General Medicare Information
Conditions of Participation

1. **Definition of a practitioner**

   The *Medical Services Payment Act* defines a medical practitioner as a person lawfully entitled to practice medicine in the place in which that person carries on such practice.

2. **Participating practitioner**

   A participating practitioner as defined in the Regulations under the *Medical Services Payment Act* is a medical practitioner who has elected in accordance with the Regulations to practice his profession within the provisions of the Act and Regulations, i.e. "opted-in".

3. **Procedure to become a non-participating practitioner**

   Any practitioner licensed in New Brunswick who has not "opted-in" is deemed to have opted-out. No other action is required in order for the practitioner to have an opted-out status.

   A practitioner who has opted-in to the plan and subsequently wishes to change his status and opt-out totally can do so by notifying the Department of his intention in writing. His change in status becomes effective from the date of receipt by the Department of such written notification, or from the date specified by the practitioner.

   Opted-out practitioners

   Opted-out practitioners are not paid directly by Medicare for the services, which they render. They must bill their patients in all cases. The patients are not entitled to a reimbursement from Medicare.

   It should be noted that an opted-in practitioner can elect to opt-out for any given patient only for the total management of the condition under care, including any complications, which may develop within a reasonable length of time.

   For a series of services for which a composite fee applies, or for which the fees are interrelated, the practitioner would have to either opt-in or opt-out for the entire series of services beyond the initial consultation.

   Opting-out is not permissible for emergency care, for services to hospitalized patients unless agreed to prior to admission, or in the course of care already undertaken on an opted-in basis. Reasonable access to services must not be denied by opting-out.

   The patients are not entitled to any reimbursement, either in whole or in part, for services billed above tariff and by accepting care under these conditions; the patient waives the right to such reimbursement. Patient notification requirements in relation to opting-out provisions are outlined below.

4. **Conditions regarding submission and payment of claims**

   Opted-in practitioners

Conditions of participation (continued)

An opted-in practitioner bills the plan directly for the services, which he renders.

If an opted-in practitioner wishes to opt-out for a particular patient or a particular service, he cannot bill Medicare; instead he first obtains the patient's agreement to be treated on an opted-out basis, after which he may bill the patient for the service in question.

5. **Information to patients regarding opted-out status**

The following procedure must be adhered to in every instance where an opted-in physician decides to opt-out for a service. The practitioner must advise the patient in advance of rendering service that he is opting-out for those services, and

(a) if the charges are not to exceed the Medicare tariff, the practitioner must complete the specified Medicare claim forms and indicate the exact total amounts he has charged the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and forwarding the claim form to Medicare.

(b) if the charges are to be in excess of the Medicare tariff, the practitioner must inform the beneficiary prior to rendering the services:

- that he is opting-out and charging fees above such tariff;
- that in accepting service under these conditions the beneficiary waives all rights to Medicare reimbursement; and
- that the patient is entitled to seek the services from another practitioner on an opted-in basis.

The physician must obtain a signed waiver from the patient on the specified form and forward such form to Medicare without delay. No Medicare claim form is to be completed in these instances.

Participating Physician's Agreement

I, a duly registered medical practitioner, apply to practice my profession in accordance with the *Medical Services Payment Act* and Regulations. In particular, I agree to accept payment by the Medicare Branch for any entitled services provided by me for which I submit an account to the Medicare Branch as payment in full for that service and I shall not make any further claim against any person with respect to that service.

Conditions of participation (continued)

Patient's Medicare Coverage Waiver

1. I acknowledge that I have been informed by Dr. _____ that he is opting-out of Medicare for the following service(s) he will be providing to _____/_____
   (patient's name) (Medicare-number)
   and that he will be charging fees higher than the ones payable by Medicare:
   Service Code _____
   Date of Service _____

2. I understand also that in accepting the service(s) under these conditions I waive all rights to any reimbursement from Medicare for these services.

3. I have been informed by the practitioner that this service(s) is available from a practitioner who would accept Medicare payments as payments in full.

4. I accept the service(s) referred to above under these conditions.

_____ _____
Signature of Beneficiary Date

Practitioner's Opting-Out Statement

I certify that I have informed the above-named beneficiary that I am opting-out as stated above. I have no reason to believe that in so doing I am restricting reasonable access to necessary medical services.

I also certify that this opting-out provision is not being invoked for emergency condition or for continuation of care commenced on an opted-in basis. Further, in the case of care provided in a hospital, I certify that I informed the patient of my opting-out in advance of the admission to the hospital.

_____ _____
Signature of Practitioner Date

Claims Submission and Payment Procedure

1. **Required information**

The Regulations under the *Medical Services Payment Act* require that all claims must be submitted with the following information:

- whether the practitioner or beneficiary is to be paid;
- patient's name;
- patient's Medicare number;
- patient's date of birth;
- patient's sex;
- practitioner's name and practitioner number;
- whether surgeon, assistant, collaborating surgeon or anaesthetist;
- time spent by practitioner on service(s) if required to determine amount of payment;
- referring practitioner's name and practitioner number;
- diagnosis;
- date(s) of services charged;
- number of services charged;
- date of admission to and date of discharge from hospital if in-patient care is involved;
- whether services are provided at practitioner's office, patient's home, hospital (inpatient), hospital out-patient or emergency department, nursing home, or elsewhere;
- service code(s) and fee charges;
- total line count;
- treatment information or remarks;
- date of completion of form;
  signature of the patient in the case of services for which the practitioner is opted-out.

2. **Submission of claim form**

Since Spring 1992, Medicare fee-for-service claims must be submitted by electronic means. Independent consideration billing must be submitted manually on paper claims.

In order to submit claims electronically, a practitioner should first request an Application Manual from Medicare, which contains detailed information pertinent to the electronic billing process. One can select either Medicare's billing software (Telemed) or billing software from a private company; if opting for Telemed; this must be requested at time of application. In either case, BLAST communication software is required and will be provided by Medicare.

Application and agreement forms are supplied with the Application Manual. After Medicare has confirmed that the documentation is in order, a Teletransmission Specification Manual will be provided and, for Telemed users, software programs diskettes and installation instructions.

Paper claim forms are scanned by a computer controlled optical character reader (O.C.R.) which stores the information supplied in the boxed-in areas on the forms.

Claims submission and payment procedure (continued)

The Single Patient Claim Form is used when billing service codes with I.C. fees, services which cannot be submitted electronically, services with supporting documentation or when requesting independent consideration.

The Non-Resident Claim Form is used for the same reasons as the Single Patient Claim Form, but the service is rendered to a non-resident patient.

The Pay Beneficiary Claim Form must be used when the practitioner is billing the patient directly because he has opted-out and will not be charging in excess of the Medicare tariff, otherwise no claim is to be submitted to Medicare.

In order that claims may be processed and paid promptly, it is essential that claim forms be completed carefully.

Incomplete or inaccurate claims require manual handling, review and, where possible, correction by Medicare staffs. Such claims cannot be processed and settled as promptly as those, which are complete and accurate.

3. **Submission of claims - opted-out services**

For any service for which a practitioner has opted-out he must, before providing the service, inform the patient that he will be charging him directly for the service. If he is not charging in excess of the Medicare tariff, the appropriate paper claim form must be completed by the practitioner's office. The patient then takes the completed claim form and mails it to the address shown on the claim form. Payment is then made directly to the beneficiary.

If the practitioner charges in excess of the Medicare tariff, the patient must sign a Medicare Coverage Waiver. The practitioner then mails the waiver form to Medicare. No claim may be submitted for reimbursement in these circumstances.

1. **Residents of other countries**

The practitioner must bill patients directly for services rendered if they are not a resident of Canada. Service information should be supplied to facilitate reimbursement by their own plan or insurance.

2. **Residents of other provinces**

(A) If a practitioner renders a service to a patient who is a resident of a province/territory of Canada other than New Brunswick, or to a patient who is not yet eligible under Medicare, an out of province paper claim form must be completed and submitted (either by the patient or the practitioner) to the patient's Health Care Plan for any of the following situations:

- The patient is a resident of the Province of Quebec;
- The patient does not present a current and valid health insurance card;
- The service rendered is an excluded service under the Interprovincial Reciprocal Billing Agreement;
- The practitioner elects to obtain payment directly from the patient.

Claims submission and payment procedure (continued)

(B) **Non-resident claim form**

For eligible services (other than those enumerated in the preceding section) which are provided under the Reciprocal Interprovincial Billing Agreement the practitioner may claim as a participating physician and be paid directly by Medicare New Brunswick by completing a Non-Resident Claim Form. Medicare later claims these payments back from the province of residence on a reciprocal payment basis.

Services Excluded Under The Interprovincial Medical Reciprocal Billing Agreement

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

1. Surgery for alteration of appearance (cosmetic surgery);
2. Sex-reassignment surgery;
3. Surgery for reversal of sterilization;
4. Therapeutic abortions;
5. Routine periodic health examinations including routine eye examinations;
6. In-vitro fertilization, artificial insemination;
7. The treatment of port-wine stains on other than the face or neck, regardless of the modality of treatment;
8. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy;
9. Services to persons covered by other agencies; R.C.M.P., Armed Forces, Workplace Health, Safety and Compensation Commission, Department of Veterans Affairs, Correctional Services of Canada (Federal penitentiaries);
10. Services requested by a “third-party”;
11. Team conference(s);
12. Genetic screening and other genetic investigation, including DNA probes;
13. Procedures still in the experimental/developmental phase;
14. Anaesthetic services and surgical assistant services associated with all the foregoing.

(4) **Payment of claims**

Payment to practitioners

Cheques are issued to all opted-in practitioners on a regular (i.e. every two weeks) basis for all claims, which have been approved for payment.

Each cheque covers the claims listed on the reconciliation statement to which the cheque refers.

(5) **Adjustments in claims**

Certain services may be paid at a rate, which differs from, that claimed or anticipated by the practitioner.

Claims submission and payment procedure (continued)

Such adjustments in payment can result from a variety of factors such as the application of assessment rules or Fee Schedule interpretations, inaccurate claims by practitioners, uninsured services, composite fees for which partial payment has already been made, and so on.

The Practitioner Payment Reconciliation Statement, which accompanies each cheque to the practitioner, provides an explanation of these adjustments.

If a claim cannot be processed for payment as outlined above, a Claims Correction Statement or other document is sent to the practitioner.

The practitioner must resubmit a new claim or other document with the corrected or additional information in order for the claim to be paid.

For further information regarding rejected claims and appeal procedures, refer to Appeal Procedures on page 1/8.

(6) **Patient identification**

The beneficiary's identification card contains his name, date of birth, Hospital/Medicare identification number expiry date. This information is required on the claim form except for the expiry date.

(7) **Procedure if patient is not registered**

If a practitioner renders service to a New Brunswick resident who is not registered with Medicare, he can proceed in either of the following ways:

(a) The practitioner can opt-out for the service in question and bill the patient directly, putting the onus on the patient to register and to obtain payment from Medicare if eligible.

(b) The practitioner can assist the patient by advising him to write directly to Medicare Registration for a registration form, which the patient must complete and return. Having been issued an identification number, the patient should then give this information to the practitioner who can enter it on a completed form and bill Medicare directly.

Appeal Procedures

1. **Appeals by physicians**

   Where a participating physician has a complaint, with respect to the assessment of an account for an entitled service, he/she has the right to have the matter reviewed by an appeals committee. Such a review is initiated by a request in writing from the physician to the Director of Medicare.

   Changes in the appeals process are underway. However, an interim appeals mechanism is in place and functioning.

   For additional information, please contact the New Brunswick Medical Society or Medicare Practitioner Liaison Services. A detailed description of the new appeals process will be provided to you, when it becomes available, as a replacement page for the fee schedule.

2. **Appeals by beneficiaries**

   The appeal procedures for beneficiaries apply to all claims in respect of entitled services whether they were billed as opted-in or opted-out services and whether they were provided by participating or non-participating practitioners.

   Where a beneficiary has any complaint with respect to his eligibility to receive payment for entitled services, or with respect to the assessment of an account for an entitled service, he has the right to have the matter complained of reviewed by the Insured Services Appeal Committee, established under the General Regulation under the *Medical Services Payment Act*.

   This review will be undertaken on receipt by the Director of Medicare of a request from the beneficiary.

   The Insured Services Appeal Committee will advise the Minister with respect to the disputed entitlement or assessment. The Minister will then decide on the action to be taken, and the Director will notify the beneficiary of the outcome of the review.

Excluded Services

The range of entitled services under Medicare New Brunswick includes all services rendered by medical practitioners that are medically required; it also includes certain surgical-dental procedures when performed either by physicians or by dental surgeons.

Certain services, as listed in Schedule 2 of the Regulation under the *Medical Services Payment Act*, are specifically excluded from the range of entitled services under Medicare, namely:

a) elective plastic surgery or other services for cosmetic purposes;

Excluded services (continued)

a.1) abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital approved by the jurisdiction in which the hospital is located and two medical practitioners certify in writing that the abortion was medically required;

a.2) surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract itself, due to the existence of an illness or other complication;

b) medicines, drugs, materials, surgical supplies or prosthetic devices;

c) biological products as listed in section 107, 108 and 109 of Regulation 66-43 under the *Health Act*;

d) advise or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;

e) examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;

f) dental services provided by a medical practitioner;

f.1) services that are generally accepted within New Brunswick as experimental or that are provided as applied research;

f.2) services that are provided in conjunction with or in relation to the services referred to in paragraph (f.1);

g) distance or traveling time which is not specifically provided for in the Schedule of Fees;

h) testimony in a court or before any other tribunal;

i) immunization, examinations or certificates for purpose of travel, employment, emigration, insurance, or at the request of any third party;

j) services provided by medical practitioners to members of their immediate family;

k) psychoanalysis;

l) electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;

m) laboratory procedures not included as part of an examination or consultation fee;

n) refraction's;

n.1) services provided within the Province by medical practitioners or dental practitioners for which the fee exceeds the rate prescribed in this Regulation;

Excluded services (continued)

o) the fitting and supplying of eye glasses or contact lenses;

p) trans-sexual surgery;

p.1) radiology services provided in the Province by a private radiology clinic;

q) acupuncture;

r) complete medical examinations when performed for the purpose of a periodic check-up and not for medically necessary purposes;

s) circumcision of the newborn;

t) reversal of vasectomies;

u) second and subsequent injections for impotence;

v) reversal of tubal ligations;

w) intrauterine insemination;

x) gastric stapling or gastric by-pass; and

y) venipuncture for the purposes of the taking of blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility.

Supplies and Materials

As a general principle, a practitioner shall not charge for those items related to supplies and equipment usually provided in an office except as identified below in Section II. Equally, as a general principle, a practitioner may charge for those items of supplies and equipment usually provided primarily by the hospital.

I. **Included**

Included in the fees for entitled services unless otherwise specified:

A. All administrative processes surrounding a visit (whether under direct control of the physician or not) such as appointments, registration, charting, billing and reporting to a referring physician.

B. The use of all materials and equipment usually available in the office such as gowns, thermometers, specula and minor diagnostic and therapeutic equipment.

C. Any disposable items such as gowns, table paper, thermometers, lancets, specula, syringes (less than 10cc) and needles.

Excluded services (continued)

D. Single use supplies and materials utilized, applied or administered at the time of the entitled service, for example:

(1) in the simple dressing of wounds or lesions;
(2) for the taking, preservation or standard mailing of specimens;
(3) in the use of diagnostic equipment, such as ECG paper and disposable electrodes; and
(4) in the performance of allergy testing, with the exception of rare specific antigens.

E. Simple patient aids such as basic prepared instructions and diet sheets.

II. **Excluded**

The physician may determine if charges should be levied to patients or to someone acting on the patient's behalf for the following types of costs:

(1) long distance telephone, tele-transmission or courier services;
(2) books or commercial literature;
(3) injectable, oral or other drugs or medication, including anaesthetic agents;
(4) substantial or medicated dressings applied at the time of the visit;
(5) devices such as IUD's and diaphragms;
(6) casts, supports, orthotic appliances and also special alternative materials for purely cosmetic purposes or for sports use;
(7) reusable items such as elastic bandages or hosiery;
(8) any other take home supplies; and
(9) laboratory tests except where listed as a benefit in the Physician's Manual.

Patient Eligibility and Registration

Refer to the pamphlet entitled "Answers to your questions".

Practitioner Audit

1. **General information**

Accounts paid by NB Medicare to either doctors or patients are subject to verification. This in no way implies criticism of persons providing or receiving services but assists in maintaining an efficient public program and as a check to confirm that payments are recorded and paid correctly. Audits are conducted in a strict confidential environment.

Documentation is an integral component of a medical service. Good medical records enhance quality and continuity of care and provide protection for both patient and practitioner.

Documentation for all services, which are billed to NB Medicare, must be completed before such claims are submitted for payment.

All claims submitted to NB Medicare must be verifiable by your patient records with respect to the service performed and billed. If such records cannot be produced and in the absence of suitable

Practitioner audit (continued)

explanation, then the specific service involved will be deemed not to have been rendered and thus not payable. A practitioner shall make every effort to provide or make available, upon request by Medicare, patient records to clarify or verify services submitted for payment.

For Medicare monitoring purposes, a practitioner must maintain records to support his/her billings to NB Medicare for a period of seven years.

2. **Records standards**

A clinical record of a service must include (at a minimum) the following legible information:

- Patient name, Medicare # and Date of Birth
- Name of referring practitioner, where applicable
- Name of Consultant, if referred
- Date of Service
- Reason for the service, i.e. Presenting complaint
- Findings/evidence of physical examination (part or region) or emotional disorder – if applicable.
- Diagnosis
- Plan of investigation or treatment (including medications, if applicable)
- For procedures, in addition to the above, a brief description of the service performed should be included.
- For time based codes, e.g. Counseling, the start time and duration is required.
- For time of day codes, i.e. Emergency visits, premium fees, the time of day is required.

3. **Audit interval**

- All practitioners will be audited on a random basis.

- Non-random audit will be conducted as warranted, based on utilization review or other data.

4. **On-site audit**

- Auditors will be employees of the Department of Health & Wellness.
- The personnel will adhere to standards of confidentiality.
- Auditors may make on-site visits on two working days' written notice. Efforts will be made to minimize any disruption of normal office activities.
- Auditors will be authorized to make notes, photocopies, etc. as necessary to document their findings.
- A refusal of an on-site audit is considered an offence under the *Medical Services Payment Act.*

5. **Verification letters**

Verification Letters are sent to beneficiaries who are asked to complete and return them to NB Medicare. This process is to determine if the service provided corresponds with the service billed.

Practitioner audit (continued)

6. **Audit findings**

Subsequent to a review of all information gathered during the monitoring process, one or more of the following actions may be undertaken:

- Acceptance of the practitioner's explanation.
- Educational advice.
- Recovery of funds
- Follow-up audits if necessary to determine compliance.
- Referral of the matter to such agencies as Professional Review Committee, legal authorities, and NB College of Physicians and Surgeons.

7. **Professional Review Committee**

The Professional Review Committee (PRC) consists of 5 practicing physicians who are nominated by the NB Medical Society and appointed by the Minister of the Department of Health and Wellness. This Committee reviews all matters forwarded to it by the Medicare Monitoring Section. Refer to the *Medical Services Payment Act and Regulation 84-20* for the responsibilities/mandate of this committee.

Assessment Rules

1. Basis of payment

In discussions between the New Brunswick Medical Society and the Department of Health & Wellness regarding the basis of payment for entitled services under Medicare, certain modifications, clarifications and interpretations of the Society's Fee Schedule were agreed.

In addition to the amendments which are incorporated in the Society's Fee Schedule a number of special items are included in the Medicare Payment Schedule which further modify the Fee Schedule for Medicare payment purposes but which do not form part of the Fee Schedule. These special items are recorded in the printed Manual as Medicare notes, and some are contained in the assessment rules, which follow.

2. Assessment rules - general

A number of the main assessment rules, which will apply to the assessment of accounts under the Medicare Plan, are incorporated in the Society's printed Fee Schedule as reprinted below.

It should be noted that these rules are not part of the Society's Fee Schedule. They are interspersed throughout the Schedule for convenience or reference and to assist the physician in billing the plan accurately.

All of the assessment rules are shown in the numbered list on the following pages.

The list includes those rules, which are in the body of the Fee Schedule.

3. Assessment rules - details

Details of the assessment rules which will be applied to claims under Medicare are given in the following list:

Rule 1 Services rendered for or at the request of a third party are not entitled services under Medicare.

Rule 2 Consultations, examinations or written reports for medicolegal purposes are not entitled services under Medicare.

Rule 3 Certification for a driver's license is not an entitled service under Medicare.

Rule 4 Mileage is not an entitled service under Medicare, except as specifically provided for in the Schedule of Fees.

Rule 5 Telephone advice is not an entitled service under Medicare, except as specifically provided for in the Schedule of Fees.

Assessment rules (continued)

Rule 6 Services listed in Schedule 2 of the Regulations under the *Medical Services Payment Act* are not entitled services under Medicare. (See pages 1/8 - 1/10).

☞ ***Medicare Note: Supplies And Materials, See Pages 1/10 and 1/11.***

Rule 7 Under Medicare, claims for first office visits with complete examination for a specialist will be allowed only once per 365-day period for any patient.

Rule 8 (Deleted 01/07/83)

Rule 9 Under Medicare, claims for first office visits with regional examination will be allowed only once in any 90-day period for any patient. In addition, such claims will not be allowed if the visit took place within 90 days of a preceding first visit with complete examination.

Rule 10 Visit fees cannot be charged for days on which a physician charges psychotherapy or psychiatric care fees except when the visit is for a consultation or a first day's hospital care.

☞ ***Medicare Note: See Medicare Note On Pages 5/4 and 5/40.***

Rule 11 Payment for a consultation under Medicare will not be made unless the recorded medical history for the patient indicates a prior service rendered by the physician shown on the consultant's claim form as the referring physician. If there is no such prior service by the referring physician the claim will be paid as a non-referred office visit.

☞ ***Medicare Note: See Medicare Note On Page 3/7, Item (8).***

Rule 12 Payment for a sickness-related complete physical examination by a general practitioner will not be made where such an examination has been performed on the patient by the same physician in the preceding 42 days.

Rule 13 When the performance of a List A or List B procedure is the sole purpose of attendance in an outpatient or emergency department, the fee for the procedure alone is payable. Also, if any visit or consultation fee has been paid during the preceding 30 days, no further visit or consultation fee may be claimed on the day of the List A or B procedure except in an emergency situation where independent consideration must be required.

Rule 14 Venipuncture (code 2050) for the taking of specimens for laboratory testing is not payable when a visit, consultation or procedure fee is paid to the physician.

Assessment rules (continued)

Rule 15 Electrocardiograms are entitled services under Medicare only when performed by specialists in internal medicine or pediatrics.

Rule 16 The opting-out privilege for participating physicians may not be invoked for emergency conditions, for patients undergoing a period of hospital care unless arranged prior to admission to hospital, or for continuation of care.

Rule 17 Claims under detention fee cannot be approved unless accompanied by adequate explanatory information describing the circumstances, which necessitated detention. The total time spent in caring for the patient must be provided.

Rule 18 Where a major assessment on the day of admission is paid, the hospital per diem rate will not be paid for the day of the major assessment.

Rule 19 In computing the number of days stay on which payments for in-hospital care will be based, the day of admission and the day of discharge will each be counted as one day and they are both payable.

Rule 20 (Deleted 01/04/81)

Rule 21 (Deleted 01/11/97)

Rule 22 (Deleted 01/08/94)

Rule 23 (Deleted 01/04/81)

Rule 24 Preoperative examinations and visits, excluding intensive care, which are performed by the operating surgeon within a period of 30 days preceding the surgical procedure are deemed to be included in the surgical fee, except as provided in assessment rule 25 and in specific Medicare notes in the Manual. Preoperative care in hospital by a referring physician is payable when this care is necessary for investigation and treatment. Preoperative assessment by the anaesthetist is included in the anaesthetic fee.

Rule 25 In the case of specialists in urology, consultations, office examinations and office visits preceding surgical operations on the urogenital system are paid in addition to the fee for the surgical procedure except where such consultations, examinations or visits are performed on the same day as the surgical procedure, in which case they are deemed to be included in the surgical fee.

Rule 26 (Deleted 01/08/92)

Assessment rules (continued)

Rule 27 All medical services (including home, office and hospital care, but excluding intensive care), rendered by the surgeon during the normal postoperative period are deemed to be included in the surgical fee.

☞ ***Medicare Note: See Medicare Note On Page 4/6.***

Rule 28 *For all surgical procedures the normal postoperative period will be taken as 30 days.

Rule 29 Unless otherwise specified two collaborating surgeons may each be paid 70% of the amounts that would be paid to a solo surgeon. Payment of an assistance fee to a third physician will only be made if the need for the assistant is explained on the surgeon's claim or accompanying documentation.

Rule 30 When more than one List A or List B procedure is done, the fee for the principal procedure will be paid in full and the additional procedure, when payable, will be paid at 75% of the appropriate fee.

Rule 31 (Deleted 15/09/94)

Rule 32 When a diagnostic endoscopic procedure is done, the fee includes dilatation as may be required to facilitate or enable completion of the endoscopy. If, for therapeutic purposes, a dilatation is done the appropriate dilatation or therapeutic endoscopy fee may be billed.

Rule 33 Diagnostic endoscopies are considered as "independent operative procedures". Payment will be made in the following manner:

i) 100% of the listed fee when the endoscopy is the sole procedure performed;
ii) 75% of the listed fee when it is followed by surgery on the same day;
iii) 0% if normally done as part of a concurrent operative procedure (e.g. peritoneoscopy and tubal ligation).

Rule 34 The fees for delivery, for cesarean section and for other operative delivery include the post-delivery or postoperative care in the hospital.

Rule 35 When a patient is transferred to an obstetrician immediately prior to or during delivery due to the development of unforeseen complications, the fee for delivery is payable to both the obstetrician and the transferring physician.

If the delivery is by caesarean section, the transferring physician may be paid a surgical assistance fee in addition, where applicable.

Rule 36 (Deleted 01/04/80)

Assessment rules (continued)

Rule 37 Premature care refers to the care of an infant weighing 2.5 kilograms or less at birth, and where more than one child is involved the listed fee applies per child.

Rule 38 (Deleted 01/04/85)

Rule 39 The elapsed time on which the charge for anaesthesia is based is calculated as starting at the point at which the anaesthetist commences to administer the anaesthesia and ending when the patient is removed from the operating theatre to go to the recovery room. The time involved in preparing the patient prior to administration of the anaesthesia and the time involved in supervising the patient's recovery after he has been removed from the operating theatre are not intended to be included in the elapsed time on which the charge for anaesthesia is based.

Rule 40 Professional fees for audiometry (code 2030) are not payable when visit or consultation fees are claimed.

Rule 41 When two or more special examinations in otolaryngology are performed on the same day, the major examination may be claimed in full and the lesser examinations at 75% of the listed fees, to a maximum of three paid examinations.

Rule 42 No visit or consultation fee is payable when special examinations in otolaryngology are the sole purpose of a visit.

Rule 43 (Deleted 01/09/93)

Rule 44 A first visit with complete examination for specialists in ophthalmology will include the following special procedures where these are necessary: fundus examination, gonioscopy, tonometry, biomicroscopy, indirect ophthalmoscopy or three mirror slit lamp examination of fundus.

Rule 45 Under Medicare, payment for nursing home care will be made only for visits for which the physician is specially called to the nursing home. Routine, regular visits for custodial care will not be paid on this basis.

Rule 46 The fees applicable to extended care admission and daily care shall be payable either on admission from the community or on transfer from within the institution. Payment for the appropriate extended care codes will not be limited by the postoperative period, other than to the surgeon.

Rule 47 An outpatient or emergency department service paid by sessional or fee-for-service will not be paid in addition to a hospital admission fee when done during the same hospital-based encounter. However, should a hospital-based visit fee during one visit be followed by an admission, during a separate visit, both services shall be deemed

Assessment rules (continued)

payable. Time of day must be indicated for these types of billings. This rule is intended to support the general payment principle that when separate services are provided at separate times (unless precluded by another assessment rule) both shall be payable.

Schedule of Fees
of the New Brunswick Medical Society
April 1, 2004

Table of Contents

General Preamble

1. The Schedule of Fees is an average schedule and is intended as a guide to the profession in assessing charges for services rendered. Fees as specified are for professional services and do not include charges for drugs, injectable materials or appliances.

   This schedule is basically a "single listing" schedule. Most procedures are listed once only with certain specific exceptions. There is a multiple listing for calls and consultations in the various fields of practice.

2. **Principles of billing**

   "Benefits" under the *Medical Services Payment Act* are limited to services, which are medically required for the diagnosis and/or treatment of a patient, and are not excluded by legislation or regulations.

   All benefits listed in the New Brunswick Schedule of Fees, except where specific exceptions are identified, must include a direct face to face encounter with the patient by the physician, appropriate physical examination when pertinent to the service and ongoing monitoring of the patient's condition during the encounter.

   If it is not medically necessary for a patient to be personally reassessed prior to prescription renewal, specialty referral, release of laboratory results, etc., claims for these services must not be made to the plan regardless of whether or not a physician chooses to see his/her patients personally or speak with them via the telephone.

   Claims for missed appointments must not be submitted to New Brunswick Medicare.

   The listing of any service or procedure in the New Brunswick Schedule of Fees, therefore, does not necessarily ensure coverage by Medicare for all occurrences.

   ☞ ***Medicare Note: A participating physician under Medicare who "opts out" for the management of a particular patient is required to inform the patient as outlined on page 1/2.***

   Each medical practitioner who participates in the care of a patient is entitled to compensation commensurate with the services rendered to the patient.

   The attending physician or surgeon, wherever possible, should acquaint the patient or person financially responsible with the obligation involved in his case. This applies particularly to consultations, supportive or directive care.

   Each medical practitioner participating in the care of a patient should render directly to the patient or to the financially responsible party a statement of charges, preferably specifying service or procedure with the appropriate fee as laid down in the Schedule. This should be done at the time service is rendered or at regular intervals. Should any variations from this Schedule be appropriate or desirable, an explanation should be added, e.g. courtesy reduction in consideration of special circumstances.

General preamble (continued)

Charges by an organized clinic or medical partnership should specify fees for services rendered by each member of the group.

A patient is entitled to receive a personal receipt for monies paid by him.

3. **Terms and definitions**

(1) ***Specialist***

Specialist is defined, for purposes of application of any given service in this schedule, as one whose name appears in the Specialist Register authorized by the College of Physicians and Surgeons of New Brunswick in the specialty which normally is considered to encompass the service in question.

The rates listed under the heading "Specialists in…" apply only to services performed by a specialist in his field of practice.

(2) Call or visit refers to services by a physician to a patient for diagnosis and/or treatment at home, office, or hospital.

A visit fee applies to, and includes, services such as:
- initial hyposensitization injection and assessment;
- removal of foreign body from eye;
- otoscopy and/or removal of cerumen;
- urinary bladder catheterization;
- proctoscopic examination;
- repeat routine Pap smear;
- postcoital test;
- simple removal of finger or toenail;
- insertion of naso-gastric tube;
- certain supplies and materials (see pages 1/10 and 1/11);
- prostatic massage;
- vaginal insufflation

a) Office call or visit - services rendered in the doctor's office (excluding special procedures, consultations, etc.).

(i) First - in new illness, or in prolonged illness in which the physician has not rendered services during the previous 30 days.
(ii) Subsequent - continuing services except (i).
(iii) For injection, or procedure, only - visits solely for this purpose.

b) Hospital visit - services rendered to a patient formally admitted to hospital for diagnosis and/or treatment.

General preamble (continued)

(i) First visit - major assessment on day of admission. Same day office visits may be paid if an independent consideration request is made outlining the urgency of the hospital admission.

☞ ***Medicare Note: The fee for a first hospital care visit for every specialty implies responsibility for, and includes, the history and physician examination for admission purposes.***

(ii) Subsequent visits - daily care fees normally apply.

(iii) Out patient and emergency department visits - apply to attendance on an outpatient basis.

c) Home visits - services rendered to a patient at his/her personal residence. Extra patient refers to an additional member of the same family or persons living in the household examined and prescribed for at any home visit.

d) Emergency visit - a situation where the demands of the patient and/or the physician's interpretation of the condition require that he responds immediately at the sacrifice of regular office hours or routine of medical practice. The need for immediate response is the intended controlling feature. Immediate attendance because of personal choice or availability of the physician is not considered an emergency visit. Urgent visits for acute or chronic conditions, which do not interfere with routine medical practice, do not constitute emergency visits. **Emergency visits may include any visit codes for services rendered on an emergency basis at the office, home, nursing home, Extra Mural, or hospital, or emergency calls in which the patient is seen outside - e.g. on the street. All claims for emergency based visits must show the time of day the services were rendered**.

e) ICU visit and services rendered to a patient formally admitted to the unit for diagnosis and/or treatment.
   (i) Initial Assessment payable once per session except in case where anaesthetists bill for respiratory care. Refer to Medicare note page 4/7.

(3) **Examinations**

a) A complete examination shall include a full history, complete physical examination and detailed examination of one or more parts or systems in certain instances. Routine laboratory work such as routine urinalysis and haemoglobin estimation, venipuncture if necessary, a record of the findings and advice to the patient will be considered part of the examination.

☞ ***Medicare Note: See Assessment Rules 7 and 12.***

b) A regional examination shall comprise a full history of the presenting complaint and detailed examination of the affected part, region or system as needed to make a diagnosis, exclude disease and/or assess function on a patient previously assessed by the referring physician; will include a review of pertinent x-ray and laboratory data and such special examinations as are considered to be essential to a regional or specific assessment.

General preamble (continued)

c) Scheduled visits to designated OPD facilities for clinics, should be billed at appropriate OPD codes and fees.

☞ ***Medicare Note: Claims for regional examination will be allowed only once in any 90 day period for any patient. In addition, such claims will not be allowed if the visit took place within 90 days of a preceding first visit with complete examination (Assessment Rule 9).***

d) A visit, applicable to first or subsequent visits in which a complete or regional examination is not required, includes the necessary examination of the affected part, region or system, a record of the findings, diagnosis and recommended treatment.

e) A health examination (for insurance, pre-employment, preschool, routine periodic, etc.). This refers to examination of individuals at any age who may or may not have signs or symptoms of disease or disability. The fee charged will depend upon the evaluation. Examinations additional to (3)a) or (3)b) may warrant an increased fee.

f) *For billing purposes, a visit is not considered appropriate when billed in relation to a non-insured service, unless the examination/inquiry is necessary to facilitate a decision with respect to appropriateness of treatment.

☞ ***Medicare Note: Health examinations for or at the request of a third party are not entitled services under Medicare. (See Assessment Rule 1) Routine health examinations for purposes of a periodic check-up are not an entitled services.***

(4) **Consultations**

A consultation refers to the situation where a physician in light of his/her professional knowledge of the patient, or when recently asked to do so by the patient or person acting on the patient's behalf, specifically requests the opinion of another physician competent to give advise in this field, because of the complexity, obscurity or seriousness of the case. The consultant is obliged to perform an assessment, review the laboratory or other data and submit his/her findings, opinions and recommendations in writing to the referring physician.

A consultation is not to be claimed as such when:

(i) The patient presents his/herself to the consultant's office without prior knowledge of the primary physician. The sending of a report to the primary physician under these circumstances does not justify a consultation.
(ii) The primary physician has not been asked for professional advice but was simply asked by the patient for the name of a specialist in a particular field and the patient seeks out the specialist him/herself.
(iii) *Billed in relation to a non-insured service, unless the examination/injury is necessary to facilitate a decision with respect to appropriateness of treatment.

General preamble (continued)

☞ ***Medicare Note: A covering colleague is considered as "the same physician" for purposes of assessment. A request for a covering physician to routinely attend a patient during a physician's absence is not a consultation for payment purposes. However, when there is a medical necessity for the second physician's intervention totally unrelated to the referring physician's absence, a claim for a consultation may be appropriate.***

a) A major consultation shall comprise a full history and enquiry into and examination of all parts or systems, as pertinent to the specialty and may include, in addition, a detailed examination of one or more parts or systems on a patient previously assessed by the referring physician; will include a review of pertinent x-ray and laboratory data and such special examinations as are considered to be essential to a complete assessment in this specialty. The consultant's opinion and recommendations shall be submitted to the referring physician in writing.

b) A regional consultation shall comprise a full history of the presenting complaint and detailed examination of the affected part, region or system as needed to make a diagnosis, exclude disease and/or assess function on a patient previously assessed by the referring physician; will include a review of pertinent x-ray and laboratory data and such special examination as are considered to be essential to a regional or specific assessment. The consultant's opinion and recommendations shall be submitted to the referring physician in writing.

c) A repeat consultation is a consultation performed by the same physician within thirty days of a prior consultation, for the same or related condition, as a result of a new request from the attending physician.

☞ ***Medicare Note: Payment for a consultation under Medicare will not be made unless the recorded medical history for the patient indicates a prior service rendered by the physician shown on the consultant's claim form as the referring physician. If there is no such prior service by the referring physician the claim will be paid as a non-referred office visit. (See Assessment Rule 11). See Medicare Note on page 3/7, item (8).***

(5) **Obstetrical services**

Obstetrical fees are intended to cover the care of the average case and include less serious obstetrical complications.

Obstetrical care is paid on a visit basis plus delivery, as outlined in the Schedule.

(6) **Paediatric services**

For the purpose of this Schedule of Fees, the following age groups are defined:

a) Newborn care refers to routine care of a well-baby during the first ten days, including complete examination and necessary parental advice.

General preamble (continued)

b) Premature care refers to care of an infant weighing 5½ lbs., (2.5 kg), or less at birth.

c) Well-baby care refers to periodic office visits of a well-baby, up to one year of age, (code 19 and 89) for routine supervision of growth and development and parental instructions.

(7) **Surgical services**

Except where otherwise specifically stated in the Schedule, the fee for surgical procedure includes the following:

- Normal preoperative examination and visits when the patient proceeds to surgery done by the same surgeon within a period of 30 days.

- Investigation and preparation of the patient.

- *The total postoperative care during the normal postoperative period. (30 days)

In unusually complicated cases needing prolonged pre or postoperative care, additional charges may be made at the discretion of the surgeon.

Where a procedure is specified as "independent procedure", the procedural fee may be charged in addition to the pre and postoperative visit fees, consultations, etc.

Where a surgical procedure is performed in the course of a home visit, the home visit fee may be charged in addition to the procedural fee.

☞ ***Medicare Note: All medical services (including home, office and hospital care) rendered by the surgeon during the normal postoperative period are deemed to be included in the surgical fee. (See Assessment Rule 27). For all surgical procedures the normal postoperative period will be taken as 30 days. (See Assessment Rule 28).***

(8) **Referred and transferred patients**

Referred patient is a patient referred to a specialist for consultation and returned to the referring physician for continuing care.

☞ ***Medicare Note: Medicare will require that the consulting practitioner fill in the referring practitioner's name and number on the claim form. Consultations made within 6 months of the referral date will be considered valid.***

Transferred patient is a patient transferred from the care of one physician to another for assessment and continuing care.

General preamble (continued)

☞ ***Medicare Note: When a patient is transferred from the care of one physician to another in the same specialty for the convenience of the physician (covering for vacations, rotations, etc.), the period of care is, for payment purposes, considered as continuous.***

a) For the services rendered prior to the transferal of the patient, the referring physician may charge on a fee-for-service basis, for example:
   (i) Home, office or hospital visits as rendered;
   (ii) In addition to (i) above, in acute cases if detained he may charge a fee as listed in the schedule for detention fees.

b) For services rendered as an assistant during an operation the referring physician may charge an assistant's fee (see page 4/5).

   In cases in which the referring physician is required to be present in the interest of the patient but does not actually assist at the surgical procedure, he may charge on a per visit basis for this service.

c) For the services rendered after an operation, the referring physician may charge on the basis of supportive care fees and/or convalescent care fees as outlined in the Schedule (see pages 4/5 and 4/6).

☞ ***Medicare Note: Payment for supportive care is made only on proof of medical necessity.***

(9) **Anaesthetic services**

See preamble to section on anaesthetic services.

(10) ***Independent consideration**

Unusual procedures, or conditions, which vary considerably with regard to the time, skill and responsibility involved, may be assessed by independent consideration.

