions required) | 225 | 5+T |

**DERMABRASION**

| | | | | |
|---|---|---|---|---|
| MASG | 98.93A | Dermabrasion full face - prior approval | 100 | 5+T |
| MISG | 98.93B | Dermabrasion less than 1/4 of face - prior approval | 25 | 5+T |
| MISG | 98.93C | Dermabrasion single area face; e.g., trauma scar - prior approval | 35 | 4+T |
| MASG | 98.93D | Dermabrasion between 1/4 and 1/2 face - prior approval | 75 | 5+T |

**INSERTION OF TISSUE EXPANDER(S)**

| | | | | |
|---|---|---|---|---|
| MASG | 98.98 | Insertion of tissue expander(s) - plus multiples, if applicable | 100 | 4+T |
| VADT | 98.98A | Percutaneous expansion/inflation of a tissue expander - plus multiples, if applicable | 13 | |

**OTHER OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 98.99H | MOHS micrographic surgery (MMS) for the removal of a histologically confirmed cutaneous malignancy – initial level and debulking<br>*Physician Restrictions in Place (See Appendix J) | 155 | |
| ADON | 98.99I | Additional levels (comprehensive of all additional levels for complete excision)<br>*Physician Restrictions in Place (See Appendix J) | 135 | |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

# PSYCHIATRY

(SP=PSYC)

For further details refer to the Preamble.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 105.75 | |
| | | RF=REFD, US=PREM (ME=TELE) | 142.76 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 158.63 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 75+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 101.25+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 112.50+MU | |
| CONS | 03.08A | Extended Comprehensive Psychiatry Consultation – When direct physician to patient time exceeds 60 minutes | | |
| | | RF=REFD (ME=TELE) | 132.19+MU | |
| | | RF=REFD, US=PREM (ME=TELE) | 178.46+MU | |
| | | RF=REFD, US=PR50 (ME=TELE) | 198.29+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 48.22 | |
| | | RF=REFD, US=PREM (ME=TELE) | 66.22 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 72.33 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 48.22+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 66.22+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 72.33+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 37.5+MU | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 55.5+MU | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 56.25+MU | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 37.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 55.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 56.25+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination Including Psychiatric Evaluation and Certification if indicated | | |
| | | LO=OFFC (RF=REFD) | 34.29 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 14.41 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

VIST 03.03A Geriatric Office Visit (for patients aged 65+)
LO=OFFC (ME=VTCR*) (RF=REFD) ..... 17.69
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD ..... 14.47
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 17.69

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD ..... 14.47
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 17.69

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 30.32

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 30.32

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 41.04

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 30.32

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 30.32

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 11.25

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT, DTOX or EMCC)

VIST 03.04 Initial Visit with Complete Examination
Including Psychiatric Evaluation and Certification if indicated
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 34.29
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 34.29+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT (RF=REFD) ..... 32.15
LO=HOSP, FN=INPT, RO=DETE (RF=REFD) ..... 32.15+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC (RF=REFD) ..... 16
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT (RF=REFD) ..... 16+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC (RF=REFD) ..... 16
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT (RF=REFD) ..... 16+MU

| | | | |
|---|---|---|---|
| VIST | 03.03 | Subsequent Visit - Daily to 56 Days | |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | 16 |
| | | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) | 16+MU |
| VIST | 03.03 | Subsequent Visit - Weekly after 56 Days - Maximum 80 units per week | |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) | 16 |
| | | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) | 16+MU |
| ADON | 03.02A | Hospital Discharge Fee | |
| | | LO=HOSP, FN=INPT | 10 |
| VIST | 03.03 | Urgent Hospital Visit | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD) | 23.57 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD) | 23.57+MU |
| VIST | 03.03 | Hospital Emergency Visit | |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD) | 37.72 |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD) | 37.72+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) | 14.47 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) | 14.47+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 21.43 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 21.43+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 21.43 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 21.43+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 27.86 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 27.86+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 21.43 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 21.43+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 21.43 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) | 21.43+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) | 7.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 7.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) | 7.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 7.5+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) | 11.25 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) | 11.25+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) | 11.25 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) | 11.25+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) | 11.86 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) | 11.86+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) | 11.25 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 11.25+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) | 11.25 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 11.25+MU |
| VIST | 03.03 | Detox Centre (0800 - 1700) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT (RF=REFD) | 22.83 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, RO=DETE (RF=REFD) | 22.83+MU |
| VIST | 03.03 | Detox Centre (1701 - 2000) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 30.32 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 30.32+MU |
| VIST | 03.03 | Detox Centre (2001 - 2359) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 30.32 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 30.32+MU |
| VIST | 03.03 | Detox Centre (0000 - 0800) | |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 41.04 |
| | | LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 41.04+MU |
| VIST | 03.03 | Detox Centre (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 30.32 |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 30.32+MU |
| VIST | 03.03 | Detox Centre (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 30.32 |
| | | LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) | 30.32+MU |
| VIST | 03.03 | Detox Centre (0801 - 1200) Extra Patient | |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN (RF=REFD) | 9 |
| | | LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 9+MU |

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV (RF=REFD) ..... 9
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 9+MU

VIST 03.03 Detox Centre (1701 - 2000) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT (RF=REFD) ..... 11.25
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (2001 - 2359) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD (RF=REFD) ..... 11.25
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (0000 - 0800) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.25
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) ..... 11.25
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 11.25
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 11.25+MU

**INSTITUTIONAL VISITS**

VIST 03.03 Nursing Home Visit (0800 - 1700)
LO=NRHM, PT=FTPT (RF=REFD) ..... 22.83
LO=NRHM, PT=FTPT, RO=DETE (RF=REFD) ..... 22.83+MU

VIST 03.03 Nursing Home Visit (1701 - 2000)
LO=NRHM, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 30.32
LO=NRHM, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Nursing Home Visit (2001 - 2359)
LO=NRHM, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 30.32
LO=NRHM, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Nursing Home Visit (0000 - 0800)
LO=NRHM, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 41.04
LO=NRHM, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 41.04+MU

VIST 03.03 Nursing Home Visit (0801 - 1200) Sat., Sun., Holidays
LO=NRHM, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) ..... 30.32
LO=NRHM, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Nursing Home Visit (1201 - 1700) Sat., Sun., Holidays
LO=NRHM, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 30.32
LO=NRHM, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Nursing Home Visit (0801 – 1200) Extra Patient
LO=NRHM, PT=EXPT, TI=AMNN (RF=REFD) ..... 11.25
LO=NRHM, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Nursing Home Visit (1201 – 1700) Extra Patient
LO=NRHM, PT=EXPT, TI=NNEV (RF=REFD)..... 11.25
LO=NRHM, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 11.25+MU

VIST 03.03 Nursing Home Visit (1701 - 2000) Extra Patient
LO=NRHM, PT=EXPT, TI=EVNT (RF=REFD) ..... 11.25
LO=NRHM, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Nursing Home Visit (2001 - 2359) Extra Patient
LO=NRHM, PT=EXPT, TI=ETMD (RF=REFD) ..... 11.25
LO=NRHM, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Nursing Home Visit (0000 - 0800) Extra Patient
LO=NRHM, PT=EXPT, TI=MDNT (RF=REFD)..... 11.25
LO=NRHM, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)..... 11.25+MU

VIST 03.03 Nursing Home Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=NRHM, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 11.25
LO=NRHM, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 11.25+MU

VIST 03.03 Nursing Home Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=NRHM, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 11.25
LO=NRHM, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Nursing Home - Emergency Visit
LO=NRHM, US=UIOH (RF=REFD)..... 37.72
LO=NRHM, US=UIOH, RO=DETE (RF=REFD)..... 37.72+MU

**HOME**

VIST 03.04 Initial Visit
LO=HOME (RF=REFD)..... 26.79
LO=HOME, RO=DETE) (RF=REFD)..... 26.79+MU

VIST 03.03 Home Visit (0800 - 1700)
LO=HOME, PT=FTPT (RF=REFD) ..... 22.83
LO=HOME, PT=FTPT, RO=DETE (RF=REFD) ..... 22.83+MU

VIST 03.03 Home Visit (1701 - 2000)
LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)..... 30.32
LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)..... 30.32+MU

VIST 03.03 Home Visit (2001 - 2359)
LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)..... 30.32
LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)..... 30.32+MU

| | | | |
|---|---|---|---|
| VIST | 03.03 | Home Visit (0000 - 0800) | |
| | | LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 41.04 |
| | | LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 41.04+MU |
| VIST | 03.03 | Home Visit (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 30.32 |
| | | LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 30.32+MU |
| VIST | 03.03 | Home Visit (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 30.32 |
| | | LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) | 30.32+MU |
| VIST | 03.03 | Home Visit - Extra Patient | |
| | | LO=HOME, PT=EXPT (RF=REFD) | 11.25 |
| VIST | 03.03 | Home Emergency Visit | |
| | | LO=HOME, US=UIOH (RF=REFD) | 37.72 |
| | | LO=HOME, US=UIOH, RO=DETE (RF=REFD) | 37.72+MU |
| VIST | 03.03 | Continuing Care | |
| | | LO=HOME, RO=CNTC, RF=REFD | 14.47 |
| | | LO=HOME, RO=CCDT, RF=REFD | 14.47+MU |
| VIST | 03.03 | Directive Care | |
| | | LO=HOME, RO=DIRC, RF=REFD | 14.47 |
| | | LO=HOME, RO=DRDT, RF=REFD | 14.47+MU |

**HOME CARE**

| | | | |
|---|---|---|---|
| VIST | 03.04 | Transfer to Home Care from Inpatient | |
| | | LO=HMHC, OL=INPT (RF=REFD) | 30.64 |
| | | LO=HMHC, OL=INPT, RO=DETE (RF=REFD) | 30.64+MU |

**CORRECTIONAL CENTRE**

| | | | |
|---|---|---|---|
| VIST | 03.03 | Office Visit | |
| | | LO=CCNT, RP=SUBS (RF=REFD) | 13.91 |
| VIST | 03.03 | Urgent Care - Request by Patient (1701 - 2000) | |
| | | LO=CCNT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 30.32 |
| VIST | 03.03 | Urgent Care - Request by Patient (2001 - 2359) | |
| | | LO=CCNT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 30.32 |
| VIST | 03.03 | Urgent Care - Request by Patient (0000 - 0800) | |
| | | LO=CCNT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 41.04 |
| VIST | 03.03 | Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=CCNT, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) | 30.32 |

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=CCNT, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)..... 30.32

VIST 03.03 Urgent Care - Extra Patient
LO=CCNT, PT=EXPT (RF=REFD)..... 11.25

VIST 03.03 Correctional Centre - Emergency Visit
LO=CCNT, US=UIOH (RF=REFD)..... 37.72
LO=CCNT, US=UIOH, RO=DETE (RF=REFD)..... 37.72+MU

**OTHER**

VIST 03.03 Unspecified Emergency Visit
LO=OTHR, US=UIOH (RF=REFD) ..... 37.72
LO=OTHR, US=UIOH, RO=DETE (RF=REFD) ..... 37.72+MU

VIST 03.03 Unspecified Location (0800 - 1700)
LO=OTHR, PT=FTPT (RF=REFD) ..... 22.83
LO=OTHR, PT=FTPT, RO=DETE (RF=REFD) ..... 22.83+MU

VIST 03.03 Unspecified Location (1701 - 2000)
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 30.32
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Unspecified Location (2001 - 2359)
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 30.32
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Unspecified Location (0000 - 0800)
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 41.04
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 41.04+MU

VIST 03.03 Unspecified Location (0801 - 1200) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 30.32
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 30.32+MU

VIST 03.03 Unspecified Location (1201 - 1700) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 30.32
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Unspecified Location - Extra Patient
LO=OTHR, PT=EXPT (RF=REFD) ..... 11.25

## PROCEDURES

**PSYCHIATRIC MENTAL STATUS DETERMINATION**

PSYC 08.11A Psychiatric assessment of accused person requested by the court
(it is necessary to indicate the judge's name involved in the case)..... 43.94

**OTHER PSYCHIATRIC EVALUATION AND INTERVIEW**

| | | | | |
|---|---|---|---|---|
| PSYC | 08.19A | Child psychiatric assessment<br>(25.29 units per 15 min. thereafter) | 50.57 per 30 min. | |
| PSYC | 08.19B | Therapeutic/diagnostic interview - relating to a child with parents and/or caregivers, allied health professionals, education, correction and other community resources<br>(22.37 units per 15 min. thereafter) | 44.73 per 30 min. | |

**OTHER ELECTROSHOCK THERAPY (EST)**

| | | | | |
|---|---|---|---|---|
| MISG | 08.38A | Electroconvulsive therapy | 42.97 | 4+T |

**HYPNOTHERAPY**

| | | | | |
|---|---|---|---|---|
| PSYC | 08.41 | Hypnotherapy*<br>(17.90 units per 15 min. thereafter)<br>*Physician Restrictions in Place (See Appendix J) | 35.8 per 30 min. | |

**GROUP THERAPY**

| | | | | |
|---|---|---|---|---|
| PSYC | 08.44 | Group therapy<br>Group psychotherapy per patient 4-8 members<br>(6.04 units per 15 min. thereafter) | 12.07 per 30 min. | |
| PSYC | 08.44A | Mindfulness-Based Cognitive Therapy (MBCT)* (min 8 – max 12 patients)<br>Group therapy fee per patient per two-hour session<br>*Physician Restrictions in Place (See Appendix J) | 14.3 | |

**FAMILY THERAPY**

| | | | | |
|---|---|---|---|---|
| PSYC | 08.45 | Family therapy (2 or more members)<br>(18.81 units per 15 min. thereafter) | 37.62 per 30 min. | |

**UNSPECIFIED PSYCHIATRIC THERAPEUTIC PROCEDURES**

| | | | | |
|---|---|---|---|---|
| PSYC | 08.49B | Psychotherapy<br>(22.38 units per 15 min. thereafter) | 44.76 per 30 min. | |

**ROUTINE PSYCHIATRIC VISIT NEC**

| | | | | |
|---|---|---|---|---|
| PSYC | 08.5B | Psychiatric care<br>(21.78 units per 15 min. thereafter) | 43.56 per 30 min. | |

# RADIOLOGY

(Includes SP=DIRD, NCMD, RADI, RDON)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|

**CONSULTATIONS**

| | | | |
|---|---|---|---|
| CONS | 03.08 | Comprehensive Consultation (Major Malignancy) | |
| | | SP=RDON, RF=REFD (ME=TELE) | 34 |
| | | SP=RDON, RF=REFD, US=PREM (ME=TELE) | 52 |
| | | SP=RDON, RF=REFD, US=PR50 (ME=TELE) | 52 |
| | | SP=RDON, RO=DETE, RF=REFD (ME=TELE) | 34+MU |
| | | SP=RDON, RO=DETE, RF=REFD, US=PREM (ME=TELE) | 52+MU |
| | | SP=RDON, RO=DETE, RF=REFD, US=PR50 (ME=TELE) | 52+ MU |
| CONS | 03.07 | Limited Consultation (Minor Malignancy) | |
| | | SP=RDON, RF=REFD (ME=TELE) | 23.5 |
| | | SP=RDON, RF=REFD, US=PREM (ME=TELE) | 41.5 |
| | | SP=RDON, RF=REFD, US=PR50 (ME=TELE) | 41.5 |
| | | SP=RDON, RO=DETE, RF=REFD (ME=TELE) | 23.5+MU |
| | | SP=RDON, RO=DETE, RF=REFD, US=PR50 (ME=TELE) | 41.5+MU |
| | | SP=RDON, RO=DETE, RF=REFD, US=PREM (ME=TELE) | 41.5+MU |
| CONS | 03.07 | Repeat Consultation | |
| | | SP=RDON, RP=REPT, RF=REFD (ME=TELE) | 23 |
| | | SP=RDON, RP=REPT, RF=REFD, US=PREM (ME=TELE) | 41 |
| | | SP=RDON, RF=REPT, RO=REFD, US=PR50 (ME=TELE) | 41 |
| | | SP=RDON, RP=REPT, RO=DETE, RF=REFD (ME=TELE) | 23+MU |
| | | SP=RDON, RP=REPT, RO=DETE, RF=REFD, US=PREM (ME=TELE) | 41+MU |
| | | SP=RDON, RP=REPT, RO=DETE, RF=REFD, US=PR50 (ME=TELE) | 41+MU |
| CONS | 03.08 | Therapeutic Radiology Comprehensive Consultation | |
| | | SP=DIRD/NCMD/RADI, RF=REFD (ME=TELE) | 30 |
| | | SP=DIRD/NCMD/RADI, RF=REFD, US=PREM (ME=TELE) | 48 |
| | | SP=DIRD/NCMD/RADI, RF=REFD, US=PR50 (ME=TELE) | 48 |
| | | SP=DIRD/NCMD/RADI, RO=DETE, RF=REFD (ME=TELE) | 30+MU |
| | | SP=DIRD/NCMD/RADI, RO=DETE, RF=REFD, US=PREM (ME=TELE) | 48+MU |
| | | SP=DIRD/NCMD/RADI, RO=DETE, RF=REFD, US-PR50 (ME=TELE) | 48+MU |
| CONS | 03.09B | Second Opinion Consultation review of an outside institution non-plain film imaging study including but not limited to CT, Ultrasound, MRI, Nuclear medicine or angiographic studies at the request of a specialist | 30+MU |

**OFFICE**

VIST 03.03 Treatment Planning, Dosage Calculation and Preparation
LO=OFFC, SP=RDON, RO=TRPL (RF=REFD) ..... 20

VIST 03.03 Office Visit
LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) ..... 13
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 – 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5

**CANCER PATIENT**

VIST 03.04 Comprehensive reassessment of a cancer patient
RO=CAPT, RP=SUBS ..... 25

VIST 03.03 Telephone advice and medical chart review of a cancer patient by the Oncologist
RO=TCCP ..... 11.5

## PROCEDURES

**DIGITAL BREAST TOMOSYNTHESIS**

ADON 02.25C Unilateral Diagnostic Digital Breast Tomosynthesis (regions required)
(not to be used for screening) ..... 5

ADON 02.25D Bilateral Diagnostic Digital Breast Tomosynthesis (regions required)
(not to be used for screening) ..... 10

**OTHER X-RAY NEC**

VEDT 02.79B PET / CT scan and interpretation, one body region ..... 87 4+T

VEDT 02.79C PET / CT scan and interpretation, multiple body regions
(Including whole body scan) ..... 125 4+T

ADON 02.89C Ultrasound performed by radiologist during premium time ..... 30

**IMPLANTATION OR INSERTION OF RADIOACTIVE ELEMENTS**

| | | | |
|---|---|---|---|
| MASG | 06.34A | Gold seed implants | 90 |
| MASG | 06.34B | Caesium needle implants | 90 |

**INJECTION OR INSTILLATION OF RADIOISOTOPES**

| | | | |
|---|---|---|---|
| MISG | 06.35A | Strontium 90 treatment | 15 |
| VADT | 06.35B | Thyroid malignancy | 20 |
| VADT | 06.35C | Hyperthyroidism | 20 |
| VADT | 06.35D | Polycythemia | 10 |
| VADT | 06.35E | Metastatic disease of bone | 20 |
| VADT | 06.35F | Arthritis single or multiple site | 8 |

**OTHER RADIOTHERAPEUTIC PROCEDURE**

| | | | | |
|---|---|---|---|---|
| VADT | 06.39D | Percutaneous image guided radiofrequency ablation of solid tumour<br>- plus multiples, to a maximum of 3, if applicable | 250 | 4+T |
| VEDT | 50.0B | Endovascular Thrombectomy-Intracranial | 300 | |

## INTERPRETATIONS

These codes must be claimed from LO=HOSP.
Exceptions are the following Mammography interpretations: R484, R485, R486

| CODE | GROUP | DESCRIPTION | UNIT VALUE |
|---|---|---|---|
| R1 | Other | Interpretation of submitted films | 6.25 |
| | | US=PREM, US=PR50 | 15.25 |
| R2 | Other | Fluoroscopy in O.R | 3.13 |
| R3 | Other | Conventional tomography | 9.38 |
| R5 | H&N | Skull – routine views | 4.40 |
| | | US=PREM, US=PR50 | 13.40 |
| R6 | H&N | Temporomandibular joints | 4.34 |
| R7 | H&N | Internal auditory meati | 4.34 |
| R8 | H&N | Sella turcica | 4.34 |
| R9 | H&N | Optic foramina | 4.34 |
| R11 | H&N | Mastoids – added view | 4.34 |

| | | | |
|---|---|---|---|
| R12 | H&N | Eye for foreign body | 4.34 |
| | | RG=BOTH | 8.68 |
| | | US=PREM, US=PR50 | 13.34 |
| | | RG=BOTH, US=PREM, US=PR50 | 26.68 |
| R15 | H&N | Facial bones | 4.40 |
| | | US=PREM, US=PR50 | 13.40 |
| R20 | H&N | Mandible | 3.31 |
| | | US=PREM, US=PR50 | 12.31 |
| R25 | H&N | Nasal bones | 3.31 |
| R30 | H&N | Sinuses – paranasal | 3.88 |
| | | US=PREM, US=PR50 | 12.88 |
| R35 | H&N | Salivary gland region | 3.31 |
| R45 | H&N | Panorex (teeth – full set) | 4.97 |
| R50 | H&N | Arthrogram | 20.76 |
| | | RG=BOTH | 41.52 |
| R55 | H&N | Dacrocystogram | 5.53 |
| | | RG=BOTH | 11.06 |
| R60 | H&N | Sialogram | 9.38 +MU |
| | | RG=BOTH | 18.76 +MU |
| R70 | H&N | Speech study | 44.24 |
| R105 | Bone | Cervical spine | 5.19 |
| | | US=PREM, US=PR50 | 14.19 |
| R110 | Bone | Thoracic spine | 3.31 |
| | | US=PREM, US=PR50 | 12.31 |
| R115 | Bone | Lumbar spine | 5.19 |
| | | US=PREM, US=PR50 | 14.19 |
| R120 | Bone | Sacrum / coccyx | 3.31 |
| | | US=PREM, US=PR50 | 12.31 |
| R125 | Bone | Scoliosis series | 8.85 |
| R126 | Bone | Scoliosis with stress | 11.07 |
| R129 | Bone | Metastatic series (5) | 9.12 |
| R130 | Bone | Metabolic bone survey | 9.12 |

| | | | |
|---|---|---|---|
| R131 | Bone | All long bones added to R129 | 2.28 |
| R140 | Mylo | Discogram | 11.07 |
| R150 | Mylo | Lumbar myelogram | 18.75 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |
| R151 | Mylo | Complete myelogram | 28.14 |
| | | US=PREM | 37.99 |
| | | US=PR50 | 42.21 |
| R152 | Mylo | Cervical injection myelogram | 18.75 |
| R185 | Other | Fetal study | 3.31 |
| R205 | Bone | Shoulder | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R210 | Bone | Scapula | 3.41 |
| | | RG=BOTH | 6.82 |
| R215 | Bone | A.C joints with and without weights | 3.41 |
| | | RG=BOTH | 6.82 |
| R220 | Bone | Clavicle | 3.41 |
| | | RG=BOTH | 6.82 |
| R221 | Bone | Bone age determination | 4.53 |
| R223 | Bone | Scaphoid | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R224 | Bone | Humerus | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R225 | Bone | Elbow | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R226 | Bone | Wrist | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |

| | | | |
|---|---|---|---|
| R227 | Bone | Forearm | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R228 | Bone | Hand | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R229 | Bone | Finger | 1.71 +MU |
| | | RG=BOTH | 3.42 +MU |
| R230 | Bone | Arthrogram shoulder | 20.76 |
| | | RG=BOTH | 41.52 |
| R305 | Bone | Hip | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R310 | Bone | Pelvis | 3.41 |
| | | US=PREM, US=PR50 | 12.41 |
| R315 | Bone | Pelvis and hips | 3.99 |
| R320 | Bone | Sacroiliac joints | 3.31 |
| R321 | Bone | Patella | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R322 | Bone | Foot | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R323 | Bone | Ankle | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R324 | Bone | Knee | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R325 | Bone | Calcaneus | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |

| | | | |
|---|---|---|---|
| R326 | Bone | Tibia and fibula | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R327 | Bone | Toe | 1.71 +MU |
| | | RG=BOTH | 3.42 +MU |
| R328 | Bone | Feet – weight bearing | 6.64 |
| | | RG=BOTH | 13.28 |
| R335 | Bone | Femur | 3.41 |
| | | RG=BOTH | 6.82 |
| | | US=PREM, US=PR50 | 12.41 |
| | | RG=BOTH, US=PREM, US=PR50 | 24.82 |
| R340 | Bone | Orthoroentgenogram (leg length measurement) | 2.58 |
| R350 | Bone | Arthrogram hip | 20.76 |
| | | RG=BOTH | 41.52 |
| R351 | Bone | Arthrogram knee | 20.76 |
| | | RG=BOTH | 41.52 |
| R403 | Other | Fluoroscopy 10 minutes | 12.50 |
| | | US-PREM, US=PR50 | 21.50 |
| R404 | Chest | Single view | 3.13 |
| | | US=PREM, US=PR50 | 12.13 |
| R405 | Chest | Multiple views | 5.13 |
| | | US=PREM, US=PR50 | 14.13 |
| R425 | Chest | Ribs, each side | 2.90 |
| | | RG=BOTH | 5.80 |
| | | US=PREM, US=PR50 | 11.90 |
| | | RG=BOTH, US=PREM, US=PR50 | 23.80 |
| R435 | Chest | Sternum | 3.31 |
| | | US=PREM, US=PR50 | 12.31 |
| R439 | Bone | Dual photon densitometry | 11.73 |
| R440 | Bone | Sternoclavicular joints | 3.41 |
| R445 | H&N | Neck – for soft tissue | 3.31 |
| | | US=PREM, US=PR50 | 12.31 |

| | | | |
|---|---|---|---|
| R470 | Chest | Bronchogram unilateral | 11.07 |
| R484 | Mammo | Mammography screening bilateral | 5.09 |
| R485 | Mammo | Mammography unilateral | 7.19 |
| R486 | Mammo | Breast cystography | 6.63 |
| | | RG=BOTH | 13.26 |
| R490 | Mammo | Mammography diagnostic bilateral | 14.07 |
| R495 | Mammo | Needle localization | 34.39 |
| | | RG=BOTH | 68.78 |
| R500 | Mammo | Galactography | 6.63 |
| | | RG=BOTH | 13.26 |
| R505 | Mammo | Stereotactic localization | 19.29 |
| | | RG=BOTH | 38.58 |
| R510 | Mammo | Surgical specimen radiography | 3.82 |
| | | RG=BOTH | 7.64 |
| R605 | Abdomen | Survey Film | 3.13 |
| | | US=PREM, US=PR50 | 12.13 |
| R610 | Abdomen | Multiple films | 3.88 |
| | | US=PREM, US=PR50 | 12.88 |
| R620 | G.I. | Esophagus | 14.62 |
| R625 | G.I. | Upper G.I. series | 18.69 |
| | | US=PREM | 27.69 |
| | | US=PR50 | 28.04 |
| R630 | G.I. | Upper G.I. paediatric | 28.05 |
| R635 | G.I. | Small bowel study | 9.67 |
| R640 | G.I. | Enteroclysis | 26.57 |
| R650 | G.I. | Colon – barium only | 14.91 |
| | | US=PREM, US=PR50 | 23.91 |
| R655 | G.I. | Colon paediatric –single | 22.37 |
| | | US=PREM | 31.37 |
| | | US=PR50 | 33.56 |
| R660 | G.I. | Colon – double contrast | 19.92 |
| R666 | G.I. | Defaecography | 26.57 |