The attending physician or physicians should assess their charges in equity with comparable items in the Schedule (**see insert pg**. **4/10-11**)

Fees listed in the physician's manual are the normal maximum fees on which Medicare payments will be based. In situations where exceptional circumstances warrant a greater fee than is provided for in the Fee Schedule a claim should be submitted for "Independent Consideration", Physicians will be required to:

- submit the claim under the appropriate code;
- request independent consideration and submit requested fee, and;
- provide supporting documentation

General preamble (continued)

***New Services**

A new service is defined as a specifically identified technology, service or program which is entirely new to the province, not a replacement of an existing technology, service or program.

In cases where a physician is planning to or has provided a new service they must proceed as indicated below.

For new services which meet the above definition, a submission must be made to the New Brunswick Medical Society for consideration by the New Service Item Committee (NSIC).

The physician must submit a claim to Medicare for the new procedure pending review by the NSIC. Interim payment will be made for a period of six (6) months. If no submission is received by the Committee within the interim period, payment will cease at the end of the six months. No charge will be made to the patient until such time as it is determined by the NSIC that the service will not be approved. Extension of the six month period, for items which have been submitted but not resolved, will be subject to agreement by the Department of Health and Wellness and New Brunswick Medical Society.

Fees listed in the physician's manual are the normal maximum fees on which Medicare payments will be based. Physicians submitting a claim for a new service will be required to:

- Submit the claim under service code 888;
- Request independent consideration and
- provide supporting documentation and comparable fee with an existing code and
- Submit a New Service Item Form to the NSIC

(11) **Detention fees**

A detention fee may be charged when the physician is required to spend considerable extra time in immediate attendance on the patient (and to the exclusion of all other work). **(See page 4/4)**

(12) **Laboratory services**

a) Laboratory procedures are provided to hospital inpatients under the Hospital Care Program.

b) Outpatients: Most laboratory procedures are available to physicians on referring their patients or specimens through a hospital or outpatient department of a hospital, and are classified as outpatient laboratory services.

A listing of laboratory procedures available, and their current cost rates on a cost basis is available from the Provincial Laboratory Services.

c) Laboratory services performed by or under the supervision of a private physician - see Diagnostic and Therapeutic Procedures and various sections of this Schedule.

General preamble (continued)

4. **Disputed fees**

The New Brunswick Medical Society provides appropriate committees to advise on matters of dispute re fees. These may be referred by the physician, by the patient, or by a paying agency through the Secretary of the Society.

5. **Revision of schedule**

A continuing committee on tariff is maintained by the New Brunswick Medical Society. Its purpose is to relate fees to the current practice of medicine. Members who detect errors in this Schedule, or wish to make recommendations re new procedures should forward their observations to the Executive Secretary of the Society. Amendments to the Schedule of Fees may be issued from time to time.

General preamble (continued)

Unit Values

Specialty	Uncertified Specialty	Unit Value	Date
Anaesthesia			
General Unit (I and Z)	1.24*	1.24*	01/04/04
Anaesthesia Unit (I and Z)	14.04*	14.04*	01/04/04
Cardiac & Thoracic Surgery		1.05	01/04/01
Dermatology	1.36*	1.36*	01/04/04
Diagnostic Radiology	.96 (75% of certified rate)	1.28	01/04/01
General Surgery	1.15*	1.15*	01/04/04
General Practice		1.32*	01/04/04
Internal Medicine	1.05	1.05	01/04/03
Medical Oncology	1.05		01/04/01
Neurology	1.33*	1.33*	01/04/04
Neurosurgery	1.33	1.33	01/04/03
Nuclear Medicine	0.99* (75% of certified rate)	1.32*	01/04/04
Obstetrics and Gynaecology	1.21*	1.21*	01/04/04
Ophthalmology	1.12	1.12	01/04/03
Orthopaedic Surgery	1.14*	1.14*	01/04/04
Otolaryngology	1.05	1.00	01/04/03
Paediatrics	1.21*	1.21*	01/04/04
Physical Medicine & Rehab	1.38*	1.38*	01/04/04
Plastic Surgery	1.28*	1.28*	01/04/04
Psychiatry	1.08	1.08*	01/04/04
Radiation Oncology	0.99	0.99	01/04/01
Respirology	1.29*	1.29*	01/04/04
Rheumatology	1.10*	1.10*	01/04/03
Urology	1.16	1.16	01/04/01

***NOTE: Effective 01/04/04 a Standardized Surgical Assist Unit Value (applicable to all assistants) will be $1.32. In the future, this unit value fee will be adjusted in line with General fee Schedule increases.**

Unit value changes for Uncertified Specialists in the future will be consistent with the unit value for the Certified Specialty. Uncertified Specialists with a unit value higher than certified will remain at the higher rate until the Specialty catches up. This does not apply to Radiology – Uncertified is 75% of Certified fee.

General preamble (continued)

Sessional Rates

Specialty	Rates	Effect Date
Anaesthesia	103.00*	01/04/04
Cardiac Surgery	103.00*	01/04/04
Dermatology	103.00*	01/04/04
Emergency Medicine	128.00*	01/04/04
General Surgery	103.00*	01/04/04
General Practice - ER	128.00*	01/04/04
All Other (Clinics, etc)	103.00*	01/04/04
Nursing Home	103.00*	01/04/04
Internal Medicine	103.00*	01/04/04
Neurology	103.00*	01/04/04
Neurosurgery	104.33	01/04/01
Obstetrics and Gynaecology	103.00*	01/04/04
Ophthalmology	103.00*	01/04/04
Orthopaedics	103.00*	01/04/04
Otolaryngology	103.00*	01/04/04
Paediatrics	103.00*	01/04/04
Physical Medicine	105.30	01/04/01
Plastic Surgery	103.00*	01/04/04
Psychiatry	103.00*	01/04/04
Radiology	N/A	N/A
Respirology	103.00*	01/04/04
Rheumatology	103.00*	01/04/04
Urology	103.00*	01/04/04
Closed Critical Care Adult Units	125.00/hr Daytime	01/04/03
- Specialist	400.00 – After hours coverage (evenings, nights, weekends, holidays)	
- General Practice	90.00/hr – (Evenings, nights, weekends, holidays)	

For non-certified specialists, the general rate value is the same as General Practice.

General preamble (continued)

Legend

All procedures listed in the Physician's Manual have been assigned a letter code (A, B, C or D) under the heading "List". The meaning of these codes is as follows:

"A" This identifies a "List A" procedure. List A procedures are payable in addition to same-day visit or consultation fees, but not to surgery performed on the same day by the same physician. These procedures are payable at 75% with other List A or B procedures on the same day.

"B" This identifies a "List B" procedure. List B procedures are payable in addition to same-day visit or consultation fees, or to surgery fees unless they are a normal component of the surgery. When followed by same-day surgery by the same physician, they are payable at 75% of the normal rate.

"C" *This identifies procedures which are not payable in addition to same-day visits or consultations. However, care in the normal pre and postoperative periods is payable with such procedures. Exceptions to this procedure/visit ruling include: visits with specific ophthalmology or specific audiometry procedures, as well as tray fees.

"D" This identifies surgical procedures, which carry restrictions in the payment of pre and postoperative care.

Abbreviations

BU - Basic Units
IC - Independent Consideration
TU - Time Units
VF - Visit Fee
+/- - with or without

Items Common To All Practitioners

A. **Uninsured Services**

1. **Mileage** - when applicable, $2.00 per mile, one way.

☞ ***Medicare Note: Mileage is not an entitled service, except as specifically provided for in the schedule of fees. (See Assessment Rule 4).***

2. **Telephone calls** - requiring advice and/or the prescribing of medication (depending upon the complexity)

☞ ***Medicare Note: Telephone advice is not an entitled service, except as specifically provided for in the schedule of fees. (See Assessment Rule 5)***

3. **Certification** - death (insurance purposes)
   Disability
   Health
   Insurance report (based on previous exam)
   Mental illness or alcoholism
   Health examinations with completion of forms

☞ ***Medicare Note: The above services relating to certification are not entitled services. (See Assessment Rule 3)***

4. **Expert witness fee**

☞ ***Medicare Note: Services rendered as an expert witness are not entitled services. (See Assessment Rule 2)***

5. Industrial and public health medicine or other services at the request of a public body

☞ ***Medicare Note: When calculating fees to be levied for uninsured services with an I.C. (independent consideration) listing, the physician should consider the amount of income that would have been generated in a similar length of time examining patients on an insured basis.***

☞ ***Medicare Note: Services rendered for or at the request of a third party are not entitled services. (See Assessment Rule 1)***

6. Blood alcohol samples and documentation at the request of the Department of Justice.

   a) **Visit and Examination Fees**
   Injured patient: bill under appropriate Medicare codes and fees.

	Code	Units
Non-injured patient, regardless of time of day, weekends or holidays.		
- physician on hospital premises	2959	21
- physician called to the hospital	2960	52

Items Common to all Practitioners (continued)

	List	Code	Units

☞ ***Medicare Note: Visit and examination fees are not payable when the physician rendering the service is already remunerated under a sessional or salaried arrangement.***

b) **Blood samples and documentation**

Taking of blood samples and completion of relevant documentation	B	2961	28

☞ ***Medicare Note: This is payable in addition to visit and examination fees and surgical procedures that may be provided to the same patient on the same day.***

c) **Detention**

Delays resulting in a requirement for the presence of a physician beyond one-half hour not related to the care of the patient, per 15 minutes		2962	13

☞ ***Medicare Note: After hours emergency premium does not apply to this service.***

☞ ***Medicare Note: Medicare from the Department of Justice recovers payment for the above services.***

B **Miscellaneous services**

1. **Nursing homes** - preadmission complete examination		2000	30
First patient seen during visit		2001	25
Emergency visit, nighttime and weekends, first patient		1752	50
Each additional patient		9	14

☞ ***Medicare Note: Payment will be made only for visits for which the physician is specially called to the nursing home. Routine, regular visits for custodial care will not be paid on this basis (See Assessment Rule 45). Claims for emergency visits*** (as defined on page 3/4) ***must show the time of day the services were rendered.***

2. **Emergency visits**

This listing applies to bona fide emergency visits, as defined on page 3/4, that are made to the hospital (for in-patient only), to the office, or to undefined locations such as the scene of an accident. It does not apply to home visits, nursing homes visits or to visits in an outpatient or emergency department: specific provisions for these categories of services are listed elsewhere in this Manual.

These fees do not apply, for instance, to pre-arranged after-hours attendance, nor do they apply when patients are seen as emergencies either in the office during office hours or in hospital during regular rounds to patients.

November 1, 2002

TO ALL PHYSICIANS

STATUTORY HOLIDAYS

Please note that the statutory holidays for physicians are as follows:

a) New Year's Day;
b) Good Friday;
c) Easter Monday;
d) Victoria Day;
e) Canada Day;
f) New Brunswick Day;
g) Labour Day;
h) Thanksgiving Day;
i) Remembrance Day;
j) Christmas Day;
k) Boxing Day.

Items Common to all Practitioners (continued)

	List	Code	Units

"Daytime" applies to attendance between 08:00 and 18:00 hours on weekdays.
"Nighttime" applies to attendance between 18:00 and 08:00 hours, weekdays.
"Weekends" applies to attendance on Saturdays, Sundays and legal holidays.

☞ ***Medicare Note: Legal holidays (see insert)***

Daytime emergency visit		2855	21
Additional patient – office		2858	21
– other location		2859	14
Nighttime and weekends		2856	47
Additional patient		2861	22

☞ ***Medicare Note: Claims for emergency visits* (as defined on page 3/4) *must show the time of day the services were rendered.***

3. **Visits to hospital emergency or outpatient departments**

"Daytime", "nighttime" and "weekends" are defined above. "First patient" means the first person attended when a physician has made a special visit to the hospital. These codes do not apply when a physician has come from another location on the hospital premises and do not apply to the first patient seen by a physician providing scheduled on-site coverage. This also applies to "on-call" room attendance in health care facilities. "Additional patient" means any person attended in the department, other than a first patient as defined above. "On-site office" means that the physician maintains an office located in the hospital or physically connected to it.

Limit use of code 2854 to once per hour.

All scheduled appointments and clinics in out-patient departments should be billed as code 2021.

Daytime attendance			
First patient (when called to attend)		2020	22
First patient-special visit from on-site office		2925	18
Additional patient		2021	18*
Nighttime and weekend attendance			
First patient attended (other than by the scheduled on-site physician) in a hospital where on-site coverage is provided		2831	34
First patient attended in a hospital without any on-site coverage		2854	86
– physician coming from on-site office		2926	34
Additional patient, any hospital		2832	23

☞ ***Medicare Note: When the performance of a list A or B procedure is the sole purpose of attendance in an outpatient or emergency department, the fee for***

Items Common to all Practitioners (continued)

	List	Code	Units

the procedure alone is payable. Also, if any visit or consultation fee has been paid during the preceding 30 days, no further visit or consultation fee may be claimed on the day of the List A or B procedure except in an emergency situation where independent consideration must be requested. (Assessment Rule 13). Claims under hospital emergency or outpatient department visit codes must show the time of day the services were rendered.

Emergency services non-regional facilities.

Physicians who provide ER services in the approved non-regional facilities will be eligible to receive $400 per 12am-8am shift. As well, physicians will be able to bill for services rendered during that time period. Only one physician per facility per night is eligible for the $400 payment. Physicians must be on-site or available within fifteen minutes of the facility.

Physicians who are eligible for the $400 premium may be paid a fee of $100 per hour. Physicians may opt to receive this fee from the 6pm-12am shift seven days a week only or may also elect to receive such fees for the 8am-6pm shifts on weekends and statutory holidays.

Physicians must be on-site for the hourly rate. The only service, which can be billed over and above the hourly rate, will be the OBS delivery fee.

	Code	Units
4. **Detention fee** (see definition in the General Preamble, page 3/8), per 15 minutes	200	13

☞ ***Medicare Note: Claims under detention fee cannot be approved unless accompanied by adequate explanatory information describing the circumstances which necessitated detention. By definition detention may be claimed only when the practitioner's whole time is given to the patient to the exclusion of all other work. This is interpreted to mean that the physician is occupied at the patient's bedside; it does not cover waiting time, etc. Detention fees do not apply until the specified time for an appropriate visit has elapsed (for example: consult, complete exam, admission to hospital or intensive care = 1 hr; and repeat consult, hospital or intensive care day and office visit = ½ hr). Detention is not paid in addition to procedures.***
A visit, is not applicable when: you are already on the hospital premises and are called to see your hospitalized patient (you are the attending physician) on an emergency basis, or you are the operative surgeon rendering a visit in the post operative period; however a submission for detention alone, may apply if time spent with the patient is over and above the first ½ hr. Your billing must indicate the total time spent with the patient and substantiate why no visit was billed.

☞ ***Medicare Note: The above applies to both regular and ICU detention (refer to specialty sections for ICU codes).***

EXPLAINING THE NEED FOR A SECOND ASSISTANT

A notation outlining the need for a second assistant must appear on the lead surgeon's claim, or on a document accompanying the claim, to enable the second assistant to be paid.

In electronic billing, the only field available to record this is the **DIAGNOSIS** field, and also the **SERVICE DESCRIPTION** field when the billing software has been programmed to allow overwriting of the service description that automatically appears when entering a service code. Since a diagnosis and service description must be given in these fields, the maximum 40 spaces available obviously cannot all be used for another purpose.

To enable the required information to be entered in such a limited space and so avoid the need for a paper claim, the use of a special code "EEE" is proposed, to be followed by a brief statement of the reason for the second assistant. For example, if the reason for having a second assistant is the presence of a large tumor in a grossly obese patient, one could write "EEE large tumor, obese++", and still have 15 spaces remaining to enter a diagnosis or service description. The use of the letters EEE of course simply says: "A second assistant was required because…" using only 4 characters (3 letters and a blank).

Items Common to all Practitioners (continued)

	List	Code	Units

5. **Surgical assistance fees:**

(a) A surgical assistant is paid 33% (minimum 25 units) of the listed surgical fee for the first procedure, and at 50 or 75% of that rate (similarly to the surgeon's fees) for assistance at additional procedures during the same operative session.

(b) Surgical assistance is payable when there is a medical necessity for an assistant. In the case of cataract surgery, this is outlined more specifically in Schedule 2 of the Regulations.

(c) Assistance fees do not apply in the case of surgical procedures with a listed fee of 77 units or less except in special circumstances, in which case an explanatory note should be submitted.

(d) Assistance fees are not payable for diagnostic endoscopic procedures unless specified in the Schedule.

(e) Surgical assistance fees are not payable to a surgeon who receives procedure fees for other surgery during the same operative session.

(f) *Provision has been made to pay for cross-assisting at surgery in situations where physicians from different specialties assist one another at the same operative session. This would apply in situations where each physician is responsible for a primary procedure during the same operative session. Where applicable this would obviate the need to call a third physician to assist in some cases.

☞ ***Medicare Note: If more that one assistant is required, the medical necessity must be explained on the surgeon's claim or accompanying documentation.***

	Role
6. **Collaborating surgery:** The role of collaborating surgery may be invoked in unusually serious or complex surgical situations where the clinical circumstances are such that there is a need for intraoperative shared decision making, over and above the input of a consultant or surgical assistant.	6

Collaborating surgery fees include the participation of both surgeons in patient evaluation and management as necessary, prior to and/or following surgery, to the same extent as if one were billing as a solo surgeon.

7. **Concurrent care**
Care of a patient by more than one doctor where the medical indications require the services of more than one physician for the adequate care of the patient, including, **directive, continuing, supportive care**.

Items Common to all Practitioners (continued)

Directive care is care given by a specialist at the request of the attending physician and may include up to 3 visits per week at the appropriate daily hospital care rates (see specific specialty for codes)

Continuing care is care given by a specialist at the request of the attending physician in a situation in which the patient is transferred to the specialist.

	Code
Supportive care is necessary care rendered by the referring physician in addition to that rendered by a consultant physician while a patient is hospitalized and may include up to three visits per week at the appropriate daily hospital care rates	199

Transfer of care

Definition:
A physician who is receiving a patient into his care may bill a Transfer Code. The transfer must entail a direct hands-on evaluation of the patient by the accepting physician. The transfer code is not applicable where the physician receiving the patient in transfer has rendered a major consultation, first day hospital admission, or another complete examination within the previous 30-day period. It must be noted that a transfer code is not a consultation service as it does not request an opinion or recommendation on treatment: it is continuing care by another physician. When a physician takes over the complete care for the remaining stay, subsequent hospital codes would apply. All Transfer Codes require a referring physician; this must be the previous attending physician.

In the case of post-operative situations, if no transfer occurs, but the surgeon requests assistance for patient management by a second physician for a different diagnosis/condition, then supportive/directive care codes may apply for the second physician. In a true transfer of care to the second physician, by the surgeon during the post-operative period, for a different diagnosis/condition, the receiving physician may bill a transfer code and hospital care codes.

☞ ***Medicare Note: This definition applies to hospital and ICU transfers. See specialty sections for specific codes and fees.***

When services by the consultant(s) are required beyond the consultative stage, the manner of attendance by the consultant(s) and the attending physician should be specifically defined, as far as possible at the time of consultation.

Each physician should render a separate account for this service, with an explanatory note.

Situations where specific fees are designated for procedures requiring a team of physicians are not considered to be concurrent care.

8. **Sessional fees** **(See Page 3/11 for rates)**

Items Common to all Practitioners (continued)

	List	Code	Units

☞ ***Medicare Note: The fees apply to prearranged sessions, approved by Medicare. The total time billed is calculated to the nearest half-hour increment or part thereof.***

9. **Special care units**

(1) **Intensive care** - the following fees apply to services rendered in intensive care units and concentrated care units recognized as such by the Department of Health and Wellness, including neonatal intensive care units and burn units, by physicians with relevant training and/or experience.

	Code	Units
Initial assessment and institution of care		
Non-specialists	21	181*
Specialists (except in Anaesthesia, general surgery, internal medicine, neurology, neurosurgery, and paediatrics: see the appropriate specialty listings for specific service codes)	2876	221*
Daily rate for the attending physician		
Non-specialists	22	31*
Specialists (as above)	2877	39*
Intensive care requiring detention		
Non-specialists - per ¼ hour	23	40
Specialists (as above) - per ¼ hour	2878	50

☞ ***Medicare Note: See service description on detention page 4/4.***

☞ ***Medicare Note: Directive care in intensive care units (maximum five visits per week)***

Non-specialists	25	18*
Specialists (all specialties)	198	22*
For patient on ventilator, per day, maximum 3 days (payable only in ICU to the physician who supervises the ventilator care), add	1798	20*

☞ ***Medicare Note: A consultation fee is not payable in addition to the initial assessment fee. As well, an initial assessment code does not apply where the same physician has rendered a major consultation within the previous 24 hours. Daily care ICU fees would apply. Intensive care fees are inclusive of procedures, unless otherwise specified. During the first 24 hours following surgery these fees do not apply to the surgeon unless admission to the intensive care unit occurred prior to surgery or unless the patient is transferred to the unit after his return to the surgical floor. Claims for detention must include appropriate explanatory information. (See Assessment Rule 17).***

Items Common to all Practitioners (continued)

	List	Code	Units
(2) **Other special care** - the following fees apply to services rendered in units identified and agreed upon by the Department of Health and Wellness and the New Brunswick Medical Society. Such units are structured, staffed and administered so as to provide a level of care meeting the needs of patients who should otherwise be attended in a recognized intensive care or concentrated care unit.			
Initial assessment and institution of care			
Non-specialists		136	81
Specialists		137	99
Transfer of an inpatient from another ward, same physician		138	30
Daily rate for the attending physician			
Non-specialists		139	28
Specialists		140	35
Care requiring detention			
Non-specialists - per ¼ hour		141	13
Specialists - per ¼ hour		142	15
Directive care (maximum three visits per week)			
– non-specialists		143	13
– specialists		144	16

☞ ***Medicare Note: A consultation fee is not payable in addition to the initial assessment fee. Special care fees are inclusive of procedures. During the first 24 hours following surgery these fees do not apply to the surgeon unless admission to the special care unit occurred prior to surgery or unless the patient is transferred to the unit after his return to the surgical floor. Claims for detention must include appropriate explanatory information. (See Assessment Rule 17).***

10. **Miscellaneous services**

A. Not payable in addition when a consultation or visit fee applies:

	List	Code	Units
Anticoagulants - supervision of long term therapy, per month (telephone service)	C	1898	8
Haemoglobin estimation	C	1886	3
Hyposensitization injections, including supervision (except initial injection and assessment), per visit	C	1894	13*
Injections - intradermal, intramuscular or subcutaneous, and therapeutic injections (one or more per visit)	C	2	13*
Urinalysis - complete, including microscopic	C	1884	3
Venipuncture-adult or child 4 years and older **(IC Only)**	C	2050	5

☞ ***Medicare Note: Only when physician specifically called to perform procedure.***

Items Common to all Practitioners (continued)

	List	Code	Units
Injection for intravenous pyelogram (not payable to the interpreting radiologist)	C	1945	8

B. Payable in addition to a consultation, visit fee or minor surgery (77 units or less) only when rendered in the office.

Tray fee for pap test	C	1999	6

11. **Total parenteral nutrition (hyperalimentation)**

Consultation, with assessment of nutritional status and degree of hypermetabolism. The consultant's opinion regarding the type of malnutrition and proposed plan of nutritional therapy shall be submitted to the referring physician in writing		2475	57
Daily care following the date of institution of parenteral nutrition – 2nd – 30th day, per day		2478	11
– after 30 days, per day		2480	4

☞ ***Medicare Note: Claims for intravenous hyperalimentation must indicate the medical necessity. Hyperalimentation and intensive care/daily hospital care/directive care are not payable to the same physician for the same period of hospitalization.***

Total parenteral nutrition fees are payable in the pre and postoperative period to the same or different physician. However, it is not payable to the surgeon on the day of surgery.

12. **After-hours emergency premium**

After-hours is defined as 18:00 to 08:00 hours on weekdays and all day on Saturdays, Sundays and statutory holidays; and, for non-specialists only, anaesthesia at the sacrifice of regularly scheduled office hours. The premium is *38% of the normal rate of payment with a minimum for the total billing of 30 general units or 3 anaesthesia units. Between the hours of midnight and 06:00 hours, the premium increases to *65%.

Emergency services for this purpose are defined as services, which must be performed without delay because of the medical condition of the patient. This includes non-elective cesarean sections.

The premium does not apply to services performed by physicians providing scheduled on-site coverage during after-hours periods.

The premium applies to the following emergency services:

a) surgical procedures performed under general, spinal or epidural anaesthesia and surgical assistance and anaesthesia related thereto;
b) procedures performed under major nerve root blocks;
c) reduction of shoulder dislocations (Code 502);
d) daytime anaesthesia by non-specialist at the sacrifice of regularly scheduled office hours;

Items Common to all Practitioners (continued)

	List	Code	Units

e) consultations;
f) emergency hospital admissions;
g) initial assessments in intensive care and concentrated care units;
h) initial management of trauma;
i) after-hours detention;
j) cadaver - organ, tissue or bone removal;
k) obstetrical deliveries, including medically indicated induction of labour, which proceeds to delivery after hours.

☞ ***Medicare Note: Claims involving premium payments must show the time of day the service was rendered. The total amount billed (fee plus premium) should be entered on the same claim line. Services performed under major nerve block must be identified on the claim.***

Refer to IC insert for values and details for billing purposes.

13. **Cancer premium - see page 6/1.**

14. **Miscellaneous visit fees**

(1) **Extramural hospital** - the following service codes apply exclusively to services related to patients admitted to the Extramural Hospital program:

Home visit - with admission to the program	204	60
To a previously admitted patient	205	50
Emergency visit	206	60
Additional patient, admitted or not, seen during a home visit	208	15
Visit (other than home visit) with admission to the program	209	35
Mileage, one-way, per km over and above the initial 5 km	207	1
*Electronic communication initiated by a staff member	210	8
Visit to a physician's office by an Extramural Hospital staff member to discuss health matters in relation to an Extramural patient	195	15
– in relation to two or more patients	196	21

☞ ***Medicare Note: Billings under code 196 are to be submitted on a single patient claim form using one patient's Medicare number. The names and medicare numbers of the other patients discussed must be provided in the remarks section of the claim. Codes 195 and 196 are payable in addition to same-day visits or telephone consultations.***

☞ ***Medicare Note: Claims for emergency visits (as defined on page 3/4) must show the time of day the services were rendered.***

(2) **Counseling**

a) Patient counseling - per ¼ hour	193	21

INFORMATION TABLE RE: CLAIMING I.C./CANCER/EMERGENCY PREMIUM

PLEASE KEEP THIS TABLE HANDY FOR YOUR REFERENCE WHEN COMPLETING CLAIMS FOR RELATED SERVICES

I.C. NUMERIC VALUE	DESCRIPTION	HOW TO CALCULATE THE DESIRED BILLED FEE
1	Independent Consideration	Enter the I.C. Fee Requested in "Fee" Field
2	After Hours Emergency Premium	Listed Fee + 38% or 30U minimum = Total Fee
3	I.C. & After Hours Emergency Premium	I.C. Fee Requested + 38% or 30U minimum = Total Fee
4	Cancer Premium	Listed Fee + 35% (Surgeon Only) = Total Fee
5	Cancer Premium & After Hours Emergency Premium	Listed Fee + 35% + 38% = Total Fee
6	I.C. & Cancer Premium	I.C. Fee Requested + 35% = Total Fee
7	I.C., Cancer Premium & After Hours Emergency Premium	I.C. Fee Requested + 35% + 38% = Total Fee
8	After hours Emergency Premium – Midnight – 06:00	Listed fee + 65% or minimum 30U = Total Fee
9	I.C. & After Hours Emergency Premium – Midnight – 06:00	I.C. Fee Requested + 65% or 30U minimum = Total Fee

Anaesthesia Billings: Basic Units + Time + 38% or 3 anaesthesia units minimum – **IC (2)**
Basic Units + Time + 65% or 3 anaesthesia units minimum – **IC (8)**

When after-hours emergency premium is billed (including weekends and holidays) the time of day must be indicated.

6 PM - Midnight = IC (2)
Midnight - 6 AM = IC (8)
6 AM - 8 AM = IC (2)

Midnight – 6 AM weekends & holidays = IC (8)
6 AM – Midnight weekends & holidays = IC (2)

Please note: Claims billed as Independent Consideration, I.C. of 1, 3, 6, 7 and 9 must be submitted on a Single Patient Claim Form with appropriate explanation or documentation. The "I.C." field should be completed for each service submitted on the claim form.

The I.C. numeric values 2, 4, 5 and 8 must be submitted via teletransmission.

Items Common to all Practitioners (continued)

	List	Code	Units
Discussion with a patient of health on matters dealing with the "family" unit, such as marriage counseling, contraceptive advice and sexually transmitted diseases.			

☞ ***Medicare Note: This fee is not payable in addition to consultation or visit fees, nor does it apply to counseling of a patient with respect to his/her own state of health. The total time spent with the patient must be provided.***

b) Family counseling - per ¼ hour 216 21
Discussion of a patient's health with family member(s) in situations where such discussion is necessary for a treatment decision or for arranging support services.

This service code applies also when the **counseling** of a family member is necessary in severe life-threatening conditions or major chronic health problems.

Explanatory notes:

1) Only informing or discussing with other persons (such as family members) a patient's condition, as opposed to formal **counseling**, even in cases of serious illness is considered to be included in patient care fees, and such exchanges cannot be billed to Medicare. However, one may elect to bill these other persons themselves for repeated or time-consuming interviews.

2) Except as provided under certain specific codes, the fees for attending children include any exchanges with accompanying persons whenever the interview, advice, etc. would take place with the patient alone were it not for his/her age. More particularly, family counseling fees do not apply to the parents unless they obtain true **counseling** in serious circumstances as outlined in the above definition.

☞ ***Medicare Note: Code 216 cannot be billed when the family member interviewed is the object of a visit or consultation in his/her own right. This code must be billed under the patient's own Medicare number; in addition the identity of the interviewee must be entered on the claim. The total time spent must be provided.***

3) Home visits

First patient seen (see appropriate service code under each specialty listing)	--	--
Emergency visit (requiring immediate attention initiated by the patient or someone acting on the patient's behalf)	8	60
Additional patient, any home visit	5	14

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.*** **Claims for emergency visits (as defined on page 3/4) must show the time of day the services were rendered.**

4) **Extended care/restorative care** - the following service codes apply exclusively to services related to hospital patients admitted to designated extended care units:

Items Common to all Practitioners (continued)

	List	Code	Units
First day's assessment and care, except where the physician was attending the patient immediately prior to transfer to the extended care unit		1745	34
Subsequent days		1746	12
Additional daily fee for unit director		1747	6

☞ ***Medicare Note: See Assessment Rule # 46***

5) **Relief care beds** - the following services codes apply exclusively to services related to patients admitted to the relief care program in New Brunswick hospitals.

Preadmission examination		1748	30
Minor examination on admission (not applicable if the physician has billed a preadmission examination)		1749	20
Attendance at the request of nursing staff or if daily care becomes necessary - per diem rates as for hospital Care		1750	VF
Visit requiring special trip to the hospital - as for emergency Visits in other locations		1751	VF

☞ ***Medicare Note: See Medicare note following emergency visit in other location, page 4/3.***

6) **Reassessment for chemotherapy**

Minimum 28 day interval		283	33*

7) **Initial management of multiple systems trauma**

This code applies to the comprehensive assessment and the performance of usual resuscitative or stabilizing measures by the physician in charge. It includes, as required, intravenous lines, pressure infusion sets and pharmaceutical agents, urinary catheters, blood gases, nasogastric tubes and tracheal toilet. This code is payable in instances of trauma or injury which is life-threatening, or trauma affecting more than one system or area of the body with a high risk of disabling injury

	C	2956	120

(See also specific Specialty listings for management of trauma).

☞ ***Medicare Note: This is payable in addition to necessary surgical procedures, where appropriate.***

☞ ***Medicare Note: An initial management of trauma code is payable to one physician only, except when early transfer to a physician in another specialty or to another hospital is required.***

6) **Attendance during transport** - when a physician is

Items Common to all Practitioners (continued)

	List	Code	Units
required to attend a patient in transport to another health care facility, "one-way" detention per quarter hour		2979	52

☞ ***Medicare Note: Claims must state the actual one way traveling time, excluding waiting time or making arrangements.***

7) **Attendance fees - victims of alleged sexual assault** - examination and early attendance. To include necessary examinations, medical attendance and patient counseling (including parents when the patient is a child) as well as taking of specimens, completion of reports and forms and other medico-legal requirements and liaison with other parties 1893 280

Additional time after the first 2 hours may be billed as detention.

☞ ***Medicare Note: The total time, inclusive of code 1893 must be given when billing detention. Attendance fees are not payable when the physician rendering the service is remunerated under a sessional or salaried arrangement. After hours premium does not apply to this service.***

New Brunswick Mandated On-Call Program

1. Mandate

1.1 To provide compensation for mandated on-call in New Brunswick hospitals and nursing homes for specialists and general practitioners.

2. Objective

2.1 Primary objective of the Program is to meet the emergency/urgent needs of the public and to ensure that physicians who provide on-call coverage as defined are compensated.

This agreement does not modify, nullify or void any medical staff by-laws, privilege rules and regulations, between a Regional Health Authority/Nursing Home and a physician concerning work performed on an on-call basis.

3. Exclusions

The Program applies to physicians working under all payment modalities. Physicians who already receive on-call remuneration or other methods of compensation, agreed to by the Department of Health and Wellness (DHW) and the New Brunswick Medical Society (NBMS), to reimburse them for on-call will be excluded. Exclusions are:

Arrangements agreed to by DHW and NBMS:

- On call for surgeons and anesthetists in Sussex, Grand Falls, Perth-Andover, Woodstock & Caraquet
- Non-regional emergency rooms
- Yearly stipend for availability in Black's Harbour, Grand Manan and Harvey
- Intensivists working in closed ICUs without on site coverage
- Any future payment arrangements agreed to by the parties which include remuneration for on-call

Other Department of Health and Wellness (DHW) initiatives:

- Hospitalist projects (Miramichi and Saint John Regional Hospitals)

In situations where physicians are receiving supplementary payments for on-call from their Regional Health Authority (RHA), the funding from this initiative will be paid to the RHA to offset the cost of their current arrangements.

To work toward pay equity for on-call across the province, RHAs will remain at existing rates until the physician leaves or the term of their agreement/contract expires, with the exception of the aforementioned arrangements above.

4. Principles

New Brunswick mandated on-call program (continued)

4.1 Remuneration is only available for mandated on-call as determined by the Board within the Regional Health Authorities and/or by individual Nursing Homes.

4.2 There must be a response within 10 minutes or, if required, attendance within 20 minutes unless alternative arrangements are stipulated by the RHA/Nursing Home.

4.3 This program does not include routine consultations or work not defined as emergent/urgent. Physicians may continue to provide these services during the on-call period but must be available as described above. This program does not include routine on-call coverage for a physician's own patients and those of their on-call group, however is intended for new admissions and orphan patients. As always, providing on-call coverage includes caring for hospitalized patients.

4.3.1 This stipend does not include on-call availability during normal working hours on week days.

4.3.2 After Hour Emergency Premium is not billable in addition to this service code.

4.4 The Department requires prior notification, from the RHA or Nursing Home, of <u>two weeks</u> of any proposed additions or deletions to the number of rotations. Any changes will be made following proper consultation with the NBMS. DHW will notify the appropriate party of the decision. At the inception of the On-call program, the parties agreed to fund the existing General Practice on-call groups to their full compliment. The number of General Practice on-call groups will not change unless negotiated by the parties.

4.5 Only first call (primary) will be compensated.

4.6 All on-call rotations will be remunerated at the same rate.

4.7 Criteria for availability: If a physician is participating as part of a service that is available 365 days (24x7) then they would qualify. If a physician is part of group that is unable to cover 365 days then the following applies: a solo physician must be available a minimum of 90 days of the year. A 2 physician group must be available a minimum of 180 days, a 3 physician group must be available a minimum of 270 days and 4 or more physician group must be available 365 days. This criterion will be monitored quarterly by the parties.

4.8 Where call is shared between Fee-For-Service and salaried physicians, billing must be submitted Fee-For-Service.

4.9 A parallel system has been created for physicians where there is a solo salaried physician providing call or where the entire group is salaried. Funding will come from the salaried pool.

4.10 A physician will receive only one on-call stipend per night, regardless of how many services are covered or if it is for one or more regions/nursing homes of the province.

New Brunswick mandated on-call program (continued)

4.11 Locums will be eligible for this remuneration, if they are replacing a physician who meets the criteria.

4.12 When a physician is called in to examine, diagnose and treat a patient he/she may bill the appropriate Fee-For-Service fee.

4.13 RHAs will be required to submit information upon request providing monthly details (physician's name, specialty and date of service). Regions must document all out-of-region physician rotations coverage.

5. Billing

5.1 Service code (8999) has been developed for Fee-For-Service billing purposes. The date of service on the claim will reflect the date the on-call shift begins. One physician will be compensated per date of service. Only one service/date can be billed on a claim.

General Practice

	List	Code	Units

See legend – Pg. 3/13 for description of list A, B, C and D.

The fees cannot be correctly interpreted without reference to the General Preamble.

Consultations (see definitions in General Preamble)			
Major or regional consultation		10	45
Repeat, within 30 days		12	30
Office visits, to include where applicable hemoglobin, urinalysis, injections, pelvic examination and services to which they apply as outlined on page 3/3.			
Office visit, to be billed by General/Family physicians when providing service within the context of a community-based family practice, which is defined as one in which the physician maintains a comprehensive patient chart to record the service code 1 and all other encounters, provides all necessary follow-up care for that encounter and takes responsibility for initiation and follow-up on all related referrals.....		1	24*
Seniors Office Visit			
For complex case assessment for seniors 75 years of age or over, presenting with multiple systems pathology including medication review, as required		8101	31*

☞ ***Medicare Note: Once multiple system pathology has been diagnosed, the senior's office code may be billed for subsequent visits regardless of presenting complaint(s).***

Service code 1 applies also to office consultations and complete examinations that cannot be claimed at a higher fee under other codes, for example due to limitations in frequency or service intervals.

Injections – intradermal, intramuscular or subcutaneous, and therapeutic injections (one or more per visit)	C	2	13
Immunization including tray fee (maximum of 2 @ 100%) Payable in addition to same day office visit fee.....	C	8102	8
Immunization, including tray fee (maximum fee) Not payable in addition to same day office visit ...	C	8103	13
Hyposensitization – injections, including supervision (except initial injections, and assessment) per visit	C	1894	13
Walk–in Clinic – Visit			
Office visits in a location identified as a walk-in clinic..		3*	21
Complete physical examination			
Complete examination performed for medically necessary purposes		7	33

General practice (continued)

	List	Code	Units

The expression "for medically necessary purposes" means that a complete examination is required in order to enable the physician to identify and define the nature and/or cause of the patient's presenting complaint(s) or condition, so as to allow appropriate recommendations and/or management.

To meet the requirements of service code 7, a complete examination **must** comprise at least the following:

- The taking or updating of a full past history of the patient, including family history; a detailed inquiry on the presenting complaint(s), and a comprehensive functional inquire;
- A physical examination pertinent to the major body systems, namely: cardiovascular, respiratory, digestive, genitourinary, musculoskeletal, hemolymphatic and nervous. (From the patient's perspective, this means examination of the mouth, neck, chest (lungs and heart), abdomen, and extremities; and, where indicated, may include also eyes, ears, nose, breasts, pelvic, rectal, reflexes.)

- Keeping a written record of all positive and pertinent negative findings, lab work, advice and treatment.

For physicians entering practice in a new location, or when accepting new patients in an established practice, code 7 may be claimed at the first visit only if the complete examination is warranted by the nature of the presenting complaint(s). Code 7 cannot be claimed for routinely doing a complete assessment of a new patient or as increased payment for comprehensive initial documentation.

Service code 7 does not apply to a complete examination for the purpose of a periodic check-up, or to a third-party request, as these are excluded services under Medicare. Third-party requests include examinations done in connection with employment, insurance, legal proceedings, admission to educational institution or camp and similar requests. Mandatory hospital examinations are also considered third-party requests, except in those individual instances where a complete examination is medically required.

Service code 7 cannot be claimed within 42 days of payment of a complete examination fee to the same physician.

Supportive Care (see service description page 4/6)	199	18*

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2173	34
Subsequent – 2nd to 30th day, per day	2174	18
– after 30 days, per day	2176	12

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19, and 24.***

General practice (continued)

	List	Code	Units
Transfer Code - hospital care (see service description page 4/6)		45	31
Transfer Code - ICU care (see service description page 4/6)		1819	31
Initial management of multiple systems trauma	C	2923	120

This code applies to the comprehensive assessment and the performance of usual resuscitative or stabilizing measures by the physician in charge. It includes, as required, intravenous lines, pressure infusion sets and pharmaceutical agents, urinary catheters, blood gases, nasogastric tubes and tracheal toilet. This code is payable in instances of trauma or injury which is life-threatening, or trauma affecting more than one system or area of the body with a high risk of disabling injury.

☞ ***Medicare Note: This is payable in addition to necessary surgical procedures, where appropriate.***

☞ ***Medicare Note: An initial management of trauma code is payable to one physician, except when early transfer to a physician in another specialty or to another hospital is required.***

Home visits (See also page 4/11)		4	40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Visit to vessel – in harbor		214	40
– at wharf		386	35

☞ ***Medicare Note: The above service cannot be charged to Medicare unless in relation to visits to individual patients.***

Postmortem examination			IC

☞ ***Medicare Note: Postmortem examinations are not entitled services.***

Obstetrical care – payable on the basis of visit fees plus a delivery fee. Refer to Assessment Rule 34 and 35.

Delivery	D	14	330
Multiple births - per additional birth, add	D	1413	50
Prenatal complete examination		15	31
Pre and/or postnatal visits other than complete examinations **(see also Assessment Rule 34)**		16	24*
Prenatal care and assisting at caesarean section - visit basis plus assistant fee.			

☞ ***Medicare Note: Delivery fees include attendance during prolonged labour. The fee for a prenatal complete examination, code 15 is not payable within 42 days of***

General practice (continued)

	List	Code	Units

a previous complete examination. Code 7, is not payable within 42 days of a prenatal complete examination.

Newborn infant care, per child 17 40

The routine care of a well-baby in hospital up to ten days, including complete physical examination and necessary instructions to mother.

☞ ***Medicare Note: A patient identification number is required on all claims. For unregistered newborn infants the identification number of the mother should be used, with the newborn's complete date of birth and sex code 3 or 4 whichever is applicable, until such time as the infant has been registered with Medicare.***

Premature care – up to three weeks, per week 18 56
– next three weeks, per week 30 28

☞ ***Medicare Note: Premature care refers to the care of an infant weighing 2.5 kilograms or less at birth and where more than one child is involved the listed fee applies per child. (See Assessment Rule 37)***

Well -baby care - to include examination and instructions regarding health care 19 24*

Psychotherapy, per 15 minutes 20 21

☞ ***Medicare Note: See Assessment Rule 10, psychotherapy fees do not apply until after one hour has elapsed for the major consultation or first hospital admission. When billing alone or in combination with other services, the total time must be provided.***

Case conference dealing with family violence with allied health workers and teachers on behalf of the patient, per 15 minutes 211 20

☞ ***Medicare Note: Case conference is payable in addition to other necessary services that may be provided to the patient on the same day and should be billed under the patient's Medicare number. The total time spent must be provided.***

Anaesthesia fees - refer to section "Specialists in Anaesthesia", pages 5/5 - 5/8.

Denver screening ..... B 2172 30

Specialists in Anaesthesia
Anaesthetic Services Preamble

See legend - Pg. 3/13 for description of list A, B, C and D.

The fee is for professional services only and includes:

(a) Preanaesthetic evaluation of the patient as an anaesthetic risk, ordering of the premedication as indicated, administration of all types of anaesthesia, fluids or blood incident to anaesthesia or surgical procedure, and immediate postanaesthesia supervision.

(b) Immediate supportive and resuscitative measures in the operating room and/or the recovery ward as indicated by the patient's condition and by the surgeon's requirements including cases for resuscitation of an infant delivered by Caesarian Section or Operative Delivery. However, insertion of arterial cannulae, catheterization for central venous pressure and the insertion of Swan Ganz catheter are payable in addition.

(c) Treatment of any complication arising from anaesthesia within 48 hours.

The anaesthetists' fees are determined by adding the basic and time units and, where applicable, modifying units and multiplying the sum by unit value.

For procedures with basic units = 4, time units are computed by allowing one unit for each 15 minutes or part thereof of anesthesia time up to one hour and two units for each 15 minutes or part thereof up to 4 hours then 3 units for remaining time for each 15 minutes or part thereof.

For procedures with basic unit > 4, time units are computed by allowing one unit for each 15 minutes or part thereof of anesthesia time up to two hours and two units for each 15 minutes or part thereof up to 4 hours then 3 units for remaining time for each 15 minutes or part thereof.

☞ ***Medicare Note: The elapsed time on which the charge for anaesthesia is based is calculated as starting at the point at which the anaesthetist commences to administer the anaesthesia and ending when the patient is removed from the operating theatre to go to the recovery room. The time involved in preparing the patient prior to administration of the anaesthesia and the time involved in supervising the patient's recovery after he has been removed from the operating theatre are not intended to be included in the elapsed time on which the charge for anaesthesia is based. (See Assessment Rule 39)***

In special cases where the services of more than one anaesthetist are deemed necessary in the interest of the patient, the fees shall be increased by 50% of that computed for the procedure; each anaesthetist to receive half of the total fee.

When multiple or bilateral surgical procedures are done during the same anaesthetic, the anaesthetic charge shall be based upon the basic units for the major procedure plus time. When bilateral procedures or surgical revisions are carried out at separate times with separate anaesthetics, the anaesthetist shall be entitled to receive a full anaesthetic fee for each procedure.

In procedures where no value is listed, or with I.C., the basic portion of the calculated value will be the same as listed for a comparable procedure considering region.

Specialists in Anaesthesia (continued)

	List	Code	Units Gen	Units An

When a physician administers an anaesthetic and also performs a procedure on the same patient, he should charge for one service only.

☞ ***Medicare Note: Claims for anaesthesia in addition to universally required details must show:***

1) ***Anaesthetic time;***
2) ***Service code of primary or major operation performed;***
3) ***Fee billed, in units, to include basic units and time units;***
4) ***The "no. of services" box and the "fee" box must be equal. When billing anaesthetic service (s), the role box on the claim form must be recorded with a 2; this applies to both specialists and non-specialists anaesthetists.***

Unit Value - see page 3/10 - 3/11.

Modifying units - to be added according to the following:

(i)	Infants less than 5 kg. (11 lbs.) in weight	5
(ii)	intraoperative haemodynamic manipulation to facilitate surgery (25% below normal range)	10
(iii)	deep hypothermia circulatory arrest	10
(iv)	use of controlled hypothermia to 32°C or less	15
(v)	infants between 5 and 10 kg	1
(vi)	patient over age 70	1
(vii)	one lung anaesthesia	6
(viii)	awake endotracheal intubation for difficult airway (Not payable in addition to one lung anaesthesia).	3
(ix)	spinal cord integrity monitoring (including wake-up test)	6

After-hours emergency premium ..... (page 4/9)

Special procedures

Minor procedure or maneuver requiring anaesthesia.	C	832		4

This code covers those situations where the procedure is not normally performed under anaesthesia but is necessary in specific cases. Examples are: lumbar puncture or urinary bladder catheterization in infants or incompetent adults.

Obstetrical anaesthesia	C	1909		4
Dental anaesthesia	C	1910		4
Neuraxial anaesthesia				
For surgery - basic units for procedure plus time units.				
Obstetrical neuraxial analgesia/anaesthesia for labor and delivery, continuous infusion or intermittent top-ups.				
Institution	C	2449		8
Maintenance – continuous infusion – per hour, (maximum 8 units), add	C	1793		1

Specialists in Anaesthesia (continued)	List	Code	Units Gen	Units An
– intermittent top-ups – per injection, (maximum 10 units), add	C	1794		2
Delivery – add	C	1795		TU

☞ ***Medicare Note: The type of maintenance must be indicated on the claim form.***

Continuous infusion neuraxial analgesia				
Lumbar, institution	C	2452		6
Maintenance (maximum 26 units) - per 2 hours, Add	C	1796		1
Thoracic, institution	C	2454		8
Maintenance (maximum 24 units) - per 2 hours, Add	C	1797		1
Brachial Plexus Analgesia Institution	C	8323*		8
Re-injection, visit/consult incl. daytime, add	C	8325*		2
Re-injection, visit/consult incl. nighttime/weekend, add	C	8326*		3
Uninterrupted perfusion (max 26 units) per 2 h	C	8324*		1
Intermittent neuraxial injection of narcotic substance via a catheter for pain control.				
Installation of catheter or blood patch graft, including first injection (Consultation payable in addition, if applicable)	C	1770		8
Subsequent injection, visit/consultation fee included, daytime	C	1771		2
– nighttime, weekends and legal holidays	C	1772		3

☞ ***Medicare Note: The time required to perform service code 1770 must not be claimed as part of the anaesthesia time when calculating surgical anaesthesia. Claims for subsequent injection, service codes 1771 and 1772, must show the time of day the services were rendered.***

Resuscitation				
During anaesthesia – included in anaesthesia time				
Independent of anaesthesia	C	219		6
Maximum				12

Consultations and visits			
Assessment re fitness for anaesthesia		201	25
If followed by anaesthetic			0
Preanaesthetic consultation, above and beyond the normal preoperative assessment, at the specific request of the attending physician – specialist		217	58
Non-specialist		218	31
Major or regional consultation		1505	65
Repeat consultation		1084	30
Office visit		1499	19

Specialists in Anaesthesia (continued)	List	Code	Units Gen	Units An
Hospital care				
First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2927	62	
Subsequent – 2nd to 30th day, per day		2928	19*	
– after 30 days, per day		2929	12*	
Transfer Code – hospital care (see service description page 4/6)		300	62	
Directive Care – see service description page 4/5		40	19*	

Intensive care – this is to apply to services rendered in recognized intensive care units and concentrated care units.

Initial assessment and institution of care		313	221*	
Daily rate, per day		314	39*	
Intensive care, requiring detention Per ¼ hour		315	50	
Directive care		198	22*	
Transfer Code – ICU care (see service description page 4/6)		1820	62	

☞ ***Medicare Note: *See Medicare note under Intensive care, page 4/7.***

Monitored <u>perioperative</u> care and supportive care (incorporates anaesthesia "stand-by")		1812		4

When the attendance of an anaesthetist is required, or requested by another physician, for supportive care or monitoring of conditions co-incident to a procedure but when anaesthesia is not administered.

Patient controlled analgesia is an acute pain management modality utilized in lieu of traditional intramuscular narcotic injection for pain management. It allows the patient to exercise control of their acute pain. Initiation of PCA would involve patient assessment, education, and the actual activation of the PCA apparatus. Maintenance of PCA would involve 24 hour coverage of patients on PCA. This includes visits and telephone consultation by same or different physician.

Initiation or Maintenance of PCA is only payable once per day same or different physician. Also, it is not payable in addition to a consultation, visit, ICU or hospital care by the same physician. PCA services are payable to the same physician, on the same service date as general anaesthesia, if at a separate session. Both claims must indicate the time of day.

Patient Controlled Analgesia (PCA) - for parenteral control of acute pain.

Initiation		841	62	
Maintenance		842	12	

Specialists in Anaesthesia (continued)	List	Code	Units Gen	Units An

☞ ***Medicare Note: These codes are applicable to certified and non-certified anaesthetists.***

Specialists in Cardiac Surgery

	Code	Units
See legend - Pg. 3/13 for description of list A, B, C and D.		
These fees cannot be correctly interpreted without reference to the General Preamble.		
Referred cases		
Consultations (see definitions in the General Preamble)		
Major or regional consultation	100	113*
Repeat consultation – within 30 days for same illness or complication thereof.....	101	52*
Hospital care		
First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	8320	43
Subsequent – 2nd to 30th day, per day	8321	20
– after 30 days, per day	8322	13
Directive Care – see service description page 4/5.....	8111	19

☞ ***Medicare Note: Service codes 100 and 101 are restricted to specialists in cardiovascular surgery who provide services in a cardiac surgery unit.***

Other visit fees – as for specialists in General Surgery (pages 5/12 - 5/13).

Specialists in Dermatology

	List	Code	Units

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)		
Major or regional consultation	125	67*
Repeat within 30 days for same illness or complication thereof	126	35*

Office visits		
First visit with complete dermatological examination	119	30
First visit with regional examination	120	19
Other office visits	121	19

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care		
First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2255	62
Subsequent – 2nd to 30th day, per day	2256	18
– after 30 days, per day	2258	12
Transfer Code – hospital care (see service description page 4/6)	310	62
Transfer Code – ICU care (see service description page 4/6)	1822	62
Directive Care – see service description page 4/5	46	18*

☞ ***Medicare Note: For ICU service codes (see page 4/7).***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits	127	40

(See also page 4/11)

Specialists in Dermatology (continued)

	List	Code	Units
☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***			
Dermatological procedures			
Diagnostic skin biopsy (restricted to specialists)	A	134	27
Ultraviolet phototherapy (UVB)	C	155	5
– PUVA therapy	C	154	23
☞ ***Medicare Note: One visit per week is payable in addition to code 155 or 154.***			
Dermabrasion of face - See Plastic Surgical Procedures, page 20/5.			
Dermabrasion of single area (e.g. trauma scar) - See Integumentary System, page 7/3.			
Allergy tests	B	1895	(page 21/1)
Laser destruction of skin lesions			
Lesion up to one centimeter in diameter, not involving nails, joints or orifices - claim under appropriate surgical excision code and fee			
Other lesions - requiring up to ½ hour of laser treatment	B	129	108
– up to ¾ hour	B	130	140
– up to 1 hour	B	131	172
– each additional ¼ hour	B	135	30
☞ ***Medicare Note: Laser treatment fees include intraoperative biopsies. The time elapsed must be noted on the claim form. Claims for laser treatment extending beyond two hours must be accompanied by an operative report.***			

Specialists in General Surgery

	List	Code	Units

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)			
Major or regional consultation		31	80
Repeat consultation - within 30 days for same illness or complication thereof		33	41
Office visits			
New condition seen for the first time, to include complete history and physical examination		26	30
First visit with regional examination		27	20
Subsequent visit, with complete examination - allowed once in any 90 day period (this code is to be used for the reevaluation of patients previously treated for malignant disease or for major arterial disease)		28	30
Other office visits		29	19*

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care			
First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2381	42
Subsequent – 2nd to 30th day, per day		2382	19
– after 30 days, per day		2384	13
Transfer Code - hospital care (see service description page 4/6)		327	36
Directive Care - see service description page 4/5		47	19

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits (See also page 4/11)		34	40

Specialists in General Surgery (continued)

	List	Code	Units

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Intensive care - this is to apply to services rendered in intensive care units such as surgical intensive care units, and in concentrated care units.

Initial assessment and institution of care.....		2833	221*
Daily rate, per day		2834	39*
Intensive care, requiring detention			
Per ¼ hour.....		2835	50
Directive care.....		198	22*
Transfer Code - ICU care (see service description page 4/6)		1823	36

☞ ***Medicare Note: See Medicare note under Intensive care, page 4/7.***

☞ ***Medicare Note: ICU detention fees following same day surgery by general surgeon may be approved on an individual consideration basis. The practitioner must provide sufficient documentation describing the circumstances which necessitated detention. See service description page 4/4.***

Initial management of multiple systems trauma..... C 2416 120

This code applies to the comprehensive assessment and the performance of usual resuscitative or stabilizing measures by the physician in charge. It includes, as required, intravenous lines, pressure infusion sets and pharmaceutical agents, urinary catheters, blood gases, nasogastric tubes and tracheal toilet. This code is payable in instances of trauma or injury, which is life-threatening, or trauma affecting more than one system or area of the body with a high risk of disabling injury.

☞ ***Medicare Note: This is payable in addition to necessary surgical procedures, where appropriate.***

☞ ***Medicare Note: An initial management of trauma code is payable to one physician only, except when early transfer to a physician in another specialty or to another hospital is required.***

Specialists in Internal Medicine

	Code	Units
See legend - Pg. 3/13 for description of list A, B, C and D.		
(Applicable to subspecialties e.g. Allergy, Cardiology)		
These fees cannot be correctly interpreted without reference to the General Preamble.		
Referred cases		
Consultations (see definition in the General Preamble)		
Major or regional consultation	41	121*
Repeat - within 30 days for same illness or complication thereof	42	56
Therapeutic radiology oncology		
Radiotherapy consultation	73	51
Office visits		
First visit with complete examination and diagnostic survey of a new patient not attended during the previous 90 days	35	42
First visit with regional examination	36	28
Subsequent visit with complete reexamination	37	28
Other office visits	38	22

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

☞ ***Medicare Note: See Assessment Rule 7.***

Hospital care		
First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2401	72
Subsequent – 2nd to 30th day, per day	2402	22
– after 30 days, per day	2404	14
Transfer Code - hospital care (see service description page 4/6)	301	62
Directive Care - see service description page 4/5	197	22

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits	44	40
(See also page 4/11)		

Specialists in Internal Medicine (continued)

	List	Code	Units

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Intensive care - this is to apply to services rendered in recognized intensive care units and concentrated care units.

Initial assessment and institution of care.....	220	221*
Daily rate, per day	221	39*
Intensive care, requiring detention		
Per ¼ hour (see service description page 4/4)	222	50
Directive care	198	22*
Transfer Code - ICU care (see service description		
page 4/6)	1821	62

☞ ***Medicare Note: See Medicare note under Intensive care, page 4/7.***

Permanent Pacemaker follow-up (including		
Implantable Loop Recorder and ICD)		
Visit only-no programming and no adjustment.....	8141*	26
Visit – Programming, adjustment, single chamber		
(ILR)	8142*	50
Visit – Programming, adjustment, dual chamber		
(ICD).....	8143*	75

Specialists in Neurology

	List	Code	Units

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (See definitions in the General Preamble)		
Major or regional consultation	161	82
Repeat consultation - within 30 days for same illness or complication thereof	162	40

Office visits

First visit, with complete examination and diagnostic survey of a new patient not attended during the previous 90 days	156	50
Subsequent visit, with complete reexamination	157	22
Subsequent visit for complete reassessment of a previously referred patient; allowed once in any 30 day period	160	42*
Other office visits	159	21

The code for other office visits applies also to office consultations and examination that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2501	62
Subsequent – 2nd to 30th day, per day	2502	19
– after 30 days, per day	2504	12

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Transfer Code - hospital care (see service description page 4/6)	8302	62
Directive Care - see service description page 4/5	61	19*
Home visits (See also page 4/11)	164	40

Specialists in Neurology (continued)

	List	Code	Units

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Intensive care - this is to apply to services rendered in recognized intensive care units and concentrated care units.

Initial assessment and institution of care		224	221
Daily rate per day		225	35
Intensive care, requiring detention			
Per ¼ hour (see service description page 4/4)		226	50
Directive care		198	22
Transfer code - ICU care (see service description page 4/6)		1827	62

☞ ***Medicare Note: See Medicare note under Intensive Care, page 4/7.***

Special procedures

Electroencephalography - interpretation only	B	168	25*
Insertion of subtemporal needles, add	B	169	17
With activating drugs, e.g. metrazol, add	B	170	17
Interpretation of hospital performed sleep E.E.G	B	167	65*
Electrocorticogram - supervision and interpretation	B	171	154
Depth electroencephalography with electrical stimulation, as during thalamotomies	B	172	77
Echoencephalography - procedure and interpretation	B	173	15
Brainstem evoked response audiometry	C	2035	15
Somatosensory evoked potential	C	2645	15
Visual evoked potential	C	2646	15
Time repetitive stimulation study (max 3)	B	831	40
Single fibre EMG	B	830	160
Electromyography			
Major - muscles of more than one region examined	B	174	60
Minor - examination of a specific muscle or region	B	175	30
Nerve conduction studies, per nerve studied (in addition to electromyographic examination fee if done at the same time)	B	176(1)	20
Perimetry and tangent screen	B	184	23
Caloric tests (vestibular studies)	B	185	15
Tensilon test	B	183	15

See also “Diagnostic and Therapeutic Procedures” on page 21/1, “Clinical Procedures” on page 22/1 and “Diagnostic and Minor Treatment Procedures” on pages 17/1-2.

(1) This code is payable at 100% of the fee whenever eligible for payment.

Specialists in Neurosurgery

	List	Code	Units
See legend - Pg. 3/13 for description of list A, B, C and D.			

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)			
Major or regional consultation		186	72
Repeat consultation - within 30 days for same illness or complication thereof		188	33

Office visits

New condition seen for the first time, to include complete history and physical examination or regional examination		189	32
Other office visits		192	18

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2391	75
Subsequent – 2nd to 30th day, per day		2392	18
– after 30 days, per day		2394	12

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rule 16, 18, 19 and 24.***

Transfer Code - hospital care (see service description page 4/6)		8303	75
Directive Care - see service description page 4/5		62	18*
Major consultation in hospital		2857	78
Closed head injury, complete assessment - initial examination and recommendation re. Further management	C	1512	88

☞ ***Medicare Note: In the absence of a surgical procedure, daily care is payable following code 1512.***

Intensive care - this is to apply to services rendered in recognized intensive care units and concentrated care units.

Initial assessment and institution of care		1508	221*

Specialists in Neurosurgery (continued)

	List	Code	Units
Daily rate, per day		1513	39*
Intensive care, requiring detention			
Per ¼ hour (see service description page 4/6)		1514	50
Directive care		198	22*
Transfer Code - ICU care (see service description page 4/6)		1828	75

☞ ***Medicare Note: See Medicare Note under Intensive care, page 4/7.***

Specialists in Obstetrics and Gynaecology

	List	Code	Units
See legend - Pg. 3/13 for description of list A, B, C and D.			

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)			
Major or regional consultation		54	63*
Repeat consultation - within 30 days for same illness or complication thereof		56	24
Office visits - first visit with complete Examination		48	25
First visit with regional examination		49	20
Other office visits		50	20

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2411	42
Subsequent – 2nd to 30th day, per day		2412	19
– after 30 days, per day		2414	13
Transfer Code - hospital care (see service description page 4/6)		8309	36
Transfer Code - ICU care (see service description page 4/6)		1834	36
Directive Care - see service description page 4/5		166	19

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rule 16, 18, 19 and 24.***

Home visits (See also page 4/11)		53	40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Insertion of laminaria tent	A	2083	23

Specialists in Obstetrics and Gynaecology (continued)

	List	Code	Units
Obstetrical care - payable on the basis of visit fees plus a delivery fee. Refer to Assessment Rule 34 and 35.			
Obstetrical delivery (complicated or uncomplicated)	D	58	398
Multiple births - per additional birth, Add.....	D	1413	50
First prenatal visit with complete examination		2002	45
Subsequent prenatal and/or postnatal visits.....		60	26
(See also Assessment Rule 34)			

☞ ***Medicare Note: Delivery fees include attendance during prolonged labour. The fee for a prenatal complete examination, code 2002, is not payable within 90 days of a complete examination by the same physician, and a complete examination fee, code 48, is not payable within 90 days of a prenatal complete examination.***

Specialists in Ophthalmology

	List	Code	Units Gen	Units An

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)				
Major or regional consultation		69	76*	
Repeat - within 30 days for same illness or complication thereof		71	43	
Other referrals				
Complete Ophthalmological examination at the request of an optometrist, including a written report to the optometrist and, where appropriate, copy to the family physician		282	72	
Office visits				
First visit with complete ophthalmological examination		64	42	

☞ ***Medicare Note: A first visit with complete examination for specialists in ophthalmology will include the following special procedures where these are necessary: fundus examination, gonioscopy, tonometry, biomicroscopy, indirect ophthalmoscopy or three mirror slit lamp examination of fundus (Assessment Rule 44).***

First visit not requiring a complete exam		65	25	
Other office visits, not including special tests or procedures		66	28*	

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Procedures - tonography as an individual procedure	C	228	23	
Fundus examination, gonioscopy, tonometry, biomicroscopy as individual procedures, each	C	229	9	
Fundus examination under general anaesthetic	B	230	77	4
Indirect ophthalmoscopy or 3 mirror slit lamp examination of fundus	C	232	15	
Ophthalmodynamometry	B	280	15	
Fundus photos, technical fee	B	233	20	
Retinophoto interpretation	B	2996	8	
Fundus Photo, technical fee and Retinophoto interpretation	B	8181	28	
Ultrasound, eye, for axial length or foreign body	B	2403	21	
Keratometry	B	2997	12	

Specialists in Ophthalmology (continued)

	List	Code	Units Gen	Units An
Farnsworth 100 Color Vision Test	C	2998	20	
Hess Lancaster Test	C	2999	15	

Hospital care

First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2421	43	
Subsequent – 2nd to 30th day, per day		2422	20	
– after 30 days, per day		2424	13	
Transfer Code - hospital care (see service description page 4/6)		330	36	
Transfer Code - ICU care (see service description page 4/6)		1825	36	
Directive Care - see service description page 4/5		57	20*	

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits (See also page 4/11)		72	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Visual fields

Tangent screen, Autoplot visual field exam, including interpretation	C	231	15	
Goldman or equivalent kinetic perimetry, 2 isopters or More				
- performance & interpretation	B	116	34	
- performance only	B	117	19	
- interpretation only	B	118	15	

Computerized visual fields

Automated threshold static perimetry, complete				
- performance & interpretation	B	105	40	
- performance only	B	106	26	
- interpretation only	B	112	15	

Specialists in Ophthalmology (continued)

	List	Code	Units Gen	Units An
Automated suprathreshold perimetry (central screening)				
- performance & interpretation	B	113	25	
- performance only	B	114	15	
- interpretation only	B	115	10	
Ultrasound - eye				
Quantitative standardized "A" scan	B	2023	34	
Real time "B" scan	B	2027	34	
"A" and "B" modes	B	2029	51	
"A" and "B" modes plus immersion	B	2031	68	
Contact lens fitting				
Therapeutic contact lens fitting, including 3 months follow up care (excludes cost of lens)	D	2911	200	
– bilateral, add	D	2912	77	

The fitting of contact lenses, when done for conditions listed below, is an insured service under Medicare. The fitting of such lenses as an alternative to eyeglasses remains an uninsured service.

The appropriate type of contact lens may be fitted at the discretion of the physician to protect the integrity of the healthy cornea in conditions which threaten it, to promote healing of the cornea when damaged in disease processes or surgical procedures, to restore monocular or binocular vision where this cannot be achieved by other methods and to improve visual field where this is compromised high refractive error. The improvement of visual acuity per se does not come within this definition.

When medically indicated, Medicare coverage applies in the following conditions: albinism, aniridia, anterior membrane corneal dystrophies, aphakia, astigmatism requiring over 5 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 (6 dioptres spherical equivalent or over in children under age 16, 10 dioptres spherical equivalent or over in adults), keratoconus, neuroparalytic keratopathy, nystagmus, trachoma, paralysis of superior rectus muscle, pemphigus, post penetrating keratoplasty, post-operative discomfort or lacerations or perforations, prevention of symblepharon, recurrent corneal erosion, Stevens-Johnson syndrome, stromal herpes simplex, thermal burns, trichiasis, vernal conjunctivitis. As developments and improvements occur, additional conditions may be added to this list.

Bandage contact lens Includes follow-up care. Consultation payable in addition.	D	2913	77	
Certification for driver's license			15	

☞ ***Medicare Note: Certification for a driver's licence is not an entitled service under Medicare. (See Assessment Rule 3)***

Specialists in Ophthalmology (continued)

	List	Code	Units Gen	Units An
Corneal foreign bodies	C	235	30	
Under anaesthesia	C	236	77	4
Low vision therapy	C	234	35	

Specialists in Orthopaedic Surgery

	List	Code	Units
See legend - Pg. 3/13 for description of list A, B, C and D.			

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)			
Major or regional consultation		81	67*
Repeat consultation - within 30 days for same illness or complication thereof		83	28

Office visits

New condition seen for the first time, to include complete history and physical examination		76	23
First visit with regional examination		77	18
Other office visits		78	18

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2431	43
Subsequent – 2nd to 30th day, per day		2432	20
– after 30 days, per day		2434	13
Transfer Code - hospital care (see service description page 4/6)		8304	36
Transfer Code - ICU care (see service description page 4/6)		1829	36
Directive Care - see service description page 4/5		63	20

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Management of multiple orthopaedic trauma	C	2922	80

Complete assessment and institution of care to include diagnostic and therapeutic procedures. This code applies to fractures of two or more limbs or areas; to compound or mixed fractures even if same limb; or to spinal cord trauma with actual or suspected paralysis. It does not apply to one or two simple cast applications or uncomplicated closed reductions.

Specialists in Orthopaedic Surgery (continued)

	List	Code	Units
Management of multiple systems trauma.....	C	2956	(page 4/12)

☞ ***Medicare Note: This is payable in addition to necessary surgical procedures, where appropriate.***

Home visits..... 84 40
(See also page 4/11)

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Medicolegal - examination and written report..... 38-77
Letter or written report of previous examination with prognosis and opinion..... 15-38

☞ ***Medicare Note: Examinations and written reports for medicolegal purposes are not entitled services under Medicare (See Assessment Rule 2).***

Specialists in Otolaryngology

	List	Code	Units Gen	Units An

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)			
Major or regional consultation		107	69
Repeat - within 30 days for same illness or complication thereof		109	30

Office visits

First visit, transferred or not transferred, requiring complete history and detailed examination		102	32*

Service code 102 includes physical examinations pertaining to this field of specialty and such necessary procedures as catheterization of Eustachian tubes, indirect laryngoscopy, nasopharyngoscopy, etc. but not to include vestibular tests, audiograms or direct laryngoscopy.

First visit not requiring complete examination		103	25*
Other office visits		104	25*

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

☞ ***Medicare Note: See Assessment Rule 42.***

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2441	46
Subsequent – 2nd to 30th day, per day		2442	21
– after 30 days, per day		2444	14
Transfer Code - hospital care (see service description page 4/6)		329	36
Transfer Code - ICU care (see service description page 4/6)		1824	36
Directive Care - see service description page 4/5		52	21*

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits		110	40

Specialists in Otolaryngology (continued)

	List	Code	Units Gen	Units An

(See also page 4/11)

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Special examinations

a) Composite audiometry fees - these fees apply only to special examinations performed on the physician's premises and/or using his equipment. They include the technical component of the procedure, the physician's services during the examination and the interpretation of the test results.

Pure tone audiometry, AC & BC	C	2022	15	
Speech audiometry	C	2024	15	
Impedance audiometry	C	2338	15	
Special or advanced audiometric testing: site of lesion, galvanic skin response, Stanger test, etc.	C	2028	15	
Sound field audiometry (auditory threshold assessment in children up to 3 years of age)	C	2032	30	
Hearing aid evaluation or fitting of tinnitus masker	C	2034	42	

b) Professional audiometry fee ..... C 2030 6

This fee applies to the physician's services relative to audiometry performed elsewhere than on his premises. It includes the interpretation of the test results.

A professional fee may not be claimed when a composite fee is payable.

☞ ***Medicare Note: See Assessment Rules 40 & 41. The use of special examination codes is restricted to Specialists in Otolaryngology.***

c) Other examinations

Brainstem evoked response audiometry	C	2035	15	
Vestibular studies	C	111	15	
Tympanometry	C	1800	15	
Caloric Test	C	2644	15	
Somatosensory Evoked Potential	C	2645	15	
Visual Evoked Potential	C	2646	15	

Electronystagmography ..... C 2036 15

☞ ***Medicare Note: The use of service code 2036 is restricted to specialists in otolaryngology, ophthalmology and neurology.***

Medicolegal - consultation and report..... IC
(See Assessment Rule 2)

Tonsillectomy +/- adenoidectomy – under 16 years	D	240	100	4
– adult	D	241	133	4
Adenoidectomy	C	242	76	4

Specialists in Otolaryngology (continued)

☞ ***Medicare Note: Use of service codes 240 to 242 is restricted to Specialists in Otolaryngology.***

Specialists in Paediatrics

	List	Code	Units Gen	Units An
See legend - Pg. 3/13 for description of list A, B, C and D.				
These fees cannot be correctly interpreted without reference to the General Preamble.				
Referred cases				
Consultations (see definitions in the General Preamble)				
Major or regional consultation		93	134*	
Repeat consultation - within 30 days for same illness or complication thereof		94	51	
Office visits - first visit with complete examination		85	38	
First visit with regional examination		86	29*	
Subsequent visit requiring complete examination - allowed once in any 30-day period (This code to be used only on the treatment of children with major chronic health problems. A specific pathological diagnosis must be given.)		90	76	
Well-baby care to include examination and instructions regarding health care		89	29*	
Other office visits		87	25	
Injections				
Immunization, including tray fee (maximum of 2 @ 100%) Payable in addition to same day consultation or office visit fees	C	8102	8	
Immunization, including tray fee (maximum fee), not payable in addition to same day office visit	C	8103	13	
The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.				
Hospital care				
First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2451	94	
Subsequent – 2nd to 30th day, per day		2453	23	
– after 30 days, per day		2455	15	
Transfer Code - hospital care (see service description page 4/6)		8305	87	
Directive Care - see service description page 4/5		68	23	

Specialists in Paediatrics (continued)

	List	Code	Units Gen	Units An

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Special attendance at delivery	A	2171	45	

☞ ***Medicare Note: This fee is payable only when the paediatrician is in attendance at the specific request of the attending physician because of anticipated complications such as newborn distress, and is payable once only in instances of multiple births.***

Newborn care of a healthy baby for first 10 days, including parental advice		92	52*	

☞ ***Medicare Note: A consultation fee does not apply to newborn care requested by the delivering physician, except when a consultation is requested for documented medical reasons.***

Premature care - first visit with complete examination		243	56	
Thereafter up to 3 weeks, per week		244	56	
Next 3 weeks, per week		245	31	
After 6 weeks, per visit (not to exceed 2 visits per week)		246	16	
Supportive care, per visit		2860	16	
Home visit		96	40	

(See also page 4/11)

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing home or similar institutions.***

Intensive care - this is to apply to services rendered in paediatric intensive care units and concentrated care units.

Initial assessment and institution of care		247	230*	
Daily rate, per day		248	45*	
Intensive care requiring detention Per ¼ hour (see service description page 4/4)		237	50	
Directive care		198	22*	
Transfer Code - ICU care (see service description page 4/6)		1830	87	

☞ ***Medicare Note: See Medicare note under Intensive care, page 4/7.***

Special procedures - Denver screening	B	2172	30	
Neurodevelopmental examination for learning disabilities	C	91	175	

Specialists in Paediatrics (continued)

	List	Code	Units Gen	Units An
Replacement transfusion – first	A	249	192	
– subsequent	A	250	100	

☞ ***Medicare Note: Adoption examinations are not an entitled service.***

Interpretation of hospital performed sleep E.E.G.	B	8211	65*	
Electroencephalography – interpretation only	B	8212	25*	
Routine survey of pulmonary function to provide information in ventilation, gas mixing and diffusion	B	8213	45*	
Psychotherapy, per 15 minutes		2228	21	
Family counseling, per 15 minutes		239	41*	

Discussion of a child's health with family member(s). This service applies only to counseling for severe life threatening conditions, major chronic health problems, severe behavioral problems or school learning difficulties.

Therapeutic interview, per 15 minutes		194	41*	

Case conference on behalf of the patient with allied health workers, teachers and clergy, but excluding hospital personnel.

☞ ***Medicare Note: Service codes 194 and 239 will be payable in addition to other necessary services that may be provided to the same patient on the same day, and should be billed under the patient's Medicare number. The total time spent must be provided.***

Specialists in Pathology

	Units
See legend - Pg. 3/13 for description of list A, B, C and D.	
Autopsy with report	IC
Microscopic examination of autopsy tissues only, with report	IC
Surgical pathology	
With microscopic examination and report, per case	IC
Gross examination only with report, per case	IC
Medicolegal consultation with report	IC
Office consultation	IC
Surgical consultation with report	IC
With frozen section	IC
Without frozen section	IC
Examination of slides and opinion (e.g. tissue, blood smear, bacteriological smear, cytology, etc	IC
Interpretation of bone marrow smears	
Without sternal puncture	IC
With sternal puncture, etc	IC
Dark field examination and opinion	IC
Seminal fluid examination	IC
Special examination in disputed paternity with report	IC
Chromosome analysis with report	IC
Certification, based on previous examination	IC

☞ ***Medicare Note: Services listed above are not entitled service in New Brunswick.***

Specialists in Physical Medicine and Rehabilitation

	Code	Units
See legend - Pg. 3/13 for description of list A, B, C and D.		

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)		
Major or regional consultation	202	93*
Repeat consultation - within 30 days for same illness or complication thereof	287	45*

Office visits

First visit with complete examination of a new patient not attended during the previous 90 days	288	31
First visit with regional examination	289	18
Other office visits	290	18

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2491	62
Subsequent – 2nd to 30th day, per day	2492	18
– after 30 days, per day	2494	15
Transfer Code - hospital care (see services description page 4/6)	8308	62
Transfer Code - ICU care (see services description page 4/6)	1833	62
Directive Care - see service description page 4/5	98	18

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits (See also page 4/11)	293	40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes for similar institutions.***

Miscellaneous - physical medical and rehabilitative

Specialists in Physical Medicine and Rehabilitation (continued)

	List	Code	Units Gen	Units An
supervision, per treatment day where required	C	298	6	
Special procedures - faradic and galvanic testing.....	A	299	15	
Electromyography				
Major - muscles of more than one region examined	B	302	60	
Minor - examination of a specific muscle or region.....	B	303	30	
Nerve conduction studies.....	B	176(1)	20	
Timed repetitive stimulation study (max 3).....	B	831	40	
Single fibre EMG.....	B	830	160	
Other therapeutic procedures not exceeding 1 hour - e.g. heat, light electrotherapy, ultrasound, hydrotherapy, mechanotherapy, exercise, and occupational therapy - visit fee.....	B	304	8	

(1) This code is payable at 100% of the fee whenever eligible for payment.

Specialists in Plastic Surgery

	Code	Units
See legend - Pg. 3/13 for description of list A, B, C and D.		

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)		
Major or regional consultation	305	51
Repeat consultation - within 30 days for same illness or complication thereof	306	23

Office visits

First visit, depending on the complexity of the case And time involved	307	30
First visit with regional examination	203	20
Other office visits	308	18

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2461	38
Subsequent – 2nd to 30th day, per day	2462	17
– after 30 days, per day	2464	12
Transfer Code - hospital care (see service description page 4/6)	8306	36
Transfer Code - ICU care (see service description page 4/6)	1831	36
Directive Care - see service description page 4/5	80	17*

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits (See also page 4/11)	311	40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Specialists in Plastic Surgery (continued)

Team procedures - major complex reconstructive surgery

Plastic surgeons may claim under independent consideration (service code 888) for the payment of complex reconstructive surgical procedures on a time basis.

The rate of payment is 200 units per hour, and includes any premium that might otherwise apply. This rate applies to either solo or collaborating surgery, and payment is made according to each one's actual operative time.

This special form of payment is limited to complex procedures such as reconstruction following extensive resection of head and neck cancer, reconstruction following major trauma, or after extensive ablative surgery to the trunk or limbs. It cannot be claimed unless the operative time covers at least four hours.