| | | | |
|---|---|---|---|
| R670 | G.I. | Cholecystogram | 4.97 |
| R690 | G.I. | T-tube cholangiogram | 6.63 |
| R691 | G.I. | Operative cholangiogram | 4.66 |
| R695 | G.I. | ERCP | 6.63 |
| R709 | G.I. | Herniography | 9.38 |
| R710 | G.I. | Fistula/sinus with contrast | 4.40 |
| | | US=PREM, US=PR50 | 13.40 |
| R745 | G.I. | Percutaneous transhepatic cholangiogram | 6.63 |
| | | US=PREM, US=PR50 | 15.63 |
| R815 | G.I. | Intravenous urogram (IVP) | 14.53 |
| | | US=PREM, US=PR50 | 23.53 |
| R823 | G.U. | Retrograde pyelogram | 4.53 |
| R830 | G.U. | Voiding cystourethrogram | 11.07 |
| R835 | G.U. | Cystogram paediatric | 18.75 |
| R840 | G.U. | Loopogram | 4.40 |
| R845 | G.U. | Retrograde urethrogram | 4.53 |
| | | US=PREM, US=PR50 | 13.53 |
| R846 | G.U. | Cavernosogram | 4.40 |
| R850 | G.U. | Antegrade (t-tube) pyelogram | 4.53 |
| | | RG=BOTH | 9.06 |
| | | US=PREM, US=PR50 | 13.53 |
| | | RG=BOTH, US=PREM, US=PR50 | 27.06 |
| R865 | G.U. | Renal cystogram | 6.63 |
| | | RG=BOTH | 13.26 |
| R885 | G.U. | Vasogram | 4.40 |
| | | RG=BOTH | 8.80 |
| R895 | G.U. | Hysterosalpingogram | 5.53 |
| R910 | G.U. | Pelvimetry | 6.63 |
| R1001 | Vascular | Venous DSA – abnormal or renal | 35.52 |
| | | US=PREM | 47.95 |
| | | US=PR50 | 53.28 |

| | | | |
|---|---|---|---|
| R1002 | Vascular | Venous DSA – aortic arch | 39.58 |
| | | US=PREM | 53.43 |
| | | US=PR50 | 59.37 |
| R1003 | Vascular | Pulmonary angiogram bilateral | 93.79 |
| | | US=PREM | 126.62 |
| | | US=PR50 | 140.69 |
| R1004 | Vascular | Pulmonary angiogram unilateral | 62.53 |
| R1006 | Vascular | Unilateral peripheral arteriogram | 22.14 |
| | | US=PREM | 31.14 |
| | | US=PR50 | 33.21 |
| R1007 | Vascular | Bilateral peripheral arteriogram | 33.21 |
| | | US=PREM | 44.83 |
| | | US=PR50 | 49.82 |
| R1008 | Vascular | Aortography (abdominal) | 44.21 |
| | | US=PREM | 59.68 |
| | | US=PR50 | 66.32 |
| R1009 | Vascular | Visceral selective arteriogram | 44.21 |
| | | US=PREM | 59.68 |
| | | US=PR50 | 66.32 |
| R1010 | Vascular | Venogram extremity | 25.01 |
| | | RG=BOTH | 50.02 |
| | | US=PREM | 34.01 |
| | | US=PR50 | 37.52 |
| | | RG=BOTH, US=PREM | 68.02 |
| | | RG=BOTH, US=PR50 | 75.04 |
| R1011 | Vascular | Venocavogram selective | 22.14 |
| R1012 | Vascular | Visceral venogram | 22.14 |
| R1013 | Vascular | Spinal artery selective | 22.14 |
| | | US=PREM | 31.14 |
| | | US=PR50 | 33.21 |
| R1014 | Vascular | Bronchial artery selective | 44.21 |
| R1015 | Vascular | Lymphangiogram | 44.21 |
| R1016 | Vascular | Arch aortogram | 44.21 |
| | | US=PREM | 59.68 |
| | | US=PR50 | 66.32 |
| R1017 | Vascular | Spleenoportogram | 53.90 |

| | | | |
|---|---|---|---|
| R1018 | Vascular | Intraoperative angiogram | 43.77 |
| R1021 | Vascular | Common carotid bilateral | 55.83 |
| | | US=PREM | 75.37 |
| | | US=PR50 | 83.75 |
| R1022 | Vascular | Internal carotid bilateral | 55.83 |
| | | US=PREM | 75.37 |
| | | US=PR50 | 83.75 |
| R1023 | Vascular | External carotid bilateral | 55.83 |
| | | US=PREM | 75.37 |
| | | US=PR50 | 83.75 |
| R1024 | Vascular | Vertebral bilateral | 55.83 |
| | | US=PREM | 75.37 |
| | | US=PR50 | 83.75 |
| R1026 | Vascular | Common carotid unilateral | 30.45 |
| | | US=PREM | 41.11 |
| | | US=PR50 | 45.68 |
| R1027 | Vascular | Internal carotid unilateral | 30.45 |
| | | US=PREM | 41.11 |
| | | US=PR50 | 45.68 |
| R1028 | Vascular | External carotid unilateral | 30.45 |
| | | US=PREM | 41.11 |
| | | US=PR50 | 45.68 |
| R1029 | Vascular | Vertebral unilateral | 30.45 |
| | | US=PREM | 41.11 |
| | | US=PR50 | 45.68 |
| R1056 | Cardiac | Coronary arteries | 50.75 |
| | | US=PREM | 68.51 |
| | | US=PR50 | 76.13 |
| R1057 | Cardiac | Coronary arteries with ergot | 25.38 |
| R1058 | Cardiac | Coronary artery grafts | 50.75 |
| | | US=PREM | 68.51 |
| | | US=PR50 | 76.13 |
| R1059 | Cardiac | P.T.C.A | 50.75 |
| | | US=PREM | 68.51 |
| | | US=PR50 | 76.13 |
| R1061 | Cardiac | Right ventriculogram | 25.38 |
| | | US=PREM | 34.38 |
| | | US=PR50 | 38.07 |

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|---|---|---|---|
| R1062 | Cardiac | Left venticulogram | 25.38 |
| | | US=PREM | 34.38 |
| | | US=PR50 | 38.07 |
| R1063 | Cardiac | Cardiac panning <45 min. | 60.90 |
| R1064 | Cardiac | Cardiac panning >45 min. | 121.81 |
| R1071 | Cardiac | Aortic root (cardiac) | 25.38 |
| | | US=PREM | 34.38 |
| | | US=PR50 | 38.07 |
| R1105 | C.T. | CT head without contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1111 | C.T. | CT head with contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1115 | C.T. | CT head with and without contrast | 53.27 |
| | | US=PREM | 71.91 |
| | | US=PR50 | 79.91 |
| R1121 | C.T. | CT neck without contrast | 42.33 |
| R1125 | C.T. | CT neck with contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1130 | C.T. | CT neck with and without contrast | 53.27 |
| R1135 | C.T. | CT thorax without contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1141 | C.T. | CT thorax with contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1145 | C.T. | CT thorax with and without contrast | 53.27 |
| | | US=PREM | 71.91 |
| | | US=PR50 | 79.91 |
| R1150 | C.T. | CT abdomen without contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1155 | C.T. | CT abdomen with contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |

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|---|---|---|---|
| R1160 | C.T. | CT abdomen with and without contrast | 53.27 |
| | | US=PREM | 71.91 |
| | | US=PR50 | 79.91 |
| R1162 | C.T. | CT extremities without contrast | 42.33 |
| | | RG=BOTH | 84.66 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| | | RG=BOTH, US=PREM | 114.30 |
| | | RG=BOTH, US=PR50 | 127 |
| R1163 | C.T. | CT extremities with contrast | 42.33 |
| | | RG=BOTH | 84.66 |
| R1164 | C.T. | CT extremities with and without contrast | 53.27 |
| | | RG=BOTH | 106.54 |
| R1165 | C.T. | CT pelvis without contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1166 | C.T. | CT pelvis with contrast | 42.33 |
| | | US=PREM | 57.15 |
| | | US=PR50 | 63.50 |
| R1167 | C.T. | CT pelvis with and without contrast | 53.27 |
| | | US=PREM | 71.91 |
| | | US=PR50 | 79.91 |
| R1169 | C.T. | CT spine without contrast | 42.33 +MU |
| | | US=PREM | 57.15 +MU |
| | | US=PR50 | 63.50 +MU |
| R1170 | C.T. | CT spine with contrast | 42.33 +MU |
| R1172 | C.T. | CT spine with and without contrast | 53.27 +MU |
| R1173 | C.T. | Densitometry CT | 9.07 |
| R1180 | C.T. | 3D reconstruction | 12.16 |
| | | US=PREM, US=PR50 | 21.16 |
| R1186 | C.T. | CT head special without contrast | 42.33 +MU |
| | | US=PREM | 57.15 +MU |
| | | US=PR50 | 63.50 +MU |
| R1187 | C.T. | CT head special with contrast | 42.33 +MU |
| | | US=PREM | 57.15 +MU |
| | | US=PR50 | 63.50 +MU |

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|---|---|---|---|
| R1188 | C.T. | CT head special with and without contrast | 53.27 +MU |
| | | US=PREM | 71.91 +MU |
| | | US=PR50 | 79.91 +MU |
| R1205 | Ultrasound | Abdomen General | 25.39 |
| | | US=PREM | 34.39 |
| | | US=PR50 | 38.09 |
| R1206 | Ultrasound | Spine | 25.39 |
| R1211 | Ultrasound | Aorta | 12.50 |
| | | US=PREM, US=PR50 | 21.50 |
| R1212 | Ultrasound | Appendix | 18.75 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |
| R1213 | Ultrasound | Kidneys | 18.75 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |
| R1214 | Ultrasound | Pylorus | 18.75 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |
| R1220 | Ultrasound | Pelvis | 18.75 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |
| R1225 | Ultrasound | Endovaginal | 26.95 |
| | | US=PREM | 36.38 |
| | | US=PR50 | 40.43 |
| R1226 | Ultrasound | Endovaginal with pelvic | 38.70 |
| | | US=PREM | 52.25 |
| | | US=PR50 | 58.05 |
| R1231 | Ultrasound | Endorectal | 25.39 |
| R1245 | Ultrasound | Obstetrical | 27.51 |
| | | US=PREM | 37.14 |
| | | US=PR50 | 41.27 |
| R1246 | Ultrasound | Obstetrical, recheck | 12.50 |
| | | US=PREM, US=PR50 | 21.50 |
| R1250 | Ultrasound | Biophysical profile | 4.84 +MU |
| | | US=PREM, US=PR50 | 13.84 +MU |
| R1255 | Ultrasound | Obs. Multiple (add on) | 20.04 +MU |
| | | US=PREM | 29.04 +MU |
| | | US=PR50 | 30.06 +MU |

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|---|---|---|---|
| R1256 | Ultrasound | Obs. Multiple – recheck (add on) | 6.25 +MU |
| R1264 | Ultrasound | Cerebral | 33.49 |
| | | US=PREM | 45.21 |
| | | US=PR50 | 50.24 |
| R1265 | Ultrasound | Thyroid/parathyroid (neck) | 18.75 |
| R1275 | Ultrasound | Scrotum | 25.45 |
| | | US=PREM | 34.45 |
| | | US=PR50 | 38.18 |
| R1280 | Ultrasound | Shoulder | 18.75 |
| | | RG=BOTH | 37.50 |
| R1285 | Ultrasound | Hip | 18.75 |
| | | RG=BOTH | 37.50 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |
| | | RG=BOTH, US=PREM | 55.50 |
| | | RG=BOTH, US=PR50 | 28.13 |
| R1295 | Ultrasound | Breast, single | 12.50 |
| | | RG=BOTH | 25 |
| R1296 | Ultrasound | Chest | 18.75 |
| R1297 | Ultrasound | Popliteal fossa | 12.50 |
| | | RG=BOTH | 25 |
| R1298 | Ultrasound | Subcutaneous mass | 12.50 |
| | | US=PREM, US=PR50 | 21.50 |
| R1306 | Ultrasound | Intraoperative U/S | 47.56 |
| R1307 | Ultrasound | Portable – M.D. in attendance | 18.75 |
| | | US=PREM | 27.75 |
| | | US=PR50 | 28.13 |
| R1309 | Ultrasound | Fetal echo | 78.16 +MU |
| R1310 | Ultrasound | Two dimensional cardiac | 47.56 |
| R1311 | Ultrasound | M-Mode cardiac | 25.44 |
| R1312 | Ultrasound | Doppler – quantitative, cardiac | 30.45 |
| R1313 | Ultrasound | Doppler – qualitative, cardiac | 15.23 |

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|---|---|---|---|
| R1335 | Ultrasound | Doppler abdominal blood vessels | 33.49 |
| | | US=PREM | 45.21 |
| | | US=PR50 | 50.24 |
| R1340 | Ultrasound | Carotid doppler | 33.49 |
| R1345 | Ultrasound | Doppler – extremities | 18.75 +MU |
| | | RG=BOTH | 37.50 +MU |
| | | US=PREM | 57.75 +MU |
| | | US=PR50 | 28.13 +MU |
| | | RG=BOTH, US=PREM | 55.50 +MU |
| | | RG=BOTH, US=PR50 | 56.26 +MU |
| R1405 | M.R.I. | Cranial multisection SE | 40.97 |
| | | US=PREM | 55.31 |
| | | US=PR50 | 61.46 |
| R1406 | M.R.I. | Cranial multisection IR | 25.76 |
| R1407 | M.R.I. | Cranial repeat, sequence | 19.91 +MU |
| | | US=PREM | 28.91 +MU |
| | | US=PR50 | 29.87 +MU |
| R1409 | M.R.I. | Ent multisection SE | 40.97 |
| | | US=PREM | 55.31 |
| | | US=PR50 | 61.46 |
| R1411 | M.R.I. | Ent multisection IR | 25.76 |
| R1412 | M.R.I. | Ent repeat, sequence | 19.91 +MU |
| | | US=PREM | 28.91 +MU |
| | | US=PR50 | 29.87 +MU |
| R1415 | M.R.I. | Thorax multisection SE | 46.83 |
| | | US=PREM | 63.22 |
| | | US=PR50 | 70.25 |
| R1416 | M.R.I. | Thorax multisection IR | 40.97 |
| | | US=PREM | 55.31 |
| | | US=PR50 | 61.46 |
| R1417 | M.R.I. | Thorax repeat, sequence | 23.42 +MU |
| | | US=PREM | 32.42 +MU |
| | | US=PR50 | 35.13 +MU |
| R1420 | M.R.I. | Abdomen multisection SE | 46.83 |
| | | US=PREM | 63.22 |
| | | US=PR50 | 70.25 |
| R1421 | M.R.I. | Abdomen multisection IR | 40.97 |
| | | US=PREM | 55.31 |
| | | US=PR50 | 61.46 |

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| R1422 | M.R.I. | Abdomen repeat, sequence | 23.42 +MU |
| | | US=PREM | 32.42 +MU |
| | | US=PR50 | 35.13 +MU |
| R1425 | M.R.I. | Pelvis multisection SE | 46.83 |
| | | US=PREM | 63.22 |
| | | US=PR50 | 70.25 |
| R1426 | M.R.I. | Pelvis multisection IR | 40.97 |
| | | US=PREM | 55.31 |
| | | US=PR50 | 61.46 |
| R1427 | M.R.I. | Pelvis repeat sequence | 23.42 +MU |
| | | US=PREM | 32.42 +MU |
| | | US=PR50 | 35.13 +MU |
| R1430 | M.R.I. | Extremities multisection SE | 40.97 +MU |
| | | RG=BOTH | 81.94 +MU |
| | | US=PREM | 55.31 +MU |
| | | US=PR50 | 61.46 +MU |
| | | RG=BOTH, US=PREM | 110.62 +MU |
| | | RG=BOTH, US=PR50 | 122.92 +MU |
| R1431 | M.R.I. | Extremities multisection IR | 25.76 +MU |
| | | RG=BOTH | 51.52 +MU |
| R1432 | M.R.I. | Extremities repeat, sequence | 19.91 +MU |
| | | RG=BOTH | 39.82 +MU |
| | | US=PREM | 28.91 +MU |
| | | US=PR50 | 29.87 +MU |
| | | RG=BOTH, US=PREM | 57.82 +MU |
| | | RG=BOTH, US=PR50 | 59.74 +MU |
| R1440 | M.R.I. | Spine (one seq.) multisection SE | 37.47 |
| | | US=PREM | 50.58 |
| | | US=PR50 | 56.21 |
| R1441 | M.R.I. | Spine (one seq.) multisection IR | 24.58 |
| R1442 | M.R.I. | Spine (one seq.) repeat, sequence | 18.73 +MU |
| | | US=PREM | 27.73 +MU |
| | | US=PR50 | 28.10 +MU |
| R1445 | M.R.I. | Spine (two adjoining) multisection SE | 44.50 |
| | | US=PREM | 60.08 |
| | | US=PR50 | 66.75 |
| R1446 | M.R.I. | Spine (two adjoining) multisection IR | 37.47 |
| R1447 | M.R.I. | Spine (two adjoining) repeat sequence | 22.25 +MU |
| | | US=PREM | 31.25 +MU |
| | | US=PR50 | 33.38 +MU |

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| R1450 | M.R.I. | Spine (two not add.) multisection SE | 66.74 |
| R1451 | M.R.I. | Spine (two not add.) multisection IR | 37.47 |
| R1452 | M.R.I. | Spine (two not add.) repeat sequence | 32.78 +MU |
| R1453 | M.R.I. | Add 30 percent for gating | 7.03 +MU |
| | | US=PREM, US=PR50 | 16.03 +MU |
| R1776 | Nuc. Med. | Labelled WBC | 41.04 |
| | | US=PREM | 55.40 |
| | | US=PR50 | 61.56 |
| R1777 | Nuc. Med. | Gallium (one area) | 28.14 |
| R1778 | Nuc. Med. | Gallium (multiple areas) | 35.08 |
| R1790 | Nuc. Med. | Vascular study (flow) add on | 11.73 |
| | | US=PREM, US=PR50 | 20.73 |
| R1810 | Nuc. Med. | Brain scan | 11.73 |
| | | US=PREM, US=PR50 | 20.73 |
| R1811 | Nuc. Med. | Brain perfusion | 46.89 |
| | | US=PREM | 63.30 |
| | | US=PR50 | 70.34 |
| R1812 | Nuc. Med. | CSF study (cisternogram) | 35.18 |
| R1813 | Nuc. Med. | Shunt function study | 46.89 |
| R1814 | Nuc. Med. | Radionuclide arthrogram | 35.18 |
| R1816 | Nuc. Med. | Bone scan – one area | 23.45 |
| | | US=PREM | 32.45 |
| | | US=PR50 | 35.18 |
| R1817 | Nuc. Med. | Bone scan – multiple areas | 28.14 |
| | | US=PREM | 37.99 |
| | | US=PR50 | 42.21 |
| R1818 | Nuc. Med. | Bone marrow – one area | 23.45 |
| R1819 | Nuc. Med | Marrow scan – multiple areas | 28.14 |
| R1820 | Nuc. Med. | Bone density | 11.73 |
| R1830 | Nuc. Med. | Lung ventilation scan | 23.45 |
| | | US=PREM | 32.45 |
| | | US=PR50 | 35.18 |

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| R1835 | Nuc. Med. | Lung scan perfusion | 23.45 |
| | | US=PREM | 32.45 |
| | | US=PR50 | 35.18 |
| R1840 | Nuc. Med. | Liver and spleen | 18.75 |
| R1843 | Nuc. Med. | Haemangioma (RBC) | 28.14 |
| R1845 | Nuc. Med. | Spleen scan (RBC) | 18.75 |
| R1850 | Nuc. Med. | Hepatobiliary | 23.45 |
| | | US=PREM | 32.45 |
| | | US=PR50 | 35.18 |
| R1853 | Nuc. Med. | Bile salt study | 23.45 |
| R1855 | Nuc. Med. | Gastric emptying | 23.45 |
| R1860 | Nuc. Med | Ectopic gastric mucosa | 23.45 |
| R1865 | Nuc. Med | G.I. Bleed | 46.89 |
| | | US=PREM | 63.30 |
| | | US=PR50 | 70.34 |
| R1870 | Nuc. Med. | G.E. reflux | 18.75 |
| R1871 | Nuc. Med | Esophageal motility | 46.89 |
| R1872 | Nuc. Med. | Ciliary motion study | 31.27 |
| R1873 | Nuc. Med. | Peritoneal/venous shunt | 23.45 |
| R1875 | Nuc. Med. | Renal static imaging | 11.73 |
| | | US=PREM, US=PR50 | 20.73 |
| R1880 | Nuc. Med. | Renal scan and renogram | 35.18 |
| | | US=PREM | 47.49 |
| | | US=PR50 | 52.77 |
| R1881 | Nuc. Med. | A.C.E. renal scan | 46.89 |
| R1885 | Nuc. Med. | Diuretic stimulation (add on) | 11.73 |
| R1890 | Nuc. Med. | Testicular scan | 23.56 |
| | | US=PREM | 32.45 |
| | | US=PR50 | 35.18 |
| R1899 | Nuc. Med | Residual urine (add on) | 11.73 |

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| R1904 | Nuc. Med. | Myocardial rest | 23.45 |
| | | US=PREM | 32.45 |
| | | US=PR50 | 35.18 |
| R1905 | Nuc. Med. | Myocardial stress and rest | 37.52 |
| | | US=PREM | 50.65 |
| | | US=PR50 | 56.28 |
| R1906 | Nuc. Med. | Myocardial rest quantitative (add on) | 7.04 |
| | | US=PREM, US=PR50 | 16.04 |
| R1907 | Nuc. Med. | Myocardial stress and rest quantitative (add on) | 11.73 |
| | | US=PREM, US=PR50 | 20.73 |
| R1910 | Nuc. Med. | MUGA with quantitative | 23.45 |
| R1911 | Nuc. Med. | Exercise MUGA | 58.62 |
| R1912 | Nuc. Med. | Myocardial infarction | 23.45 |
| | | US=PREM | 32.45 |
| | | US=PR50 | 35.18 |
| R1913 | Nuc. Med. | Cardiac first pass | 28.14 |
| R1914 | Nuc. Med. | Cardiac shunt | 23.45 |
| R1915 | Nuc. Med. | Venoscintigram | 23.45 |
| R1920 | Nuc. Med. | Thyroid uptake | 18.75 |
| R1921 | Nuc. Med. | Thyroid scan | 18.75 |
| R1922 | Nuc. Med. | Thyroid uptake special | 23.45 |
| R1925 | Nuc. Med. | Adrenal scan | 70.34 |
| R1930 | Nuc. Med. | Parathyroid scan | 35.18 |
| R1935 | Nuc. Med. | Tumour imaging | 28.14 |
| R1940 | Nuc. Med. | Salivary gland scintigraphy | 23.45 |
| R1945 | Nuc. Med. | Dacroscintigraphy | 30.48 |
| R1946 | Nuc. Med. | Lymphoscintigram | 23.45 |
| R1947 | Nuc. Med. | Isolated limb perfusion | 11.73 |
| | | RG=BOTH | 23.46 |
| R1950 | Nuc. Med. | Tomography (add on) | 12.50 +MU |

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| R1951 | Nuc. Med. | Hepatobiliary with pharmacologic stimulation | 35.18 |
| R1955 | Nuc. Med. | Hyperthyroidism (therapy) | 42.21 |
| R1960 | Nuc. Med. | Carcinoma of thyroid (therapy) | 58.62 |
| R1961 | Nuc. Med. | Metastatic carcinoma (therapy) | 42.21 |
| R1962 | Nuc. Med. | Ascites or pleural effusion (therapy) | 42.21 |
| R1963 | Nuc. Med. | Synovectomy (therapy)<br>RG=BOTH | 42.21<br>84.42 |
| R1964 | Nuc. Med. | Polycythemia (therapy) | 42.21 |
| R1970 | Nuc. Med. | Red cell volume | 11.73 |
| R1971 | Nuc. Med. | Plasma volume | 11.73 |
| R1972 | Nuc. Med. | Red cell survival | 23.45 |
| R1973 | Nuc. Med. | Sequestration study | 46.89 |
| R1974 | Nuc. Med. | Ferrokinetics | 23.45 |
| R1976 | Nuc. Med. | Stool for blood loss | 11.73 |
| R1977 | Nuc. Med. | I-131 Gastrointestinal protein loss study | 11.73 |
| R1978 | Nuc. Med. | C-14 Breath test | 11.73 |
| R1979 | Nuc. Med. | Glomerular filtration rate (with blood samples)<br>US=PREM, US=PR50 | 11.73<br>20.73 |
| R1981 | Nuc. Med. | Schilling test with or without intrinsic factor | 11.73 |
| R1995 | Nuc. Med. | Retrograde nuclide cystogram | 18.75 |

# SURGERY

(Includes SP=GNSG, CASG, THSG, VASG)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 39.4 | |
| | | RF=REFD, US=PREM (ME=TELE) | 57.4 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 59.1 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 39.4+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 57.4+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 59.1+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 29.1 | |
| | | RF=REFD, US=PREM (ME=TELE) | 47.1 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 47.1 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 29.1+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 47.1+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 47.1+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 27 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 45 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 45 | |
| | | RF=REFD, RP=REPT, RO=DETE (ME=TELE) | 27+MU | |
| | | RF=REFD, RP=REPT, RO=DETE, US=PREM (ME=TELE) | 45+MU | |
| | | RF=REFD, RP=REPT, RO=DETE, US=PR50 (ME=TELE) | 45+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Exam | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) | 13 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (ME=VTCR*) (RF=REFD) | 16.5 | |
| | | *Physician Restrictions in Place (See Appendix J) | | |