Specialists in Psychiatry

	List	Code	Units Gen	Units An

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)			
Major or regional consultation	A	321	161*
Repeat consultation - within 30 days for same illness or complication thereof	A	322	50

Office visits

First visit with complete examination, including psychiatric evaluation and certification if indicated	A	324	72
Other office visits	A	325	18

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	A	2471	97*
Subsequent – 2nd to 30th day, per day	A	2472	22
– after 30 days, per day	A	2474	14
Transfer Code - hospital care (see service Description page 4/6)	A	8301	80
Transfer Code - ICU care (see service description page 4/6)	A	1826	80
Directive Care - see service description page 4/5	A	59	22

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 24.***

Home visits (See also page 4/11)	A	328	40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Specialists in Psychiatry (continued)

	List	Code	Units Gen	Units An
Other procedures				
Electroconvulsive therapy	A	333	40*	4
Psychotherapy, per ¼ hour		332	36*	
Psychiatric care: assessment and treatment (other than by psychotherapy) of a patient by a psychiatrist for the purpose of altering the patient's biopsychosocial functioning, per ¼ hour		331	36*	

☞ ***Medicare Note: For a major or regional consultation or a first day's hospital care, codes 331 and 332 do not apply to the first hour. When billing these codes alone or in combination with other services, the total time must be provided. See also Assessment Rule 10. Psychoanalysis is not a benefit under Medicare.***

Group psychiatric care or psychotherapy - 2 or more persons, per ¼ hour		341	38
Family psychiatric care or psychotherapy - 2 or more family members receiving care during the same session, per ¼ hour		2837	38

☞ ***Medicare Note: The exact fee payable for group or family psychiatric care and psychotherapy is determined by the actual total time spent by the practitioner. This total fee must be billed under one service code, by apportioning it (equally where possible) under each patient's Medicare number. The total time of the session and the number of patients must be provided on each claim.***

Diagnostic and/or therapeutic interview with para medical organizations, employers, teachers, clergy (not applicable to interviews with persons working in hospitals or clinics where the psychiatrist practices); similar interviews with members of the family, child guidance with parents, assessment conference with parents; per ¼ hour		340	36*

☞ ***Medicare Note: Service code 340 is not payable with codes 341 or 2837 for the same individuals. Claims under code 340 must be billed under the patient's Medicare number and not under the Medicare numbers of the persons being interviewed. The interviewees and the total time spent must be identified on the claim.*** **When billing these codes alone or in combination with other services, the total time must be provided.**

Specialists in Respirology

	Code	Units

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)		
Major or regional consultation	8310	114*
Repeat consultation – within 30 days for same illness or complication thereof	8311	44
Office Visits		
First office visit with complete exam and diagnostic survey of a new patient not attended during the previous 90 days	8242	45
First office visit with Regional exam	8243	30
Subsequent visit with complete reexamination	8244	30
Other office visits	8245	21*
Hospital care		
First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	8312	66
Subsequent – 2nd to 30th day, per day	8313	21*
– after 30 days, per day	8314	13
Directive Care - see service description page 4/5	8241	21*

Other visit fees – as for specialists in Internal Medicine (pages 5/14 & 15).

Specialists in Rheumatology

	Code	Units

See legend - Pg. 3/13 for description of list A, B, C and D.

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)		
Major or regional consultation	8315	106*
Repeat consultation – within 30 days for same illness or complication thereof.....	8316	52*

Hospital care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	8317	71
Subsequent – 2nd to 30th day, per day	8318	22
– after 30 days, per day	8319	14
Directive Care - see service description page 4/5	8342	22

Other visit fees – as for specialists in Internal Medicine (pages 5/14 & 15).

Specialists in Urology

	List	Code	Units Gen	Units An
See legend - Pg. 3/13 for description of list A, B, C and D.				

These fees cannot be correctly interpreted without reference to the General Preamble.

Referred cases

Consultations (see definitions in the General Preamble)			
Major or regional consultation	A	343	55
Repeat consultation - within 30 days for same illness or complication thereof	A	345	28

Office visits

New condition seen for the first time, to include complete history and physical examination	A	346	30
First visit with regional examination only	A	347	19*
Other office visits	A	349	19*

The code for other office visits applies also to office consultations and examinations that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

Hospital care

First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	A	2481	40
Subsequent – 2nd to 30th day, per day	A	2482	18
– after 30 days, per day	A	2484	12
Transfer Code - hospital care (see service description page 4/6)	A	8307	36
Transfer Code - ICU care (see service description page 4/6)	A	1832	36
Directive care - see service description page 4/5	A	97	18

☞ ***Medicare Note: For ICU service codes (see page 4/7)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Assessment Rules 16, 18, 19 and 25.***

Home visits (See also page 4/11)	A	351	40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence. They do not apply to patients in nursing homes or similar institutions.***

Specialists in Urology (continued)

	List	Code	Units Gen	Units An
Management of genitourinary tract trauma - complete assessment and institution of care, to include diagnostic and therapeutic procedures. This code applies to trauma resulting in major injuries such as tear or rupture to the kidneys, ureters, bladder or urethra	C	2864	80	

☞ ***Medicare Note: Cystoscopy and surgical procedures are payable in addition.***

Intra corporal treatment of impotence, trial injection and supervision (only payable once). Instruction & test-dosing of intaurethral pellet for impotence. .	B	350*	38	4
Saline stimulate erection	B	536	6	4

Surgical Procedures
Preamble

As a general rule:

1. When multiple operative procedures are performed on any one functional organ or structure, the fee for the principal procedure only shall be charged, unless otherwise specified.

2. a) When multiple operative procedures are performed on different organs or structures in the same area of the body, unless otherwise provided in the Schedule, the secondary procedures when done for existing pathology as well as sterilization procedures, are payable at 50% of the fees listed for those procedures.

   b) Surgery through a single incision is usually indicative of "same area" for this purpose.

   c) The removal of the appendix, the lysis of adhesions, the destruction or removal of small ovarian cysts is not payable additionally.

3. a) When multiple operative procedures are performed in different areas of the body, secondary procedures are payable at 75% of the fees listed for those procedures.

   b) Similarly, unless otherwise specified, bilateral same procedures are payable at an additional fee of 75% of that shown for the unilateral procedure.

   c) The performance of procedures through different incisions, although generally indicative of "different areas", is not the sole criterion for the application of this rule. Thus, the following examples shall be considered as same areas and are payable at 50%:

      1. The hand or foot, including dorsal and volar aspects, but not the digits or the metacarpophalangeal joints.
      2. The face as defined on page 7/2. (Bilateral procedures on eyelids and eyebrows are also payable at 50%.)
      3. The knee and immediately adjacent structures.
      4. The scrotum or perineum and the anal region.

4. When major surgery with a listed fee of 350 units or more is performed involving cancer (except cancer in situ), the fee for the surgeon will be increased by a premium of 35%.

5. Prior consultation should take place with Medicare to determine the coverage status of a proposed service whenever reasonable doubt exists as to the eligibility for a benefit. A request form has been developed for this purpose.

   Use of the new, simplified form is voluntary, but recommended. It is suggested that information be either typed or printed legibly to ensure efficient processing.

Integumentary System

	List	Code	Units Gen	Units An
See Legend – Pg. 3/13 For Description Of List A, B, C and D.				
Skin and subcutaneous tissue				
Incision				
Abscess				
Subcutaneous – boil, carbuncle, infected cyst, superficial lymphadenitis, paronychia, felon, etc.				
Local anaesthetic	C	355	20	
General anaesthetic	C	356	31	4
Perianal or pilonidal – local anaesthetic	C	357	20	
General anaesthetic – complete care	D	358	92	4
Ischiorectal – simple incision, local anaesthetic	C	359	20	
Unroofing – complete care	D	360	113	4
Haematoma – local anaesthetic	C	362	20	
General anaesthetic – depending on size and other complicating factors	C	363	31	4
Tongue-tie, release – infant			VF	
Child – local anaesthetic	C	365	20	
– general anaesthetic	C	366	31	4
Removal of foreign body or fibroma				
Local anaesthetic	C	367	20	
General anaesthetic	C	368	46	4

☞ ***Medicare Note: Pre and postoperative care for the above <u>at visit fees unless otherwise specified.</u>***

Skin lesions

Papillomata, naevi, moles, sebaceous cysts and other non-malignant lesions or tumors of the skin and/or subcutaneous tissue.

- Removal by non-surgical methods such as electrocautery, curettage, cryotherapy (total fee)	C	2089	20	4
- Biopsy by excision or total excision (max 3 per day)	C	369	31	4
- Diagnostic punch skin biopsy	A	837	27	

☞ ***Medicare Note: Since September 15, 1994 the removal of minor skin lesions is not an insured service except when cancer is suspected. In other situations of medical necessity, claims for independent consideration may be submitted. More specifically:***

A **Is covered by Medicare**

1. The removal of lesions recognized as presenting a significant risk of producing malignant lesions. Examples are neurofibromatosis (Von Recklinghausen's disease), and keratoses in chronic dialysis patients.
2. The removal of non-malignant skin lesions which, because of their location or size, result in recurrent frequent bleeding or recurring infections not amenable to non-surgical management.

Integumentary system (continued)

B **Is not covered by Medicare:**

1. The removal of benign skin lesions which do not carry a significant risk of becoming malignant lesions (for example, common warts, skin tags, papillomata, sebaceous cysts).
2. Chronic irritation by itself is usually not an example of medical necessity for Medicare coverage purposes. Prior submissions for approval may be made to Medicare in special or unusual situations.

☞ ***Medicare Note: Procedures using sutures for closing of defects includes follow-up for removal of sutures.***

	List	Code	Units Gen	Units An
Lipoma				
- Simple	C	378	52	4
- complicated	D	379	IC	4
Carcinoma of skin				
- Excision and repair	C	370	54	4
- Complicated or extensive excision and repair, depending on site	C	371	IC	4
Prior to skin grafting	C	373-374	(p. 20/4)	

☞ ***Medicare Note: Claims submitted to Medicare using code 379 or 371 must give details of lesion, size, location, etc.***

Excision of dermoid cyst, face	D	1756	115	4
Plantar wart – simple, excision, complete care	C	384	38	4
Neuroma – simple, subcutaneous	C	380	38	4
Morton's neuroma – excision	D	2811	77	4
Pilonidal disease – simple excision and/or marsupialization	D	372	154	4
Finger or toenail – simple removal			VF	
Resection of portion of nail, nailbed or matrix	C	376	38	4
Removal of nail, including destruction of nailbed and shortening of phalanx	C	377	77	4
Introduction				
Implantation of hormone pellets	C	385	38	

☞ ***Medicare Note: Procedures using sutures for closing of defects includes follow-up for removal of sutures.***

Suture				
Face – first 5 cm	D	2227	46	5
More than 5 cm	D	2487	72	5
Complicated	D	387	IC	6

☞ ***Medicare Note: Face is defined for this purpose as the area situated above the mandibular angle, in front of the ears, and up to (but not including) the scalp.***

Integumentary system (continued)

	List	Code	Units Gen	Units An
Other areas - first 5 cm	D	99	23	4
More than 5 cm	D	2488	38	4
Complicated	D	387	IC	6

☞ ***Medicare Note: As a general guideline, claims under code 387 for lacerations in excess of 10 cm, will be assessed on the basis of 72 units for the first 10 cm. for facial lacerations plus 5 units per additional cm. or 38 units for other areas plus 3 units per additional cm.***

For lacerations involving <u>both</u> the face and other areas, the facial lacerations will be assessed first as outlined above, the other areas being assessed by adding 3 units per cm. for their total length. Claims under service code 387 cannot be paid unless exact measurements are given for <u>each</u> location.

☞ ***Medicare Note: Repair of lacerations includes follow-up visits for suture removal.***

Revision				
Excision or revision of scars (non-cosmetic)	D	2489	IC	5
Destruction				
Dermabrasion of – single area (e.g. trauma scar)	C	390	95	6

See also Plastic Surgical Procedures page 20/5.

Tendons, tendon sheaths, fascia

(See page 8/14 to 8/15)

Operations on the breast

Incision				
Drainage of intramammary abscess, single or multiloculated – including pre and postoperative care	D	404	62	4
Repeat incision	D	405	62	4
Aspiration of cyst of breast	A	1900	15	
Excision				
Biopsy, lesion of breast, including fine needle aspiration biopsy	B	2450	35	4
Lumpectomy, excisional biopsy, or partial mastectomy	B	407	112	4
With axillary node dissection	D	2924	438	6
Mastectomy – simple or subcutaneous	D	408	185	5
– radical or modified radical	D	409	438	6
Mastectomy, male – simple	D	410	92	4

☞ ***Medicare Note: Code 408 is payable for male patients <u>if</u> under the age of 18 years or for diagnosis/ pathology related to tumors. Otherwise, code 410 should be billed for all other medically required services.***

Integumentary system (continued)

Mastectomy: see Plastic Surgical Preamble, page 20/1.

Repair: see Plastic Surgical Procedures, page 20/7.

Musculoskeletal System

See legend – pg. 3/13 for description of list A, B, C and D.

Preamble

1. Bone grafts associated with arthrodesis are not payable as additional procedures.

2. Except when due to complications, the removal of internal fixation devices during the defined postoperative period is included in the procedure fees.

3. Fees for dislocations, fractures and other major musculoskeletal procedures include preoperative splinting, the application of initial and one repeat cast or splint, and the removal of all casts and splints during the defined postoperative period.

4. Cast or splint application fees include the removal during the defined postoperative period.

5. Unless otherwise provided a fracture fee applies also to a fracture-dislocation.

6. Manipulation fees are not payable in addition to fracture or dislocation fees.

7. Closed reduction fees include skin or skeletal traction.

8. Closed reductions requiring external skeletal fixation are payable as operative reductions.

9. The fee for management of a compound fracture not requiring operative reduction is the fee for a closed reduction plus 50%. When an operative reduction is required, the operative reduction fee only shall apply.

10. When a closed reduction is followed on the same day by an operative reduction or a transfer the closed reduction is payable at 75% except if performed by the same physician, in which case a cast fee only is payable.

Classification

Musculoskeletal system (continued)

Casts and splints

☞ ***Medicare Note: Slings are not payable under cast or splint codes; they are included instead in visit or consultation fees.***

	List	Code	Units Gen	Units An
Casts – upper extremity	D	516	23	4
Shoulder spica	D	515	77	4
Club foot, cast or strapping – unilateral	C	520	23	4
– bilateral	C	521	38	4
Lower extremity	D	517	31	4
Postamputation rigid cast dressing, add	D	2594	77	TU
Instant prosthesis, add	D	2595	77	TU
Hip spica	D	518	77	4
Fracture cast brace, add	D	2596	77	TU
Body cast	D	519	77	4
Minerva jacket	D	514	77	4
Removal of cast (non payable during postoperative period			VF	
Splints or stabilizing bandage				
Hand, wrist	A	2138	23	
Elbow	A	2139	23	
Shoulder	A	2140	31	
Below knee, including foot	A	2142	23	
Whole leg, midthigh to toe	A	2141	31	
Body cast	A	2144	38	
Neck	A	2143	23	
Application of external fixator, unrelated to fracture or arthrodesis treatment	D	504	100	

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Bones				
☞ ***Medicare Note: "Large bone" means femur, tibia, fibula, humerus, radius, ulna, pelvis, spine and mandible.***				
Incision				
Bone biopsy				
Punch biopsy – vertebra +/- x-ray control	B	538	115	4
– other bones	B	2598	50	4
– with x-ray control	B	2599	92	4
Open biopsy – vertebra	B	539	231	7
– pelvis	B	1961	115	4
– other bones	B	1960	77	4
Drainage of bone (osteomyelitis)				
Incision of periosteum and drainage	D	2250	38	4
Saucerization and/or sequestrectomy – small bone	D	2248	115	4
– large bone	D	561	231	5
Secondary closure	D	2601	IC	4
Vertebrae – incision and drainage	D	2602	115	5
– sequestrectomy and/or saucerization	D	2603	231	5
Osteotomy (+/- internal fixation)				
Phalanx, metacarpal or metatarsal	D	2041	77	4
Each additional	D	2605	77	TU
Ulna	D	2606	231	4
Radius	D	2607	231	4
Radius and ulna	D	2608	269	4
Humerus	D	528	346	5
Clavicle	D	2609	192	5
Midtarsal	D	2610	308	4
Os calcis	D	2611	308	4
Tibia +/- fibula – child	D	2612	269	4
– adult	D	2637	385	6
Femur	D	2613	385	8
Pelvis – innominate osteotomy, shelf operation	D	555	346	8
Vertebra	D	2614	462	8
Excision (see also "Fractures" and "Amputation")				
Removal of internal fixation appliances	D	475	115	4
Minor incision only	D	1963	38	4
Exostosis – small bone	D	1998	77	4
– large bone	D	2068	154	4
Bone cyst, curettage and packing				
Phalanges	D	2597	154	4
Carpal or tarsal bone	D	2615	269	4
Radius or ulna	D	2616	231	4

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Humerus or tibia	D	598	269	5
Femur	D	599	385	6
Insertion of Gentamicin beads – large bones	D	833	115	4
– small bones	D	834	77	4
Ostectomy (see also: "Joints – reconstruction")				
Hand – phalanx	D	2617	115	4
Metacarpal	D	2618	154	4
Carpal	D	535	192	4
With prosthetic replacement	D	2619	308	4
Radius – styloid	D	2620	154	4
– head	D	531	154	4
– with prosthetic replacement	D	2621	385	4
Ulna – distal end	D	534	154	4
– olecranon	D	2622	192	4
Humerus, head	D	2623	308	5
With prosthetic replacement	D	2624	568	10
Clavicle – partial or total	D	2830	192	5
Acromium	D	526	154	5
Foot – phalanx	D	2626	115	4
Metatarsal	D	2627	154	4
Bunion – exostectomy only	D	587	77	4
Scaphoid or accessory	D	2628	192	4
Tarsal bar	D	2629	308	4
Talus	D	2630	269	4
Patella – partial	D	571	265	4
– complete	D	572	303	4
Hip – femoral head and neck (Girdlestone)	D	558	308	8
Coccygectomy	D	440	154	4
Vertebra – neural arch with nerve exploration (Gill procedure)	D	2727	539	8
Repair and reconstruction (osteoplasty)				
Shortening of small bone	D	2631	115	4
Each additional	D	2632	75%	TU
Shortening of radius and ulna	D	2633	269	4
Shortening of humerus, tibia or femur	D	564	423	8
Lengthening of tibia or femur	D	565	539	8
Epiphysiodesis or stapling – tibia or femur	D	582	231	5
– tibia and femur	D	583	308	5
Slipped epiphysis – internal fixation	D	556	385	8
Wedge osteotomy plus fixation	D	557	462	8
Bone graft				
Bone graft, not associated with arthrodesis, add	D	2634	35%	TU

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
☞ ***Medicare Note: A bone graft applies to the taking of bone from another site; it does not apply, therefore, to packing with fragments or cancellous bone from the operative site itself.***				
Removal of cadaver bone for allografts – from femur	D	603	269	
– from tibia +/- fibula	D	604	231	
Fractures				
Initial traction treatment prior to operative reduction	C	2017	38	
Use of AO type compression apparatus, additional to the fee for operative reduction	C	2018	46	TU
Insertion of cranioskeletal traction or fixation devices	D	1541	250	5
– with Halo jacket (include readjustments)	D	2946	375	5
Reinsertion of cranioskeletal traction or fixation devices	D	2947	96	5
Bone stimulator, including application of electrodes (if done in conjunction with osteotomy, plating or grafting: payable at 50%)	D	1972	231	4
Upper extremity				
Phalanges				
Terminal – no reduction, one or more	D	2648	31	
– closed reduction	D	2649	62	4
– operative reduction	D	2650	115	4
Middle or proximal – no reduction, one or more	D	2651	31	
Closed reduction	D	2652	62	4
Operative reduction	D	2653	115	4
Each additional fracture	D	2654	75%	TU
Bennett's fracture-dislocation – closed reduction	D	2655	77	4
Operative reduction	D	2656	154	4
Metacarpals – no reduction, one or more	D	2657	31	
Closed reduction	D	2658	62	4
Operative reduction	D	2659	115	4
Each additional fracture	D	2660	75%	TU
Carpal bones except scaphoid				
No reduction, one or more	D	2661	77	
Closed reduction	D	2662	77	4
Operative reduction	D	2663	192	4
Scaphoid – no reduction	D	2664	92	
– operative reduction	D	2665	269	4
– partial or complete excision	D	2666	192	4
Radius or ulna – no reduction	D	2672	62	
– closed reduction	D	2673	115	4

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
– operative reduction	D	2674	231	4
Radius and ulna – no reduction	D	2675	62	
Closed reduction	D	2676	115	4
Monteggia or Galeazzi	D	2677	115	4
Operative reduction	D	2678	269	4
Monteggia or Galeazzi	D	2679	269	4
Radius, head or neck – no reduction	D	2680	92	
– closed reduction	D	2681	115	4
– operative reduction	D	2682	154	4
Olecranon – no reduction	D	2683	62	
– closed reduction	D	2684	62	4
– operative reduction	D	2685	192	4
Humerus, epicondyle and condyle, medial or lateral				
No reduction	D	2686	77	
Closed reduction	D	2687	154	4
Operative reduction	D	2688	269	4
Humerus, supra or transcondylar – no reduction	D	2689	62	
Closed reduction	D	2690	154	4
With traction	D	2604	154	4
Operative reduction	D	2691	303	6
Humerus, shaft – no reduction	D	2692	77	
– closed reduction	D	2693	154	4
– operative reduction	D	2694	269	5
– IM locking nails	D	1839*	350	6
Humerus, tuberosity – no reduction	D	2695	77	
– closed reduction	D	2696	154	4
– operative reduction	D	2697	269	6
Humerus, neck – no reduction	D	2698	77	
– closed reduction	D	2699	154	4
– operative reduction	D	2700	269	6
Humerus, neck, with dislocation of humeral head				
Closed reduction	D	2701	154	4
Operative reduction	D	2702	303	6
Scapula – no reduction	D	2703	46	
– closed reduction	D	2704	154	4
– operative reduction	D	2705	269	5
Clavicle– no reduction	D	2706	46	
– closed reduction	D	2707	77	4
– operative reduction	D	2708	192	5
Lower extremity				
Phalanges				
Terminal – no reduction, one or more	D	2709	31	
– closed reduction	D	2710	62	4
– operative reduction	D	2711	115	4
Middle or proximal – no reduction, one or more	D	2712	31	
Closed reduction	D	2713	62	4

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Operative reduction	D	2714	115	4
Each additional fracture	D	2715	75%	TU
Metatarsals – no reduction, one or more	D	2716	31	
Closed reduction	D	2717	62	4
Operative reduction	D	2718	115	4
Each additional fracture	D	2719	75%	TU
Tarsal bones except os calcis				
No reduction, one or more	D	2720	77	
Closed reduction	D	2721	154	4
Operative reduction	D	2722	269	4
Os calcis – no reduction	D	2723	77	
Closed reduction	D	2724	154	
Operative reduction	D	2725	269	4
With primary arthrodesis	D	2726	385	4
Ankle – no reduction	D	2728	62	4
Medial malleolus – closed reduction	D	2729	77	4
– operative reduction	D	2730	192	4
Lateral malleolus – closed reduction	D	2731	62	4
– operative reduction	D	2732	192	4
Bimalleolar or trimalleolar – closed reduction	D	2733	154	4
– operative reduction	D	2735	231	4
Fibula – no reduction	D	2736	54	
– closed reduction	D	2737	54	4
– operative reduction	D	2738	192	4
Tibia +/- fibula – no reduction	D	2739	77	
Closed reduction	D	2740	154	4
With traction	D	2734	251	4
Operative reduction	D	2741	269	4
IM locking nails	D	1840*	350	6
Patella – closed reduction	D	2742	77	
– operative reduction	D	2743	265	4
– patellectomy – partial	D	2744	265	4
– total	D	2745	303	4
Femur, shaft or transcondylar				
Closed reduction – child	D	2748	192	4
– adult	D	2749	269	4
Operative reduction	D	2750	385	8
IM locking nails	D	1838*	450	8
Femur, neck or intertrochanteric				
Closed reduction	D	2752	269	4
Operative reduction, blind pinning (e.g. Smith-Petersen, Knowles)	D	2753	350	8
Direct reduction with internal fixation (e.g. compression screw and sideplate)	D	2754	510	8
Femur, head – prosthetic replacement	D	2755	568	8

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Trunk				
Pelvis – no reduction – maximum	D	2756	77	
One or more bones – closed reduction by manipulation, sling or traction	D	2757	231	4
Operative reduction	D	2758	385	8
Acetabulum +/- dislocation – closed reduction	D	2759	231	4
– operative reduction, hips	D	2760	432	8
– one pillar	D	2642	875	8
– two pillars	D	2643	1250	8
Spine				
Coccyx, non-operative	C	2761	VF	
Sacrum, non-operative	C	2762	VF	
Vertebral process	C	2763	VF	
Surgical removal	D	2764	115	8
Vertebral body – no reduction (cast extra)	C	2765	VF	
Closed reduction (cast, frame, brace, etc. extra)	C	2766	VF	
Operative reduction (graft extra)	D	2767	462	10
Double Harrington instrumentation, add	D	2751	200	TU
Decompression laminectomy and operative reduction	D	2768	462	10
Anterior cervical decompression +/- fusion	D	2769	462	10
Two levels	D	2746	539	10
Ribs	C	2770	VF	
Complicated	D	2747	IC	
Sternum – no reduction	C	2771	VF	
– closed reduction	D	2772	46	4
– operative reduction	D	2773	IC	4-13

Skull – injuries

Non-operative			VF	
Elevation of depressed fracture of skull or removal of bone fragments with no dural penetration (simple)	D	414	231	10
Debridement and closure of compound craniocerebral injury with treatment of brain laceration, repair of dura, skull and scalp	D	415	462	11
Craniectomy with evacuation of intracranial haematoma, extradural or subdural	D	416	462	11
Cranioplasty, meaning closure of skull defect with any material (metallic, plastic or bone)	D	417	308	11
Subtemporal decompression	D	418	308	11

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Facial bones				
Mandible, fractures – no reduction			VF	
Interdental and intermaxillary wiring	D	423	154	8
Simple or compound, unilateral or bilateral, reduction and fixation	D	424	269	8
Skeletal pinning, circumferential wiring of mandible, wiring of Gunning splints or dentures	D	2229	231	8
Operative reduction and intermaxillary wiring	D	426	357	8
Bilateral	D	427	500	8
Mandible, incision or resection				
Mandibular osteotomy – malocclusion	D	2440	308	6
Bilateral	D	1700	539	6
Prognathism and micrognathism – double resection of mandible – one or more stages	D	2230	616	10
Tumors – enucleation, resection , partial resection of mandible	D	2231	231	10
With bone graft	D	2232	346	10
Hemimandibulectomy	D	2233	308	10
Bone graft to jaw or face – autologous	D	2234	308	10
– non-autologous	D	2235	231	10
Maxilla, fractures – no reduction			VF	
Lefort type I – reduction and dental wiring including circumferential wiring	D	2236	154	12
External craniofacial fixation	D	2237	385	12
Lefort types II and III – facial suspension	D	428	385	12
Lefort type III complicated, with antral packing, suspension, etc	D	2238	462	12
Malar fractures – no reduction			VF	
Simple elevation	D	2239	115	6
Operative reduction with pinning, interosseous or Kirshner wires	D	2240	231	8
Maxillo-orbital fractures – operative reduction with antrostomy and packing	D	2241	269	8
Naso-orbital fractures – closed reduction	D	2242	115	6
– operative reduction	D	2243	231	7
Nasal fractures – no reduction			VF	
– closed reduction	D	420	77	6
– operative reduction	D	421	154	6
Removal of fracture fixation devices				
Facial suspension	D	429	100	6
Intermaxillary	D	2003	38	6

☞ ***Medicare Note: Removal of devices are not payable during normal postoperative period.***

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Facial Bones – Other Procedures				
Osteotomies – facial bones (not applicable to fractures)				
Malar (maxillary)	D	1703	582	15
Low maxillary osteotomy and advancement (LeFort I), including bone grafts	D	1704	582	15
Two segments	D	1705	769	15
Three or more segments	D	1706	910	15
Maxillary osteotomy and advancement (LeFort II), including bone grafts	D	1707	910	20
Total maxillary advancement (LeFort III), including bone grafts	D	1708	1219	25
Hypertelorism correction – extracranial approach	D	1709	1151	25
– intracranial approach	D	1710	1546	25
Maxillectomy – partial or complete	D	2096	500	12
With orbital exenteration	D	2097	650	12
Joints				
Manipulation under general anaesthesia	B	2145	31	4
With aspiration and/or injection	B	2671	46	4
Dislocations – reduction				
Finger, thumb – closed	D	507	23	4
– operative	D	508	108	4
Metacarpophalangeal joint – operative	D	2774	115	4
Wrist, carpal bones – closed	D	505	115	4
– operative	D	506	231	4
Elbow – closed	D	503	54	4
– operative	D	2775	154	4
Shoulder – closed	D	502	54	4
– operative	D	2776	269	6
– recurrent dislocation repair	D	525	308	6
Acromioclavicular joint				
Closed	D	500	46	4
With pin fixation	D	2777	120	4
Operative +/- pin fixation	D	501	192	5
Sternoclavicular joint – closed	D	499	38	4
– operative	D	2778	308	5
Toe – closed	D	2779	23	4
– operative	D	2780	108	4
Tarsal joint – closed	D	512	115	4
– operative	D	513	231	4
Ankle – closed	D	2781	115	4
– operative	D	2782	231	4
Patella – closed	D	511	54	4
– recurrent dislocation repair	D	2783	269	4

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Knee – closed	D	1949	154	4
– operative with ligament repair	D	1959	308	4
Hip – closed	D	509	154	4
– operative	D	510	308	8
Hip, congenital dislocation				
Closed reduction – unilateral	D	2784	154	4
– bilateral	D	2785	231	4
Closed plus adductor tenotomy – unilateral	D	553	231	4
– bilateral	D	554	308	4
Operative reduction	D	551	385	8
With shelf operation	D	552	462	8
Sacrococcygeal joint, non-operative	C	2788	VF	
Spine – see "Joints – excision" and "Joints – arthrodesis"				
Temporomandibular joint	D	2244	23	4
Arthroscopy (+/- biopsy)				
Diagnostic arthroscopy	B	1962	139	6
Arthroscopic meniscectomy, knee				
– one meniscus	D	2932	355	6
– medial and lateral	D	2933	412	6
Arthroscopic meniscal suturing	D	1841	355	6
Arthroscopic removal of loose body				
– knee	D	2934	296	6
– ankle	D	2935	258	6
– shoulder	D	2936	296	6
– elbow	D	2937	258	6
Division of synovial plica	D	2938	295	6
Osteochondritis dissecans				
– curettage	D	2939	252	6
– internal fixation	D	2940	412	6
Lateral retinacular release	D	2941	219	6
Chondral shaving of patella	D	2942	210	6
Shaving of one femoral condyle	D	2943	231	6
– of both femoral condyles	D	2944	308	6
Removal of foreign body, staples, screws or pins	D	2945	219	6
Secondary arthroscopic procedure, same knee				
Lateral retinacular release, add	D	1779	77	TU
Debridement of the medial femoral condyle, add	D	1780	77	TU
Debridement of tibial plateau, add	D	1781	77	TU
Debridement of the patello-femoral joint, add	D	1782	77	TU
Division of synovial plica, add	D	1783	77	TU

☞ ***Medicare Note: Only one secondary procedure, service codes 1779-1783, is payable in addition to a primary arthroscopic procedure on the same knee.***

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Incision (arthrotomy, exploration, debridement, loose body removal)				
Finger	D	2790	108	4
Toe	D	2791	108	4
Wrist	D	2792	154	4
Elbow	D	532	154	4
Shoulder	D	2793	192	6
Ankle	D	1967	154	4
Knee	D	570	192	4
Hip	D	547	269	8
Excision				
Ganglion, synovial cyst	D	398	77	4
Capsulectomy, capsulotomy, synovectomy, finger or metacarpophalangeal joint	D	2796	192	4
Each additional, same finger	D	2797	50%	TU
Synovectomy, wrist +/- ulnar head excision	D	2798	269	4
Popliteal (Baker's) cyst of knee	D	575	192	4
Meniscectomy, knee – one meniscus	D	568	251	4
– medial and lateral	D	569	308	4
Synovectomy, knee	D	2005	231	4
Osteochondritis dissecans – curettage	D	2800	251	4
– internal fixation	D	2801	308	4
Neurectomy, hip	D	559	269	4
Discectomy – lumbar	D	542	385	8
Thoracic – Posterior approach	D	1596	539	10
– transthoracic	D	2370	539	13
Cervical – posterior approach	D	2802	462	10
– anterior approach	D	2600	462	10
Any level – repeat	D	2647	539	8-13
– two or more	D	2803	539	8-13
Meniscectomy, temporomandibular joint	D	2245	154	6
Condylectomy	D	2246	231	6
Reconstructive arthroplasty (see also "Ostectomy")				
Finger or thumb joint, including synovectomy and silastic replacement	D	2317	192	4
Each additional joint, maximum 539 units	D	2318	77	TU
Carpal bone replacement	D	2619	308	4
Wrist – ulnar head replacement	D	1755	385	4
– radio-carpal replacement	D	2804	385	4
– total replacement	D	2799	539	4
Elbow – radial head replacement	D	2621	385	4
– total replacement	D	2625	462	4
Shoulder – total replacement	D	2805	568	10
Revision of replacement arthroplasty of the shoulder, add	D	8402	40%	10

	List	Code	Units Gen	Units An
Acromioclavicular joint	D	2806	192	4
Toe, including Keller, McBride (see also "Ostectomy")	D	585	192	4
Mitchell osteotomy or Lapidus procedure	D	2829	269	4
Hammer toe	D	588	115	4
Each additional toe, either foot	D	589	77	TU
Overlapping 5th toe	D	2807	115	4
Hoffmann procedure for rheumatoid arthritis	D	2808	385	4
Ankle, total replacement	D	2809	462	6
Knee – hemiarthroplasty – single component	D	1979	308	6
– double component	D	1997	377	6
– total replacement	D	1978	611*	11*
Revision of replacement arthroplasty of the knee, add	D	8403	40%	10
Hip – femoral prosthesis	D	2786	568	8
Cup arthroplasty	D	2787	539	10
Total replacement	D	2004	682	13*
Revision of replacement arthroplasty, add	D	2789	40%	12

☞ ***Medicare Note: Secondary procedures payable in conjunction with hip replacement/revisions, at 50% are: sciatic nerve exploration (code 1490), femoral osteotomy (code 2613), open reduction with internal fixation of femur (code 2754), and cup arthroplasty (acetabular reconstruction) code 2787).***

Tenoplasty codes 2309 and 2310 performed via separate incisions are payable at 75%.

"Removal" only (solo) of prothesis – non-cemented	D	8400	420	8
– cemented	D	8401	524	8
Arthrodesis (fusion)				
Finger, thumb	D	2813	154	4
Wrist	D	533	308	4
Elbow	D	530	308	4
Shoulder	D	523	385	6
Foot – midtarsal, subtalar, triple	D	592	385	4
– pantalar	D	593	462	4
Ankle	D	584	346	4
Knee	D	574	346	4
Hip	D	548	462	8
Sacroiliac joint	D	546	308	7
Spine – fusion only	D	541	462	8
Each additional level, and	D	2814	77	TU
Fusion(s) additional to other procedures, add	D	2815	115	TU
Instrumentation (excluding plate, wires, etc.)	D	8404	1175	12

☞ ***Medicare Note: Instrumentation to include fractures, disc operations, fusions, grafts and corporectomy.***

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Scoliosis – anterior approach	D	2810	IC	9
Harrington rods – correction, fusion and casts	D	540	900	12
Removal of Harrington apparatus	D	2812	192	8
Luque instrumentation – with fusion	D	543	1175	12
Tendons, fascia, ligaments				
Incision				
Web space abscess – local anaesthesia	C	2635	15	
– general anaesthesia	C	2636	31	4
Acute tenosynovitis, tenovaginitis, total care	D	361	92	4
Exploration of fascia, fasciotomy	D	396	113	4
Closed (blind) fasciotomy	D	2818	62	4
Four-compartment fasciotomy	D	397	231	4
Exploration of tendon, tendon sheath (including drainage, removal of foreign body	D	392	92	4
Tendon release – trigger finger	D	394	92	4
– wrist	D	395	92	4
Tenotomy	D	2819	115	4
Excision				
Ganglion, tendon sheath	D	2821	77	4
Tumor, tendon sheath	D	2822	77	4
Tendon sheath for tuberculosis	D	400	231	4
Tenosynovectomy (independent procedure) – extensor	D	2823	115	4
Flexor tendon	D	2824	192	4
Fibrosis, tendon sheath: de Quervain, etc	D	399	92	4
Dupuytren's contracture, total care (including Z-plasties) – localized excision	D	401	154	4
Palmar fasciectomy, one or more fingers	D	403	462	4
Plus skin graft	D	402	550	4
Decompression of carpal tunnel	D	611	115	4
Epicondylar stripping (tennis elbow)	D	1964	115	4
Repair, reconstruction				
Tendon suture – hand, wrist, foot, ankle				
Extensor – one	D	613	115	4
– multiple	D	614	231	4
Flexor – one	D	615	192	4
– two	D	616	269	4
– each additional	D	2820	77	TU
Collateral ligament repair	D	2641	192	4
Repair of digital or palmar nerve during a procedure, add	D	2325	115	4
Suture of minor nerve, independent procedure	D	2324	154	4

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Repair of tendon				
Biceps, upper or lower end	D	619	231	5
Achilles	D	618	269	4
Patellar	D	2825	269	4
Quadriceps	D	620	269	4
Tenoplasty: shortening or lengthening, tenonectomy, any location, independent procedure – one tendon	D	2309	115	4
Two or more tendons	D	2310	192	4
ACL Reconstruction +/- Arthroscopy	D	822	533	6
Reconstruction of flexor tendon pulleys	D	2640	192	4
Patelloplasty	D	2638	269	4
Lateral retinacular release	D	2639	115	4
Hip flexion contracture	D	560	269	6
Insertion of silastic tendon	D	2307	269	4
Insertion of silastic rod in flexor tendon sheath	D	2308	192	4
Club foot, vertical talus				
Tendon lengthening	D	594	154	4
Plus posterior capsulotomy	D	595	231	4
Medial release and tendon lengthening	D	596	308	4
Tarsal – metatarsal release	D	591	250	4
Tendon transfer, transposition, tenodesis – one	D	2069	308	4
Each additional	D	2070	50%	4
Free tendon graft, total procedure	D	617	308	4
Intrinsic release of finger, independent procedure	D	2320	154	4
Correction of boutonniere deformity	D	2321	154	4
Correction of swan neck deformity	D	2322	154	4
Repair of rotator cuff, shoulder	D	524	269	6
Detachment of fascia lata, lengthening iliotibial band	D	1968	154	6
Digital transplant, vascular pedicle – total care	D	2313	500	4
Multiple injured hand, e.g. lawnmower or chain saw injuries involving several structures – total care, including staged procedures (operative reports required) maximum 769 units	D	2316	IC	6
Repair traumatic amputation of finger distal to metacarpophalangeal joint	D	2006	38	4
With free skin graft, complete care	D	2007	77	4
With pedicle graft, complete care	D	2008	115	4
Ligaments				
Ankle – early repair	D	2667	192	4
Each additional	D	2668	50%	TU
– late repair	D	2794	231	4
Each additional	D	2669	50%	TU
Knee – early repair	D	576	231	4
Each additional	D	577	50%	TU

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
– later repair	D	2795	269	4
Each additional	D	2670	50%	TU
Meniscal suture – one meniscus	D	578	251	4
– medial and lateral menisci	D	579	308	4
Bursae				
Excision				
Elbow – olecranon bursa	D	601	77	4
Shoulder	D	527	154	4
Knee – prepatellar bursa	D	602	77	4
Hip – trochanteric bursa	D	2826	154	4
Muscles				
Incision				
Myotomy – tennis elbow	D	2827	115	4
Division of sternomastoid – torticollis	D	522	208	4
Division of scalenus anticus	D	605	231	4
With resection of cervical rib	D	606	308	5
Excision				
Biopsy of muscle	B	607	38	4
Removal of foreign body or fibroma				
Local anaesthetic	D	2828	77	
General anaesthetic	D	608	IC	4
Excision of muscle tumor	D	609	IC	4
Reconstruction				
Gastrocnemius slide, unilateral	D	1969	154	4
Quadricepsplasty	D	567	269	4
Iliopsoas transplant	D	1966	385	6
Amputations				
Upper extremity				
Hand				
Metacarpophalangeal joint or distal				
One	D	629	54	4
Each additional	D	630	38	TU
Transmetacarpal, thumb or finger – one	D	627	77	4
Each additional	D	628	38	TU
All metacarpals	D	626	192	4
Ray amputation	D	2314	192	4
Wrist, disarticulation	D	625	192	4
Forearm, through radius and ulna	D	624	231	4

Musculoskeletal system (continued)

	List	Code	Units Gen	Units An
Arm, through humerus	D	623	231	5
Shoulder, disarticulation	D	622	269	9
Interthoracoscapular (forequarter)	D	621	462	15
Lower extremity				
Foot				
Any joint or phalanx – one	D	640	54	4
– each additional	D	641	38	TU
Transmetatarsal – one	D	637	77	4
– each additional	D	638	38	TU
– all	D	636	192	4
Ankle (Syme's)	D	635	269	4
Leg, through tibia and fibula	D	634	231	6
Thigh, through femur	D	633	269	6
Hip, disarticulation	D	632	385	10
Interpelviabdominal (hindquarter)	D	631	539	15

Respiratory System

	List	Code	Units Gen	Units An
See legend – Pg. 3/13 for description of list A, B, C and D.				
Nose				
Incision				
Drainage of nasal abscess, complete care	D	642	59	
Drainage of septal abscess, complete care	D	643	98	4
Excision				
Biopsy of soft tissue	B	644	54	4
Biopsy of bone	B	645	31	
Excision of nasal polyps – unilateral	B	647	77	4
Excision of choanal polyp	D	648	54	4
Excision of nasopharyngeal fibroma	D	649	385	4
Excision of intranasal lesions by lateral rhinotomy approach	D	1773	375	7
Excision of tumor of nasopharynx (Wilson, transpalatal approach)	D	2037	308	4
Rhinophyma, complete, including skin grafts if necessary	D	650	154	4
Septectomy, submucous resection	D	651	154	4
Including septoplasty	D	652	192	4
With correction of nasal deformity;	D	653	385	6
Repair				
Rhinoplasty, complete management, including septectomy and grafts where necessary	D	660	462	8
☞ *Medicare Note: Rhinoplasty: See plastic surgical preamble, page 20/1.*				
Turbinate reduction, unilateral or bilateral, to include cautery, cryosurgery or turbinectomy	B	654	45	4
Endoscopy				
Rhinoscopy with removal of foreign body in nose	B	658	15	
Under general anaesthesia	B	659	31	4
Nasopharyngoscopy	C	2853	36	
Surgical technique for atrophic rhinitis – unilateral	D	661	115	4
– bilateral	D	662	231	4
Insertion of septal button	D	700	115	4
Manipulation				
Control of primary nasal haemorrhage				
With cauterization of nasal septum	B	666	15	4
With anterior nasal packing	A	667	15	4
With posterior nasal packing – local anaesthesia	D	668	77	
– general anaesthesia.	D	670	115	4

Respiratory system (continued)

	List	Code	Units Gen	Units An
With cauterization (electric) of nasal septum	B	669	31	4
Control of secondary haemorrhage – same as above				
Catheterization of Eustachian tube for infiltration of middle ear	A	1922	29	

Nose – accessory sinuses

Nose

Endoscopy

Diagnostic sinoscopy – unilateral	B	1786	92	4
With biopsy +/- removal of benign growth	B	1788	123	4
– bilateral	B	1787	138	4
With biopsy +/- removal of benign growth	B	1789	185	4

Incision

Antrum puncture, unilateral	A	672	15	4
Maxillary sinusotomy, simple antrum window operation				
Unilateral	D	673	92	4
Bilateral	D	674	154	4
Radical antrum, unilateral	D	675	231	4
Sphenoid sinusotomy	D	676	115	4
Frontal sinusotomy, external trephine operation				
Simple	D	677	115	4
Radical	D	678	385	4
Combined external frontal, ethmoid and sphenoid sinusotomy.....	D	679	385	4

Excision

Ethmoidectomy – unilateral	D	656	154	4
With sinoscopy +/- construction of maxillary ostium	D	1790	231	4
– bilateral	D	657	231	4
With sinoscopy +/- construction of maxillary ostium	D	1791	347	4
Radical ethmoidectomy – external approach	D	1777	300	4
– transantral (including Caldwell-Luc)	D	1778	300	4
Debridement of lymphomas (face-ethmoid/nasal structures).				
– location 3 and 5	D	823	98	5
– repeat	D	824	74	5

Larynx

Excision

Laryngectomy – without neck dissection	D	680	550	10
With neck dissection – unilateral	D	681	804	14

Respiratory system (continued)

	List	Code	Units Gen	Units An
– bilateral	D	682	950	14
Epiglottidectomy	D	683	192	10
Laryngofissure	D	684	308	6
Thyrotomy (McNaughton Keel)	D	685	231	6
Introduction				
Intubation of larynx (independent procedure)	C	687	23	
Endoscopy				
Laryngoscopy, direct – without biopsy	B	688	62	6
– with biopsy	B	689	62	6
Laryngoscopy – with removal of foreign body	D	690	115	6
– with removal of benign growth	D	691	154	6
– with injection of vocal cord	D	692	154	6
Microlaryngoscopy, additional to laryngoscopy fee	C	1728	36	TU
Repair				
Laryngoplasty: plastic operation on larynx	D	693	IC	7
Arytenoidopexy (King or Kelly)	D	694	308	6
Laryngocele – external	D	695	308	6
– internal	D	696	231	6
Trachea and bronchi				
Introduction				
Tracheal aspiration in infants (independent procedure)	A	704	15	
Endoscopy **(See also Assessment Rules 32 and 33)**				
Rigid bronchoscopy +/- biopsy	B	698	92	6
Therapeutic, including suctioning	B	2587	92	6
Rigid bronchoscopy				
Therapeutic, with removal of foreign body	D	701	154	6
Dilatation of stenosis	D	2588	154	6
Repeat	D	2589	115	6
Flexible bronchoscopy +/- biopsy	B	699	92	6
Therapeutic, including suctioning	B	2591	92	6
Flexible bronchoscopy, diagnostic – brush biopsy of all segments	B	2590	293	6
Transbronchial lung biopsy via flexible bronchoscope	B	1724	112	6
Bronchoscopy with palliative endobronchial tumor resection including laser or cryotherapy, add	B	731	54	TU
Incision				
Tracheostomy	D	697	185	6
Change of tracheostomy tube			VF	

Respiratory system (continued)

	List	Code	Units Gen	Units An
Creation of tracheo-oesophageal fistula	D	702	154	4
Insertion of voice prosthesis	B	703	20	4
Excision				
Segmental resection of cervical trachea	D	2485	600	24
Resection of mediastinal trachea with either sternotomy or thoracotomy	D	2486	700	24
Repair				
Tracheal trauma				
Tracheorrhaphy – cervical	D	706	150	6
– intrathoracic	D	2490	308	13
Closure of tracheostomy or tracheal fistula	D	707	115	6
Closure of tracheoesophageal fistula	D	708	593	13
Tracheoplasty: plastic operation on trachea	D	705	IC	13
Chest wall and mediastinum				
Endoscopy				
Thoracoscopy +/- biopsy	B	735	92	6
Mediastinoscopy	B	713	185	6
Mediastinopleuroscopy	B	2509	254	6
Incision				
Mediastinotomy with drainage	D	709	308	12
Excision				
Chest wall tumor involving ribs or cartilage	D	711	385	12
With prosthetic reconstruction of chest wall	D	2507	539	12
Mediastinal tumor	D	712	700	12
Anterior mediastinotomy	D	2508	254	6
Repair				
Reconstruction of pectus excavatum	D	710	625	12
Rewiring of the Sternum	D	820	154	10
Surgical collapse, thoracoplasty – one stage	D	714	308	10
– multistage, each	D	715	185	10
Schede's operation	D	716	370	5
Pneumolysis – intrapleural	D	717	139	5
– extrapleural	D	718	231	5
Apicolysis – intrafascial or extrafascial	D	719	231	5
– extrapleural	D	720	231	5
Pneumothorax – first	C	721	23	
– subsequent	C	722	12	5
Phrenicotomy	D	723	92	5

Respiratory system (continued)

	List	Code	Units Gen	Units An
Lungs and pleura				
Incision				
Tube thoracostomy with water seal				
Pneumothorax or effusion	B	724	38	4
Drainage of empyema, aftercare extra	C	725	115	6
Drainage of lung abscess	D	726	277	13
Thoracotomy – exploratory, including biopsy and/or removal of foreign body	D	727	277	13
With repair of lung fistula	D	2495	IC	13
With control of haemorrhage (includes postoperative haemorrhage)	D	2496	277	13
With talc poudrage	D	2499	462	15
With pulmonary decortication – partial	D	2498	462	15
– total	D	2497	539	15
With decortication and muscle graft closure of bronchopleural fistula	D	2500	539	15
Biopsy of pleura or lung – open	D	728	277	13
Excision				
Pneumonectomy	D	729	625	13
Lobectomy, total or segmental	D	730	625	13
With concomitant decortication	D	2505	639	15
Wedge resection, single or multiple	D	732	450	13
With pleurectomy	D	779	639	13
Sleeve resection with lobectomy	D	2506	616	13
Pleurectomy, any type (independent procedure)	D	733	462	15
Resection of bullae and pleurodesis	D	734	462	15
With pleurectomy	D	782	639	15

Cardiovascular System

	List	Code	Units Gen	Units An
See legend – pg. 3/13 for description of list A, B, C and D.				
Veins				
Repair				
Major peripheral vein	D	1970	154	5
With graft	D	1971	231	5
Venous anastomosis				
Portocaval	D	737	850	10
Splenorenal – proximal	D	738	850	10
– distal	D	2510	900	10
Mesocaval +/- graft	D	739	850	10
Resection of A-V aneurysm or fistula +/- graft	D	740	IC	10
Creation of A-V fistula	D	741	277	8
Revision, reversal or closure of arteriovenous fistula	D	783	114	8
Insertion or removal of peritoneal/venous shunt (Denver)	D	840	254	8
Suture				
Declotting of shunt	D	2511	75	6
Ligation – jugular vein, internal	D	742	115	10
Femoral	D	743	116	5
Inferior vena cava, ligation or plication	D	744	308	10
Insertion of special transvenous devices	D	2512	150	10
Popliteal	D	745	115	5
Saphenous	C	746	38	4
Excision, ligation, injection				
Injection – single	C	747	8	4
– multiple at same sitting	C	748	15	4
Ligation, multiple – one leg	D	749	92	4
Ligation, long saphenous, saphenofemoral junction – one leg	D	750	92	4
Ligation – long saphenous – one leg with stripping	D	751	139	4
With multiple low ligation – ligation of perforators	D	752	154	4
Ligation and stripping – short saphenous	D	753	77	4
Long and short saphenous veins – one leg	D	754	192	4
With multiple low ligation	D	2178	231	4
High ligation – bilateral with stripping	D	755	231	4
With multiple low ligation	D	756	269	4
Bilateral long and short saphenous – high ligation and stripping	D	757	308	4
With multiple low ligation	B	2177	385	4
Recurrent complicated varicose veins	D	758	IC	4
Excision of ulcer, multiple ligation of veins and skin				

Cardiovascular system (continued)	List	Code	Units Gen	Units An
graft				
– one leg	D	759	192	4
– both legs	D	760	308	4
Above plus sympathectomy – extra	D	761	115	6
Excision of stasis ulcer and skin graft – one leg	D	762	123	4
– both legs	D	763	185	4
Subfascial ligation	D	764	231	4
With stripping of veins	D	765	308	4
Thrombectomy, iliac or femoral	D	766	385	8

Arteries

Introduction				
Percutaneous or cannulation – for arteriography, infusion chemotherapy, etc			(page 22/1)	
Regional isolation perfusion – iliac	D	2516	385	10
– peripheral or axillary.	D	2517	300	10
Incision				
Arteriotomy or temporal artery biopsy	B	767	54	4
Aortotomy	D	768	115	10
Arterial puncture	A	769	15	4
Insertion of arterial cannulae – payable in addition to ICU daily care	A	778	30	
Transection of artery – peripheral	D	770	115	4
Intraabdominal or intrathoracic	D	771	154	10
Embolectomy – aortic	D	789	539	17
Embolectomy or thrombectomy				
Aortoiliac bifurcation or graft	D	2532	350	17
Iliac or femoral	D	790	385	10
Mesenteric	D	791	462	10
Renal	D	792	462	10
Other peripheral artery or graft	D	2541	300	10
Suture				
Suture of lacerated major artery of a limb	D	2522	231	10
Ligation				
Ligation of artery	C	2518	77	4
Internal maxillary artery (Caldwell-Luc approach)	D	2519	340	10
Anterior ethmoid artery – epistaxis	C	808	77	4
Ligation carotid, neck	D	1566	308	15
Internal iliac artery (unilateral or bilateral)	D	2520	231	7

Excision and/or repair (repair of artery implies endarterectomy and/or bypass graft and includes thrombo/embolectomy of vessels in the same area or through the same incision).

Glomectomy – unilateral	D	2521	150	10

Cardiovascular system (continued)	List	Code	Units Gen	Units An
Carotid body tumor	D	794	462	15
Carotid endarterectomy	D	1973	700	15
Carotid aneurysm – reconstruction or excision with graft	D	2523	462	15
Aortic arch reconstruction; innominate, subclavian and/or vertebral	D	2525	539	15
– with thoracotomy, add	D	2526	139	TU
– ruptured, and	D	798	165	TU
Subclavian aneurysm – reconstruction or excision with graft	D	2527	462	15
Thoracic aorta aneurysm – repair or excision with graft – ascending	D	773	1120	45
– arch	D	774	1322	45
– descending +/- temporary shunt	D	2528	1066	IC
– ruptured, add	D	798	165	TU
Thoraco-abdominal aneurysm	D	799	IC	IC
Abdominal aorta aneurysm	D	775	925	17
Plus implantation of major branch or reconstruction of iliac arteries	D	2529	1070	17
With rupture	D	776	1090	20
Renal artery – endarterectomy	D	1974	539	10
Aneurysm – reconstruction or excision with graft	D	2536	539	10
Splenic artery aneurysm – reconstruction or excision with graft	D	777	385	12
Mesenteric or coeliac artery repair – aneurysm	D	2533	385	10
Removal of band only	D	2534	385	10
Endarterectomy or graft	D	2535	462	10
Aortoiliac repair				
Bifurcation – repair only	D	784	693	17
Plus common femoral repair – unilateral	D	2530	743	17
– bilateral	D	2531	900	17
Iliac repair	D	785	539	17
Iliofemoral bypass graft	D	2537	500	17
Common femoral/profunda femoris repair (when sole procedure performed)	D	2538	385	10
Extended profundoplasty	D	2524	575	10
Axillofemoral or femorofemoral graft	D	2339	539	12
Aortofemoral unilateral graft	D	2340	539	17
Femoropopliteal endarterectomy and/or bypass graft (synthetic)	D	2539	539	10
Femoral or popliteal aneurysm – excision, reconstruction or ligation	D	780	385	10
With graft	D	781	539	10
Femoro-ante/posttibial endarterectomy and/or bypass graft (synthetic)	D	2179	575	10
Femoropopliteal/tibial vein graft	D	786	700	10
In situ saphenous vein arterial bypass				

Cardiovascular system (continued)	List	Code	Units Gen	Units An
– Femoral/popliteal	D	787	945	10
– Femoral/tibial or peroneal (trifurcation)	D	795	1135	10
– Femoral/pedal	D	796	1300	10
Reversed vein distal bypass graft with mid-calf vein implantation	D	788	945	10
Arterioplasty +/- patch graft	D	804	231	10
Peripheral arteries other than listed – aneurysm	D	2540	300	10

Heart and pericardium

Preamble – catheterization

a) Therapeutic catheterization fees (codes 814 to 819, page 10/6) include all same-day heart and coronary catheterization and angiography except when done for the first time or when more than 30 days have elapsed since angiography was last performed. In such cases either code 1870 or 1871, (page 10/5) is payable in addition.

b) Percutaneous angioplasty fees include the placement of a temporary pacemaker during the same session. They also include repeat angioplasty within 2 hours.

c) Additional procedures, where payable, are at 50% of the listed fee; "add-on" fees are paid at the full amount shown.

d) Procedures 814 to 819, page 10/6, include usual preoperative and postoperative care; intensive care (except on the day of the procedure) and preoperative consultations are payable as for major surgery. After-hours premiums apply only to consultations and to procedures done under general anaesthesia.

e) If, in an emergency, an anaesthetist is called to a catheterization laboratory to perform anaesthesia or anaesthetic management pending transfer to surgery, he may claim 10 anaesthesia units in addition to the basic units or other fees that may apply. This is payable only if the anaesthetist's services commence before the transfer to the operating theatre.

Diagnostic procedures

Atrial or ventricular puncture	B	1921	77	5
Catheterization, right heart	B	1918	115	5
Hepatic wedge pressure	B	1919	77	4
Catheterization, left heart, retrograde	B	1864	177	5
Transseptal catheterization	B	1865	255	5
Selective coronary catheterization and angiograms, add	B	1866	100	TU
Bypass graft catheterization, each, add	B	1867	67	TU
– internal mammary graft (subclavian), add	B	1868	67	TU
Angiography, except coronary, all injections, add	B	1869	49	TU
Diagnostic left +/- right heart angiography plus coronary angiography done at the time of				

Cardiovascular system (continued)	**List**	**Code**	**Units Gen**	**Units An**
angioplasty, when payable, total add-on fee	B	1870	159	TU
Diagnostic coronary angiography done at the time of angioplasty, when payable, total add-on fee	B	1871	87	TU
Selective pulmonary catheterization, add	B	1872	40	TU
Assessment of pulmonary vascular resistance changes (includes all agents), add	B	1873	55	TU
Ergonivine stimulation test, add	B	1874	85	TU
Studies: Fick determination, thermodilution cardiac output, metabolic studies, oxymetry, isotope studies, etc, per series, add	B	1875	29	TU
Ascending aortogram (for aortic pathology), add	B	1876	48	TU
Percutaneous myocardial biopsy, add	B	1877	78	TU
Electrophysiology and pacemakers				
Introduction of catheter pacemaker	B	825	154	5
Insertion of internal pacemaker				
Thoracotomy and implantation of electrodes into myocardium	D	826	385	20
Insertion of permanent external pacemaker and placement of transvenous electrodes				
Team procedure – cardiologist	D	2009	192	9
– surgeon	D	2009	192	9
Solo procedure	D	2010	308	9
Replacement or readjustment of transvenous electrodes				
Team procedure – cardiologist	D	2011	115	9
– surgeon	D	2011	115	9
Solo procedure	D	2012	154	9
Placement of pulse generator only				
Team procedure – cardiologist	D	2025	115	9
– surgeon	D	2025	115	9
Solo procedure	D	2026	154	9
Two-chamber pacings, team procedure– cardiologist	D	1912	288	9
– surgeon	D	1912	288	9
Solo procedure	D	1913	410	9
Reprogramming of Pacemaker	---		VF	---

***Refer to page 5/16 for "follow-up Pacemaker visits".**

☞ ***Medicare Note: Detention fees may be billed after initial visit time has elapsed.***

All the above fees (2009 to 1913) to include postoperative care by cardiologist, and pre and postoperative care by surgeon.

Electrophysiologic study with programmed stimulation of atria or ventricles and/or endomyocardial mapping	D	1878	330	9

Cardiovascular system (continued)	List	Code	Units Gen	Units An
Repeat electrophysiological study to assess response to medication or surgery	D	1879	165	9
His bundle and atrial pacing	D	1880	165	9
Therapeutic procedures				
Intraaortic balloon pump, percutaneous (includes removal)	C	812	257	10
Decannulation by another physician	C	813	54	5
PTCA (percutaneous transluminal coronary angioplasty), one vessel, all lesions	D	814	445	20
– additional vessel, add	D	815	176	TU
Percutaneous balloon valuloplasty	D	816	458	20
Percutaneous angioplasty for coarctation of aorta	D	817	367	20
Percutaneous closure of patent ductus arteriosus	D	818	341	20
Creation of ASD by balloon septostomy	D	819	270	20
Cardiac surgery				
General				
Pump bypass and/or cardiac mechanical stabilization to include cannulation, decannulantion and supervision, add	D	8000	310	TU
– Re-operation with pump and/or cardiac mechanical stabilization more than one month after original operation, add	D	8001	548	TU
☞ ***Medicare Note: A fee of 45 anaesthesia basic units shall apply to any surgery requiring pump bypass.***				
Circulatory assist device, e.g. intraaortic balloon (includes daily care & supervision), open, decannulation extra	D	8002	295	15
– percutaneous; see Interventional Cardiology				
Decannulation of circulatory assist device (includes repair of artery) – open	A	8003	118	10
Repositioning of intra-aortic balloon pump (beyond 24 hours or original insertion) – open	A	8004	123	15
Preliminary diagnostic catheterization extra.				
Incision and/or excision				
Cardiac massage – open, add to surgery fee	D	8005	154	TU
Rewiring of Sternum	D	820	154	10
Pericardiectomy – one side open	D	8006	476	20
– both sides open or sternal splits	D	8007	782	20

Cardiovascular system (continued)	List	Code	Units Gen	Units An
Cardiotomy with exploration and/or removal of foreign body or tumor	D	8008	543	20
His bundle ablation and/or division or accessory conduction pathway (to include cardiotomy and mapping)	D	8010	748	45
Resection/ablation for ventricular tachycardia (to include cardiotomy, mapping, with or without His bundle)	D	8011	953	45
Excision – tumour of ventricular wall	D	8012	892	45
– ventricular aneurysm	D	8013	845	45
– aneurysm of sinus of Valsalva	D	8014	845	45
Excision of extensive endocardial scar, add to ventriculotomy or aneurysm repair	D	8015	123	TU
Ligation or division of patent ductus arteriosus				
– under 16	D	8016	520	20
– adult	D	8017	684	20
Interruption of bronchial collateral arteries (one or more)				
– sole procedure	D	8018	684	20
– when done in conjunction with other cardiac surgery, add	D	8019	171	TU
Resection of coarctation of aorta, under 16	D	8020	616	20
– adult	D	8021	756	20
Congenital heart procedures – e.g. Blalock, Glenn, Potts, Waterston or Central	D	8022	600	20
Creation or atrial septal defect by thoracotomy or Sterling Edwards	D	8023	600	20
Closure of atrial septal defect:				
secundum	D	8024	684	45
– with anomalous pulmonary venous drainage	D	8025	771	45
– endocardial cushion and valve defect	D	8026	1018	45
Closure of ventricular septal defect(s)	D	8027	927	45
Donor cardiectomy	D	8028	415	20
Donor heart-lung removal	D	8029	531	20
Repair				
Coronary endarterectomy	D	8030	783	45
– when done in conjunction with coronary artery repair, add	D	8031	189	TU
Coronary artery bypass/repair – one	D	8032	915	45
– two	D	8033	1145	45
– each additional	D	8034	165	TU
Use of internal mammary for construction of bypass graft, add	D	8035	171	TU
Total repair Tetralogy of Fallot	D	8036	1019	45
– with previous arterial shunt	D	8037	1159	45

Cardiovascular system (continued)	List	Code	Units Gen	Units An
Total anomalous pulmonary venous drainage	D	8038	879	45
Total correction transposition or great vessels	D	8039	879	45
Arterial repair of transposition	D	8040	1318	45
Complete A-V canal	D	8041	1157	45
Single ventricle	D	8042	1318	45
Double outlet – right/left ventricle	D	8043	1019	45
Double outlet ventricle with transposition	D	8044	1318	45
Truncus arteriosus	D	8045	1318	45
Interrupted aortic arch	D	8046	1157	45
Aorto-pulmonary window	D	8047	737	45
R-V outflow tract with valve and tubular graft	D	8048	832	45
Debanding arterioplasty or pulmonary artery	D	8049	546	20
Pulmonary artery banding	D	8050	737	20
Correction or cor triatriatum	D	8051	737	45
Vascular ring	D	8052	546	20
Valves				
Pulmonary valvotomy	D	8053	828	45
Pulmonary valvotomy and infundibular resection	D	8054	933	45
Pulmonary valve replacement	D	8055	933	45
Tricuspid valvotomy	D	8056	882	45
Tricuspid annuloplasty	D	8057	782	45
Tricuspid valve replacement	D	8058	933	45
Mitral valvotomy	D	8059	805	45
Mitral valvotomy – restenosis	D	8060	871	45
Mitral annuloplasty	D	8061	871	45
Mitral replacement	D	8062	1015	45
Mitral valvoplasty	D	8063	968	45
Aortic valvuloplasty	D	8064	871	45
Aortic valvotomy	D	8065	849	45
Aortic infundibular resection (ventriculomyotomy)	D	8066	969	45
Aortic valve replacement	D	8067	1019	45
Patch aortoplasty with pericardium or graft, add	D	8068	171	TU
Aortic annuloplasty (reconstruction and enlargement of aortic annulus) add	D	8069	270	TU
Replacement of aortic valve, of ascending aorta and reimplantation of coronary arteries (modified Bentall procedure)	D	8070	1889	45

Haemic and Lymphatic Systems

	List	Code	Units Gen	Units An
See Legend – Pg. 3/13 for description of list A, B, C and D.				
Spleen and marrow				
Incision				
Splenic puncture – biopsy	A	1954	46	
For injection of contrast substance	A	864	46	
Excision				
Splenectomy	D	865	308	7
See also: laparotomy for acute trauma				
Hodgkin's disease – staging, laparotomy, splenectomy, liver biopsy and retroperitoneal node biopsy	D	2341	385	7
Biopsy of marrow				
Aspiration, needle or punch	B	866	38	4
Bone button	B	867	46	4
Iliac crest open biopsy	B	1961	115	4
Lymph channels				
Excision				
Cystic hygroma	D	868	277	6
Lymphoedema – Kondoleon	D	869	277	4
– radical sleeve excision	D	870	539	6
– lymphangiogram	B	871	139	4
Excision of lymph glands				
Tumor, suprahyoid – unilateral	D	872	231	6
– bilateral	D	873	346	6
Radical neck dissection	D	874	508	14
Dissection of inguinal glands	D	875	231	4
Radical dissection of axillary glands	D	876	350	4
Radical dissection of inguinal glands including iliac glands	D	877	339	6
Radical dissection of inguinal and iliac glands, bilateral	D	878	508	6
Radical retroperitoneal node dissection	D	2019	508	8
Biopsy – cervical, axillary, inguinal	B	879	66	4
Scalene	B	880	92	4

Digestive System

	List	Code	Units Gen	Units An
See legend – pg. 3/13 for description of list A, B, C and D.				
Mouth				
Incision				
Drainage of Ludwig's angina, complete care	D	881	98	5
Excision				
Biopsy	B	882	31	4
Excision of simple lesion	C	883	31	4
Excision of leukoplakia – limited	C	884	46	4
– extensive	D	885	185	4
Excision of ranula or dermoid cyst	D	886	92	4
Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa	D	887	139	4
With hemimandibulectomy	D	889	308	10
Either of above combined with unilateral neck dissection	D	890	616	14
Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible	D	1774	500	12
Extended resection, as above with partial resection of maxilla	D	1775	650	12
Destruction				
Cauterization of leukoplakia	C	891	46	4
Suture				
Closure of antro-oral fistula – with flap	D	892	231	4
With radical antrotomy	D	893	269	4
Lips				
Excision				
Biopsy	B	894	31	4
Lip shave	D	895	154	4
Excision of simple lesion	C	896	31	4
V-excision for carcinoma	D	897	139	4
Plus radical neck dissection	D	898	500	14
Excision one-half lip plus reconstruction, one or more stages, total fee	D	899	308	4
Plus radical neck dissection	D	900	539	14
Total excision of lip plus reconstruction, one or more stages, total fee	D	901	462	6
Plus radical neck dissection	D	902	539	14
Repair				

Digestive system (continued)	List	Code	Units Gen	Units An
Hare lip – unilateral	D	903	231	8
– bilateral	D	904	385	8
Tongue				
Excision				
Biopsy	B	905	31	4
Local excision of simple tumor	D	906	92	4
Hemiglossectomy	D	907	254	8
Plus radical neck dissection	D	908	593	14
Total glossectomy	D	909	305	8
Plus radical neck dissection	D	910	593	14
Repair				
Suture of extensive lacerations	D	911	IC	4
Minor lacerations	C	912	23	4
Teeth and gums				
Incision				
Drainage of alveolar abscess – general anaesthetic	C	913	52	4
Excision				
Biopsy of gum	B	914	31	4
Dentigerous cyst	D	915	185	4
Mucous cyst	C	916	52	4
Suture				
Suture of gum, secondary	C	917	31	4
Palate and uvula				
Incision				
Palate abscess	C	918	52	4
Excision				
Uvulectomy – independent procedure	C	919	52	4
Biopsy	B	920	31	4
Excision of simple lesion	C	921	46	4
Excision of malignant lesion with reconstruction	D	922	IC	4
Repair				
Cleft palate	D	923	269	8
Revision, with bone graft	D	2291	308	8
Suture				
Suture of palate wound	C	924	23	4
Uvulopalatopharyngoplasty	D	828	225	4
Push-back of palate and/or pharyngeal flap	D	925	346	8
Repair of palate fistula	D	2292	231	8

Digestive system (continued)	List	Code	Units Gen	Units An
Salivary glands and ducts				
Incision				
Sialolithotomy, under general anaesthesia – simple .	C	926	46	4
Complicated	D	927	139	4
Excision				
Submandibular gland	D	928	185	4
Parotid gland – excision of tumor only	D	929	277	6
Superficial parotid lobectomy	D	1976	484	7
Total parotidectomy	D	930	571	8
Plus radical neck dissection	D	931	825	14
Repair				
Plastic repair of duct	D	932	192	4
Relocation or repositioning, submandibular duct	D	1975	290	4
Dilation of duct as independent procedure	C	933	59	4
Probing				
Duct	C	934	29	
Catheterization for sialogram	C	935	59	4
Pharynx, adenoids and tonsils				
Incision				
Biopsy of pharynx	B	936	31	4
Fine needle aspiration of tonsillar abscess	B	1801	15	---
Drainage of retropharyngeal abscess				
Internal approach	B	937	77	4
External approach	D	938	136	4
Drainage of peritonsillar abscess, operation only	C	939	44	4
Excision				
Branchial cyst	D	940	231	4
Branchial sinus	D	941	308	4
Pharyngo-oesophageal diverticulum	D	942	385	4
Thyroglossal duct cyst	D	943	192	4
Cyst and sinus	D	944	277	4
Tonsillectomy +/- adenoidectomy – under 16	D	945	90	4
– adult	D	946	120	4
Adenoidectomy	D	863	68	4
Excision of tonsil tag, unilateral	D	947	62	4
Excision of lingual tonsil (independent procedure) ..	D	948	62	4
Excision of tumor of parapharyngeal space	D	1776	500	8
Pharyngectomy, transhyoid or lateral	D	1727	520	9
Repair				

Digestive system (continued)	List	Code	Units Gen	Units An
Choanal atresia	D	949	385	8
Choanal atresia dilation – initial	C	2038	59	4
– repeat	C	2039	40	4
Push–back flap (pharyngeal)	D	950	346	8
Retropharyngeal insertion of plastic for rhinolalia	D	951	115	4
Suture				
Suture of external wound or injury of pharynx	D	952	IC	4
Oesophagus				
Dilation of oesophagus				
Active +/- guiding string	B	982	66	4
Passive, using mercury filled tubes	B	983	35	4
Dilation, pneumatic dilator	B	984	66	4
Retrograde dilation	B	985	43	4
Dilation under fluoroscopic control	B	988	74	4
Dilation with oesophagoscopy, indirect – initial	D	986	185	4
– repeat	D	987	93	4
Endoscopy (See also Assessment Rules 32 and 33)				
Oesophagoscopy +/- biopsy	B	964	92	4
With removal of foreign body	D	965	154	4
Introduction of Souttar tube – via oesophagus	D	968	115	4
Blakemore tube	D	967	100	4
☞ ***Medicare Note: Gastroscopy payable in addition to above 2 codes.***				
Endoscopic Haemostasis	D	1003	206	4
Repeat within 30 days	D	1005	103	4
Injection				
Oesophageal varices with oesophagoscopy – initial	D	979	206	4
– repeat.	D	966	103	4
Introduction of Mousseau or Bardin tube	D	981	231	6
Incision				
Cervical oesophagostomy – adult	D	953	231	6
– newborn	D	2542	308	13
Thoracic oesophagostomy	D	954	308	13
Heller procedure	D	955	462	13
Total thoracic oesophageal myotomy when sole procedure performed	D	2543	562	13
Excision				
Intrathoracic diverticulum or leiomyoma of oesophagus	D	956	407	13
Cricopharyngeal diverticulum or cricopharyngeal myotomy	D	957	346	13
Oesophageal resection, including reconstruction, 1st surgeon	D	1784	900	15
2nd surgeon	D	1785	500	
Oesophagogastrectomy	D	962	678	13

Digestive system (continued)	List	Code	Units Gen	Units An
Oesophageal bypass with colon or jejunum when **sole procedure** performed	D	963	593	13
Repair				
Oesophagoplasty (repair of stricture)	D	969	508	13
Oesophageal hiatus hernia				
Abdominal approach	D	970	385	7
Plus cholecystectomy, if indicated	D	971	555	7
Transthoracic approach	D	972	500	13
With gastroplasty or intrathoracic fundal plication	D	2547	515	13
Recurrent hiatus hernia				
Abdominal or transthoracic approach	D	2342	539	13
Thoracoabdominal approach	D	2548	639	13
With myotomy, add	D	2549	91	TU
Rupture oesophagus	D	973	424	13
Cervical drainage	D	974	269	6
Transabdominal repair of diaphragmatic rupture	D	977	500	13
Oesophagogastrostomy	D	975	593	7
Oesophagoduodenostomy or oesophagojejunostomy	D	976	593	7
Oesophagotomy with ligation of varices	D	978	407	13
Stomach				
Incision				
Gastrotomy button	A	2985	46	5
Gastrotomy with removal of tumor or foreign body	D	989	254	7
Pyloromyotomy (Ramstedt's)	D	990	254	10
Simple tube gastrostomy	D	991	254	5
In conjunction with abdominal surgery, add	D	1051	75	TU
Introduction of Souttar tube – via laparotomy	D	2546	308	7
Living tissue gastrostomy (Janeway etc,)	D	992	339	7
Percutaneous endoscopic gastrostomy: two physician team, per surgeon	B	1000	150	5
Percutaneous endoscopic gastrostomy "Solo Procedure"	D	2986	204	5
Excision				
Excisional biopsy – by gastroscopy	B	993	153	4
– by gastrotomy	D	994	254	7
– by intubation	B	995	34	
Gastrectomy – wedge resection for ulcer	D	996	305	7
Partial or subtotal	D	997	575	7
Plus repair of hiatus hernia	D	998	593	7
After previous gastroenterostomy or partial gastrectomy	D	999	593	7
Parietal cell vagotomy for peptic ulcer	D	2181	508	7
Total gastrectomy	D	1001	678	7
Excision of gastroduodenal lesion (recurrent ulcer)	D	1002	593	7
Excision of gastrojejunal lesion (recurrent ulcer)	D	1004	593	7

Digestive system (continued)	List	Code	Units Gen	Units An
Revision of gastrectomy plus Roux-en-y anastomosis, interposition of jejunal loop or reverse jejunal loop	D	2182	593	7
Any of the above plus vagotomy, add	D	2553	127	TU
Any of the above plus cholecystectomy, add	D	1006	170	TU
Plus cholecystectomy and cholangiography, add	D	2550	204	TU
Plus choledochoscopy, add	D	2551	60	TU
Plus cholecystectomy and exploration of common bile duct, add	D	2552	204	TU
And cholangiography, add	D	1032	233	TU
Endoscopy				
Upper gastrointestinal tract +/- biopsy	B	964	92	4
Gastroscopy removal of foreign body	D	1007	154	4
Ileoscopy in conjunction with gastroscopy and colonoscopy, add	B	827	46	---
Repair				
Pyloroplasty	D	1009	305	7
Plus vagotomy	D	1010	424	7
Vagotomy, bilateral – after previous gastric surgery for peptic ulcer	D	1977	254	7
Gastroduodenostomy, gastrojejunostomy, or gastrogastrostomy	D	1011	305	7
Plus vagotomy	D	1012	424	7
Pyloroplasty or gastroenterostomy with vagotomy and hiatal hernia	D	1013	508	7
Any of the above plus cholecystectomy, add	D	1014	170	TU
Suture				
Closure of gastrostomy of other external fistula of stomach	D	1015	204	5
Closure of perforated ulcer or wound of stomach	D	1016	305	7
Closure of gastrocolic or gastrojejunocolic fistula				
One stage	D	1017	593	7
Two stages including colostomy	D	1018	593	7
With vagotomy	D	2344	678	7
Gastric cooling	D	1019	92	4
Intestines (except rectum)				
Endoscopy				
Sigmoidoscopy +/- biopsy of rectum or sigmoid	B	2046	23	4
Fibersigmoidoscopy	B	2045	38	4
Colonoscopy +/- biopsy	B	2057	158	4
With fulguration of polyp, add	B	2465	40	
Each additional polyp (max. 2)	B	2466	15	
With excision of polyp, add	B	2467	90	
Each additional polyp (max. 2)	B	2468	35	
Incision				

Digestive system (continued)	List	Code	Units Gen	Units An
Ileostomy for ulcerative colitis	D	1020	426	6
Kock's pouch ileostomy	D	2183	428	6
Ileostomy or jejunostomy (with tube)	D	1021	355	6
Nutritional jejunostomy, in conjunction with other abdominal surgery, add	D	2987	75	TU
1st stage Mikulicz	D	1022	426	6
Colostomy	D	1023	355	6
Revision for stenosis	D	1024	92	6
Caecostomy, as single procedure	D	1025	355	6
Enterotomy or colotomy	D	1026	305	6
With operative sigmoidoscopy	D	1027	339	6
Multiple	D	1028	424	6
Colomyotomy	D	2554	385	6
Excision				
Biopsy by intubation	A	1029	46	4
Local excision of lesion of small intestine	D	1030	305	6
Preparation of intestinal segment for ureteral substitution	D	2168	339	6
Resection of diverticulum of duodenum	D	2555	359	6
Enterectomy – small intestine	D	1031	400	6
Large intestine				
Terminal ileum, caecum and ascending colon	D	1034	508	7
Partial colectomy	D	1035	478	7
Hemicolectomy – right	D	1036	508	7
– left	D	2556	578	7
Total colectomy				
With ileostomy – without perineal resection	D	1037	850	8
With abdominoperineal resection– single team	D	1038	900	10
Two team – 1st surgeon	D	1039	850	10
– 2nd surgeon	D	1040	300	
With ileorectal anastomosis	D	2184	678	8
Intestinal obstruction				
Without resection	D	1042	375	8
With Baker's jejunostomy tube, add	D	2557	100	TU
With resection	D	1043	500	8
Reduction of volvulus or intussusception, etc	D	1044	339	8
Enteroenterostomy	D	1045	339	8
Duodenal atresia – duodenojejunostomy	D	1046	375	8

Multiple stage procedures, preliminary colostomy, bowel resection, closure of colostomy, etc. to be paid at fee listed for the individual procedure.