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU RO=CNTC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly After 56 Days - Maximum 44 unit per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

| | | | |
|---|---|---|---|
| ADON | 03.02A | Hospital Discharge Fee | |
| | | LO=HOSP, FN=INPT | 10 |
| VIST | 03.03 | Urgent Hospital Care | |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD) | 22 |
| | | LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD) | 22+MU |
| VIST | 03.03 | Emergency Visit | |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD) | 35.2 |
| | | LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD) | 35.2+MU |
| VIST | 03.03 | Resuscitation of Newborn | |
| | | LO=HOSP, FN=INPT, RO=RESC (RF=REFD) | 50 |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD) | 68 |
| | | LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD) | 75 |
| | | LO=HOSP, FN=INPT, RO=RNDT (RF=REFD) | 50+MU |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD) | 68+MU |
| | | LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD) | 75+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) | 13.5 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) | 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) | |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) | 26 |
| | | LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) | 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) | 20 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) | 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) | 7 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 7+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU | |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU | |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU | |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU | |

## PROCEDURES

**OTHER NONOPERATIVE BRONCHOSCOPY**

| | | | | |
|---|---|---|---|---|
| VADT | 01.09D | Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of one or two mediastinal nodal stations and or hilar nodal stations or structures..... | 125 | |
| VADT | 01.09E | Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of three or more nodal stations and or hilar nodal stations or structures..... | 150 | |

**OTHER NONOPERATIVE ESOPHAGOSCOPY**

| | | | | |
|---|---|---|---|---|
| MASG | 01.12D | Esophagoscopy with insertion of selectron..... | 150 | 4+T |

**SOFT TISSUE X-RAY OF FACE, HEAD AND NECK**

| | | | | |
|---|---|---|---|---|
| MISG | 02.05A | Catheterization for sialogram ..... | 10.2 | |

**SINOGRAM OF ABDOMINAL WALL**

| | | | | |
|---|---|---|---|---|
| MISG | 02.53 | Sinogram of abdominal wall - plus multiples, if applicable ..... | 10 | |

**OTHER INTUBATION OF RESPIRATORY TRACT**

| | | | | |
|---|---|---|---|---|
| MASG | 10.05B | Insertion of intra-tracheal oxygen catheter..... | 150 | 6+T |

**INSERTION OF (NASO-) INTESTINAL TUBE**

| | | | | |
|---|---|---|---|---|
| MISG | 10.08 | Insertion of (naso-) intestinal tube ..... | 20.4 | 4+T |

**DILATION OF RECTUM**

| | | | | |
|---|---|---|---|---|
| MISG | 10.22 | Dilation of rectum | | |
| | | AN=GENL | 20 | 4+T |

**DILATION OF ANAL SPHINCTER**

| | | | | |
|---|---|---|---|---|
| MISG | 10.23 | Dilation of anal sphincter | 20 | 4+T |

**DILATION AND MANIPULATION OF ENTEROSTOMY STOMA**

| | | | | |
|---|---|---|---|---|
| MISG | 10.24 | Dilation and manipulation of enterostomy stoma | | |
| | | AN=GENL | 20 | 4+T |

**MANUAL REDUCTION OF RECTAL OR ANAL PROLAPSE**

| | | | | |
|---|---|---|---|---|
| MISG | 10.26 | Manual reduction of rectal or anal prolapse | | |
| | | AN=GENL | 50 | 4+T |

**REPLACEMENT OF GASTROSTOMY TUBE**

| | | | | |
|---|---|---|---|---|
| MISG | 11.02 | Replacement of gastrostomy tube or jejunostomy tube | 25 | 6+T |
| | | AN=GENL | 50 | 6+T |
| MISG | 11.02A | Revision of gastrostomy | 25 | 6+T |
| | | AN=GENL | 50 | 6+T |

**REMOVAL OF INTRALUMINAL FOREIGN BODY FROM RECTUM AND ANUS WITHOUT INCISION**

| | | | | |
|---|---|---|---|---|
| MAAS | 12.16 | Removal of intraluminal foreign body from rectum and anus without incision | IC | IC+T |

**INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 13.59I | Tissue plasminogen activator (PDA) injection | 50 | |

**OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS**

| | | | | |
|---|---|---|---|---|
| MASG | 17.39B | Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm), posterior interosseus nerve (radial nerve in forearm wrist) (regions required) | 125 | 4+T |
| MASG | 17.39C | Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required) | 125 | 4+T |

**TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES**

| | | | | |
|---|---|---|---|---|
| MASG | 17.5B | Ulnar nerve release at the elbow (cubital tunnel) (regions required) | 125 | 4+T |
| | | RP=REPT | 200 | 4+T |

**ASPIRATION OF THYROID FIELD**

| | | | | |
|---|---|---|---|---|
| MISG | 19.01A | Fine needle aspiration of thyroid - plus multiples, if applicable | 25 | 4+T |

**OTHER INCISION OF THYROID FIELD**

| | | | | |
|---|---|---|---|---|
| MASG | 19.09 | Other incision of thyroid field thyroid gland - abscess | 60 | 4+T |

**UNILATERAL THYROID LOBECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 19.1A | Total lobectomy | 225 | 8+T |

**EXCISION OF LESION OF THYROID**

| | | | | |
|---|---|---|---|---|
| MASG | 19.22A | Excision of solitary nodule | 150 | 8+T |
| MASG | 19.22B | Surgical biopsy | 120 | 6+T |

**OTHER PARTIAL THYROIDECTOMY NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 19.29A | Sub-total bilateral thyroidectomy | 275 | 8+T |
| MASG | 19.29B | Partial lobectomy | 225 | 8+T |
| ADON | 19.29C | Unilateral limited node dissection (This code is an add-on to HSC codes 19.1A, 19.22A 19.29A, 19.29B and 19.3 (regions required). The anaesthetist should claim the code with the highest listed basic.) | 60 | 9+T |
| ADON | 19.29D | Bilateral limited node dissection (This code is an add-on to HSC codes 19.1A, 19.22A 19.29A, 19.29B and 19.3. The anaesthetist should claim the code with the highest listed basic.) | 120 | 10+T |

**COMPLETE THYROIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 19.3 | Complete thyroidectomy | 290 | 8+T |
| ADON | 19.3A | Radical neck dissection (This code is an add-on to HSC codes 19.1A, 19.22A 19.29A, 19.29B and 19.3 (regions required). The anaesthetist should claim the code with the highest listed basic.) | 200 | 10+T |

**EXCISION OF THYROGLOSSAL DUCT OR TRACT**

| | | | | |
|---|---|---|---|---|
| MASG | 19.6 | Excision of thyroglossal duct or tract | 120 | 4+T |
| MASG | 19.6A | Excision of thyroglossal duct - cyst and sinus | 200 | 5+T |

**PARTIAL PARATHYROIDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 19.71A | Parathyroidectomy for hyperplasia | 275 | 7+T |
| MASG | 19.71B | Excision of parathyroid tumour | 275 | 7+T |
| MASG | 19.71C | Excision of parathyroid tumour - if sternal splitting required | 325 | 13+T |

**PERCUTANEOUS (NEEDLE) BIOPSY OF THYROID**

| | | | | |
|---|---|---|---|---|
| MISG | 19.81 | Percutaneous (needle) biopsy of thyroid - Silverman/tru-cut needle biopsy | 38 | 6+T |

**THYMECTOMY, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 20.71 | Thymectomy, unqualified | 300 | 13+T |

**CONTROL OF EPISTAXIS BY ANTERIOR NASAL PACKING**

| | | | | |
|---|---|---|---|---|
| MISG | 33.01 | Control of epistaxis by anterior nasal packing | 20 | |

**CONTROL OF EPISTAXIS BY POSTERIOR (AND ANTERIOR) PACKING**

| | | | | |
|---|---|---|---|---|
| MISG | 33.02A | Treatment of epistaxis posterior packing | 30 | 4+T |

**CONTROL OF EPISTAXIS BY LIGATION OF ETHMOIDAL ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 33.04 | Control of epistaxis by ligation of ethmoidal arteries | 51 | 4+T |

**CONTROL OF EPISTAXIS BY (TRANSANTRAL) LIGATION OF THE MAXILLARY ARTERY**

| | | | | |
|---|---|---|---|---|
| MASG | 33.05 | Control of epistaxis by (transantral) ligation of the maxillary artery | 225 | 7+T |

**CONTROL OF EPISTAXIS BY LIGATION OF THE EXTERNAL CAROTID ARTERY**

| | | | | |
|---|---|---|---|---|
| MASG | 33.06 | Control of epistaxis by ligation of the external carotid artery (regions required) | | |
| | | ME=SIMP | 76.5 | 5+T |
| MASG | 33.06A | Application of occlusion clamp (regions required) | 153 | 10+T |

**TURBINECTOMY BY DIATHERMY OR CRYOSURGERY**

| | | | | |
|---|---|---|---|---|
| MISG | 33.51 | Turbinectomy by diathermy or cryosurgery - single or bilateral | 27 | 4+T |
| | | AN=GENL | 40.5 | 4+T |
| | | AN=LOCL | 27 | |

**INCISION OF GUM OR ALVEOLAR BONE**

| | | | | |
|---|---|---|---|---|
| MISG | 36.0 | Incision of gum or alveolar bone | | |
| | | AN=GENL | 20 | 4+T |

**EXCISION OF LESION OR TISSUE OF GUM**

| | | | | |
|---|---|---|---|---|
| MISG | 36.21 | Excision of lesion or tissue of gum | 20 | 4+T |
| MISG | 36.21A | Excision of mucous cyst | 20 | 4+T |

**SUTURE OF (TRAUMATIC) LACERATION OF GUM**

| | | | | |
|---|---|---|---|---|
| MISG | 36.22 | Suture of (traumatic) laceration of gum | 20 | 4+T |

**EXCISION OF DENTAL LESION OF JAW**

| | | | | |
|---|---|---|---|---|
| MASG | 36.3 | Excision of dental lesion of jaw | 120 | 4+T |

**OTHER LOCAL EXCISION OF TONGUE**

| | | | | |
|---|---|---|---|---|
| MISG | 37.09A | Excision tongue biopsy | 20 | 4+T |
| MASG | 37.09B | Local excision of simple tumour of tongue | 75 | 4+T |

**PARTIAL GLOSSECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 37.1 | Partial glossectomy | 150 | 8+T |
| MASG | 37.1A | Hemiglossectomy plus radical neck dissection | 375 | 10+T |

**COMPLETE GLOSSECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 37.2 | Complete glossectomy | 180 | 8+T |
| MASG | 37.2A | Total glossectomy plus radical neck dissection | 375 | 10+T |

**SUTURE OF (TRAUMATIC) LACERATION OF TONGUE**

| | | | | |
|---|---|---|---|---|
| MAAS | 37.41 | Suture of (traumatic) laceration of tongue | IC | 6+T |

**INCISION OF SALIVARY GLAND OR DUCT**

| | | | | |
|---|---|---|---|---|
| MASG | 38.0 | Incision of salivary gland or duct | | |
| | | AN=GENL, ME=COMP | 90 | 4+T |
| | | AN=LOCL, ME=COMP | 90 | |
| MISG | 38.0 | Incision of salivary gland or duct | | |
| | | AN=GENL, ME=SIMP | 30 | 4+T |
| | | AN=LOCL, ME=SIMP | 30 | |

**OTHER EXCISION OF LESION OF SALIVARY GLAND**

| | | | | |
|---|---|---|---|---|
| MISG | 38.19A | Biopsy of parotid tumour | 25 | 4+T |

**SIALOADENECTOMY, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 38.21 | Sialoadenectomy, unqualified | 140 | 4+T |

**COMPLETE SIALOADENECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 38.23A | Excision of parotid gland tumour only | 180 | 6+T |
| MASG | 38.23B | Removal of parotid tumour without preservation of facial nerve | 245 | 7+T |
| MASG | 38.23C | Removal of parotid tumour without preservation of facial nerve plus unilateral radical neck dissection | 375 | 10+T |
| MASG | 38.23D | Removal of parotid tumour with preservation of facial nerve | 325 | 7+T |
| MASG | 38.23E | Removal of parotid tumour with preservation of facial nerve plus unilateral radical neck dissection | 455 | 10+T |
| MASG | 38.23F | Removal of recurrent parotid tumour with preservation of facial nerve | 350 | 7+T |

**OTHER REPAIR AND PLASTIC OPERATIONS ON SALIVARY GLAND**

| | | | | |
|---|---|---|---|---|
| MASG | 38.39 | Other repair and plastic operations on salivary gland | 120 | 5+T |
| MASG | 38.39B | Repositioning submandibular salivary gland ducts for drooling | 150 | 4+T |

**PROBING OF SALIVARY DUCT**

| | | | | |
|---|---|---|---|---|
| MISG | 38.91 | Probing of salivary duct | 5 | |
| MISG | 38.91A | Dilation of salivary duct | 10 | |

**DRAINAGE OF FACE OR FLOOR OF MOUTH**

| | | | | |
|---|---|---|---|---|
| COCR | 39.0 | Drainage of face or floor of mouth - incision and drainage of Ludwig's angina | 40 | |

**INCISION OF PALATE**

| | | | | |
|---|---|---|---|---|
| MISG | 39.1 | Incision of palate | 20 | 4+T |

**LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PALATE**

| | | | | |
|---|---|---|---|---|
| MISG | 39.21A | Biopsy of palate and/or uvula | 20 | 4+T |
| MISG | 39.21B | Excision of simple lesion of palate and uvula | 30 | 4+T |

**WIDE EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PALATE**

| | | | | |
|---|---|---|---|---|
| MASG | 39.22A | Excision of malignant lesion of palate and uvula - with reconstruction | 140 | 8+T |

**OTHER EXCISION OF MOUTH**

| | | | | |
|---|---|---|---|---|
| MASG | 39.39B | Excision of ranula or dermoid cyst | 60 | 4+T |
| MASG | 39.39C | Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa | 100 | 6+T |
| MASG | 39.39D | Local excision for carcinoma of floor of mouth - with hemimandibulectomy | 240 | 8+T |
| MASG | 39.39E | Local excision for carcinoma of floor of mouth, mandible alveolar margin of buccal mucosa with hemimandibulectomy and unilateral neck dissection | 345 | 8+T |
| MISG | 39.39F | Biopsy - mouth | 20 | 4+T |
| MASG | 39.39G | Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa with unilateral neck dissection | 345 | 8+T |

**EXCISION OF UVULA**

| | | | | |
|---|---|---|---|---|
| MISG | 39.62 | Excision of uvula, uvulectomy | 20 | 4+T |

**OTHER OPERATIONS ON ORAL CAVITY**

| | | | | |
|---|---|---|---|---|
| MASG | 39.99A | Excision of leukoplakia<br>ME=MAJO | 120 | 4+T |
| MISG | 39.99A | Excision of leukoplakia<br>ME=MINO | 30 | 4+T |
| | | ME=SIMP | 20 | 4+T |
| MISG | 39.99B | Cauterization of leukoplakia | 30 | 4+T |

**CLOSURE OF BRANCHIAL CLEFT FISTULA**

| | | | | |
|---|---|---|---|---|
| MASG | 41.42A | Excision branchial cyst | 150 | 4+T |
| MASG | 41.42B | Excision branchial sinus | 150 | 5+T |

**CLOSURE OF TRACHEOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 43.62 | Closure of tracheostomy | 120 | 6+T |

**CLOSURE OF OTHER FISTULA OF TRACHEA**

| | | | | |
|---|---|---|---|---|
| MASG | 43.63 | Closure of other fistula of trachea | 350 | 7+T |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |

**REVISION OF TRACHEOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 43.64 | Revision of tracheostomy | 120 | 6+T |

**CONSTRUCTION OF ARTIFICIAL LARYNX AND RECONSTRUCTION OF TRACHEA (WITH GRAFT)**

| | | | | |
|---|---|---|---|---|
| MASG | 43.65 | Construction of artificial larynx and reconstruction of trachea (with graft) | 400 | 13+T |
| MISG | 43.65A | Tracheo esophageal puncture | 50 | 4+T |
| MISG | 43.65B | Placement of a voice prosthesis | 50 | 6+T |
| MASG | 43.65C | Tracheo esophageal puncture and placement of a voice prosthesis | 100 | 6+T |

**OTHER REPAIR AND PLASTIC OPERATIONS ON TRACHEA**

| | | | | |
|---|---|---|---|---|
| MASG | 43.69 | Other repair and plastic operations on trachea, tracheal splint, transthoracic | 400 | 13+T |
| MISG | 43.69A | Tracheal dilation | 50 | 6+T |

**OTHER OPERATIONS ON LARYNX**

| | | | | |
|---|---|---|---|---|
| MASG | 43.95A | Excision - suprahyoid tumour (regions required) | 150 | 6+T |

**OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF LUNG**

| | | | | |
|---|---|---|---|---|
| MASG | 44.29A | Biopsy of pleural/lung (regions required) | 200 | 13+T |

**SEGMENTAL RESECTION OF LUNG (BASILAR) (SUPERIOR)**

| | | | | |
|---|---|---|---|---|
| MASG | 44.3 | Segmental resection of lung (basilar) (superior) | | |
| | | PO=SEGM (regions required) | 300 | 13+T |
| | | PO=WEGE (regions required) - plus multiples, if applicable | 240 | 13+T |

**LOBECTOMY OF LUNG**

| | | | | |
|---|---|---|---|---|
| MASG | 44.4 | Lobectomy of lung (regions required) - plus multiples, if applicable | 385 | 13+T |
| MASG | 44.4A | VATS lung lobectomy (regions required) - plus multiples, if applicable | 480 | 13+T |

**COMPLETE PNEUMONECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 44.5 | Complete pneumonectomy (regions required) | 400 | 13+T |

**INCISION OF LUNG**

| | | | | |
|---|---|---|---|---|
| MASG | 45.1A | Drainage of lung abscess (regions required) | 180 | 13+T |
| MASG | 45.1B | Exploratory removal of foreign body | 250 | 13+T |

**DESTRUCTION OF PHRENIC NERVE FOR COLLAPSE OF LUNG**

| | | | | |
|---|---|---|---|---|
| MASG | 45.21 | Destruction of phrenic nerve for collapse of lung | 60 | 5+T |

**ARTIFICIAL PNEUMOTHORAX FOR COLLAPSE OF LUNG**

| | | | | |
|---|---|---|---|---|
| MISG | 45.22 | Artificial pneumothorax for collapse of lung | | |
| | | RP=INTL | 15 | |
| | | RP=SUBS | 7.5 | |

**THORACOPLASTY FOR COLLAPSE OF LUNG**

| | | | | |
|---|---|---|---|---|
| MASG | 45.24A | Thoracoplasty - one stage | 200 | 10+T |
| MASG | 45.24B | Thoracoplasty - multi-stage - each | 120 | 9+T |

**OTHER SURGICAL COLLAPSE OF LUNG**

| | | | | |
|---|---|---|---|---|
| MASG | 45.29A | Apicolysis - extra-fascial (Sembs) | 150 | 5+T |
| MASG | 45.29B | Apicolysis - extra-pleural | 150 | 5+T |
| MASG | 45.29C | Schede's operation | 240 | 10+T |

**FREEING OF ADHESIONS OF LUNG AND CHEST WALL**

| | | | | |
|---|---|---|---|---|
| MASG | 45.3A | Pneumolysis - intra-pleural | 90 | 5+T |
| MASG | 45.3B | Pneumolysis - extra-pleural | 150 | 5+T |

**OTHER REPAIR AND PLASTIC OPERATION ON BRONCHUS**

| | | | | |
|---|---|---|---|---|
| MASG | 45.43A | Bronchoplasty | 400 | 13+T |

**PUNCTURE OF LUNG**

| | | | | |
|---|---|---|---|---|
| MASG | 45.94A | Aspiration of lung tumour under fluoroscopy (regions required) | 51 | |

**EXPLORATORY THORACOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 46.02 | Exploratory thoracotomy | 130 | 13+T |

**INSERTION OF INTERCOSTAL CATHETER (WITH WATER SEAL) FOR DRAINAGE**

| | | | | |
|---|---|---|---|---|
| MASG | 46.04A | Incision thoracotomy - closed drainage, includes Hemlick valve device (Regions required) | 80 | 4+T |

**OTHER INCISION OF PLEURA**

| | | | | |
|---|---|---|---|---|
| MASG | 46.09A | Claggett window procedure (regions required) | 325 | 13+T |
| MASG | 46.09B | Incision thoracotomy - rib resection and drainage | 120 | 13+T |

**INCISION OF MEDIASTINUM**

| | | | | |
|---|---|---|---|---|
| MASG | 46.1 | Incision of mediastinum | 150 | 6+T |

**EXCISION OR DESTRUCTION OF LESION OR TISSUE OF MEDIASTINUM**

| | | | | |
|---|---|---|---|---|
| MASG | 46.2 | Excision or destruction of lesion or tissue of mediastinum | 300 | 13+T |

**EXCISION OR DESTRUCTION OF LESION OF CHEST WALL**

| | | | | |
|---|---|---|---|---|
| MASG | 46.3A | Excision of chest wall tumour involving ribs or cartilage with reconstruction | 310 | 9+T |

**DECORTICATION OF LUNG (PARTIAL) (TOTAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 46.41 | Decortication of lung – Primary procedure (regions required) | 280 | 15+T |
| MASG | 46.41A | Pleurectomy with bullous emphysema (regions required) | 300 | 13+T |

**SCARIFICATION OF PLEURA**

| | | | | |
|---|---|---|---|---|
| ADON | 46.5A | Tetracycline poudrage (in addition to insertion of chest tube) | 25 | |

**REPAIR OF PECTUS DEFORMITY**

| | | | | |
|---|---|---|---|---|
| MASG | 46.64 | Repair of pectus deformity | 335 | 11+T |
| MASG | 46.64A | Removal of pectus bar | 75 | 4+T |
| MASG | 46.64B | Removal of intra-aortic balloon | 100 | 10+T |
| | | CO=CRBY | | 35+T |
| | | **Note**: For insertion of intra-aortic balloon, see Health Service Code 49.61 | | |

**OTHER OPERATIONS ON DIAPHRAGM**

| | | | | |
|---|---|---|---|---|
| MASG | 46.79A | Insertion of peritoneal venous shunt - Denver or Laveen | 175 | 6+T |
| MASG | 46.79B | Removal of peritoneal venous shunt - Denver or Laveen | 100 | 6+T |
| MASG | 46.79C | Revision of peritoneal venous shunt - Denver or Laveen | 125 | 6+T |

**THORACOSCOPY, TRANSPLEURAL**

| | | | | |
|---|---|---|---|---|
| MASG | 46.81 | Thoracoscopy, transpleural | 100 | 13+T |
| MASG | 46.81A | Thoracoscopy with instillation of Fibrin Glue | 75 | 4+T |

**CLOSED HEART VALVOTOMY, MITRAL VALVE**

| | | | | |
|---|---|---|---|---|
| MASG | 47.02A | Valvotomy - transatrial | 300 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 47.02B | Valvotomy - transventricular | 325 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 47.02C | Valvotomy for re-stenosis of mitral valve | 400 | 20+T |
| | | CO=CRBY | | 35+T |

**CLOSED HEART VALVOTOMY, AORTIC VALVE**

| | | | | |
|---|---|---|---|---|
| MASG | 47.03 | Closed heart valvotomy, aortic valve | 400 | 35+T |

**CLOSED HEART VALVOTOMY, TRICUSPID VALVE**

| | | | | |
|---|---|---|---|---|
| MASG | 47.04 | Closed heart valvotomy, tricuspid valve | 350 | 20+T |
| | | CO=CRBY | | 35+T |

**CLOSED HEART VALVOTOMY, PULMONARY VALVE**

| | | | | |
|---|---|---|---|---|
| MASG | 47.05A | Pulmonary stenosis - Brock Procedure (regions required) | 300 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 47.05B | Pulmonary valvotomy with inflow occlusion (regions required) | 350 | 20+T |
| | | CO=CRBY | | 35+T |

**OPEN HEART VALVULOPLASTY OF MITRAL VALVE WITHOUT REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 47.12A | Open mitral commissurotomy | 400 | 35+T |

**OPEN HEART VALVULOPLASTY OF AORTIC VALVE WITHOUT REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 47.13 | Open heart valvuloplasty of aortic valve without replacement | 400 | 35+T |

**OPEN HEART VALVULOPLASTY OF TRICUSPID VALVE WITHOUT REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 47.14 | Open heart valvuloplasty of tricuspid valve without replacement | 500 | 20+T |
| | | CO=BPU5 | | 40+T |
| | | CO=CRBY | | 35+T |
| | | CO=UN5K | | 25+T |

**OPEN HEART VALVULOPLASTY OF PULMONARY VALVE WITHOUT REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 47.15 | Open heart valvuloplasty of pulmonary valve without replacement (Regions required) | 400 | 35+T |

**OTHER REPLACEMENT OF MITRAL VALVE**

| | | | | |
|---|---|---|---|---|
| MASG | 47.23 | Other replacement of mitral valve | 500 | 35+T |
| MASG | 47.23A | Mitral valve replacement - double | 600 | 35+T |
| MASG | 47.23B | Mitral valve replacement - triple | 1000 | 35+T |

**OTHER REPLACEMENT OF AORTIC VALVE**

| | | | | |
|---|---|---|---|---|
| MASG | 47.25 | Other replacement of aortic valve | 500 | 35+T |
| MASG | 47.25A | Aortic valve and ascending aorta with reimplantation or coronary arteries (Bio-Bentall or Mechanical Bentall repair) | 1105 | 35+T |
| MASG | 47.25B | Valve sparing aortic root replacement or remodeling (David or Yacoub) with reimplantation of coronary arteries (VSR) | 1105 | 35+T |
| VEDT | 47.25C | Transcutaneous Aortic Valve Implantation/Replacement (TAVI) | | |
| | | RO=FPHN | 611 | 20+T |
| | | RO=SPHN | 611 | |

**ANNULOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 47.33A | Tricuspid annuloplasty | 300 | 35+T |
| MASG | 47.33B | Mitral annuloplasty | 400 | 35+T |

**CREATION OF SEPTAL DEFECT IN HEART**

| | | | | |
|---|---|---|---|---|
| MASG | 47.43 | Creation of septal defect in heart | 350 | 20+T |
| | | CO=CRBY | | 35+T |

**REPAIR OF ATRIAL SEPTAL DEFECT WITH PROSTHESIS, OPEN TECHNIQUE**

| | | | | |
|---|---|---|---|---|
| MASG | 47.52A | Closure atrial septal defect | 350 | 20+T |
| | | CO=CRBY | | 35+T |

**REPAIR OF VENTRICULAR SEPTAL DEFECT WITH PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 47.54 | Repair of ventricular septal defect with prosthesis | 450 | 35+T |
| MASG | 47.54A | Repair of ventricular septal defect with removal of banding | 500 | 20+T |
| | | CO=CRBY | | 35+T |

**REPAIR OF ENDOCARDIAL CUSHION DEFECT WITH PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 47.55A | Closure of septum primum with/without value repair | 500 | 35+T |