Repair				
Faecal fistula, radical with resection	D	1047	465	6
Revision of ileostomy or colostomy	D	1048	92	6

Digestive system (continued)	List	Code	Units Gen	Units An
Full thickness	D	2185	296	6
Closure of perforation	D	1049	296	6
With colostomy	D	1050	339	6
Closure of colostomy +/- resection	D	1053	350	6
Plication of small intestine for adhesions	D	1054	407	6
Manipulation				
Dilation of enterostomy, colostomy etc.				
With anaesthetic	C	1055	31	4
Without anaesthetic			VF	
Intubation of small intestine	B	1057	36	4
Revision of intestinal bypass	D	2558	462	8
Meconium ileus (Hiatt-Wilson)	D	2559	385	10
Dilation of a colonic or pyloric stricture				
– passive	B	838	35	4
– with balloon	B	839	66	4
Meckel's diverticulum and the mesentery				
Excision				
Meckel's diverticulum	D	1058	360	6
Local excision of lesion	D	1059	360	6
Resection of mesentery	D	1060	360	6
Appendix				
Incision				
Drainage of abscess, complete care	D	1061	300	6
Excision				
Appendectomy	D	1062	300	6
Rectum				
Incision				
Proctotomy – with exploration	D	1064	92	4
With decompression (imperforate anus)	D	1065	92	4
With drainage (perirectal abscess)	D	1066	92	4
Pelvic abscess – drainage	D	1067	127	4
Manipulation				
Anorectal manometry	B	1073	38	---
Excision				
Proctectomy – anterior resection of rectum	D	1068	725	7
Proctectomy/Pelvic Pouch procedure	D	802	939	8
Perineal resection of rectum	D	1069	407	7
Abdominoperineal resection plus colostomy				

Digestive system (continued)	List	Code	Units Gen	Units An
Single team	D	1070	850	10
Two team – 1st surgeon	D	1071	800	10
– 2nd surgeon	D	1072	300	
Hartmann procedure	D	1074	500	7
Colonic reconstruction – following Hartmann procedure	D	2186	600	7
Abdominoperineal pull-through for Hirschsprung's disease or imperforate anus	D	1075	593	8
Proctosigmoidectomy for prolapse	D	1079	508	8
Transrectal excision of large villous adenoma of rectum	D	2560	265	4
Posterior approach for excision of rectal lesion with resection of sacrococcygeal segment	D	2561	265	6
Polyp excision or cauterization – low rectum	B	1080	46	4
Upper rectum and sigmoid through sigmoidoscope	B	1081	92	4
Biopsy of rectosigmoid for Hirschsprung's disease	B	1082	62	4
Rectal disimpaction	C	2850	23	
Repair				
Excision of mucous membrane	D	1085	154	4
Major repair – perineal approach	D	1086	305	4
– abdominal approach	D	1087	525	7
Thiersch wire procedure	D	1088	101	7
Suture of rectum				
External approach	D	1089	204	4
Intraperitoneal approach	D	1090	339	7
Closure of fistula				
Rectovaginal	D	1091	339	6
Rectovesical	D	1092	339	6
Anus				
Incision				
Thrombosed haemorrhoid – local anaesthetic	C	1093	23	
– general anaesthetic	C	1094	38	4
Excision				
Local excision of anal lesion such as fissure or malignancy (including sphincterotomy)	D	1095	92	4
Haemorrhoidectomy (sigmoidoscopy extra if not performed in preceding 30 days)	D	1096	154	4
With excision of anal fissure, add	D	1095	50%	TU
Using rubber band technique or infrared coagulation	C	1980	50	

Digestive system (continued)	List	Code	Units Gen	Units An
Anal polyp, haemorrhoidectomy tags	C	1097	46	4
Fistula-in-ano – low level	D	1098	154	4
High level with division of internal sphincter	D	1099	277	4
Biopsy – general anaesthesia	B	1100	31	4
Introduction				
Haemorrhoid injections – initial	A	1101	15	
– subsequent	A	1102	8	
Injections for pruritus ani or fissure	A	1103	15	4
Dilation of anal fistula	B	1083	43	4
Repair				
Excision of scar, for stenosis	D	1104	92	4
Anoplasty for stenosis	D	1105	185	4
Repair of anal sphincter	D	1106	231	4
Plus repair of anorectal ring	D	1107	254	4
Repair of imperforate anus – membranous obstruction of anus	D	1108	92	4
Rectal atresia – perineal repair	D	1109	407	4
Abdominoperineal repair	D	1110	508	10
With normal anal canal – abdominoperineal repair	D	1114	593	10
Destruction				
Cauterization of fissure	C	1118	15	4
Electrodesiccation of condylomata	C	1119	77	4
Manipulation				
Dilation of anal sphincter under general anaesthesia (independent procedure)	C	1120	15	4
Liver				
Incision				
Hepatotomy – exploratory	D	1121	305	8
Drainage of abscess or cyst	D	1122	305	8
Removal of foreign body	D	1123	305	8
Incision and packing of wound	D	1124	305	8
Excision				
Hepatectomy – local excision of lesion	D	1125	305	7
Left lobectomy	D	1126	678	12
Partial lobectomy	D	2562	447	12
Extended or complete right lobectomy	D	2563	823	12
Biopsy – needle	B	1953	38	4
Wedge/Open liver biopsy, add (when performed in addition to abdominal surgery)	B	2989	54	TU

Digestive system (continued)	List	Code	Units Gen	Units An
Repair				
Marsupialization of cyst or abscess	D	1128	305	7
Suture				
Rupture or wound	D	1129	305	7
Biliary tract				
Endoscopy				
Cholecystoscopy	B	2983	100	6
Endoscopy retrograde cholangiopancreatography (ERCP), +/- biopsy, +/- cytology	B	2875	202	6
– Endoscopic sphincterotomy, add	B	2894	90	TU
– Endoscopic placement of biliary or pancreatic duct stent, add	B	2895	77	TU
– Biliary lithotripsy, add	B	2984	77	TU
– Extraction of common bile duct stones, add	B	2896	77	TU
– Balloon dilatation of common bile duct or pancreatic duct stricture, add	B	2897	77	TU
– Nasobiliary drainage, add	B	2898	77	TU
Incision				
Cholecystostomy	D	1130	254	7
Cholecystoenterostomy, including enteroenterostomy	D	1131	400	7
Plus gastroenterostomy	D	2565	508	7
Cholecystogastrostomy	D	1133	305	7
Choledochoduodenostomy or choledochoenterostomy	D	1134	508	7
Common bile duct exploration	D	1135	407	7
With duodenotomy, sphincterotomy	D	1136	508	7
Plus sphincteroplasty, add	D	2566	58	TU
Plus pancreatogram, add	D	2567	58	TU
Plus internal drainage of pancreatic cyst, add	D	2568	255	TU
Plus external drainage of pancreatic cyst or abscess, add	D	2569	250	TU
Incision				
Open pancreatic biopsy, additional	B	2988	58	TU
Excision				
Lesion of hepatic ducts	D	1137	465	7
Excision of ampulla of Vater	D	1139	465	7
Cholecystectomy (by laparoscopy or laparotomy)	D	1140	339	7
With operative cholangiogram	D	1141	407	7
Cholecystectomy and exploration of bile duct	D	1142	420	7
With operative cholangiogram	D	1143	482	7
Plus duodenotomy	D	1144	524	7
Plus pancreatogram, add	D	2570	58	TU

Digestive system (continued)	List	Code	Units Gen	Units An
Plus internal drainage of pancreatic cyst, add	D	2571	255	TU
Plus external drainage of pancreatic cyst or abscess, add	D	2572	250	TU
Excision of gallbladder remnant or cystic duct remnant	D	2573	370	7
Plus cholangiogram, add	D	2574	58	TU
With exploration of common bile duct and cholangiogram	D	2575	539	7
Choledochoscopy in addition to bile duct surgery, add	D	1138	60	TU
Any bile duct surgery plus hiatal hernia repair, add	D	2576	193	TU
Repair				
Surgical reconstruction of common bile duct	D	1145	678	7
Transhepatic hepaticojejunostomy with stent (Rodney-Smith)	D	2577	786	12
Suture				
Closure of fistula	D	1146	423	7
Pancreas				
Incision				
Pancreatotomy	D	1147	425	7
Pancreatic abscess or cyst	D	1148	500	7
Excision				
Pancreatectomy – total	D	1149	1000	7
Local excision of lesion	D	1150	407	7
Distal pancreatectomy and splenectomy	D	1151	900	7
Pancreaticoduodenal resection (Whipple type operation)	D	1152	1000	12
Excision pancreatic cyst	D	1153	407	7
Repair				
Pancreatic cystogastrostomy	D	1154	510	7
Pancreatic cystoduodenostomy	D	1155	510	7
Pancreatic cystojejunostomy – side to side	D	1156	510	7
– Roux-en-Y	D	2578	580	7
Longitudinal pancreatic jejunostomy (Puestow)	D	2971	804	12
Marsupialization of cyst	D	1157	425	7
Abdomen, peritoneum and omentum				
Introduction				
Injection of air	B	1168	31	

Digestive system (continued)	List	Code	Units Gen	Units An
Endoscopy				
Peritoneoscopy (laparoscopy)	B	1169	105	6
Therapeutic laparoscopy with laser				
– including the first ½ hour	D	2975	169	6
– each additional ¼ hour	D	2976	30	TU

☞ ***Medicare Note: Laser treatment fees include intraoperative biopsies. The time elapsed must be noted on the claim form.***

Incision				
Diagnostic laparotomy with the finding of non-resectable cancer	B	1078	137	6
Laparotomy +/- biopsy	D	1158	192	6
Mini-laparotomy	D	2990	137	6
Lysis of adhesions	D	1033	IC	6

☞ ***Medicare Note: Service code 1033 applies only in cases of special difficulty (see Surgical Preamble, page 6/1). Normally no payment will be made under this code when the fees for concurrent procedures exceed 192 units, which is the fee for service code 1158.***

Multiple system trauma – laparotomy for acute trauma	D	2456	265	10
Post cancer treatment laparotomy, or staging laparotomy, for ovarian carcinoma	D	2954	350	7
Peritoneal abscess – drainage of subphrenic abscess	D	1159	305	7
Intraabdominal abscess, other	D	1160	300	6
Drainage of abdominal wall abscess, general anaesthetic	B	1161	46	4
Removal foreign body, abdominal wall				
Gun shot	D	1162	IC	6
Removal of deep infected sutures (not applicable to operating surgeon during postoperative period)	D	2188	92	4
Excision				
Desmoid tumor, depending on extent	D	1163	IC	4
Omentectomy (cancer related) with major surgery, add	D	2991	96	TU
Umbilectomy, plastic	D	1164	92	4
Lipectomy, removal of panniculus	D	1165	693	10

☞ ***Medicare Note: Abdominoplasty: See Plastic Surgical Preamble, page 20/1.***

Retroperitoneal tumor	D	1166	370	6
Mesenteric cyst	D	1167	231	6
Repair				

Digestive system (continued)	List	Code	Units Gen	Units An
Herniotomy and herniorrhaphy				
Inguinal or femoral – single	D	1170	250	4
– bilateral	D	1171	369	4
– bilateral – one primary, one recurrent	D	2579	424	4
Repair of congenital hernia with hydrocele				
Unilateral	D	1172	254	4
Bilateral	D	2580	370	4
Inguinal and femoral – same side	D	1173	254	4
Sliding hernia	D	1174	254	4
Inguinal or femoral repair by prosthesis or graft	D	1175	254	4
Recurrent hernia	D	1176	305	4
Bilateral	D	2581	424	4
Recurrent hernia repair by prosthesis or graft	D	1177	339	4
Preperitoneal approach for inguinal hernia repair	D	2582	254	4
Umbilical hernia – adult	D	1178	254	4
– child	D	1179	169	4
Enterocele, infant	D	1180	254	10
Omphalocele, infant	D	1181	339	10
Diaphragmatic hernia	D	1182	424	12
With prosthesis	D	1183	465	12
Transabdominal repair of diaphragmatic rupture	D	977	500	13
Incisional or ventral hernia – repair by suture	D	1184	305	6
– repair by prosthesis	D	1185	339	6
Recurrent incisional or ventral	D	2583	365	6
With prosthesis	D	2584	400	6
Repair of ventral hernia at same session as a definitive intraabdominal procedure, add	D	2585	153	TU

☞ ***Medicare Note: Service codes 1184, 1185 and 2585 apply also to the repair of a diastasis recti exceeding 5 cm.***

Epigastric hernia	D	1186	185	4
Strangulated or incarcerated hernia				
Without resection	D	1187	339	6
With resection	D	1188	500	6
Suture				
Secondary closure for evisceration	D	1189	154	6

Endocrine System

	List	Code	Units Gen	Units An
See Legend – Pg. 3/13 for description of list A, B, C and D.				
Thyroid gland				
Incision				
Abscess, complete care	D	1190	92	4
Excision				
Fine needle aspiration	B	1754	31	4
Biopsy – needle	B	1191	31	4
– surgical	D	1192	185	6
Thyroidectomy				
Bilateral total thyroidectomy	D	1193	550*	8
Total lobectomy	D	1194	400*	8
Subtotal bilateral thyroidectomy	D	1195	360	8
Partial lobectomy	D	1196	305	8
Excision of solitary nodule	D	1197	284	8
If one of the following procedures is carried out with codes 1193 to 1197, add:				
Limited node dissection – unilateral	D	1198	101	TU
– bilateral	D	1199	204	TU
Radical neck dissection, unilateral	D	1200	296	14
Parathyroid, thymus and adrenal glands				
Excision				
Parathyroidectomy for hyperplasia	D	1201	500*	10
Parathyroid tumor	D	1202	438*	10
If sternal splitting required	D	1203	508	12
Thymectomy	D	1204	508	12
Adrenal exploration, unilateral	D	1205	254	10
Adrenal functional tumor (pheochromocytoma)	D	1223	308	17
Adrenalectomy, unilateral	D	1206	424	10

Urological Procedures

See Legend – Pg. 3/13 for description of list A, B, C and D.

The fee for a urological surgical procedure shall include the usual postoperative care as carried out by the operating surgeon in accordance with paragraph (7) of "Surgical Services" of the General Preamble, pages 3/7. The surgical fee shall include certain preoperative care as outlined in Assessment Rule 25.

	List	Code	Units Gen	Units An
Kidney and perinephrium				
Endoscopy				
Renal pelvis – endoscopic brush biopsy, to include cystoscopy	B	1267	196	4
Operative nephroscopy	D	1731	308	7
In conjunction with another procedure, add	D	1732	60	TU
Incision				
Drainage of kidney abscess, including excision of carbuncle	D	1211	231	7
Drainage of perinephric abscess	D	1212	154	7
Adrenal exploration, unilateral	D	1213	303	10
Renal exploration or open renal biopsy	D	1214	231	7
Nephrostomy	D	1215	269	7
Nephrolithotomy	D	1216	350	7
For staghorn calculus filling renal pelvis and calyces, to include x-ray control	D	2345	440	7
Transection of aberrant renal vessel	D	1217	269	7
Secondary operation – additional	D	1218	77	TU
Pyelostomy	D	1219	269	7
Cutaneous pyelostomy, unilateral	D	1982	308	7
Pyelolithotomy	D	1220	308	7
With diversion of urine	D	1221	350	7
Coagulum pyelolithotomy, unilateral	D	1730	370	7
Excision				
Renal cyst	D	1224	269	7
Heminephrectomy	D	1225	450	7
Nephrectomy – ectopic	D	1227	440	7
Lumbar	D	1228	375	7
Transperitoneal	D	1229	368	7
Thoracoabdominal	D	1230	500	13
Radical – lumbar or thoracoabdominal	D	1231	545	13
Nephroureterectomy	D	1232	440	10
With resection of ureterovesical junction	D	1233	609	10
Renal transplantation				
Donor nephrectomy – live	D	2071	368	8
– cadaver, uni or bilateral	D	2072	368	8

Urological procedures (continued)

	List	Code	Units Gen	Units An
Return travel time for purposes of performing a donor nephrectomy – detention fee basis		200	(Page 4/4)	
Total nephrological management of donor	D	2073	215	
Supervision of renal perfusion only	C	2074	72	
Transplantation, total surgical care	D	2075	715	13
Nephrological component of transplantation	D	2076	215	
Repair				
Pyeloureteroplasty or endoscopic pyleoplasty	D	1235	381	7
Nephropexy	D	1236	231	7
With renal sympathectomy	D	1237	308	7
Symphysiotomy for horse shoe kidney +/- nephropexy and associated procedures	D	1238	440	7
Renal hypothermia – additional	D	1239	38	TU
Suture				
Ruptured or lacerated kidney – repair or removal	D	1241	323	8
Ureter				
Extra Corporeal Lithotripsy (ESWL) (Consultation payable in addition, if applicable)	D	1815*	300	6
Endoscopic procedures				
Calibration and/or dilation, one/both sides	B	1263	62	4
Removal of calculus including ureteral meatotomy if required (basket extraction)	D	1264	204	4
Manipulation only, stone not removed	D	1265	120	4
Therapeutic ureteroscopy				
Therapeutic ureteroscopy for removal of calculi, including ureteral dilation	D	1278	286	6
– plus basket extraction, add	D	1269	77	TU
– plus stent insertion, add	D	1270	115	TU
– plus ultrasound or electrohydraulic lithotripsy, add	D	1271	77	TU
Percutaneous procedures				
Establishment of nephrostomy tract for stone extraction	B	2121	340	6
– with simultaneous extraction of renal stone under fluoroscopy, add	D	2058	133	TU
Endoscopic removal of stones through percutaneous tract, first attempt	D	1272	254	6
Subsequent attempts to remove stones for same illness per session	D	1273	190	6
– removal or attempt using ultrasound or electrohydraulic lithotripsy, add	D	1276	77	TU

Urological procedures (continued)

	List	Code	Units Gen	Units An
Incision				
Periureteral abscess	D	1242	308	6
Ureterotomy, including ureterolithotomy				
Upper two-thirds	D	1243	308	6
Lower one-third	D	1244	370	6
Excision				
Ureterectomy	D	1245	269	6
Including ureterovesical junction	D	1246	331	6
Repair				
Ureterovesical anastomosis, reimplantation	D	1247	407	6
Ureterocolic anastomosis or transplant	D	1250	346	7
With cystectomy, one stage	D	1251	554	11
With cystectomy and colostomy	D	1252	646	11
Ileoureteral substitution	D	1253	462	7
Ureteroileal conduit – total procedure	D	1248	554	9
Team procedure – urologist	D	2166	346	9
Preparation of stoma, add	D	2167	45	
Preparation of intestinal segment	D	2168	339	
Cystectomy, additional to ileoureteral surgery	D	1249	254	
Revision of ureterointestinal anastomosis	D	2346	370	7
Ureteroureterostomy	D	1254	385	6
Transureteroureterostomy	D	1734	462	7
Ureterostomy, cutaneous – unilateral	D	1255	308	6
Ureterovaginal fistula	D	1256	370	6
Ureterolysis for periureteral fibrosis, unilateral	D	1257	308	6
Spontaneous or traumatic rupture or transection				
Immediate – upper two-thirds	D	1259	269	6
– lower one-third	D	1260	308	6
Late repair – upper two-thirds	D	1261	308	6
– lower one-third	D	1262	346	6

Bladder

Cystoscopy **(See also Assessment Rule 32)**				
Diagnostic – this service includes catheterization of ureters, calibration of ureters, injection of opaque medium for pyelography and ureterography (retrograde pyelogram), collection of ureteral specimens of urine (split function test, Howard's test, intravenous function tests), urethroscopy, calibration and dilation of urethra, and bimanual examination	B	1266	69	4
With meatotomy and plastic repair	D	1281	110	4

Urological procedures (continued)

	List	Code	Units Gen	Units An
☞ ***Medicare Note: Diagnostic cystoscopy done in conjunction with code 1274, 1275 or 1394 is payable once during the 30-day preoperative period and at 75% of the listed fee if performed on the same day of surgery.***				
Therapeutic – this service includes simple electrocoagulation of tumors and of Hunner's ulcer, resection of the bladder neck in the female, electrosurgical meatotomy of ureteral orifice, removal of foreign body or calculus, evacuation of clot and biopsy. Simple meatotomy, dilation of urethra etc., if required, are included in this service	D	1277	162	4
With electroexcision of tumors including base and adjacent muscles – single	D	1274	238	5
– multiple	D	1275	339	5
With insertion of radioactive substance in addition to associated procedures, add	D	1279	38	TU
Litholapaxy, visual or tactile, and removal of fragments	D	1280	185	4
Insertion of Gibbon's stent or indwelling J catheter	D	1753	231	6

			P	T
Urodynamic studies				
Cystometrogram, complete study	B	2077	23	46
Electromyography	B	2078	23	46
Urethral pressure study	B	2079	30	60
Urinary flow study	B	2080	7	14
Trans-abdominal ultrasound for determination of bladder volume	B	8604*	5	10

(P, T = professional, technical components)

			Gen	An
Incision				
Cystotomy or cystostomy (Please indicate whether cystotomy or cystostomy when billing with other procedures)	D	1282	115	5
With electrocoagulation of tumor	D	1283	231	5
Cystotomy with trochar and cannula and insertion of tube	B	1284	54	4
Cystolithotomy	D	1285	154	5
Excision				
Ureterocelectomy	D	1286	231	5
With ureteral reimplantation	D	1287	370	5

Urological procedures (continued)

	List	Code	Units Gen	Units An
Cystectomy, partial – for atony	D	1288	308	6
For tumor or diverticulum	D	1289	370	6
With reimplantation of ureter	D	1290	415	6
Cystectomy or prostatocystectomy, total	D	1291	370	11
Additional to ileoureteral surgery	D	1249	254	
With colocystoplasty	D	1292	616	11
Second surgeon	D	1293	154	
Radical cystectomy, to include hysterectomy in the female, and seminal vesicles and prostate in the male	D	1268	609	8
Ileal-Neo Bladder	D	8603*	900	9
Excision of urachus and repair of bladder	D	1294	231	6
Repair				
Exstrophy – primary closure	D	1295	308	6
Urinary diversion for bladder exstrophy and excision of ectopic bladder and repair of abdominal wall	D	1296	616	6
Excision of bladder and repair of abdominal wall	D	1297	231	6
Cutaneous vesicostomy	D	1984	308	6
Repair of ruptured bladder	D	1298	277	6
Ileocystoplasty (or colocystoplasty)	D	1299	462	7
Boari flap +/- psoas hitch	D	1733	462	6
Suprapubic resection of bladder neck	D	1300	231	6
Plastic repair of bladder neck (child-adult)	D	1301	308	6
With ureteroneocystostomy – unilateral, add on	D	1302	77	TU
– bilateral, add on	D	1303	154	TU
Closure of fistula – external, suprapubic	D	1304	185	5
Vesicovaginal – transvesical approach	D	1305	415	6
Vesicorectal or vesicosigmoid	D	1306	308	6
Vesicopexy, with fixation of anterior vesical wall	D	1208	370	5
Fascial Wall Sling	D	8600*	550	5

Urethra

Endoscopy				
Biopsy including endoscopy	B	1307	46	4
Internal urethrotomy	D	1308	92	4
Removal of foreign body or calculus	D	1309	115	4
Meatal extraction of foreign body	C	1310	23	4
Incision				
Urethral sphincterotomy	D	2170	254	4
Urethrotomy – external	D	1311	185	4
– internal, under direct vision	D	2862	185	4
Meatotomy and plastic repair	C	1312	54	4

Urological procedures (continued)

	List	Code	Units Gen	Units An
For extravasation of urine with multiple drainage	D	1313	185	4
With external urethrotomy or cystotomy	D	1314	277	4
Periurethral abscess	C	1315	38	4
Excision				
Caruncle	C	1316	54	4
With cystoscopy	D	1317	92	4
Urethral papilloma, single or multiple	D	1318	92	4
Prolapse	C	1319	62	4
With cystoscopy	D	1320	92	4
Stricture – one stage, with diversion	D	1321	277	4
– two stage – first stage	D	1322	139	4
– second stage	D	1323	277	4
Diverticulectomy – male or female	D	1324	192	4
Posterior urethral valve – by endoscopy	C	1325	77	4
Open operation	D	1326	192	4
Biopsy	B	1327	23	4
Urethrectomy, total	D	1985	308	4
Repair				
Artificial urinary sphincter implant	D	1207	500	5
Urethral sling	D	1328	231	4
Urethrovesical suspension for stress incontinence	D	1329	277	5
With partial cystectomy	D	1330	370	5
Laparoscopic bladder suspension	D	8341	356	5
Surgical prosthesis for incontinence	D	1986	308	4
Urethroplasty	D	1987	IC	4
(Johanson) each stage	D	2298	310	4
One-stage patch urethroplasty	D	1729	370	4
Peri-urethral collagen injections for the correction of incontinence	D	836	225	4
Suture				
Rupture – anterior urethra (diversion of urine extra)	D	1331	185	4
Posterior urethra – immediate repair	D	1332	323	4
– late repair	D	1333	462	4
Membranous urethra	D	1334	277	4
Rectourethral fistula	D	1335	308	6
With colostomy	D	1336	385	6
Manipulation				
Dilation of stricture – local anaesthetic	A	1337	15	
General anaesthetic	A	1338	38	4
Filiforms and followers	A	1339	28	

Male Reproduction System

	List	Code	Units Gen	Units An
See legend – Pg. 3/13 for description of list A, B, C and D.				
Penis				
Cytology				
Cytology, using colposcopic technique. Includes biopsies and curetting	B	1957	32	
Incision				
Preputiotomy – newborn	C	1340	8	
– infant or child under 12 years	C	1341	8	4
– adult	C	1342	15	4
Reduction of paraphimosis, including dorsal slit – general anaesthesia	C	2084	38	4
Excision				
Circumcision – surgical removal of foreskin	D	1345	162*	4
Penile frenotomy – general anaesthetic	C	2085	38	4
Condylomata	C	1346	38	4
Biopsy	B	1347	23	4
Amputation				
Partial	D	1348	231	4
With inguinal glands dissection – 1 or 2 stages	D	1349	370	5
Total with inguinal and femoral glands dissection – 1 or 2 stages	D	1350	462	5
Repair				
Plastic reconstruction following circumcision	D	2086	116	4
Epispadias	D	1351	231	4
Hypospadias – including urinary diversion				
Chordee repair – first stage	D	1352	154	4
Plastic reconstruction of urethra – penile	D	1353	269	4
Penoscrotal or perineal	D	1354	346	4
Closure of urethrocutaneous fistula	D	1355	154	4
Priapism, vascular shunt, single surgeon or team procedure	D	1988	231	4
Penile prosthesis for impotence	D	2347	154	4
Inflatable penile prosthesis				
– insertion or reinsertion	D	8339	340	4
– removal	D	8340	255	4
☞ ***Medicare Note: Reinsertion fee includes the removal of original prosthesis.***				
Excision of Peyronie's Plaque	D	8601	194	4
Nesbit procedure for Peyronie's Disease	D	8602	350	4

Male reproduction system (continued)

	List	Code	Units Gen	Units An
Testes				
Incision				
Abscess	C	1356	38	4
Excision				
Orchidectomy – unilateral	D	1357	139	4
Radical for malignancy (complete removal of cord to internal inguinal ring)	D	2348	250*	4
Biopsy – single	B	1358	38	4
With vasography	D	1359	77	4
Repair				
Orchidopexy or exploration of testis by inguinal approach, unilateral	D	1360	277	4
Reduction of torsion of testis or appendix testis and repair	D	1361	139	4
Ruptured testicle	D	1362	139	4
Testicular prosthesis for congenital defect	D	2349	123	4
Epididymis				
Incision				
Abscess	C	1363	38	4
Excision				
Spermatocele	D	1364	139	4
Epididymectomy, unilateral	D	1365	139	4
Anastomosis, epididymovasostomy, unilateral	D	1366	139	4
Tunica vaginalis				
Excision				
Hydrocele, unilateral	D	1367	139	4
Aspiration	B	1368	8	
Scrotum				
Incision				
Abscess or haematocele	C	1369	38	4
Exploration, unilateral	D	1370	92	4
Suture				
Trauma – laceration – depending on extent and complications (see lacerations, Integumentary System)	D	1371	IC	4

Male reproduction system (continued)

	List	Code	Units Gen	Units An
Vas deferens				
Vasography – single procedure	C	1372	38	4
Repair				
Anastomosis, unilateral	D	1373	130	4
Including biopsy and vasography	D	1374	177	4
Suture				
Ligation, bilateral (vasectomy)	C	1375	132	4
Spermatic cord				
Excision				
Hydrocele – single	D	1377	139	4
Varicocele – single	D	1376	139	4
High ligation through retroperitoneum	D	2863	228	6
Seminal vesicles				
Incision				
Abscess	D	1378	77	4
Excision				
Vesiculectomy	D	1379	462	4
Prostate				
Incision				
With drainage of abscess	D	1380	77	4
With removal of calculus (perineal)	D	1381	269	4
Biopsy, perineal – open operation	D	1382	154	4
Needle	B	1383	62	4
With cystoscopy	B	1384	101	4
Ultrasound of prostate	B	1209	77	4
With needle biopsy	B	1210	108	4
Excision				
Perineal	D	1385	370	7
Radical	D	1386	462	7
With vesiculectomy	D	1387	554	7
Suprapubic – one stage or two stages	D	1388	407	7
With diverticulectomy	D	1389	508	7
With partial cystectomy for atony of bladder	D	1390	508	7
Retropubic – simple	D	1391	407	7
Radical	D	1392	508	7

Male reproduction system (continued)

	List	Code	Units Gen	Units An
With vesiculectomy	D	1393	609	7
Endoscopy				
Transurethral electroresection	D	1394	427	6
Transurethral drainage	C	1395	77	5
Resection of bladder neck – child	D	1396	153	5
– adult	D	1397	254	5

Female Reproduction System

	List	Code	Units Gen	Units An
See Legend – Pg. 3/13 for description of list A, B, C and D.				
Abortion				
Incomplete. Examination of uterus without D & C or anaesthesia (in hospital procedure only)	C	1398	50	0
Complete			VF	
Incomplete, including D & C (prenatal visits extra according to office schedule)	D	1400	100	4
Therapeutic – including saline or prostaglandin induction	D	1401	125	4
Hysterotomy, abdominal or vaginal	D	1402	192	6
Operative delivery				
Caesarean section (restricted to Spec. Obs/Gyn)	D	8701	513	8
Caesarean section	D	1404	425	8
Caesarean hysterectomy, subtotal or total (restricted to Spec. Obs/Gyn)	D	8702	600	10
Caesarean hysterectomy, subtotal or total	D	1405	600	10
Operative delivery, other than by caesarean section (restricted to Spec. Obs/Gyn)	D	8703	447	7
Operative delivery, other than by caesarean section	D	1406	370	7
Multiple births, either vaginal or caesarean section deliveries – per additional birth, add	D	1413	50	TU
Repair of perineal, cervical or vaginal lacerations (intrapartum) – consultation and procedure	D	1407	77	7
Retained placenta removal – consultation and procedure	D	1408	77	7
Surgical or medical induction of labor – consultation and procedure, one or more attempts	C	1409	55	5

☞ ***Medicare Note*: *Delivery fees include attendance during prolonged labour. Codes 1407 and 1408 are not payable in addition to a delivery fee to the same physician. Similarly, code 1409 is not payable if delivery or caesarean section follows within three days.***

Suture of incompetent cervix during pregnancy	D	1411	154	4
Intrauterine foetal transfusion	D	1412	192	
External Cephalic Version	C	8704*	100	
Amniocentesis	B	1414	50	
Prenatal scalp sampling, total fee for first and subsequent pH samplings	B	2953	50	
Insertion of an intra-uterine pressure catheter	B	1811	50	
Oxytocin challenge test	A	2350	23	

Vulva

Female reproduction system (continued)

	List	Code	Units Gen	Units An
Incision				
Hymenectomy – local anaesthesia	C	1415	23	
– general anaesthesia	C	1416	38	4
Abscess of vulva, Bartholin or Skene's gland				
Complete care	C	1417	38	
Local anaesthesia	C	1418	38	
General anaesthesia	C	1419	38	4
Marsupialization or cautery	C	1420	38	4
Excision				
Superficial laser destruction of vulvar lesions			(page 5/12)	
Vulvectomy – simple	D	1421	185	6
Radical – without gland dissection	D	1422	269	6
– with complete bilateral gland dissection	D	1423	462	6
Cyst of Bartholin's gland	D	1424	92	4
Clitoris – amputation	D	1425	92	4
Condylomata	D	1426	77	4

Vagina

Incision				
Colpotomy, posterior, drainage or needling	C	1427	70	4
Excision				
Local excision of cyst	D	1428	108	4
Repair				
Cystocele or rectocele	D	1429	174	4
Cystocele and rectocele	D	1430	300	4
Cystocele, rectocele and prolapse (Fothergill)	D	1431	308	4
Cystocele, rectocele and excision of cervical stump	D	1432	308	4

☞ ***Medicare Note: For codes 1429 to 1431 please indicate cystocele or rectocele on claim.***

Vaginal vault prolapse (posthysterectomy, vaginal or abdominal	D	1433	348	4
Colposacropexy for vaginal vault prolapse	D	2973	450	7
Rectocele and repair of anal sphincter	D	1434	277	4
Perineorrhaphy	D	1435	102	4
Colpocleisis (LeFort)	D	1436	277	4
Operation for artificial vagina	D	1437	308	6
Repair of double vagina	D	1438	139	4
Closure of fistula – vesicovaginal	D	1439	308	6
– rectovaginal	D	1440	308	6
– ureterovaginal	D	1441	370	6
Urethral caruncle or prolapse of mucosa	D	1442	62	4
Enterocele	D	1443	319	5

Female reproduction system (continued)

	List	Code	Units Gen	Units An
Retropubic operation for incontinence (Marchetti) ...	D	1444	277	5
Ureterolysis for release of ureteric obstruction – Laparotomy or Laparoscopy	D	1257	308	6
Haematoma – evacuation, local anaesthesia	C	362	15	
Evacuation of vulvar or vaginal haematoma, general anaesthesia	C	2851	85	4
Repair of lacerations			(page 7/3)	
Perineal release/double Z-plasty	D	8335	300	4
Manipulation				
Examination and/or dilation, general anaesthesia (independent operation)	C	1445	31	4

Fallopian tubes

Endoscopy				
Culdoscopy	C	1446	77	4
Incision				
Ectopic pregnancy – management by conservative surgical technique	D	1792	311	6
Excision				
Salpingectomy and salpingo-oophorectomy (uni or bilateral)	D	1447	261	6
Repair				
Tubal plastic operation	D	1448	261	6
Sterilization, abdominal or vaginal (full fee payable in addition to delivery, 50% if with caesarean section)	D	1449	157	6

☞ ***Medicare Note: Please indicate abdominal or vaginal when billing other procedures.***

Ovary

Excision				
Ovarian cyst	D	1450	231	6
Paraovarian cyst	D	1451	231	6
Wedge biopsy – ovaries	D	1760	231	6
Post-cancer treatment laparotomy, or staging laparotomy, for ovarian carcinoma	D	2954	350	7

Uterus and cervix uteri

Incision

Female reproduction system (continued)

	List	Code	Units Gen	Units An
Hysterotomy	D	1452	231	6
Excision				
Diagnostic curettage	B	1453	81	4
Myomectomy	D	1454	277	6
Hysterectomy				
Laparoscopic assisted Vaginal Hysterectomy	D	835	425	6
Total – abdominal (restricted to spec Obs/Gyn)	D	8700	334	6
Total – abdominal	D	1455	325	6
Vaginal	D	1456	328	6
Abdominal or vaginal with rectocele and/or cystocele repair	D	1457	405	6
☞ ***Medicare Note: Please indicate abdominal or vaginal when billing other procedures.***				
Partial or subtotal +/- adnexae	D	1458	231	6
With rectocele and/or cystocele	D	1459	308	6
Sacrospinous vault suspension, add	D	2974	77	TU
Radical (Wertheim)	D	1460	539	8
Extended Hysterectomy with staging	D	1817	473	6
Para-aortic node sampling (add on)	D	1818	110	--
Septate uterus	D	1461	308	6
Cervical polyp, without D & C	B	1462(1)	15	4
Amputation of cervix	D	1463	139	4
Cervical stump – vaginal	D	1464	185	4
– abdominal	D	1465	231	6
Biopsy of cervix, vagina or vulva under general anaesthesia	B	1466	38	4
Hydrocele of canal of Nuck	D	1467	92	4
Presacral neurectomy	D	1468	277	6
Transcervical endometrial resection/ablation	D	1835	328	6
(1) These codes are payable at 100% of the fee whenever eligible for payment.				
Introduction				
Insufflation, Rubin's test	C	1469	31	4
Paracervical block for pelvic evaluation	B	1803	38	--
Endometrial biopsy	B	1470(1)	20	4
Hysterosalpingogram	B	2164	63	
I U C D – insertion	B	1472(1)	25	4
– removal	C	2852	15	
Diaphragm fitting	A	1723	13	
Endoscopy				
Hysteroscopy – Diagnostic, +/- D and C, +/- biopsy	B	2977	90	4
Therapeutic Hysteroscopy	D	2978	162	4
Hysteroscopic resection endometrial or myometrial				

Female reproductive system (continued)	**List**	**Code**	**Units Gen**	**Units An**
tumors	D	1836	339	6
Colposcopy				
Screen	C	2419	8	
Investigation of abnormal cytology under colposcopic technique including biopsies and curetting	B	2420	48	
Laser conization of cervix or loop electrosurgical excision procedure of the cervix including same day colposcopy	B	2930	113	4
Laser conization within 30 days of prior colposcopy or conization	B	2931	77	4

☞ ***Medicare Note: Consultations on referred cases are payable in addition to codes 2930 and 2931 unless a consultation fee has been paid in the preceding 30 days.***

Repair				
Suturing of vagina, cervix or vulva under general anaesthesia (extra partum)	D	1722	85	6
Hysteropexy (uterine suspension)	D	1473	192	6
With D & C	D	1474	277	6
With rectocele and cystocele	D	1475	308	6
Cervix +/- biopsy	D	1476	139	3
Incompetent cervix – any suture repair	D	1477	154	4
Repair of inversion of uterus – operative	D	1478	277	4
– manual	D	1479	115	4
Interposition operation	D	1480	308	4
Electrocautery of cervix, office procedure	B	1481(1)	15	
Cryotherapy or laser treatment of cervix for condylomata	C	2351	30	4
Biopsy of vagina, cervix or vulva – office procedure	B	1482(1)	15	
Conization of cervix	D	1483	92	4
Insertion of radium – per application	D	1484	154	4

(1) These codes are payable at 100% of the fee whenever eligible for payment.

Neurosurgical Procedures

See Legend – Pg. 3/13 for description of list A, B, C and D.

Preamble

In cases of paraplegia and in cases of cerebral lesions, traumatic or other, treated surgically the schedule of fees for daily visits is added to the surgical fee after one month of hospitalization.