**TOTAL REPAIR OF TETRALOGY OF FALLOT**

| | | | | |
|---|---|---|---|---|
| MASG | 47.81 | Total repair of Tetralogy of Fallot | 500 | 35+T |
| MASG | 47.81A | Total repair of Tetralogy of Fallot with previous systemic pulmonary shunt | 600 | 35+T |

**TOTAL REPAIR OF TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION**

| | | | | |
|---|---|---|---|---|
| MASG | 47.82 | Total repair of total anomalous pulmonary venous connection (regions required) | 350 | 20+T |
| | | CO=CRBY | | 35+T |

**TOTAL REPAIR OF TRUNCUS ARTERIOSUS**

| | | | | |
|---|---|---|---|---|
| MASG | 47.83A | Repair of double outlet right ventricle | 500 | 35+T |

**INTERATRIAL TRANSPOSITION OF VENOUS RETURN**

| | | | | |
|---|---|---|---|---|
| MASG | 47.91 | Interatrial transposition of venous return repair - Mustard Procedure | 500 | 35+T |
| | | CO=BPU5 | | 40+T |

**OTHER OPERATIONS ON VALVES OF HEART**

| | | | | |
|---|---|---|---|---|
| MASG | 47.96A | Fontan Procedure for single ventricle | 517 | 35+T |

**REMOVAL OF CORONARY ARTERY OBSTRUCTION**

| | | | | |
|---|---|---|---|---|
| MASG | 48.0B | Open repair of coronary artery | 350 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 48.0G | Insertion or placement of endovascular stent | 250 | 8+T |
| MASG | 48.0H | Coronary endarterectomy (by-pass graft) | 500 | 20+T |
| | | CO=CRBY | | 35+T |

**AORTOCORONARY BYPASS OF ONE CORONARY ARTERY**

| | | | | |
|---|---|---|---|---|
| MASG | 48.12 | Aortocoronary bypass of one coronary artery | 450 | 20+T |
| | | CO=CRBY | | 35+T |

**AORTOCORONARY BYPASS OF TWO CORONARY ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 48.13 | Aortocoronary bypass of two coronary arteries | 600 | 20+T |
| | | CO=CRBY | | 35+T |

**AORTOCORONARY BYPASS OF THREE CORONARY ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 48.14 | Aortocoronary bypass of three coronary arteries | | |
| | | - plus multiples, if applicable | 700 | 20+T |
| | | CO=CRBY | | 35+T |

**HEART REVASCULARIZATION BY ARTERIAL IMPLANT**

| | | | | |
|---|---|---|---|---|
| MASG | 48.2A | Repair - coronary arteries - Vineberg Procedure | 350 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 48.2B | Double Vineberg Procedure | 450 | 20+T |
| | | CO=CRBY | | 35+T |
| ADON | 48.2C | Total arterial grafting | 100 | |

**PERICARDIOCENTESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 49.0B | Pericardial insufflation with powder | 150 | 20+T |
| | | CO=CRBY | | 35+T |
| MISG | 49.0C | Atrial or right ventricular puncture | 20 | 5+T |

**CARDIOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 49.12A | Cardiotomy with exploration | 300 | 20+T |
| | | CO=CRBY | | 35+T |

| | | | | |
|---|---|---|---|---|
| MASG | 49.12B | Cardiotomy with removal of foreign body | 250 | 20+T |
| | | CO=CRBY | | 35+T |

**PERICARDIECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 49.2 | Pericardiectomy | | |
| | | PO=SBTL | 300 | 20+T |
| | | PO=PART | 200 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 49.2A | Biopsy of pericardium by thoracotomy | 150 | 13+T |

**EXCISION OF ANEURYSM OF HEART**

| | | | | |
|---|---|---|---|---|
| MASG | 49.31 | Excision of aneurysm of heart | 500 | 35+T |

**EXCISION OF OTHER LESION OF HEART**

| | | | | |
|---|---|---|---|---|
| MASG | 49.39A | Excision of tumours of heart; e.g., myxoma | 450 | 35+T |
| MASG | 49.39B | Excision of ventricular diverticulum | 300 | 35+T |
| MASG | 49.39C | Resection of myocardial fibrosis | 500 | 35+T |
| MASG | 49.39D | Resection of myocardium | 500 | 35+T |

**REPAIR OF HEART AND PERICARDIUM**

| | | | | |
|---|---|---|---|---|
| MASG | 49.4A | Suture of wound | 250 | 20+T |

**HEART TRANSPLANTATION**

| | | | | |
|---|---|---|---|---|
| MASG | 49.5A | Donor cardiectomy | 257.56 | 35+T |
| MASG | 49.5B | Orthotopic cardiac transplantation recipient | 771.98 | 35+T |

**IMPLANT OF PULSATION BALLOON**

| | | | | |
|---|---|---|---|---|
| MASG | 49.61 | Implant of pulsation balloon | 134.5 | 10+T |
| | | **Note**: For removal of intra-aortic balloon, see Health Service Code 46.64B | | |

**IMPLANT OF OTHER HEART ASSIST SYSTEM**

| | | | | |
|---|---|---|---|---|
| MASG | 49.62A | Left or right external ventricular assist device implantation | | |
| | | (Regions required) | 350 | 35+T |

**PACEMAKER IMPLANTATION NOS**

| | | | | |
|---|---|---|---|---|
| MASG | 49.71A | Permanent transvenous pacemaker/epicardial pacemaker | 130 | 9+T |
| | | CO=PACM | | 14+T |
| MASG | 49.71B | A-V sequential pacemaker | 200 | 9+T |
| | | CO=PACM | | 14+T |

| | | | | |
|---|---|---|---|---|
| MASG | 49.71C | Insertion of atrial pacemaker | 155 | 9+T |
| | | CO=PACM | | 14+T |
| MASG | 49.71D | Insertion of permanent pacemaker | 130 | 20+T |
| | | AP=THOR | | 20+T |
| | | AP=THOR, CO=PACM | | 25+T |
| | | ME=EXTN | | 9+T |
| | | ME=EXTN, CO=PACM | | 14+T |
| MASG | 49.71E | Insertion of CRT pacemaker/defibrillator device – composite fee | 360 | 9+T |
| | | CO=PACM | | 14+T |
| MASG | 49.71F | Insertion of CRT pacemaker/defibrillator device – team fee | | |
| | | RO=FPHN | 200 | 9+T |
| | | RO=SPHN | 160 | 9+T |
| | | CO=PACM | | 14+T |
| ADON | 49.71G | Defibrillator testing | 60 | 9+T |
| | | CO=PACM | | 14+T |

**IMPLANTATION OF ENDOCARDIAL ELECTRODES**

| | | | | |
|---|---|---|---|---|
| MASG | 49.73A | Implantation of AICD device | 200 | 20+T |
| | | CO=PACM | | 25+T |

**REPLACEMENT OF ENDOCARDIAL ELECTRODES**

| | | | | |
|---|---|---|---|---|
| MASG | 49.82 | Replacement of endocardial electrodes | 130 | 9+T |
| | | CO=PACM | | 14+T |
| MASG | 49.82A | Adjustment transvenous pacemaker leads - within 30 days of insertion | 75 | 9+T |
| | | CO=PACM | | 14+T |
| MASG | 49.82B | Adjustment transvenous pacemaker leads - after 30 days of insertion | 150 | 9+T |
| | | CO=PACM | | 14+T |

**REPLACEMENT OF PULSE GENERATOR**

| | | | | |
|---|---|---|---|---|
| MASG | 49.83A | Battery change of pacemaker | 100 | |
| | | AP=THOR | | 20+T |
| | | AP=THOR, CO=PACM | | 25+T |
| | | ME=EXTN, CO=PACM | | 14+T |
| | | ME=EXTN | | 9+T |

**REMOVAL OF CARDIAC PACEMAKER SYSTEM WITHOUT REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 49.87 | Removal of cardiac pacemaker system without replacement | 150 | 6+T |
| MASG | 49.87B | Complete removal of cardiac pacemaker system without replacement using laser sheath removal of the pacemaker leads, to include any necessary debridement of the chest wall and any imaging - plus multiples, if applicable. | 200 | 14+T |

**OPEN CHEST CARDIAC MASSAGE**

| | | | | |
|---|---|---|---|---|
| ADON | 49.91 | Open chest cardiac massage | 100 | |

**OTHER OPERATIONS ON HEART AND PERICARDIUM NEC**

| | | | | |
|---|---|---|---|---|
| ADON | 49.99A | Retrieval of heart for harvesting of valves | 100 | |
| ADON | 49.99B | MAZE procedure performed during open-heart procedures | 50 | |
| ADON | 49.99C | Repeat open heart surgery | 120 | |

**INCISION OF UPPER LIMB VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.03A | Embolectomy - arm (regions required) | 204 | 5+T |

**INCISION OF AORTA**

| | | | | |
|---|---|---|---|---|
| MASG | 50.04 | Incision of aorta | 76.5 | 5+T |
| MASG | 50.04A | Embolectomy - aortic | 255 | 10+T |

**INCISION OF OTHER THORACIC VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.05A | Pulmonary embolectomy | 300 | 20+T |
| | | CO=CRBY | | 35+T |

**INCISION OF ABDOMINAL ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 50.06A | Embolectomy - inferior or superior | 255 | 10+T |
| MASG | 50.06B | Embolectomy - renal (regions required) | 255 | 10+T |
| MASG | 50.06C | Thrombectomy - iliac (regions required) | 205 | 10+T |

**INCISION OF ABDOMINAL VEINS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.07A | Embolectomy - iliac (regions required) | 200 | 10+T |

**INCISION OF LOWER LIMB VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.08A | Embolectomy - femoral (regions required) | 200 | 10+T |
| MASG | 50.08B | Thrombectomy - femoral (regions required) | 205 | 10+T |

**INCISION OF VESSELS OF UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MISG | 50.09A | Arteriotomy | 35.7 | 5+T |

**ENDARTERECTOMY OF INTRACRANIAL VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.11A | Thromboendarterectomy - with patch graft | 240 | 10+T |

**ENDARTERECTOMY OF OTHER VESSELS OF HEAD AND NECK**

| | | | | |
|---|---|---|---|---|
| MASG | 50.12A | Thromboendarterectomy - with patch graft | 240 | 10+T |

**ENDARTERECTOMY OF UPPER LIMB VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.13A | Thromboendarterectomy - with patch graft | 240 | 10+T |
| MASG | 50.13B | Peripheral arterial graft - brachial (regions required) | 255 | 5+T |
| MASG | 50.13C | Peripheral arterial graft - axillary (regions required) | 255 | 6+T |

**ENDARTERECTOMY OF AORTA**

| | | | | |
|---|---|---|---|---|
| MASG | 50.14B | Thromboendarterectomy - with patch graft | 240 | 10+T |

**ENDARTERECTOMY OF OTHER THORACIC VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.15A | Thromboendarterectomy - with patch graft | 240 | 10+T |
| MASG | 50.15B | Peripheral arterial graft-subclavian (regions required) | 306 | 6+T |

**ENDARTERECTOMY OF ABDOMINAL ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 50.16A | Thromboendarterectomy - with patch graft | 240 | 10+T |
| MASG | 50.16B | Peripheral arterial graft - mesenteric - inferior or superior | 255 | 10+T |

**ENDARTERECTOMY OF ABDOMINAL VEINS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.17A | Aorta-thromboendarterectomy | 306 | 17+T |
| MASG | 50.17B | Aorta-thromboendarterectomy and patch graft | 340 | 17+T |
| MASG | 50.17C | Peripheral arterial graft - renal (regions required) | 255 | 10+T |

**ENDARTERECTOMY OF LOWER LIMB VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.18A | Thromboendarterectomy - with patch graft | 240 | 10+T |
| MASG | 50.18B | Extended profundoplasty - thromboendarterectomy with/without graft | 250 | 10+T |

**ENDARTERECTOMY OF VESSELS OF UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 50.19A | Thromboendarterectomy - with patch graft | 240 | 10+T |

**RESECTION OF OTHER VESSELS OF HEAD AND NECK WITH ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.22A | Incision aneurysm of sinus of valsalva | 510 | 35+T |
| MASG | 50.22B | Excision of carotid aneurysm (regions required) | 306 | 10+T |

**RESECTION OF AORTA WITH ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.24A | Coarctation of aorta | 357 | 20+T |

**RESECTION OF OTHER THORACIC VESSELS WITH ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.25A | Excision of innominate aneurysm | 306 | 10+T |
| MASG | 50.25B | Excision of subclavian, innominate aneurysm (regions required) | 204 | 10+T |

**RESECTION OF ABDOMINAL ARTERIES WITH ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.26A | Excision of iliac aneurysm (regions required) | 204 | 10+T |
| MASG | 50.26B | Excision of splenic/hepatic aneurysm | 204 | 10+T |

**RESECTION OF LOWER LIMB VESSELS WITH ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.28A | Excision of femoral, popliteal aneurysm (regions required) | 204 | 10+T |

**RESECTION OF INTRACRANIAL VESSELS WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 50.31 | Resection of intracranial vessels with replacement | IC | IC+T |

**RESECTION OF OTHER VESSELS OF HEAD AND NECK WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 50.32 | Resection of other vessels of head and neck with replacement | IC | IC+T |
| MASG | 50.32A | Excision of carotid aneurysm (regions required) | 306 | 10+T |

**RESECTION OF UPPER LIMB VESSELS WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 50.33 | Resection of upper limb vessels with replacement | IC | IC+T |

**RESECTION OF AORTA WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 50.34A | Dissecting aneurysm | 408 | 17+T |
| MASG | 50.34B | Excision of thoracic aorta aneurysm | 510 | 35+T |
| MASG | 50.34C | Excision of abdominal aorta aneurysm with rupture | 430 | 20+T |
| MASG | 50.34D | Excision of thoracic aorta aneurysm with rupture | 550 | 35+T |
| MASG | 50.34E | Excision of abdominal aortic aneurysm | 380 | 17+T |

**RESECTION OF OTHER THORACIC VESSELS WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 50.35 | Resection of other thoracic vessels with replacement | IC | IC+T |
| MASG | 50.35A | Excision of innominate aneurysm | 306 | 10+T |
| MASG | 50.35B | Repair of subclavian, innominate aneurysm by graft (regions required) | 255 | 10+T |

**RESECTION OF ABDOMINAL ARTERIES WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 50.36A | Repair of iliac aneurysm by graft | 255 | 10+T |
| MASG | 50.36B | Excision aneurysm - splenic, hepatic - with grafting | 306 | 10+T |

**RESECTION OF ABDOMINAL VEINS WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MASG | 50.37A | Aortic graft plus bilateral common femoral artery repair | 420 | 17+T |
| MASG | 50.37B | Aortic graft plus unilateral common femoral artery repair | 400 | 17+T |
| MASG | 50.37C | Aorta - bifurcation graft | 340 | 17+T |

**RESECTION OF LOWER LIMB VESSELS WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 50.38 | Resection of lower limb vessels with replacement | IC | IC+T |
| MASG | 50.38A | Repair of femoral, popliteal aneurysm by graft (regions required) | 255 | 10+T |

| | | | | |
|---|---|---|---|---|
| MASG | 50.38B | Femoral graft with prosthesis (regions required) | 270 | 10+T |
| MASG | 50.38C | Femoral graft with reverse saphenous vein including harvesting of vein (Regions required) | 310 | 10+T |

**RESECTION OF VESSELS OF UNSPECIFIED SITE WITH REPLACEMENT**

| | | | | |
|---|---|---|---|---|
| MAAS | 50.39 | Resection of vessels of unspecified site with replacement | IC | IC+T |

**LIGATION AND STRIPPING OF VARICOSE VEINS OF LOWER LIMB VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.48A | Ligation of varicose veins - multiple - one leg (regions required) | 80 | 4+T |
| MISG | 50.48B | Venous ligation - long saphenous - sapheno - femoral junction (Regions required) | 50 | 4+T |
| MASG | 50.48C | Venous ligation - long saphenous with stripping (regions required) | 96.9 | 4+T |
| MASG | 50.48D | Ligation - long saphenous - with multiple low ligation - ligation of perforators (Regions required) | 100 | 4+T |
| MASG | 50.48E | Venous ligation - short saphenous ligation and stripping (regions required) | 56.1 | 4+T |
| MASG | 50.48F | Venous ligation and stripping - long and short saphenous (regions required) | 130 | 4+T |
| MASG | 50.48G | High venous ligation with stripping - bilateral | 170 | 4+T |
| MASG | 50.48H | High venous ligation with stripping and multiple low ligations - bilateral | 200 | 4+T |
| MASG | 50.48I | Bilateral long and short saphenous, high ligation and stripping | 180 | 4+T |
| MAAS | 50.48J | Recurrent complicated varicose veins | IC | 4+T |
| MASG | 50.48K | Excision of ulcer - venous ligation and skin graft (regions required) | 127.5 | 4+T |
| MASG | 50.48L | Excision of ulcer - venous ligation and skin graft - both legs | 204 | 4+T |
| ADON | 50.48M | Excision of ulcer - venous ligation and skin graft plus sympathectomy - both legs | 76.5 | 4+T |
| MASG | 50.48N | Sub-fascial venous ligation | 153 | 4+T |
| MASG | 50.48O | Sub-fascial venous ligation - with stripping of veins | 204 | 4+T |
| MASG | 50.48P | Cauterization of varicose veins | 56.1 | 4+T |

**PLICATION OR OTHER INTERRUPTION OF VENA CAVA**

| | | | | |
|---|---|---|---|---|
| MASG | 50.6B | Insertion of filters/balloon into the inferior vena cava AP=PERC | 125 | 10+T |
| MASG | 50.6C | Suture ligation - inferior vena cava | 183.6 | 10+T |

**OTHER SURGICAL OCCLUSION OF OTHER VESSELS OF HEAD AND NECK**

| | | | | |
|---|---|---|---|---|
| MASG | 50.72A | Suture ligation - jugular vein (regions required) | 61.2 | 8+T |

**OTHER SURGICAL OCCLUSION OF AORTA**

| | | | | |
|---|---|---|---|---|
| MASG | 50.74A | Division of vascular ring - esophagus | 255 | 20+T |

**OTHER SURGICAL OCCLUSION OF OTHER THORACIC VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.75A | Repair - banding of pulmonary artery (regions required) | 300 | 35+T |
| | | CO=BPU5 | | 40+T |
| MASG | 50.75B | Coil embolization of collateral vessels in children | | |
| | | - plus multiples, if applicable | 250 | 8+T |
| | | AP=PERC | 350 | 8+T |
| MASG | 50.75C | Device closure of patent ductus arteriosus - in a child | 250 | 8+T |
| MASG | 50.75D | Repair - patent ductus arteriosus | 250 | 20+T |
| | | CO=CRBY | | 35+T |
| | | CO=UN5K | | 25+T |
| MASG | 50.75E | Transection of artery - intra-thoracic | 102 | IC+T |
| MASG | 50.75F | Percutaneous device closure of patent ductus arteriosus - in an adult | 200 | |

**OTHER SURGICAL OCCLUSION OF ABDOMINAL ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 50.76B | Transection of artery - intra-abdominal | 102 | IC+T |

**OTHER SURGICAL OCCLUSION OF ABDOMINAL VEINS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.77A | Transection of artery - peripheral | 76.5 | 4+T |
| MASG | 50.77B | Suture ligation - iliac vein (regions required) | 153 | 10+T |
| MAAS | 50.77C | Portal Vein Embolization | IC at 140 MSU/hr | |

**OTHER SURGICAL OCCLUSION OF LOWER LIMB VESSELS**

| | | | | |
|---|---|---|---|---|
| MASG | 50.78A | Suture ligation - femoral vein superficial (regions required) | 61.2 | 8+T |
| MASG | 50.78B | Suture ligation - popliteal vein (regions required) | 61.2 | 8+T |
| MISG | 50.78C | Suture ligation - saphenous vein (regions required) | 25.5 | 4+T |
| MASG | 50.78D | Suture ligation - femoral vein - deep (regions required) | 61.2 | 8+T |
| MASG | 50.78E | Suture ligation - femoral vein - common (regions required) | 61.2 | 8+T |

**OTHER VENOUS CATHETERIZATION**

| | | | | |
|---|---|---|---|---|
| MASG | 50.93G | Implantation of subcutaneous venous access system (i.e., port-a-cath) | 100 | 5+T |
| MISG | 50.93H | Removal/manipulation of venous access system | 25 | 4+T |

**SYSTEMIC TO PULMONARY ARTERY SHUNT**

| | | | | |
|---|---|---|---|---|
| MASG | 51.0A | Pulmonary repair - aortic anastomosis - Potts (regions required) | 350 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 51.0B | Pulmonary repair - subclavian - Blalock | 350 | 20+T |
| | | CO=CRBY | | 35+T |
| MASG | 51.0C | Repair - Waterston shunt | 350 | 20+T |
| | | CO=CRBY | | 35+T |

**INTRA-ABDOMINAL VENOUS ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.1A | Transjugular intrahepatic porto-systematic shunt | 150 | |
| MASG | 51.1B | Venous anastomosis - umbilical to saphenous shunt | 306 | 10+T |
| MASG | 51.1C | Venous anastomosis - porto-caval (regions required) | 357 | 10+T |
| MASG | 51.1D | Venous anastomosis - spleno-renal (regions required) | 357 | 10+T |
| MASG | 51.1E | Venous anastomosis - meso-caval (regions required) | 357 | 10+T |

**OTHER SHUNT OR VASCULAR BYPASS**

| | | | | |
|---|---|---|---|---|
| ADON | 51.2A | Ex-vivo reconstruction of pancreas with vascular grafts | 200 | |

**AORTA-SUBCLAVIAN-CAROTID BYPASS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.22 | Aorta-subclavian-carotid bypass including harvesting of vein | 300 | 10+T |

**AORTA-RENAL BYPASS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.24 | Aorta-renal bypass including harvesting of vein | 380 | 17+T |

**AORTA-ILIAC-FEMORAL BYPASS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.25A | Aortic graft plus femoropopliteal graft | 550 | 17+T |
| MASG | 51.25B | Iliac artery to popliteal/femoral (regions required) | 275 | 10+T |

**OTHER INTRA-ABDOMINAL SHUNT OR BYPASS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.26A | Spleno/hepato/ileo by-pass graft including harvesting of vein | 380 | 17+T |

**ARTERIOVENOSTOMY FOR RENAL DIALYSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.27 | Arteriovenostomy for renal dialysis | 140 | 4+T |

**OTHER (PERIPHERAL) SHUNT OR BYPASS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.29A | Crossed femoral graft | 240 | 10+T |
| MASG | 51.29B | Axillo-femoral graft (regions required) | 275 | 10+T |
| MASG | 51.29C | Popliteal-tibial arterial graft (regions required) | 255 | 10+T |

| | | | | |
|---|---|---|---|---|
| MASG | 51.29D | In situ venous femoral artery bypass graft (regions required) | 380 | 10+T |
| MASG | 51.29E | Femoral post tibial/peroneal/ant tibial graft with prosthesis (regions required) | 300 | 10+T |

**SUTURE OF VESSEL**

| | | | | |
|---|---|---|---|---|
| MASG | 51.3A | Repair of severed digital artery (regions required)<br>- plus multiples, if applicable | 150 | 4+T |

**REMOVAL OF ARTERIOVENOUS SHUNT FOR RENAL DIALYSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.43 | Removal of arteriovenous shunt for renal dialysis | 102 | 7+T |

**OTHER REVISION OF VASCULAR PROCEDURE**

| | | | | |
|---|---|---|---|---|
| MASG | 51.49A | Removal of infected graft including revascularization - aortic/iliac | 700 | 10+T |
| MASG | 51.49B | Removal of infected graft including revascularization - femoral<br>(Regions required) | 350 | 10+T |

**OTHER REPAIR OF BLOOD VESSEL NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 51.59D | Arterioplasty - femoral (regions required) | 153 | 10+T |
| MASG | 51.59E | Arterioplasty - iliac (regions required) | 153 | 10+T |
| MASG | 51.59F | Femoral post tibial/peroneal/ant tibial graft with reversed vein<br>(Regions required) | 330 | 10+T |
| ADON | 51.59H | Re-Implantation of spinal arteries, per island | 100 | |

**EXTRACORPOREAL CIRCULATION AUXILIARY TO OPEN HEART SURGERY**

| | | | | |
|---|---|---|---|---|
| ADON | 51.61 | Extracorporeal circulation auxiliary to open heart surgery<br>PO=COML<br>PO=PART | 204<br>204 | |
| MASG | 51.61A | Manipulation - cardiac massage - assisted circulation for cardiac/respiratory failure | 400 | 35+T |
| ADON | 51.61B | Off pump CAB (Coronary Artery Bypass) surgery (Octopus, etc.) | 204 | |

**OPERATIONS ON CAROTID BODY AND OTHER VASCULAR BODIES**

| | | | | |
|---|---|---|---|---|
| MASG | 51.8A | Excision of carotid body tumour with graft (regions required) | 331.5 | 10+T |
| MASG | 51.8B | Excision of carotid body tumour with vessel bypass (regions required) | 357 | 10+T |
| MASG | 51.8C | Excision of carotid body tumour (regions required) | 255 | 6+T |

**INJECTION OF SCLEROSING AGENT OR SOLUTION INTO VEIN**

| | | | | |
|---|---|---|---|---|
| MASG | 51.92 | Injection of sclerosing agent or solution into vein (regions required)<br>Compression sclerotherapy (feganization) one per leg per year | 77 | |
| MISG | 51.92 | Injection of sclerosing agent or solution into vein (regions required)<br>Compression sclerotherapy (feganization) RP=SUBS<br>(RP=SUBS - after the first 12 months, 15.3 units is payable per treatment to a maximum of 100 units per succeeding 12-month period)<br><br>Note: Service encounters with a diagnosis of varicose veins, varicose veins with inflammation, or any claim that states compression sclerotherapy or feganization is payable. Service encounters with a diagnosis of spider veins or nevi, telangiectasia, superficial varicosities or for cosmetic reasons are not payable. Any after care (consults or visits) with the same diagnosis by the physician who performed the service is not payable in the following year. | 15.3 | |
| MISG | 51.92A | Injection (vein) single or multiple | 10.2 | |

**REPLACEMENT OF VESSEL-TO-VESSEL CANNULA**

| | | | | |
|---|---|---|---|---|
| MISG | 51.94A | Removal of A.V. shunt | 25.5 | 6+T |

**SIMPLE EXCISION OF LYMPHATIC STRUCTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 52.1A | Cystic hygroma | 180 | 6+T |

**EXCISION OF AXILLARY LYMPH NODE**

| | | | | |
|---|---|---|---|---|
| MISG | 52.13 | Excision of axillary lymph node (regions required) | 32 | 4+T |

**EXCISION OF INGUINAL LYMPH NODE**

| | | | | |
|---|---|---|---|---|
| MISG | 52.14 | Excision of inguinal lymph node (regions required) | 32 | 4+T |