☞ ***Medicare Note: The normal postoperative period is *30 days.***

	List	Code	Units Gen	Units An
Peripheral nerves				
Nerve biopsy	B	1546	38	4
Primary suture, major nerve	D	1485	269	4
Exploration and neurolysis, or transposition, major	D	1486	192	4
Neurectomy – major nerve	D	1487	231	4
– minor nerve	D	1497	154	4
Secondary suture, major nerve	D	1488	269	4
Nerve graft	D	1503	314	4
Exploration brachial plexus	D	1489	385	5
Sciatic nerve exploration and neurolysis	D	1490	308	4
Entrapment syndrome	D	1491	154	4
Transplantation of neuroma	D	1504	154	4
Excision of tumor	D	1492	308	4
Neurovegetative system				
Sympathectomy – cervical	D	1493	308	6
– cervical thoracic	D	1494	385	10
– thoracolumbar (Smithwick)	D	1495	616	13
– lumbar	D	1496	254	6
Diagnostic and minor treatment procedures				
(See also "Diagnostic and Therapeutic Procedures" on page 21/1 and "Clinical Procedures" on page 22/1).				
Lumbar puncture	B	177	38	
Subdural tap	B	178	23	
Each additional tap	B	179	23	
Ventricular puncture	C	1500	77	4
Ventricular drainage (continuous)	D	1501	154	4
Cisternal puncture	B	180	46	
Myelogram	B	181	63	4
Pneumoencephalogram	B	182	107	5
Ventriculogram	B	1506	179	6
Echoencephalogram	B	173	15	

Neurosurgical procedures (continued)

	List	Code	Units Gen	Units An
Stimulation – dorsal column, visit fee included	C	2377	23	
Cerebellar, visit fee included	C	2378	38	
Transcutaneous (excludes acupuncture)				
Initial, including consultation, examination, etc ...	C	2379	77	
Subsequent, visit fee included	C	2380	23	

Cranial trauma

Skull				
Traction			(page 8/5)	
Operative treatment				
Simple depressed fracture – dura intact	D	1517	231	15
Dura lacerated	D	1518	385	15
Serious brain damage	D	1519	462	15
Compound depressed fracture – dura intact	D	1520	308	15
Dura lacerated	D	1521	462	15
Sinus involvement or serious brain damage (foreign body, haematoma, etc.)	D	1522	550	15
Decompressive craniectomy – subtemporal	D	1523	308	15
– suboccipital	D	1524	462	15
Diagnostic burr holes – initial	D	1525	154	15
– each additional	D	1526	77	
Craniotomy for orbital decompression	D	1527	539	15
Cranioplasty	D	1528	462	15
Meninges, surgical management of extradural haematoma, or subdural haematoma, hygroma, effusion – extradural	D	1529	616	11
Subdural – with burr holes	D	1530	462	11
– with craniotomy	D	1531	616	11
– child by repeated aspiration	D	1532	231	11

Spinal trauma (See also Musculoskeletal System)

Fracture of spinous process (surgical removal)	D	1533	115	8
Vertebral fracture, fracture-dislocation, dislocation or subluxation.				
Without cord injury – supervision bed rest			VF	
Operation reduction	D	2767	462	10
With internal fixations	D	1539	539	8
Operation reduction and fusion in conjunction with orthopaedic surgeon (neurosurgical fee)	D	1540	462	8
Cranioskeletal traction tongs	D	1541	250	5
With cord injury – supervision bed rest only			VF	
Operative reduction	D	1543	539	8
With internal fixations	D	1544	539	8
Operative reduction and fusion in conjunction				

Neurosurgical procedures (continued)

	List	Code	Units Gen	Units An
with orthopaedic surgeon (neurosurgical fee)	D	1545	462	8
Cranioskeletal traction tongs	D	1541	250	5
Instrumentation (excluding plate, wires, etc.)	D	8404*	1175	12

☞ ***Medicare Note: Instrumentation to include fractures, open dislocations, fusions, grafts and corporectomy.***

Skull lesions

Linear craniectomy for craniosynostosis – one suture ...	D	1547	308	11
Two sutures, total fee, one or two stages	D	1548	462	11
More than two sutures, total fee, one or more stages	D	2353	616	11
Excision of skull tumor	D	1549	385	11
With cranioplasty	D	2354	462	11
Craniectomy for osteomyelitis	D	1550	IC	11
Reopening of craniotomy for postoperative haematoma or infection, or for removal of bone or plate	D	2376	231	11
Craniotomy for hypertelorism	D	2355	616	15

Brain

Craniotomy – supratentorial approach – for removal of foreign body, cyst, tumor, pituitary tumor, intracerebral haematoma, lobectomy	D	1551	769	15
– infratentorial or basal approach	D	2957	1200	15
For excision of cortical scar for epilepsy	D	1552	769	15
For hemispherectomy	D	1553	769	15
For arteriovenous malformation	D	1554	1600	15
For obliteration of cerebral aneurysm	D	1555	1600	15
For brain biopsy	D	1556	616	15
For hypophysectomy or section of pituitary stalk	D	1557	769	15
For transsphenoidal hypophysectomy	D	2951	1160	15
For medullary or mesencephalic tractotomy	D	1558	769	15
For carotid-cavernous fistula	D	1559	769	15
For stereotactic destruction of nerve including ventriculography	D	2365	616	15
For cerebrospinal fluid rhinorrhea	D	1758	850	15
Craniotomy – use of operative microscope, add	D	2958	100	
Stereotactic biopsy of tumors, abscesses or other lesions	D	1837	450	15
Awake Craniotomy with Cortical mapping for brain tumor	D	8750*	1700	15
Brain abscess				
Craniotomy and total excision, complete care	D	2356	769	15
Burr hole and aspiration	D	2357	308	7
Subsequent	D	2358	154	7

Neurosurgical procedures (continued)

	List	Code	Units Gen	Units An
Subsequent aspiration	D	2359	77	7
Shunts for treatment of hydrocephalus – any type, including revision (ventriculoatrial, ventriculoperitoneal, lumboperitoneal, etc.), ventriculocisternostomy (Torkildsen)	D	1561	462	15
Removal of shunt	D	2360	154	10
As an additional procedure	C	1502	85	
Puncture of shunt reservoir for aspiration or injection procedure	D	2361	154	7
Stereotactic thalamotomy, pallidotomy, cingulotomy with depth recording and stimulation	D	1563	616	15
Puncture for aspiration or tumor biopsy (including burr hole)	D	1564	231	7
Lobotomy	D	1565	231	15
Implantation of cerebellar stimulators	D	2362	154	15
Implantation of pressure recording device catheter or transducer for monitoring	D	2363	154	15
Subsequent revision or replacement	D	2364	38	7

Vascular procedures

Silverstone clamp or ligation of carotid	D	1566	308	15
Carotid endarterectomy	D	1973	700	15
With patch graft	D	1568	764	15
With graft and bypass shunt	D	1569	828	15
Cerebral artificial embolization – extracranial	D	1570	385	15
– intracranial	D	1571	616	15
Vertebral endarterectomy with patch graft	D	1572	539	15
Intracranial arterial reconstructive surgery (embolectomy, endarterectomy, etc.)	D	1573	769	15
Cerebral revascularization – extracranial-intracranial microvascular anastomosis	D	1560	1040	15

Spinal cord

Laminectomy – for excision of neoplasm, haematoma, vascular anomaly, constrictive pachymeningitis of spinal cord or nerve roots	D	1574	539	8
For opening of dura and exploration or biopsy of cord or nerve roots or section of denticulate ligaments	D	1575	539	12
For decompression of spinal cord or cauda equina	D	1576	539	8
For treatment of epidural abscess	D	1577	539	8
For exploration of syringomyelic cavity	D	1578	539	12
For spinothalamic tractotomy (cordotomy)	D	1579	462	8
For anterior or posterior rhizotomy	D	1580	462	8

Neurosurgical procedures (continued)

	List	Code	Units Gen	Units An
For rhizotomy for spasmodic torticollis including spinal accessory nerve	D	1581	539	9
Multiple level laminectomies	D	821	639	8
Implantation of spinal cord stimulator – permanent	D	2366	539	8
Temporary (percutaneous)	D	2367	231	8
Removal or revision of cord stimulator	D	2368	231	8
Percutaneous cordotomy (lesion generator)	D	2950	350	6
Excision of meningocele	D	1582	308	12
Excision of myelomeningocele or encephalocele	D	1583	462	12
Myelotomy, unilateral or bilateral	D	2369	539	8
Cranial nerves				
Posterior fossa craniectomy – with rhizotomy	D	1584	616	15
With grafting VII nerve	D	1585	539	15
Microvascular decompression of trigeminal nerve	D	1757	900	15
Percutaneous trigeminal rhizotomy	D	2948	300	6
Revision within 60 days	D	2949	225	6
Nerve anastomosis – facial-hypoglossal or facial-accessory nerve	D	1586	385	6
Subtemporal craniectomy – with rhizotomy of V nerve	D	1587	539	15
With decompression of Gasserian ganglion	D	1588	539	15
Extracranial section of spinal accessory nerve and/or other peripheral nerve for treatment of spasmodic torticollis	D	1589	231	6
Avulsion of mandibular, supraorbital, infraorbital, occipital nerves	D	1590	92	4
Chemical destruction	C	1591	54	
Discs				
Cervical				
Removal of protrudes disc – unilateral	D	1592	539	10
Bilateral, multiple or recurrent	D	1593	650	10
Anterior disc and fusion – one space	D	1594	539	10
– two spaces	D	1595	650	10
Thoracic – removal of protruded disc	D	1596	539	10
Transthoracic removal of disc lesion	D	2370	539	13
Lumbar – unilateral	D	1597	385	8
– bilateral, multiple or recurrent	D	1598	539	8
Removal of disc or laminectomy in conjunction with orthopaedic surgeon for fusion – unilateral	D	1599	385	8
Bilateral,, multiple or recurrent	D	1600	462	8
Chemonucleolysis under fluoroscopic control	D	1759	250	6

Operations on the Eye

	List	Code	Units Gen	Units An
See legend – Pg. 3/13 for description of list A, B, C and D.				
All major surgical procedures include 30 days postoperative care.				
☞ ***Medicare Note: No additional fee is payable for the use of an operative microscope in the performance of ophthalmological procedures.***				
Surgical removal of the eye				
Evisceration of ocular contents – without implant	D	1646	192	5
With implant +/- attachment of muscles	D	1647	231	5
Enucleation of eyeball – without implant	D	1643	192	5
With implant +/- attachment of muscles	D	1644	231	5
Secondary procedures on implant	D	1645	154	5
Removal of donor eyes	C	2470	80	
Corneal – Scleral rim removal	C	2994	154	---
Preservation of corneal tissue	C	2995	115	---
Exenteration of orbit +/- skin graft				
Removal of orbital contents +/- skin graft	D	1660	462	5
With therapeutic removal of orbital bone	D	1661	616	5
With temporalis muscle transplant	D	2189	462	5
Operations on extraocular muscles				
Strabismus surgery – one or more muscles	D	1655	387*	6
Subsequent operations, within three months	D	1656	115	6
Biopsy	D	2190	231	5
Removal of lesion	D	2191	231	5
Repair of muscles after trauma	D	2192	231	5
Other operations on orbit				
Orbital abscess, incision and drainage	D	1657	154	5
Orbital exploration	D	1658	385	5
Removal of orbital tumor or lesion	D	1659	385	5
Orbitotomy with removal of intraorbital foreign body	D	1662	231	5
Retro-orbital injection	C	1663	38	
Reduction of orbital floor fracture +/- plasty of floor of orbit	D	2241	269	8
Orbital rim – closed reduction	D	2193	115	4
– operative reduction	D	2194	231	4
Eyelids				
Trichiasis epilation	A	1624	8	
Electrolysis and/or cryotherapy	C	1625	23	4
Botulinum oculin toxin injection for blephrospasm	C	2992	50	---

Operations on the eye (continued)

	List	Code	Units Gen	Units An
Abscess, incision and drainage	C	1626	15	4
Chalazion or tarsal cyst – local anaesthesia	C	1627	25	
– general anaesthesia	C	2415	38	4
Canthotomy division of canthus with sutures	C	1628	23	4
All plastic operations on lid or orbit				
Minor	D	1630	48	5
Major	D	1631	318	5
Ptosis – lid suspension or levator resection	D	2266	225	5

☞ ***Medicare Note: Blepharoplasty: see plastic surgical preamble, page 20/1.***

Tarsorrhaphy	D	2195	115	4
Repair of ectropion or entropion				
Simple, Ziegler operation, office procedure	C	2267	38	
Full thickness horizontal shortening of lid ect/ent	D	2268	150	4
Excision and full thickness reconstruction of lid for malignant tumor, total care				
Up to and including 1/3 of lid	D	2271	150	5
Greater than 1/3 of lid	D	2272	385	5
Repair trauma of eyelid – repair laceration	D	2227	46	5
Repair full thickness	D	2196	154	5

Nasolacrimal system

Dilatation, probing or irrigation, office procedure				
Single	A	1633	15	
Bilateral	A	1634	23	
Probing lacrimal duct, uni or bilateral – general anaesthetic	C	1635	49	4
Lacrimal sac abscess – incision	C	1636	38	4
Dacryocystectomy	D	1637	231	5
Dacryocystorhinostomy	D	1638	366	5
Lacrimal gland excision	D	1639	231	5
Intubation nasolacrimal duct	C	1640	54	4
Repair of torn canaliculus	D	1641	231	5
Conjunctivorhinostomy +/- tube	D	2197	308	5
Repair of fistula	D	2198	269	5
Minor operations on punctum	C	2199	23	5
Injection for radiography	C	2277	23	

Conjunctiva

Subconjunctival or sub-tenon injection	A	1601	15	4
Wound suture	C	1602	23	4
Excision pterygium	D	1603	102*	4
Peritomy	D	1604	54	4

Operations on the eye (continued)

	List	Code	Units Gen	Units An
Biopsy of conjunctiva	B	1605	54	4
Grattage (scraping of conjunctiva for trachoma follicles)	C	1606	23	4
Rolling of conjunctiva follicles	C	1607	23	4
Gunderson's flap	D	1608	269	4
Purse string conjunctival flap	D	1609	115	4
Free graft of conjunctiva	D	1610	77	4
Buccal mucous membrane	D	1611	115	4
Excision of malignant lesion, conjunctiva	D	2296	154	4
With graft	D	2297	231	4
Division of symblepharon	D	2374	154	4
Removal of subconjunctival foreign body	C	2385	23	4
Reconstruction of cul-de-sac +/- graft	D	2386	231	4
Incision and drainage	C	2387	38	4
Sclera				
All penetrating wounds +/- prolapse	D	1621	310	6
Repair of staphyloma	D	2388	308	6
Cornea				
Cauterization of corneal ulcer – chemical, thermal, electric or mechanical	C	1612	15	4
Penetrating wounds of cornea +/- iris prolapse	D	1613	310	6
Paracentesis of aqueous	C	1614	38	4
Superficial keratectomy	D	1615	231	6
Lamellar keratoplasty	D	1616	385	6
Penetrating keratoplasty	D	1617	571	6
Penetrating graft combined with cataract extraction	D	2389	600	6
Dermoid cyst	D	1618	115	6
Keratotomy	C	1619	38	6
Removal of foreign body embedded in cornea by magnet	C	1620	38	4
Biopsy	B	2390	54	4
Diagnostic scraping	C	2395	15	4
EDTA or similar treatment	C	2396	23	4
Operations for glaucoma				
Posterior sclerotomy (independent procedure)	D	2397	115	6
Trabeculectomy	D	2469	481	6
Iridotomy, iridectomy of other procedure for relief of glaucoma	D	1622	245	6
Intraocular				
Laser of the eye other than retina	D	1814	216*	6

Operations on the eye (continued)

	List	Code	Units Gen	Units An
Does not apply to refractive correction				
Intraocular foreign body (all forms)	D	1642	310	6
Cataract operations				
Cataract, adult, all forms, including dislocated types	D	1648	442	6
Cataract, congenital or development – initial	D	1649	442	6
Subsequent needling	C	1650	77	6
Capsulectomy, as independent procedure	D	1651	346	6
Cataract extraction with intraocular lens insertion, one stage	D	2398	436*	6
Secondary insertion of intraocular lens	D	2399	375	6
Removal of intraocular lens	D	1672	257	6
Surgical replacement of dislocated intraocular lens	D	1673	257	6
Other operations on anterior segment				
(i.e. other than operations on cornea and operations for glaucoma or cataract)				
Lysis of adhesions in anterior segment	D	2400	115	6
Removal of iris tumor	D	1623	154	6
Removal of lesion by (irido) cyclectomy	D	2405	IC	6
Removal of epithelial downgrowth	D	2406	IC	6
Retina				
Retinopexy – any method	D	1653	616	6
Removal of encircling band +/- scleral implant	D	2371	150	6
Removal of scleral implant as sole procedure (not payable in addition to major surgery)	D	2372	115	6
Cryotherapy of retina, for any reason	D	1654	300	6
Laser of the retina	D	1813	286	6
Does not apply to refractive correction				
Intravenous fluorescein				
Without photography	B	2407	23	
With fundus photos, no interpretation	B	2408	38	
With fundus photos and interpretation	B	281	58	
Angiogram, interpretation only	B	284	26	
Vitreous				
Aspiration of vitreous	C	1652	77	6
Discission of anterior hyaloid membrane and/or vitreous strands	C	2409	77	6
Vitrectomy – anterior	D	2410	231	6
– posterior	D	2040	611	8

Operations of the Ear

	List	Code	Units Gen	Units An
See legend – Pg. 3/13 for description of list A, B, C and D.				
External ear				
Incision				
Drainage of abscess or haematoma of auricle or external auditory canal	C	1664	59	4
Drainage of extensive haematoma of pinna, under general anaesthetic	C	1769	115	4
Excision				
Biopsy of ear	B	1665	15	
Local excision of lesion on ear	C	1666	59	4
Complete excision of ear – amputation of ear	D	1667	115	4
Radical excision of malignant lesion of external ear canal	D	1668	308	4
Endoscopy				
Removal of cerumen		VF	(page 3/3)	
Otoscopy with removal of foreign body or myringotomy tubes from external ear canal	C	1669	15	
Under general anaesthetic	C	1670	38	4
Repair				
Otoplasty – correction of congenitally deformed ears, unilateral (under 18 years of age)	D	1671	318	5
☞ ***Medicare Note: Adult Otoplasty: see Plastic Surgical Preamble, page 20/1.***				
Reconstruction of ear for microtia or loss of ear				
Partial – first stage	D	2273	154	5
– subsequent stages	D	2274	154	5
Total – major stage	D	2275	231	4
– minor stage	D	2276	154	4
– maximum			616	
Drainage of haematoma	C	2278	38	4
Wedge excision and reconstruction	D	2280	115	4
Accessory auricle – removal	D	2281	75	4
Preauricular sinus – simple	D	2282	77	4
– complicated or recurrence	D	2283	154	4
Construction of ear canal for congenital atresia				
Without mastoidectomy	D	1674	539	4
With mastoidectomy	D	1675	616	7
Removal of ear canal exostosis	D	2042	231	4
Middle ear				

Operations of the ear (continued)

	List	Code	Units Gen	Units An
Incision				
Myringotomy, tympanotomy, plicotomy (without aftercare) – unilateral	C	1676	23	4
– bilateral	C	1677	46	4
Myringotomy, (operative microscope) and insertion of prosthesis – unilateral	C	1678	38	4
– bilateral	C	1679	88	4

☞ ***Medicare Note: A consultation is payable in addition to service codes 1676, 1677 and 1678.***

Excision				
Mastoidectomy, simple, unilateral	D	1680	231	7
Radical or modified radical, unilateral	D	1681	385	7
Microsurgical cleaning of mastoid cavity	C	1735	98	5
Removal of middle ear polyp by snare	C	1682	31	4
Ossiculectomy	C	1683	77	5
Repair				
Tympanotomy with round window fistula repair and closure	D	1768	325	7
Revision of radical mastoid cavity	D	1684	385	7
Stapes mobilization	D	1685	385	7
Stapedectomy	D	1686	539	7
Facial nerve decompression	D	1687	462	7
Facial nerve graft	D	1688	539	7
Middle ear exploration	D	1689	231	7

Internal ear

Incision				
Labyrinthotomy – any type	D	1690	385	7
Excision				
Labyrinthectomy	D	1691	462	7
Repair				
Fenestration of semicircular canal	D	1692	385	7
Revision of fenestration operation	D	1693	385	7
Endolymphatic shunt (House)	D	1694	IC	7
Endolymphatic sac decompression	D	1736	539	7
Myringoplasty	D	1695	231	7
Ossicular chain reconstruction				
Without myringoplasty	D	1696	308	7
With myringoplasty	D	1697	385	7
Tympanoplasty	D	1698	539	7
Tympanomastoid (mastoidectomy plus				

Operations of the ear (continued)

	List	Code	Units Gen	Units An
tympanoplasty +/- musculoplasty)	D	1699	616	7

Plastic Surgical Procedures
Preamble

See legend – pg. 3/13 for description of list A, B, C and D.

1. Refer to the Surgical Procedures Preamble on page 6/1 for payment guidelines on multiple procedures.

2. The postoperative period for plastic surgery is *30 days; listed fees include all management of the patient during that period including the management of all complications of the procedures performed.

3. Surgery performed for cosmetic purposes is not an entitled service under Medicare. It follows that anaesthesia and hospitalization incurred for these procedures are not entitled services.

In more specific terms, the following are examples of services not eligible for payment:
(a) Hair transplantation
(b) Rhytidectomy
(c) Excision of xanthelasma
(d) Aesthetic lasabrasion
(e) Excision of tattoos, except for late complications
(f) Adult otoplasty except post-trauma
(g) Aesthetic blepharoplasty
(h) Aesthetic rhinoplasty
(i) Mastopexy
(j) Aesthetic augmentation mammoplasty
(k) Aesthetic abdominoplasty
(l) Aesthetic liposuction

4. Plastic surgery performed <u>other than for cosmetics</u> to correct the effects of trauma, burns, sepsis, as well as the surgical excision of lesions for treatment or diagnosis, is eligible for benefits.

   The length of time since the causal event occurred as well as the age of the patient will be taken into account for purposes of determining coverage in specific cases. In the case of acne scars, the time elapsed since the condition has last been active will be considered.

5. Plastic surgery initiated <u>prior to the age of 18 years</u> for the correction of congenital cosmetic defects is eligible for benefits. Moreover, corrective surgery for the following indications is eligible for benefits without any age limitation:

   a) Breast agenesis, dysgenesis or congenital deformity
   b) Cleft lip growth deformities
   c) Growth abnormalities
   d) Gynaecomastia surgery for tumor of major functional disability.

(Specific exceptions are listed in paragraph 3.) There is also no age limitation for the correction of the effects of trauma to the nose.

Plastic surgical procedures (continued)

6. Prior consultation should take place with Medicare to determine the coverage status of proposed surgery whenever reasonable doubt exists as to its eligibility for benefits. A request form has been developed for this purpose.

Skin grafts and tissue shifts

Local tissue shifts

The following fees apply in situations requiring unusual time-consuming techniques of excision or repair such as Z-plasty, rotation flaps, local pedicle flaps, etc. commonly employed by plastic and reconstructive surgeons to obtain maximum functional results. The stated fees include the creation of defect and the necessary preparation for repair or the debridement and repair of complicated lesions.

Multiple tissue flaps are those shifts/Z – plasties required to close a single defect/area.

These fees are for major procedures, e.g. joint contracture; they do not apply to simple closure of wounds, undermining of wound edges, etc.

☞ ***Medicare Note: When lesser procedures of the above nature are necessary an adjusted fee should be claimed.***

☞ ***Medicare Note: Claims submitted to Medicare must state the size and location of the lesion and the type of repair.***

	List	Code	Units Gen	Units An
Single tissue shift	D	2200	200	4
With free skin graft to secondary defect	D	2201	260	4
Multiple (1)	D	2202	320	5
With free skin graft to secondary defect	D	2203	361	5
Eyebrow, eyelid, lip, ear, nose – single	D	2204	241	5
– multiple (1)	D	2205	320	5

(1) in same functional area

Flaps from a distance

Upper limb, first stage (each additional, add 50%)	D	2206	277	4
With skin graft to donor area	D	2207	320	4
Lower limb, first stage including cast (each additional, add 50%)	D	2208	415	4
With skin graft to donor area	D	2209	462	4
Indirect flaps: tubes and jumps				
First Stage	D	2865	277	4
With free skin graft	D	2866	393	4
Each additional stage	D	2867	208	4
With free skin graft	D	2868	324	4

Plastic surgical procedures (continued)

Muscle pedicle flap, including skin grafts	D	612	420	5
Neurovascular pedicle flap	D	805	500	10

Head and neck reconstruction

First stage, with deltopectoral flap, including lining of flap	D	2210	462	12
Second stage deltopectoral flap	D	2211	231	9

Skin grafts

The fees listed for skin grafts include the taking and the application of the grafts including refrigerated autografts.

Xenografts and homografts may be claimed at 50% of the appropriate listed fee.

Full thickness				
Eyelids, nose, lips, complete treatment	D	2212	231	5
Tip of finger, complete treatment	D	2007	77	4
Finger, more than one phalanx, complete treatment .	D	2213	154	4
Partial thickness				
Non-functional region – area covered				
Less than 6.25 sq. cm. (1 sq. in.)	D	2214	54	4
Less than 62.5 sq. cm. (10 sq. in.)	D	2215	115	4
Less than 625 sq. cm. (100 sq. in.)	D	2216	231	5
Each additional 6.25 sq. cm. (1 sq. in.)	D	2217	3	TU
Functional areas				
Important major joints or the hand – primary	D	2218	231	4
Secondary, to include excision of scar tissue ..	D	2219	385	4
Head and/or neck – less than 62.5 sq. cm. (10 sq. in.)	D	2220	154	5
62.5 to 187.5 sq. cm. (10 – 30 sq. in.)	D	2221	231	5
More than 187.5 sq. cm. (30 sq. in.)	D	2222	539	5
Cavity grafting				
Orbit, including mucosa	D	2223	308	5
Nose	D	2224	231	5
Mouth	D	2225	308	4
Operation for congenital absence of vagina – plastic surgery and postoperative care	D	2226	308	5
Perineal/rectal cavity grafting	D	2295	308	5
Bone cavity grafting, large bone, up to 7.5 cm.	D	580	463	5

Tissue expanders

Insertion of tissue expander – head, neck, covering a major joint, or for myelomeningocele	C	2315	462	4
– breast or other area	C	2311	308	4

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An

☞ ***Medicare Note: Each additional expander insertion during the same operative session is payable at 75% of the listed fee if different or bilateral area, or 50% if the same or adjacent area (e.g. face and neck same side; either side of the spine).***

Subsequent inflation of tissue expander	C	2319	25	

☞ ***Medicare Note: Each additional expander inflation during the same visit is payable at 50% of the listed fee.***

Skin lesions, superficial tumors, etc. –
see page 7/1.

Laser destruction of skin lesions –
see page 5/11.

Carcinoma

Wide excision prior to skin grafting, if done during different operative sessions – head and neck	C	373	92	6
– trunk and limbs	C	374	66	4

Wounds – see sutures pages 7/2-3

Burns

Initial care – minor burns		388	VF	
– severe extensive	C	389	IC	
Surgical debridement of necrotic tissue				
Initial, for each 5% of body surface area	C	317	30	5
Repeat for each 5% of body surface area	C	318	20	5
Tangential total excision of burn tissue prior to immediate graft, additional to skin graft fee				
First 5% of body surface area, add	C	319	100	5
Each additional 5% area, add	C	320	50	

☞ ***Medicare Note: In cases of severe burns treated in burn units, claims may be submitted on an intensive care fee basis, using the appropriate service codes. In other location, claims may be submitted on a detention fee basis, using code 389. Claims under code 389 must give the location and percentage of body surface burned by degree of burn, and any significant details concerning the patient's general health.***

Keloids

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An
Intralesional injection of scar – per session	C	381	28	
Large or functional areas	C	382	IC	4

☞ ***Medicare Note: Service codes 381 and 382 are restricted to specialists in plastic surgery and dermatology.***

Cheeks

Facial paralysis – static slings	D	2251	308	5
Dynamic slings	D	2252	385	5
Composite repair for facial paralysis, plication of paralysed muscles and resection or paralysis of overactive muscles	D	2253	385	6
Combined muscle transplant done in one or more stages for facial paralysis	D	2254	539	6
Dermabrasion – less than ¼ of face	C	150	67	6
– ¼ to ½ of face	D	151	200	6
– full face	D	152	405	6

☞ ***Medicare Note: Dermabrasion for cosmetic purposes is not covered.***

Salivary fistula – repair of Stensen's duct	D	932	192	4

Nose

Removal of hump	D	2259	154	4
Reconstruction of nasal tip, ala or columella	D	2260	269	4
Nasal implant – bone graft	D	2261	308	4
– synthetic	D	2262	231	4
Septectomy, submucous resection, including septoplasty, with correction of nasal deformity	D	653	385	6
Rhinoplasty, complete management, including septectomy and grafts where necessary	D	660	462	8
Forehead rhinoplasty – total care	D	2263	539	6

☞ ***Medicare Note: Rhinoplasty for cosmetic purposes is not covered.***

Rhinophyma, complete, including skin grafts if required	D	650	154	4
Nasal fractures – no reduction			VF	
– closed reduction	D	420	77	6
– operative reduction	D	421	154	6

Orbit

Bone graft to orbit – autologous	D	2264	308	5
– non-autologous	D	2265	231	5
Ptosis – lid suspension or levator resection	D	2266	225	5

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An
Repair of ectropion or entropion				
Simple, Ziegler operation, office procedure	C	2267	38	
Full thickness horizontal shortening of lid ent/ect	D	2268	150	4
Chalazion or other benign lesion of lid or conjunctive	C	1627	25	
Coronal or bilateral eyebrow lift	D	2180	320	4
Direct flap to eyebrow, total fee – 1st stage	D	2269	231	4
– 2nd stage	D	2270	115	4
Excision and full thickness reconstruction of lid for malignant tumor, total care				
Up to and including 1/3 of lid	D	2271	150	5
Greater than 1/3 of lid	D	2272	385	5
Ears				
Otoplasty – correction of congenitally deformed ears, unilateral (under 18 years of age)	D	1671	318	5
Reconstruction of ear, for microtia of loss of ear				
Partial – first stage	D	2273	154	5
– subsequent stage	D	2274	154	5
Total – major stage	D	2275	231	4
– minor stage	D	2276	154	4
– maximum			616	
Drainage of haematoma	C	2278	38	4
Wedge excision and reconstruction	D	2280	115	4
Complete excision of ear	D	1667	115	4
Accessory auricle – removal	D	2281	75	4
Accessory sinus – simple	D	2282	77	4
– complicated or recurrence	D	2283	154	4
Mouth				
Biopsy	B	882	31	4
Excision of simple lesion	C	883	31	4
Excision of ranula or dermoid cyst	D	886	92	4
Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa	D	887	139	4
With hemimandibulectomy	D	889	308	10
Closure of antro-oral fistula – with flap	D	892	231	4
– with radical antrotomy	D	893	269	4
Genioplasty for facial reconstruction				
One-step advancement	D	1701	130	6
Two-step advancement	D	1702	162	6
Lips				
Biopsy	B	894	31	4

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An
Lip shave, vermilionectomy	D	895	154	4
Excision of simple lesion	C	896	31	4
V-excision, vermilion	D	2284	115	4
V-excision to sulcus	D	2285	192	4
Traumatic cleft lip	D	391	192	4
Excision one-half lip and reconstruction, one or more stages	D	899	308	4
Total excision of lip and reconstruction, one or more stages	D	901	462	6
Abbe reconstruction, total care	D	2286	385	6
Cleft lip repair, including repair of nasal deformity				
– unilateral – one stage	D	2287	350	8
– staged procedure, maximum	D	2288	500	8
– bilateral – one stage	D	2289	500	8
– staged procedure, maximum	D	2290	625	8

Palate and uvula

Uvulectomy – independent procedure	C	919	52	4
Biopsy	B	920	31	4
Excision of simple lesion	C	921	46	4
Excision of malignant lesion with reconstruction	D	2336	IC	4
Cleft palate, repair	D	923	269	8
Revision, with bone graft	D	2291	308	8
Push-back of palate and/or pharyngeal flap	D	925	346	8
Repair of palate fistula	D	2292	231	8

Breast

Reconstruction following mastectomy				
Immediate prosthesis insertion, add	D	2845	197	
Breast mound creation by prosthesis and/or soft tissue	D	2846	392	5
Breast reconstruction – grafts or pedicle flaps	D	2900	641	6
– transverse lower abdominal rectus flap (Drever)	D	352	573	5
Second procedure or revision	D	2848	392	5
Removal of prosthesis	D	2849	92	4
Reduction mammoplasty	D	411	535	6
Augmentation mammoplasty	D	412	392	5

☞ ***Medicare Note: Mammoplasty and breast reconstruction are not entitled procedures unless performed for other than cosmetic reasons. Reconstruction following mastectomy for medical reasons is not considered cosmetic.***

Trunk

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An
Decubitus ulcer				
For total care – excision of all tissue including bone and all necessary repair procedures such as rotation of a flap to cover the primary defect and application of skin grafts to secondary defects.				
Closure of sacral or trochanteric decubitus ulcer				
Not requiring excision of bone	D	2293	320	5
With excision of bone	D	2294	420	5
Abdominal lipectomy (for functional disability only)				
– with repair of hernia	D	2337	924	10

☞ ***Medicare Note: Service code 2337 applies also to repair of diastasis recti by a major procedure such as kiehl-type, double-layer shelving or vest-type aponeurosis repair. Prior approval must be requested from Medicare in each case to determine eligibility for coverage as an entitled benefit.***

Genitalia

Epispadias	D	1351	231	4
Hypospadias – first stage, including urinary diversion	D	1352	154	4
Plastic reconstruction of urethra – penile	D	1353	269	4
Penoscrotal or perineal	D	1354	346	4
Closure of urethrocutaneous fistula	D	1355	154	4
Urethral stricture, repair – one stage, with diversion	D	1321	277	4
Two stages – first	D	1322	139	4
– second	D	1323	277	4
Urethroplasty (Johanson) each stage	D	2298	310	4

Limbs

For lymphoedema of limbs – Kondoleon	D	869	277	4
Radical sleeve excision – entire lower limb, total care	D	870	539	6
Thompson procedure				
Upper extremity – forearm	D	2299	231	4
Arm	D	2300	154	4
Entire upper extremity – one or two stages – total care	D	2301	385	4
Lower extremity – leg	D	2302	385	4
Thigh	D	2303	385	4
Entire lower extremity – one or two stages – total care	D	2304	769	4
Excision of ulcer, multiple ligation of veins and skin graft				
– one leg	D	759	192	4
– both legs	D	760	308	4

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An
Excision of stasis ulcer and skin graft – one leg	D	762	123	4
– both legs	D	763	185	4
Hand				
Syndactyly – first cleft, local flaps	D	2305	154	4
Skin grafts, free or pedicle	D	2306	231	4
Direct full thickness flap to finger, total fee	D	2008	115	4
Neurovascular pedicle flap	D	2418	308	4
Microsurgical repair				
Total amputation: reimplantation – thumb	D	2880	1071	14
Finger	D	2881	928	14
(Maximum thumb and/or fingers: 2463 units)				
Hand, to include at least 3 digits	D	2882	2000	14
Forearm	D	2883	2000	14
Foot.....	D	2884	1786	14
Leg	D	2885	1786	14
Partial amputation: microsurgical repair – payable on an individual structure basis; total fee not to exceed 75% of repair fee for total amputation	D	2886	IC	9
Individual structure microsurgery				
Microvascular surgery – artery or vein	D	2887	314	5
Microneural surgery – neuroplasty, neuroanastomosis	D	2888	314	5
Nerve graft	D	2889	478	5
(Cable graft additional 50% of fee)				
(Multiple cable remote payable at 75%)				
Free vascularized skin and subcutaneous tissue transplant				
– Elevation of transplant and closure of donor site .	D	1843	766	14
– Preparation of microvascular recipient site	D	1844	810	14
– Transplantation, with microvascular anastomoses	D	1845	810	14
Free vascularized innervated skin and subcutaneous tissue transplant				
– Elevation of transplant and closure of donor tissue	D	1846	900	14
– Preparation of microvascular recipient site	D	1847	900	14
– Transplantation, with microvascular anastomoses and microneural nerve repair	D	1848	842	14
Free vascularized muscle or musculocutaneous tissue transplant				
– Elevation of transplant and closure of donor site ..	D	1849	766	14
– Preparation of microvascular recipient site	D	1850	810	14
– Transplantation, with microvascular anastomoses	D	1851	766	14
Free vascularized muscle or musculocutaneous tissue transplant with tendon and nerve				

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An
– Evaluation of transplant and closure of donor site.	D	1852	1036	14
– Preparation of microvascular recipient site	D	1853	1036	14
– Transplantation, with microvascular anastomoses, microneural repair, and tendon repairs	D	1854	1036	14
Free vascularized bone transplant				
– Elevation of transplant and closure of donor site ..	D	1855	766	14
– Preparation of microvascular recipient site	D	1856	810	14
– Transplantation, with microvascular anastomoses and bony fixation	D	1857	900	14
Free vascularized osteocutaneous or osteomuscular tissue transplant				
– Elevation of transplant and closure of donor site .	D	1858	918	14
– Preparation of microvascular recipient site	D	1859	918	14
– Transplantation, with microvascular anastomoses, osteotomies, and bony fixation	D	1860	918	14
Free microvascular toe or finger transplant				
– Elevation of transplant and closure of donor site ..	D	1861	918	14
– Preparation of microvascular recipient site	D	1862	918	14
– Transplantation, with microvascular anastomoses, tendon, nerve, and bone repair	D	1863	1080	14
Miscellaneous				
Repair of meningocele, total care	D	1582	308	8
Encephalocele or myelomeningocele	D	1583	462	8
If team procedure plastic surgeon's portion of above				
Multiple flaps +/- graft	D	2326	269	8
Single flap – with skin graft	D	2327	231	8
– without skin graft	D	2328	154	8
Excision of axillary sweat glands for hyperhidrosis, unilateral	D	2329	269	4
Dermis-fat graft	D	2417	308	4
Lipoma				
– Suction assisted lipectomy – small area	D	353	115	4
– large area, or head, neck or major joint	D	354	154	4

☞ ***Medicare Note: Aesthetic Liposuction: see Plastic Surgical Preamble page 20/1.***

☞ ***Medicare Note: Claims submitted to Medicare using code 354 must give details of lesion, size location, etc.***

Tattooing surgery
(for haemangioma, vitiligo, lentigines, etc.)

Face – ¼ or less	D	2330	77	4
– ¼ to ½	D	2331	154	4
– full face	D	2332	231	4

Plastic surgical procedures (continued)

	List	Code	Units Gen	Units An
Non-facial area – per 6.25 sq. cm. (1 sq. in.)	D	2333	38	4
– 62.5 sq. cm. (10 sq. in.)	D	2334	77	4
– 625 sq. cm. (100 sq. in.)	D	2335	154	4

☞ ***Medicare Note: Tattooing surgery for cosmetic purposes is not an entitled service under Medicare.***

Diagnostic and Therapeutic Procedures

	List	Code	Units Gen	Units An

See legend – Pg. 3/13 for description of list A, B, C and D.

These fees apply when such procedures are carried out by or under the supervision of a physician. Cost of medication used in any of these procedures is additional.

☞ ***Medicare Note: The cost of medication is not a benefit under Medicare.***

☞ ***Medicare Note: See Assessment Rule 13.***

Allergy

Initial hyposensitization injection and assessment			(page 3/3)	
Hyposensitization injection, including supervision ...				
(except initial injection and assessment), per visit ..	C	1894	13*	
Desensitization acute, e.g. antitetanus serum,				
penicillin	B	1892	8	
Tests, and antigen, any method – per test	B	1895	3	
Maximum for any 6 month period: 30 tests			90	
Aspiration of (also see injection of medication)				
Abdomen – see paracentesis				
Bladder	A	1899	15	
Breast cyst	A	1900	15	
Bursa	A	1901	15	
Cisterna magna	A	1902	23	
Duodenum – by intubation for secretion test (after				
one hour charge extra on detention fee basis)	B	1903	38	
Hydrocele	B	1368	8	
Joint	A	1905	15	
Lumbar puncture	B	177	38	
Oesophagus or stomach and preparation of material				
for cytological exam	B	1907	15	
Pericardium – aspiration or needle biopsy	A	1908	115	4
Thyroid cyst	A	1911	15	
B.C.G. vaccination, including necessary tuberculin tests	B	1914	8	
Cardiac arrest – supervision of resuscitative measures				
(including cardioversion where applicable)	A	1725	77	
Services of an additional physician (max. 2)	A	1726	20	

☞ ***Medicare Note: Service code 1725 or 1726 represents the total fee payable for a physician's services during the emergency. However, the attending physician or the consultant may claim for services provided at different times on the same day by indicating this on the claim form.***

Cardiology, interventional – see Cardiovascular System				
Cardioversion	B	1916	77	5
Catheterization – Eustachian tube	A	1922	29	
Dialysis for renal failure – acute renal failure and				

Diagnostic and Therapeutic Procedures (continued)

	List	Code	Units Gen	Units An
chemical intoxications, to include diagnosis, management, supervision of first dialysis and attendance during the first 24 hours	C	1923	462	
Each succeeding dialysis, supervision and care associated therewith	C	1924	308	
Dialysis for chronic renal failure – initiation of home dialysis regimen, including consultation, assessment, advice and management of problems, as well as first dialysis (any method)	C	1743	308	
In hospital dialysis (any method), including management during dialysis	B	1927	62	
Home dialysis, weekly management and supervision fee, not applicable when another dialysis fee is payable during that week – per patient	B	1744	35	
Mileage for house calls to patients on home dialysis, per kilometre in excess of 5 km, one way		215	1	
Dilation of ileostomy or colostomy	A	1990	8	
Dilation of oesophagus (see also page 12/4)				
Dye dilution densimetry curve including procedure and interpretation				
Initial (from the ear)	B	1928	23	
Repeat	B	1929	8	
Initial (from the artery)	B	1930	38	
Repeat	B	1931	15	
Electrocardiogram **(see Assessment Rule 15)**				
Procedure with interpretation				
Office	B	1932	20	
Home	B	1933	23	
Before and after exercise	B	1934	23	
Interpretation only, office	B	1935	8	
Interpretation of tracings taken in hospital - for the first 2000 interpretations, $5.60 per ECG - for each subsequent interpretations, $3.92 per ECG The interpretation of tracings from a computerized ECG management system is paid at 75% of the above rates.				