**SIMPLE EXCISION OF OTHER LYMPHATIC STRUCTURE**

| | | | | |
|---|---|---|---|---|
| MISG | 52.19 | Simple excision of other lymphatic structure (regions required)<br>Excision - cervical gland biopsy | 32 | 4+T |

**RADICAL NECK DISSECTION, UNILATERAL**

| | | | | |
|---|---|---|---|---|
| MASG | 52.32 | Radical neck dissection, unilateral (regions required) | 360 | 10+T |
| MASG | 52.32A | Radical neck dissection with preservation of spinal accessory nerve (Regions required) | 380 | 10+T |

**RADICAL NECK DISSECTION, BILATERAL**

| | | | | |
|---|---|---|---|---|
| MASG | 52.33 | Radical neck dissection, bilateral | 540 | 10+T |
| MASG | 52.33A | Radical neck dissection with preservation of spinal accessory nerve | 570 | 10+T |

**RADICAL EXCISION OF OTHER LYMPH NODES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.4A | Retro-peritoneal lymph node dissection | 300 | 8+T |

**RADICAL EXCISION OF AXILLARY LYMPH NODES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.42 | Radical excision of axillary lymph nodes (regions required) | 185 | 6+T |

**RADICAL EXCISION OF PERI-AORTIC LYMPH NODES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.43 | Radical excision of peri-aortic lymph nodes | 150 | 8+T |

**RADICAL EXCISION OF ILIAC LYMPH NODES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.44 | Radical excision of iliac lymph nodes (regions required) | 210 | 6+T |

**RADICAL GROIN DISSECTION**

| | | | | |
|---|---|---|---|---|
| MASG | 52.45 | Radical groin dissection (regions required) | 100 | 6+T |

**RADICAL EXCISION OF OTHER LYMPH NODES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.49A | Staging operation for Hodgkin's Disease | 300 | 8+T |
| MASG | 52.49B | Deep pelvic lymphadenectomy (regions required) | 110 | 8+T |

**OTHER LYMPHANGIOGRAM**

| | | | | |
|---|---|---|---|---|
| MASG | 52.85 | Other lymphangiogram (regions required) | 91.8 | 5+T |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON LYMPHATIC STRUCTURES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.89A | Staging laparotomy includes omentectomy, biopsies and washings (stand alone composite fee) | 275 | 8+T |
| ADON | 52.89B | Staging laparotomy includes omentectomy, biopsies and washings (add on) (when a staging laparotomy is done in conjunction with other procedures by the same surgeon, an add on fee may be approved) | 100 | |
| MASG | 52.89C | Staging laparotomy in addition supracolic omentectomy - stand alone | 325 | 8+T |
| ADON | 52.89D | Staging laparotomy in addition supracolic omentectomy - add on | 150 | |
| ADON | 52.89E | Sentinel Lymph Node Biopsy for cancer | 50 | |

**OTHER OPERATIONS ON LYMPHATIC STRUCTURES**

| | | | | |
|---|---|---|---|---|
| MASG | 52.9B | Radical sleeve excision | 300 | 6+T |
| MASG | 52.9C | Lympho-venous anastomosis | 250 | 6+T |
| MASG | 52.9F | Lymphedema of limbs - modified Kondoleon - excision and grafting | 180 | 5+T |
| MASG | 52.9G | Lymphedema - entire lower limb | 250 | 5+T |

**BONE MARROW TRANSPLANT**

| | | | | |
|---|---|---|---|---|
| MASG | 53.0 | Bone marrow transplant | 2900 | 9+T |
| | | Composite fee day 1-39 in hospital | | |
| MASG | 53.0A | Composite fee day 40 -100 in hospital | 580 | 9+T |

**PUNCTURE OF SPLEEN**

| | | | | |
|---|---|---|---|---|
| MISG | 53.1A | Splenic puncture for injection of contrast substance | 30 | 4+T |

**ASPIRATION OF BONE MARROW FROM DONOR FOR TRANSPLANT**

| | | | | |
|---|---|---|---|---|
| MASG | 53.41 | Aspiration of bone marrow from donor for transplant | 150 | 9+T |

**REPAIR AND PLASTIC OPERATIONS ON SPLEEN**

| | | | | |
|---|---|---|---|---|
| MASG | 53.53A | Splenectomy | 250 | 7+T |

**OTHER OPERATIONS ON SPLEEN NEC**

| | | | | |
|---|---|---|---|---|
| MISG | 53.59 | Other operations on spleen NEC (excision - bone button) | 30 | 4+T |

**OTHER INCISION OF ESOPHAGUS**

| | | | | |
|---|---|---|---|---|
| MASG | 54.09 | Other incision of esophagus | | |
| | | Esophagotomy | | |
| | | AP=CERV | 120 | 6+T |
| | | AP=THOR | 180 | 13+T |

**OTHER LOCAL EXCISION OF ESOPHAGEAL DIVERTICULUM**

| | | | | |
|---|---|---|---|---|
| MASG | 54.22A | Excision intrathoracic diverticulum | 240 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |
| MASG | 54.22B | Excision extrathoracic diverticulum - one stage | 180 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |

**TOTAL ESOPHAGECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 54.33A | Resection of esophagus one stage | 400 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |

**ESOPHAGOGASTROSTOMY (INTRATHORACIC)**

| | | | | |
|---|---|---|---|---|
| MASG | 54.42 | Esophagogastrostomy (intrathoracic) | 300 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |

**ESOPHAGEAL ANASTOMOSIS WITH INTERPOSITION OF SMALL BOWEL (INTRATHORACIC)**

| | | | |
|---|---|---|---|
| MASG | 54.43 | Esophageal anastomosis with interposition of small bowel (intrathoracic) ..... 300 | |
| | | AP=ABDO ..... | 7+T |
| | | AP=CERV ..... | 6+T |
| | | AP=THOR ..... | 13+T |

**OTHER ESOPHAGOENTEROSTOMY (INTRATHORACIC)**

| | | | |
|---|---|---|---|
| MASG | 54.44A | Esophageal bypass with colon/jejunum ..... 350 | |
| | | AP=ABDO ..... | 7+T |
| | | AP=CERV ..... | 6+T |
| | | AP=THOR ..... | 13+T |

**ESOPHAGEAL ANASTOMOSIS WITH INTERPOSITION OF COLON (INTRATHORACIC)**

| | | | |
|---|---|---|---|
| MASG | 54.45 | Esophageal anastomosis with interposition of colon (intrathoracic) | |
| | | RO=FPHN ..... 400 | |
| | | RO=SPHN ..... 100 | |
| | | RO=SNAS ..... 115 | |
| | | AP=ABDO ..... | 7+T |
| | | AP=CERV ..... | 6+T |
| | | AP=THOR ..... | 13+T |

**ESOPHAGEAL ANASTOMOSIS WITH OTHER INTERPOSITION (INTRATHORACIC)**

| | | | |
|---|---|---|---|
| MASG | 54.47 | Esophageal anastomosis with other interposition (intrathoracic) | |
| | | RO=FPHN ..... 400 | |
| | | RO=SPHN ..... 100 | |
| | | RO=SNAS ..... 115 | |
| | | AP=ABDO ..... | 7+T |
| | | AP=CERV ..... | 6+T |
| | | AP=THOR ..... | 13+T |
| MASG | 54.47A | Esophagectomy with immediate reconstruction by interposition of hollow viscus (Stomach, colon, or small bowel) ..... 1000 | |
| | | AP=ABDO ..... | 7+T |
| | | AP=CERV ..... | 6+T |
| | | AP=THOR ..... | 13+T |

**ESOPHAGOMYOTOMY**

| | | | |
|---|---|---|---|
| MASG | 54.6 | Esophagomyotomy ..... 300 | |
| | | AP=ABDO ..... | 7+T |
| | | AP=CERV ..... | 6+T |
| | | AP=THOR ..... | 13+T |
| MASG | 54.6A | Esophagomyotomy and valvuloplasty ..... 350 | |
| | | AP=ABDO ..... | 7+T |
| | | AP=CERV ..... | 6+T |
| | | AP=THOR ..... | 13+T |

**INSERTION OF PERMANENT TUBE INTO ESOPHAGUS**

| | | | | |
|---|---|---|---|---|
| MASG | 54.71 | Insertion of permanent tube into esophagus | | |
| | | - introduction of Souter tube | 75 | 4+T |

**SUTURE OF ESOPHAGUS**

| | | | | |
|---|---|---|---|---|
| MASG | 54.72 | Suture of esophagus | 300 | |
| | | Repair ruptured esophagus | | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |
| MASG | 54.72A | Repair ruptured esophagus - cervical drainage | 175 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |

**REPAIR OF ESOPHAGEAL STRICTURE**

| | | | | |
|---|---|---|---|---|
| MASG | 54.75 | Repair of esophageal stricture | 250 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |
| MASG | 54.75A | Thal Procedure | 350 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |

**INJECTION OR LIGATION OF ESOPHAGEAL VARICES**

| | | | | |
|---|---|---|---|---|
| MASG | 54.91A | Esophageal varices with esophagoscopy | 90 | 4+T |
| MASG | 54.91D | Esophagotomy with ligation of varices | 240 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |
| ADON | 54.91E | Ligation of esophageal varices | 50 | |
| ADON | 54.91F | Injection of esophageal varices | 50 | |

**DILATION OF ESOPHAGUS**

| | | | | |
|---|---|---|---|---|
| MISG | 54.92A | Dilation of esophagus indirect - active, with/without guiding string | 28.5 | 4+T |
| MISG | 54.92B | Dilation of esophagus - passive, using mercury filled tubes | 9.5 | 4+T |
| MISG | 54.92C | Pneumatic dilator | 30 | 4+T |
| MISG | 54.92D | Retrograde dilation | 10 | 4+T |
| MASG | 54.92E | Dilation of esophagus with esophagoscopy | | |
| | | RP=INTL | 120 | 4+T |

| | | | | |
|---|---|---|---|---|
| MISG | 54.92E | Dilation of esophagus with esophagoscopy | | |
| | | RP=REPT | 50 | 4+T |
| MISG | 54.92F | Dilation of esophagus under fluoroscopic control | 35 | 4+T |

**GASTROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 55.0A | Gastrotomy with removal of foreign body | 150 | 7+T |

**TEMPORARY GASTROSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 55.1 | Temporary gastrostomy | 175 | 7+T |

**PERMANENT GASTROSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 55.2 | Permanent gastrostomy | 200 | 7+T |

**PYLOROMYOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 55.3 | Pyloromyotomy | 210 | 10+T |
| | | CO=UN5K, RO=ANAE | | 15+T |

**OTHER LOCAL EXCISION OF LESION OR TISSUE OF STOMACH**

| | | | | |
|---|---|---|---|---|
| MASG | 55.43A | Gastrectomy - wedge resection for ulcer | 185 | 7+T |

**PARTIAL GASTRECTOMY WITH ANASTOMOSIS TO ESOPHAGUS**

| | | | | |
|---|---|---|---|---|
| MASG | 55.5 | Partial gastrectomy with anastomosis to esophagus | 400 | |
| | | AP=ABDO | | 7+T |
| | | AP=CERV | | 6+T |
| | | AP=THOR | | 13+T |

**PARTIAL GASTRECTOMY WITH ANASTOMOSIS TO DUODENUM**

| | | | | |
|---|---|---|---|---|
| MASG | 55.6A | Gastrectomy | | |
| | | PO=PART | 300 | 7+T |
| | | PO=SBTL | 300 | 7+T |
| MASG | 55.6B | Antrectomy or subtotal gastrectomy - plus vagotomy | 300 | 7+T |
| MASG | 55.6C | Gastrectomy plus cholecystectomy at same time | | |
| | | PO=PART | 350 | 7+T |
| | | PO=SBTL | 350 | 7+T |
| MASG | 55.6D | Gastrectomy plus repair of hiatus hernia | | |
| | | PO=PART | 350 | 7+T |
| | | PO=SBTL | 350 | 7+T |
| MASG | 55.6E | Gastrectomy after previous gastroenterostomy or partial gastrectomy | 350 | 7+T |

**PARTIAL GASTRECTOMY WITH ANASTOMOSIS TO JEJUNUM**

| | | | | |
|---|---|---|---|---|
| MASG | 55.7A | Antrectomy or subtotal gastrectomy - plus vagotomy | 300 | 7+T |
| MASG | 55.7B | Gastrectomy plus repair of hiatus hernia | | |
| | | PO=PART | 350 | 7+T |
| | | PO=SBTL | 350 | 7+T |
| MASG | 55.7C | Roux-en-y Anastomosis | 240 | 7+T |
| MASG | 55.7D | Gastrectomy after previous gastroenterostomy or partial gastrectomy | 350 | 7+T |

**OTHER PARTIAL GASTRECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 55.8A | Gastrogastrostomy | 180 | 7+T |
| MASG | 55.8B | Gastrogastrostomy plus vagotomy | 240 | 7+T |

**OTHER TOTAL GASTRECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 55.99 | Other total gastrectomy | 350 | 7+T |

**VAGOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 56.0 | Vagotomy | | |
| | | AP=ABDO | 180 | 7+T |
| | | AP=THOR | 240 | 7+T |

**SELECTIVE VAGOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 56.03 | Selective vagotomy | 245 | 7+T |

**PYLOROPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 56.1 | Pyloroplasty | 180 | 7+T |
| MASG | 56.1A | Pyloroplasty and vagotomy | 240 | 7+T |

**GASTROENTEROSTOMY (WITHOUT GASTRECTOMY)**

| | | | | |
|---|---|---|---|---|
| MASG | 56.2A | Gastroduodenostomy or gastrojejunostomy | 180 | 7+T |
| MASG | 56.2B | Gastroduodenostomy or gastrojejunostomy plus vagotomy | 240 | 7+T |

**REVISION OF GASTRIC ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 56.4A | Excision of gastroduodenal lesion (recurrent ulcer) | 350 | 7+T |
| MASG | 56.4B | Excision of gastro-jejunal lesion (recurrent ulcer) | 350 | 7+T |
| MASG | 56.4C | Excision of gastro-jejunal lesion (recurrent ulcer) plus vagotomy | 400 | 7+T |
| MASG | 56.4D | Excision of gastroduodenal lesion (recurrent ulcer) plus vagotomy | 400 | 7+T |
| MASG | 56.4E | Conversion of Billroth II to Billroth I | 375 | 7+T |

**SUTURE OF STOMACH**

| | | | | |
|---|---|---|---|---|
| MASG | 56.51 | Suture of stomach | 180 | 7+T |

**CLOSURE OF GASTROSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 56.52 | Closure of gastrostomy | 150 | 5+T |

**CLOSURE OF OTHER GASTRIC FISTULA**

| | | | | |
|---|---|---|---|---|
| MASG | 56.53A | Closure of gastrocolic/gastro-jejuno-colic fistula - one stage | 350 | 7+T |
| MASG | 56.53B | Closure of gastrocolic/gastro-jejuno-colic fistula including colostomy - two stages | 350 | 7+T |

**OTHER REPAIR OF STOMACH NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 56.59A | Collis gastroplasty | 400 | 13+T |

**GASTRIC PARTITIONING FOR OBESITY**

| | | | | |
|---|---|---|---|---|
| MASG | 56.93 | Gastric partitioning for obesity - prior approval | 300 | 10+T |
| MASG | 56.93A | Reversal of gastroplasty | 300 | 10+T |

**INCISION OF LARGE INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 57.04A | Enterotomy or colotomy - single | 180 | 6+T |
| MASG | 57.04B | Multiple colotomy with operative sigmoidoscopy | 240 | 6+T |

**OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF DUODENUM**

| | | | | |
|---|---|---|---|---|
| MASG | 57.12 | Other local excision or destruction of lesion or tissue of duodenum | 200 | 6+T |

**OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SMALL INTESTINE, EXCEPT DUODENUM**

| | | | | |
|---|---|---|---|---|
| MASG | 57.14 | Other local excision or destruction of lesion or tissue of small intestine, except duodenum | 200 | 6+T |
| MASG | 57.14A | Meckel's diverticulum | 175 | 6+T |

**OTHER PARTIAL RESECTION OF SMALL INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 57.42A | Enterectomy with anastomosis - small intestine - duodenectomy | 240 | 6+T |
| MASG | 57.42B | Enterectomy with anastomosis - small intestine - other | 240 | 6+T |

**CAECECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 57.52A | Terminal ileum, caecum and ascending colon | 300 | 6+T |

**RIGHT HEMICOLECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 57.53 | Right hemicolectomy | 300 | 7+T |
| MASG | 57.53A | Excision of terminal ileum plus caecum | 300 | 6+T |

**LEFT HEMICOLECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 57.55 | Left hemicolectomy | 300 | 7+T |

**OTHER PARTIAL EXCISION OF LARGE INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 57.59 | Other partial excision of large intestine | 300 | 6+T |
| MASG | 57.59A | Laparoscopic assisted colectomy; right, left, or segmental | | |
| | | RG=ASCE | 350 | 8+T |
| | | RG=DESC | 350 | 8+T |
| | | RG=OTSE | 350 | 8+T |
| MASG | 57.59B | Low anterior resection of rectosigmoid with low pelvic anastomosis (coloproctostomy) | | |
| | | RO=FPHN | 405 | 8+T |
| | | RO=SPHN | 300 | 8+T |

**TOTAL COLECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 57.6A | Enterectomy with colostomy, caecostomy or ileostomy, resection of colon, total colectomy with ileostomy and abdominal perineal resection | 550 | 8+T |
| | | RO=ABAS | 169 | 8+T |
| | | RO=ABDM | 500 | 8+T |
| | | RO=PEAS | 68 | 8+T |
| | | RO=PRIN | 200 | 8+T |
| MASG | 57.6B | Total colectomy without perineal resection | 400 | 8+T |
| MASG | 57.6C | Laparoscopic Total Colectomy | 500 | 8+T |
| MASG | 57.6D | Total proctocolectomy with ileostomy and abdominal perineal resection | | |
| | | RO=FPHN | 550 | 8+T |
| | | RO=SPHN | 400 | 8+T |

**SMALL-TO-SMALL INTESTINAL ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 57.7A | Entero-enterostomy - plus multiples, if applicable | 180 | 6+T |
| MASG | 57.7B | Duodenal atresia-duodeno-jejunostomy | 200 | 6+T |

**BRUSH BIOPSY OF SMALL INTESTINE**

| | | | | |
|---|---|---|---|---|
| MISG | 57.91 | Brush biopsy of small intestine | 50 | |
| ADON | 57.94A | Colonic biopsy during pull through operation for Hirschsprung's Disease (maximum 3 biopsies) - plus multiples, if applicable | 25 | |

**EXTERIORIZATION OF SMALL INTESTINE**

| | | | | |
|---|---|---|---|---|
| ADON | 58.01A | Ileostomy (loop or defunctioning) | 90 | |
| | | RO=SPHN | 67.50 | |

**EXTERIORIZATION OF LARGE INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 58.03 | Exteriorization of large intestine - first stage Mikulicz | 180 | 6+T |

**COLOSTOMY, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 58.11 | Colostomy, unqualified | 175 | 6+T |
| MASG | 58.11A | Caecostomy - as single procedure | 120 | 6+T |
| MASG | 58.11B | Colostomy within one month of definitive procedure | 100 | 6+T |

**ILEOSTOMY, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 58.21A | Ileostomy for ulcerative colitis | 180 | 6+T |
| MASG | 58.21B | Continent ileostomy | 450 | 6+T |

**OTHER ENTEROSTOMY NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 58.39A | Ileostomy/jejunostomy with tube | 175 | 6+T |

**REVISION OF INTESTINAL STOMA, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 58.41A | Revision of colostomy/ileostomy | 65 | 6+T |
| MASG | 58.41B | Revision for stenosis/obstruction more than 4 weeks after original operation | 75 | 6+T |
| MASG | 58.41C | Revision of ileostomy | 60 | 6+T |

**OTHER REVISION OF STOMA OF LARGE INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 58.44A | Revision of colostomy/ileostomy | 65 | 6+T |
| MASG | 58.44B | Revision for stenosis/obstruction more than 4 weeks after original operation | 75 | 6+T |

**CLOSURE OF STOMA OF SMALL INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 58.52A | Closure of enterostomy plus resection | 200 | 6+T |

**CLOSURE OF STOMA OF LARGE INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 58.53 | Closure of stoma of large intestine - closure of colostomy | 200 | 5+T |

**OTHER SUTURE OF SMALL INTESTINE, EXCEPT DUODENUM**

| | | | | |
|---|---|---|---|---|
| MASG | 58.73 | Other suture of small intestine, except duodenum | 150 | 6+T |

**SUTURE OF LARGE INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 58.75A | Closure of perforation | 150 | 6+T |
| MASG | 58.75B | Closure of perforation with colostomy | 250 | 6+T |

**CLOSURE OF FISTULA OF LARGE INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 58.76A | Repair of faecal fistula, radical with resection | 250 | 6+T |

**CORRECTION OF VOLVULUS/INTUSSUSCEPTION**

| | | | | |
|---|---|---|---|---|
| MASG | 58.81 | Correction of volvulus/intussusception | 185 | 6+T |

**APPENDECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 59.0 | Appendectomy (when an appendectomy is claimed with other abdominal surgery, a pathology report is required) | 175 | 6+T |

**DRAINAGE OF APPENDICEAL ABSCESS**

| | | | | |
|---|---|---|---|---|
| MASG | 59.1 | Drainage of appendiceal abscess | 120 | 6+T |

**PROCTOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 60.0A | Proctotomy with exploration | 60 | 4+T |
| MASG | 60.0B | Proctotomy with decompression (imperforate anus) | 60 | 4+T |
| MASG | 60.0C | Proctotomy with drainage (perirectal abscess) | 60 | 4+T |
| MASG | 60.0D | Pelvic abscess – drainage | 75 | 4+T |

**PROCTOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 60.1 | Proctostomy | 150 | 4+T |

**FULGURATION OF RECTAL LESION OR TISSUE (WITH CAUTERY)**

| | | | | |
|---|---|---|---|---|
| MISG | 60.21 | Fulguration of rectal lesion or tissue (with cautery) | 30 | 6+T |
| MASG | 60.21A | Cauterization of small rectal carcinoma | 75 | 4+T |
| MISG | 60.21A | Cauterization of small rectal carcinoma<br>RP=REPT (up to 30 days after initial procedure) | 30 | 4+T |

**LOCAL EXCISION OF RECTAL LESION OR TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 60.24A | Rectal or sigmoid polyp - low | 30 | 4+T |
| MASG | 60.24B | Rectal or sigmoid polyp - upper rectum and sigmoid | 60 | 4+T |
| MASG | 60.24C | Transanal Endoscopic Microsurgery<br>*Physician Restrictions in Place (See Appendix J) | 325 | 6+T |

**SOAVE SUBMUCOSAL RESECTION OF RECTUM**

| | | | | |
|---|---|---|---|---|
| MASG | 60.31B | Anterior resection, mucosectomy and coloanal anastomosis | 450 | 8+T |
| | | RO=ABAS | 119 | 8+T |
| | | RO=ABDM | 350 | 8+T |
| | | RO=PEAS | 68 | 8+T |
| | | RO=PRIN | 200 | 8+T |

**OTHER PULL-THROUGH RESECTION OF RECTUM**

| | | | | |
|---|---|---|---|---|
| MASG | 60.39A | Abdominal - perineal pull through for Hirschsprung's Disease or imperforate anus | 450 | 10+T |
| | | RO=ABAS | 135 | 10+T |
| | | RO=ABDM | 350 | 10+T |
| | | RO=PEAS | 108 | 10+T |
| | | RO=PRIN | 200 | 10+T |
| MASG | 60.39B | Rectal atresia - perineal repair | 240 | 4+T |
| MASG | 60.39C | Rectal atresia - abdomino-perineal repair | 450 | 8+T |
| | | RO=ABAS | 135 | 8+T |
| | | RO=ABDM | 350 | 8+T |
| | | RO=PEAS | 108 | 8+T |
| | | RO=PRIN | 200 | 8+T |
| MASG | 60.39D | Abdomino-perineal repair with normal anal canal | 450 | 8+T |
| | | RO=ABAS | 135 | 8+T |
| | | RO=ABDM | 350 | 8+T |
| | | RO=PEAS | 108 | 8+T |
| | | RO=PRIN | 200 | 8+T |
| MASG | 60.39E | Repair of imperforate anus - membranous obstruction. | 60 | 4+T |

**ABDOMINOPERINEAL RESECTION OF RECTUM**

| | | | | |
|---|---|---|---|---|
| MASG | 60.4B | Laparoscopic Assisted Abdominoperineal Resection<br>*Physician Restrictions in Place (See Appendix J) | 630 | 8+T |
| MASG | 60.4C | Open abdominoperineal resection; complete proctectomy with colostomy | | |
| | | RO=FPHN | 550 | 8+T |
| | | RO=SPHN | 400 | 8+T |

**OTHER ANTERIOR RESECTION**

| | | | | |
|---|---|---|---|---|
| MASG | 60.52 | Other anterior resection | 350 | 8+T |
| MISG | 60.52A | Lower anterior resection where E.E.A. stapler is used | | |
| | | RO=SPHN | 50 | |
| MASG | 60.52B | Laparoscopic assisted anterior resection | | |
| | | RO=FPHN *Physician Restrictions in Place (See Appendix J) | 420 | 8+T |
| | | RO=SPHN | 315 | 8+T |

**POSTERIOR RESECTION**

| | | | | |
|---|---|---|---|---|
| MASG | 60.53 | Posterior resection | 240 | 6+T |

**HARTMANN RESECTION**

| | | | | |
|---|---|---|---|---|
| MASG | 60.55 | Hartmann resection | 325 | 8+T |
| MASG | 60.55B | Sleeve resection villus adenoma and rectal mucosa | 100 | 5+T |

| | | | | |
|---|---|---|---|---|
| MASG | 60.55C | Closure of Enterostomy, large or small intestine; with resection and colorectal/ Ileorectal anastomosis (eg, closure of Hartmann type procedure) | 390 | 8+T |

**OTHER RESECTION OF RECTUM NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 60.59A | Proctosigmoidectomy for prolapse | 300 | 6+T |
| MASG | 60.59B | Proctectomy with rectal mucosectomy, ileoanal anastomosis, and creation of ileal reservoir (Ileal Pouch Anal Astomosis) | 630 | 8+T |

**SUTURE OF RECTUM**

| | | | | |
|---|---|---|---|---|
| MASG | 60.61 | Suture of rectum | | |
| | | AP=EXTR | 120 | 4+T |
| | | AP=INPR | 200 | 6+T |

**ABDOMINAL PROCTOPEXY**

| | | | | |
|---|---|---|---|---|
| MASG | 60.65 | Abdominal proctopexy | 180 | 6+T |

**OTHER PROCTOPEXY**

| | | | | |
|---|---|---|---|---|
| MASG | 60.66A | Rectal prolapse - excision of mucous membrane | 90 | 4+T |
| MASG | 60.66B | Rectal prolapse perineal repair major | 180 | 4+T |
| MASG | 60.66C | Rectal prolapse abdominal approach | 250 | 6+T |

**INCISION OF PERIANAL ABSCESS**

| | | | | |
|---|---|---|---|---|
| MISG | 61.01 | Incision of perianal abscess | 25 | |
| | | AN=LOCL | 25 | |
| MISG | 61.01A | Ischiorectal abscess | 25 | |
| | | AN=LOCL | 25 | |
| MASG | 61.01B | Unroofing | 60 | 4+T |

**ANAL FISTULOTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 61.11A | Seton suture for post-operative fistula | 25 | 4+T |
| MASG | 61.11B | Fistula in-ano, low level | 90 | 4+T |
| MASG | 61.11C | Fistula in-ano, high with division of internal sphincter | 180 | 4+T |

**LOCAL EXCISION OR DESTRUCTION OF OTHER LESION OR TISSUE OF ANUS**

| | | | | |
|---|---|---|---|---|
| MASG | 61.2 | Local excision or destruction of other lesion or tissue of anus | 60 | 4+T |
| MISG | 61.2A | Cauterization of fissure | 10 | 4+T |

| | | | | |
|---|---|---|---|---|
| MISG | 61.2B | Electro-desiccation of condylomata | 25 | 4+T |
| MISG | 61.2C | Local excision for malignancy | 30 | 4+T |
| MISG | 61.2D | Excision biopsy of anus | | |
| | | AN=GENL | 20 | 4+T |

**EXCISION OF HEMORRHOIDS**

| | | | | |
|---|---|---|---|---|
| MASG | 61.36A | Hemorrhoidectomy with sigmoidoscopy and excision of fissure | 90 | 4+T |

**EVACUATION OF THROMBOSED HEMORRHOIDS**

| | | | | |
|---|---|---|---|---|
| MISG | 61.37 | Evacuation of thrombosed hemorrhoids - plus multiples, if applicable | 22.5 | |
| | | AN=GENL | 35 | 4+T |
| | | AN=LOCL | 22.5 | |

**OTHER PROCEDURES ON HEMORRHOIDS**

| | | | | |
|---|---|---|---|---|
| MISG | 61.39A | Excision of anal polyp, hemorrhoidal tags | 30 | 4+T |

**DIVISION OF ANAL SPHINCTER**

| | | | | |
|---|---|---|---|---|
| MASG | 61.4A | Internal sphincterotomy plus excision of fissure | 85 | 4+T |

**OTHER REPAIR OF ANUS AND ANAL SPHINCTER**

| | | | | |
|---|---|---|---|---|
| MASG | 61.69B | Rectal prolapse - Thiersch Wire Procedure | 60 | 4+T |
| MASG | 61.69C | Excision of scar, for stenosis | 60 | 4+T |
| MASG | 61.69D | Anoplasty - for stenosis | 120 | 4+T |
| MASG | 61.69E | Repair of anal sphincter | 150 | 4+T |
| MASG | 61.69F | Repair of anal sphincter and anorectal ring | 200 | 4+T |
| MASG | 61.69G | Comprehensive anal sphincteroplasty for the treatment of anal incontinence | 220 | 4+T |

**HEPATOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 62.0 | Hepatotomy | 180 | 7+T |
| MASG | 62.0A | Drainage of abscess/cyst of liver | 180 | 7+T |
| MASG | 62.0B | Removal of foreign body of liver | 180 | 7+T |
| MASG | 62.0C | Incision and packing of wound of liver | 180 | 7+T |

**MARSUPIALIZATION OF LESION OF LIVER**

| | | | | |
|---|---|---|---|---|
| MASG | 62.11 | Marsupialization of lesion of liver | 185 | 7+T |

**PARTIAL HEPATECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 62.12 | Partial hepatectomy - local excision of lesion | 200 | 7+T |
| ADON | 62.12A | Open liver biopsy | 25 | |

**LOBECTOMY OF LIVER**

| | | | | |
|---|---|---|---|---|
| MASG | 62.2 | Lobectomy of liver | 475 | 12+T |

**OTHER TRANSPLANT OF LIVER**

| | | | | |
|---|---|---|---|---|
| MASG | 62.49 | Other transplant of liver | | |
| | | RO=FPHN | 1450 | 45+T |
| | | RO=SPHN | | 460 |
| | | RO=SSAN | | Time Only |
| MASG | 62.49A | Recipient hepatectomy | | |
| | | RO=FPHN | 1000 | |
| | | RO=SPHN | 460 | |
| MASG | 62.49B | Donor hepatectomy | | |
| | | RO=FPHN | 500 | 20+T |
| | | RO=SPHN | 350 | 20+T |

**SUTURE OF LIVER**

| | | | | |
|---|---|---|---|---|
| MASG | 62.51 | Suture of liver | 185 | 8+T |

**OTHER CHOLECYSTOTOMY AND CHOLECYSTOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 63.09 | Other cholecystotomy and cholecystostomy | 175 | 7+T |

**TOTAL CHOLECYSTECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 63.12 | Total cholecystectomy | 235 | 7+T |
| MASG | 63.12A | Cholecystectomy and exploration of bile duct | 275 | 7+T |
| MASG | 63.12B | Cholecystectomy with operative cholangiogram | 260 | 7+T |
| MASG | 63.12C | Cholecystectomy and exploration of bile duct with operative cholangiogram | 300 | 7+T |
| MASG | 63.12D | Cholecystectomy and exploration of bile duct plus duodenostomy | 300 | 7+T |

**ANASTOMOSIS OF GALLBLADDER TO INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 63.22 | Anastomosis of gallbladder to intestine | 180 | 7+T |
| MASG | 63.22A | Cholecystenterostomy plus enteroenterostomy | 250 | 7+T |

**ANASTOMOSIS OF GALLBLADDER TO STOMACH**

| | | | | |
|---|---|---|---|---|
| MASG | 63.24 | Anastomosis of gallbladder to stomach | 180 | 7+T |

**ANASTOMOSIS OF COMMON BILE DUCT TO INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 63.26 | Anastomosis of common bile duct to intestine | 240 | 7+T |
| MASG | 63.26A | Choledochojejunostomy with roux-en-y loop | 300 | 8+T |

**COMMON DUCT EXPLORATION FOR REMOVAL OF CALCULUS**

| | | | | |
|---|---|---|---|---|
| MASG | 63.31A | Common duct exploration with duodenotomy, sphincterotomy and removal of stone | 300 | 7+T |

**INCISION OF COMMON DUCT**

| | | | | |
|---|---|---|---|---|
| MASG | 63.41 | Incision of common duct - common duct exploration | 240 | 7+T |

**EXCISION OF AMPULLA OF VATER (WITH REIMPLANTATION OF COMMON DUCT)**

| | | | | |
|---|---|---|---|---|
| MASG | 63.52 | Excision of ampulla of vater (with reimplantation of common duct) | 275 | 7+T |

**OTHER EXCISION OF COMMON DUCT**

| | | | | |
|---|---|---|---|---|
| MASG | 63.53 | Other excision of common duct choledochectomy | 300 | 7+T |

**EXCISION OF OTHER BILE DUCT**

| | | | | |
|---|---|---|---|---|
| MASG | 63.59 | Excision of other bile duct lesion of hepatic ducts | 275 | 7+T |

**CHOLEDOCHOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 63.62 | Choledochoplasty | 400 | 7+T |

**REPAIR OF OTHER BILE DUCTS**

| | | | | |
|---|---|---|---|---|
| MASG | 63.69A | Biliary tract - closure of fistula | 275 | 7+T |
| MASG | 63.69B | Repair of hepatic duct injuries by jejunal mucosal grafting (regions required) | 500 | 8+T |

**OTHER PANCREATOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 64.09 | Other pancreatotomy | 200 | 7+T |

**LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PANCREAS AND PANCREATIC DUCT**

| | | | | |
|---|---|---|---|---|
| MASG | 64.1 | Local excision or destruction of lesion or tissue of pancreas and pancreatic duct | 240 | 7+T |
| MASG | 64.1A | Islet cell tumour | 240 | 7+T |
| MASG | 64.1B | Excision of pancreatic cyst | 240 | 7+T |

**MARSUPIALIZATION OF PANCREATIC CYST**

| | | | | |
|---|---|---|---|---|
| MASG | 64.2 | Marsupialization of pancreatic cyst | 200 | 7+T |

**INTERNAL DRAINAGE OF PANCREATIC CYST**

| | | | | |
|---|---|---|---|---|
| MASG | 64.3 | Internal drainage of pancreatic cyst | 200 | 7+T |

**DISTAL PANCREATECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 64.42 | Distal pancreatectomy | 240 | 7+T |

**TOTAL PANCREATECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 64.5 | Total pancreatectomy | 500 | 9+T |
| MASG | 64.5A | Donor pancreatectomy | 500 | 10+T |

**RADICAL PANCREATICODUODENECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 64.6 | Radical pancreaticoduodenectomy | 500 | 9+T |

**ANASTOMOSIS OF PANCREAS (DUCT)**

| | | | | |
|---|---|---|---|---|
| MASG | 64.7A | Pancreaticogastrostomy - duodenostomy - jejunostomy | 240 | 7+T |
| MASG | 64.7B | Pancreaticogastrostomy | 240 | 7+T |
| MASG | 64.7C | Pancreaticogastrostomy - duodenostomy | 240 | 7+T |
| MASG | 64.7D | Puestow Procedure | 400 | 9+T |

**PANCREATIC TRANSPLANT, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 64.81A | Implantation of pancreas | 460 | 10+T |

**REPAIR OF INGUINAL HERNIA, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 65.01 | Repair of inguinal hernia, unqualified (regions required) | 140 | 4+T |
| MASG | 65.01A | Repair of inguinal hernia with hydrocoele (regions required) | 160 | 4+T |
| MASG | 65.01B | Strangulated/incarcerated hernia - without resection (regions required) - plus multiples, if applicable | 160 | 8+T |
| MASG | 65.01C | Strangulated/incarcerated hernia - with resection (regions required) - plus multiples, if applicable | 250 | 8+T |
| MASG | 65.01D | Recurrent hernia (regions required) | 200 | 4+T |
| MASG | 65.01E | Sliding hernia (regions required) | 140 | 4+T |
| MASG | 65.01F | Repair of inguinal hernia, unqualified, by laparoscopy (regions required) | 140 | 6+T |
| MASG | 65.01G | Repair of inguinal hernia, unqualified, by laparoscopy with hydrocoele (Regions required) | 160 | 6+T |
| MASG | 65.01H | Strangulated/incarcerated hernia - without resection - by laparoscopy (Regions required) - plus multiples, if applicable | 160 | 8+T |
| MASG | 65.01I | Recurrent hernia - by laparoscopy (regions required) | 200 | 6+T |
| MASG | 65.01J | Sliding hernia - by laparoscopy (regions required) | 140 | 6+T |

**REPAIR OF FEMORAL HERNIA**

| | | | | |
|---|---|---|---|---|
| MASG | 65.04 | Repair of femoral hernia (regions required) | 140 | 4+T |
| MASG | 65.04A | Strangulated/incarcerated hernia - without resection (Regions required) - plus multiples, if applicable | 160 | 8+T |
| MASG | 65.04B | Strangulated/incarcerated hernia - with resection (Regions required) - plus multiples, if applicable | 250 | 8+T |
| MASG | 65.04C | Recurrent hernia (regions required) | 200 | 4+T |
| MASG | 65.04D | Repair of femoral hernia by laparoscopy (regions required) | 140 | 6+T |
| MASG | 65.04E | Strangulated/incarcerated hernia - without resection - by laparoscopy (Regions required) - plus multiples, if applicable | 160 | 8+T |
| MASG | 65.04F | Recurrent hernia - by laparoscopy (regions required) | 200 | 6+T |
| MASG | 65.04G | Repair of inguinal and femoral hernia - same side (regions required) | 160 | 4+T |

**REPAIR OF INGUINAL HERNIA, UNQUALIFIED, WITH GRAFT OR PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 65.11 | Repair of inguinal hernia, unqualified, with graft or prosthesis (Regions required) | 160 | 4+T |
| MASG | 65.11A | Recurrent hernia repair by prosthesis or graft (regions required) | 210 | 4+T |

**REPAIR OF FEMORAL HERNIA WITH GRAFT OR PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 65.14 | Repair of femoral hernia with graft or prosthesis (regions required) | 160 | 4+T |
| MASG | 65.14A | Recurrent hernia repair by prosthesis or graft (regions required) | 210 | 4+T |

**BILATERAL REPAIR OF INGUINAL HERNIA, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 65.21 | Bilateral repair of inguinal hernia, unqualified | 210 | 4+T |
| MASG | 65.21A | Bilateral repair of inguinal hernia, unqualified, with hydrocoele | 240 | 4+T |
| MASG | 65.21B | Strangulated/incarcerated hernia - without resection | 240 | 8+T |
| MASG | 65.21C | Strangulated/incarcerated hernia - with resection | 375 | 8+T |
| MASG | 65.21D | Recurrent hernia | 300 | 4+T |
| MASG | 65.21E | Sliding hernia | 210 | 4+T |
| MASG | 65.21F | Bilateral repair of inguinal hernia, unqualified by laparoscopy | 210 | 6+T |
| MASG | 65.21G | Bilateral repair of inguinal hernia, unqualified by laparoscopy with hydrocoele | 240 | 6+T |
| MASG | 65.21H | Strangulated/incarcerated hernia - without resection - by laparoscopy | 240 | 8+T |

| | | | | |
|---|---|---|---|---|
| MASG | 65.21I | Recurrent hernia - by laparoscopy | 300 | 6+T |
| MASG | 65.21J | Sliding hernia - by laparoscopy | 210 | 6+T |

**BILATERAL REPAIR OF FEMORAL HERNIA**

| | | | | |
|---|---|---|---|---|
| MASG | 65.25 | Bilateral repair of femoral hernia | 210 | 4+T |
| MASG | 65.25A | Strangulated/incarcerated hernia - without resection | 240 | 8+T |
| MASG | 65.25B | Strangulated/incarcerated hernia - with resection | 375 | 8+T |
| MASG | 65.25C | Recurrent hernia | 300 | 4+T |
| MASG | 65.25D | Bilateral repair of femoral hernia by laparoscopy | 210 | 6+T |
| MASG | 65.25E | Strangulated/incarcerated hernia - without resection - by laparoscopy | 240 | 8+T |
| MASG | 65.25F | Recurrent hernia - by laparoscopy | 300 | 6+T |
| MASG | 65.25G | Repair of inguinal and femoral hernia (both), each side | 240 | 4+T |

**BILATERAL REPAIR OF INGUINAL HERNIA, UNQUALIFIED, WITH GRAFT OR PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 65.31 | Bilateral repair of inguinal hernia, unqualified, with graft or prosthesis | 240 | 4+T |
| MASG | 65.31A | Recurrent hernia repair by prosthesis or graft | 315 | 4+T |

**BILATERAL REPAIR OF FEMORAL HERNIA WITH GRAFT OR PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 65.35 | Bilateral repair of femoral hernia with graft or prosthesis | 240 | 4+T |
| MASG | 65.35A | Recurrent hernia repair by prosthesis or graft | 315 | 4+T |

**REPAIR OF UMBILICAL HERNIA WITH PROSTHESIS**

| | | | | |
|---|---|---|---|---|
| MASG | 65.41A | Recurrent umbilical hernia repair with prosthesis or graft | 210 | 4+T |

**OTHER REPAIR OF UMBILICAL HERNIA**

| | | | | |
|---|---|---|---|---|
| MASG | 65.49 | Other repair of umbilical hernia | | |
| | | AG=ADUT | 150 | 4+T |
| | | AG=CH16 | 90 | 4+T |
| MASG | 65.49A | Strangulated/incarcerated hernia - without resection - plus multiples, if applicable | 160 | 8+T |
| MASG | 65.49B | Strangulated/incarcerated hernia - with resection - plus multiples, if applicable | 250 | 8+T |
| MASG | 65.49C | Omphalocoele - infant | 250 | 10+T |
| MASG | 65.49D | Recurrent hernia | 200 | 4+T |
| MASG | 65.49E | Strangulated/incarcerated hernia - without resection - by laparoscopy - plus multiples, if applicable | 160 | 8+T |

| | | | | |
|---|---|---|---|---|
| MASG | 65.49F | Recurrent hernia - by laparoscopy | 200 | 6+T |

**REPAIR OF INCISIONAL HERNIA**

| | | | | |
|---|---|---|---|---|
| MASG | 65.51 | Repair of incisional hernia | 200 | 6+T |
| MASG | 65.51A | Recurrent hernia | 200 | 4+T |
| MASG | 65.51B | Incisional hernia post-operative repair by prosthesis | 210 | 6+T |
| MASG | 65.51D | Initial ventral or incisional hernia repair by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis | 220 | 6+T |
| MASG | 65.51E | Reccurent verntral or incisional hernia repair, by laparoscopy, reducible Or strangulated, with mesh, with or without enterolysis | 325 | 6+T |

**REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL**

| | | | | |
|---|---|---|---|---|
| MASG | 65.59A | Recurrent hernia | 200 | 4+T |
| MASG | 65.59B | Epigastric hernia | 140 | 4+T |
| MASG | 65.59D | Total Abdominal Wall Reconstruction with myofascial advancement flaps | IC 130/hr | 8+T |

**REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH**

| | | | | |
|---|---|---|---|---|
| MASG | 65.7 | Repair of diaphragmatic hernia, abdominal approach | 240 | 9+T |
| MASG | 65.7A | Recurrent hiatal hernia repair, abdominal approach | 375 | 9+T |
| MASG | 65.7B | Pyloroplasty/gastroenterostomy with vagotomy and hiatal hernia | 300 | 7+T |
| MASG | 65.7C | Diaphragmatic hernia with prosthesis | 275 | 9+T |
| MASG | 65.7D | Esophageal hiatus hernia | 250 | 7+T |

**REPAIR OF DIAPHRAGMATIC HERNIA, THORACIC APPROACH**

| | | | | |
|---|---|---|---|---|
| MASG | 65.8 | Repair of diaphragmatic hernia, thoracic approach | 240 | 13+T |
| MASG | 65.8A | Recurrent hiatal hernia repair, thoracic approach | 375 | 13+T |
| MASG | 65.8B | Belsey Procedure - modified/straight | 325 | 13+T |
| MASG | 65.8C | Esophageal hiatus hernia | 275 | 13+T |
| MASG | 65.8D | Repair of diaphragmatic hernia, thoracic approach with prosthesis | 275 | 13+T |

**INCISION OF ABDOMINAL WALL**

| | | | | |
|---|---|---|---|---|
| COCR | 66.0A | Drainage of abdominal wall abscess AN=GENL | 30 | 4+T |
| MAAS | 66.0B | Gun shot - removal foreign body, abdominal wall | IC | IC+T |

**OTHER LAPAROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 66.19 | Other laparotomy | 175 | 6+T |
| MASG | 66.19A | Lap with insertion of zipper fastener | 100 | 6+T |
| MASG | 66.19B | Drainage of subphrenic abscess | 180 | 7+T |
| MASG | 66.19C | Drainage of abdominal abscess | 180 | 6+T |

**EXCISION OR DESTRUCTION OF LESION OR TISSUE OF ABDOMINAL WALL OR UMBILICUS**

| | | | | |
|---|---|---|---|---|
| MASG | 66.2A | Umbilectomy - plastic | 60 | 4+T |

**EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PERITONEUM**

| | | | | |
|---|---|---|---|---|
| MASG | 66.3 | Excision or destruction of lesion or tissue of peritoneum | 175 | 6+T |
| MASG | 66.3B | Resection of mesentery | 175 | 6+T |
| MAAS | 66.3C | Excision of desmoid tumour | IC | 4+T |
| MASG | 66.3D | Excision of mesenteric cyst | 175 | 6+T |

**FREEING OF PERITONEAL ADHESIONS**

| | | | | |
|---|---|---|---|---|
| MASG | 66.4A | Intestinal obstruction - without resection | 250 | 8+T |
| MASG | 66.4B | Intestinal obstruction - with resection | 300 | 8+T |
| MASG | 66.4C | Intestinal obstruction - two stage with enterostomy, resection and subsequent closure | 300 | 8+T |

**RECLOSURE OF POST-OPERATIVE DISRUPTION OF ABDOMINAL WALL**

| | | | | |
|---|---|---|---|---|
| MASG | 66.51A | Secondary closure for evisceration | 115 | 6+T |

**PLICATION OF (SMALL) INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 66.61 | Plication of (small) intestine | 240 | 6+T |

**REPAIR OF GASTROSCHISIS**

| | | | | |
|---|---|---|---|---|
| MASG | 66.63 | Repair of gastroschisis | 100 | 10+T |

**OTHER REPAIR OF ABDOMINAL WALL**

| | | | | |
|---|---|---|---|---|
| MASG | 66.64A | Omental flap to repair extra-abdominal defect - abdominal surgery | 250 | IC+T |
| MASG | 66.64B | Omental flap to repair extra-abdominal defect - plastic surgery | 150 | IC+T |

**BIOPSY OF PERITONEUM**

| | | | | |
|---|---|---|---|---|
| ADON | 66.82A | Omental biopsy | 25 | |

**LAPAROSCOPY**

| | | | | |
|---|---|---|---|---|
| MASG | 66.83 | Laparoscopy | 88 | 6+T |
| | | ME=LASR | 138 | 6+T |
| | | ME=ELEC | 138 | 6+T |

**CREATION OF PERITONEOVASCULAR SHUNT**

| | | | | |
|---|---|---|---|---|
| MASG | 66.94 | Creation of peritoneovascular shunt | 175 | 6+T |

**PERITONEAL DIALYSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 66.98C | Laparotomy for insertion of peritoneal catheter | 125 | 6+T |
| MASG | 66.98D | Laparotomy for removal of peritoneal catheter | 125 | 6+T |

**OTHER OPERATIONS IN ABDOMINAL REGION NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 66.99A | Excision of retroperitoneal tumour | 300 | 7+T |
| MAAS | 66.99B | Cytoreductive Surgery with or without perioperative intraperitoneal chemotherapy (Sugarbaker Procedure) | IC at 175MSU/hr | 12+T |

**REPAIR OF OTHER FISTULA OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.73A | Closure of recto-vesical or rectro-vaginal fistula - including colostomy and closing of colostomy | 300 | 6+T |
| MASG | 69.73G | Closure of fistula recto-vesical | 200 | 6+T |
| ADON | 69.77A | Duodenal neocystotomy of a pancreas | 180 | |

**ASPIRATION BIOPSY OF OVARY**

| | | | | |
|---|---|---|---|---|
| MISG | 77.81A | Transvaginal ultrasound - guided needle aspiration of endometrium or simple ovarian cyst | | |
| | | SP=GNSG | 35 | |
| | | SP=OBGY | 35 | |

**TOTAL SALPINGECTOMY (UNILATERAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 78.1A | Salpingectomy for morbidity, not for sterilization (regions required) | 130 | 6+T |

**OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES**

| | | | | |
|---|---|---|---|---|
| MASG | 78.39A | Interruption or removal of fallopian tubes for the purpose of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral) | 105 | 6+T |

**PELVIC EVISCERATION**

| | | | | |
|---|---|---|---|---|
| MASG | 80.7 | Pelvic evisceration | | |
| | | AP=ANTE | 600 | 8+T |
| | | AP=POST | 600 | 8+T |
| | | PO=COML | 750 | 8+T |

**REPAIR OF FISTULA OF VAGINA**

| | | | | |
|---|---|---|---|---|
| MASG | 82.62 | Repair of fistula of vagina | 200 | 6+T |

**CERVICAL CAESAREAN SECTION**

| | | | | |
|---|---|---|---|---|
| OBST | 86.1 | Cervical caesarean section | | |
| | | SP=GNSG | 366.91 | 7+T |
| | | SP=OBGY | 366.91 | 7+T |
| | | -plus multiples, if applicable | 49.39 | |
| | | CO=INFE | | 10+T |
| OBST | 86.1A | Caesarean section with tubal ligation | | |
| | | SP=GNSG | 395.13 | 7+T |
| | | SP=OBGY | 395.13 | 7+T |
| | | -plus multiples if applicable | 49.39 | |
| | | CO=INFE | | 7+T |

**REMOVAL OF INTRAPERITONEAL EMBRYO**

| | | | | |
|---|---|---|---|---|
| MASG | 86.3A | Surgical removal of extrauterine (ectopic) pregnancy - by any means (regions required) | 130 | 6+T |

**DELIVERY NEC**

| | | | | |
|---|---|---|---|---|
| OBST | 87.98 | Delivery NEC | | |
| | | RF=REFD | 200 | 4+T |
| | | Multiple vaginal births - each additional | | |
| | | - plus multiples, if applicable | 65 | |

**DIVISION OF OTHER FACIAL BONE**

| | | | | |
|---|---|---|---|---|
| MASG | 88.72A | Maxillectomy for carcinoma | 300 | 10+T |

**OTHER PARTIAL OSTECTOMY, UNSPECIFIED SITE**

| | | | | |
|---|---|---|---|---|
| MASG | 89.79B | Excision elongated styloid process via neck exploration external | 150 | 4+T |

**TOTAL OSTECTOMY, SCAPULA, CLAVICLE AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| MASG | 89.80A | First rib resection with thoracotomy | 250 | 13+T |
| MASG | 89.80D | First rib resection | 230 | 9+T |

**OTHER REPAIR OR PLASTIC OPERATION ON BONE**

| | | | | |
|---|---|---|---|---|
| MASG | 90.4A | Reclosure of sternal wound | 150 | 9+T |
| MASG | 90.4B | Resternotomy for post-op hemorrhage | 150 | 20+T |

**OTHER REPAIR OR PLASTIC OPERATION ON BONE OTHER REPAIR OR PLASTIC OPERATION ON BONE, SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)**

| | | | | |
|---|---|---|---|---|
| MASG | 90.40B | Repair of Sternal Non-union | 750 | 20+T |

**INCISION AND DRAINAGE OF PALMAR AND THENAR SPACE**

| | | | | |
|---|---|---|---|---|
| MASG | 94.04 | Incision and drainage of palmar and thenar space | | |
| | | AN=GENL (regions required) | 80 | 4+T |
| | | AN=REGL (regions required) | 80 | 4+T |

**INCISION OF OTHER SOFT TISSUE**

| | | | | |
|---|---|---|---|---|
| MASG | 95.09A | Incision abscess – plantar space | | |
| | | AN=GENL (regions required) | 80 | 4+T |
| | | AN=REGL (regions required) | 80 | 4+T |

**EXCISION OF LESION OF OTHER SOFT TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 95.29B | Tru cut needle biopsy | 38 | |

**MASTOTOMY**

| | | | | |
|---|---|---|---|---|
| COCR | 97.0A | Incision and drainage of intramammary abscess single or multiloculated | | |
| | | RP=INTL (regions required) | 40 | 4+T |
| | | RP=REPT (regions required) | 40 | 4+T |