☞ ***Medicare Note: Hospital electrocardiograms are billed to and paid by the hospital. The payment rate is based on the combined (inpatients and outpatients) total annual tracings taken in a hospital, whether interpreted by one or by many physicians.***

24 hour ambulatory blood pressure monitoring	B	8950*	25	
Holter 24 hr monitoring-total interpretation fee	B	2952	39	
Submaximal stress E.C.G. – with treadmill or ergometer and oscilloscopic continuous monitoring including E.C.G.'s taken during the procedure and resting E.C.G.'s before and after procedure	B	2373	62	

Diagnostic and Therapeutic Procedures (continued)

	List	Code	Units Gen	Units An
Endocrinology and metabolism				
Antidiuretic hormone response test	B	1936	23	
Hypertonic saline infusion test	B	1937	38	
Benzodioxine histamine	B	1938	23	
Water tolerance test	B	1939	15	
Insulin sensitivity test	B	1940	38	
Endometrial aspiration – office procedure	B	2352	12	
Enterotest (string)	B	1906	8	
Examination of eye under general anaesthesia	B	2049	31	
Fluoroscopy and/or orthodiagram	B	1941	8	
Fractional test-meal, samples and analysis	B	1943	23	
Augmented histamine test-meal	B	1944	31	4
Gastric lavage – diagnostic and emergency	B	1942	15	
Injections (cost of injectable material additional)				
By cutdown	A	1946	23	
By scalp vein	A	1947	15	
Injection of medication – bursa, ganglion, joint or tendon, including preliminary aspiration if necessary	B	1948	15	
Intravenous cancer chemotherapy – per treatment	B	1950	10	
Children under 10 years	B	2838	15	
Injection of I.V. infusion of albumin	B	1881	10	
Injection of I.V. gammoglobulin	B	1882	10	
Intravenous injection for haemophiliacs, per treatment				
– adults	B	2816	10	
– children under 10 years	B	2817	15	
Lumbar puncture with intrathecal chemotherapy	B	1983	50	
Needle biopsy procedures – bone marrow	B	866	38	4
Kidney	A	1952	54	
Liver	B	1953	38	4
Spleen	A	1954	46	
Pleura	A	1955	31	
Transthoracic lung biopsy with fluoroscopy	B	2066	63	
Pericardium	A	1908	115	4
Synovial tissue	A	1956	38	
Prostate	B	1383	62	4

☞ ***Medicare Note: The following codes are not to be used in conjunction with surgical or obstetrical procedures, in which case the appropriate procedure codes apply.***

Nerve blocks, diagnostic and therapeutic				
Head and neck				
Supraorbital nerve	B	295	23	
Infraorbital nerve	B	296	23	

Diagnostic and Therapeutic Procedures (continued)

	List	Code	Units Gen	Units An
Occipital nerve	B	297	23	
Maxillary nerve	B	260	64	
Mandibular nerve	B	259	38	
Trigeminal ganglion	B	425	92	
Other cranial nerve block	B	270	46	
Cervical plexus	B	258	46	
Stellate ganglion	B	1056	64	
Superior laryngeal nerve	B	1399	64	
Brachial plexus	B	261	38	
Trunk				
Suprascapular nerve	B	271	23	
Intercostal block – first nerve	B	272	23	
– additional nerve	B	273	12	
Paravertebral block – thoracic nerve	B	1534	46	
– additional thoracic nerve	B	1542	23	
– lumbar nerve	B	274	46	
– additional lumbar nerve	B	275	23	
Coeliac ganglion	B	413	92	
Sympathetic block – thoracic	B	276	92	
– lumbar (unilateral)	B	257	54	
Miscellaneous nerve blocks				
Single somatic nerve, not specifically listed	B	1762	23	
– additional nerve	B	1763	12	
Diagnostic intrathecal block	B	1764	46	
Epidural block – cervical	B	1765	100	
– thoracic	B	1766	80	
– lumbar	B	1767	46	
– caudal	B	263	38	
Epidural with steroid, add	B	277	10	
Injection of joint – sacroiliac	B	1887	29	
– vertebral	B	1888	50	
Trigger point injection	B	1889	15	
– additional	B	1890	8	
Intravenous Guanethidine block	B	1802	64	
Injection of alcohol, phenol or other sclerosing agents – basic fee as above	B	294	IC	
Nerve block with cryoanalgesia, add	B	292	50%	
Special noninvasive procedures such as transcutaneous electrical nerve stimulation (TENS) (excludes acupuncture)			VF	
Pain clinics – the initial visit by each physician is payable at a consultation fee, when not covered by a sessional fee.				
Oesophagus				
HCL drip test	B	2094	23	
Motility studies	B	2095	54	

Diagnostic and Therapeutic Procedures (continued)

	List	Code	Units Gen	Units An
Oesophagus and stomach				
24 hour Ph. Ambulatory monitoring	B	1799	54	
Paracentesis				
Thoracic – puncture of pleural cavity for aspiration (diagnostic and therapeutic), initial or subsequent	B	2592	38	
Abdominal – aspiration for diagnostic sample	B	1992	15	
Therapeutic aspiration, including diagnostic and sample	B	1993	38	
Thoracic or abdominal – administration of chemotherapy, including therapeutic aspiration and sample	B	1994	38	4
Perirenal insufflation of air	B	1995	38	
Phonocardiogram – supervision and interpretation	B	1996	23	
Plasmapheresis – initial	B	1535	75	
– repeat, 2nd to 5th	B	1536	50	
– additional, same year	B	1537	38	
Pulmonary function studies				
1. Routine survey of pulmonary function to provide information in ventilation, gas mixing and diffusion	B	2098	38	
2. Individual tests				
a) Arterial carbon dioxide tension by a breathing technique	B	2099	15	
b) Arterial puncture with gas analysis at rest	B	2100	23	
c) Arterial puncture with gas analysis at rest and on exercise	B	2101	38	
d) Blood volumes	B	2102	15	
e) Diffusion capacity at rest	B	2103	15	
f) Diffusion capacity on exercise	B	2104	15	
g) Dye dilution curve – ear oximeter	B	2105	8	
h) Dye dilution curve and cardiac output	B	2106	15	
i) Gas mixing	B	2107	8	
j) Lung volumes (residual volume, total lung capacity)	B	2108	23	
k) Maximum breathing capacity	B	2109	8	
l) Mechanics of breathing at rest	B	2110	23	
m) Mechanics of breathing on exercise	B	2111	23	
n) Oximetry				
1. 90% desaturation time	B	2112	8	
2. Change of arterial oxygen saturation on exercise	B	2113	8	
3. . Change of arterial oxygen saturation on exercise breathing oxygen	B	2114	8	
o) Oxygen consumption	B	2115	8	
p) Respiratory centre carbon dioxide stimulation test	B	2116	15	
q) Resting ventilation, spirogram and vital capacity	B	2117	8	

Diagnostic and Therapeutic Procedures (continued)

	List	Code	Units Gen	Units An
r) Timed vital capacity	B	2118	8	
s) Non specific bronchial provocative test	B	2131	50	
Replacement of pyelostomy, ureterostomy, nephrostomy or cystostomy tube	B	1989	8	4
Rheumatology & physical medicine – examination of joint fluid for white cell count	B	2135	10*	
Uric acid crystals	B	2136	15*	
Mucin clot	B	2137	6*	
Overnight sleep apnea study – interpretation only	B	2134	46	
Stasis ulcer – application and/or change of Unna's paste or similar application, icthopaste, etc	A	2043	8	
Sterility investigation – male, sperm cell count and morphology	B	2047	8	
Female, see Female Reproduction System				
Tonometry, by tonometer	B	2048	8	
Ultrasound, heart				
Trans-eosophageal echocardiogram	B	1816	48*	
Echography, pericardial effusion, M-mode	B	2980	14	
Echocardiography, complete, M-mode	B	2981	31	
With bidimensional imaging	B	2982	46	
Echocardiography – Doppler				
Qualitative, to detect absence or presence of valvular disease – interpretation	B	2966	19	
– interpretation and performance	B	2967	25	
Quantitative, to detect valvular disease and calculate valve areas and pressure gradients – interpretation	B	2968	34	
– interpretation and performance	B	2969	45	
Ultrasound, carotid				
Carotid assessment – unilateral or bilateral for spectral analysis	B	2970	41	
Ultrasound, obstetrical				
Biophysical profile – performed and interpreted by the physician	B	1896	46	
- physician present but not performing the procedure (includes interpretation)	B	1897	23	
Ultrasound, peripheral vascular (including doppler)				
- peripheral vascular assessment, one area (ex: ankle), one or two levels	B	2425	10	
- one limb only	B	2122	8	
- bilateral assessment (see next page)	B	2123	13	
- as above with segmental pressure recordings and/or wave form analysis and/or spectral analysis, +/- exercise testing	B	2955	20	
- one limb only	B	2124	15	

Diagnostic and Therapeutic Procedures (continued)

	List	Code	Units Gen	Units An
- bilateral assessment (see below)	B	2125	25	
- peripheral vascular testing of limb (at least 3 levels), with segmental pressure recordings and/or wave form analysis and/or spectral analysis	B	2126	25	
- one limb only	B	2127	19	
- bilateral assessment (see below)	B	2128	31	
- peripheral testing of limb, as above, with exercise testing	B	2586	31	
- one limb only	B	2129	23	
- bilateral assessment (see below)	B	2130	39	

Non-invasive vascular tests (ultrasound, duplex only)

- Non-invasive vascular assessment of abdominal aorta, mesenteric, renal or iliac arteries	B	1804	30	
- Arterial vascular assessment, upper or lower extremity – +/- graft (with or without exercise)				
- Unilateral	B	1805	54	
- Bilateral	B	1806	108	
- Venous vascular assessment, upper or lower extremity				
- Unilateral	B	1807	54	
- Bilateral	B	1808	108	

☞ ***Medicare Note: Duplex examinations include doppler when performed on same area/limb.***

The Doppler and Duplex service codes and fees include the physician's supervision and participation in the procedures, as applicable, and must comprise a permanent record of the interpretation of the findings. They do not apply to subsequent interpretations by any practitioner. Codes 2425, 2955, 2126 and 2586 include contralateral comparison studies; the "bilateral assessment" fee is payable solely when symptomatology in the second limb warrants assessment as confirmed by the studies.

Venipuncture – infant or child under 4 years I.C. only . (see note page 4/8)	A	2051	8	
- adult or child 4 years and older I.C. only	C	2050	5	
Femoral vein puncture	A	2052	15	
Jugular vein puncture	A	2053	15	
Umbilical vein catheterization	A	2081	15	
Umbilical artery catheterization	A	2082	31	
Venisection, therapeutic	A	2054	8	
Phlebotomy, therapeutic, for polycythemia	A	2055	8	

Venous cannulation

Applies also to replacement unless otherwise stated. (Excludes simple venipunctures such as phlebotomy, intravenous medication via syringe, butterfly setups for IV drips, etc.).

Diagnostic and Therapeutic Procedures (continued)

	List	Code	Units Gen	Units An
Insertion of peripheral indwelling venous catheter	A	2477	15	
Insertion of central indwelling catheter via peripheral route, such as for central venous pressure or total parenteral nutrition – payable in addition to ICU daily care	A	2476	30	
Insertion and subcutaneous tunnelling of central indwelling catheter to vena cava, such as Hickman-Broviac or Port-A-Cath or Pas-Port	B	1885	115	4
With subcutaneous chamber	B	1883	200	4
Removal: See Medicare note				

Right heart catheterization, such as by Swan-Ganz catheter for cardiac monitoring, see code 1918 under Cardiovascular System.

Insertion or Removal of permanent Peritoneal Dialysis Catheter	B	8336	200	

☞ ***Medicare Note: If separate site, both insertion and removal will be paid at 100%. If otherwise, second procedure will be paid at 75%. This must be clearly indicated on claim submission. <u>An attempted insertion will be paid as an insertion</u>.***

Clinical procedures associated with Diagnostic Imaging (List B)

	List	Code	Units Gen	Units An

See legend – pg. 3/13 for description of list A, B, C and D.

These procedural fees are intended to cover compensation for professional services such as placing an instrument and introducing contrast media (except oral or rectal administration for study of the alimentary tract and intravenous injections). Radiological charges are additional.

☞ ***Medicare Note: See unit values, page 3/11-3/12.***

Special procedural fees

Breast mass, needle localization with mammography ...	B	1715	63	
Myelogram – 1 area	B	181	63	4
– 2 or more areas	B	2013	89	4
– posterior fossa	B	2014	107	6
Discogram – one level	B	2146	63	4
– each additional level	B	2119	32	TU
Facet joint injection – per joint	B	2120	50	
Bronchogram – unilateral	B	2147	36	6
– bilateral	B	1711	54	6
Laryngogram	B	2148	36	4
Arthrogram	B	2149	27	4
Double contrast	B	2062	44	
Pneumoencephalogram	B	182	107	5
Ventriculogram	B	1506	179	6
Velopharyngogram	B	1991	36	
Angiography				
Arteriography – percutaneous (needle only)	B	800	77	4
Non-selective – percutaneous (with catheter)	B	2156	89	4
– by cut-down	B	2154	133	4
Selective (e.g. renal, cerebral, vertebral) – each artery, add	B	2063	44	TU
Super selective (e.g. gastroduodenal, distal hepatic, pudendal, distal mesenteric branch) – each artery, add	B	2061	59	TU
Myocardial perfusion scan (inj Thallium)	B	1738	28	
Myocardial wall motion scan	B	1741	54	
Myocardial wall motion scan ejection	B	1742	64	

☞ ***Medicare Note: If interpretation only, bill at 50% of listed fee for codes 1738, 1741 and 1742.***

Angioplasty (percutaneous transluminal dilation of arterial stenoses and occlusions under local

Clinical procedures associated with diagnostic imaging (List B) (continued)

	List	Code	Units Gen	Units An
anaesthesia)				
– iliac	B	1712	340	
– femoral	B	1713	340	
– renal	B	1714	425	
Venogram	B	736	44	4
Inferior venacavagram	B	2839	89	
Transjugular liver biopsy (includes selective venous catheterization, contrast injection, manometry and performance of biopsy)	B	2155	160	
Embolization of vessel, additional to angiography fee	B	2515	85	TU
Lymphogram	B	2158	89	5
Bilateral	B	2064	133	
Sialogram	B	2159	44	4
Dacryocystogram	B	2160	44	4
Presacral insufflation	B	2161	44	4
Splenoportogram	B	2162	63	4
Percutaneous transhepatic portography	B	1721	89	
Percutaneous transhepatic cholangiogram	B	2163	89	4
Percutaneous biliary drainage (introduction of catheter into the common bile duct and duodenum under diagnostic imaging) – includes percutaneous transhepatic cholangiogram	B	1716	340	
Percutaneous extraction of common bile duct stone under fluoroscopy	B	2375	133	4
Endoscopic retrograde cholangiopancreatography (ERCP) +/- biopsy, +/- cytology	B	2875	202	6
Hysterosalpinogram	B	2164	63	4
Bead chain examination of bladder	B	2169	46	
Voiding cystourethrogram	B	2165	9	
Retrograde urethrogram or cystogram, without cystoscopy	B	2015	27	
Percutaneous renal cystogram	B	2016	63	4
Percutaneous insertion of nephrostomy tube under local anaesthesia, under fluoroscopy	B	2840	133	
Percutaneous nephrostomy with ureteric dilation or stent insertion under diagnostic imaging	B	1720	231	
Percutaneous establishment of nephrostomy tract for stone extraction	B	2121	340	6
Ileal loopogram	B	2087	27	
Hypotonic duodenography with intubation	B	2065	17	
Intubation of small intestine	B	1057	36	4
Percutaneous diagnostic tap of fluid collection under diagnostic imaging	B	1717	63	
Percutaneous insertion of drainage tube into fluid collection under diagnostic imaging	B	1718	95	
Percutaneous intraabdominal needle biopsy of solid				

Clinical procedures associated with diagnostic imaging (List B) (continued)

	List	Code	Units Gen	Units An
mass under diagnostic imaging	B	1719	79	
Transthoracic lung biopsy with fluoroscopy	B	2066	63	6
Endobronchial brush biopsy	B	2067	63	6

(Section A) Specialists in Diagnostic Radiology

The fees include consultation between the certified diagnostic radiologist and the referring physician, supervision of x-ray service, fluoroscopy, interpretation of radiographs and fluoroscopic findings.

1) For purposes of this schedule, "radiology" refers to Diagnostic Radiology, Nuclear Medicine.

2) The rate(s) of payment per unit (unit values) are listed on page 3/10 of the General Preamble.

3) New clinical and diagnostic procedures associated with radiology are found on page 23/9-11. These codes include procedural services plus interpretation fees.

4) Where cine or videotape is used, fee to be increased by 25% unless this is generally considered to be an integral part of the technique for a procedure.

5) If the examinations which are requested by the referring physician yield abnormal findings or if they would yield information which, in the opinion of the radiologist, would be insufficient or if a different examination is necessary to obtain the diagnostic information required, governed by the needs of the patient, the radiologist may add further views or change the examination and claim for them in accordance with the listing.

Fee schedule interpretations

1. The number of views obtained is governed by the needs of the patient and requirements of the referring physician and the opinion of the radiologist. The radiologist may claim for views thus obtained and in accordance with the listing. (Reference - item 5, page 23/1).

2. Comparison views when deemed necessary are payable as "specialized" views.

3. The fee for "additional views extra" may only be claimed for interpretation of a view which is not considered to be included in the routine examination of that part or area and which has been specifically requested by the referring physician or deemed clinically necessary by the interpreting radiologist.

4. No additional fee is payable for use of image intensifying equipment.

5. Fluoroscopy charges should not be submitted for any examination performed by the radiologist where fluoroscopy is generally regarded as an integral part of the examination e.g. examinations of the G.I. tract, clinical procedures associated with diagnostic imaging.

6. Abdomen and chest studies should not be routinely claimed in gastrointestinal examinations unless specifically requested.

7. Three or more views of the chest should not be routinely claimed when a chest examination is requested.

Specialists in diagnostic radiology (continued)

8. Nasal bones or accessory nasal sinuses should not be routinely claimed in skull examinations unless specifically requested.

9. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examinations unless specifically requested.

10. No fee may be claimed for interpretation of views of a joint unless all of the views normally required for that joint have been examined.

11. Conventional films of the spine before myelography may only be billed for, if the radiologist is unable to obtain previous films done at his/her facility or other institutions.

12. Claims for new procedures or interpretations not precisely covered by an existing service code in the Radiology fee schedule, must be submitted as I.C. under service code 888 and include the billing information. A submission should be sent to the New Service Items Committee.

13. "Call back" to hospital applies when a radiologist is called back to the hospital after the normal working hours.

    a) "night time" applies to attendance between 18:00 and 08:00 hours during weekdays.

    b) "weekends" applies to attendance on Saturdays, Sundays and legal holidays. (See insert).

A call back does not apply when a radiologist has come from another location on the hospital premises nor when a radiologist is providing scheduled after hour coverage during the time periods described above. Only one call back per trip to the hospital is payable regardless of the number of X-rays examined. An additional call back is payable for additional trips made within the same shift or period as outlined above.

☞ ***Medicare Note: Claims for "call back" must show the time of day the service was rendered.***

	Code	Units
Chest and thoracic viscera		
Chest – single view	3000	3
– two views	3001	6
– three or more views	3002	7
Portable chest film	3003	5
Fluoroscopy alone	3004	8
Chest or heart fluoroscopy and films (three or more)	3005	11
Thoracic inlet	3006	5
Ribs – one side	3007	5
– both sides	3008	7
Sternum or sternoclavicular joints	3009	5

Specialists in diagnostic radiology (continued)

	Code	Units
Specialized views of ribs, or sternoclavicular joints	3048	3
Tomography	3010	12

Abdomen and gastrointestinal tract

Abdomen – single view	3011	5
– multiple views – perforation/obstruction	3012	8
Portable abdomen – Single view	3232	5
– Two or more views	3233	8
Pharynx and oesophagus	3013	9
Dilation of oesophagus under fluoroscopic control	3234	8
Upper G.I. series (oesophagus, stomach & duodenum)	3014	17
With hypotonic duodenography (without intubation)	3015	23
Double contrast with glucagon (Barium meal examination)	3235	23
Hypotonic duodenography with intubation	3016	16
Combined G.I. with delayed film	3017	22
And Maxeran	3236	28
Small bowel motility exam	3018	17
And Maxeran	3019	23
Enteroclysis	3229	23
Cholecystogram	3020	6
With fluoroscopy	3021	10
Cholangiogram – intravenous	3022	13
Operative	3023	7
T-tube with fluoroscopy	3024	10
Drip infusion	3025	18
With planigraphy	3026	23
Cholecystokinin cholecystogram	3027	18
Barium enema	3028	17
Double contrast	3029	23*
Single or double contrast with glucagon	3030	23
Endoscopic retrograde cholangiopancreatography (ERCP)	3031	70
Colonoscopy, radiological control	3032	16
Tomography	3033	12

Genitourinary system

Pyelogram – intravenous +/- rapid sequence	3034	17
– with planigraphy	3035	23
– with diuretic washout	3036	23
– retrograde	3037	6
Retrograde ileal conduit pyelogram	3038	6
With fluoroscopy	3039	12

Specialists in diagnostic radiology (continued)

	Code	Units
Cystogram	3040	6
Cystourethrogram (voiding) retrograde	3041	17
With intravenous pyelogram	3042	20
Chain cystourethrogram	3043	17
Retrograde urethrogram	3044	17
Functional pyelogram – drip infusion	3045	19
With diuretic washout	3046	23
With planigraphy	3047	23
Percutaneous antegrade pyelogram	3049	6
With fluoroscopy	3050	12
Nephrostomy tube pyelogram	3051	6
With fluoroscopy	3052	12
Vasogram	3053	6
With fluoroscopy	3054	12
Hysterosalpingogram	3055	6
With fluoroscopy	3056	12
Pregnancy – single view	3057	5
Foetogram/placentogram – without contrast media	3058	7
With contrast media in bladder	3059	9
Pelvimetry	3060	9
Tomography	3061	12

Head and neck

Skull	3062	7
Special additional views extra	3063	4
Portable skull	3214	7
Sella turcica (when skull not examined)	3064	4
Facial bones	3065	6
Orbit, special views extra	3215	5
Paranasal sinuses	3066	6
Mastoids	3067	7
Internal auditory meati (when skull not examined)	3068	7
Nose	3069	5
Optic foramina	3070	5
Eye – foreign body	3071	5
– localization of foreign body	3072	14
Mandible or maxilla	3073	6
Portable mandible	3216	6
Temporomandibular joints	3074	6
Teeth – one area (up to ¼ set)	3075	2
– upper or lower (up to ½ set)	3076	4
– complete (full	3077	7
Salivary gland region	3078	6
Nasopharynx and/or neck – soft tissues	3079	5
Portable neck – soft tissue	3217	5

Specialists in diagnostic radiology (continued)

	Code	Units
Tomography	3080	12

Upper extremity

Shoulder	3081	5
Clavicle	3082	5
Scapula	3083	5
Acromioclavicular joints	3084	5
With weights	3085	7
Humerus	3086	5
Elbow	3087	5
Forearm	3088	5
Wrist	3089	5
Scaphoid	3090	3
Hand (two or more fingers)	3091	5
Hand for soft tissues	3218	5
Finger or thumb	3092	3
Specialized views of any of the above	3093	3
Portable upper extremity	3219	5
Tomography	3094	12

Lower extremity

Hip	3095	5
Hip pinning – interpretation only	3096	6
– supervision and interpretation	3097	20
Femur	3098	5
Knee	3099	5
Patella	3100	3
Lower leg	3101	5
Ankle	3102	5
Os calcis	3103	5
Foot (2 or more toes)	3104	5
Toe	3105	3
Specialized views of any of the above	3106	3
Portable lower extremity	3220	5
Leg length studies (Orthoroentgenogram/scanogram)	3107	6
Full length leg (standing)	3224	6
Tomography	3108	12

Spine and pelvis

Cervical spine – routine	3109	6
With additional views (including obliques)	3110	8
Thoracic spine	3111	6
With additional views	3112	8
Lumbar spine	3113	6
With additional views	3114	8

Specialists in diagnostic radiology (continued)

	Code	Units
Sacrum and/or coccyx	3115	5
Sacroiliac joints	3116	5
Facet joint injections – radiological fluoroscopy control	3117	8
Pelvis	3118	5
Additional views extra	3221	3
Pelvis and hip	3119	6
Pelvis and sacroiliac joints	3120	6
Portable pelvis and spine	3222	6
Spine – scoliosis series	3121	12
Tomography	3122	12

Miscellaneous

Call back to hospital, night or weekend	3311	26
Directive Care visit	4102	16
Interpretation of submitted films – per examination	3123	8

☞ ***Medicare Note: Code 3123 is to compensate a radiologist when radiographs made elsewhere are sent to him/or for written opinion. It does not apply when the radiographs referred to above are used for comparison purposes with radiographs made in the consultant's facility.***

Skeletal survey – 1st anatomical area	3124	6
– each additional anatomical area	3125	3
Screening mammography fee asymptomatic female	3206	13*
Diagnostic mammography fee symptomatic female	3207	23*
Body section radiography – tomogram	3128	12
Sinus tract injection	3129	9
Bone age determination (skeletal maturation)	3130	6
Bone density (mineral content measurement)	3131	12
additional sites	3225	6
Skin thickness measurement	3132	6
Tissue specimen	3223	3
Transvenous cardiac pacemaker placement (temporary or permanent) – radiological control	3133	15
High kilovoltage technique	3134	8
Regional fluoroscopy (specify)	3135	8

Special procedures interpretation only

Myelogram – 1 area	3136	15
– 2 or more areas	3137	23
– posterior fossa	3138	16
Discogram	3139	15
Bronchogram – one side	3140	15
– both sides	3141	22

Specialists in diagnostic radiology (continued)

	Code	Units
Laryngogram	3142	15
Arthrogram	3143	15
Double contrast	3144	15
Velopharyngogram	3145	15
Ventriculogram or encephalogram	3146	16
Angiography		
Peripheral venogram – unilateral	3147	9
– bilateral	3148	14
Venacavagram, inferior or superior		
Bilateral simultaneous injections	3149	15
Using film changer cine or videotape (surcharge not applicable)	3150	23
Arteriography		
Using single films – non-selective	3153	8
– selective	3154	15
Using film changer, cine or videotape (surcharge not applicable) – non-selective	3155	15
– selective	3156	23

Cardiac angiography and angioplasty

Radiologist's interpretation and reporting of any same-day combination of the following procedures done in conjunction with left and/or right heart catheterization: left/right ventriculography, left/right coronary arteriography, bypass graft angiography, aortic arch interpretation, assessment of valves for stenosis/insufficiency/etc., coronary angioplasty, valvuloplasty	3202	88

If an emergency or sudden change in the patient's condition results in additional cardiac angiography on the same day, the radiology component is payable as a separate fee under this code.

Lymphogram	3157	15
Sialogram	3158	8
Dacryocystogram	3159	8
Percutaneous transhepatic cholangiogram	3162	15
Transthoracic lung biopsy with fluoroscopy	3164	15

Computerized tomography

Head scan	3166	50
With enhancement	3167	58
With repeat scan with enhancement	3168	75
Chest	3169	75
Neck	3308	75

Specialists in diagnostic radiology (continued)

	Code	Units
Abdomen	3309	75
Pelvis	3310	75
Extremities/ankle or shoulder	3226	75
Sinus	3230	50
Cervical, thoracic or lumbar	3312	75

Ultrasound

The following unit values are applied to interpretation of diagnostic ultrasound investigations:

Head and neck		
Echoencephalography – mid-line, A-mode	3194	12
Neonate brain	3170	43
Transcranial adult (including doppler)	3227	41
Carotid assessment – unilateral or bilateral, duplex exam	3201	41
Thyroid B scan	3171	22
Thorax		
Chest masses, pleural effusion	3196	36
Breast masses – each breast	3197	22
Heart echography		
Pericardial effusion, M-mode	3172	22
Complete, M-mode	3173	45
With bidimensional imaging	3174	72
Abdomen – complete scan	3175	45
Limited exam – gallbladder, aorta, etc	3176	25
Pelvis	3177	36
Endorectal prostate	3231	66
Endorectal prostate with biopsy	3237	92
Obstetrics, pregnancy – complete	3178	40
Testes, popliteal cysts, ganglia, etc	3198	25
Extremities		
Single vessel vascular study	3179	15
Arterial doppler study – one leg	3238	45
– two legs	3239	90
Deep vein thrombosis – one leg	3240	45
– two legs	3241	90

Notes:

1. A-mode implies a one dimentional ultrasonic measurement procedure.
2. M-mode implies a one dimentional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
3. Scan B-mode implies a two-dementional ultrasonic scanning procedure with a two-dimentional display.

Magnetic resonance images

The following fees include provision of clinical supervision (approving, modifying and intervening in the imaging examination); provision of quality control of all elements of the

Specialists in diagnostic radiology (continued)

	Code	Units
technical components of the procedure; and interpretation of the results of the diagnostic examination.		
Any technique, any number of views, any region of the body, ie. head, neck, spine, chest, abdomen, pelvis, extremities	3208	105
Scans involving more than one region of the body, i.e. head-cervical spine, abdomen-pelvis, cervical spine-dorsal, lumbar spine.		
First region	3209	105
Second region	3210	52
Third region	3211	52
Gadolinium injection (contrast) including additional views and interpretation	3212	31

Clinical and diagnostic procedures

This series of codes includes the clinical procedural services plus the interpretations of acquired imaged views – Additional codes for interpretation section are not to be billed.

Liver biliary system

Percutaneous extraction of bile duct stone under fluroscopy plus cholangiogram	3242	123
Percutaneous transhepatic cholangiogram	3243	90
Percutaneous biliary drainage	3244	301
Biliary stent (in addition)	3286	286
Exchange of drainage tube nephrostomy/biliary under imaging	3252	49
Splenoportogram	3292	66
Percutaneous trans-hepatic portography	3293	88

Urinary

Percutaneous insertion of nephrostomy tube with local anaesthesia under fluroscopy	3245	123
Percutaneous nephrostomy with ureteric dilation or stent insertion under diagnostic imaging	3246	203
Percutaneous establishment of nephrostomy tract for stone extraction	3247	283
Percutaneous renal cystogram	3294	57
Retrograde urethrogram or cystogram without cystoscopy	3295	39
Voiding cystourethrogram	3296	24
Chain (bead) cystogram	3297	55
Hysterosalpingogram (includes procedure, flouroscopy and int) by radiologist	3298	63
Ileal loopogram (conduit)	3299	34

Specialists in diagnostic radiology (continued)

	Code	Units
Other body procedures		
Percutaneous diagnostic tap of fluid collection under diagnostic imaging	3248	51
Percutaneous insertion of drainage tube into fluid collection under diagnostic imaging	3249	77
Percutaneous intra abdominal needle biopsy of solid mass under diagnostic imaging	3250	64
Sinogram (sinus tract injection)	3291	25
Transthoracic lung biopsy with fluoroscopy	3251	66
Percutaneous gastrostomy or jejeunostomy	3255	130
Intubation of small intestine under imaging	3300	30
Hypotonic duodenography with intubation	3301	30
Breast		
Needle localization with mammography	3258	59
Stereotaxic biopsy	3259	105
Mammary ductography	3260	25
Myelogram		
One area	3261	68
Two or more areas	3262	98
Posterior fossa	3263	106
Discogram		
One level	3264	68
Each additional	3265	42
Facet joint injection (per joint)	3266	42
Sacro-iliac joint injection (per joint)	3267	42
Arthrogram		
Single	3268	38
Double contrast	3269	52
Angiography		
Aorto bifemoral and peripheral run-off (including arterial access)	3287	164
Access arterial system and flush	3270	88
Selective arterial injection (includes as many views/ runs as needed; renal, cerebral, vertebral)	3271	59
Pharmacology intervention	3272	19
Super selective plus injection (includes as many vessels as needed)	3273	71
Embolization of vessel (arterial or venous)	3257	71
Percutaneous removal of intravascular foreign bodies (i.e. catheter, snare, ultrasound, angiography	3253	122
Thrombolytic therapy (arterial)	3302	187
Angioplasty (percutaneous transluminal dilation of arterial, venous stenosis and occlusions under local anaesthesia)		
Aorta, iliac, femoral popliteal	3280	277
Renal, brachiocephalic, cerebral	3281	346

Specialists in diagnostic radiology (continued)

	Code	Units
Stent arterial or venous (includes angioplasty)	3288	400
IVC Filter (transjugular or transfemoral)	3289	210
Venography		
Access venous system (central)	3274	96
Selective venous injection (renal, pulmonary, jugular, etc)	3275	59
Peripheral venogram		
unilateral	3276	45
bilateral	3277	86
Transjugular liver biopsy	3256	130
Embolization of vessel (arterial or venous)	3257	71
Tunnelled central venous assessment		
without subcutaneous port	3278	97
with subcutaneous port	3279	168
Stent arterial or venous (includes angioplasty)	3288	400
IVC Filter (transjugular or transfemoral)	3289	210
Thrombolytic therapy (venous)	3303	187
Transjugular intrahepatic portosystemic shunt	3254	494
Velopharyngogram	3304	44
Laryngography	3305	44
Bronchogram		
Unilateral	3306	44
Bilateral	3307	66
Lymphogram		
Single leg	3282	90
Bilateral	3283	142
Sialogram	3284	45
Dacryocystogram	3285	45
Biophysicial profile performed and interpreted by physician	3313	37
Physician present but not performing profile (includes interpretation)	3314	19
Lumbar puncture	3315	31

Specialists in Therapeutic Radiology and Nuclear Medicine

	Code	Units
Radioisotope therapy		
Treatment of hyperthyroidism, or of cardiac disease, per course	4060	46
Radioisotope therapy – carcinoma thyroid – per course	4011	62
Treatment of polycythaemia vera, per course	4012	38
Treatment of metastatic carcinoma of bone, per course (example Strontium)	4013	46
Treatment of ascites or pleural effusion due to malignant disease, excluding any operative procedure	4014	46
Joint injections (includes procedure and interpretation).	4015	28
Radioisotope diagnostic procedures		
Thyroid		
Thyroid uptake – single determination	4016	8
– multiple determination	4017	12
Thyroid scan	4018	18
Thyroid uptake and scan	4019	27
Thyroid in vitro studies	4020	8
Blood		
Blood volume	4021	8
Plasma iron clearance	4022	15
Red cell utilization	4023	15
Red cell survival	4024	15
Sequestration studies	4025	31
Electrolyte spaces	4026	15
Lymphoscintigraphy	4100*	49
Renal urinary system		
Renogram	4028	23
Renal scan	4029	23
Scan plus renogram	4030	38
repeat with ACE inhibitor	4090	61
Renal function study	4031	15
Bladder residual in addition to other tests	4066	15
Testicular scan (including flow study)	4062	39
Voiding cystourethrogram	4094	20

Specialists in therapeutic radiology and nuclear medicine (continued)

	Code	Units
Gastrointestinal tract		
Salivary gland scan	4042	30
Oesophageal transit study	4076	82
Gastric reflux	4093	33
Gastric emptying	4064	63
Gallbladder ejection fraction (includes HIDA)	4079	51
Hepatobiliary scan HIDA (liver, gallbladder and bile duct)	4037	30
Hepatobiliary kinetics	4077	46
Liver scan/spleen scan	4036	23
Hepatobilary post cck	4078	51
Liver and spleen tomoscintigraphy to include liver scan	4074	41
Hepatic tomography RBC to include pool & flow	4075	64
Tag red cell scan	4063	23
GI Bleed search (includes flow studies and tag red cell scan)	4080	46
Delayed imaging after 24 hrs	4081	13*
Abdominal scintigraphy with pertechnetate (Meckels's) including pool and flow	4085	46
Schilling	4038	8
Repeat after intrinsic factor	4039	8
Schilling test with dual isotopes and intrinsic factor	4040	12
Stool protein search	4073	8
Cardiovascular system		
Circulation studies	4044	15
Dynamic flow studies (aorta, branches & veins)	4045	23
Venoscintigraphy	4088	45
Monitoring pharmocology study	4065	56
Myocardial perfusion scan (Thallium)	4068	23
Pericardial effusion scan	4067	23
Myocardial perfusion scan with tomography and Stress	4091	42
Myocardial perfusion scan with tomography resting or redistribution	4092	42
Infarct-avid cardiac scan	4069	23
With tomography	4095	42
Ejection fraction scan	4070	23
Myocardial wall motion scan	4071	44
With ejection fraction	4072	52
Radioisotopic Detection of Cardiac Shunt	4103	40

Specialists in therapeutic radiology and nuclear medicine (continued)

	Code	Units
☞ ***Medicare Note: When codes 4071 or 4072 are done in conjunction with myocardial perfusion scans, bill at 50%.***		
Respiratory system		
Lung scan – ventilation or perfusion	4047	38
– ventilation and perfusion on same day	4048	60
Radioisotopic Pulmonary Aspiration Study	4101	20
Central nervous system		
Brain scan	4049	31
Brain scan and flow study	4050	38
RISA Cisternography	4051	77
Cerebral tomography with HMPAO (includes brain scan)	4084	49
Radioisotopic Study of Ventricular Shunt	4099	39
Skeletal system		
Abdominal scintigraphy with I131 + MIBG all days	4082	50
Bone scan	4052	46
Metabolic studies	4053	23
Bone tomoscintigraphy (includes code 4052)	4083	64
Other systems		
Whole body (non-bone)	4086	46
Parathyroid scans	4055	23
Gallium – tumor and abscess localization	4056	47*
Indium – tagged white blood cell scan	4061	46
Placenta scan	4057	31
Tear duct scintigraphy	4087	40
Tomography – for any nuclear scan, add	4058	29
Scintimammography	4098	40

NEW SITE CODES

Walk-in Clinics - definition

- Primary care services offered through clinics/offices characterized by extended hours of operation; no requirement for an appointment; and episodic care with little or no follow-up.
- There is no standard patient roster – the patient list is constantly changing.

Effective December 12, 2002, site codes will now be assigned to all Walk-in Clinics. Please contact Medicare for any new or existing clinics not listed below. When billing service code 0003, a site code will be mandatory on you claim submission.

New Site Code	Clinic	Address
300	Nashwaaksis After Hours Clinic	Fredericton
301	Regent Street After Hours Clinic	Fredericton
302	St. George Street After Hours Clinic	Moncton
303	Riverview After Hours Clinic	Riverview
304	St. Peter Avenue After Hours Clinic	Bathurst
305	Saint John After Hours Medical Clinic	Saint John
306	New Maryland After Hours Medical Clinic	New Maryland
307	KV After Hours Medical Clinic	Rothesay
308	Chatham After Hours Clinic	Miramichi East
309	Pleasant St. After Hours Clinic	Miramichi West
310	Clinique sans rendez-vous (Bateman St.)	Edmundston
311	After Hours Medical Clinic – Moncton North	Moncton
312	Saint John Outreach	Saint John
313	Clinique Dr Louis N Bourque	Moncton
314	Clinique Après Heures Providence	Moncton
315	Centre Médical Régional de Shediac	Shediac
316	Clinique Après Heures Champlain	Dieppe

317	Charlotte County Family Medicine Clinic	St. Stephen
*318	Main Street Family Medical Clinic	Moncton
*319	Sussex Family Medical Clinic	Sussex
*320	St. Andrews Medical Clinic	St. Andrews

Telemedicine – Effective December 12, 2002

Site codes have been assigned to each hospital facility in the province for telemedicine services. When a service provided via telemedicine is billed, the site code on your claim submission should stipulate the actual facility in which the patient is receiving the service.

Region	Site Code	Facility
1	420	Moncton Hospital
	426	Sackville Memorial Hospital
	438	Albert County Hospital
	445	Stella-Maris-de-Kent Hospital
	448	Dr. Georges L. Dumont Hospital
2	415	Centracare Saint John
	416	Grand Manan Hospital
	429	Saint John Regional Hospital
	431	Saint Joseph's Hospital
	433	Charlotte County Hospital
	434	Sussex Health Centre
3	401	Dr. Everett Chalmers Regional Hospital
	412	Stan Cassidy Centre for Rehabilitation
	417	Harvey Community Hospital
	419	Queen's North Health Complex
	423	Hotel-Dieu of Saint Joseph
	424	Tobique Valley Hospital
	436	Carleton Memorial Hospital
	443	Northern Carleton Hospital
	446	Oromocto Public Hospital
4	409	Hopital regional d'Edmundston
	432	Hotel- Dieu Saint Joseph de Saint-Quentin
	442	Hopital general de Grand-Sault
5	405	Hopital Regional de Campbellton
	408	Hopital St. Joseph de Dalhousie
	411	Restigouche Hospital Centre
6	418	Centre hospitalier de Lameque
	439	Hopital Regional de Chaleur
	440	Centre hospitalier de Tracadie
	441	Centre hospitalier de l'Enfant-Jesus
7	422	Miramichi Regional Hospital Facility