**LOCAL EXCISION OF LESION OF BREAST**

| | | | | |
|---|---|---|---|---|
| MASG | 97.11 | Local excision of lesion of breast (regions required) | | |
| | | - plus multiples, if applicable | 62 | 4+T |
| MASG | 97.11A | Excisional biopsy of breast - with imaging control (regions required) | 100 | 4+T |
| | | - plus multiples, if applicable | | |
| MASG | 97.11B | Lumpectomy for breast tumour (regions required) | | |
| | | - plus multiples, if applicable | 75 | 4+T |

**UNILATERAL COMPLETE MASTECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.12 | Unilateral complete mastectomy | | |
| | | ME=SIMP, SE=FEML (regions required) | 135 | 4+T |
| | | ME=SIMP, SE=MALE (regions required) | 120 | 4+T |

**BILATERAL COMPLETE MASTECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.13 | Bilateral complete mastectomy | | |
| | | ME=SIMP, SE=FEML | 202.5 | 4+T |
| | | ME=SIMP, SE=MALE | 180 | 4+T |

**UNILATERAL EXTENDED SIMPLE MASTECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.14 | Unilateral extended simple mastectomy | | |
| | | ME=RADI (regions required) | 280 | 6+T |
| ADON | 97.14A | Where skin graft is necessary add to simple mastectomy or radical or modified radical mastectomy (regions required) | 50 | |

**BILATERAL EXTENDED SIMPLE MASTECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.15 | Bilateral extended simple mastectomy | | |
| | | ME=RADI | 420 | 6+T |
| | | May not be billed with 52.89E or 52.42 | | |

| | | | | |
|---|---|---|---|---|
| ADON | 97.15A | Where skin graft is necessary add to simple mastectomy or radical or modified radical mastectomy<br>RG=BOTH ..... 75 | | |

**RESECTION OF QUADRANT OF BREAST**

| | | | | |
|---|---|---|---|---|
| MASG | 97.27 | Resection of quadrant of breast (regions required) ..... 110 | | 4+T |
| MASG | 97.27A | Quadrant resection, lumpectomy, radical mastectomy with axillary dissection .. 280<br>(Regions required) | | 6+T |

**UNILATERAL REDUCTION MAMMOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.31A | Unilateral mammoplasty with nipple transplantation (regions required) ..... 163<br>- prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | | 8+T |
| MASG | 97.31C | Unilateral functional pedicled breast reduction (regions required)..... 250<br>- prior approval unless performed for malignant or pre-malignant conditions | | 8+T |

**BILATERAL REDUCTION MAMMOPLASTY**

| | | | | |
|---|---|---|---|---|
| MASG | 97.32 | Bilateral reduction mammoplasty ..... 244.5<br>- prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | | 8+T |
| MASG | 97.32B | Bilateral functional pedicled breast reduction ..... 375<br>- prior approval unless performed for malignant or pre-malignant conditions | | 8+T |

**UNILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 97.43 | Unilateral augmentation mammoplasty by implant or graft (regions required) .. 128<br>- prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | | 5+T |

**BILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT**

| | | | | |
|---|---|---|---|---|
| MASG | 97.44 | Bilateral augmentation mammoplasty by implant or graft ..... 192<br>- prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition | | 5+T |

**INCISION OF PILONIDAL SINUS OR CYST**

| | | | | |
|---|---|---|---|---|
| COCR | 98.02 | Incision of pilonidal sinus or cyst<br>AN=GENL..... 30 | | 4+T |
| MISG | 98.02 | Incision of pilonidal sinus or cyst ..... 25<br>AN=LOCL ..... 25 | | 4+T |

**OTHER INCISION WITH DRAINAGE OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.03A | Incision abscess, subcutaneous - boil, carbuncle, infected cyst, superficial lymphadenitis, paronychia, felon, etc.<br>AN=GENL..... 25 | | 4+T |

| | | | | |
|---|---|---|---|---|
| MISG | 98.03C | Incision of hematoma | 28 | |
| | | AN=GENL | 40 | 4+T |
| | | AN=LOCL | 28 | |

**INCISION WITH REMOVAL OF FOREIGN BODY OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.04 | Incision with removal of foreign body of skin and subcutaneous tissue | 27.5 | |
| | | AN=GENL | 27.5 | 4+T |
| | | AN=LOCL | 27.5 | |
| MISG | 98.04B | Removal of complicated foreign body - plus multiples, if applicable | | |
| | | AN=GENL | 50 | 4+T |

**DEBRIDEMENT OF WOUND OR INFECTED TISSUE**

| | | | | |
|---|---|---|---|---|
| MAAS | 98.11 | Debridement of wound or infected tissue | | |
| | | ME=COMP | IC | IC+T |
| MASG | 98.11A | Excision of stasis ulcer and skin graft (regions required) | 81.6 | 4+T |

**LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.12A | Removal of fibroma - plus multiples, if applicable | 27.5 | |
| | | AN=GENL | 27.5 | 4+T |
| | | AN=LOCL | 27.5 | |
| MISG | 98.12B | Carcinoma of skin - local excision, primary closure - plus multiples, if applicable | 40 | 4+T |
| MASG | 98.12F | Excision - lipoma - complicated, large and involving deeper structures | 65 | 4+T |
| MASG | 98.12H | Excision - dermoid cyst - face/skull | 96 | 4+T |
| MISG | 98.12M | Curettage of plantar warts, junctional nevi or molluscum contagiosum - plus multiples, if applicable | 14 | 4+T |
| MISG | 98.12N | Excision of plantar warts, junctional nevi or molluscum contagiosum - plus multiples, if applicable | 25 | 4+T |
| MISG | 98.12O | Excision lip biopsy | 20 | 4+T |
| MASG | 98.12P | Lip shave | 60 | 4+T |
| MISG | 98.12Q | Wedge resection of lip, vermilion | 33.6 | 4+T |
| MISG | 98.12R | Destruction (dermabrasion) of single area (e.g., trauma scar) (Prior-Approval Required) | 35 | 4+T |
| MAAS | 98.12S | Extensive and complicated lesions | IC | 4+T |
| MISG | 98.12U | Cryotherapy of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable | 12 | |

| | | | | |
|---|---|---|---|---|
| MISG | 98.12V | Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable | 12 | 4+T |
| MISG | 98.12W | Simple excision of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable | 20 | 4+T |
| MISG | 98.12X | Electrocautery of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable | 12 | 4+T |
| MISG | 98.12Y | Excision sebaceous cyst on face/neck - infected or other medical reason for excision - plus multiples, if applicable | 20 | 4+T |
| MISG | 98.12Z | Excision sebaceous cyst on other area - infected or other medical reason for excision - plus multiples, if applicable | 16 | 4+T |

**RADICAL EXCISION OF SKIN LESION**

| | | | | |
|---|---|---|---|---|
| MASG | 98.13A | Carcinoma of skin - local excision plus full/split thickness graft - plus multiples, if applicable | 70 | 4+T |
| MASG | 98.13B | Carcinoma of skin - local excision plus skin graft larger than 5 square inches | 85 | 4+T |
| MASG | 98.13C | Carcinoma of skin - local excision with rotation flaps - plus multiples, if applicable | 192 | 4+T |
| MISG | 98.13D | Excision of hemangioma under general anaesthesia | 50 | 4+T |
| MASG | 98.13E | Excision of hydradenitis suppurative (regions required) | 100 | 4+T |
| MASG | 98.13F | Wedge resection of lip, vermilion to sulcus | 90 | 4+T |
| MASG | 98.13G | V-excision for carcinoma of lip - plus radical neck dissection | 350 | 10+T |
| MASG | 98.13H | V-excision for carcinoma of lip - 1/2 lip - plus reconstruction | 150 | 4+T |
| MASG | 98.13I | V-excision for carcinoma of lip - 1/2 lip - plus radical neck dissection | 375 | 10+T |
| MASG | 98.13J | Total excision of carcinoma of lip plus reconstruction | 200 | 4+T |
| MASG | 98.13K | Total excision carcinoma of lip plus reconstruction and radical neck dissection | 375 | 10+T |

**EXCISION OF PILONIDAL SINUS OR CYST**

| | | | | |
|---|---|---|---|---|
| MASG | 98.14A | Simple excision or marsupialization of pilonidal cyst | 100 | 4+T |
| MISG | 98.22 | Suture of skin and subcutaneous tissue of other sites - plus multiples, if applicable | | |
| | | ME=SIMP, AN=LOCL | 11 | |
| | | ME=SIMP | 11 | |
| MISG | 98.22A | Suture of simple wounds or lacerations - child's face - plus multiples, if applicable | 17 | 4+T |
| MISG | 98.22D | Suture minor laceration or foreign body wound - plus multiples, if applicable | 20 | |
| | | AN=GENL | 20 | 4+T |
| MISG | 98.22F | Suture extensive laceration or foreign body wound - plus multiples, if applicable | 50 | |
| | | AN=GENL | 50 | 4+T |

**OTHER REPAIR AND RECONSTRUCTION OF SKIN AND SUBCUTANEOUS TISSUE NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 98.79A | Reclosure of sternal wound | 150 | 9+T |

**BIOPSY OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.81C | Biopsy of skin/mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management | 20 | 4+T |
| MISG | 98.81D | Punch biopsy of skin or mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management | 15 | |

**ASPIRATION OF SKIN AND SUBCUTANEOUS TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 98.91A | Fine needle aspiration - plus multiples, if applicable | 25 | |

**REMOVAL OF NAIL, NAILBED OR NAILFOLD**

| | | | | |
|---|---|---|---|---|
| MISG | 98.96A | Excision of fingernail - radical, to include destruction of nail bed and shortening of phalanx, if necessary - plus multiples, if applicable | 40 | 4+T |
| MISG | 98.96B | Wedge resection toenail to include matrices (Regions required) - plus multiples, if applicable | 30 | |
| | | AN=GENL | 30 | 4+T |
| | | AN=LOCL | 30 | |
| MISG | 98.96C | Excision of fingernail - simple, complete, partial or wedge (Regions required) - plus multiples, if applicable | 20 | 4+T |
| MISG | 98.96D | Excision of toenail - simple, complete, partial or wedge (Regions required) - plus multiples, if applicable | 20 | 4+T |
| MISG | 98.96E | Excision of toenail - radical, to include destruction of nail bed and shortening of phalanx, if necessary (regions required) - plus multiples, if applicable | 40 | 4+T |

**OTHER OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE NEC**

| | | | |
|---|---|---|---|
| MISG | 98.99D | Excision lipoma - simple removal - large and causing interference with function - plus multiples, if applicable | 20 |
| MISG | 98.99E | Excision of simple neuroma - subcutaneous - large or causing interference with function - plus multiples, if applicable | 20 |
| MISG | 98.99F | Cryotherapy of plantar warts or molluscum contagiosum - plus multiples, if applicable | 12 |
| MISG | 98.99G | Electrocautery of plantar warts or molluscum contagiosum - plus multiples, if applicable | 12 |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

**PREMIUM**

| | | | |
|---|---|---|---|
| ADON | AHSP1 | After Hours Service Premium (extended service hours) | 35% |

# UROLOGY

(SP=UROL)

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTION / MODIFIERS | BASE UNITS | ANAES UNITS |
|---|---|---|---|---|
| **CONSULTATIONS** | | | | |
| CONS | 03.08 | Comprehensive Consultation | | |
| | | RF=REFD (ME=TELE) | 35.6 | |
| | | RF=REFD, US=PREM (ME=TELE) | 53.6 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 53.6 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 35.6+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 53.6+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 53.6+MU | |
| CONS | 03.07 | Limited Consultation | | |
| | | RF=REFD (ME=TELE) | 26.1 | |
| | | RF=REFD, US=PREM (ME=TELE) | 44.1 | |
| | | RF=REFD, US=PR50 (ME=TELE) | 44.1 | |
| | | RF=REFD, RO=DETE (ME=TELE) | 26.1+MU | |
| | | RF=REFD, RO=DETE, US=PREM (ME=TELE) | 44.1+MU | |
| | | RF=REFD, RO=DETE, US=PR50 (ME=TELE) | 44.1+MU | |
| CONS | 03.07 | Repeat Consultation | | |
| | | RF=REFD, RP=REPT (ME=TELE) | 22.5 | |
| | | RF=REFD, RP=REPT, US=PREM (ME=TELE) | 40.5 | |
| | | RF=REFD, RP=REPT, US=PR50 (ME=TELE) | 40.5 | |
| | | RF=REFD, RO=DETE, RP=REPT (ME=TELE) | 22.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE) | 40.5+MU | |
| | | RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE) | 40.5+MU | |
| **OFFICE** | | | | |
| VIST | 03.04 | Initial Visit with Complete Examination | | |
| | | LO=OFFC (RF=REFD) | 24 | |
| VIST | 03.03 | Initial Visit with Regional Examination | | |
| | | LO=OFFC, RP=INTL (RF=REFD) | 12 | |
| | | LO=OFFC, AG=OV65, RP=INTL (RF=REFD) | 16.5 | |
| VIST | 03.03 | Subsequent Visit | | |
| | | LO=OFFC, RP=SUBS (RF=REFD) | 13 | |
| VIST | 03.03A | Geriatric Office Visit (for patients aged 65+) | | |
| | | LO=OFFC (RF=REFD) | 16.5 | |

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD ..... 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD ..... 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD ..... 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) ..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) ..... 10.5

**HOSPITAL** (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

| | | |
|---|---|---|
| ADON | 03.02A | Hospital Discharge Fee<br>LO=HOSP, FN=INPT ..... 10 |
| VIST | 03.03 | Urgent Hospital Visit<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22<br>LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU |
| VIST | 03.03 | Emergency Visit<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2<br>LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU |
| VIST | 03.03 | Outpatient Visit (0800 - 1700)<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5<br>LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (2001 - 2359)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800)<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26<br>LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (1201-1700) Sat., Sun., Holidays<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20<br>LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU |
| VIST | 03.03 | Outpatient Visit (1701 - 2000) Extra Patient<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) ..... 10.5<br>LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU |

| | | | |
|---|---|---|---|
| VIST | 03.03 | Outpatient Visit (2001 - 2359) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (0000 - 0800) Extra Patient | |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) | 11.4 |
| | | LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) | 11.4+MU |
| VIST | 03.03 | Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) | 10.5+MU |
| VIST | 03.03 | Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays | |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) | 10.5 |
| | | LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) | 10.5+MU |

## PROCEDURES

**OTHER NONOPERATIVE CYSTOSCOPY**

(For other cystoscopy procedures, please refer to Diagnostic and Therapeutic Section)

| | | | | |
|---|---|---|---|---|
| MASG | 01.34D | Cystoscopy with brush biopsy of renal pelvis | 75 | 4+T |
| ADON | 01.34E | Cystoscopy with insertion of radioactive substance | 25 | 4+T |
| MASG | 01.34F | Cystoscopy with urethral meatotomy and plastic repair | 55 | 4+T |
| MISG | 01.34H | Cystoscopy - with biopsy of bladder (transurethral) | 48 | 4+T |

**URETHROSCOPY**

| | | | | |
|---|---|---|---|---|
| MISG | 01.35 | Urethroscopy | 14.1 | 4+T |
| MISG | 01.35A | Urethroscopy including biopsy | 30 | 4+T |

**REMOVAL OF INTRALUMINAL FOREIGN BODY FROM URETHRA WITHOUT INCISION**

| | | | | |
|---|---|---|---|---|
| MASG | 12.24A | Removal of foreign body or calculus of urethra | 75 | 4+T |

**OTHER REMOVAL OF INTRALUMINAL FOREIGN BODY WITHOUT INCISION**

| | | | | |
|---|---|---|---|---|
| MISG | 12.29A | Urethra meatal extraction of foreign body | 15 | 4+T |

**INJECTION OF STEROID**

| | | | | |
|---|---|---|---|---|
| MISG | 13.53D | Injection of Peyronie's plaque | 20 | 4+T |

**UNILATERAL EXPLORATION OF ADRENAL FIELD**

| | | | | |
|---|---|---|---|---|
| MASG | 20.02 | Unilateral exploration of adrenal field (regions required) | 150 | 7+T |

**BILATERAL EXPLORATION OF ADRENAL FIELD**

| | | | | |
|---|---|---|---|---|
| MASG | 20.03 | Bilateral exploration of adrenal field | 225 | 7+T |

**EXCISION OF LESION OF ADRENAL GLAND**

| | | | | |
|---|---|---|---|---|
| MASG | 20.11A | Excision of functioning tumours – pheochromocytoma (regions required) | 200 | 10+T |

**UNILATERAL ADRENALECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 20.12 | Unilateral adrenalectomy (regions required) | 200 | 10+T |
| MASG | 20.12A | Adrenalectomy, bilateral | 300 | 10+T |

**INSERTION OF INTERPLEURAL CATHETER**

| | | | | |
|---|---|---|---|---|
| ADON | 46.04L | Intraoperative placement of interpleural catheter for paravertebral block | 50 | |

**OTHER SURGICAL OCCLUSION OF ABDOMINAL ARTERIES**

| | | | | |
|---|---|---|---|---|
| MASG | 50.76C | Transection of aberrant renal vessel (regions required) | 175 | 7+T |

**OTHER (PERIPHERAL) SHUNT OR BYPASS**

| | | | | |
|---|---|---|---|---|
| MASG | 51.29F | Microvascular penile revascularization using epigastric artery | 550 | 8+T |

**REVISION OF INTESTINAL STOMA, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 58.41D | Partial resection of ileal conduit and revision of stoma (regions required) | 200 | 5+T |

**NEPHROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.01A | Drainage of kidney abscess, including excision of carbuncle (regions required) | 150 | 7+T |
| MASG | 67.01B | Renal exploration | 125 | 7+T |
| MASG | 67.01C | Nephrolithotomy (regions required) | 210 | 7+T |

**NEPHROSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.02 | Nephrostomy (regions required) | 175 | 7+T |
| MISG | 67.02 | Nephrostomy<br>AP=PERC (regions required) | 50 | 4+T |
| MASG | 67.02E | Subcutaneous nephrostomy tunnelling for palliative urinary diversion: initial tube placement (regions required) | 67 | 4+T |
| MISG | 67.02F | Subcutaneous nephrostomy tunnelling for palliative urinary diversion: tube placement (regions required) | 33 | 4+T |

**PYELOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.11A | Extended pyelolithotomy and nephrostomy plus renal artery occlusion and hypothermia (regions required) | 350 | 8+T |
| MASG | 67.11B | Pyelolithotomy with diversion of urine (regions required) | 200 | 7+T |
| ADON | 67.11C | Secondary operation | 50 | |
| MASG | 67.11D | Percutaneous endopyelotomy (regions required) | 350 | 8+T |
| MASG | 67.11E | Pyelolithotomy (regions required) | 175 | 7+T |

**PYELOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.12 | Pyelostomy (regions required) | 175 | 7+T |

**MARSUPIALIZATION OF KIDNEY LESION**

| | | | | |
|---|---|---|---|---|
| MASG | 67.21A | Renal biopsy - open (regions required) | 100 | 7+T |

**OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF KIDNEY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.29A | Excision of renal cyst (regions required) | 175 | 7+T |

**PARTIAL NEPHRECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.3 | Partial nephrectomy (regions required) | 220 | 7+T |
| ADON | 67.3A | Heminephrectomy, adrenalectomy - secondary operation (regions required) | 50 | |

**TOTAL NEPHRECTOMY (UNILATERAL)**

| | | | | |
|---|---|---|---|---|
| MASG | 67.41 | Total nephrectomy (unilateral) PT=CDDR (regions required) | 170 | |
| MASG | 67.41A | Nephrectomy - ectopic (regions required) | 200 | 7+T |
| MASG | 67.41B | Nephrectomy - lumbar (regions required) | 205 | 7+T |
| MASG | 67.41C | Nephrectomy - transperitoneal (regions required) | 200 | 7+T |
| MASG | 67.41D | Nephrectomy - thoraco-abdominal (regions required) | 275 | 13+T |
| MASG | 67.41E | Radical nephrectomy lumbar of thoraco-abdominal (regions required) | 282.1 | 13+T |
| MASG | 67.41F | Nephro-ureterectomy (regions required) | 240 | 7+T |
| MASG | 67.41G | Nephro-ureterectomy with resection of ureterovesical junction (regions required) | 300 | 7+T |
| ADON | 67.41H | Secondary operation (regions required) | 47 | |

**BILATERAL NEPHRECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.44 | Bilateral nephrectomy | | |
| | | PT=CDDR | 255 | |
| MASG | 67.44A | Nephrectomy - ectopic | 300 | 7+T |
| MASG | 67.44B | Nephrectomy - lumbar | 307.5 | 7+T |
| MASG | 67.44C | Nephrectomy - transperitoneal | 300 | 7+T |
| MASG | 67.44D | Nephrectomy - thoraco-abdominal | 412.5 | 13+T |
| MASG | 67.44E | Radical nephrectomy lumbar of thoraco-abdominal | 423.15 | 13+T |
| MASG | 67.44F | Nephro-ureterectomy | 360 | 7+T |
| MASG | 67.44G | Nephro-ureterectomy with resection of ureterovesical junction | 450 | 7+T |
| ADON | 67.44H | Secondary operation | 94 | |

**RENAL AUTOTRANSPLANTATION**

| | | | | |
|---|---|---|---|---|
| MASG | 67.51 | Renal autotransplantation | | |
| | | RO=FPHN (regions required) | 315 | 13+T |
| | | RO=SNAS (regions required) | 106 | 13+T |
| | | RO=SPHN (regions required) | 315 | 13+T |

**OTHER KIDNEY TRANSPLANTATION**

| | | | | |
|---|---|---|---|---|
| MASG | 67.59 | Other kidney transplantation | | |
| | | SP=GNSG (regions required) | 460 | |
| | | SP=UROL (regions required) | 460 | |
| | | PT=RECP | | 10+T |
| | | PT=DONR | | 7+T |

**NEPHROPEXY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.6 | Nephropexy (regions required) | 150 | 7+T |
| MASG | 67.6A | Nephropexy with renal sympathectomy (regions required) | 200 | 7+T |

**SUTURE OF KIDNEY**

| | | | | |
|---|---|---|---|---|
| MASG | 67.71A | Suture ruptured/lacerated kidney - repair/removal (regions required) | 210 | 7+T |

**SYMPHYSIOTOMY FOR HORSESHOE KIDNEY**

| | | | | |
|---|---|---|---|---|
| ADON | 67.75A | Renal hypothermia | 25 | |
| ADON | 67.75B | Secondary operation (regions required) | 50 | |
| MASG | 67.75C | Symphysiotomy for horse shoe kidney with or without nephropexy and associated procedure (regions required) | 240 | 7+T |

**OTHER REPAIR OF KIDNEY NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 67.79A | Pyeloureteroplasty (regions required) | 210 | 7+T |

**NEPHROSCOPY**

| | | | | |
|---|---|---|---|---|
| ADON | 67.83 | Nephroscopy (regions required) | 50 | |
| ADON | 67.83A | Transvesical nephroscopy (regions required) | 50 | |

**PERCUTANEOUS ASPIRATION OF KIDNEY**

| | | | | |
|---|---|---|---|---|
| MISG | 67.92C | Aspiration of renal cyst (regions required) | 50 | 4+T |

**REPLACEMENT OF NEPHROSTOMY TUBE**

| | | | | |
|---|---|---|---|---|
| MISG | 67.93 | Replacement of nephrostomy tube (regions required) | 15 | 4+T |

**OTHER OPERATIONS ON KIDNEY NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 67.99A | Percutaneous renal and upper ureteral stone removal multiple stones without electrohydraulic or ultrasonic lithotripsy (regions required) | 300 | 7+T |
| MASG | 67.99B | Percutaneous renal and upper ureteral stone removal - multiple staghorn with electrohydraulic and/or ultrasonic lithotripsy (regions required) | 330 | 7+T |
| MASG | 67.99C | Repeat percutaneous ureteral stone removal through original access within one week (regions required) | 200 | 7+T |

**TRANSURETHRAL CLEARANCE OF URETER AND RENAL PELVIS**

| | | | | |
|---|---|---|---|---|
| MASG | 68.0A | Endoscopic meatotomy if required (basket extraction) | 138.6 | 4+T |
| MASG | 68.0B | Ureteral manipulation only, stone not removed (regions required) | 80 | 4+T |

**URETEROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.2A | Ureterotomy upper two-thirds (regions required) | 170 | 7+T |
| MASG | 68.2B | Ureterotomy lower one-third (regions required) | 220 | 7+T |

**URETERECTOMY, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MASG | 68.31 | Ureterectomy, unqualified (regions required) | 175 | 7+T |

**PARTIAL URETERECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.32A | Ureterocelectomy | 150 | 6+T |
| MASG | 68.32B | Ureterocelectomy with ureteral reimplantation | 240 | 6+T |

**TOTAL URETERECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.33A | Ureterectomy including ureterovesical junction (regions required) | 215 | 7+T |

**FORMATION OF CUTANEOUS URETEROILEOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.41 | Formation of cutaneous ureteroileostomy | 320 | 6+T |
| MASG | 68.41A | Cystectomy, coke pouch and creation of continent urinary pouch diversion e.g., Indiana pouch | 700 | 6+T |
| MASG | 68.41B | Uretero-ileal conduit with total cystectomy | 460 | 6+T |
| MASG | 68.41C | Radical cystectomy and urethrectomy | 590 | 6+T |

**FORMATION OF OTHER CUTANEOUS URETEROSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.51 | Formation of other cutaneous ureterostomy (regions required) | 150 | 6+T |
| MASG | 68.51A | Ureterostomy with t-tube (regions required) | 150 | 6+T |

**REVISION OF OTHER CUTANEOUS URETEROSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.52A | Revision of ileal conduit stoma (regions required) | 100 | 5+T |

**OTHER URINARY DIVERSION TO INTESTINE**

| | | | | |
|---|---|---|---|---|
| MASG | 68.62A | Uretero-colic anastomosis/transplant (regions required) | 225 | 6+T |
| MASG | 68.62B | Uretero-colic anastomosis/transplant with cystectomy, one stage (Regions required) | 360 | 6+T |
| MASG | 68.62C | Uretero-colic anastomosis/transplant with cystectomy and colostomy (Regions required) | 420 | 6+T |

**REVISION OF URETERO-INTESTINAL OR PYELO-INTESTINAL ANASTOMOSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 68.63 | Revision of uretero-intestinal or pyelo-intestinal anastomosis (Regions required) | 240 | 6+T |

**URETERONEOCYSTOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.72A | Repeat repair to uretero-vesical junction with psoas hitch (regions required) | 350 | 8+T |
| MASG | 68.72B | Repeat repair to uretero-vesical junction with ureteral taper (regions required) | 350 | 8+T |
| MASG | 68.72C | Ureterovesical anastomosis, reimplantation (regions required) | 250 | 6+T |
| MASG | 68.72D | Ureterovesical anastomosis, reimplantation bilateral | 315 | 6+T |
| MASG | 68.72E | Bilateral ureteral reimplantation with bilateral tapering | 425 | 8+T |

**TRANSURETEROURETEROSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.73 | Transureteroureterostomy (regions required) | 300 | 6+T |

**OTHER ANASTOMOSIS OR BYPASS OF URETER NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 68.79A | Uretero-ureterostomy (regions required) | 250 | 6+T |
| MASG | 68.79B | Repair to uretero-vesical junction RP=REPT (regions required) | 290 | 8+T |

**SUTURE OF URETER**

| | | | | |
|---|---|---|---|---|
| MASG | 68.82A | Rupture/transection of ureter - immediate - upper 2/3 (regions required) | 175 | 6+T |
| MASG | 68.82B | Rupture/transection of ureter - immediate - lower 1/3 (regions required) | 200 | 6+T |
| MASG | 68.82C | Rupture/transection of ureter - late repair - upper 2/3 (regions required) | 200 | 6+T |
| MASG | 68.82D | Rupture/transection of ureter - late repair - lower 1/3 (regions required) | 225 | 6+T |

**CLOSURE OF OTHER FISTULA OF URETER**

| | | | | |
|---|---|---|---|---|
| MASG | 68.84 | Closure of other fistula of ureter | 240 | 6+T |
| MASG | 68.84A | Repair - uretero-vaginal fistula (regions required) | 240 | 6+T |

**OTHER REPAIR OF URETER**

| | | | | |
|---|---|---|---|---|
| MASG | 68.89A | Ureterocoele (regions required) | 75 | 6+T |
| MASG | 68.89B | Ileo-ureteral substitution (regions required) | 300 | 6+T |

**URETEROSCOPY**

| | | | | |
|---|---|---|---|---|
| MASG | 68.95A | Ureteroscopy with/without biopsy (regions required) | 135 | 4+T |
| MASG | 68.95B | Percutaneous ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithotripsy (regions required) | 300 | 7+T |
| MASG | 68.95C | Ureteroscopy plus basket (regions required) | 200 | 7+T |

**OTHER INVASIVE DIAGNOSTIC PROCEDURES ON URETER**

| | | | | |
|---|---|---|---|---|
| MASG | 68.98A | Exploration of ureter (regions required) | 150 | 6+T |

**OTHER OPERATIONS ON URETER NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 68.99B | Incision - peri-ureteral abscess (regions required) | 100 | 6+T |
| MISG | 68.99C | Calibration and/or dilation of ureter - one/both sides | 40 | 4+T |
| MASG | 68.99D | Ureteral stent - via cystoscope (regions required) | 108.9 | 4+T |
| MASG | 68.99E | Percutaneous ureteral stone removal - single stone without electrohydraulic or ultrasonic lithotripsy (regions required) | 250 | 7+T |
| MASG | 68.99F | Percutaneous ureteral stone removal - single stone with electrohydraulic and/or ultrasonic lithotripsy (regions required) | 300 | 7+T |

**TRANSURETHRAL CLEARANCE OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.0A | Cystoscopy with removal of foreign body/calculus | 67.3 | 4+T |
| MASG | 69.0B | Cystoscopy with litholapaxy, visual/tactile and removal of stone fragments | 105 | 4+T |
| MASG | 69.0C | Cystoscopy with ultrasonic/electrohydraulic lithotripsy | 125 | 4+T |

**OTHER CYSTOTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 69.13 | Other cystotomy | 75 | 5+T |
| MASG | 69.13A | Cystolithotomy | 90 | 5+T |

**OPEN (SUPRAPUBIC) CYSTOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 69.14 | Open (suprapubic) cystostomy | 75 | 5+T |
| MISG | 69.14A | Cystotomy with trochar and cannula and insertion of tube | 30 | 5+T |

**OTHER TRANSURETHRAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.29A | Cystoscopy with electrocoagulation of tumour - single | 55 | 4+T |
| MASG | 69.29B | Cystoscopy with electroexcision of tumour/tumours including base and adjacent muscle - single | 123.7 | 4+T |
| MASG | 69.29C | Cystoscopy with electrocoagulation of Hunner's ulcers | 60 | 4+T |
| MASG | 69.29D | Cystoscopy with resection of bladder neck | 90 | 4+T |
| MASG | 69.29E | Cystoscopy with electrosurgical ureteral meatotomy | 75 | 4+T |
| MISG | 69.29F | Endoscopy - transurethral drainage | 50 | 5+T |
| MASG | 69.29G | Cystoscopy with electrocoagulation of tumour - multiple | 87.1 | 4+T |
| MASG | 69.29H | Cystoscopy with electroexcision of tumour/tumours including base and adjacent muscle - multiple | 198 | 4+T |

**EXCISION OF URACHUS**

| | | | | |
|---|---|---|---|---|
| MASG | 69.31A | Excision of urachus and repair of bladder | 125 | 6+T |

**OPEN EXCISION OR DESTRUCTION OF OTHER LESION OR TISSUE OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.39A | Cystotomy/cystostomy with electrocoagulation of tumour | 150 | 5+T |
| MASG | 69.39B | Suprapubic resection of bladder neck | 150 | 5+T |

**PARTIAL CYSTECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 69.4A | Cystectomy, partial for atony | 140 | 6+T |
| MASG | 69.4B | Excision of bladder tumour/diverticulum | 200 | 6+T |
| MASG | 69.4C | Excision of bladder tumour/diverticulum with reimplantation of ureter | 270 | 8+T |

**OTHER TOTAL CYSTECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 69.59A | Complete cystectomy without transplant | 240 | 6+T |

**RECONSTRUCTION OF URINARY BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.6A | Complete cystectomy without transplant with colocystoplasty | | |
| | | RO=FPHN | 400 | 8+T |
| | | RO=SPHN | 100 | |
| MASG | 69.6B | Ileocystoplasty (or colocystoplasty) | 300 | 5+T |

**SUTURE OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.71 | Suture of bladder | 180 | 5+T |

**REPAIR OF OTHER FISTULA OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.73D | Closure of fistula external suprapubic | 120 | 4+T |
| MASG | 69.73E | Closure of fistula vesicovaginal - transvesical approach | 240 | 6+T |
| MASG | 69.73F | Closure of fistula vesicorectal or vesicosigmoid | 200 | 6+T |

**CYSTOURETHROPLASTY AND PLASTIC REPAIR OF BLADDER NECK**

| | | | | |
|---|---|---|---|---|
| MASG | 69.74 | Cystourethroplasty and plastic repair of bladder neck | 200 | 5+T |
| ADON | 69.74A | Plastic repair of bladder neck with ureteroneocystostomy (add-on to HSC 69.74 only) (regions required) | 50 | |

**REPAIR OF BLADDER EXSTROPHY**

| | | | | |
|---|---|---|---|---|
| MASG | 69.75A | Exstrophy, urinary diversion for bladder exstrophy and excision of ectopic bladder and repair of abdominal wall | 400 | 6+T |

**CYSTOGRAM AND CYSTO-URETHROGRAM**

| | | | | |
|---|---|---|---|---|
| MISG | 69.83 | Cystogram and cysto-urethrogram | 16 | 4+T |

**SPHINCTEROTOMY OF BLADDER**

| | | | | |
|---|---|---|---|---|
| MASG | 69.91 | Sphincterotomy of bladder | | |
| | | AP=TRUR | 120 | 4+T |

**EXTERNAL URETHROTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 70.0 | External urethrotomy | 120 | 4+T |
| MASG | 70.0A | Perineal urethrostomy | 75 | 4+T |

**EXCISION OR DESTRUCTION OF URETHRAL LESION OR TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 70.2A | Urethral caruncle or prolapse of mucosa | 40 | 4+T |
| MISG | 70.2B | Excision of urethral caruncle | 35 | 4+T |
| MASG | 70.2C | Excision of urethral caruncle - including cystoscopy | 55 | 4+T |
| MASG | 70.2D | Excision of urethral papilloma - single/multiple | 60 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 70.2E | Excision of urethral stricture - one stage with diversion | 180 | 4+T |
| MASG | 70.2F | Excision of urethral stricture - two stage - first stage | 90 | 4+T |
| MASG | 70.2G | Excision of urethral stricture - two stage - second stage | 180 | 4+T |
| MASG | 70.2H | Diverticulectomy | 125 | 4+T |
| MISG | 70.2I | Excision of posterior urethral valve by endoscopy | 50 | 4+T |
| MASG | 70.2J | Excision of posterior urethral valve by endoscopy - open operation | 125 | 4+T |
| MISG | 70.2K | Excision of urethral prolapse | 40 | 4+T |
| MASG | 70.2L | Excision of urethral prolapse with cystoscopy | 60 | 4+T |
| MISG | 70.2M | Biopsy of urethra | 15 | 4+T |
| MASG | 70.2N | Excision urethra and re-anastomosis | 200 | 6+T |

**SUTURE OF URETHRA**

| | | | | |
|---|---|---|---|---|
| MASG | 70.31A | Suture of rupture anterior urethra (diversion of urine stream) | 120 | 4+T |
| MASG | 70.31B | Suture of rupture posterior urethra - immediate repair | 210 | 4+T |
| MASG | 70.31C | Suture of rupture posterior urethra - late repair | 300 | 4+T |
| MASG | 70.31D | Suture of membranous urethra | 180 | 4+T |

**CLOSURE OF OTHER FISTULA OF URETHRA**

| | | | | |
|---|---|---|---|---|
| MASG | 70.33A | Suture of recto-urethral fistula | 200 | 6+T |
| MASG | 70.33B | Suture of recto-urethral fistula with colostomy | 250 | 6+T |

**OTHER RECONSTRUCTION OF URETHRA**

| | | | | |
|---|---|---|---|---|
| MASG | 70.35A | Urethroplasty for posterior urethral rupture | | |
| | | ME=FTSG | 300 | |
| | | ME=SDSG | 150 | |
| MASG | 70.35B | Urethroplasty for anterior urethral strictures | | |
| | | ME=FTSG | 175 | 6+T |
| | | ME=SDSG | 100 | 6+T |
| MASG | 70.35C | Urethroplasty - one stage with pedicle graft | 300 | 6+T |
| MASG | 70.35D | Urethroplasty marsupialization | | |
| | | ME=FTSG | 100 | 6+T |
| | | ME=SDSG | 150 | 6+T |

**URETHRAL MEATOPLASTY**

| | | | | |
|---|---|---|---|---|
| MISG | 70.36A | Meatotomy and plastic repair | 30 | 4+T |
| MASG | 70.36B | Meatotomy and plastic repair for extravasation urine with multiple drainage | 120 | 4+T |
| MASG | 70.36C | Meatotomy and plastic repair with external urethrotomy/cystotomy | 180 | 4+T |

**FREEING OF STRICTURE OF URETHRA**

| | | | | |
|---|---|---|---|---|
| MASG | 70.4A | Cold knife urethrotomy | 128.7 | 4+T |
| MASG | 70.4B | Internal urethrotomy | 60 | 4+T |

**DILATION OF URETHRA**

| | | | | |
|---|---|---|---|---|
| MISG | 70.5 | Dilation of urethra | | |
| | | AN=GENL | 22 | 4+T |
| | | AN=LOCL | 10 | |
| MISG | 70.5A | Dilation of urethra filiforms and followers | 22 | 4+T |

**INCISION OF PERIURETHRAL TISSUE**

| | | | | |
|---|---|---|---|---|
| MISG | 70.91A | Incision periurethral abscess | 25 | 4+T |

**IMPLANTATION OF ARTIFICIAL URINARY SPHINCTER**

| | | | | |
|---|---|---|---|---|
| MASG | 70.93A | AMS artificial (hydraulic) urinary sphincter | 280 | 6+T |
| MASG | 70.93B | Bladder neck positioning of cuff for artificial sphincter | 400 | 7+T |
| MAAS | 70.93C | Differential fee for re-operation of bladder neck level | IC | 7+T |

**URETEROLYSIS WITH FREEING OR REPOSITIONING OF URETER FOR RETROPERITONEAL FIBROSIS**

| | | | | |
|---|---|---|---|---|
| MASG | 71.02 | Ureterolysis with freeing or repositioning of ureter for peri-ureteral fibrosis (Regions required) | 215 | 6+T |

**OTHER INCISION OF RETROPERITONEAL TISSUE**

| | | | | |
|---|---|---|---|---|
| MASG | 71.09A | Drainage of perinephric abscess (regions required) | 100 | 7+T |

**SUPRAPUBIC SLING OPERATION**

| | | | | |
|---|---|---|---|---|
| MASG | 71.4 | Suprapubic sling operation | 135 | 4+T |
| MASG | 71.4C | Synthetic mid urethral sling for female urinary incontinence, any approach | 150 | 4+T |
| MASG | 71.4D | Pubo-vaginal sling with autologous fascia for female urinary incontinence, includes Cystoscopy as required | 350 | 6+T |

**RETROPUBIC URETHRAL SUSPENSION**

| | | | | |
|---|---|---|---|---|
| MASG | 71.5A | Urethrovesical suspension for stress incontinence | 158.4 | 5+T |

**OTHER REPAIR OF URINARY (STRESS) INCONTINENCE**

| | | | | |
|---|---|---|---|---|
| MASG | 71.7A | Insertion of rigid prosthesis for urinary incontinence | 225 | 6+T |
| MASG | 71.7B | Cystoscopy and endoscopic mucosal injection teflon (Sting) - plus multiples, if applicable | 100 | 4+T |
| MASG | 71.7C | Cystoscopy and injection of collagen into periurethral tissue at bladder neck for stress urinary incontinence | 75 | 4+T |
| MASG | 71.7D | Urethrovesical suspension with partial cystectomy/vesicopexy | 200 | 5+T |
| MASG | 71.7F | Cystoscopy with intravesicular injection(s) of chemodenervating agent | 90 | 4+T |

**ULTRASONIC FRAGMENTATION OF URINARY STONES**

| | | | | |
|---|---|---|---|---|
| MASG | 71.96A | Lithotripsy - one side, one stone (regions required) | 163.3 | 6+T |
| MASG | 71.96B | Lithotripsy one side, one stone - repeat within one week (regions required) | 160 | 6+T |
| MASG | 71.96C | Lithotripsy bilateral stones | 262.5 | 6+T |
| MASG | 71.96D | Lithotripsy one side, multiple stones (regions required) | 247.5 | 6+T |
| MASG | 71.96E | Lithotripsy bilateral multiple stones | 370 | 6+T |

**INCISION OF PROSTATE**

| | | | | |
|---|---|---|---|---|
| MISG | 72.0A | Incision of prostate with drainage of abscess | 50 | 4+T |
| MASG | 72.0B | Incision of prostate with removal of calculus (perineal) | 175 | 4+T |

**TRANSURETHRAL PROSTATECTOMY**

| | | | | |
|---|---|---|---|---|
| MAAS | 72.1A | Endoscopy - revision of transurethral resection of prostate | IC | 6+T |
| MASG | 72.1B | Endoscopy - transurethral electro-resection | 237.6 | 7+T |
| MASG | 72.1C | Endoscopy - resection of bladder neck – transurethral prostatectomy | 128.7 | 5+T |
| MASG | 72.1D | Transurethral electro-resection of the prostate by laser | 237.6 | 7+T |
| MASG | 72.1E | Laser Anatomic Endoscopic Enucleation of prostate >60 grams with morcellation (HoLEP, ThuLEP not for photoselective vaporization or green light laser) | 406 | 7+T |

**SUPRAPUBIC PROSTATECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 72.2 | Suprapubic prostatectomy | 200 | 7+T |
| MASG | 72.2A | Prostatectomy with diverticulectomy | 300 | 7+T |
| MASG | 72.2B | Prostatectomy with partial cystectomy for atony of bladder | 300 | 8+T |

**RETROPUBIC PROSTATECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 72.3 | Retropubic prostatectomy<br>ME=SIMP | 232.6 | 7+T |
| MASG | 72.3A | Prostatectomy radical with vesiculectomy includes deep pelvic lymphadenectomy | 325 | 8+T |
| MASG | 72.3B | Prostatectomy - radical includes deep pelvic lymphadenectomy | 303 | 8+T |

**RADICAL PROSTATECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 72.4A | Prostatectomy with vesiculectomy includes deep pelvic lymphadenectomy | 360 | 8+T |
| MASG | 72.4B | Prostatectomy - radical including deep pelvic lymphadenectomy | 300 | 8+T |

**LOCAL EXCISION OF LESION OF PROSTATE**

| | | | | |
|---|---|---|---|---|
| MASG | 72.51A | Excision and open biopsy of prostate | 100 | 4+T |

**PERINEAL PROSTATECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 72.52 | Perineal prostatectomy | 240 | 7+T |

**INCISION OF SEMINAL VESICLE**

| | | | | |
|---|---|---|---|---|
| MISG | 72.62 | Incision of seminal vesicle | 50 | 4+T |

**EXCISION OF SEMINAL VESICLE**

| | | | | |
|---|---|---|---|---|
| MASG | 72.63 | Excision of seminal vesicle | 300 | 4+T |

**INCISION OF PERIPROSTATIC TISSUE**

| | | | | |
|---|---|---|---|---|
| MASG | 72.71A | Mobilization of prostate with bilateral pelvic lymphadenectomy | 257.4 | 8+T |
| MASG | 72.71B | Mobilization of prostate for insertion of interstitial radioisotopes | 150 | 5+T |

**OTHER OPERATIONS ON PROSTATE NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 72.89A | Insertion of prostatic stent including cystoscopy | 100 | 4+T |

**INCISION OF SCROTUM AND TUNICA VAGINALIS**

| | | | | |
|---|---|---|---|---|
| MISG | 73.0A | Incision of scrotum abscess/hematocoele | 25 | 4+T |
| MASG | 73.0B | Incision and exploration of scrotum | 60 | 4+T |

**EXCISION OF HYDROCOELE (OF TUNICA VAGINALIS)**

| | | | | |
|---|---|---|---|---|
| MASG | 73.1 | Excision of hydrocoele (of tunica vaginalis) (regions required) | 90 | 4+T |

**EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SCROTUM**

| | | | | |
|---|---|---|---|---|
| MISG | 73.2A | Excision of minor scrotal lesions e.g., sebaceous cysts, fibroma | 15 | 4+T |
| MASG | 73.2B | Resection of scrotum | 90 | 4+T |

**SUTURE OF SCROTUM AND TUNICA VAGINALIS**

| | | | | |
|---|---|---|---|---|
| MAAS | 73.31 | Suture of scrotum and tunica vaginalis | IC | 4+T |

**INCISION OF TESTES**

| | | | | |
|---|---|---|---|---|
| MISG | 74.0 | Incision of testis (regions required) | 25 | 4+T |

**EXCISION OR DESTRUCTION OF TESTICULAR LESION**

| | | | | |
|---|---|---|---|---|
| MISG | 74.1A | Excisional biopsy of testis (regions required) | 25 | 4+T |
| MASG | 74.1B | Excisional biopsy of testis with vasography (regions required) | 60 | 4+T |

**UNILATERAL ORCHIECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 74.2 | Unilateral orchiectomy (regions required) | 74.2 | 4+T |
| MASG | 74.2A | Radical orchidectomy (regions required) | 130 | 4+T |

**REMOVAL OF BOTH TESTES (IN SAME OPERATIVE EPISODE)**

| | | | | |
|---|---|---|---|---|
| MASG | 74.31 | Removal of both testes (in same operative episode) | 111.3 | 4+T |
| MASG | 74.31A | Radical orchidectomy | 195 | 4+T |

**ORCHIOPEXY**

| | | | | |
|---|---|---|---|---|
| MASG | 74.4 | Orchiopexy (regions required) | 163.3 | 4+T |

**SUTURE OF TESTES**

| | | | | |
|---|---|---|---|---|
| MASG | 74.51A | Repair ruptured testicle (regions required) | 90 | 4+T |

**INSERTION OF TESTICULAR PROSTHESIS (BILATERAL) (UNILATERAL)**

| | | | | |
|---|---|---|---|---|
| MISG | 74.6 | Insertion of testicular prosthesis (bilateral) (unilateral) (regions required) | 50 | 4+T |

**EXCISION OF VARICOCOELE AND HYDROCOELE OF SPERMATIC CORD**

| | | | | |
|---|---|---|---|---|
| MASG | 75.0A | Excision of spermatic cord hydrocoele (regions required) | 75 | 4+T |
| MASG | 75.0B | Excision of spermatic cord varicocoele (regions required) | 95 | 4+T |

**EXCISION OF CYST OF EPIDIDYMIS**

| | | | | |
|---|---|---|---|---|
| MASG | 75.1A | Excision of spermatocoele (regions required) | 90 | 4+T |

**EPIDIDYMECTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 75.3 | Epididymectomy (regions required) | 80 | 4+T |

**REDUCTION OF TORSION OF TESTES OR SPERMATIC CORD**

| | | | | |
|---|---|---|---|---|
| MASG | 75.42 | Reduction of torsion of testes or spermatic cord (regions required) | 75 | 4+T |

**STERILIZATION PROCEDURE, UNQUALIFIED**

| | | | | |
|---|---|---|---|---|
| MISG | 75.61 | Vasectomy procedure, unqualified | 49.5 | 4+T |

**RECONSTRUCTION OF (SURGICALLY) DIVIDED VAS DEFERENS**

| | | | | |
|---|---|---|---|---|
| MASG | 75.72A | Anastomosis vas deferens - not post vasectomy (regions required) | 200 | 4+T |
| MASG | 75.72B | Anastomosis vas deferens with biopsy and vasography (regions required) | 100 | 4+T |

**EPIDIDYMOVASOSTOMY**

| | | | | |
|---|---|---|---|---|
| MASG | 75.73 | Epididymovasostomy (regions required) | 90 | 4+ |

**CONTRAST VASOGRAM**

| | | | | |
|---|---|---|---|---|
| MISG | 75.83 | Contrast vasogram | 25 | 4+T |

**EPIDIDYMOTOMY**

| | | | | |
|---|---|---|---|---|
| MISG | 75.92A | Incision of epididymis abscess | 25 | 4+T |

**CIRCUMCISION**

| | | | | |
|---|---|---|---|---|
| MISG | 76.0 | Circumcision | | |
| | | AG=ADUT | 44.5 | 4+T |
| | | AG=CH16 | 45 | 4+T |

**LOCAL EXCISION OR DESTRUCTION OF LESION OF PENIS**

| | | | | |
|---|---|---|---|---|
| MISG | 76.1A | Excision of penis condylomata | 20 | 4+T |

**AMPUTATION OF PENIS**

| | | | | |
|---|---|---|---|---|
| MASG | 76.2 | Amputation of penis | | |
| | | PO=PART | 90 | 4+T |
| MASG | 76.2A | Amputation of penis with inguinal gland dissection - 1 or 2 stages | | |
| | | PO=PART | 240 | 4+T |
| MASG | 76.2B | Amputation of penis with inguinal and femoral glands - 1 or 2 stages | | |
| | | PO=COML | 300 | 6+T |

**RELEASE OF CHORDEE**

| | | | | |
|---|---|---|---|---|
| MASG | 76.32 | Release of chordee | 125 | 5+T |

**REPAIR OF EPISPADIAS OR HYPOSPADIAS**

| | | | | |
|---|---|---|---|---|
| MASG | 76.33 | Repair of epispadias or hypospadias | 150 | 4+T |

| | | | | |
|---|---|---|---|---|
| MASG | 76.33A | Hypospadias repair and meatal advancement and glanuloplasty (MAGPI) | 150 | 4+T |
| MASG | 76.33B | One stage hypospadias flip/flap repair | 180 | 5+T |
| MASG | 76.33C | Repair of hypospadias with tibular graft, glansplasty and suprapubic or perineal cystostomy one stage | 450 | 4+T |
| MASG | 76.33D | Hypospadias including urinary diversion chordee repair ME=FTSG | 100 | 4+T |
| MASG | 76.33E | Closure urethrocutaneous fistula | 100 | 4+T |
| MASG | 76.33F | Repair of peno-scrotal or perineal hypospadias | 260 | 4+T |

**OTHER REPAIR OF PENIS**

| | | | | |
|---|---|---|---|---|
| MISG | 76.39A | Frenuloplasty | 40 | 4+T |
| MASG | 76.39B | Nesbitt Procedure | 300 | 4+T |
| MISG | 76.39C | Excision of Peyronie's plaque | 50 | 4+T |
| MASG | 76.39D | Excision of Peyronie's plaque with tunica vaginalis graft | 275 | 6+T |
| MASG | 76.39E | Plastic reconstruction urethra penile | 175 | 4+T |

**BIOPSY OF PENIS**

| | | | | |
|---|---|---|---|---|
| MISG | 76.81 | Biopsy of penis | 15 | 4+T |

**DORSAL OR LATERAL SLIT OF PREPUCE**

| | | | | |
|---|---|---|---|---|
| MISG | 76.91 | Dorsal or lateral slit of prepuce | | |
| | | AG=ADUT | 10 | 4+T |
| | | AG=CH16 | 5 | 4+T |
| | | AG=NWBN | 5 | 4+T |

**DIVISION OF PENILE ADHESIONS**

| | | | | |
|---|---|---|---|---|
| MISG | 76.93 | Division of penile adhesions | 25 | 4+T |

**INSERTION OR REPLACEMENT OF INTERNAL PROSTHESIS OF PENIS**

| | | | | |
|---|---|---|---|---|
| MASG | 76.95A | Insertion of rigid penile prosthesis for impotence | 140 | 5+T |
| MASG | 76.95B | Insertion of semi-rigid or malleable penile prosthesis | 140 | 5+T |
| MASG | 76.96B | Removal with or without reinsertion of semi-rigid or malleable penile prosthesis | IC 125/hr | 5+T |
| MASG | 76.95C | Inflatable penile prosthesis-insertion of all components (pump, cylinders and reservoir) | 230 | 6+T |

| | | | | |
|---|---|---|---|---|
| MASG | 76.96C | Inflatable penile prosthesis-removal of any or all components (pump, cylinders and reservoir) with or without reinsertion | IC 130/hr | 6+T |

**OTHER OPERATIONS ON PENIS**

| | | | | |
|---|---|---|---|---|
| MASG | 76.97A | Creation of corpus spongiosum to corpus cavernosum shunt | 200 | 6+T |

**OTHER OPERATIONS ON EXTERNAL GENITAL ORGANS NEC**

| | | | | |
|---|---|---|---|---|
| MASG | 76.99A | Dorsal vein ligation | 85 | 5+T |
| MASG | 76.99B | Extensive dorsal vein ligation | 300 | 5+T |

**SURGICAL PROCEDURES NOS**

| | | | | |
|---|---|---|---|---|
| ADON | 99.09A | Morbid obesity surgical add on | 32.9 | 4.6 |

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